Medical Facilities Planning

Acute Care Services Committee Minutes

April 8, 2009

10:00 am – 12 Noon

The Jane S. McKimmon Center

MEMBERS PRESENT: Michael Tarwater; Bill Bedsole; Greg Beier; Dr. Don Bradley; Dr. Dana Copeland; Dr. Lawrence Cutchin; Dr. Sandra Greene, Jack Nichols; Dr. Zane Walsh; Dr. Dan Myers
MEMBERS ABSENT: Daniel Hoffmann; Medical Facilities Planning Section Staff Present: Victoria McClanahan; Floyd Cogley; Kelli Fisk DHSR Staff Present: Jeff Horton; Lee Hoffman Attorney General's Office: Marc Lodge

Standing Agenda	Discussion	Motions	Recommendations/ Actions
Welcome & Introductions	Mr. Tarwater welcomed members, staff and visitors to the meeting. He noted that the meeting is open to the public, but that the meeting did not include a Public Hearing. Therefore, discussion was limited to members of the Committee and staff, unless questions were directed specifically to someone in the audience.		
Review of Executive Order No. 10: Ethical Standards for the State Health Coordinating Council	Mr. Tarwater reviewed Executive Order 10 Ethical Standards for the State Health Coordinating Council, which had been mailed to the members. Mr. Tarwater gave an overview on the procedures to observe before taking action at the meeting. Each member of the Committee commented on his or her professional and institutional interest. None of the members indicated having a financial benefit that would be derived from any matter coming before the Committee for action. Therefore, no member recused himself or herself from voting on any matter coming before the Committee at the meeting. Dr. Walsh noted that he had a potential conflict of interest with the Inpatient Rehabilitation Methodology since he admitted patients to inpatient rehabilitation beds and that he would probably recuse himself from voting on inpatient rehabilitation bed needs in his HSA.		
Approval of minutes from the September 16, 2008 Meeting	Motion to approve the minutes.	J. Nichols S. Greene	Minutes approved
Review of Acute Care Policies and Acute Care Bed Need Methodology	Ms. McClanahan reviewed the acute care policies and the Acute Care Bed Need Methodology. No recommendations for changes were made.		None .
Update on Acute Care Bed Need Methodology Work Group	Dr. Greene updated the Committee on the Acute Care Bed Need Methodology work group, noting the following: ▪ Adjusted need determination petitions raising concerns about the Acute Care Bed Need growth rate were filed last year ▪ The work group includes two representatives from each HSA, Dr. Copeland (SHCC) and Melanie Phelps (Medical Society) ▪ Work group has met once, since formation, on February 23 ▪ Work group consensus was that using HSA specific growth rates was not appropriate, given the variation in growth within the HSAs ▪ Using county specific growth rates is promising but there are issues with counties with hospitals of 100 or fewer beds and growth rates of five percent or higher ▪ Using a four year rolling average growth rate instead of a three year rolling average growth rate was		No change to the Acute Car Bed Need methodology for the 2010 SMFP. Reconvene the work group in the fall to review additional data and consider changing the methodology spring of 2010

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	discussed ▪ Recommendation to consider small counties with high growth rates as outliers ▪ Recommendation to add a case mix index so that we are not rewarding higher average length of stay ▪ Recommendation to consider changing the occupancy factors used in the methodology ▪ Projecting acute care bed need using county specific growth rates resulted in a need for 790 beds ▪ Work Group member consensus was that given the current economy, now is not the right time to change the methodology such that need for 790 beds is projected ▪ Work group recommends not changing the acute care bed need methodology for the 2010 SMFP and reconvening in the fall to review additional data and to consider changing the methodology spring of 2010 Discussion: ▪ Work group is moving to a different place than expected but appears to be on track ▪ Work group report reiterates how critical and important accurate data are ▪ Whereas serving the underserved is not addressed in the acute care bed need methodology, it is addressed elsewhere in the health planning process, e.g., the awarding of CONs and the Basic Principles ▪ It is not feasible to incorporate case mix index into the methodology and it would not add to the quality of the methodology output ▪ Work group should take adequate time to ensure the best possible outcome ▪ Health policy changes from Washington may impact providing care to the underserved and the balance between inpatient and outpatient care delivery		
Acute Care Policies and Acute Care Bed Need Methodology	Motion made to carry forward the current Acute Care Bed Need Policies & Methodology.	D. Bradley D. Copeland	Motion unanimously approved
Review of Operating Room Need Methodology	Ms. McClanahan reviewed the Operating Room Need Methodology. No recommendations for changes were made.		None
Trauma Case Reporting Update	Ms. McClanahan provided an update on reporting trauma cases excluded from the OR methodology. She noted that the North Carolina Office of Emergency Medical Services (NC OEMS) is in the process of developing a reporting system, which can be queried for trauma cases by hospital. Using the new reporting system would mean accepting the NC OEMS definition of "trauma case". The following motion was made: ▪ For the 2010 Proposed Plan, use the current method for excluding trauma cases from the OR methodology. ▪ Add a note to the Proposed 2010 SMFP describing the NC OEMS reporting system and requesting comments on querying the system for trauma case numbers to be excluded from the OR methodology. Once the new trauma case reporting system is operational, compare data from the system to data submitted by the trauma centers.	J. Nichols S. Greene	Motion unanimously approved
Consideration of Operating Room Petitions	Ms. McClanahan reviewed the Agency Report on the Affordable Health Care Facilities and the Southern Surgical Center petitions. Both petitioners requested approval of a pilot demonstration project for ambulatory surgery centers.		

