Acute Care Services Committee
Single Specialty Ambulatory Surgery Facility Demonstration Project
Final Report, September 17, 2019

Background

The 2010 State Medical Facilities Plan (SMFP) included adjusted need determinations for three new separately licensed single specialty ambulatory surgical facilities (ASF) with two operating rooms (ORs) each. The SHCC chairman established a workgroup in 2009 to develop a plan for the demonstration project. The workgroup was charged to do the following.

- Develop a plan to evaluate and test the concept of single special ambulatory surgery centers in North Carolina.
- Formulate recommendations regarding the number of sites and potential geographic locations for pilot projects.
- Identify measures that can be used to evaluate the success of the pilot projects, to include measures of value, access to the uninsured, and quality and safety of care.
- Recommend how the test sites will be held accountable and responsible in the event they are unsuccessful in meeting target guidelines.

No overall goal of the demonstration was articulated, but the evaluation criteria indicated that the Agency was to examine whether physician-owned single specialty ASF are able to improve safety and quality, access, and value. The demonstration sites needed to show that the ASFs can provide services to patients who are indigent, specifically Medicaid recipients and self-pay or charity patients. The purpose of the Agency's evaluation is to make recommendations regarding the future of the demonstration project.

The three demonstration project facilities are:
- Piedmont Outpatient Surgery Center (POSC) in Winston-Salem, an Otolaryngology (ENT) surgery center, licensed February 6, 2012.
- Triangle Orthopaedics Surgery Center (TOSC) in Raleigh, licensed February 25, 2013.
- Mallard Creek Surgery Center (MCSC) in Charlotte, an orthopedic surgery center licensed May 1, 2014

The Agency received reports annually for 5 years for each facility, detailing their compliance with the demonstration project criteria in the SMFP. The Agency was directed to evaluate the project after all facilities had submitted 5 annual reports. The last report was received in 2019.

Adherence to Demonstration Criteria

The 2010 SMFP set out several criteria on which the facilities were to be assessed (see Attachment 1). The criteria are based on the principles of quality, access, and value laid out in

Chapter 1 of the SMFP. Each facility submitted an annual report to Certificate of Need (CON) describing their activities during the previous 12 months.

Attachment 2 is a summary of the criteria and how the facilities adhered to each one. With one exception, the facilities appeared to have no barriers to adhering to all criteria. The exception was the requirement 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" (see Attachment 1 for a detail description). The Agency had concerns regarding why the facilities did not always meet this important criterion. In fact, the Agency required corrective action for one facility (TOSC). TOSC was able to increase its services to indigent patients as a result of this corrective action.

What came to be called the "7% requirement" was problematic for two primary reasons. First, the criterion required examination of revenue "collected" for cases performed during the reporting year. Standard accounting practices use revenue "earned." Cases performed near the end of the reporting year were likely to show no revenue collected, because claims were still being processed by payers. Therefore, the amount of revenue actually collected in a reporting year may be lower than the revenue earned during that year.

Second, the 7% requirement was based on Medicare allowable reimbursement amounts. OrthoCarolina (Mallard Creek Surgery Center) raised this concern in a petition received in the Summer of 2017. During the time that the demonstration was ongoing, private insurance providers began to cover procedures in ASFs that they previously covered only in hospitals. However, the Centers for Medicare and Medicaid Services (CMS) did not yet cover these facilities in ASFs. Therefore, these procedures had no Medicare allowable reimbursement rate. When a procedure with no Medicare allowable amount was covered by private insurance, the calculations for the 7% requirement could suppress the revenue attributed to Medicaid and self-pay. See Tables 1 through 4 in Attachment 3 for a more detailed explanation of the effects of this situation.

As a result of these concerns, the Agency changed the calculations for reports submitted in 2018 and 2019 to the following:

> The percentage of the facility's total ~~collected~~ earned 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~~ earned from self-pay and Medicaid cases, divided by the total ~~collected~~ earned revenues for all surgical cases performed in the facility for procedures for which there is a Medicare allowable fee.

Agency Analysis

The overarching evaluation question in the Agency's examination of the project as a whole is whether single specialty ASFs improved quality and safety, access, and value. It is worthy of note that the Agency cannot determine whether there were improvements on any of these measures, because all of the facilities were new. Thus no baseline measures were available. It was possible to determine whether there were improvements during the course of the demonstration, though.

