Mr. Jerry Parks
Chairman, North Carolina State Health Coordinating Council
c/o Medical Facilities Planning Branch
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, NC 27699-2714

August 16, 2013

Re: Comments in Opposition to a Petition by Blue Ridge Bone & Joint Clinic for a Demonstration Project for a Single Specialty, Two Operating Room, Ambulatory Surgical Facility in the Buncombe-Madison-Yancey Operating Room Service Area in the *2014 State Medical Facilities Plan*

Dear Mr. Parks:

Mission Health System (Mission) appreciates an opportunity to comment on a Petition by Blue Ridge Bone & Joint Clinic (BRBJ) for a Single Specialty, Two Operating Room, Ambulatory Surgical Facility Demonstration Project in the Buncombe-Madison-Yancey Operating Room Service Area in the *2014 State Medical Facilities Plan* (*2014 SMFP*) (BRBJ 2013 Petition).

Background Information

Beginning in the fall of 2008, the SHCC's Single Specialty Ambulatory Surgery work group met and drafted recommendations for a demonstration project "to evaluate and test the concept of single specialty ambulatory surgery centers in North Carolina."

The SHCC approved plans for the demonstration project on May 27, 2009, which included three sites. The *2010 SMFP* outlined criteria for the three demonstration project facilities. Consistent with the terms of the criteria outlined in the *2010 SMFP*, three certificates of need were awarded to:

1. Piedmont Outpatient Surgery Center, LLC and Stratford Executive Associates, LLC to develop a single-specialty ENT ambulatory surgical facility in the Triad area.
2. Triangle Orthopaedics Surgery Center to develop a single specialty ambulatory surgical facility in the Triangle area.
3. University Surgery Center, LLC to develop a single specialty ambulatory surgical facility in the Charlotte area.

Piedmont Outpatient Surgery Center received its license effective February 6, 2012. At its May 8, 2013 meeting, the Acute Care Services Committee reviewed a Single Specialty Ambulatory Surgery Center Demonstration Project Report submitted by Piedmont Outpatient Surgery Center for the period March 1, 2012 to March 1, 2013. The Committee determined that the Piedmont Outpatient Surgery Center had not demonstrated substantial compliance with the

demonstration project criteria outlined in the Plan and the Certificate of Need due to the failure of the facility to report utilization and payment data to the statewide processor. In discussion with the facility administrator, it was revealed that the facility had not been submitting information because of a misinterpretation of the requirement. The facility has signed a contract with Truven Health Analytics as of May 10, 2013 for submission of that data. At its May 29, 2013 meeting, the SHCC approved the Single Specialty Ambulatory Surgery Center Demonstration Project Report submitted by Piedmont Outpatient Surgery Center for the period March 1, 2012 to March 1, 2013.

Triangle Orthopaedics Surgery Center received its license effective February 25, 2013. Triangle Orthopaedics Surgery Center has not yet been operational for a full year. As such, it has not submitted its first Single Specialty Ambulatory Surgery Center Demonstration Project Report to the Agency, and the Agency has not determined whether the facility has demonstrated substantial compliance with the demonstration project criteria outlined in the Plan and the Certificate of Need.

On January 11, 2013, the University Surgery Center, LLC received a Declaratory Ruling to relocate to an alternative site in Charlotte. As of August 2, 2013, the University Surgery Center, LLC has not received its license.

All Petitions Submitted by BRBJ have been Denied by the SHCC

In 2009, BRJB petitioned the SHCC to add Buncombe County as a site to the Single Specialty Ambulatory Surgery Facility Demonstration Project. In 2010, 2011, and 2012, respectively, BRJB submitted a petition to approve a demonstration project for a single specialty, two operating room, orthopaedic ambulatory surgery facility in the Buncombe-Madison-Yancey OR service area.

The SHCC denied all four petitions from BRJB, basing its denial upon the following principles:

1. Limit the demonstration project to three sites initially
2. Evaluate each facility after each facility has been in operation for five years
3. Consider expanding the number of facilities beyond the original three demonstration sites only if the Agency determines that the demonstration facilities are meeting or exceeding all criteria.