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	The Agency recommended denial of the petitions given that a Single Specialty Ambulatory Surgery work group is in the process of developing a Single Specialty Ambulatory Surgery demonstration project. Motion made to accept the agency's recommendation to deny the petitions.	 G. Beier J. Nichols	 Motion unanimously approved
Single Specialty Ambulatory Surgery Work Group Update	Dr. Cutchin presented the criteria for the Single Specialty Ambulatory Surgery Demonstration Project developed by the Single Specialty Ambulatory Surgery work group. Discussion included the following: • Question asked about bringing an action in superior court if the Agency determines that a facility is not in compliance with any one of the demonstration project criteria. Response was that the North Carolina Attorney General's office recommended this action as the way to address facilities non-compliance with criteria. • It was noted that handling non-compliance with criteria could possibly be handled by issuing a time limited CON, however it has not been made clear if this action is feasible. • Suggestion made that a termination clause be included as part of the demonstration project application as an alternative to bringing an action in superior court for non-compliance with criteria. Response was that this idea of having a contract with the demonstration project facilities was discussed by the work group but the Agency was unable to find any provision in the law that would allow the Agency to take away a license and terminate a facility's operations due to a contract and facilities would have the right to appeal such termination. Additionally, bringing an action in superior court for non-compliance with criteria is the remedy that is in the current Certificate of Need Law. • Suggestion made that there be some kind of financial consequence if demonstration project facilities are noncompliant with criteria. • Point made that bringing an action in superior court for non-compliance with criteria was the action suggested by the Agency as the best way under current law to address noncompliance. • Suggestion made that demonstration project facilities' CONs are conditioned such that the facilities are required to pay into a fund, such as the State Medicaid fund, if the facilities do not meet the indigent care requirements. • Members asked if they thought that there would be demonstration project applicants who would choose to pay into a fund rather than meet indigent care criteria. • Given that the goal is to provide access to the underserved, suggestion made that those demonstration project facilities that do not meet the indigent care requirements be required to pay double the indigent care requirement amount. • Point made that paying into a fund for noncompliance has been suggested in the past for similar projects and that this idea presented issues precluding its implementation. Reiterated that bringing an action in superior court for non-compliance with criteria was the remedy suggested by the Agency as the best way under current law to address noncompliance. • Suggestion made that if the Agency has to take corrective action and ends up in court to terminate a demonstration projects' CON, the applicant would be disqualified for a period of time. The Agency responded that this idea would need to be researched. • Suggestion made that the AG's office research this idea and advise the work group before May 6 so that the Committee could have answers to the question in time to act on the work group's recommendations before the Proposed Plan is published. • Comment made that the purpose of the demonstration project was to get information about the impact of		Ask the work group to resolve the issues raised today by clarifying definitions and adding more detail, where needed, and provide an update to the Committee at the May 6 meeting.

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	the project and to compare different ways of providing surgical services, therefore providing the SHCC with a plan for proceeding in a way that protects stakeholders' interests, improves patient care, and creates value. Given this, concern was expressed that the Committee not be too focused on anticipating what will happen with the demonstration project because there will be an opportunity to evaluate what we have learned and the SHCC will be able adjust expectations as to, for example, the amount of indigent care that is feasible to expect. Then the SHCC will be able to base any further expansion of the demonstration project on that expectation. The demonstration project should be rich enough in its variability that the SHCC will be able to make legitimate comparisons among different demonstration project facilities. Question asked if after five years, in order to continue to operate, the demonstration project facilities could be required to reapply for a CON under the criteria in place at that time for new or additional single specialty ambulatory surgery facilities. Question remains as to what to do with demonstration project facilities that are not meeting the criteria after five years in operation. • Committee reminded that the work group addressed all the points made in the charge to the work group and was mindful of concerns about expanding the demonstration project, which was one of the reasons the project was limited to three facilities. The work group's consensus was that this project would not harm stakeholders and would provide valuable information that would help the SHCC decide if this is a viable option for providing surgical care to North Carolina citizens. • Committee reminded that one of the most important parts of the recommendations to come from the work group was the recommendation to determine how the test sites will be held accountable and responsible in the event that they are unsuccessful in meeting the criteria. The work group would like the Agency to be able to issue to the demonstration project facilities a time limited CON or use some other clear enforcement mechanism but nothing has come forth so far. • Suggestion that statutory changes, if needed to achieve the work group's goals, should be pursued. • Suggestion that some common quality measures, which have been approved by the Agency, be required of all demonstration project facilities. The North Carolina Center for Patient Safety and Quality was cited as a source of quality and safety metrics. • Support for requiring physicians to establish or maintain "call" for the hospitals was voiced because this would require the physicians to be credentialed by the hospital. • Rationale for "encouraging" rather than "requiring" physicians to establish or maintain "call" for the hospitals was provided – work group wanted to prevent the possibility of a hospital denying a demonstration project facility physician privileges because the physician would be in competition with the hospital. • Question asked if over utilization and self-referring were addressed by the work group – response was that these ideas were not addressed. • Suggestion made that the preference for facilities owned wholly or in part by physicians be eliminated. Noted that the SHCC is moving away from the concept of "qualified applicants" for some healthcare services and that some states are prohibiting physician owned facilities. Response was that by stating a preference for physician ownership, the work group was encouraging an innovative approach and that the spirit of the project was aimed at answering questions about physician owned single specialty facilities. • Suggestion that if six facilities, two in each location, with different ownership structures, were approved then this would provide the SHCC with good data to use to make determinations about the best way for the facilities to be organized and operate. Response was that the work group had much discussion		

