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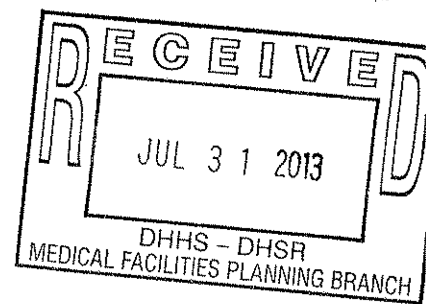

My name is Cathy Wright and I represent the North Carolina Orthopaedic Association, a professional medical association of nearly 400 orthopaedic surgeons. As a consultant, I promote their legislative interests in the North Carolina General Assembly. I'm here today to say that the process and procedures for applying for and obtaining a Certificate of Need for free-standing, single-specialty ambulatory surgery centers are unfair and should be changed.

As you know, CON law was first implemented in the early 1970s. Many of the surgery cases that were performed back in the 1970s used general anesthesia with large incisions. Patients were admitted to the hospital for a week or more. Now, 40 years later, these types of surgery have evolved to become minimally invasive outpatient procedures with local anesthesia or moderate sedation. Patients go home the same day of surgery. And you may <u>also</u> know, today ambulatory surgery is reimbursed 40 percent less than the same procedure performed at a hospital. These savings can be passed on to individuals, employers, insurance providers, and the government (Medicaid, State Health Plan).

Unfortunately, North Carolina CON law has not been updated to respond to changes in technology even though 75 percent of all surgery cases can now be safely performed on an outpatient basis. In North Carolina the current Certificate of Need law and regulations make it extremely difficult for new single-specialty ambulatory surgery centers to be developed because hospital-based operating rooms would have less utilization. However, I believe that the CON law was never intended to limit competition, or to protect any healthcare provider's market share or financial success. What the CON law is supposed to do is to prevent unnecessary duplication of healthcare services. CON law is supposed to improve patients' <u>access</u> to <u>lower cost</u> healthcare.

I'd like to share a couple of anecdotes about the consequences of lack of access to care and how it can affect a patient's care.

I spoke with a physician about his experience in a large hospital main OR. He had scheduled early morning surgery for an infant (as you know the child was NPO/nothing by mouth) but the procedure was delayed, and delayed, and eventually "bumped." This was all very hard on the ill child and

certainly was inconvenient for the family. The physician was, however, able to switch the child's procedure over to the ASC, with outstanding results, and subsequently continued to operate as much as he could in the outpatient facility. A practice manager told me about one of their patients that had to be sent a great distance to the hospital because they had no available ASC in the area. The patient's husband had to take the day off from work and travel many miles for his wife's procedure. Minor inconveniences, you may say, but as a former nurse it's all about total patient care. If the health care community can do a better job of providing care, we'll all be better off in the long run.

Under the current CON system, the only time an application for ambulatory surgery operating rooms can be submitted is when the State Medical Facilities Plan shows that all of the existing operating rooms are approaching full utilization and a "need determination" is calculated. When this occurs, multiple competing applications are submitted. While single-specialty ambulatory surgery centers may offer the lower costs and charges, other comparative factors, which could favor hospitals, are analyzed. The current CON system causes proposals for hospital-based operating rooms to compete with the proposals for ambulatory surgery centers. I respectfully request that proposals for single-specialty ambulatory surgery centers be analyzed separately.

Thank you for your consideration.

Attachments:
Improve Certificate of Need law to reduce health care costs
Medicaid & State Health Plan ASC historical data

Now is the Time to Improve Certificate of Need Law To Reduce Health Care Costs

Expanding the use of licensed ambulatory surgical facilities, as North Carolina did in 2005, would reduce health care costs. The Certificate of Need (CON) law should be changed again to allow the development of other single-specialty ambulatory surgery centers.

The 2005 law allowed physicians and hospitals to develop more cost-effective ambulatory surgical facilities with gastrointestinal procedure rooms in the state. The centers offer lower costs and charges which in turn encourages more people to obtain screening colonoscopy procedures that lead to the early detection and treatment of precancerous polyps. The change reduced the costs of GI endoscopy procedures in North Carolina over the last six years by an estimated $224 million. Research published in the New England Journal of Medicine in February 2012 reported that the death rate from colorectal cancer was cut by 53 percent in those who had colonoscopies and whose doctors removed precancerous polyps.

Cost savings and greater access to outpatient surgery would occur if the Certificate of Need law was changed again to allow for single-specialty ambulatory surgery centers for other surgical specialties including orthopedics, ophthalmology, otolaryngology, plastic surgery, general surgery, urology and others. Physicians, hospital-owned physician groups or other legal entities, including joint ventures, can submit proposals. The centers also are required to provide care to Medicaid and charity patients and to provide annual reports documenting the care they provide and its costs.

