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North Carolina Hospital Association

July 31, 2009

MEMORANDUM

TO: Victoria McClanahan, Planner
Medical Facilities Planning Section
NC Division of Health Service Regulation

FROM: Mike Vicario, Vice President of Regulatory Affairs
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SUBJECT: Comments/ Single Specialty Ambulatory Surgery Demonstration Project

The Proposed 2010 State Medical Facilities Plan includes a request for comments on the Single Specialty Ambulatory Surgery Demonstration Project by the end of July 2009. NCHA has the following comments on the Demonstration Project, which currently proposes three ambulatory surgery centers with two operating rooms each, one in the Triad, one in the Triangle and one in the Charlotte Metro area of North Carolina.

1. *Service Areas*: The location of the proposed demonstration projects was chosen as the three largest metropolitan areas with counties having 200,000 persons, more than 50 ORs and at least one separately licensed ambulatory surgery center. This to "prevent the facilities from harming hospitals in rural areas, which need revenue from surgical services to offset losses from other necessary services..." The need for hospitals to cost shift between services is a characteristic of today's healthcare finance system, one that the State Health Coordinating Council should consider as it deliberates whether expensive operating room and other resources are best utilized by numerous physician specialties in a community-based hospital model, or by single specialists seeking convenient sites for their selected surgeries. However there are other related factors that might also affect hospitals in the service areas selected for this project. The number and utilization of existing ambulatory surgery centers, and the number of surplus operating rooms in the area, as defined by the State's well-established need methodology, could increase the potential for financial harm to existing hospital surgery programs. These utilization based factors are taken into account in the OR need methodology, resulting in the identification of needed or surplus ORs in a service area. However, these same factors, which are central to the determination of need, have not been accounted for in the establishment of the specialty surgery demonstration projects.

   The three demonstration projects could be better coordinated with the existing need methodology for operating rooms by expanding the service areas to include HSAs I and II (including the Triad), HSAs III and V (including Charlotte), and HSAs IV and VI (including the Triangle). These regions include the three original service areas, but also would allow the CON Section to review applications from other locations. This would also be consistent with previous demonstration projects, which have normally included the entire state. This proposed amendment would enhance

the policy and would "*prevent the demonstration facilities from harming hospitals both in rural areas and in areas where excess ORs and multiple ambulatory surgery sites exist by diminishing their ability to offset losses from other necessary services through the provision of surgical services"* as follows.

In order to minimize the negative affect of developing new operating rooms in these areas, the CON Section should consider factors such as population, the number and utilization of existing ambulatory and other operating rooms, and the payer mix of existing providers. It should also require applicants to document how their proposed project will be consistent with the statutory requirement to ensure that applications do not result in unnecessary duplication of health service capabilities or facilities, as well as provide a specific explanation as to how the applicant proposes to serve a defined set of patients more effectively than the current organization of ambulatory surgery services and providers.

2. *Physician ownership*: NCHA does not believe that a wholly physician-owned surgery center model would incorporate any additional benefits with regard to quality, access or value than other ownership structures. NCHA would not support a policy that provides differential preference to projects with higher percentages of physician ownership. Any proposal for a separately licensed, single specialty ambulatory surgery center, with partial or total physician ownership, should be eligible for participation in the demonstration project with equal status.

3. *Indigent care requirement*: NCHA does not support the current option that allows each surgery center to establish an amount equal to at least 7% of its total revenues provided to indigent ***or*** Medicaid patients as a means of demonstrating accessibility to services. According to 2010 Hospital License Renewal information, 3.5% of ambulatory surgical cases are Self Pay/Indigent/Charity patients, and 12.2% of ambulatory surgical cases are Medicaid patients, totaling 15.7% of cases. A goal of the demonstration project is to establish a firm commitment to serve medically underserved populations. Both indigent (or self pay) persons and Medicaid recipients represent "medically underserved" patients.

