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Petition to the State Health Coordinating Council Regarding Operating Room Methodology and Policies *2018 State Medical Facilities Plan*

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Petitioner:		***Contact:***	
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STATEMENT OF REQUESTED ADJUSTMENT

J. Arthur Dosher Memorial Hospital (Dosher), requests the following change to the *2018 State Medical Facilities Plan (SMFP)* to address a policy change for acute care hospitals:

Policies Applicable to Acute Care Hospitals (AC)

Policy AC-7: Critical Access Hospitals: *To ensure the viability of Critical Access Hospitals (CAH) in North Carolina, addition of one or more operating rooms to a service area in which a CAH operates is only permitted if the certificate of need application includes a signed letter from an authorized representative of the CAH stating that the project will not have an adverse impact on the its ability to provide comprehensive emergency, inpatient and outpatient medical services to residents of the CAH service area. This shall apply if the CAH has an active license in good standing with NC DHSR.*

In addition, Dosher asks that the Agency consider the following recommendation regardless of the methodology it chooses for calculating need for operating rooms:

Methodology Recommendation Operating Rooms

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 2,000 case hours per operating room per year. The hours assume 250 days a year, 8 hours a day.

REASONS FOR THE PROPOSED ADJUSTMENTS

STATUE

Statutory Findings of Fact, GS 131E-175 (3), (3a), and (4), from the General Assembly focus on the importance of equal access to all population groups, access and continued viability of rural populations, and costly underuse of expensive resources.

> *(3) That, if left to the marketplace to regulate health service facilities and healthcare services, geographical maldistribution of these facilities and services would occur and, further, less than equal access to all population groups, especially those that have traditionally been medically underserved, would result.*
>
> ***(3a) "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."***
>
> *(4) "That the proliferation of unnecessary health service facilities results in costly duplication an underuse of facilities, with the3 availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health services.*

CRITICAL ACCESS HOSPITALS

By definition, Critical Access Hospitals (CAHs) are critical rural health care facilities. They are limited to 25 beds and primarily operate in rural areas. Among rural hospitals, 61 percent are CAHs and 17 percent are sole community hospitals.[1] Medicare and Medicaid pay them differently, on the basis of each hospitals reported, allowable costs for acute inpatient, outpatient, and post-acute swing bed care. Medicaid pays 100, and Medicare, 101 percent. Unfortunately, "allowable costs" do not include the cost of caring for charity patients. Hence, costs of paying for charity patients must be absorbed from other sources.

The Medicare/Medicaid allowable cost structure means that right sizing is essential in a CAH. To maintain efficient costs, a hospital must maintain certain minimum levels of service. Otherwise its costs to Medicare go up. With insufficient surgical case volumes, the CAHs may have insufficient revenue to from other payers to offset the cost of care for charity patients.

North Carolina has 21 critical access hospitals.[2] All are rural. Many are in health care systems, others are managed by health care systems. Many rely on local resources to stay viable. Some are in counties that are also served by other hospitals and ambulatory surgery centers.

[1] Medpac Payment Basics, Critical Hospital Payment System, October 2015. http://www.medpac.gov/docs/default-source/payment-basics/critical-access-hospitals-payment-system-15.pdf

[2] Appendix G, 2017 State Medical Facilities Plan.

DOSHER IMPACT AS SIGNAL OF STATEWIDE PROBLEM

The operating room methodology in Chapter 6 of the SMFP has a direct impact on Critical Access Hospitals (CAHs). For example, simple rounding up in the methodology in the *2016 State Medical Facilities Plan* converted a need of 0.37 operating rooms to a need for one operating room in Brunswick County. This rounding created a situation in which Dosher faces the possibility of competition from freestanding ambulatory surgery centers involving investments of $10 to $14 million, for facilities with the capacity of three operating rooms, and beds that can accommodate patients for 23-hour stays. Safeguards could prevent possible reoccurrence throughout the state; and thus, protect all CAHs in the future.

Dosher looked at the need in the 2016 Plan, its own volume and the case volume at the other hospital in the county. Dosher had sufficient capacity. It could not justify another operating room. Moreover, in conversations with the other hospital in the county, Dosher understood that hospital would apply for one operating room and it would be located at their existing campus. It did not know that the same hospital and others had much bigger plans.

