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Chairman, North Carolina State Health Coordinating Council
c/o Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, NC 27699-2714

MISSION HOSPITAL

August 14, 2015

Re: Comments Opposing the Petition Submitted by Blue Ridge Bone & Joint Clinic for a Single Specialty, Two Operating Room, Ambulatory Surgical Facility Demonstration Project in the Buncombe-Madison-Yancey Operating Room Service Area in the *2016 State Medical* ***Facilities Plan***

Dear Dr. Ullrich:

Mission Health (Mission) appreciates an opportunity to comment on the Petition submitted by Blue Ridge Bone & Joint Clinic (BRBJ) for a Single Specialty, Two Operating Room, Ambulatory Surgical Facility Demonstration Project in the Buncombe-Madison-Yancey Operating Room Service Area in the *2016 State Medical Facilities Plan* (*2016 SMFP*) (2015 Petition). The Petition is essentially the same Petition submitted by the Petitioner in 2014. No additional facts or details which would support approval of the Petition have been provided by the Petitioner. Therefore, the SHCC should once again deny the Petition.

A. SMFP Single Specialty Ambulatory Surgery Demonstration Project

Beginning in the fall of 2008, the SHCC's Single Specialty Ambulatory Surgery work group met and drafted recommendations for a Demonstration Project "to evaluate and test the concept of single specialty ambulatory surgery centers in North Carolina."

The SHCC approved plans for the Demonstration Project on May 27, 2009, which included three ambulatory specialty sites. The Petitioner requested Buncombe County be included in the original demonstration project and was denied.

The *2010 SMFP* outlined criteria for the three Demonstration Project facilities. On page 85 of the 2010 SMFP, the following Criterion was defined for the Demonstration Project facilities, with emphasis added:

> "The Agency will evaluate each facility **after each facility has been in operation for five years**. **If** the Agency determines that the facilities are meeting or exceeding all criteria the work group encourages the SHCC to consider allowing expansion of the single specialty ambulatory surgical facilities beyond the three demonstration sites."

Consistent with the terms of the criteria outlined in the *2010 SMFP*, three certificates of need were awarded. All three Single Specialty Ambulatory Surgery Center Demonstration Projects are now licensed and operational. They are:

1. Piedmont Outpatient Surgery Center, LLC, which has been operational for three years;
2. Triangle Orthopaedics Surgery Center, which has been operational for two years; and
3. University Surgery Center, LLC d/b/a Mallard Creek Surgery Center, which has been operational since May 2014.

To date, none of the three projects have been operational for the five years; therefore, none have met the five year Criterion. Two Single Specialty Ambulatory Surgery Center Demonstration Projects have been found to be in substantial compliance with the Demonstration Project criteria outlined in the *SMFP* and the Certificate of Need. The third has just finished its first year and recently submitted its first Single-Specialty Demonstration Project Annual Evaluation Report. The following table summarizes data from both the Annual Ambulatory Surgical Licensure Renewal Applications and the Single-Specialty Demonstration Project Annual Evaluation Reports submitted by these providers in the last three years.

Single-Specialty Demonstration Project Data

	2012		2013		2014	
	LRA	Facility Evaluation Report	LRA	Facility Evaluation Report	LRA	Facility Evaluation Report
University d/b/a/ Mallard Creek - Orthopedic					**Oct - Sep**	**May - Apr**
Medicaid Pts					2	59
Self Pay Pts					5	48
Total Pts					190	
Percent Medicaid and Self Pay Pts					3.68%	
Medicaid and Self Pay Percent of Total Net Revenue Reported						**4.9%**
Triangle - Orthopedic			**Oct - Sep**	**Mar-Feb**	**Oct - Sep**	**Mar-Feb**
Medicaid Pts			23	151	91	262
Self Pay Pts			26	56	223	45
Total Pts			632		1850	
Percent Medicaid and Self Pay Pts			7.75%		16.97%	
Medicaid and Self Pay Percent of Total Net Revenue Reported				**9.33%**		**7.77%**
Piedmont - ENT	**Oct - Sep**	**Jan-Dec**	**Oct - Sep**	**Jan-Dec**	**Oct - Sep**	**Jan-Dec**
Medicaid Pts	130	582	720	684	610	643
Self Pay Pts	12	40	28	22	32	20
Total Pts	945		1930		1968	
Percent Medicaid and Self Pay Pts	15%		38.76%		32.62%	
Medicaid and Self Pay Percent of Total Net Revenue Reported		**12.36%**		**9.22%**		**7.02%**

Source: Annual Ambulatory Surgical Licensure Renewal Applications; Single-Specialty Demonstration Project Annual Evaluations

As shown in the previous table, two of the providers exceeded the 7.0% Medicaid/Self Pay percent of net patient revenue goal in the first year. One did not. The Medicaid/Self Pay

percent of net patient revenue decreased in both year two and year three for Piedmont and the Medicaid/Self Pay percent of net patient revenue decreased in year two for Triangle.