If North Carolina added 100 ambulatory surgical centers over the next seven years, the change would produce cumulative cost savings of a projected $147 million for Medicaid and State Health Plan patients.

North Carolina citizens currently have limited access to licensed ambulatory surgery centers as compared to the overall U.S. population; North Carolina has fewer ambulatory surgery centers per capita as compared to other Southeastern states. The exception is Virginia, which also has a restrictive Certificate of Need law.

	2012 NC Total (NC State Plan)	2010 US Total (MEDPAC)
Total Licensed ASCs (Surgical and GI Endoscopy)	96	5,316
Population	9,781,022	308,745,538
ASCs per 100,000 Population	0.98	1.72

Sources: 2012 North Carolina State Medical Facilities Plan and MEDPAC Report to Congress: Medicare Payment Policy, March 2012

North Carolina has 13 additional ambulatory surgery centers currently in development. Most are multi-specialty facilities. Only three single-specialty ambulatory surgery centers have been approved in recent years.

Due to the cost efficiencies of ambulatory surgical centers, the 2012 Medicare facility reimbursement rates are 43 percent lower than hospital reimbursement rates. Medicaid, the State Health Plan, and commercial insurance typically reimburse ASC facilities at substantially lower rates than hospitals. Patient co-payments are also lower for ambulatory surgery centers. The following table provides a comparison of the national Medicare reimbursement rates:

Types of Surgical Procedures	**2012 Medicare Facility Reimbursement Rates**	
	National Average Hospital Rates	**National Average ASC rates**
Cataract and lens procedures	**$1,667**	**$953**
Tonsil and adenoid procedures	**$1,743**	**$1,005**
Hernia / hydrocel procedures	**$2,304**	**$1,329**
Level 1 foot procedures	**$1,546**	**$892**
Arthroscopy knee	**$2,075**	**$1,197**
Carpel tunnel	**$1,316**	**$759**
Incise finger tendon sheath	**$1,158**	**$668**
Cystoscopy	**$474**	**$273**
Lower back epidural	**$522**	**$301**

Source: Centers for Medicare and Medicaid Services

In summary, changing the Certificate of Need law to allow for the development of additional single-specialty ambulatory surgical centers would:

- Provide cost-savings to patients, insurance companies and government providers;
- Create increased access and competition;
- Support the future recruitment of physician specialists to North Carolina;
- Increase investment in facilities, create jobs and expand the tax base.

Medicaid Ambulatory Surgery Historical Data

	2011	2012
Hospital Medicaid Ambulatory Surgery Paid Amounts	$74,799,293	$85,191,372
Hospital Medicaid Ambulatory Surgery Cases	164,489	172,673
Average $ Paid per Case	$454.74	$493.37
ASC Medicaid Ambulatory Surgery Paid Amounts	$13,597,774	$14,589,820
ASC Medicaid Ambulatory Surgery Cases	46,951	43,895
Average $ Paid per Case	$289.62	$332.38
Combined ASC and Hospital Paid Amounts	$88,397,067	$99,781,192
Combined ASC and Hospital Ambulatory Cases	211,440	216,568
Average $ Paid per Case	$418.07	$460.74
Variance between Hospital and ASC per Case Paid Amou	$165.12	$160.99
Percentage Variance of Hospital and ASC Paid Amount	36.31%	32.63%

NC Medicaid Surgery Utilization Mix of ASC and Hospital Cases	2012	% Mix
Hospital Medicaid Ambulatory Surgery Cases	172,673	80%
ASC Medicaid Ambulatory Surgery Cases	43,895	20%
Total NC Medicaid Surgery Utilization	216,568	

State Health Plan Ambulatory Surgery Historical Data

	2011	2012
Hospital SHP Ambulatory Surgery Paid Amounts	$186,272,164	$186,586,774
Hospital SHP Ambulatory Surgery Cases	60,847	58,383
Average $ Paid per Case	$3,061.32	$3,195.91
ASC SHP Ambulatory Surgery Paid Amounts	$14,216,247	$15,714,905
ASC SHP Ambulatory Surgery Cases	14,798	13,485
Average $ Paid per Case	$960.69	$1,165.36
Combined ASC and Hospital Paid Amounts	$200,488,411	$202,301,679
Combined ASC and Hospital Ambulatory Cases	75,645	71,868
Average $ Paid per Case	$2,650.39	$2,814.91
Variance between Hospital and ASC per Case Paid Amou	$2,100.63	$2,030.55
Percentage Variance of Hospital and ASC Paid Amounts	68.62%	63.54%

NC SHP Surgery Utilization Mix of ASC and Hospital Cases	2012	% Mix
Hospital SHP Ambulatory Surgery Cases	58,383	81%
ASC SHP Ambulatory Surgery Cases	13,485	19%
Total Combined SHP Ambulatory Surgery Cases	71,868	