CATAWBA VALLEY MEDICAL CENTER

August 25, 2009

DFS Health Planning
RECEIVED
AUG 26 2009
Medical Facilities
Planning Section

Ms. Sandra B. Greene, DrPH, Chair
Acute Care Committee
State Health Coordinating Council
Division of Health Service Regulation
Medical Facilites Planning Section
2714 Mail Service Center
Raleigh, NC 27699-2714

RE: Proposed Ambulatory Surgery Demonstration Projects

Dear Dr. Greene:

It has come to our attention that a number of petitions were received that could open the ambulatory surgery demonstration projects proposed in the draft 2010 SMFP to the counties of Catawba and Burke. As an entity of Catawba County government, Catawba Valley Medical Center must strongly oppose this position.

First, as is the case with the three locations for which demonstration projects were included in the proposed 2010 SMFP, there is already an excess of operating rooms in Catawba and Burke Counties. According to the draft 2010 SMFP, Burke and Catawba Counties already contain an excess of 12.72 ORs. In addition to excess OR capacity, these two counties already offer residents surgical services in at least four separate locations. These factors clearly suggest residents' access to surgical services is not hampered by geographic accessibility.

The draft 2010 SMFP states that the purpose of the demonstration projects is to provide an "innovative idea with the potential to improve safety, quality, access and value." However, the draft 2010 SMFP does not include an explanation of why limiting the proposed demonstration projects to physician ownership represents "innovation" in "improving safety, quality, access and value." A growing number of studies suggest otherwise. While physician ownership of ambulatory surgery centers does tend to increase utilization, studies suggest that the reason is not improved capacity but financial incentives on the part of physician owners. Studies have also suggested that owner/doctors affiliated with limited service facilities routinely refer their most lucrative cases to their own facilities. "The high-cost, most seriously ill patients and those with inadequate insurance or none at all are increasingly referred to the full-service community hospitals." ("Adverse Effect of Physician-Owned Limited Service Facilities: Healthy Competition Depends on Level Playing Field," Attachment 1, page 2.) See also Attachment 2, "Urologist Ownership of Ambulatory Surgery Centers and Urinary Stone Surgery Use.")

(continued)

The rationale provided in the draft 2010 SMFP also fails to describe how the demonstration projects are likely to improve financial accessibility by any significant degree. The criteria for the demonstration projects as currently designed combines self-pay revenue with Medicaid revenue to reach the required seven percent of total revenue. This may or may not be comparable to the payor mix of other surgical service providers in the proposed service areas. Instead, the demonstration projects should be required to provide uncompensated care equal to the amount provided by other providers in the service area and provide documentation of compliance on an annual basis. This is particularly important since research suggests that, "...physician-owned limited service facilities are prone to select the healthiest, most financially attractive patients." (Ibid.)

In addition, the proposed demonstration projects would do little to improve the quality of surgical services currently provided. While it is likely that adherence to the WHO Safety Checklist will improve the quality and safety of care provided in the proposed demonstration projects as compared to a facility without similar practices, this single requirement is unlikely to assure the safety and quality of the surgical service as compared to accreditation by a recognized quality improvement organization such as The Joint Commission, the AAAASF or the AAAHC.

To further assure improvements in quality and safety of care, applicants for the demonstration projects should be required to submit pre-defined performance measures. At a minimum, applicants should be required to submit data elements contained in CMS' "Surgical Care Improvement Project" data set. This would allow for the comparison of existing providers and new providers approved under the demonstration project criteria to document whether, in fact, improvements in care were achieved.

In conclusion, the current economic downtown, exacerbated by rising unemployment, make it increasingly difficult to accept that increasing the number of physician-owned ambulatory surgery centers would improve financial access to needed surgical services. Instead, given the results of the attached studies, such a strategy is more likely to raise health care costs in general while further increasing the likelihood of the demise of North Carolina's safety net hospitals.

Sincerely,

J. Anthony Rose, FACHE
President and CEO

Attachments