The demonstration is for a five year timeframe to measure the long-term effectiveness of the project. The SHCC should wait until the original demonstration is complete and fully evaluated prior to adding any additional single-specialty ambulatory surgical need determinations in the SMFP.

B. Previous Petitions Submitted by the Petitioner have been Denied by the SHCC

In 2009, the Petitioner petitioned the SHCC to add Buncombe County as a site to the Single Specialty Ambulatory Surgery Facility Demonstration Project. In 2010, 2011, 2012, 2013, 2014, and 2015 respectively, BRJB submitted a petition to approve a demonstration project for a single specialty, two operating room ambulatory surgery facility in the Buncombe-Madison-Yancey Operating Room Service Area.

The SHCC denied all previous petitions from BRJB, basing its denial upon the following principles:

1. Limit the Demonstration Project to three sites initially
2. Evaluate each facility after each facility has been in operation for five years
3. Consider expanding the number of facilities beyond the original three demonstration sites only if the Agency determines that the facilities are meeting or exceeding all criteria.

The SHCC must wait until all three Demonstration Project facilities are operational for five years, and each found to have demonstrated substantial compliance with the Demonstration Project criteria outlined in the *SMFP* and the Certificate of Need before it considers expansion of the number of facilities beyond the original three.

In addition, the Agency Recommendation related to the Petitioner's 2011 Petition, the Agency stated that:

> [...] no conclusions have been drawn, 'positive' or 'negative,' about the impact of [the three demonstration project] facilities. Indeed, the purpose of the demonstration project is to test that hypothesis. The Agency also wishes to clarify that the three demonstration project sites were authorized in the *2010 SMFP* and **no additional** demonstration sites were authorized in the *2011 SMFP*. As noted above, the underlying concept of the demonstration project was to '...evaluate each facility **after each facility has been in operation for five years** [...].' [**Emphasis** in the original].

The Agency added:

> [...] 'the opportunity for competition' by itself is not a goal of the *SMFP* and that the anticipated '**positive impact** on quality, cost and access' [of the three demonstration project facilities], **has not yet been affirmed**. [**Emphasis** added.]

Accordingly, Mission respectfully requests that the SHCC act consistently with the Agency's precedent to deny the 2015 Petition.

C. Existing Orthopaedic Ambulatory Surgery Center in Buncombe County

According to its 2015 Ambulatory Surgery Center License Renewal Application, the Orthopaedic Surgery Center of Asheville has a medical staff of 30 with three licensed operating rooms in Asheville. In FY 2014, the Orthopaedic Surgery Center of Asheville performed 3,201 ambulatory surgical cases, 3,069 of which were orthopedic cases and 132 were podiatry cases, in its three licensed operating rooms.

The following table calculates the available capacity at the Orthopaedic Surgery Center of Asheville based on *SMFP* planning threshold of 1,872 hours per operating room per year which represents 80% of total capacity: 2,340 total hours per operating room per year. With three operating rooms, surgically capacity of the Orthopaedic Surgery Center of Asheville equals 7,020 hours using *SMFP* definitions.

Orthopaedic Surgery Center of Asheville
Operating Room Capacity: FFY 2012 to FFY 2014

October-September	FY 2012	FY 2013	FY 2014
Total Ambulatory Surgical Cases	2,968	3,106	3,201
Total Estimated Hours per Ambulatory Surgical Case	1.5	1.5	1.5
Total Estimated Hours	4452	4,659	4,802
SMFP Operating Room Capacity: Hours per Operating Room per Year	2,340	2,340	2,340
OSCA Total Capacity – Hours per Room x 3 ORs	7,020	7,020	7,020
Utilization of Total Capacity	**63.4%**	**66.4%**	**68.4%**
SMFP Planning Threshold: Hours per Operating Room per Year	1,872	1,872	1,872
Operating Rooms Needed per Year	2.4	2.5	2.6

Source: SMFP; LRAs

As reflected in the previous table, current utilization of the three existing orthopedic specialty operating rooms in Buncombe County is less than 80% based upon SMFP defined parameters.

Mission respectfully requests that the SHCC fully appreciate the existence of a robust physician-owned orthopedic ambulatory surgery center with available surgical capacity in the Buncombe-Madison-Yancey Operating Room Service Area and deny the 2015 Petition.