In terms of quality and safety, all three facilities showed consistently high marks in these areas in all five years of the demonstration. Quality and safety were measured by examination of adverse surgical outcomes and results of the surgical safety checklist.

Based on the 7% requirement calculations, the annual reports show that they can provide access to indigent patients, but just barely (Table 1). Facilities reported that the recruitment of indigent patients required much diligence.

Table 1. Percentage of Self-Pay/Charity Care, and Medicaid Revenue, from Demonstration Project Reports

Report Submission Year	% Self-Pay/Charity Care and Medicaid Revenue		
	Piedmont Outpatient Surgery Center	Triangle Outpatient Surgery Center	Mallard Creek Surgery Center
2013	12		
2014	12	9	
2015	7	8	7
2016	8	5	7
2017	11	11	8
2018*		10	8
2019*			8

*Revised 7% calculation used.
Source: Demonstration Project annual reports

Table 2 shows the percentage of self-pay/charity care and Medicaid patients based on the payer mix chart on the annual license renewal applications. At the time the Agency implemented the change in the 7% requirement calculation, POSC had completed its reporting requirements. This facility had consistently been able to exceed the 7% requirement. An important reason for this result is that POSC had a large proportion of pediatric patients. The two most common procedures performed were tonsillectomy/adenoidectomy and tympanostomy. These procedures, most commonly performed on children, accounted for about half of POSC's total surgical volume[1]. This fact helped POSC serve a relatively large number of Medicaid patients. Even so, POSC's 7% requirement percentage was not much higher than the other two facilities, in part because these two procedures do not produce large revenue.

The two remaining facilities had more challenges meeting the 7% requirement simply because they are orthopedic facilities. Two factors are important. First, adults comprise a minority of Medicaid enrollees. The likelihood of Medicaid-covered patients requiring orthopedic surgery is probably lower than their likelihood of requiring many other types of surgery. Second, for several years of operation, some relatively high-revenue procedures (e.g., total knee replacement) did not

[1] In 2018, 53% of North Carolina Medicaid enrollees were children.
https://www.northcarolinahealthnews.org/2019/06/06/medicaid-by-the-numbers-2019/

have an ASF Medicare allowable amount, even though private insurers covered them in ASFs. It was not until 2018 that CMS established Medicare allowable reimbursement for some of these more complicated procedures.

Table 2. Self-Pay, Charity Care, and Medicaid Patients as a Percentage of Total Patients

Licensure Year	% Self-Pay/Charity and Medicaid Patients		
	Piedmont Outpatient Surgery Center	Triangle Outpatient Surgery Center	Mallard Creek Surgery Center
2014	39		
2015	33	17	
2016	33	14	11
2017	35*	7	15
2018	35	7*	14
2019	35	7	12*

* Last year of demonstration project
Source: Ambulatory Surgical Facility License Renewal Applications

A secondary question is how such facilities compare to other ASFs and to ambulatory surgical services in hospitals. To address this question, we used payer mix data from license renewal applications. Table 3 shows the results for the FFY 2018 reporting year, for facilities with a full year of data.[2] Eye surgery centers were also excluded because their patient mix is highly skewed toward Medicare as the primary payer (69%).

[2] Three new facilities that had partial data and were excluded. The new single specialty dental surgery centers were also excluded because they were too new to have a full year of data.

Table 3. Payer Mix Comparisons, 2018

Facility	Payer Source (%)				
	Self-Pay/ Charity	Medicaid	Medicare	Insurance	Other/ Unknown
POSC	1.5	33.1	11.6	53.8	0.0
TOSC	1.9	5.5	15.6	69.1	7.8
MCSC	7.2	4.7	16.0	63.7	8.5
Multispecialty ASFs (n=29)	1.8	9.3	38.6	47.0	3.3
Other Orthopedic ASFs (n=2)	0.9	2.3	27.7	63.9	5.2
All ASFs	1.9	8.1	43.0	43.7	3.4
Hospital Ambulatory Surgery	5.9	12.9	36.6	40.7	4.5

Source: 2019 Ambulatory Surgery Facility and Hospital License Renewal Applications

Table 3 shows that the two orthopedic demonstration sites had a somewhat similar payer mix as other orthopedic ASFs, but the profile differed substantially from multispecialty ASFs. Overall, multispecialty ASFs served a higher percentage of indigent patients than single specialty ASFs. On a national level in 2017, ASFs had a mean of 9% and a median of 6% of cases covered by Medicaid. Note that this figure includes all specialties as well as gastrointestinal (GI) endoscopies[3]. The statistics in Table 3 exclude GI endoscopies.