To date, two of the three demonstration project facilities have not been licensed and operational for a full year. As a result, those two facilities also have not demonstrated substantial compliance with the demonstration project criteria outlined in the Plan and the Certificate of Need.

It is clear that the SHCC must wait until all three demonstration project facilities are licensed, operational for five years, and each found to have demonstrated substantial compliance with

the demonstration project criteria outlined in the Plan and the Certificate of Need before it considers expansion of the number of facilities beyond the original three.
Further, in the Agency Recommendation to deny BRBJ's 2011 Petition, the Agency stated that:

> [...] no conclusions have been drawn, 'positive' or 'negative,' about the impact of [the three demonstration project] facilities. Indeed, the purpose of the demonstration project is to test that hypothesis. The Agency also wishes to clarify that the three demonstration project sites were authorized in the *2010 SMFP* and **no additional** demonstration sites were authorized in the *2011 SMFP*. As noted above, the underlying concept of the demonstration project was to '...evaluate each facility **after each facility has been in operation for five years** [...].' [**Emphasis** in the original].

The Agency added:

> [...] 'the opportunity for competition' by itself is not a goal of the *SMFP* and that the anticipated '**positive impact** on quality, cost and access' [of the three demonstration project facilities], **has not yet been affirmed**. [**Emphasis** added.]

Accordingly, Mission respectfully requests that the SHCC act consistently with well-reasoned precedent to deny the BRBJ 2013 Petition.

Underutilized Operating Room Capacity at the Physician-owned Orthopaedic Ambulatory Surgery Center in Buncombe County

The Orthopaedic Surgery Center of Asheville has a medical staff of 31 with three licensed operating rooms in Asheville. According to its 2013 Ambulatory Surgery Center License Renewal Application, in FY 2012, the Orthopaedic Surgery Center of Asheville performed 2,968 ambulatory surgical cases, 2,771 of which were orthopaedic cases and 197 were podiatry cases, in its three licensed operating rooms.

BRBJ fails to recognize by name the Orthopaedic Surgery Center of Asheville. It also fails to analyze that the three licensed operating rooms were underutilized in FY 2012, the most recent year for which data is publicly available. The following table calculates the underutilized capacity at the Orthopaedic Surgery Center of Asheville based on a planning threshold of 1,872 hours per operating room per year.

Orthopaedic Surgery Center of Asheville
Underutilized Operating Room Capacity: FY 2012

October-September	FY 2012
Total Ambulatory Surgical Cases	2,968
Total Estimated Hours per Ambulatory Surgical Case	1.5
Total Estimated Hours	4,452
Planning Threshold: Hours per Operating Room per Year	1,872
Operating Rooms Needed per Year	2.37
Licensed Ambulatory Surgical Operating Rooms	3.00
Underutilized Capacity	**0.63**

The Buncombe-Madison-Yancey Operating Room Service Area has more than 10 operating rooms. Under the rounding rules in the Operating Room Need Methodology, fractions of 0.50 or greater are rounded to the next whole number. Consequently, the underutilized capacity at the Orthopaedic Surgery Center of Asheville of 0.63 is rounded to 1.

Mission respectfully requests that the SHCC fully appreciate the existence of an orthopaedic ambulatory surgery center in the Buncombe-Madison-Yancey Operating Room Service Area – with underutilized capacity, and deny the BRBJ 2013 Petition.

Operating Room Surplus in Buncombe-Madison-Yancey Service Area

The Instructions for Writing Petitions for Adjustments to Need Determination states:

> [a]t minimum, each written petition requesting an adjustment to a need determination in the [*Proposed 2014 SMFP*] should contain:
>
> [...]
>
> 4. Evidence that health service development permitted by the proposed adjustment would not result in unnecessary duplication of health resources in the area.

In the Agency Recommendation to deny the BRBJ 2012 Petition, the Agency stated:

> The Agency urges caution in allowing additional operating rooms for a service area with a projected surplus before demonstration project data regarding impact of the model can be received and evaluated.

At the time of the September 2012 Agency Recommendation to deny the BRBJ 2012 Petition, Table 6B of the *Proposed 2013 SMFP* projected a **surplus of 1.12** operating rooms in the Buncombe-Madison-Yancey Operating Room Service Area in 2015.

