Acute Care Services Committee
Agency Report
Petition for Change in Revenue Calculation for the Single Specialty Ambulatory Surgery Demonstration Project in the 2018 State Medical Facilities Plan

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Petitioner:
OrthoCarolina
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Request:
The Petitioner proposes to change the following requirements of the demonstration project:

- Reduce the charity care requirement from 7% to 5%; and
- Exclude the revenue from procedures that do not yet have a Medicare allowable amount or are not currently ASC [ambulatory surgery center] approved by Medicare from the denominator.

Background Information:
In the fall of 2008, the SHCC created a Single Specialty Ambulatory Surgery work group that recommended a demonstration project "to evaluate and test the concept of single specialty ambulatory surgery centers in North Carolina." On May 27, 2009, the SHCC approved plans for the demonstration project, limiting the number to three sites. The 2010 SMFP outlined specific criteria for the three demonstration project facilities. The three demonstration sites are: Piedmont Outpatient Surgery Center in Forsyth County, otolaryngology specialty, licensed February 6, 2012; Triangle Orthopaedics in Wake County, licensed February 25, 2013; and Mallard Creek Surgery Center in Mecklenburg County, orthopaedic specialty, licensed May 1, 2014.

A crucial requirement of the project is to demonstrate that "the percentage of the facility's total collected revenue that is attributed to self-pay and Medicaid revenue shall be at least seven percent, which shall be calculated as follows: the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid cases, divided by the total

collected revenues for all surgical cases performed in the facility" (2010 SMFP). Each facility submits an annual report to demonstrate that it complies with this and other requirements.

Analysis/Implications:

Adjust the Calculation of Total Patient Revenue to Exclude Cases with No Medicare Allowable

As stated in the 2010 SMFP, the "seven percent requirement" exists to assure that facilities provide surgery to underserved populations. The Petitioner describes various challenges it has faced in doing so, including transportation, communication problems, as well as inconsistent attendance of patients and/or caregivers. These and other issues are not unique to Mallard Creek Surgery Center, but have been expressed by other demonstrations sites.

Of the three demonstration sites, Piedmont Outpatient Surgery Center (POSC) has the fewest challenges in meeting the seven percent requirement primarily because 58% of its patients are under 18 years of age,[1] and children comprise about half of those covered by Medicaid.[2] By the nature of the specialty, the two orthopaedic surgery practices primarily see adults. Only 6% of Mallard Creek's patients and 9% of Triangle's patients are under 18.[3]

The primary justification for the Petition is that upon implementation of the demonstration project, the SHCC did not appear to consider situations in which a surgical procedure performed in an ambulatory facility would not have a Medicare allowable fee. In the past several years, commercial insurers have begun to cover more complex procedures in the ambulatory environment that previously would have been done exclusively in hospitals. Medicare does not yet have an allowable fee for all of these procedures. Both Medicare and Medicaid reimbursements are based on the Medicare allowable. If there is no Medicare allowable, then neither Medicare nor Medicaid reimburses for the procedure.[4]

One adjustment requested by the Petitioner involves how revenue from commercial insurers is included in the calculation of the seven percent requirement. Currently, the full amount received by a commercial insurer is included in the total revenue. The Petitioner requests that the revenue be zero if the procedure has no Medicare allowable. To determine the proportion of revenue, the Medicare allowable amount for Medicaid and self-pay patients is divided by the total patient revenue. However, the value in the numerator is zero for those patients with no Medicare allowable. The denominator includes all revenue for all patients regardless of whether there is a Medicare allowable.

Table 1 provides a hypothetical example of the current calculation of fees and revenue for eight patients. Table 2 shows how these amounts would be included in calculation of the seven percent requirement. Note that Patient 6 had a procedure covered by BCBS but the procedure had no

[1] Sheps Center and Truven Health Analytics. (2017) "Hospital Outpatient and Ambulatory Surgery Visits." 2015 Data.
[2] NC Division of Medical Assistance (2017). *North Carolina Medicaid and NC Health Choice: Annual Report for State Fiscal Year 2016.*
[3] Sheps Center and Truven Health Analytics. (2017) "Hospital Outpatient and Ambulatory Surgery Visits." 2015 Data.
[4] In addition, for patients covered by Medicaid, the Medicaid reimbursement may be less than 100% of the Medicare allowable.

Medicare allowable amount.[5] Under the current calculations, Patient 6's BCBS reimbursement is included in the total patient revenue for the facility. Based on this example, the facility had revenue from self-pay and Medicaid patients of 3.8% (see Table 2).