D. Operating Room Surplus in Buncombe-Madison-Yancey Service Area

The Instructions for Writing Petitions for Adjustments to Need Determination states:

> [a]t minimum, each written petition requesting an adjustment to a need determination in the [*Proposed 2016 SMFP*] should contain:
>
> [...]
>
> 4. Evidence that health service development permitted by the proposed adjustment would not result in unnecessary duplication of health resources in the area.

In the Agency Recommendation to deny the 2014 Petition, the Agency stated:

> The SHCC has consistently decided not to allow any additional Single Specialty Ambulatory Surgery Demonstration Projects for a service area with a projected surplus before the project data regarding impact of the model can be received and evaluated.

At the time of the September 2014 Agency Recommendation, Table 6B of the *Proposed 2015 SMFP* projected a **surplus of 3.72** operating rooms in the Buncombe-Madison-Yancey Operating Room Service Area in 2017.

Table 6B of the *Proposed 2016 SMFP* projects a **surplus of 4.27** operating rooms in the Buncombe-Madison-Yancey Operating Room Service Area in 2018.

The **projected surplus** of operating rooms has **increased 115%** (4.27/3.72) in one year. Further, since the 2013 SMFP, the **projected surplus** of operating rooms in the Buncombe-Madison-Yancey Operating Room Service Area **has increased from a surplus of 1.12 to a surplus of 4.27** operating rooms.

The existence of a surplus of operating rooms in the Buncombe-Madison-Yancey Operating Room Service Area is evidence that the development of the proposed demonstration project for a single specialty, two operating room, ambulatory surgical facility would be an unnecessary duplication of services in the Buncombe-Madison-Yancey Operating Room Service Area.

E. Existing Operating Room Inventory in Buncombe-Madison-Yancey Service Area is Adequate and Proportional

Petitioner claims that there is an "inordinately large percentage of [inpatient operating rooms] and shared [operating rooms]" in Buncombe County. This is not accurate as illustrated by the following table which shows a comparison of operating room inventory by type as a percentage of total licensed and approved operating rooms in Buncombe, Mecklenburg, and Wake counties, respectively.

Comparison of Inventory by Type
As Percentage of Total Licensed and Approved Operating Rooms: FY 2014

County	Inpatient Operating Rooms as % of Total Operating Rooms	Ambulatory Operating Rooms as % of Total Operating Rooms	Shared Operating Rooms as % of Total Operating Rooms
Buncombe	15.7%	25.5%	58.8%
Mecklenburg	14.7%	24.7%	60.6%
Wake	13.5%	28.8%	57.7%
Three County Combined	15.1%	26.2%	59.3%

Source: Exhibit 3
Note: Total Inventory as per *Proposed 2016 SMFP*, Table 6A (includes CON Adjustments, Demonstration Project ORs) with no exclusions

The previous table documents that the Buncombe percentage of licensed and approved ambulatory operating rooms as a percentage of total operating rooms exceeds the percentage in Mecklenburg County. Buncombe also has a lower percentage of licensed and approved shared operating rooms as a percentage of total operating rooms than Mecklenburg County.

Further, if available operating room capacity is adjusted to reflect all ORs excluded for one reason or another for planning purposes the percentage of available ambulatory surgery rooms in Buncombe County increases.

Comparison of Inventory by Type
As Percentage of Licensed and Approved Operating Rooms with Exclusion: FY 2014

County	Inpatient Operating Rooms as % of Operating Rooms w/ Exclusions	Ambulatory Operating Rooms as % of Operating Rooms w/ Exclusions	Shared Operating Rooms as % of Operating Rooms w/ Exclusions
Buncombe	10.4%	27.1%	62.5%
Mecklenburg	5.9%	26.3%	67.8%
Wake	3.0%	30.3%	64.6%
Three County Combined	5.7%	27.8%	65.9%

Source: Exhibit 3

Note: Total Inventory as per *Proposed 2016 SMFP*, Table 6A (excludes C-Section and Burn-Trauma and other SMFP Adjustments, Demonstration Project ORs) with exclusions

The previous table documents that the Buncombe percentage of licensed and approved ambulatory operating rooms as a percentage of operating rooms with all SMFP planning exclusions by category exceeds the percentage in Mecklenburg County. Buncombe also has a lower percentage of licensed and approved shared operating rooms as a percentage of total operating rooms than the other two counties.