Table 6B of the *Proposed 2014 SMFP* projects a **surplus of 3.16** operating rooms in the Buncombe-Madison-Yancey Operating Room Service Area in 2016.

The **projected surplus** of operating rooms has **increased by 2.04** operating rooms in one year.

The existence of a surplus of operating rooms in the Buncombe-Madison-Yancey Operating Room Service Area is evidence that the development of the proposed demonstration project for a single specialty, two operating room, ambulatory surgical facility would be an unnecessary duplication of services in the Buncombe-Madison-Yancey Operating Room Service Area.

Mission respectfully requests that the SHCC heed the Agency's caution with respect to surplus operating rooms, and deny the BRBJ 2013 Petition.

Comparison of Ambulatory Surgical Payor Mix: Orthopaedic Surgery Center of Asheville and Mission Hospital

In its evaluation of the performance of each demonstration project facility, each facility is to provide to the Agency the number of and payor source of the patients it served. Using that data, the Agency must verify that the facility's total revenue attributed to self-pay and Medicaid was at least 7%.

Mission believes that it is valuable for the SHCC to review the ambulatory surgical payor mix of the existing physician-owned orthopaedic ambulatory surgery center in Buncombe County with the ambulatory surgical payor mix of Mission.

The following table shows the FY 2012 payor mix for patients of the Orthopaedic Surgery Center of Asheville, based on information reported by the facility in its 2013 Ambulatory Surgery Center License Renewal Application.

Orthopaedic Surgery Center of Asheville
Ambulatory Surgical Case Payor Mix: FY 2012

Primary Payor Source	Number of Cases	Percentage of Cases
Self Pay/Indigent/Charity	**13**	**0.4%**
Medicare & Medicaid Managed Care	1,138	36.5%
Medicaid	**177**	**5.7%**
Commercial Insurance	1,044	33.5%
Managed Care	449	14.4%
Other – Workers Comp/Federal	300	9.6%
Total	3,121	100.0%

Source: 2013 ASC LRA, page 7 (Reimbursement Source)
Note: The number of cases reported by payor exceeds the number of cases reported on page 6. No explanation is provided for the difference.

In order to meet the requirements of the Specialty Ambulatory Surgery Center Demonstration Project, the approved two orthopedic ambulatory surgical facilities[1] projected that 9.2% to 15.2% of total cases would need to be self-pay and Medicaid cases to achieve the requirement that 7% of total revenue was from self-pay and Medicaid cases. The previous table documents that **only 6.1%** of the total ambulatory surgical **cases** performed at the Orthopaedic Surgery Center of Asheville are on patients whose **primary payor source** is **Self Pay/Indigent/Charity and Medicaid**.

For comparison purposes, the following table shows the FY 2012 payor mix for ambulatory surgical patients of Mission Hospital, based on information reported by the facility in its 2013 Hospital License Renewal Application

Mission Health System
Ambulatory Surgical Case Payor Mix: FY 2012

Primary Payor Source	Number of Cases	Percentage of Cases
Self Pay/Indigent/Charity	**531**	**2.5%**
Medicare & Medicaid Managed Care	7,437	34.9%
Medicaid	**3,081**	**14.5%**
Commercial Insurance	176	0.8%
Managed Care	9,260	43.5%
Other (Worker's Comp, Champus, other governmental agencies)	805	3.8%
Total	21,290	100.0%

Source: 2013 Hospital LRA, page 7 (Reimbursement Source)

The previous table documents that **17%** of the total ambulatory surgical **cases** performed at Mission are on persons whose **primary payor source** is **Self Pay/Indigent/Charity and Medicaid**.

The most recent payor mix data substantiates that the ambulatory surgical needs of **Self Pay/Indigent/Charity and Medicaid** patients in the Buncombe-Madison-Yancey Operating Room Service Area are better met by Mission than the physician-owned orthopaedic ambulatory surgical center in Buncombe County.

Mission respectfully requests that the SHCC evaluate the facts presented, and deny the BRBJ 2013 Petition.