The incident in Brunswick County could happen again elsewhere. It brought to light several key points regarding both OR methodology and policy that merit special attention for rural areas:

1. The Findings of Fact (GS131E-175 (3, (3a), and (4) in the NC CON Statute support protecting the viability of North Carolina CAHs:
2. The operating room capacity a service area population can support can determine the viability of CAHs.
3. The absence of limitations on procedure rooms in North Carolina is a reality, and should be considered in the methodology for rural operating rooms, because one operating room in the Plan can provide a foundation for a full ambulatory surgical facility.
4. In counties with a CAH, calculations should consider distributed county need, rather than a single health system need, to assure access to medically underserved groups.
5. Rounding up can create more need than a rural county can reasonably absorb.
6. No algorithm for forecasting need could completely protect a CAH and in some cases, a need in the Plan may not harm a CAH. However, because the law requires CAHs to operate under a different set of constraints, its needs should be considered differently.
7. A policy that protects CAHs is necessary and reasonable.

PROTECTION OF RURAL ASSET BASE IN METHODOLOGY AND POLICY

Methodology

The Operating Room Workgroup heard, and has rightfully considered, needs of academic medical centers. CAHs represent the other end of the spectrum and merit similar attention. As a group, CAHs have fewer resources and less time to participate in workgroup meetings. Dosher has become painfully aware of the need to have a voice; and, for that reason, has elected to champion the cause.

Given the unusual dynamics associated with procedure rooms, CAHs can be very adversely affected by a need for just one operating room in the Plan.

Policy

The requirement in the proposed policy for an active license in good standing protects applicants for operating rooms from being held hostage if a CAH is closed or has been denied Medicare and Medicaid reimbursement.

STATEMENT OF ADVERSE EFFECTS ON PROVIDERS AND CONSUMERS IF THE ADJUSTMENT IS NOT MADE

If the SHCC fails to make both the policy and the methodology adjustments, CAHs could be the unintended victims of the Plan. The methodology change would minimize the impact. However, a methodology change alone would not control for the impact of extra procedure rooms that could be packaged with a need for one operating room to produce a full service ambulatory surgery center.

Excess capacity that competes with a CAH will have several harmful effects on consumers and on the CAH.

1. If the response to a need for one operating room is a new facility ambulatory surgery facility, it will have a different set of Medicare rules that involve a lower pricing schedule and insurance companies may direct patients to that center with the mistaken impression that the cost will be lower.
2. In fact, the price for an individual procedure may be lower. However, the lower price for the procedure does not consider the care that may be required after the center is closed and the patient calls an emergency room for follow up.
3. The cost does not include the extra costs of pre- and post- surgical care packaged in the CAH cost.
4. The cost does not include changes in patient travel costs.

Asking for a letter from a CAH could appear extraordinary. However, it is not without precedent. Other policies require a letter from the Local Management Entity provider in any CON application that involves chemical dependency services. LME's are service providers.

The CON review process has comment periods, but they are only announced on the Agency website when a public hearing is scheduled. Otherwise, the CAH must pour through a detailed chart to find the information. Often this leaves little time for preparing comments. Without a required impact letter from a CAH, the CAH may never know about the CON application. In the recent example, the CON was not announced in a newspaper with county-wide circulation. Unlike other states, North Carolina makes no provision for publication of Letters of Intent in advance of CON applications.

Hence, without a requirement for a letter, it is possible that CAHs could be adversely affected by CON applications and not know until the facility is built. Even those assisted by large systems may not perceive the impact before it is too late to challenge.

Operationally, excess surgical capacity in a CAH service area can have significant adverse effects on CAH capacity to recruit and retain surgeons. If surgeons have the opportunity for ownership in a freestanding facility, it is only natural for them to prefer to spend time with and at that facility than with a small hospital in a remote location. Consequently, the surgeon is likely to abandon privileges at the remote CAH in favor of joining the freestanding surgical center. Recruiting good surgeons to practice at CAHs is difficult in any circumstance. Desire to increase their referral base encourages many surgeons to work in CAHs. Excess capacity in a service area increases the recruiting difficulty. When the surgeons leave, patients must travel farther for service.

STATEMENT OF ALTERNATIVES CONSIDERED AND FOUND NOT FEASIBLE

OVERVIEW

Dosher considered several alternatives. The easiest, do nothing, is no longer acceptable. Other alternatives included variations on the methodology and variations on the policy.

ALTERNATIVE 1: STATUS QUO

With no change, the Brunswick County situation from 2016 could repeat. This is not acceptable. It is only a matter of time before it occurs in other counties served by CAHs. North Carolina is half rural and has 21 CAHs.