The Petitioner also implies that few ambulatory surgical procedures are performed in shared operating rooms. Mission has 47 licensed operating rooms as reflected on its 2015 Licensure Renewal Application; 30 of the 47 operating rooms are shared operating rooms providing both inpatient and outpatient surgical procedures and 9 of the 47 are dedicated ambulatory operating rooms. Over 36% of total surgical time utilized in 28 of the 30 shared operating rooms[1], or the equivalent of around 10 operating rooms, is utilized for ambulatory patients. This characterization is factually incorrect, incomplete and misleading.

Utilization of surgical services, both ambulatory operating rooms and shared operating rooms at Mission show additional capacity available as reflected in the following table.

Mission Hospital – Utilization of Licensed Operating Rooms

	Number of Operating Rooms	Utilization
Total All Operating Rooms	47	65.0%
Total Operating Rooms Less Dedicated Open Heart (6), C-Section (2) and Vascular (2) Operating Rooms	37	71.0%
Dedicated Ambulatory Only	9	63.5%
Shared ORs Only (30 Shared – 2 Vascular ORs)	28	73.4%

Source: 2014 Mission LRA; Exhibit 3

Note: Vascular ORs are shared ORs dedicated for vascular procedures both inpatient and outpatient

As shown in the previous table, utilization of the 37 operating rooms available (shared plus dedicated) for outpatient surgical patients is only 71.0%. Further, the available surgical hours in the nine dedicated ambulatory surgical operating rooms are utilized at only 63.5%, which is 1.3% less than in the previous year. Additional capacity is available in both the dedicated and shared operating rooms at Mission as illustrated in the above table.

It should also be noted, that the Mission Ambulatory Surgery Center currently operates at 63.5% of capacity as reflected above and has ample time available for additional orthopedic ambulatory surgery cases.

[1] 30 total shared ORs – 2 Vascular OR. Percentage calculation included in Exhibit 3

F. Comparison of Ambulatory Surgical Payor Mix: Orthopaedic Surgery Center of Asheville and Mission Hospital

In its evaluation of the performance of each Demonstration Project facility, each facility is to provide to the Agency the number of and payor source of the patients it served. Using that data, the Agency must verify that the facility's total revenue attributed to self-pay and Medicaid was at least 7%.

Mission believes that it is valuable for the SHCC to review the ambulatory surgical payor mix of the existing physician-owned orthopedic ambulatory surgery center in Buncombe County with the ambulatory surgical payor mix of Mission.

The following table shows the FY 2014 payor mix for patients of the Orthopaedic Surgery Center of Asheville, based on information reported by the facility in its 2015 Ambulatory Surgery Center License Renewal Application.

Orthopaedic Surgery Center of Asheville
Ambulatory Surgical Case Payor Mix: FY 2014

Primary Payor Source	Number of Cases	Percentage of Cases
Self Pay/Indigent/Charity	**10**	**0.3%**
Medicare & Medicare Managed Care	1,192	36.5%
Medicaid	**167**	**5.1%**
Commercial Insurance	1,680	51.4%
Other – Workers Comp/Federal	221	6.7%
Total	3,270	100.0%

Source: 2015 ASC LRA, page 7 (Reimbursement Source)
Note: The number of cases reported by payor is less than the number of cases reported on page 6. No explanation is provided for the difference.

The previous table documents that **only 5.4%** of the total ambulatory surgical **cases** performed at the Orthopaedic Surgery Center of Asheville are performed on patients whose **primary payor source** is **Self Pay/Indigent/Charity and Medicaid**. This is less than the Self Pay/Indigent/Charity and Medicaid provided in FFY 2013. It is not possible to verify facility's **total revenue** attributed to self-pay and Medicaid was at least 7%; however, to attain the 7% target required for the demonstration project, Piedmont and Triangle both had to have considerably more than 7% of their patient mix as Medicaid and Self Pay as reflected in the previous discussion in Section A.

For comparison purposes, the following table shows FY 2014 payor mix for ambulatory surgical patients at Mission, based on information reported in its 2015 Hospital LRA.

Mission Hospital
Ambulatory Surgical Case Payor Mix: FY 2014

Primary Payor Source	Number of Cases	FFY 2014 Percentage of Cases
Self Pay/Indigent/Charity	**559**	**2.7%**
Medicare & Medicare Managed Care	8,095	38.7%
Medicaid	**2,725**	**13.0%**
Commercial Insurance	173	0.8%
Managed Care	8,716	41.5%
Other (Worker's Comp, Champus, other governmental agencies)	720	34.3%
Total	20,988	100.0%

Source: 2015 Hospital LRA, page 7 (Reimbursement Source)
Note: Asheville Surgery Center (9 dedicated ambulatory surgery operating rooms) is included by Mission Hospital in its cumulative ambulatory surgery volume, patient origin, and payor mix reported on its 2015 Hospital LRA

The previous table documents that **15.7%** of the total ambulatory surgical **cases** performed at Mission are on persons whose **primary payor source** is **Self Pay/Indigent/Charity and Medicaid**. Therefore, Mission's Self Pay/Indigent/Charity and Medicaid payor mix **exceeds** that of the Orthopaedic Surgery Center of Asheville by **291%** (15.7%/5.4%).

