Petition Title: New CON Methodology Related to Ambulatory Surgical Operating Rooms Based on Pilot Demonstrations, Disclosure, and Consumer Choice

Petitioner:
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Request: The request is to (i) revise the composition and authority of the SHCC and (ii) establish parameters for more CON's to be issued where increased price competition would be beneficial to consumers to increase quality, access, and value of health care services. The results and core principles of this petition are to:

1. Lower cost of facility services;
2. Develop managed competition;
3. Increase disclosure and transparency of all facility costs for consumers (patients);
4. Increase (a) choice; (b) safety/quality; (c) access; and (d) value of facility services for consumers;
5. Protect the fragile rural health care delivery system;
6. Support increased levels of operational efficiency in facilities that can be documented and measured; and
7. Encourage innovation in health service delivery.

Adverse Effects: Excessive costs for facility services for consumers will continue to result in the market place without implementation of this petition's premises/objectives. Hospital providers will encounter increased competition based on the QAV Basic Principles or be managed under a "public service utility" type of approach.

Duplication: The proposed methodology allows competition where excessive pricing for facility services exists.

QAV: The petition is based on the SMFP's QAV Basic Principles.

It is the request of AHCF that hospital representatives and board members, as well as physician practice representatives, whose organizations possess CONs and who serve on the SHCC, maintain fiduciary conflicts of interest in regard to this petition and should not be permitted to vote on this petition.

It is important to note that very few participants in the health care system maintain true incentives to lower costs as described in the table below:

	Participants	**Incentive to Reduce Health Care Costs**
1	Insurance industry	No. Insurance payers and representatives are generally compensated as a percentage of medical expenses on a "mark-up basis." One of the greatest health industry misunderstandings is the belief that insurance payers and commissioned agents and consultants are truly motivated to reduce health care costs. As health costs rise, insurance participants gain increased revenues and earnings.
2	Hospitals	No primarily. Limited Yes. Increased charges generally result in increased revenues and earnings, especially for outpatient services with private payers as this petition describes. Hospitals have an incentive to reduce inpatient health care costs when paid on a prospective payment basis.
3	Physicians	No primarily. Limited Yes. Physicians are generally paid on a fee-for-service basis. Yet, many physicians continue to be concerned about the continuing burden of health care costs on their patients. As the leading care givers to patients with nurses, many, but not all, physicians tend to feel a responsibility to reduce health care costs while increasing access and safety/quality of health care services for patients.
4	Other health care providers	No. Most other health care providers are paid on a fee for service basis.
5	Pharmaceutical companies	No. Pharmaceutical companies are paid for each prescription ordered and purchased. There is an incentive to increase price and utilization of prescription drug use by consumers. However, it can be argued that prescription drugs used efficaciously can reduce hospitalization and other health care expenses.
6	Medical/DME suppliers	No. Suppliers are paid on a fee-for-service basis.
8	Consumers (Patients)	Yes with caveats. Consumers are often screened from the direct purchase costs of health care services, and if they are medially ill, there is limited incentive to seek less costly treatments. Medically ill patients seek to get well, often regardless of the cost to their health plan payer.
9	Government	Yes. Unequivocally the answer is "yes" unless lobbyists and conflicts of interests prevent elected representatives from voting on legislation that lowers health care costs.

Petition
State Health Coordinating Council ("SHCC")

Reformation of SHCC Composition and Expansion of Regulation of Health Care Facilities In the State of North Carolina

Proposed By:
Affordable Health Care Facilities, LLC
March 3, 2010

Preamble and Background

Affordable Health Care Facilities, LLC ("AHCF") has presented petitions to the SHCC in prior years. For the most part, the SHCC and the DHSR have chosen to ignore key tenets of the petitions, including:

1. increased transparency of health service pricing; and

2. Increased competition for licensed health care facilities.

It is AHCF's contention that the SHCC is primarily composed of individuals who (i) maintain conflicts of interest in holding their own CON's or representing organizations that hold CON's and (ii) do not have the political will to recommend substantive change to how the development of medical facilities in North Carolina are managed from an affordability perspective. Our nation cannot afford the health care delivery system as it is currently configured. The recent debate on health care reform has confirmed this contention. The trajectory of our national debt related to health care expenditures is unaffordable for nation and future generations of Americans.