Table 3 include the hospital-based ambulatory surgical payer mis as a point of reference only. Self-pay/Charity Care, Medicaid, and Medicare patients typically represent a large proportion of ambulatory surgical patients seen in hospitals.

Conclusions and Recommendation

In general, the demonstration project showed that single specialty ASFs serve indigent patients, and do so in a way that reflects the basic principles of quality, access, and value. The 7% requirement was based on the notion that facilities needed to be able to generate sufficient revenue while serving indigent patients. Based on annual evaluation reports, the demonstration sites had to work diligently to recruit sufficient indigent patients to achieve the 7% objective. It is unknown whether these facilities would continue the outreach activities necessary to recruit indigent patients over the long term.

A specific aim of the demonstration appears to be to show that single specialty ASFs can provide access to indigent patients while maintaining quality and safety of care. Table 3 shows that the demonstration sites fared better than other single specialty ASFs in this regard. However, multispecialty ASFs served a higher proportion of indigent patients than the single specialty

[3] VMG Health (January 11, 2018). *Multi-Specialty ASC Study Intellimarker 2017*. https://vmghealth.com

orthopedic ASFs. This finding is not surprising, because multispecialty ASFs have a broader patient base, which may result in more patients who are covered by Medicaid.

It is also not surprising that POSC served a high proportion of Medicaid patients because of their large pediatric population base. By comparison, the state has one other ENT ASF; 34% of its patients are covered by Medicaid and slightly less than 1% are self-pay/charity care patients. Based on this very limited comparison, it does not appear that the demonstration project increased access to ENT services in ASFs.

The workgroup that recommended the demonstration project asked the SHCC to consider "allowing expansion of single specialty ambulatory surgical facilities beyond the original three demonstration sites." The access principle of the SMFP has been interpreted to indicate a preference for multispecialty ASFs. It is unclear whether the intent was to give single specialty facilities the same priority as multispecialty facilities in CON applications.

Regardless, based on this analysis, the Agency sees no reason to extend the demonstration period for these facilities nor to expand the demonstration to other facilities. Therefore, we recommend that the demonstration be concluded and the facilities be included in the SMFP on the same basis as all other ASFs. That is, their inventory and procedures will be incorporated into the need determination methodology beginning with the 2020 SMFP.

Attachment 1

Table 6D: Single Specialty Ambulatory Surgery Facility Demonstration Project

CRITERIA	CRITERIA BASIC PRINCIPLE AND RATIONALE
Establish a special need determination for three new separately licensed single specialty ambulatory surgical facilities with two operating rooms each, such that there is a need identified for one new ambulatory surgical facility in each of the three following service areas: • Mecklenburg, Cabarrus, Union counties (Charlotte Area) • Guilford, Forsyth counties (Triad) • Wake, Durham, Orange counties (Triangle)	*Value* At least one county in each of the groups of counties has a current population greater than or equal to 200,000 and more than 50 total ambulatory/shared operating rooms and at least 1 separately licensed Ambulatory Surgery Center. Locating facilities in high population areas with a large number of operating rooms and existing ambulatory surgery providers prevents the facilities from harming hospitals in rural areas, which need revenue from surgical services to offset losses from other necessary services such as emergency department services.
In choosing among competing demonstration project facilities, priority will be given to facilities that are owned wholly or in part by physicians.	*Value* Giving priority to demonstration project facilities owned wholly or in part by physicians is an innovative idea with the potential to improve safety, quality, access and value. Implementing this innovation through a demonstration project enables the State Health Coordinating Council to monitor and evaluate the innovation's impact.
Each demonstration project facility shall provide care to the indigent population, as described below: 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. Following are examples of the calculation of self pay and Medicaid revenue: If Medicare allows $300 for a surgical procedure and a self-pay patient pays the facility $0, then $300 is considered self-pay revenue. If Medicare allows $300 for a surgical procedure and a self-pay patient pays the facility $50, then $250 is considered self-pay revenue.	*Access* Requiring service to indigent patients promotes equitable access to the services provided by the demonstration project facilities.