The most recent payor mix data substantiates that the ambulatory surgical needs of **Self Pay/Indigent/Charity and Medicaid** patients in the Buncombe-Madison-Yancey Operating Room Service Area are better met by Mission than the physician-owned orthopedic ambulatory surgical center in Buncombe County.

Further, the Petitioner does not discuss how a "demonstration specialty ambulatory surgery" in Buncombe County would impact payor mix at the existing specialty Orthopaedic Surgery Center of Asheville.

The composition of patients served by a physician practice is, by its nature, different from the composition of patients who would be seen by an ambulatory surgical facility. The payor mix of a physician practice includes all patients seen by the practice. In comparison, the BRBJ physicians cannot perform procedures on every patient they treat at an ambulatory surgical facility due to the nature and limitations of any ambulatory surgical facility. Some patients have comorbidities and other medical conditions which require that any surgery performed on them be done in a hospital setting. Additionally, ambulatory surgical facilities do not have emergency departments and are not required to meet the same obligations with respect to treating patients presenting with emergency medical conditions that apply to hospitals. Accordingly, the physicians of a practice refer and treat patients in a hospital setting that they would not see in an ambulatory surgical setting.

The Petitioner has likewise provided no quantitative data with respect to uninsured patients, who may or may not fall within the category of charity care patients.

G. Physician Ownership of Asheville Surgery Center

Asheville Surgery Center (ASC) is a hospital based surgery center, located separately from the Mission campus. ASC has 9 dedicated ambulatory surgery operating rooms and 2 procedure rooms. In FY 2015, Asheville Surgery Center operated at less than 65% of its capacity; a total of 8,921 ambulatory surgical cases were performed in nine operating rooms[2]. That surgical volume is reported on Mission's 2015 Hospital LRA.

However, ASC has a unique design and is a joint venture between Mission Hospital and Asheville Surgeons. While licensed as part of Mission, the facility is separately located on the Mission campus in a building owned by local surgeons. Surgeons not only own the building and utilize the surgical facility, but are also actively involved in the governance of the surgery center. Using a performance-based management model, improvements made in the last year alone include.

- New Surgery and Block Scheduling Policies which became effective February 1, 2014
- Monitoring of utilization criteria which became effective February 1, 2014
- Blocks less than 4 hours or greater than 12 hours were reviewed and reallocated, adjusted or continued, based on discussion with the holding physician or group
- Blocks below a utilization of 40% were reviewed and reallocated, adjusted or continued, based on discussion with the holding physician or group
- Blocks below a utilization of 60% were reviewed and discussed with the holding physician or group
- Blocks below a utilization of 60% at the end of July, 2014 are being adjusted, based on discussion with the holding physician or group
- Staggered start times for morning blocks and first case criteria for first come-first serve will became effective February 1, 2014
- Advance and Automatic Release Times and Criteria became effective February 1, 2014
- The policy Physician Collaboration and Adherence to Policy became effective April 1, 2014
- Urgent Classifications became effective April 1, 2014
- City Call Room and Urgent Room(s) are being addressed when first come-first serve availability on the Mission Campus is evaluated and documented to be appropriate, with a target of July 1, 2014

[2] ASC capacity = 2,340 surgical hours per OR = 9 x 2340 =21,060 surgical hours. Total ASC outpatient surgical cases = 8,921 x 1.5 hrs per case = 13,382 total surgical hours in FFY 2014. Utilization = 13,382 / 21,060 = 63.5% of total capacity at ASC. Note: this volume and utilization is less than FFY 2013.

H. Theoretical Cost Savings to Medicaid from Single Specialty Ambulatory Surgery Center Demonstration Projects are Simplistic and Overstated

The 2015 Petition reflects on potential cost savings to Medicaid on pages 7 through 9. Petitioner contends that adding ambulatory surgery centers will result in saving 70 to 150 million dollars however the data provided on pages 7 through and 10 of the petitioners 2015 Petition are simplistic and fail to address several key issues.

Petitioner does not provide any data, details, or information regarding potential savings associated solely to orthopedic cases, ENT cases, or any specialty cases, just total outpatient cases.

