Comments on Proposed Operating Room Methodology and Policies
State Medical Facilities Plan Operating Room Work Group

Commenter		*Contact*	
Name:	PDA, Inc.	**Name:**	Nancy M. Lane, President William Holding, Senior Consultant
Address:	PO Box 12844 2016 Cameron Street Raleigh, NC 27605	**E-mail:**	nlane@pda-inc.net wholding@pda-inc.net
		Phone:	919.754.0303

PDA, Inc. appreciates the opportunity to provide commentary to the SHCC regarding potential changes to the Operating Room Need Methodology in the 2018 State Medical Facilities Plan. The workgroup has a challenging, but important task to encourage improved access for operating room resources for all residents of North Carolina. PDA recommends the following:

1. The OR Workgroup should recognize the Findings of Fact (GS131E-175(3a) in the NC CON Statute and support the viability of Critical Access Hospitals in North Carolina by specific policy.

   > *That access to health care services and health care facilities is critical to the welfare of rural North Carolinians, and to the continued viability of rural communities, and that the needs of rural North Carolinians should be considered in the certificate of need review process*

2. The OR Workgroup should give consideration to how much operating room capacity a service area population can support.
3. County rather than health system need better balances supply and assures access to medically underserved groups. Need determinations should not be limited to the facility that generates the need.
4. North Carolina licensure regulations are such that a need for one operating room in the Plan creates an opening to develop a freestanding facility with capacity equivalent to an unlimited number of operating rooms.
5. The proposed working models demonstrate the sensitivity of methodology variables to the large volume of ophthalmology surgery in the state. A methodology that fails to address facilities exclusively dedicated to eye surgery can have an unintended consequence of generating need for substantial excess capacity. Eye facilities are unique because there are so many and their highest volume procedures take such little time. Not all single specialty facilities will have the same case time. For example, cataract surgeries are quick but dental surgeries can average 90+ minutes.
6. Rounding up can also create more need than a rural county can reasonably absorb.
7. All models built on facility history will disadvantage organic population growth and create cliffs at the borders of growing metro areas. Non-metropolitan counties from which many patients migrate to urban centers are disadvantaged by both the current and the proposed OR methodologies.
8. Case time use is a better predictor of need than case volume. However, use of average case times by facility type should carefully consider the actual historical range of times in the group.
9. A reasonable model should have a factor to overlay total metro areas.

Specific comments and recommendations relating to these statements follow.

1. The OR Workgroup Should Support the Viability of Critical Access Hospitals in North Carolina

Comments

- Presently, according to the 2017 SMFP, North Carolina has 21 designated Critical Access Hospitals (CAH).
- CAH provide vital services to North Carolina residents in rural areas who would otherwise have limited access to emergency, inpatient and outpatient medical services.
- Competition benefits residents of North Carolina. However, the benefits of competition do not outweigh benefits of comprehensive emergency, acute, and outpatient services provided by CAHs.
- Where competition will require reducing surgical case volume at critical access hospitals, policy and methodology should either reduce calculated need or prevent competition.
- Although Medicare pay CAHs 101 percent of "eligible" costs, and Medicaid pays 100 percent, CAHs rely on income from service to other payors to offset the true cost of providing acute care, including emergency and surgery, to Medicare, Medicaid, underinsured and charity patients.
- Income from outpatient surgery plays an important role in this essential reimbursement offset.
- A new ambulatory surgical facility in a county or a service area with a CAH may or may not have an adverse impact on a CAH. (Figure 6.1 in the SMFP defines Service area).
- As a safeguard the Plan should have a mechanism to assure that applications filed for a need identified by the methodology protect essential CAH revenue.

Recommendations

- The OR Workgroup should add a policy to the 2018 SMFP to protect CAH's.
- The policy should that require applicants proposing to add operating rooms to service areas that include CAHs to include in the application a letter from the CAH indicating that the project will not have an adverse impact on the CAH and its patients.
- A new policy, AC-7, would have the following wording:
    - *"To ensure the viability of Critical Access Hospitals in North Carolina, addition of one or more operating rooms to a service area in which a critical access hospital operates is only permitted if the certificate of need application includes a signed letter from an authorized representative of the Critical Access Hospital stating that the project will not have an adverse impact on the CAH's ability to provide comprehensive emergency, inpatient and outpatient medical services to residents of the CAH service area. This is consistent with G.S. 131E-175 (3a) which states that the needs of rural North Carolina should be considered in the certificate of need process."*

- In a service area with a Critical Access Hospital, rounding up should not occur if the Critical Access Hospital itself does not report 90 percent utilization of its operating room capacity based on an assumption of 2,106 case hours per operating room per year. The hours assume 260 days a year 9 hours a day.

