Operating Rooms

Petition:

Affordable HealthCare

Petition

State Health Coordinating Council ("SHCC") for New Need Methodology Related to Ambulatory Surgical Operating Rooms

Proposed By:

Affordable Health Care Facilities, LLC
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I. Petition

It is proposed that the SHCC change the need methodology for ambulatory surgical operating rooms to provide more price competition, increased patient access and choice, and transparency of actual service purchase costs through a managed approach allowing for increased levels of price competition, while accounting for such factors as care for indigent populations and the fragility of rural health care delivery.

Specifically, a fact-based study that reviews individual explanation of benefits ("EOBs") will be used to support the underlying review and need methodology change. Prior studies by the SHCC and other organizations have not had the mechanism in place to collect EOBs by provider and location for the basis of analysis.

The desired result of the change in need methodology for ambulatory surgical operating rooms will be:

1. **Increased levels of patient access and choice;**

2. **Lower cost for services; and**

3. **Complete transparency of cost prior to the purchasing of outpatient surgical and other services in outpatient ambulatory surgery settings.**

The Office of the Inspector General ("OIG") has already documented the cost savings of ambulatory surgery centers ("ASCs") over hospital-based outpatient

departments. CMS is moving toward further incentives to encourage the use of ASCs. Therefore, it is fiscally responsible for the SHCC through the State Medical Facilities Plan ("SMFP") to encourage development of more cost-effective ASCs with cost transparency for patients.

II. Environmental Overview

The rising cost of health care services continues to cause alarm among many constituencies in North Carolina. The fastest growing component of this health care inflation is outpatient facility-based services. CON legislation has not controlled costs in the outpatient facility sector, which includes hospitals, ASCs, and diagnostic facilities. On the one hand, we want to encourage more outpatient care to save costs over inpatient settings. However, outpatient facility costs seem to bear little relationship to underlying cost of providing the services due to lack of price regulation or cost transparency among providers for consumers to negotiate lower service pricing.

Please read the excerpt from an article written in Health Affairs by Paul B. Ginsburg, President of Center for Studying Health System Change, (January/February 2008):

> **Hospital activity.** Hospitals have been expanding capacity, not predominantly by adding new beds but by expanding specialized facilities (such as operating rooms and imaging facilities) needed to serve patients with the latest technology. When hospitals do increase inpatient beds, the new construction typically occurs in rapidly growing suburbs, where well-insured patients live. Competing hospital systems also have expanded into some communities where hospital systems have already established dominance, raising concerns about overcapacity.
>
> HSC researchers have documented the hospital "specialty-service line" strategy, and such strategies are continuing.[3] Hospitals have identified the types of services that are most profitable—under a mix of diagnosis-related group (DRG), per diem, and discounted charge reimbursement—and are expanding capacity to provide those services. Interviews with hospital executives suggest that the profitability of the services is the key to developing a service line, with cardiac procedures often topping the list. As one hospital chief executive officer (CEO) told me in response to a question about capital spending priorities: "We just list the specialty lines by profitability and go down the list." We found no hospitals developing a mental health service line; such admissions generally are considered money losers. It may have been too early, but we did not obtain indications of adjustments to these service-line strategies in response to the major revamping of the DRG system started in 2006. The changes appear to have reduced the variation in relative profitability of different DRGs but probably did not eliminate that variation.

In some larger markets or communities, we have seen a duplication of services in a form of "medical arms race" among competing health care facilities. There is

also some evidence of "shadow pricing" of such services by facilities to non-government payers. We are also finding increased levels of consolidation in markets, such as Charlotte, where the hospitals are purchasing physician practices at an increasing rate. The result is a true integrated delivery system ("IDS"). Yet, it is unclear if the IDS's are resulting in more accessible and affordable health care services or just further preserving the dominant market positions of the existing licensed facilities. It may be argued that the IDS's have reduced competition.

The ASC setting is where we have the greatest opportunity to achieve cost savings for patients or consumers. We should increase levels of pricing transparency to consumers in the ASC setting. The transparency will allow consumers to better evaluate services and their value before purchasing such services. It can be argued that such transparency will result in increased levels of price competition and more informed consumers.

III. Framework for Need Methodology Change

The SHCC has the capability to change need methodology for a CON without the requirement of new legislation. Shown below are the key premises of an approach for a new CON methodology that would allow providers to develop ASCs in place of the current need methodology volume limitations found in the SMFP:

1. Capital Cost

- Each ASC facility must have a total capital cost of less than $1.25 million per operating room in order to be eligible to apply for a CON.
- Complete architectural and engineering plans with construction cost estimates must be developed to confirm cost-effectiveness and compliance with the $1.25 million threshold.
- The ASCs must agree through affidavit to meet all state licensure, accreditation, and Medicare certification requirements in the CON application.