Second, Medicaid has a process which defines outpatient surgery by category:

- those which are appropriate to be performed in an ambulatory surgery center; and
- those which are not appropriate to be performed in an ambulatory surgery center, that must be performed in a hospital outpatient setting.

Petitioner does not subset the outpatient surgical data (presented on page 10) to compare only cases which by definition can be performed in an ambulatory surgery center, but includes all Medicaid patients, including those with co-morbidities at higher risk and higher costs. If it wishes to, North Carolina Division of Medicaid Services can expand the list of surgical procedures approved for ambulatory surgery centers; such change can occur independently of and does not necessitate the SHHC's approval of additional single specialty ambulatory surgery center demonstration projects.

Third, the data (presented on page 10) does not address the fact that many Medicaid patients have co-morbidities and disabilities, and does not remove from the data those higher risk patients receiving ambulatory surgical services at hospitals. Health disparities for many diseases are large and long-standing in North Carolina and throughout the nation. For example, a study published in the July/August 2010 issue of the North Carolina Medical Journal examined medical care costs for diabetes and documented that the diabetes prevalence among adult Medicaid enrollees was 15.7% compared with 9.1% for all North Carolina adults.[3]

The Agency's response to this data in the 2014 Petition is below.

> *Furthermore, data was presented in the petition to support the cost efficiency of procedures performed in the ASC as compared to those performed in hospitals for both Medicaid and the State Health Plan; differences in costs per case in 2012 were $160.99 and $2,030.55, respectively. This data does not take into account the different acuity levels of patients in hospitals as compared to ASC facilities.* ***Further analysis would need to be performed in***

[3] http://www.ncmedicaljournal.com/archives/?medical-care-costs-for-diabetes-associated-with-health-disparities-among-adult-medicaid-enrollees-in-north-carolina

order to take into account patient profiles and disease severity such that actual cost savings could be accurately assessed. [emphasis added]

Petitioner did not provide any further analysis to take into account patient profiles and disease severity and therefore there is no reasonable way any conclusion regarding actual cost savings can be accurately assessed. The development of additional specialty ambulatory surgery centers in North Carolina will not address the needs of the population at highest risk and with high costs.

I. Theoretical Cost Savings from Single Specialty Ambulatory Surgery Center Demonstration Projects will be Irrelevant as Payors Move to Site-neutral Payments

The 2015 Petition discusses cost-effectiveness of ambulatory surgery centers. The 2015 Petition outlines "three scenarios for projected cumulative costs for Medicaid and the State Health Plan related to ambulatory surgery." Each scenario is based on a shift of cases to "lower cost" ambulatory surgery centers. However, the Petitioner does not provide any information regarding trends by both government and private payors toward site-neutral payments.

Petitioner does not mention in its 2015 Petition that expanding cuts to hospitals' outpatient services is among the leading Medicare cost-reduction proposals gaining interest from Congress. [4]

The Medicare Payment Advisory Commission (MedPAC) recommended in March 2012 that Medicare should equalize evaluation and management office visit payment rates, regardless of whether they occur in a hospital outpatient setting or a physician's office, which would save up to $1 billion a year. Congress' board of Medicare experts issued a report on June 14, 2013 offering 66 other ambulatory payment areas where such a "site-neutral" policy could be used to derive $900 million in additional annual savings.

MedPAC advisers introduced the following three main proposals in its June 14, 2013 report:

1. The "site-neutral" policy — in which hospital outpatient departments (HOPDs) and ambulatory care settings receive similar Medicare payments — would expand to 66 additional ambulatory payment classifications, which would reduce hospital Medicare payments by $900 million.

2. HOPDs and physician offices would receive the same payment for three high-volume cardiac imaging ambulatory payment classifications, which would reduce hospital Medicare payments by $500 million.

[4] Information contained in this Section is derived from: http://kevinbrady.house.gov/kevin-brady-in-the-news/medpac-sees-hefty-savings-in-siteneutral-payment-policy/

3. HOPDs and ambulatory surgery centers would receive equal pay for 12 surgical ambulatory payment classifications, reducing hospital Medicare payments by $590 million.[5]

MedPAC voted at its January 16-17, 2014 meeting to recommend that Congress decrease the reimbursement differential between services provided in an outpatient hospital setting and services provided in a physician's office for select ambulatory payment classifications. Those recommendations were published in MedPAC's March 2014 report to Congress.[6]

