Comments on Proposed Operating Room Methodology and Policies

State Medical Facilities Plan Operating Room Work Group

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Introduction

Dosher Hospital appreciates the opportunity to provide comments to the SHCC Operating Room Work Group regarding potential changes to the Operating Room Need Methodology in the 2018 State Medical Facilities Plan. The workgroup has a challenging, but important task to encourage improved access for operating room resources for all residents of North Carolina.

How you treat methodology and policy is very important. Simple rounding up in the methodology in the 2017 State Medical Facilities Plan converted a need of 0.37 operating rooms to a need for one in the plan and in turn created a situation in which Dosher faces the possibility of competition from freestanding ambulatory surgery centers involving investments of $10 to $14 million that include the capacity of three operating rooms and beds that can accommodate patients for 23-hour stays. I doubt that anyone intended this to happen. It may not. They could be denied. Nonetheless, safeguards could prevent possible reoccurrence.

1. The OR Workgroup should recognize the Findings of Fact (GS131E-175(3a) in the NC CON Statute and support the viability of Critical Access Hospitals in North Carolina by specific policy.

   > *That access to health care services and health care facilities is critical to the welfare of rural North Carolinians, and to the continued viability of rural communities, and that the needs of rural North Carolinians should be considered in the certificate of need review process.*

2. The OR Workgroup should give consideration to how much operating room capacity a service area population can support.
3. Basing need calculations on County rather than a single health system need better balances supply and assures access to medically underserved groups. Need determinations should not be limited to the facility that generates the need.

4. North Carolina licensure regulations are such that a need for one operating room in the Plan creates an opening for anyone to develop a freestanding facility with capacity equivalent to an unlimited number of operating rooms.
5. Rounding up can also create more need than a rural county can reasonably absorb.

The OR Workgroup Should Support the Viability of Critical Access Hospitals in North Carolina

- Presently, according to the 2017 SMFP, North Carolina has 21 designated Critical Access Hospitals (CAHs)
- CAH provide vital services to North Carolina residents in rural areas who would otherwise have limited access to emergency, inpatient and outpatient medical services
- Competition benefits residents of North Carolina. However, the benefits of competition do not outweigh benefits of comprehensive emergency, acute, and outpatient services provided by CAHs.
- Where competition will require reducing surgical case volume at critical access hospitals, policy and methodology should either reduce calculated need or prevent competition.
- Although Medicare pay CAH's 101 percent of "eligible" costs, and Medicaid pays 100 percent, CAH's rely on income from service to other payors to offset the true cost of providing acute care, including emergency and surgery, to Medicare, Medicaid, underinsured and charity patients.
- Income from outpatient surgery plays an important role in this essential reimbursement offset.
- A new ambulatory surgical facility in a county or a service area with a CAH may or may not have an adverse impact on a CAH. (Service area is defined by Figure 6.1 in the SMFP)
- As a safeguard the Plan should have a mechanism to assure that applications filed for a need identified by the methodology protect essential CAH revenue.

Recommendations

- The OR Workgroup should add a policy to the 2018 SMFP to protect CAH's.
- The policy should require applicants proposing to add operating rooms to service areas that include CAHs to include in the application a letter from the CAH indicating that the project will not have an adverse impact on the CAH and its patients.
- A new policy, AC-7, would have the following wording:
    - *"To ensure the viability of Critical Access Hospitals in North Carolina, addition of one or more operating rooms to a service area in which a critical access hospital operates is only permitted if the certificate of need application includes a signed letter from an authorized representative of the Critical Access Hospital stating that the project will not have an adverse impact on the CAH's ability to provide comprehensive emergency, inpatient and outpatient medical services to residents of the CAH service area. This is consistent with G.S. 131E-175 (3a) which states that the needs of rural North Carolina should be considered in the certificate of need process."*

- In a service area with a Critical Access Hospital, rounding up should not occur if the Critical Access Hospital itself does not report 90 percent utilization of its operating room capacity based on an assumption of 2,106 case hours per operating room per year. The hours assume 260 days a year 9 hours a day. This is reasonable and conservative; a hospital can extend hours to 10 per day and days to 6 a week.