***Objective:* Build and operate the most cost-effective, efficient, and high quality facilities that meet all state licensure, accreditation, and Medicare certification requirements.**

2. Indigent Care and Community Safety Net

- Facilities must agree to have at least 5% of its total patient load being charity or indigent care (less than $200 per service in reimbursement).
- Upon annual facility licensure renewal, if the 5% charity/indigent care threshold has not been met, the facility must pay into a DHSR managed state facility fund up to 5% of the facility's average reimbursement to reach the threshold.
- Under this approach, the facilities are an integral participant in the community safety net for care.

Objective: ***The major opposition to changes in CON need methodology will come from opponents who believe that the proposed facilities will not provide their "fair share" of charity/indigent care and undermine the hospital position of being a community's health "safety net". Physicians now provide the professional services portion of charity/indigent care in the hospital setting. In the proposed facilities, the ASCs will provide 100% of both professional and facility services for charity/indigent care at a required minimum level or be forced to pay the difference to a state facility fund managed by DHSR for such care.***

3. Rural Counties and Service Areas

- Facility construction is limited to North Carolina counties with the following demographics:
  - Counties with a population of at least 85,000 and one (1) hospital; or
  - Counties with a population of at least 125,000 and two (2) or more hospitals. [1]

Objective: ***Another strong opposition argument will come from rural county hospitals and political leaders that believe the proposed change in need methodology will threaten the financial health of rural hospitals and the county's health "safety net" now being provided by the hospital(s). By limiting need methodology change to non-rural counties, this opposition argument is neutralized in large part.***

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[1] Please refer to Appendix A for a list of eligible North Carolina counties.

4. **Excessive Cost Counties and Service Areas**

   - Applicant facilities must prove through the collection of explanation of benefits (EOBs) statements and other sources that facility charges in the target counties exceed 200% of prevailing Medicare reimbursement for the services that the facility will provide before receiving a CON.

   Objective: ***The primary objective of the proposed approach is to provide necessary price competition for facilities that are not providing affordable health services to their communities and citizens. Therefore, only counties with excessive cost and reimbursement structures for facility services will be eligible. It is important to provide such price competition in combination with regulatory reporting and monitoring associated with price ceiling limits, disclosure, and transparency for any new ASC facilities.***

5. **Price Ceiling Limits, Disclosure, and Transparency for New Facilities**

   - ASC facilities agree not to charge more than 200% of prevailing Medicare reimbursement by CPT code to all payers and consumers.

   - Medicare has developed a new ASC reimbursement methodology based on CPT codes that can be accessed over the Internet if DHSR or another organization is willing to host such a web site.

   - Facilities agree to publish a list of their charges by procedure or service and file a report each year with the DHSR with these charges upon licensure renewal.

   - Facilities agree to provide each consumer with an individual financial review of his/her expected out of pocket cost for the respective payer prior to performing the procedure or service.

   Objective: ***The provision of price ceiling limits in combination with full disclosure and transparency of pricing will be a strong force for price competition in the target counties that have excessive facility costs. New facilities will not readily support the price ceiling limits and reporting requirements, but this approach is the foundation for increased price competition given regulatory oversight to support increased levels of consumer affordability with full disclosure and transparency. The approach also distinguishes new facilities from hospital and other facilities that do not want such charge disclosure and transparency. The approach clearly separates new facilities from the current market position of non-disclosure, which is quite anti-consumer and not patient centric.***

6. Single Specialty Facilities

- It is well documented that single specialty ASC facilities can operate at much lower costs and higher levels of operations efficiency than other types of health care facilities, such as larger hospitals and health systems.

- Only single specialty ASC facilities are eligible for a CON under the new proposed need methodology.

***Objective:* Document why single specialty and majority physician owned and operated facilities are more efficient and cost-effective than hospital based and other types of facilities.[2]**

7. Demonstrated Volume

- ASC facilities must demonstrate that that they will perform a minimum target level of procedures per year. If forecasted volume targets are not reached by year two (2) of operation, the facility will lose its CON and state license.

- The target procedure volume for an applicant ASC is 1,000 procedures per operating room.