On January 29, 2010 Attorney General Martha Coakley of Massachusetts released a preliminary report, Investigation of Health Care Cost Trends and Cost Drivers (attached herein as **Appendix A**). As we know, Massachusetts is a leading state working toward universal health insurance coverage for its citizens. However, Massachusetts is falling short of this universal goal from an affordability perspective. Attorney General Coakley is seeking to address this problem. The Boston Globe describes the preliminary report in a January 29 lead article:

> Coakley's staff found that payments were most closely tied to market leverage, with the largest hospitals and physician groups, those with brand-name recognition, and those that are geographically isolated able to demand the most money. "Everybody knows that there is dysfunction in the system, and nobody is happy with it,'' Coakley said in an interview yesterday. "These rising costs are unsustainable. If we don't do something about it, the only thing we'll be able to afford is health care. No one will have money for food or housing.''

The Certificate of Need ("CON") statutes were developed first and foremost to secure affordable health services:

> Article 9.
>
> Certificate of Need.
>
> **§ 131E-175. Findings of fact.**
> The General Assembly of North Carolina makes the following findings:
> (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.
> (2) That the increasing cost of health care services offered through health service facilities threatens the health and welfare of the citizens of this State in that citizens need assurance of economical and readily available health care.
> (3) That, if left to the market place to allocate health service facilities and health care 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.

It is AHCF's contention that CON regulation and the resulting SMFP have failed to adequately contain health care costs in North Carolina so as to result in affordable and accessible health insurance for our citizens, including large populations such as state employees.

Recommendation

AHCF recommends the following steps be taken to address rising health care costs in North Carolina:

1. The SHCC should be reconstituted in the following manner:

    a) The SHCC should be composed of members solely representing business and industry who (i) have no ties to health care providers through board membership or other association and (ii) are freely able to confirm that they possess no conflicts of interest.

    b) An advisory board to the newly constituted SHCC should be maintained that is composed of health care providers that represent all major components of the health care delivery system and can deliver important insight to the newly constituted membership of the SHCC.

2. The SHCC should recommend to the Governor and the North Carolina General Assembly that:

a) All health care facility service pricing (charges and reimbursement by payer) should be fully disclosed to consumers prior to the delivery of care in a transparent manner.

b) The newly constituted SHCC should be given increased regulatory authority to establish maximum charges by health care provider in much the form of a "public service utility" model.

c) In highly populated geographic areas where there is (i) confirmed consolidation of health care providers through integrated delivery systems ("IDS's") or otherwise and/or (ii) confirmed reimbursement to providers by private payers that is considered to be excessive by a "reasonable person" in relation to underlying costs or generally resulting in excessive financial returns, new applicant facilities should be given the opportunity to apply for CON's to increase competition for purposes of quality, access, and value.

AHCF fully recognizes that the above recommendations are beyond the purview of the SHCC and the DHSR in terms of authority to implement. The recommendations will require legislation enacted by the Governor and the NCGA. However, the SHCC and the DHSR can be bold in their leadership and fully consider these recommendations in a forthright manner and involve citizens and other interested parties to participate in the review of the effectiveness of the SMFP to maintain quality, access, and value of health services in North Carolina for our citizens through a more transparent approach than used to date.

Compelling Evidence

If Attorney General Cooper and his office undertook the same study of health care service pricing and reimbursement that Attorney General Coakley did in Massachusetts, AHCF believes that the same conclusions would be reached as to price being the key driver of rising health care costs. Compelling evidence can be found with most all health care facility-based services in North Carolina. With increasing employment of physicians by hospitals and larger health systems throughout the state, market leverage is only increasing so that payers, such as BCBSNC, have limited capability to negotiate reasonable reimbursement with hospitals and larger health systems.