On April 16, 2014, the U.S. Department of Health and Human Services Office of the Inspector General (OIG) released Report A-05-12-00020 entitled "Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates For Ambulatory Surgical Center-Approved Procedures To Ambulatory Surgical Center Payment Rates." In that study commissioned by Congress, OIG assessed the impact on total Medicare expenditures of providing surgical services in an ambulatory surgical center as compared with a hospital outpatient department paid under the outpatient prospective payment system (OPPS). Because Medicare ambulatory surgery center payment rates are generally lower than hospital OPPS payment rates for the same procedures, Medicare saves when surgical procedures that do not pose significant risk to patients are performed in an ambulatory surgery center instead of in a hospital. The Report quantifies those savings, and OIG found:

1. During CY 2007 through 2011, Medicare saved $7 billion for surgical procedures performed in ambulatory surgery centers instead of in other outpatient settings. It stands to save $12 billion for CY 2012 through 2017.

2. Medicare could potentially save up to an additional $15 billion for CY 2012 through 2017, if CMS reduces hospital outpatient department payment rates to ambulatory surgery center payment levels for ambulatory surgery center-approved procedures performed in outpatient departments on no-risk to low-risk beneficiaries. OIG consulted with the Agency for Healthcare Research and Quality to obtain patient risk statistics and used the risk profiles to estimate the potential additional savings possible if payment rates for ambulatory surgery center procedures performed in outpatient departments are lowered to ambulatory surgery center rates.

3. Beneficiaries have saved and should continue to save billions of dollars attributable to reduced cost-sharing amounts.

OIG made the following recommendations to CMS:

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[5] http://www.beckershospitalreview.com/racs-/-icd-9-/-icd-10/medpac-suggests-equalizing-payments-between-hospitals-ambulatory-clinics.html

[6] A copy of the March 2014 MEDPAC Report to Congress can be found here: http://www.medpac.gov/documents/Mar14_EntireReport.pdf

1. CMS should draft and submit for review a legislative proposal that would exempt the reduced expenditures attributable to reduced OPPS payment rates from budget neutrality adjustments. This would be necessary because both the OPPS and the ambulatory surgery center fee schedules are required by statute to be budget neutral to insulate both payment systems from Medicare payment fluctuations.

2. If a budget neutrality exemption for the reduced expenditures is secured, CMS should reduce OPPS payment rates to ambulatory surgery center fee schedule rates for ASC-approved procedures performed in outpatient departments on beneficiaries with no-risk or low-risk clinical needs.

3. CMS should "develop and implement a payment strategy" providing for the continued standard OPPS payment rate for beneficiaries whose clinical needs require their ambulatory surgery center -approved procedures to be performed in an outpatient department for safety and quality reasons.

CMS had an opportunity to review a pre-publication draft report and did not concur with OIG's recommendations, noting, first, that such a legislative initiative to change the payment system is not included in the President's budget. Further, CMS was concerned that the recommended changes introduced a "circularity" problem insofar as most ambulatory surgery center payment rates are based on the OPPS payment rates that OIG is recommending that CMS reduce. Finally, CMS was concerned that OIG did not provide specific clinical criteria to distinguish patient risk levels.

OIG countered that CMS could propose budget neutrality legislation for future legislative initiatives and that, historically, it has done so based on OIG recommendations. As to CMS's concerns on circularity and the absence of specific patient risk criteria, OIG effectively responded that CMS should "take the necessary steps" to implement OIG's recommendations, regardless.[7]

- **Commercial insurers have instituted payment policies limiting hospital outpatient payment to the freestanding ambulatory surgery center payment rate**

Some commercial insurers have instituted payment policies limiting hospital outpatient payment to the freestanding ambulatory surgery center payment rate even if a former ambulatory surgery center was acquired by a hospital and, after the acquisition, the ambulatory surgery center met the Medicare provider-based rule permitting higher hospital OPPS payment. Commercial payors are not bound to follow Medicare payment rules.[8] Mission reasonably

[7] A copy of the Report can be found here: https://oig.hhs.gov/oas/reports/region5/51200020.pdf

[8] http://blogs.hallrender.com/blog/oig-releases-report-recommending-reduction-of-opps-payment-rates-to-asc-rates/

believes that the theoretical savings from single specialty ambulatory surgery center demonstration projects will be determined to be irrelevant as Medicare and other payors move to site-neutral payments. Further, there is no evidence that the "costs" that are "avoided" are actually changed in any way. The primary driver of hospital-based costs are related to other services that are critical for the communities they serve and are unrelated to the specifics of any ambulatory surgery center (e.g., ED, Trauma, Pediatrics, and other cost drivers) and would be unchanged based upon any physician-owned center. Said another way, those costs would remain, and no cost "savings" would actually occur.