***Objective:* Document that the new facilities will have sufficient procedure and service volume to support operations. Letters of support from referring physicians can be used to support volume and the need for the new facilities. If procedure and service volume targets are *not* achieved, the penalty will be loss of the facility's CON and state license. The penalty is significant so as to deter low volume provider entry.**

8. Physician Commitment to "Call" Coverage

- Physician groups who develop and operate the new facilities must commit to continued "call" coverage at area hospitals in order to maintain licensure for the facilities that they may develop.

- "Call" coverage is maintained in accordance with each individual hospital's medical staff by-laws, not by state mandate as to specific requirements.

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[2] Single specialty hospitals and ASCs can provide documented evidence of lower operations costs and increased levels of operations efficiency for outpatient services.

Objective: ***Hospitals fear that once physicians develop and operate their own ASCs that they will no longer be willing to provide "call" coverage at the hospitals. Maintaining licensure of the facilities will require "call" coverage commitment.***

IV. Supporting Analysis

No change in need methodology for the development of ambulatory surgical operating rooms can occur without a fact-based analysis. The SHCC may not have the resources to undertake the data collection and some of the analysis. Therefore, it is proposed that potential petitioners undertake the analysis proposed by the framework in III. Framework for Need Methodology Change above. This analysis then can be presented to the SHCC no later than May 1, 2008 for review and public discussion.

Attached as Exhibit B is a sample EOB analysis that has been undertaken by gastroenterology practices in their CON applications for new gastrointestinal ("GI") endoscopy centers. This is the type of analysis that the SHCC should expect in addition to a comparison to prevailing Medicare reimbursement by CPT code for each health service to be delivered.

V. Potential Opposition to Petition

Opposition to this petition for need methodology change related to the development of ASCs is likely to come from existing licensed facility providers. If the existing licensed providers and their affiliated organizations (e.g. associations) choose to oppose this proposal, they are being anti-competitive and anti-patient. An alternative would be to implement a price reporting and control system such as Maryland uses in addition to consumer disclosure and transparency provisions for all licensed facilities and health service in North Carolina. The current regulatory approach is not effective at controlling health care costs and ensuring access to affordable health services for patients.

One of the most interesting aspects of health care is facility use. The more health care facilities we build, the greater the use in most every case. We must begin to regulate price through increased competition, some level of price regulation, and disclosure transparency to purchasers. The current CON methodology is ineffective at controlling health care expenditures, especially under a regulated CON methodology which does not permit new forms of enhanced delivery and competition. In the end, the proposed need methodology change will only be effective or implemented in non-competitive markets with high prices to patients.

Appendix A

Eligible North Carolina Counties Under AHF Petition Requirements

COUNTY	J06Pop	A00Pop	Growth	% Grow
ALAMANCE	139,786	130,794	8,992	6.9
ALEXANDER	36,296	33,609	2,687	8.0
ALLEGHANY	11,012	10,680	332	3.1
ANSON	25,371	25,275	96	0.4
ASHE	25,774	24,384	1,390	5.7
AVERY	18,174	17,167	1,007	5.9
BEAUFORT	46,346	44,958	1,388	3.1
BERTIE	19,355	19,757	-402	-2.0
BLADEN	32,870	32,279	591	1.8
BRUNSWICK	94,964	73,141	21,823	29.8
BUNCOMBE	221,320	206,299	15,021	7.3
BURKE	88,663	89,145	-482	-0.5
CABARRUS	157,179	131,030	26,149	20.0
CALDWELL	79,298	77,710	1,588	2.0
CAMDEN	9,284	6,885	2,399	34.8
CARTERET	63,558	59,383	4,175	7.0
CASWELL	23,523	23,501	22	0.1
CATAWBA	151,128	141,677	9,451	6.7
CHATHAM	57,707	49,334	8,373	17.0
CHEROKEE	26,816	24,298	2,518	10.4
CHOWAN	14,664	14,150	514	3.6
CLAY	10,144	8,775	1,369	15.6
CLEVELAND	96,714	96,284	430	0.4
COLUMBUS	54,656	54,749	-93	-0.2
CRAVEN	95,558	91,523	4,035	4.4
CUMBERLAND	306,545	302,962	3,583	1.2
CURRITUCK	23,518	18,190	5,328	29.3
DARE	34,674	29,967	4,707	15.7
DAVIDSON	155,348	147,269	8,079	5.5
DAVIE	39,836	34,835	5,001	14.4
DUPLIN	52,710	49,063	3,647	7.4
DURHAM	246,824	223,306	23,518	10.5
EDGECOMBE	52,644	55,606	-2,962	-5.3
FORSYTH	331,859	306,044	25,815	8.4
FRANKLIN	55,315	47,260	8,055	17.0
GASTON	197,232	190,310	6,922	3.6
GATES	11,602	10,516	1,086	10.3
GRAHAM	8,109	7,993	116	1.5