Table 1. Current Revenue Calculation Example

Patient	Insurer	Medicare Allowable	Amount Paid	Revenue
1	None/self-pay /indigent	300	0	300
2	None/self-pay /indigent	0	0	0
3	Medicaid	500	400	400
4	Medicaid	0	0	0
5	BCBS	400	600	600
6	**BCBS**	**0**	**750**	**750**
7	Aetna	300	300	300
8	Medicare	300	300	300
TOTAL		**1,800**	**2,350**	**2,650**

Table 2. Current 7% Worksheet Calculation Example

		Self-Pay	Medicaid	Total
A	# of Surgical Cases	2	2	4
B	Average Medicare Allowable Amount per Surgical Case	150	250	
C	Revenue (A x B)	300	500	
D	Revenue Collected (net revenue by payor category)	300	400	
E	Difference (C-D)	0	100	100
F	Total Net Revenue (all payors combined)			2,650
G	Percentage (E ÷ F)			3.8%

Table 3 provides a scenario that reflects the calculations proposed by the Petitioner. Here, the revenue from Patient 6 is zero, as opposed to $750 in Table 1. The revenue is zero because no Medicare allowable exists for Patient 6's procedure. Using the proposed calculation, Patient 6 would be excluded from the total revenue calculation, thus removing this patient from the denominator; the numbers appear here for illustration purposes only. Table 4 shows the self-pay and Medicaid revenue calculations under the proposed scenario. This change increased the revenue to 5.3% (see Table 4). The actual increase in the percentage depends on the proportion and type of cases that have no Medicare allowable but that are covered by private insurance.

[5] If a procedure is performed on a Medicare patient, but the procedure has no Medicare allowable, this is considered to be charity care.

Table 3. Proposed Revenue Calculation Example

Patient	Insurer	Medicare Allowable	Amount Paid	Revenue
1	None/self-pay /indigent	300	0	300
2	None/self-pay /indigent	0	0	0
3	Medicaid	500	400	400
4	Medicaid	0	0	0
5	BCBS	400	600	600
6	**BCBS**	**0**	**750**	**0**
7	Aetna	300	300	300
8	Medicare	300	300	300
TOTAL		**1,800**	**2,350**	**1,900**

Table 4. Proposed 7% Worksheet Calculation Example

		Self-Pay	Medicaid	Total
A	# of Surgical Cases	2	2	4
B	Average Medicare Allowable Amount per Surgical Case	150	250	
C	Revenue (A x B)	350	500	
D	Revenue Collected (net revenue by payor category)	350	400	
E	Difference (C-D)	0	100	100
F	Total Net Revenue (all payors combined)			1,900
G	Percentage (E ÷ F)			5.3%

Adjusting the revenue calculations in this manner accounts for the lack of reimbursement for some procedures. The Petitioner reports that had Mallard Creek used this recommended calculation method, the percentage of revenue attributable to self-pay and Medicaid would have been 8.9% rather than the 7.8% reported to the Agency for the most recent reporting year. With this change, it is possible that the facility may be more likely to provide complex procedures, which may increase access to more affordable options for some patients.

Lower the Seven Percent Requirement to Five Percent

The Petitioner also requests a reduction of the seven percent requirement to five percent. If the previous request is approved, the facility's total revenue will be lower and the percentage associated with the seven percent requirement will be higher. In the first year of operation Mallard Creek's percentage was 4.8%; in the second year it was 7.6%; and in the third year it was 7.8%. It does not seem necessary to reduce the percentage requirement, especially if the revenue calculation method is changed.

Agency Recommendation:
Eliminating procedures with no Medicare allowable fee from the calculation of total patient revenue is a reasonable way to account for the unforeseen consequences of the original calculation of the seven percent requirement. This change would apply to all three demonstration sites. As Medicare allowable fees become available for procedures, the actual reimbursement for that procedure will be included in the calculation of net patient revenue. This change will, by definition, increase the percentage of revenue attributable to self-pay and Medicaid. Therefore, the reduction of the requirement to 5% is not warranted at this time.

Another issue that has arisen within the Agency and in discussions with the demonstration sites is the accounting basis used for reporting of revenue. The language in Table 6D of the 2010 SMFP refers to revenue "collected." The sites correctly interpret this language in terms of cost accounting to mean that the facility must have received the reimbursement funds. Typically, the facilities use the accrual accounting method to tabulate revenue. That is, revenue is entered into the books when it is earned (generally when amounts are billed); it may be weeks or possibly months before the funds are actually received. Also, the language in the 2010 SMFP is not clear about which patients should be counted in the calculations – all patients seen during the reporting year, or only the patients for whom revenue has been collected. This confusion is an unintended consequence of how the demonstration criteria were worded. The Agency recommends correcting this confusion by changing the language in the applicable criterion from Table 6D of the 2010 SMFP.

With these considerations in mind and given available information and comments submitted by the August 10, 2017 deadline date for comments on petitions and comments, and in consideration of factors discussed above, the Agency makes the following recommendations.

(1) The Agency recommends approval of the request to change the seven percent requirement calculation for all three demonstration sites. Chapter 6 of the SMFP will include the following revised instructions to demonstration sites (replaced language crossed out, new language underlined):

> "the percentage of the facility's total ~~collected~~ earned revenue that is attributed to self-pay and Medicaid revenue shall be at least seven percent, which shall be calculated as follows: the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue ~~collected~~ earned from self-pay and Medicaid cases, divided by the total ~~collected~~ earned revenues for all surgical cases performed in the facility for procedures for which there is a Medicare allowable fee.

(2) The Agency recommends denial of the request to reduce the percentage of revenue attributable to self-pay and Medicaid from 7% to 5%.