CON protection has in effect provided medical facilities in North Carolina with monopolistic and oligopolistic market protection and leverage. This

market protection is only increasing with further horizontal and vertical integration by hospitals and health systems. The market leverage is best exemplified by the fact that most all hospitals/health systems negotiate only a discount off of billed charges for all outpatient services (e.g surgery, diagnostic testing, home health, DME) from BCBSNC. Most all physicians and their physician practices on the other hand all have fixed reimbursement generally established as a multiple percentage of Medicare. Hospitals should be held to fixed pricing like physicians. The financial weight of discount off of billed charges for outpatient services reimbursement falls mostly on non-Medicare patient populations.

Please review the November 2009 EOB from BCBSNC in **Appendix B** for a very common radiology service and established technology, a CT scan (pelvis and abdomen), performed at a non-profit, relatively urban community hospital:

Table I – CT Scan Reimbursement by BCBSNC (Hospital and Physician)

Facility Fee	Charge Amount	Contract Discount	Allowed Amount	Medicare Allowable
CT Abdomen (CPT 74170)	$3,111.78	$1,717.70	$1,394.08	$311.49
CT Pelvis (CPT 72193)	$2,628.77	$1,451.01	$1,177.76	$241.76
Facility Services	$515.60	$284.61	$230.99	N/A
Total Facility Fees	$6,256.15	$3,453.32	$2,802.83	$553.25

Physician Fee	Charge Amount	Contract Discount	Allowed Amount	Medicare Allowable
CT Abdomen (CPT 74170)	$212.00	$74.52	$137.48	$69.21
CT Pelvis (CPT 72193)	$187.00	$72.90	$114.10	$57.53

Facility Fee	Charge MCare Ratio	Allowable MCare Ratio	Effective Discount
CT Abdomen (CPT 74170)	999.00%	447.55%	55.20%
CT Pelvis (CPT 72193)	1087.35%	487.16%	55.20%
Facility Services	N/A	N/A	55.20%
Total Facility Fees	1130.80%	506.61%	55.20%

Physician Fee	Charge MCare Ratio	Allowable MCare Ratio
CT Abdomen (CPT 74170)	306.31%	198.64%
CT Pelvis (CPT 72193)	325.05%	198.33%

The hospital charge to Medicare allowable ratio for the facility fees was over 1,000%, nothing short of outrageous. The ultimate BCBSNC discount was 55.20% for the facility portion, which confirms a flat discount off of charge approach for reimbursement. The physician reimbursement is approximately 198% of Medicare, which is within the acceptable range.

The argument that hospitals have greater expenses due to uncompensated care than physicians does not "hold water" under rigorous analysis. First, hospitals receive disproportionate share payments from the federal government to account for uncompensated care. Please refer to **Appendix C** for disproportionate share payments made to North Carolina hospitals for Fiscal Year 2009. The purpose of these payments is to partially reimburse hospitals for uncompensated care provided. Second, physicians provide professional services as uncompensated care but receive no federal subsidies under the disproportionate share program.

It also can be argued that BCBSNC and other private payers have limited employers to maintain complete provider networks without disruption. Perhaps more importantly, private payers earn more revenues as health care expenses increase as most off of their administrative and risk fees are calculated as a "cost-plus" mark-up of paid/allowable health care expenses.

As the aforementioned radiology facility bill was further negotiated with the hospital, an argument was made by the hospital to the following effect in a "sanitized" quotation of this discussion:

> We subscribe to a comparative pricing service (PMMC) out of Charlotte. PMMC uploads Medicare data into a reporting system. We ran a comparative charge report with these two CPT's comparing [this hospital] to a Market Average which included the following hospitals [list of 8 in the region]. The time frame was calendar 2008 (the most current that they had available). The variance in our charges for these procedures compared to the market was about $229.

