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2016-2017 Operating Room Methodology Workgroup
Public Comments
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Good morning. I appreciate the opportunity to address the group and the public with thoughts I have about the current methodology. I know I also have the opportunity to address these issues as a member of the workgroup, but I wanted to present my thoughts in a more organized, public fashion.

First, while I know that revising a methodology is a significant undertaking, I think we would be remiss if we did not step back to evaluate the methodology in light of the Basic Principles in the SMFP: Safety and Quality, Access and Value. Every petitioner to the SHCC is asked to address how their petition lines up with these principles, so I think it's only fair for the workgroup to do the same. Of course, there must be a balance among all of these principles, and no methodology is perfect, but I think the more we strive to ensure that the methodology is as effective as possible in meeting these principles, the better the outcome will be.

Second, I think one of the challenges with the current methodology is that all operating rooms are considered collectively. That is, there is no difference between dedicated inpatient, shared, or dedicated outpatient operating rooms; there is no difference between hospital-based or freestanding operating rooms. This makes the methodology simpler, in a way I suppose, but it makes the

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practicality of the methodology less effective. Hospitals fill a vital role in the healthcare continuum, but so, too, do ambulatory facilities. On average, ASCs perform far fewer cases per OR than do hospitals, but they are also available fewer hours and often cannot (or will not) accommodate the sickest and most disadvantaged among us, at least not to the degree hospitals do. Yet, we also know that access to ASCs can play an important role in lowering costs and enabling collaboration. But we must also recognize that hospitals are still the safety net providers across the state, and often rely on revenue from surgery cases to care for those that cannot pay. Standing here today, I do not know the best way to balance these tensions, but I hope our discussions can stimulate good ideas. One suggestion that may be worth exploring is whether we can separate hospital-based ORs from ASC ORs in the methodology, but let the need generated by either analysis be applied for by any type of provider. I hope others have thoughts on this.

My third point ties in with the second, and that is the wide variation in utilization among providers in the same service area. This mostly impacts the larger, urban areas with multiple providers in the same service area. Currently, if some providers are well-utilized while others are less so, a need is not generated until some providers are so heavily utilized that it outweighs the other providers, putting those in need of more ORs in a difficult situation. We should also remember that in some areas, providers have ORs that they never really use. When the CON law was amended in 2001 to make all ORs subject to CON review, there were many, many applications for ORs prior to the development of a methodology in the SMFP, with dozens of new ORs approved across the state. Some of these have never been fully utilized, so while they remain in the inventory, I don't think we can ignore the impact on providers in the same service areas with more limited capacity. I recognize that the solution to this is not a simple one, but perhaps a methodology that at tracked growth rates for individual providers, such that if it reached a certain level greater than the rest of

the service area, need could be generated. Again, this is something I hope others have ideas about.

A related issue to this that I did not provide in my written comments but which I feel strongly about: although this occurs with other services in the SMFP, it seems to happen most frequently with ORs, and that is the number of CONs issued pursuant to need determinations that lie dormant for years before they are developed. Here are some examples:

- A CON for three ORs pursuant to a need determination in the 2006 SMFP—ORs eventually developed in 2014, eight years later.
- A CON for one OR pursuant to a need determination in the 2006 SMFP—OR is currently under development.
- A CON for one OR pursuant to a need determination in the 2009 SMFP—OR still undeveloped.
- A CON for three ORs pursuant to a need determination in the 2010 SMFP—ORs are still undeveloped.

I am not trying to call out anyone, and I am sure there are extenuating circumstances for each. Martha and her team do a good job at following up on the progress of these projects; however, without a policy to support it, it's hard to place a time limit on the development of these ORs. I also want to be clear—I'm not talking about projects that involve moving assets around that are already in use and owned by an applicant that wants to do something else with them. When those projects are delayed, the assets are usually already in use, so the delay doesn't create issues with undeveloped services. What I am concerned about is the OR methodology in the SMFP identifying a need for more capacity, the CON being issued, and the approved applicant waiting years before developing the ORs. This may end up needing to be a recommendation beyond the scope of this workgroup, but I know the last OR workgroup made several

recommendations of larger scope to the SHCC. I do think a policy which limits the amount of time that those awarded a CON pursuant to need determinations have before they can begin developing their projects, perhaps even just in competitive reviews, would be helpful in ensuring that identified needs are actually being addressed.

Fourth is the procedure room quandary I mentioned at the last meeting. Procedure rooms are not regulated by the CON or SMFP process, yet they are often used for the same cases that are performed in operating rooms. This is not a new issue, but it does raise questions for the methodology. Previously, surgical cases performed in procedure rooms were counted in the OR methodology. Currently they are not. Existing licensed providers can develop procedure rooms and use them for surgical cases if they need additional capacity that the OR methodology has not allocated. No change in the OR methodology will regulate these rooms; however, I do wonder whether situation could be improved by at least identifying and quantifying these cases, or perhaps by developing a methodology that would allow need for additional ORs to be generated before providers feel compelled to build procedure rooms for their surgical cases.

Finally, while my written comments address some of the finer points of the current methodology, I won't take the time to do that here today. I am sure we'll be discussing the data and the various steps in the methodology as we go through the next few months.

Thank you all for your time.