NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE RESEARCH COMMISSION

STATE LEGISLATIVE BUILDING

RALEIGH, NC 27601

April 15, 2014

TO THE MEMBERS OF THE LEGISLATIVE RESEARCH COMMISSION:

Attached for your consideration is the report to the 2014 Regular Session of the 2013 General Assembly. This report was prepared by the Legislative Research Commission's Committee on Market Based Solutions and Elimination of Anti-Competitive Practices in Health Care, pursuant to G.S. 120-30.17(1).

Senator Thomas M. Apodaca
Co-Chair

Representative Marilyn Avila
Co-Chair

Co-Chairs
Committee on Market Based Solutions and Elimination of Anti-Competitive Practices in Health Care
Legislative Research Commission

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LEGISLATIVE RESEARCH COMMISSION

COMMITTEE ON MARKET BASED SOLUTIONS AND ELIMINATION OF ANTI-COMPETITIVE PRACTICES IN HEALTH CARE

NORTH CAROLINA GENERAL ASSEMBLY

REPORT TO THE 2014 SESSION of the 2013 GENERAL ASSEMBLY OF NORTH CAROLINA

MAY, 2014

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TRANSMITTAL LETTER

May 2014

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TO THE MEMBERS OF THE 2014 REGULAR SESSION
OF THE 2013 GENERAL ASSEMBLY

The Legislative Research Commission herewith submits to you for your consideration its report and recommendations to the 2014 Regular Session of the 2013 General Assembly. The report was prepared by the Legislative Research Commission's Committee on Market Based Solutions and Elimination of Anti-Competitive Practices in Health Care, pursuant to G.S. 120-30.17(1).

Respectfully submitted,

Senator Thomas M. Apodaca

Representative Timothy K. Moore

Co-Chairs
Legislative Research Commission

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LEGISLATIVE RESEARCH COMMISSION MEMBERSHIP

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2013 – 2014

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Co-Chair

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Senator Dan Blue
Senator Harry Brown
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PREFACE

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The Legislative Research Commission, established by Article 6B of Chapter 120 of the General Statutes, is the general purpose study group in the Legislative Branch of State Government. The Commission is co-chaired by the President Pro Tempore of the Senate and the Speaker of the House of Representatives and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigation into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" (G.S. 120-30.17(1)).

The Legislative Research Commission authorized the study of **Market Based Solutions and Elimination of Anti-Competitive Practices in Health Care**, under authority of G.S. 120-30.17(1). The Committee was chaired by Senator and Representative Marilyn Avila, Co-Chairs of the Committee. The full membership of the Committee is listed under Committee Membership. A committee notebook containing the committee minutes and all information presented to the committee will be filed in the Legislative Library by the end of the **2013-2014** biennium.

COMMITTEE PROCEEDINGS

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The Legislative Research Commission's Committee on Market Based Solutions and Elimination of Anti-Competitive Practices in Health Care met 4 times after the 2013 Regular Session. The Committee's Charge can be found here. The following is a brief summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

January 21, 2014

At its initial meeting, January 21, 2014, the Committee received a background briefing from committee staff on the history of health care planning in the United States and an overview of certificate of need (CON) laws in other states. The Division of Health Service Regulation (DHSR) North Carolina Department of Health and Human Services, presented the Committee with an explanation of North Carolina's Certificate of Need Program including: the Certificate of Need law; Article 11of Chapter 131E of the General Statutes; the process for determining need for health care facilities, services; major medical equipment; and the State Medical Facilities Plan (SMFP). DHSR also specifically covered both the determination of need under the SMFP for ambulatory surgical facilities and the certificate of need process for such facilities.

The background presentations were followed by presentations from Dr. Peter Mangone, Blue Ridge Bone and Joint, and Barry Tanner, Physicians Endoscopy. Mr. Tanner spoke about the difficulties his practice, Physicians Endoscopy, had in obtaining a CON for an ambulatory surgery center (ASC) in Gaston County. Dr. Mangone told the committee that current CON regulations are inherently unfair, restrict competition, decrease patient choice, and increase health care costs. He asked that the Committee recommend revision of the current CON law to allow for physician ownership of ASC's. He noted that Mecklenburg and Wake County residents have greater access to ASC's than Buncombe County residents. However, in the past 5 years, all request filed by Blue Ridge Bone and Joint to be allowed to file a CON application have been denied due to the lack of need projected in the State Medical Facilities Plan. Limiting patient access to ASC's raises health care costs as outpatient surgical services offered in a freestanding ASC cost approximately 40% less than the same procedures performed in hospital settings.