This statement almost proves that hospitals in North Carolina compare pricing with each other and "shadow price." Without more management of pricing that is more closely related to underlying costs, the citizens of North Carolina, private payers, and state government will continue to pay outrageous reimbursement for health services from medical facilities, particularly the larger ones with more market leverage. The question that we must ask is what is fair reimbursement for a hospital in North Carolina or any other state?

Below in **Table II: Sample Hospital Financial Performance**, I have prepared an algebraic model for proposed hospital UCR reimbursement without

geographic, medical education, and other adjustments as a modeling exercise for UCR reimbursement.

Assumptions/Explanation:

1. Total operations costs are equal to $100 for all health services at a sample hospital.

2. Target total reimbursement is equal to 105 or 5% above operations cost. A 5% percent earnings margin from operations is fair for a not-for-profit hospital.

3. The patient payer mix is 42% Medicare; 2% TriCare; 6% Medicaid; 6% FEHP and SEHP (government employee health plans); 31% Commercial; 3% Private Pay; and 10% Charity Care.

4. The cost to reimbursement ratio column assumes that Medicare reimbursement is 75% of cost ($100). Medicaid reimbursement is set at 80% of Medicare or 60%. FEHP/SEHP reimbursement is set at 60% above Medicare or 120%.[1] Private Pay reimbursement is set at 30% 0r 40% of Medicare. Charity Care has no reimbursement or 0%.

The Commercial Payer "Cost to Reimbursement Ratio" is set (backed into) at the level that results in target reimbursement being equal to $105. In the table below, this Commercial reimbursement is calculated to be 194.50% of cost or 259.33% of Medicare.

Table II: Sample Hospital Financial Performance

	Payer Mix	Cost to Reimb. Ratio	Weighted Average	% of Medicare
Medicare	42.00%	75.00%	$31.50	100.00%
TriCare	2.00%	75.00%	$1.50	100.00%
Medicaid	6.00%	60.00%	$3.60	80.00%
FEHP and SEHP	6.00%	120.00%	$7.20	160.00%
Commercial	31.00%	194.50%	$60.30	259.33%
Private Pay	3.00%	30.00%	$0.90	40.00%
Charity Care	10.00%	0.00%	$0.00	0.00%
	100.00%		$105.00	
Target Reimbursement			$105.00	

[1] The GAO and CBO may have more accurate estimates as to what percentage of actual cost is covered by government sponsored health plans. If Medicare covers more than 75% of cost, then less cost shifting to private commercial payers would be required.

This computation is approximately 50% of what BCBSNC agreed to reimburse the hospital for the CT-Scans (506.61% of Medicare) in November 2009 as shown in **Table I**.

Lastly, recent research as shown in **Appendix D** has shown that ASC's offer lower cost and higher quality alternatives for consumers. The single specialty pilot demonstration for ASC's approved by the SHCC in 2009 does little to provide needed competition at the price and quality level for hospitals. We need more price competition for hospitals with ASC's.

Conclusion

If we as a state and as a nation wish to make health care affordable and universally available to all citizens, then we must make it affordable. CON legislation has failed to manage health care costs in an adequate model given evidence presented in this petition and references. Therefore, AHCF recommends a more heavy handed approach to regulating facilities and their pricing, especially given increasing market concentration and leverage resulting from expanding IDS's (e.g. vertical and horizontal integration, including physician employment). This management should begin with a reformation of the SHCC and its membership due to conflicts of interest.

A more palliative alternative may be to more fully open competition among health care facilities where excessive reimbursement can be documented as AHCF has proposed in prior petitions. If the SHCC cannot overcome its member conflicts of interests and does not have the political will to pursue such managed competition, then we as consumers are left with little other recourse than to recommend increased price regulation under a "public service utility" model.