Mission respectfully requests that the SHCC consider the ever-changing environment for health care, and the importance and effects of the cost-reduction proposals, specifically site-neutral payments, on the health care marketplace, and deny the 2015 Petition.

J. Trend Toward Ambulatory Surgery Center to Hospital Outpatient Department Conversions: A Reverse Migration

Only 40 years ago, virtually all surgeries and diagnostic procedures were performed in hospitals. Today, as a result of medical advancements and new technologies, a whole new range of procedures can be performed on an outpatient basis.

There are several facts that the Petitioner fails to mention in its Petition.

First, although the number and types of procedures that are performed in an ambulatory surgical center setting continue to expand, **studies and reports indicate a slower growth in the number of ambulatory surgical centers and volume of services performed at ambulatory surgical centers compared to previous years.**[9]

Second, according to the data from an Ambulatory Surgery Center Association, **one-third of the 179 ambulatory surgery center that have closed since 2009 did so after being purchased by hospitals and converted to hospital outpatient departments.**[10]

In North Carolina, the following freestanding ambulatory surgery centers, three of which were specialty ambulatory surgery centers, have converted to hospital based outpatient surgery centers in the last five years.

- Central Piedmont Surgery Center to Randolph Hospital - 2014
- SameDay Surgery Center New Hanover, LLC to NHRMC - 2013
- Chapel Hill Surgical Center to UNC Hospitals - 2013
- Southern Eye Center to WakeMed in Wake County - 2012

[9] Report to Congress: Medicare Payment Policy, Chpt. 5 Ambulatory Surgical Center Services, p. 115, Medicare Payment Advisory Commission (2012)

[10] http://www.ascassociation.org/AdvancingSurgicalCare/ascpolicyfocus/asctohopd

- Columbus Regional Same Day Surgery to Columbus Hospital - 2011
- Wayne ASC to Wayne Memorial - 2011
- Raleigh Women's Center to Duke Raleigh in Wake County - 2010

Conversion to hospital outpatient departments are appealing to hospitals and physicians for a number of reasons, to include less risk for physicians and co-management arrangements, which align and reward physicians for their assistance and often include incentive compensation to improve quality and efficiency. Asheville Surgery Center is a prime example of a hospital outpatient department with physician ownership and co-management.

It is quite possible that that three existing Demonstration Projects may undergo an ownership conversion at the end of each Project's required five-year operational term. That possibility is made more likely as payors move to site-neutral payments, if facility payments dilute ownership incentives, and other reforms such as accountable care organizations that control utilization gain a stronger foothold.

Mission respectfully requests that the SHCC consider the ever-changing environment for health care, particularly in view of the reverse migration and conversion from physician-owned ambulatory surgery centers to hospital outpatient departments, and deny the 2015 Petition.

K. Petitioners Desired Demonstration Project Would Not Improve Geographic Access to Surgical Services.

Promoting the effective distribution and use of health care services, facilities, and equipment is a fundamental purpose of North Carolina's Certificate of Need health planning scheme. *See* N.C. Gen. Stat. § 131E-175(7). The General Assembly, when enacting the Certificate of Need Act, N.C. Gen. Stat. §§ 131E-175, *et seq.*, made multiple findings regarding the purpose of and need for the CON regulation. *See* N.C. Gen. Stat. § 131E-175. These findings make the legislative purpose of ensuring appropriate geographic access to health service facilities and services and avoiding the "geographical maldistribution" of those facilities and services clear. *See id.*

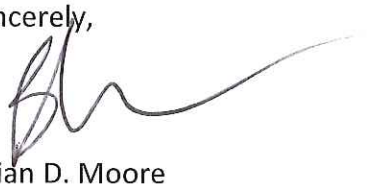
The Petitioner has requested that the SHCC add a demonstration project for a single specialty, two OR ambulatory surgical facility in the Buncombe County multicounty operating room service area. The Buncombe County multicounty operating room service area includes not only Buncombe County but also Madison and Yancey Counties. However, all of the operating rooms currently located in the multicounty service area are located in Buncombe County and in Asheville specifically. There are no operating rooms located anywhere in the three counties other than in Asheville. Depending upon the location in Madison County, Asheville is 15 miles or more away. Likewise, depending upon the location in Yancey County, Asheville is at least 30 miles away.

Conclusion

For all of the reasons set forth above, Mission respectfully requests that the SHCC deny the Petitioners 2015 Petition, and take no further action with respect to single specialty ambulatory surgical centers.

Please do not hesitate to contact me at 828.213.3059 if you have questions or if there is any additional information that I can provide. Many thanks in advance for your consideration.

Sincerely,



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