Andrew King, Acumen Health Care, and Dr. Stanford Plavin, Mobile Anesthesiologists of Georgia, spoke to the committee about the State of Georgia's approach to regulating the expansion of ambulatory surgery centers (ASC's). According to these gentlemen, Georgia's less restrictive CON law has allowed for greater access to ambulatory surgical care and increased competition among outpatient surgical care providers. Georgia has 145 acute care hospitals and 341 ASC's. By contrast, North Carolina has 111 acute care hospitals and 110 ASC's. The increased competition among ASC's has resulted in healthcare costs in Georgia that are 15% lower than in North Carolina. This is due in part

to the fact that Medicare facility reimbursement rates at ASC's are 43% lower than hospital reimbursement rates. Georgia rewrote its CON law in 1991 to level the playing field for all providers. The new law provided for freestanding multi-specialty and limited purpose ASC's with no capital cost limitations. It also provided for physician owned limited purpose ASC's with a $1MM limitation. The new provisions were applicable only in counties with a population in excess of 35, 000. In 2008, Georgia again amended its law and further relaxed the CON restrictions, including providing for exemptions from capital costs for certain physician-owned ASC's. The law added a charity care requirement ranging from 2% to 4 % dependent upon whether the new facility served Medicaid patients. As a result of the changes, Georgia now has 341 ASC's owned by physicians, hospitals, joint partnerships, and for profit groups. The vast majority of these are located in urban areas. The expansion has resulted in substantial cost savings. In 2011 the Georgia Medicare program saved $22 million on cataract surgeries alone. Dr. Plavin also noted that, at the time the changes to the law were proposed, the hospitals raised many of the same objections that the North Carolina legislature has heard regarding House Bill 177: physicians will cherry pick the paying patients; quality will decrease; hospital profits will be hurt; and some hospitals will close. He noted that in Georgia some hospitals have had financial problems, but the sources are many including low Medicare and Medicaid reimbursement, the federal Affordable Care Act cost cutting measures implemented in 2010, and the aggressive capital expansion and purchase of physician practices.

Joyce Jones, Bill Drafting Division, made the final presentation of the day and reviewed House Bill 177, which would eliminate need determinations for single specialty ambulatory surgical centers and eliminate the requirement of a CON for diagnostic centers. House Bill 177 was introduced during the 2013 Regular Session of the General Assembly and is the legislation underlying the current study.

February 18, 2014

At the February 18, 2014 meeting, the Committee continued its exploration of the CON regulation of ASC's through the determination of need for operating rooms in the State.

The first speaker was Peter Donaldson, CEO of Digestive Health Specialists. Mr. Donaldson spoke about the cost savings and increased patient access that has resulted from the amendment to the CON law in 2005 to allow licensure of endoscopy rooms for which a building permit had been issued or that were in operation prior to August 31, 2005, without first obtaining a CON. After August 31, 2005, gastrointestinal endoscopy rooms have been subject to CON review. The amendment, however, further provided that the State Medical Facilities Plan (SMFP) would not contain need determinations or policies that would limit the number of gastrointestinal endoscopy rooms that could be approved.

Prior to the change in the law, endoscopy rooms were regulated as a subset of operating rooms. Many of the procedures were performed in hospitals at greater cost than would have been in an ASC setting. With the change in the law, 56 new licensed ASC's with

endoscopy procedure rooms have been opened. Endoscopies performed in ASC settings are reimbursed by Medicare at 58% of the hospital reimbursement rate resulting in a net saving of $300 million. The new ASC's are primarily located in urban areas. Increased competition helps keep costs in check.

Mr. Donaldson also advocated that CON be required only for major health care projects. Hospitals should not be allowed to use the CON process to block the entry of lower cost providers and limit competition. Appeals should be limited to only those persons who can show that the approval of a CON application would diminish the quality of care at an existing or approved facility of the same facility licensure type providing the same scope of services.

Cody Hand, Vice President and Deputy General Counsel for the North Carolina Hospital Association next presented the hospital perspective on CON. Mr. Hand told the Committee that there are 155 hospitals in North Carolina including 5 teaching hospitals and 22 critical access hospitals. 68 of these hospitals are rural hospitals and 38 of these have less than 100 beds. Medicare/Medicaid patients make up about 66% of the average hospital charges. Reimbursement under these programs, however, is frequently below hospital cost to provide the services. Mr. Hand said that hospitals are able to provide a broad range of money losing services because of those procedures which are profitable.

When considering CON law changes, Mr. Hand asked the committee to consider several issues including service line cross subsidization, self-referral, incentives to perform unnecessary procedures, quality of care and Emergency Department coverage. Many services needed by a community, such as obstetrics, are subsidized by profitable services such as orthopedics. When physicians own both the medical practice and an operating room, there is a greater incentive to refer as many patients as possible for surgical procedures. Emergency departments need to have specialists on call for emergency cases. There is a concern that physician specialist with their own operating rooms may drop their hospital privileges and stop taking Emergency department calls.