ALTERNATIVE 2: WORK WITHIN PROPOSED OPERATING ROOM WORKGROUP METHODOLOGIES

Change the methodology or adopt the methodology recommended by the Operating Room Workgroup. Dosher followed the OR work group deliberations, and appreciates the significant time invested by the group and other contributors. Dosher saw how easily a small change in methodology could cause a repeat of the 2016 event. This alternative would require CAHs to maintain an expensive vigilance. More importantly, it would not address the critical need for a direct translation of the Findings of Fact in the statute to protection for CAHs.

ALTERNATIVE 3: REQUEST FOR ONLY PROPOSED METHODOLOGY ADJUSTMENT IN THIS PETITION

Insert only the proposed methodology change. Dosher considered this alternative seriously. It would provide clear and easily calculated protection for CAHs. It is easily quantified and easily calculated by staff who are charged to prepare the Draft Plan. Its only shortcoming is that it does not address the procedure room problem.

ALTERNATIVE 4: REQUEST FOR POLICY AND METHODOLOGY ADJUSTMENT

Combining the requirement for a letter from the CAH with the methodology is the only solution that addresses the very clear direction in the statutory Findings of Fact. Without both, CON Section staff must spend far more time and research testing a case for rejecting an application that would jeopardize the viability of a CAH. A letter is a clear yes or no. Moreover, requiring the letter would also encourage collaborative efforts in counties where resources are in short supply.

The Plan includes other adjustments to accommodate needs of CAHs. One clear example is Policy TE-3, Plan Exemption for Fixed Magnetic Resonance Imaging Scanners.[3]

EVIDENCE OF NON-DUPLICATION OF SERVICES

Because this policy expressly works to limit market saturation in counties with CAHs it will not produce unnecessary duplication of health resources in the area. In fact, the purpose is to prevent such an occurrence. By pacing growth of services in CAH service areas, it will prevent unnecessary duplication of services and the related possibilities for over-utilization of services.

The requirement that the CAH have an active license in good standing with DHSR protects the community from being held hostage to the potential capacity or future of a closed or low-quality facility.

[3] 2017 SMFP page 23.

EVIDENCE OF CONSISTENCY WITH THREE BASIC PRINCIPLES GOVERNING DEVELOPMENT OF THE NORTH CAROLINA STATE MEDICAL FACILITIES PLAN

BASIC GOVERNING PRINCIPLES

Safety and Quality

This basic principle notes:

> "…Citizens of *North Carolina rightfully expect services to be safe and efficient.*
>
> *"…As experience with the application of quality and safety metrics grows, the SHCC should regularly review policies and need methodologies and revise them as needed to address any persistent and significant deficiencies in safety and quality in a particular service area*."

The protective wording that the CAH in question have an active license in good standing would assure that the policy applies only to active and certified CAHs that are in good standing with the state and qualify for Medicare and Medicaid payments.

Access

This basic principle notes:

> "…*The first priority is to ameliorate economic barriers and the second priority is to mitigate time and distance barriers.*
>
> *"…The SHCC planning process will promote access to an appropriate spectrum of health services at a local level, whenever feasible under prevailing quality and value standards.*
>
> *"…The needs of rural and small communities that are distant from comprehensive urban medical facilities merit special consideration. In rural and small communities, selective competition that captures profitable services may threaten the viability of sole providers of comprehensive care and emergency services. For this reason, methodologies that balance, value, quality and access in urban and rural areas may differ quantitatively. The SHCC planning process will promote access to an appropriate spectrum of health services a t a local level, whenever feasible, under prevailing quality and value standards." [emphasis added]*

Protecting the CAHs clearly aligns with this principle. It will mitigate time and distance for persons served by the CAH, assure access for Medicare and Medicaid and charity patients and will only apply to CAHs that meet objective quality standard of current license and CMS certification.

Value

This basic principle notes:

> *"The SHCC defines health care value as the maximum health care benefit per dollar expended.*
>
> *"…Cost per unit of service is an appropriate metric…*
>
> *"…At the same time overutilization of more costly and/or highly specialized low-volume services without evidence-based medical indication may contribute to escalating health costs without commensurate population-based health benefit."*

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 pays 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. (Service area is defined by Figure 6.1 in the SMFP). 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.

CONCLUSION

The proposed changes are consistent with and support the statute and the Basic Principles that govern the *SMFP*. They are necessary to protect rural health care.