Appendix A (continued)

Eligible North Carolina Counties Under AHF Petition Requirements

GRANVILLE	53,840	48,498	5,342	11.0
GREENE	20,833	18,974	1,859	9.8
GUILFORD	449,078	421,048	28,030	6.7
HALIFAX	55,606	57,370	-1,764	-3.1
HARNETT	103,714	91,062	12,652	13.9
HAYWOOD	56,662	54,034	2,628	4.9
HENDERSON	100,107	89,204	10,903	12.2
HERTFORD	23,878	22,977	901	3.9
HOKE	42,202	33,646	8,556	25.4
HYDE	5,511	5,826	-315	-5.4
IREDELL	145,234	122,664	22,570	18.4
JACKSON	36,312	33,120	3,192	9.6
JOHNSTON	151,589	121,900	29,689	24.4
JONES	10,318	10,398	-80	-0.8
LEE	55,282	49,172	6,110	12.4
LENOIR	58,172	59,619	-1,447	-2.4
LINCOLN	71,302	63,780	7,522	11.8
MCDOWELL	43,632	42,151	1,481	3.5
MACON	33,076	29,806	3,270	11.0
MADISON	20,454	19,635	819	4.2
MARTIN	24,396	25,546	-1,150	-4.5
MECKLENBURG	826,893	695,427	131,466	18.9
MITCHELL	15,906	15,687	219	1.4
MONTGOMERY	27,506	26,836	670	2.5
MOORE	82,292	74,770	7,522	10.1
NASH	92,220	87,385	4,835	5.5
NEW HANOVER	184,120	160,327	23,793	14.8
NORTHAMPTON	21,524	22,086	-562	-2.5
ONSLOW	161,212	150,355	10,857	7.2
ORANGE	123,766	115,537	8,229	7.1
PAMLICO	13,097	12,934	163	1.3
PASQUOTANK	39,956	34,897	5,059	14.5
PENDER	48,724	41,082	7,642	18.6
PERQUIMANS	12,442	11,368	1,074	9.4
PERSON	37,448	35,623	1,825	5.1
PITT	146,403	133,719	12,684	9.5
POLK	19,080	18,324	756	4.1
RANDOLPH	138,586	130,470	8,116	6.2
RICHMOND	46,700	46,551	149	0.3

Appendix A

Eligible North Carolina Counties Under AHF Petition Requirements

ROBESON	129,048	123,241	5,807	4.7
ROCKINGHAM	91,830	91,928	-98	-0.1
ROWAN	134,540	130,348	4,192	3.2
RUTHERFORD	63,178	62,901	277	0.4
SAMPSON	64,057	60,160	3,897	6.5
SCOTLAND	36,994	35,998	996	2.8
STANLY	59,128	58,100	1,028	1.8
STOKES	46,335	44,707	1,628	3.6
SURRY	72,990	71,227	1,763	2.5
SWAIN	13,938	12,973	965	7.4
TRANSYLVANIA	30,360	29,334	1,026	3.5
TYRRELL	4,240	4,149	91	2.2
UNION	172,087	123,738	48,349	39.1
VANCE	43,920	42,954	966	2.2
WAKE	790,007	627,865	162,142	25.8
WARREN	19,969	19,972	-3	-0.02
WASHINGTON	13,360	13,723	-363	-2.6
WATAUGA	43,410	42,693	717	1.7
WAYNE	114,930	113,329	1,601	1.4
WILKES	66,925	65,624	1,301	2.0
WILSON	77,468	73,811	3,657	5.0
YADKIN	37,810	36,348	1,462	4.0
YANCEY	18,368	17,774	594	3.3
STATE OF	**J06Pop**	**A00Pop**	**Growth**	**% Grow**
NORTH CAROLINA	8,860,341	8,046,813	813,528	10.11

Exhibit B

Please find on the following pages sample EOBs for gastrointestinal ("GI") endoscopy procedures. In CON applications for new GI endoscopy facilities, the applicants have prepared analyses such as the following. This is the type of disclosure that should be provided to patients before purchasing a health service.