2. Non-Metropolitan Counties from Which Many Patients Migrate to Urban Centers are Disadvantaged by Both the Current and the Proposed OR Methodologies

Comments

- The models currently proposed by the OR workgroup favor the continued growth of operating room inventory in urban centers rather than suburban or rural counties. Each model proposed, whether a tiered model or the facility-based case time model, does not account for patient origin. As a result, the model rewards counties in which procedures occurred by allocating them more resources rather than allocating resources to the counties from which the patient came.
- There is significant migration across county lines for surgical services in North Carolina. For example, more patients from Rockingham County receive surgery in Guilford County than in Rockingham County.
- The migration is, in part, due to the centralization of specialized surgical services in urban areas, which is unlikely to change in the short term. However, some of the migration may be due to the lack of capacity or adequate facilities from the perspective of physicians and patients in rural and suburban counties.

Recommendations

- PDA supports methodologies and policies that encourage services to move closer to where patients live. If a significant number of patients travel long distances for surgery and could otherwise be treated closer to home, the planning methodologies and policies should support additional options. PDA recognizes that busy hospitals must be able to keep pace with surgical demand by having adequate OR capacity, however even large AMCs may wish to pursue plans for new operating rooms or ASCs across county lines if such plans are both viable and would better support patient needs. Any movement across county lines should also consider the impact on critical access and safety net providers.
- As a result, PDA supports a policy that would allow organizations to apply for operating rooms in counties adjacent to where need is generated if a particular set of conditions is met. PDA recognizes the specific of such a policy would need be discussed, however the we suggest the following:
    - Proposed conditions to place an operating room in a county *without* a need determination per the methodology:
        - The county in which the proposed facility will be placed must be adjacent to a county with a need determination

- The county in which the proposed facility will be placed must provide at minimum, 2,496 ambulatory surgical cases to the adjacent "anchor county." This amount is reasonable. Assuming a 90-minute ambulatory case time and the current SMFP OR capacity of 1,872 case hours, one OR can support 1,248 procedures. This requires a county to provide twice that number to the "anchor county" to qualify for a OR under this proposal.
- The county in which the proposed facility will be placed must *not* have a raw calculated operating room surplus
- A critical access or safety net provider does not serve the county in which the facility would be placed.
- To be approved for a CON under this policy, an applicant must demonstrate, using reasonable assumptions, that sufficient patients that previously crossed county lines into the "anchor county" for surgical services will use the proposed operating room(s) such that the proposed operating room(s) are viable.
- Proposals under this policy would be reviewed in the same batch as those of the "anchor county" and would be considered competitive proposals.
- Total operating rooms approved under this policy must be deducted from the total need determination in the "anchor county" such that no more operating rooms than in the anchor county need determination can be awarded in the batch.

- Based on analysis of current proposed models in the OR workgroup, this policy would only have the potential to affect a small number of counties currently. Depending on the model selected, these could include Davie and Granville counties.

3. Need Determinations Should Not be Limited by Facility

Comments

- PDA understands the need to ensure that hospitals, whether large, academic facilities or not, should be afforded the opportunity to have adequate operating capacity such that each facility can limit delays in surgery and provide the best patient care possible.
- However, we do not believe the OR Workgroup should consider the recommendation from Wake Forest Baptist University Hospital to limit need determinations generated by academic, "Tier 5," hospitals to only those facilities which generated the need.
- It is vitally important the state planning process not inhibit the ability for WFBU or any other hospital from providing efficient and high-quality patient care. However, the planning process should allocate resources to a service area, not a facility, just as it does with other need methodologies. By allocating resources to a service area, providers or potential providers are encouraged to compete and propose options which could benefit patients by reducing cost of service, improving accessibility, improving quality, or encouraging innovation. Other providers in the same market as AMCs should be encouraged to consider

alternatives which could help ease capacity issues at the hospital and better serve patients. For example, WFBU might consider a joint venture with other providers in a new ambulatory surgery center, which would ease capacity issues at their main hospital. That option would be eliminated if the need determination were only awarded to a single, legal entity.

Recommendation

- PDA recommends maintaining service area based need determinations, regardless of volume or capacity at any single facility within a service area.