   The Demonstration Project proposal requires only 7% of revenue, and each surgery center has the option to provide this level to indigent ***or*** Medicaid patients as a means of demonstrating accessibility to services. This wording does not specifically require the provision of a "self pay" policy or the treatment of any self-pay or indigent patients. Instead the policy permits providers to apply the difference between Medicaid and Medicare payments for same procedures toward an obligation of "at least seven percent of total revenue." This would enable an applicant to forego any services to indigent or self pay patients by relying entirely on Medicaid differentials, or contractual allowances, to meet the 7% obligation. Without a requirement to serve uninsured patients, this proposal fails to guarantee equal "access" to all medically underserved patients.

   Across the state communities face worsening situations as the numbers of unemployed and uninsured continue to rise. North Carolina hospital charity care costs have risen more than 30% for each of the past three years. Establishing a surgery center demonstration project without a

requirement to serve the uninsured will increase the mal-distribution of non-paying patients referred to hospitals for their surgery. NCHA believes that any proposal for a demonstration surgery center should include a policy to serve *all* payer classes, with a commitment to provide an amount of uncompensated care equal to the amount provided by others in the community where the facility is to be located, and an agreement to provide documentation of compliance with that policy.

Without this requirement, many existing ambulatory surgery providers will be put in the position of serving a proportionally greater share of the indigent and Medicaid patient populations from whom lower reimbursement is received, while experiencing a reduction in the volume of privately insured patients that typically subsidize these medically underserved patients.

4. *Emergency Call:* Physician owners of surgery centers are less likely to have relationships with their community hospital, including full admitting privileges and acceptance of emergency call. NCHA supports the recommendation that physicians involved in any approved demonstration project establish or maintain privileges at an area hospital and begin or continue meeting emergency department coverage responsibilities. Any specific issues that might inhibit a physician's opportunity to obtain privileges should be considered on a case-by-case basis as part of the evaluation process.

5. *Evaluation:* The demonstration pilot is proposed to include evaluations at three and five year intervals. As provisions in the existing CON law will be used to rectify projects that do not meet stated objectives, the annual evaluation must be rigorous, focused on the key elements of performance, and subject to validation. NCHA also requests that demonstration projects be required to submit fully completed annual licensure reports and that those data also be reviewed by the agency for material compliance with representations made in the certificate of need application.

   Achievement of any demonstration project goals should be evaluated based on information submitted by facilities and other affected providers. The CON applications should include the names of surgeons who will use the facility, their projected volumes, and the hospitals where they have admitting privileges, and these data should be compared with those collected during the evaluative period. Hospital and other providers' data, including the type, volume and distribution of surgeries, listed by payer category should also be collected and used in the evaluation, as part of the demonstration project's focus on access and quality.

6. *Open Medical Staff:* NCHA supports the concept of an open medical staff and believes that that it should be encouraged and considered for its potential to increase patient access to any approved demonstration project's proposed services.

7. *Quality Measures*: A uniform system of measuring quality outcomes should be implemented that is pertinent to each of the surgical specialties that could potentially be approved.

8. *Compliance:* All relevant Criteria and Standards contained in the Certificate of Need Law and Regulations should be applied in the analysis, decision and compliance determinations of any certificate of need application filed as part of this proposed demonstration project. The scope of the projects should be limited to the parameters of the demonstration project as included in The Proposed 2010 State Medical Facilities Plan so as to ensure comparability with other projects and to adhere to the goals set for each of the demonstrations.

NCHA recognizes the SHCC's interest in evaluating the single specialty ambulatory surgery model through a controlled demonstration project where the impact on the community and its healthcare system can be measured. However we remain concerned that these surgery centers are proposed outside the need methodology for operating rooms, and would not support continuation of the two very different approaches to adding new operating rooms. NCHA is willing to work with the SHCC and the Division to assist in the evaluation of these projects and the establishment of a methodology for all operating rooms that works best for North Carolina patients and communities.

NCHA thanks the State Health Coordinating Council, the Acute Care Services Committee and the Division of Health Service Regulation for the opportunity to comment on the Proposed 2010 State Medical Facilities Plan.

Please feel free to contact me if you have any questions or need additional information.