Surgical Care Affiliates, Inc.

Comments for February 14, 2017 Operating Room Methodology Workgroup Meeting

Submitted by:
Kelli Collins
Vice President of Operations
Surgical Care Affiliates, Inc.
3820 North Elm Street #102
Greensboro, NC 27455
336.854.1663
Kelli.collins@scasurgery.com

Surgical Care Affiliates, Inc. (SCA) appreciates the opportunity to provide written comments for consideration at the February 15, 2017 meeting. SCA is a leading national provider of solutions to physicians, health plans and health systems to optimize surgical care. SCA operates one of the largest networks of surgical facilities in the United States, including more than 200 ambulatory surgery centers (ASCs) located in 35 states, performing 900,000 surgeries a year. SCA operates seven ASCs in North Carolina.

SCA offers the following comments 1) regarding the workgroup's discussion and efforts to date and, 2) responsive to the Operating Room (OR) Modeling Tool the workgroup has made available on the DHSR website.

SCA supports the State Health Coordinating Council's (SHCC) planning process, and respects and values the productive efforts of the OR Methodology Workgroup during the past four months. This necessary review is timely, given the growing need for, and utilization of, surgical services in North Carolina compared to the limited number of OR need determinations in recent SMFPs.

We have analyzed different scenarios based on adjusting the various grouping inputs in the Real-Time Modeling tool. SCA supports objectivity in the planning process, and encourages inputs and/or assumptions that avoid subjectivity.

OR Methodology Model

I. Main Selection: SCA supports selection "B. Grouping" in the Main Selection of the model, and grouping by median case times. A median measure is less affected by outliers and skewed data, an important factor for developing a global methodology.

Regarding OR availability, **SCA recommends that ORs located in ASCs are considered available for surgery eight (8) hours per day and 252 days per year.** Unlike hospitals, it is not necessary that ASCs be available for emergency surgical

cases. Therefore, it is reasonable to reflect availability based on 5 days per week, 52 weeks per year, with an allowance for eight holidays (5*52=260-8=252 days per year). **SCA also advocates an ASC utilization threshold of 75% of OR capacity**. Considering OR data is two years old at the time the annual SMFP is published, and given the additional time required for regulatory approval and development of new operating rooms in North Carolina, the current 80% utilization target understates facility need, especially in ASCs. ASCs typically have a smaller complement of ORs compared to hospitals, and OR capacity constraints are more difficult to manage at smaller facilities.

II. Grouping of Academic Medical Center Teaching Hospitals: **SCA recommends not assigning teaching hospitals to a separate group.** Policy AC-3 is available for teaching hospitals to submit certificate of need applications for additional ORs, if needed, so there is no need to segregate these facilities in the methodology.

III. Grouping for Ambulatory Surgery Centers: **SCA supports including all ASCs in one tier,** with no sub-tiers for single-specialty vs. multi-specialty facilities. If median case times are ultimately used in the methodology, then there shouldn't be a dramatic impact of single-specialty ASC case times impacting the methodology. Furthermore, there are no fundamental differences vis-a-vis availability or utilization thresholds for single-specialty vs. multi-specialty ASCs. Therefore, a decision to isolate single-specialty from multi-specialty facilities in the methodology is unnecessary.

IV. Grouping Type: **SCA endorses grouping by surgical cases**. Grouping by cases is the most objective measure with respect to OR use. Grouping by hours is much less accurate because of the subjectivity currently associated with case times reported in LRAs. Based on SCA's use of the online model, grouping by surgical hours generated a greater number of need determinations. Therefore, grouping by surgical cases may also be a more conservative approach.

V. Growth Type: **SCA recommends projecting surgical cases based on case growth**. This is consistent with other methodologies in the SMFP, which utilize a multi-year trailing growth rate (e.g., hospice home care and hospice inpatient bed methodologies). While the hospice methodologies use a two-year trailing growth rate, SCA supports application of a four-year growth rate, which is less affected by dramatic one-year changes. In scenarios where the population growth rate is greater than the case growth rate, SCA supports the use of population growth rate.

The current methodology of using service area population growth to project OR need has stifled development of new ORs throughout North Carolina. SCA notes several deficiencies of a population growth rate in the OR methodology. First, service area county population growth (which for 74 of NC's 100 counties is a single

county population growth rate[1]) may not accurately represent user patients. In other words, facilities often have a diverse multi-county patient origin. Second, the overall population growth rate may not be consistent with the cohort of the population utilizing surgical services. For example, according to the U.S. Department of Health and Human Services' National Survey of Ambulatory Surgery, patients age 65 and older have significantly higher use rates for ambulatory surgical procedures. Many North Carolina counties have comparably higher population growth rates for individuals age 65+, which definitely impacts local surgical utilization. In such cases, use of an overall population growth rate suppresses the future need for additional ORs. Finally, population growth is only one contributing factor to surgical utilization. Population growth, aging, technological enhancements, and population health all impact demand for surgical services.

Use of the previously described inputs for the Real-time OR Methodology Model results in OR need in eight (8) counties.

County Summary	County OR Need
Buncombe	2
Catawba	3
Davie	14
Gaston	8
Macon	1
Mecklenburg	1
Moore	2
New Hanover	1
Grand Total	**32**

Use of the previously described assumptions results in a modest number of hypothetical need determinations compared to alternative scenarios. As an established provider of high quality, cost effective surgical services, SCA believes these methodology assumptions to be reasonable and appropriate for projecting future OR need in North Carolina.

I will be happy to respond to any workgroup questions at the February 15, 2017 meeting, if necessary. We appreciate the opportunity to provide these written comments.

[1] SCA acknowledges there are 26 counties included in multi-county service areas. The remaining 74 counties are single county service areas.