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	about the number of facilities to recommend but determined that even with more than three facilities there would still be questions about the best way for the facilities to be organized and to operate. Work group consensus was to start small to minimize harm to the existing hospitals. • Suggestion that the demonstration project facilities be required to have a set of indications and contraindications for the procedures to be done in the facilities and that the facilities be required to adhere to this set of indications and contraindications. • Suggestion that the demonstration project facilities could be compared to existing surgery providers - comparisons could include: indigent care provided and allowed charges. • Suggestion that there be separate requirements for self-pay and Medicaid amounts. Point made that some surgical specialties are almost exclusively self-pay. For example, plastic surgery reimbursement is almost all self-pay but most patients having plastic surgery are not indigent. Surgical specialties differ in the number of self-pay and Medicaid patients typically served – how would we determine for each surgical specialty how many self-pay and Medicaid patients should be served? Concern expressed about making this criteria too complex to manage. • Discussion was summarized as follows: o Objections voiced today are not objections to the demonstration project concept. o Objections show need for increased definition of some of the criteria, such as quality reporting measures, indigent care requirements. o Given that the Acute Care Committee will meet again on May 6, that there will be hearings this summer and additional Committee and SHCC meetings in the Fall, the Committee should not feel pressured to make a recommendation today on the demonstration project. • Question asked if CON applicants applying for operating rooms must meet the same requirements discussed today for the demonstration project facilities. Response was that CON applicants for operating rooms are not required to meet the same requirements but that CON holders are required to materially comply with the representations made in their CON applications. However, ambulatory surgery facility CON holders are required to be accredited within a certain period of time. • Support expressed for the 7% Medicaid/Self Pay patient standard and for using the Medicare allowable when calculating amount of Medicaid/Self Pay revenue. • Point made that the work group tried to place adequate requirements on the facilities to ensure good access and provision of quality care while at the same time enabling the facilities to succeed and be financially viable. • Noted that if the demonstration project is added to the Proposed 2010 Plan, comments could be made on the project and the project could be modified before it is added to the Final 2010 Plan.		
Operating Room Policy & Need Methodology Recommendations	Motion made to carry forward the current Operating Room Need Methodology.	J. Nichols D. Copeland	Motion unanimously approved
Review of: Policy AC-6 (Heart-Lung Bypass Machines) Open-Heart Surgery Services and Heart-Lung Bypass Machines Methodologies	Ms. McClanahan reviewed Policy AC-6 (Heart-Lung Bypass Machines); Open-Heart Surgery Services and Heart-Lung Bypass Machines Methodologies; Burn Intensive Care Services Methodology; and Bone Marrow and Solid Organ Transplantation Services Methodologies. Motion made to carry forward the current Other Acute Care Services Policy & Need Methodologies.	D. Bradley L. Cutchin	Motion unanimously approved

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Burn Intensive Care Services Methodology Bone Marrow and Solid Organ Transplantation Services Methodology			
Review of Inpatient Rehabilitation Bed Need Methodology	Ms. McClanahan reviewed the Inpatient Rehabilitation Bed Need Methodology. Motion made to carry forward the current Inpatient Rehabilitation Services Methodology.	D. Bradley B. Bedsole	Motion unanimously approved
Consideration of Affordable Health Care Facilities License Renewal Application Petition	Ms. McClanahan reviewed the Agency Report on the Affordable Health Care Facilities License Renewal Application petition. The petitioner requested that the SHCC, North Carolina DHHS and DHSR require that prior to submission to DHSR, License Renewal Applications be reviewed and approved by Licensed Certified Public Accountants or be certified in the same way as Medicare Cost Reports are certified. The Agency recommended denial of the petition based on the Agency's view that the content, structure and signature requirements for the License Renewal Applications are within the purview of the Division of Health Service Regulation and not within the purview of the State Health Coordinating Council. Motion was made to accept agency's recommendation to deny the petition.	G. Beier D. Copeland	The motion was unanimously approved
Other Business	Mr. Tarwater stated there was no other business.		
Adjournment	Mr. Tarwater adjourned the meeting.		