CRITERIA	CRITERIA BASIC PRINCIPLE AND RATIONALE
If Medicare allows $300 for a surgical procedure and Medicaid pays the facility $225, then $75 is considered Medicaid revenue. Demonstration project facilities shall report utilization and payment data to the statewide data processor as required by G.S. 131E-214.2. The Agency will monitor compliance with indigent care requirements by analyzing payment data submitted by the facilities.	
Demonstration project facilities shall complete a "Surgical Safety Checklist (adapted for use in the US)" before each surgery is performed. Note: "Surgical Safety Checklist is based on the WHO Surgical Safety Checklist developed by: World Health Organization" Each demonstration project facility shall develop a system to measure and report patient outcomes to the Agency for the purpose of monitoring the quality of care provided in the facility. If patient outcome measures are available for a facility's particular surgical specialty, the facility shall identify those measures and may use them for reporting patient outcomes. If patient outcome measures are not available, the facility shall develop its own patient outcome measures that will be reported to the Agency. Demonstration project facilities shall submit annual reports to the Agency regarding the results of patient outcome measures. Examples of patient outcome measures include: wound infection rate, post-operative infections, post-procedure complications, readmission, and medication errors.	*Safety and Quality* Implementing a system for measuring and reporting quality promotes identification and correction of quality of care issues and overall improvement in the quality of care provided.
Demonstration project facilities are encouraged to develop systems that will enhance communication and ease data collection, for example, electronic medical records that support interoperability with other providers.	*Safety and Quality, Access, Value* Electronic medical records improve the collection of quality and access to care data and collecting data is the first step in monitoring and improving quality of care and access. Interoperability facilitates communication among providers, enhancing care coordination.
Demonstration project facilities are encouraged to provide open access to physicians.	*Access* Services will be accessible to a greater number of surgical patients if the facility has an open access policy for physicians.

CRITERIA	CRITERIA BASIC PRINCIPLE AND RATIONALE
Physicians affiliated with the demonstration project facilities are required to establish or maintain hospital staff privileges with at least one hospital and to begin or continue meeting Emergency Department coverage responsibilities with at least one hospital, with the following caveat: This requirement has to be available to the physicians and not denied based upon charges that physicians are engaging in competitive behavior by providing services at a facility that is perceived to be in competition with the hospital if it so happens that the CON is issued to an organization other than the hospital. Additionally, physicians affiliated with the demonstration project facilities are required to provide annually to the Agency data related to meeting their hospital staff privilege and Emergency Department coverage responsibilities. Specific data to be reported, such as number of nights on call, will be determined by the Agency.	*Safety and Quality* Encouraging physicians to establish or maintain hospital staff privileges and to begin or continue meeting Emergency Department coverage responsibilities helps prevent a decrease in the quality of the overall healthcare system resulting from lack of resources.
Facilities shall obtain a license no later than two years from the date of issuance of the certificate of need, unless this requirement is changed in a subsequent State Medical Facilities Plan.	*Access and Value* Timely project completion increases access to services and enhances project value.
The Single Specialty Ambulatory Surgery Work Group values the collective wisdom of the North Carolina Hospital Association and the North Carolina Medical Society and requests that the two organizations work together to assist the demonstration project facilities in developing quality measures and increasing access to the underserved.	*Safety and Quality, Access and Value* Collaboration between the North Carolina Hospital Association and the North Carolina Medical Society in an effort to develop quality measures and increase access to the underserved promotes all three Basic Principles.
Facilities will provide annual reports to the Agency showing the facility's compliance with the demonstration project criteria in the State Medical Facilities Plan. The Agency may specify the reporting requirements and reporting format. The Agency will perform an evaluation of each facility at the end of the first calendar year the facility is in operation and will perform an annual evaluation of each facility thereafter. The Agency may require corrective action if the Agency determines that a facility is not meeting or is not making good progress toward meeting the demonstration project criteria.	*Safety and Quality, Access, Value* Timely monitoring enables the Agency to determine if facilities are meeting criteria and to take corrective action if facilities fail to meet criteria. This ensures that all three Basic Principles are met by the demonstration project facilities.