[1] Triangle Orthopaedics Surgery Center projected Self Pay/Indigent/Charity and Medicaid = 15.2% of total cases; and University Surgery Center projected Self Pay/Indigent/Charity and Medicaid = 9.2% of total cases

Theoretical Savings from Single Specialty Ambulatory Surgery Center Demonstration Projects will be Irrelevant as Payors Move to Site-neutral Payments

Expanding cuts to hospitals' outpatient services is among the leading Medicare cost-reduction proposals gaining interest from Congress. [2]

The Medicare Payment Advisory Commission (MedPAC) recommended in March 2012 that Medicare should equalize evaluation and management office visit payment rates, regardless of whether they occur in a hospital outpatient setting or a physician's office, which would save up to $1 billion a year. Congress' board of Medicare experts issued a report on June 14, 2013 offering 66 other ambulatory payment areas where such a "site-neutral" policy could be used to derive $900 million in additional annual savings.

MedPAC advisers introduced the following three main proposals in its June 14, 2013 report:

1. The "site-neutral" policy — in which hospital outpatient departments (HOPDs) and ambulatory care settings receive similar Medicare payments — would expand to 66 additional ambulatory payment classifications, which would reduce hospital Medicare payments by $900 million.

2. HOPDs and physician offices would receive the same payment for three high-volume cardiac imaging ambulatory payment classifications, which would reduce hospital Medicare payments by $500 million.

3. HOPDs and ambulatory surgery centers would receive equal pay for 12 surgical ambulatory payment classifications, reducing hospital Medicare payments by $590 million.[3]

Mission reasonably believes that non-governmental payors will follow the lead of Medicare on site-neutral payments. Further, Mission reasonably believes that the theoretical savings from single specialty ambulatory surgery center demonstration projects will be determined to be irrelevant as Medicare and other payors move to site-neutral payments.

Mission respectfully requests that the SHCC consider the ever-changing environment for health care, and the importance and effects of the cost-reduction proposals, specifically site-neutral payments, on the health care marketplace, and deny the BRBJ 2013 Petition.

North Carolina General Assembly Study of Single Specialty Ambulatory Surgery Centers

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[2] Information contained in this Section is derived from: http://kevinbrady.house.gov/kevin-brady-in-the-news/medpac-sees-hefty-savings-in-siteneutral-payment-policy/

[3] http://www.beckershospitalreview.com/racs-/-icd-9-/-icd-10/medpac-suggests-equalizing-payments-between-hospitals-ambulatory-clinics.html

In December 2012, the House Select Committee on the Certificate of Need Process and Related Hospital Issues submitted its final report to the House of Representatives before the 2013 Long Session convened. The House Select Committee on the Certificate of Need Process and Related Hospital Issues was charged to study the legal requirement and process governing determinations for certificate of need, including exceptions granted.

Several bills were introduced in the 2013 Long Session, to include a bill sponsored by Representative Marilyn Avila (R-Wake) to amend the certificate of need law (HB 177). HB 177 would have allowed for an expanded presence of physician-owned ambulatory surgery centers in North Carolina. On May 14, 2013, HB 177 was replaced with a committee substitute bill creating a legislative review committee to study single specialty ambulatory surgical centers. HB 177 passed the North Carolina House, and was referred to the Committee on Rules and Operations of the Senate. The General Assembly adjourned its 2013 Long Session before the Senate could pass HB 177.

The General Assembly with convene its Short Session on May 14, 2014. The purpose of the Short Session is for the General Assembly to address budget adjustments and unfinished business from the Long Session. Recommendations from interim study committees also are a part of the General Assembly's Short Session workload. Other matters eligible for consideration during the Short Session are limited to resolutions, bills with a fiscal impact, study bills, local bills (those affecting less than 15 counties), and those affecting state or local retirement and pension systems.

Mission reasonably believes that the most appropriate action for the SHCC is to deny the BRBJ 2013 Petition, and allow the North Carolina General Assembly and its committees to study carefully, deliberate fully, and to take action consistent with its legislative authority.

Conclusion

For all of the reasons set forth above, Mission respectfully requests that the SHCC deny the BRBJ 2013 Petition, and take no further action with respect to single specialty ambulatory surgical centers.

Please do not hesitate to contact me at 828.213.3059 if you have questions or if there is any additional information that I can provide. Many thanks in advance for your consideration.

Sincerely,

Brian Moore
Executive Director of Public Policy and Legislative Affairs
Mission Hospital