EOB Comparison

Payer	Procedure	Provider Charge	Disallowed Amount	Allowable Reimbursement	Patient Responsibility	Estimated Discount From Charges
BCBSNC	Colon - Hospital	$4,278.04	$1,749.72	$2,528.32	$585.66	40.90%
	Colon - Prof Anesthesia	$672.00	$386.40	$285.60	$285.60	57.50%
	Total	**$4,950.04**	**$2,136.12**	**$2,813.92**	**$871.26**	**43.15%**
Proposed Facility	Colon - Global Fee *	$2,645.00	$1,774.01	$870.99	$30 to $50	67.07%
	Total	**$2,645.00**	**$1,774.01**	**$870.99**	**$30 to $50**	**67.07%**

Payer	Procedure	Provider Charge	Disallowed Amount	Allowable Reimbursement	Patient Responsibility	Estimated Discount From Charges
United Healthcare	EGD - Hospital	$6,560.02	$2,624.01	$3,936.01	$787.20	40.00%
	EGD - CRNA	$490.00	$49.00	$441.00	$88.20	10.00%
	EGD - Prof Anesthesia	$672.00	$390.91	$281.09	$281.09	58.17%
	Total	**$7,722.02**	**$3,063.92**	**$4,658.10**	**$1,156.49**	**39.68%**
Proposed Facility	EGD - Global Fee *	$1,865.00	$1,140.00	$725.00	$30 to $50	61.13%
	EGD - Prof Anesthesia	$420.00	$210.00	$210.00	$42.00	50.00%
	Total	**$2,285.00**	**$1,350.00**	**$935.00**	**$72 to $92**	**59.08%**

Payer	Procedure	Provider Charge	Disallowed Amount	Allowable Reimbursement	Patient Responsibility	Estimated Discount From Charges
United Healthcare	Colon - Hospital	$3,432.02	$1,372.81	$2,059.21	$411.84	40.00%
	Colon - CRNA	$490.00	$49.00	$441.00	$88.20	10.00%
	Colon - Prof Anesthesia	$672.00	$33.60	$638.40	$127.68	5.00%
	Total	**$4,594.02**	**$1,455.41**	**$3,138.61**	**$627.72**	**31.68%**
Proposed Facility	Colon - Global Fee *	$2,645.00	$1,745.00	$900.00	$30 to $50	65.97%
	Colon - Prof Anesthesia	$420.00	$210.00	$210.00	$42.00	50.00%
	Total	**$3,065.00**	**$1,955.00**	**$1,110.00**	**$72 to $92**	**63.78%**

Payer	Procedure	Provider Charge	Disallowed Amount	Allowable Reimbursement	Patient ** Responsibility	Estimated Discount From Charges
Mega Life/MedCost	Colon+EGD - Hospital	$5,523.05	$1,104.61	$4,418.44	$2,918.44	20.00%
	Colon+EGD - Prof Anesthesia	$864.00	$129.60	$734.40	$516.90	15.00%
	Colon+EGD - CRNA	$630.00	$0.00	$630.00	$630.00	0.00%
	Total	**$7,017.05**	**$1,234.21**	**$5,782.84**	**$4,065.34**	**17.59%**
Proposed Facility	Colon+EGD - Facility Fee	$675.00	$150.00	$525.00	$525.00	22.22%
	Colon+EGD- Prof Anesthesia	$420.00	$210.00	$210.00	$42.00	50.00%
	Total	**$1,095.00**	**$360.00**	**$735.00**	**$567.00**	**32.88%**

Payer	Procedure	Provider Charge	Disallowed Amount	Allowable Reimbursement	Patient ** Responsibility	Estimated Discount From Charges
Assurant/MedCost	Colon+EGD - Hospital	$4,367.02	$873.40	$3,493.62	$2,083.81	20.00%
	Colon+EGD - Prof Anesthesia	$768.00	$0.00	$768.00	$768.00	0.00%
	Colon+EGD - CRNA	$400.00	$0.00	$400.00	$400.00	0.00%
	Total	**$5,535.02**	**$873.40**	**$4,661.62**	**$3,251.81**	**15.78%**
Proposed Facility	Colon+EGD - Facility Fee	$675.00	$150.00	$525.00	$262.50	22.22%
	Colon+EGD- Prof Anesthesia	$420.00	$210.00	$210.00	$42.00	50.00%
	Total	**$1,095.00**	**$360.00**	**$735.00**	**$304.50**	**32.88%**

*** "Global" fees include physician professional as well as facility reimbursement, which creates significant patient cost savings.**
**** The high deductible health plan for this patient results in much higher out-of-pocket costs versus other insurance payers.**