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Community Benefit Requirement for North Carolina Single Specialty Ambulatory Surgery Facility Demonstration Project

Background:

University Surgery Center (dba Mallard Creek Surgery Center) located in Charlotte, North Carolina is one of three demonstration projects within the state created by the 2010 State Medical Facilities Plan (SMFP). The focus of the 2010 SMFP demonstration project was to prove that a physician owned ASC can increase quality & safety, value, and access. Mallard Creek Surgery Center (Mallard Creek) is a single specialty, Orthopedic, physician owned, ambulatory surgery facility consisting of two operating rooms and one procedure room.

Mallard Creek is wholly owned by OrthoCarolina. OrthoCarolina is one of the nation's leading independent academic orthopedics practices serving North Carolina and the Southeast since 1922. OrthoCarolina provides compassionate and comprehensive musculoskeletal care including operative and non-operative care, diagnostic imaging and rehabilitative therapy. Widely known for musculoskeletal research and training, OrthoCarolina physicians have specialized expertise in foot and ankle, hip and knee, shoulder and elbow, spine, sports medicine, hand, pediatric orthopedics, and physical medicine and rehabilitation. Each year 150 OrthoCarolina physicians see nearly one million patient visits and perform over 50,000 procedures. OrthoCarolina' s core values include Quality, Service, Community and Teamwork. Those values drive everything we do and are fundamentally aligned with the vision and objectives of the 2010 SMFP ASC demonstration project.

Mallard Creek opened its doors to the community on May 7, 2014. Since then, Mallard Creek has performed over 6,000 orthopedic cases in its two operating rooms, and close to 450 cases in its procedure room. During the first year of operation, Mallard Creek struggled to achieve the charity care requirement of 7% set forth by the state demonstration project, ending the first year at 4.3%. Understanding that the charity care requirement (referred to going forward in this document as Community Benefit Care) was an important part of the demonstration project, Mallard Creek and OrthoCarolina invested significant additional resources into achieving the 7% goal and successfully ended CON year two with a 7.0% Community Benefit Care. By the end of CON year three, 7.8% of the facility's collected revenue was attributed to Community Benefit Care.

To date, Mallard Creek has encountered several challenges unique to the underserved patient population including lack of reliable transportation, lack of phone accessibility, language barriers, and inconsistent attendance on day of surgery by both the patient and caregiver. To address these many challenges, Mallard Creek continues to work tirelessly with several of Charlotte's public health clinics and businesses to ensure that the underserved population has access to the orthopedic surgical services they need . As an example, Mallard Creek addressed patient transportation issues to the surgery center by partnering with a local transit company which shares the same vision for Community Benefit Care. The transportation company agreed to the delivery or pick up of surgical patients who had no other means of access to the surgery center.

Mallard Creek is an approved CMS provider and also accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). Mallard Creek recently underwent AAAHC re-accreditation in May of 2017, and passed all 602 line items with 100% compliance and 0 deficiencies.

Current State:

As outlined in the 2010 State Medical Facilities Plan, the demonstration project requires 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.*

When the 7% Community Benefit Care was proposed in late 2008, early 2009, many of the cases that are now capable of being done in an ASC were not even contemplated. The formula was fair and reasonable at that time, as most ASC cases had Medicare allowable rates. That is not so any longer, as many of the cases we perform are absent the Medicare allowable. This trend will continue to be a challenge to meeting the Community Benefit Care requirement and may therefore put the existence of Mallard Creek in jeopardy.

Challenges:

There are several challenges inherent in the current calculation of Community Benefit Care:

Challenge #1: Lack of Medicare Allowable For Complex Cases

When the amount of Community Benefit Care is calculated based on the current formula, it is compared to a denominator which includes revenue from all case types, even those that are not yet deemed ASC appropriate by Medicare (but are approved by other private commercial payers). This makes the Community Benefit Care target of 7% much harder to achieve because many of the more costly cases are deemed ASC appropriate by commercial payers but are not approved by Medicare. Therefore, the commercial payer mix is being applied to the denominator but can't be applied to the numerator.

As an example, arthroplasty (joint replacements) of the hip, knee, and shoulder as well as many spine cases are procedures that have now become commonly approved by commercial payers to be performed in an outpatient setting, but do not currently have a Medicare allowable. Of the 2,500 cases Mallard Creek performed in CON year three, 108 cases were approved by commercial payers but were not approved by Medicare and therefore had no Medicare allowable. The revenue from these cases was included in the denominator, but because there was no Medicare allowable, could not be included in the numerator, even if we had performed them as part of the Community Benefit Care. This is not an accurate comparison and is a fundamental flaw in the calculation, given the recent trends.

Challenge #2: The 7% Target

Mallard Creek's improved efficiencies combined with an overall greater emphasis from payers on shifting appropriate orthopedic surgery to the outpatient setting will continue to create the constant challenge of not being able to meet the 7% target. This puts our CON at risk due to a calculation that is increasingly unsustainable, no longer applicable given anticipated trends, and already difficult to meet in current circumstances.

Challenge #3: Lack of Access

In addition, under the current calculation, access for underserved patients who require higher acuity surgeries that do not have the Medicare allowable is limited. The nature of these more complex cases often results in the inability of the patient to return to the workforce without surgery. This often leads to disability, and an increased cost to both the patient and society. Our surgeons desperately want to perform this surgery, but currently cannot due to the double burden of not only doing an uncompensated case, but also not getting any credit towards our Community Benefit Care target. If our surgeons were given credit for these larger cases (despite the lack of Medicare allowable) access to these cases would open up to the population in greatest need.

Proposal: Modify the Calculation

The OrthoCarolina/Mallard Creek proposal is as follows:

1) Reduce the Community Benefit Care requirement to 5% of revenue collected; and
2) Exclude revenue from procedures that do not yet have a Medicare allowable amount or are not currently ASC approved by Medicare from the denominator.

Given the difficulty of hitting the target of 7%, the first proposed change to 5% will result in a more sustainable target, while continuing to meet all of the objectives of the 2010 SMFP as more complex cases become capable of being performed in an ASC under Medicare.

The second proposed change would also provide an accurate comparison when dividing the Community Benefit Care contribution to revenue. If only certain CPT codes have a Medicare allowable, then that should not be compared to total revenue, which includes CPT codes without a Medicare allowable. By carving out any revenue generated by CPT codes that do not have a Medicare allowable, we can cleanly calculate our Community Benefit Care percentage. As more complex cases achieve a Medicare allowable, they will be added back to the denominator and can be applied to the numerator as well.

If the goal of the community benefit requirement is to increase quality & safety, value, and access, our proposal would help to ensure that Mallard Creek can continue to offer increased access to the underserved population as increasingly complex cases become ASC appropriate by Medicare.

Closing Remarks:

OrthoCarolina believes that community benefit care requirement is a positive and productive way to ensure that all patients are able to access lower cost, high quality care via Ambulatory Surgery Centers. We do, however, also believe that the current methodology falls short of the original goals of the demonstration project. We believe that our proposed changes to the Community Benefit Care requirement calculation improve our ability to achieve the original objectives of the 2010 SMFP in a sustainable and responsible manner.