CRITERIA	CRITERIA BASIC PRINCIPLE AND RATIONALE
The Agency will evaluate each facility after each facility has been in operation for five years. If the Agency determines that the facilities are meeting or exceeding all criteria, the work group encourages the State Health Coordinating Council to consider allowing expansion of single specialty ambulatory surgical facilities beyond the original three demonstration sites. The Agency may require corrective action if the Agency determines that a facility is not meeting or is not making good progress toward meeting the demonstration project criteria. If the Agency determines that a facility is not in compliance with any one of the demonstration project criteria, the Department, in accordance with G.S. 131E-190, "may bring an action in Wake County Superior Court or the superior court of any county in which the certificate of need is to be utilized for injunctive relief, temporary or permanent, requiring the recipient, or its successor, to materially comply with the representations in its application. The Department may also bring an action in Wake County Superior Court or the superior court of any county in which the certificate of need is to be utilized to enforce the provisions of this subsection and G.S. 131E-181(b) and the rules adopted in accordance with this subsection and G.S. 131E-181(b)."	

Attachment 2: Evaluation Detail

Criterion Description	Result
Physician Ownership	
In choosing demonstration sites, facilities owned wholly or in part by physicians received priority. All three sites adhered to this criterion.	All facilities were own wholly or in part by physicians.
Provide Care to People Who Are Indigent	
Each facility had to show 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. The Medicare allowable amount for self-pay the Medicaid surgical cases minus all revenue collected form self-pay and Medicaid cases divided by the total collected revenues for all surgical cases performed in the facility (2020 SMFP).	Adherence to this criterion proved problematic. This issue is discussed in more detail in the body of this report.
Surgical Safety	
The demonstration required each facility to complete the surgical safety checklist before each surgery. The checklist to be used was developed by the World Health Organization and adapted for use in the US.	All facilities demonstrated adherence to this criterion. They each showed a very high degree of safety, based on data from the checklist.
Communication	
Facilities were encouraged, but not required, to develop systems to enhance communication and support interoperability with other providers. The primary means to accomplish this goal is by use of electronic health records.	Two of the three facilities implemented an electronic health records system. The third facility, MCSC, used a manual system to facilitate record-keeping and communication.

Criterion Description	Result
Open Access	
Facilities were encouraged to provide open access to physicians, regardless of their ownership status. In addition, all physicians who practice at the facility must establish or maintain hospital privileges at at least one hospital. They must also begin or continue to provide emergency department coverage responsibilities with at least one hospital.	All facilities adhered to this criterion. Reports showed that all physicians maintained privileges at local hospitals and took emergency call as prescribed.
Timeliness of Licensure	
Facilities were required to obtain a license no later than two years from the date of issuance of the certificate of need (CON).	All three facilities met this requirement.
Develop Quality Measures (Patient Outcomes)	
The 2010 SMFP encouraged the North Carolina Healthcare Association (formerly North Carolina Hospital Association) and the North Carolina Medical Society to collaborate to develop quality measures and means to increase access to the underserved.	The records contain no evidence that this collaboration took place. However, the reporting forms used by CON contained several quality measures. The facilities reported on these measures, and frequently reported on others as well. The measures were: wound infection rate, number and percentage of post-operative infections; number and percentage of post-procedure complications; number and percentage of readmissions; and the number and percentage of medication errors. Results showed a very low incidence of negative outcomes.
Provide Annual Reports	
Facilities will provide annual reports to the Agency showing the facility's compliance with the demonstration project criteria.	All facilities adhered to this criterion.
Corrective Action	
The Agency may require corrective action if it determines that a facility is not meeting or is not making good progress toward meeting the demonstration project criteria.	TOSC was required to undertake corrective action due to failure to meet the 7% requirement. The reported to the Acute Care Services Committee as required, and improved their services to indigent patients.

Attachment 3

OrthoCarolina

EXCELLENCE
IN ORTHOPEDICS

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.