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North Carolina Division of Health Service Regulation
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Comments for the 2019 State Medical Facilities Plan (SMFP) Operating Room Methodology

Mission Health System, Inc. submits these comments regarding the need methodology for operating rooms in Chapter 6 of the proposed 2019 State Medical Facilities Plan (SMFP). Mission Health supports the robust health planning process and certificate of need law in North Carolina. We also appreciate the significant work of the State Health Coordinating Council (SHCC) to facilitate improvements in the 2018 SMFP by examining the methodology to determine future need for operating rooms.

While we support the methodology overall, we have the following comments for consideration related to:

1) Operating room deficits and surpluses calculated separately for each health system.

2) Need determination calculations use case times reported by the facility, adjusted for outliers.

3) Proposed removal of the maximum of six operating room need determination in a service area in a single year.

Background –

The General Assembly of North Carolina Statutory Findings of Fact, GS 131E-175 (1), (4), and (6) specify the need of regulation to ensure there is no proliferation of unnecessary health service facilities which creates costly duplication and underuse, placing an enormous economic burden on the public.

> (1) That the financing of health care, particularly the reimbursement of health services rendered by health service facilities, limits the effect of free market competition and government regulation is therefore necessary to control costs, utilization, and distribution of new health service facilities and the bed complements of these health service facilities.
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> ***(4) That the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services.***
>
> ***(6) That excess capacity of health service facilities places an enormous economic burden on the public who pay for the construction and operation of these facilities as patients, health insurance subscribers, health plan contributors, and taxpayers.***

Mission Health suggests the following points regarding operating room need methodology be reviewed to avoid potential unintended consequences on the overall intent of the Certificate of Need Statue.

1. Operating rooms deficits and surpluses are calculated separately for each health system.

While there is no inherent or immediate concern with calculating deficits and surpluses for each individual health system, the lack of the methodology to net out or reconcile the total for the defined service area, by definition, does not establish a true need for that service area. Therefore, artificial need for additional ORs will potentially be established given this methodology and is likely to result in duplication of resources (e.g. in service area EXAMPLE, Health System A has a total surplus of 5.2 ORs, though Ambulatory Surgery Center X has a need of 1.1 and Hospital Y has a need of 0.6 – thus based on the current needs methodology, the service area would demonstrate a need of 2.0 ORs, although the service area when netted together would actually show a surplus of 3.5 ORs).

Defining or reconciling need within the Service Area is essential to ensuring that duplicated services and unnecessary increase in healthcare spending does not occur. While this impacts a limited number of service areas across the state (due to the limited number of service areas that have more than one facility within the service area), the potential impacts in those service areas can be significant and lead to considerable unnecessary proliferation of services. If enacted, this methodology could have a multiplying impact, in that facilites that currently show a surplus of ORs will likely see deterioration in utilization of existing asset due to duplicative services entering the service area. Those exisiting facilities will therefore struggle to ever get to a point where they are able to demonstrate effective utilization of their current resources.

2. Need determination calculations use case times reported by the facility, adjusted for outliers.

The utilization of actual case times is inherently good public policy, though without any reference or requirement to be at or below industry benchmarks, it does not incentivize facilities to improve efficiency in the utilization of their OR assets. Facilities that improve efficiency are going to be disadvantaged over those facilities that do not focus on improving efficiency.

3. When a need is calculated, the minimum need determination is two operating rooms. The maximum operating room need determination in a single service area is six. These changes will be evaluated after the first year of implementation of the new methodology.

Placement of upper bound guardrails in defined service area need is good public policy, as it ensures that any given data variance or potential anomaly in a given year is not going to create an overstated need that may change in the immediately following year. Bounding the maximum number of OR's is also good fiscal public policy – with current estimate of the average cost per OR to be between $2M - $3M, an excessive number of OR's added to any given service area has the potential to significantly increase unnecessary health care spending at an unsustainable pace. However, we believe the proposal in 2019 to remove the upper cap is not good public policy because of the risk of duplication of services and increase unnecessary healthcare spending. We would suggest the state consider a tiered capping methodology that also takes into consideration the balance of individual facility need with that of a service area.

Such consideration could include something along the lines of the following:

- If service area demonstrates overall surplus of ≤ 2 ORs, the service area shall add no more than 2 ORs to the service area in a given year
- If the net of service area demonstrates between a range -2 OR surplus to 2 OR need, the service area shall add no more than 4 ORS to the service area in a given year up to the maximum of the net individual facility needs.
- If the net of the service area demonstrates a need of 2 or more OR need, the service area shall add up to the maximum facility demonstrated need AND not exceed more than 6 OR's to a service area in a given year

Mission Health recognizes the difficulty and complexity in developing this methodology, as well as the scope of work invovled in this process. We appreciate the opportunity to provide our comments for your consideration.

Sincerely,

Rowena Buffett Timms
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Mission Health