Medical Facilities Planning

North Carolina State Health Coordinating Council
Single Specialty Ambulatory Surgery Work Group Meeting Minutes

Monday, November 17, 2008

10:30 am - 12:30 pm
Council Building

MEMBERS PRESENT: Dr. Cutchin, Dr. Greene, Mr. Hauser
MEMBERS ABSENT: none
STAFF PRESENT: Mr. Horton, Ms. Brown, Ms. Hoffman, Ms. McClanahan, Ms. Fisk

AGENDA	DISCUSSION/RECOMMENDATIONS	ACTIONS
1. Welcome & Introductory Remarks	Dr. Greene welcomed attendees and work group members introduced themselves.	
2. Work Group Charge	Dr. Greene presented the Work Group Charge and identified the following as critical work group tasks: • Developing guidelines for choosing qualified applicants for a CON under the Single Specialty Ambulatory Surgery demonstration project. • Developing measures for determining demonstration project effectiveness. • Deciding what action to take if a Single Specialty Ambulatory Surgery demonstration project CON holder does not comply with projections made in their CON application.	
3. Choosing Qualified Applicants	Work group members discussed potential locations for the facilities and discussion points included: • Site facilities in large population/high population growth areas. • Don't site facilities in areas where the existing ORs are underutilized. • Specify guidelines applicants must meet instead of identifying specific locations for facilities. • The SHCC has the authority to specify the counties where the facilities will be located. • Need more than one OR per facility to be effective.	Recommend one facility be located in each of the following groups of counties (total of three facilities): • Mecklenburg, Cabarrus, Union counties • Guilford, Forsyth counties • Wake, Durham, Orange counties

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4. Demonstration Project Effectiveness Measures	Work Group discussed what to require of demonstration project facilities and how to measure project effectiveness. The discussion included the following points: • Require compliance with all DHSR licensure requirements and accreditation • Cost considerations: o Require cost projections comparable to or less than the costs of existing ambulatory surgery providers – discussed different ways to measure costs (Medicare reports, cost to patients, billed charges, rates negotiated with insurers). Point made that cost data will be hard to obtain – Medicare data easier to get than EOB data. Request audited financial statements? – more expensive than unaudited statements. o Require facilities submit top 20 procedures (by cost to patient)annually to DHSR. Or CON specifies which procedures are submitted – CON creates procedure list for each surgical specialty. o Require facilities submit weighted average of paid amounts – allowed charges including what patient and third party payer is expected to pay. Require facilities to normalize data by reporting percent of Medicare charge insurers pay. o We need to know if care provided in the facilities is less costly than care provided in other settings. o Cap facilities charges? o Issue raised regarding comparing costs of facilities providing different types of surgery, e.g., comparing an orthopedic facility's costs with an ophthalmology facility's costs. • Outcomes/Clinical Guidelines: o Should look at outcomes as well as at processes but outcome measures are difficult to obtain. Currently there are standards for gastroenterology but not for all specialties. Physicians understand what constitutes quality outcome so have Medical Society identify outcome measures. o Need to ensure guarding against overutilization as well as underutilization. o Require demonstration project facilities to develop clinical guidelines and outcome measures as part of CON process. • How will we know if demonstration project successful?	Select requirements and demonstration project effectiveness measures.

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5. Access	• Indigent care: Affordable HealthCare petition suggested 5% indigent care. Measure as percent of revenue, percent of charges? • Indigent population tends to be sicker than non indigent population. • What about ensuring care to those in areas where access is not adequate? • How can we get demonstration project facilities to reach out to those an ambulatory surgical facility would not normally reach out to? Prohibit facilities from having sign in waiting room stating, "Insurance information or payment required at time of service." • Add condition to CON encouraging treating non white population. Issue – payer mix data by race of patient not currently available. • Ask demonstration project facilities to provide at least the average amount of indigent care provided by other surgical providers in the community. • Unlike hospitals, ambulatory surgery facilities aren't required to serve the indigent so the amount of indigent care am su's provide on average would be less than the amount provided on average by hospitals. Also, hospitals offset some losses from other service lines with reimbursement from ambulatory surgery. • Ambulatory surgery centers are not providing care to patients with complex healthcare issues so hard to compare them to hospitals.	Look at licensure indigent care data for the areas where the facilities will be sited.
6. Additional Items	• In demonstration project CON review, prefer facilities o with an electronic medical record system o that are integrated with other healthcare services, e.g., pathology, MD practices, although this may not be currently feasible. • Demand for surgery provided at ambulatory surgery centers expected to grow due to changes in Medicare reimbursement rules.	
7. Next Steps	• Define evaluation measures. • Decide about specifying surgical specialties, or how to compare different surgical specialties for CON review. • Decide how to end demonstration project if it does not meet the criteria for success. • Look at what other states are doing (MA, GA, TN, LA, OH, IL).	Address at next meeting.