Single Specialty Ambulatory Surgery Demonstration Project

Project Description:

Three new single specialty ambulatory surgical facilities with two operating rooms each.

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Establish a special need determination for three new licensed ambulatory surgical facilities with two operating rooms each, such that there is a need identified for one new ambulatory surgical facility in each of the three following service areas: • Mecklenburg, Cabarrus, Union counties (Charlotte Area) • Guilford, Forsyth counties (Triad) • Wake, Durham, Orange counties (Triangle)	*Value* At least one county in each of the groups of counties has a current population greater than or equal to 200,000 and more than 50 total ambulatory/shared operating rooms and at least 1 separately licensed Ambulatory Surgery Center. Locating facilities in high population areas with a large number of operating rooms and existing ambulatory surgery providers prevents the facilities from harming hospitals in rural areas, which need revenue from surgical services to offset losses from other necessary services such as emergency department services.
Each facility shall provide care to the indigent population, as described below: • The sum of the facility's number of charity care(the category is self pay) and Medicaid surgical cases shall be at least seven percent of each facility's total number of surgical cases; and • The sum of the revenue(charges?) for charity care and Medicaid surgical cases shall be at least seven percent of the facility's total revenue; and • At least five percent of each facility's total number of surgical cases shall be charity cases and at least five percent of each facility's total revenue shall be for charity care surgical cases. A charity surgical case is defined to mean a patient coded as "Charity Care" on the UB04 claim form. *(Note: There may be other ways to define a "charity surgical case" using UB92 data. If so, we need to change this definition. Alternatively, we could use the license renewal application reimbursement*	*Access* Requiring service to indigent patients promotes equitable access to the services provided by the demonstration project facilities. Charity care is not the right designation. Self pay indicates lack of insurance. What the Sheps Center could provide: for a pilot site, it could report the number of cases that are Medicaid and self pay/self insured, and show what proportion that is of the total patient population. With respect to revenue, this is not reported on the UB04. What is reported is charges. Could we use charges as a proxy for revenue? This may be more complicated. Suggestion: go back to using revenue. Ask facility to identify

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information to count "charity surgical cases".) Charity care revenue is based on the Medicare allowable and is calculated as follows: Charity care revenue = Medicare allowable amount – all revenue collected from any source. (Note: Would the Sheps Center be able to calculate this? If not, we need to find an alternative definition that the Sheps Center can calculate.) Following are examples of the calculation of charity care revenue: If Medicare allows $300 for a surgical procedure and an uninsured patient pays the facility $0, $300 is considered charity care revenue. If Medicare allows $300 for a surgical procedure and an uninsured patient pays the facility $50, $250 is considered charity care revenue. If Medicare allows $300 for a surgical procedure and Medicaid pays the facility $225, then $75 is considered charity care revenue. Facilities shall report utilization and payment data to the statewide data processor as required by G.S. 131E-214.2. The Agency will monitor compliance with indigent care requirements by analyzing payment data submitted to the statewide data processor as reported on the UB-92. *(Note: If we use LRA data to monitor, this will change.)* ***Recommendation that indigent care requirements be changed to:*** *Agreed upon percent of Medicaid surgical patients and (just counting Medicaid patients misses the point)* *Agreed upon percent of revenue.* *The rationale is that this will be feasible for the Agency to determine and monitor. Determining which cases meet the definition of "charity cases" is complex and may not be feasible for the Agency to determine and monitor.*	Medicaid and self pay/self insured patients, difference between revenue collected and Medicare allowed. This as a percentage of total revenue must reach 7%.
Each facility shall develop a system to measure and report patient outcomes to	*Safety and Quality*

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the Agency for the purpose of monitoring the quality of care provided in the facility. If patient outcome measures are available for a facility's particular surgical specialty, the facility shall identify those measures and may use them for reporting patient outcomes. If patient outcome measures are not available, the facility shall develop its own patient outcome measures that will be reported to the Agency. Facilities shall submit annual reports to the Agency regarding the results of patient outcome measures. Examples of patient outcome measures include: wound infection rate, post-operative infections, post-procedure complications, readmission, and medication errors.	Implementing a system for measuring and reporting quality promotes identification and correction of quality of care issues and overall improvement in the quality of care provided.
Facilities are encouraged to develop systems which will enhance communication and ease data collection, for example, electronic medical records and electronic linkages with other providers.	*Safety and Quality, Access, Value* Electronic medical records improve the collection of quality and access to care data and collecting data is the first step in monitoring and improving quality of care and access. Electronic linkages facilitate communication among providers, enhancing care coordination.
Facilities are encouraged to provide open access to physicians.Could we make this stronger than "encourage"?	*Access* Services will be accessible to a greater number of surgical patients if the facility has an open access policy for physicians
Facilities shall obtain a license no later than two years from the date of issuance of the certificate of need, unless this requirement is changed in a subsequent State Medical Facilities Plan.	*Access and Value* Timely project completion increases access to services and enhances project value.
Facilities will provide annual reports to the Agency showing the facility's compliance with the demonstration project criteria in the State Medical Facilities Plan. The Agency may specify the reporting requirements and reporting format.	*Safety and Quality, Access, Value* Timely monitoring enables the Agency to determine if facilities are meeting criteria and to take corrective action if facilities fail to meet criteria. This ensures that all three Basic Principles are

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The Agency will perform a preliminary evaluation of each facility at the end of the first three operating years of each facility. The Agency may require corrective action if the Agency determines that a facility is not meeting or is not making good progress towards meeting the demonstration project criteria. The Agency will evaluate each facility after each facility has been in operation for five years. If the Agency determines at that time that a facility is not in compliance with any one of the demonstration project criteria, the Department, in accordance with G.S. 131E-190, "may bring an action in Wake County Superior Court or the superior court of any county in which the certificate of need is to be utilized for injunctive relief, temporary or permanent, requiring the recipient, or its successor, to materially comply with the representations in its application. The Department may also bring an action in Wake County Superior Court or the superior court of any county in which the certificate of need is to be utilized to enforce the provisions of this subsection and G.S. 131E-181(b) and the rules adopted in accordance with this subsection and G.S. 131E-181(b)." (Note: This was recommended by the AG's office.)	met by the demonstration project facilities. This is a good addition.
Outstanding Issues:	Would an applicant proposing more than one surgical specialty be eligible? While this is a demonstration for single specialty, I could see an applicant with 2 related specialties applying and I think we should allow this. Do we need to specifically define these facilities as "separately licensed"? Agency needs to weigh in on this issue. Other issues?

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