Mr. Hand also stated that most states without CON programs dropped their programs before the advent of the federal Emergency Medical Treatment and Labor Act (EMTALA). Those states that did so after the enactment of EMTALA are among the states with the highest healthcare costs per capita. Further, repeal of CON will not leave the State with a free market in health care. The industry remains highly regulated through the Medicare and Medicaid programs, insurance contracts and EMTALA. With particular regard to ASC's, the State Medical Facilities Plan projects that there will be 258 more operating rooms in North Carolina than are needed. Mr. Hand suggested that, given changes underway in the delivery of healthcare services including implementation of the ACA; moves toward greater price transparency; and Medicaid reform, now is not the time to remove CON determinations from healthcare services.

David French, Strategic Healthcare Consultants, addressed the issue of charity care. Charity care is difficult to measure and compare as each hospital and ASC has its own formula and its own unique polices. The State itself lacks consistent charity care

standards. In fact, few states have such standards, although Georgia is an example of a state that does have annual reporting requirements for charity care provided by ASC's. In 2013, the North Carolina General Assembly enacted legislation, SL 2013-382 (HB834), that will require non-profit hospitals and ASC's to report charity care and community benefits.

Mr. French compared charity care at hospitals and ASC's noting many similarities. One important difference, however, is that hospitals have access to financial support from foundations, charities, and gifts, while most ASC's have no charity financial support. He also made charity care comparisons between hospital-based outpatient surgeries and freestanding ASC's. Mr. French encouraged the Committee to recommend setting minimum standards for charity care for all ASC's and hospitals. Finally, he noted that the most recent version of HB 177 would limit the development of ASC's in counties with less than 100,000 and those with critical access hospitals. He also said that 85% of the hospitals in the State are part of a major health system and that only 17 independent hospitals remain. As far as ASC's being developed near the border of a smaller county with a vulnerable hospital, Mr. French stated that this is happening now as hospitals can relocate their operating rooms.

The Committee next focused on the role of procedure rooms in determinations of need for operating rooms. Azzie Conley, Head of the Licensure Section, DHSR, stated that the Department does not approve the types of procedures that may be done in procedure rooms. The nature and scope of procedures that may be performed in a procedure room is covered under the policies of the North Carolina Medical Board. Procedure rooms are not considered in determining the need for additional operating rooms in the State.

Stephen W. Keene, General Counsel, North Carolina Medical Society, said that, unlike operating rooms, procedure rooms are not defined in statute or rule. No CON or facility license is required and there is no limitation on the types of procedures that may be performed in a procedure room. Further, procedure rooms can be built to full operating room standards. When a procedure room is located in a licensed facility, a facility fee may be charged for the use of the room. There is no reimbursement for facility fees for the use of a procedure room in unlicensed setting such as a physician's office. The regulatory treatment of procedure rooms creates a strong incentive for licensed facilities to build procedure rooms rather than operating rooms. Also, because surgeries performed in procedure rooms are not reported to DHSR, that figure is not available or used in determining the need for additional operating rooms. This skews the data underlying need determinations for operating rooms.

March 18, 2014

The March 18 meeting began with two presentations on consolidation in North Carolina's healthcare system.

Mr. Mark Werner, Blue Cross/Blue Shield, spoke about consolidation among health care providers and its impact on health care costs. He noted that the health care industry was under unprecedented economic, regulatory, consumer and other pressures. He presented three slides showing the increasing consolidation among hospital systems in North Carolina from the year 2000 through 2014. He noted that increased provider consolidation results in less competition and higher costs. Research shows that as hospitals consolidate with other hospitals and buy physician practices, the hospitals have greater negotiating power and there is less competition. The result is higher prices for services and costs to consumers without an increase in quality.

Mark Hall, Professor of Law and Public Health at Wake Forest University, also addressed the consolidation issue. Hospital merger and acquisition activity has increased nearly 50% since 2009. In North Carolina, only 22 hospitals remain independent. The rest have affiliated into 19 larger systems. In just the past 3 years, there were 9 closed merger and acquisition transactions in North Carolina and Lenoir Medical Center recently has publically started a search for a partner. Professor Hall indicated that there is support in the research literature for claims that consolidation in the healthcare industry results in quality improvement and allows for more costly investment finds robust support in the literature to date. However, research also strongly supports findings of higher prices as clinicians gain market power through consolidation and raise prices to payors. Professor Hall concluded that the consolidation trend is cause for concern. He suggested continued monitoring and study of the trend, regulation of prices, and active encouragement of price negotiations.

David French, Strategic Healthcare Consultants, spoke to the Committee regarding the potential cost savings that could be realized from changes to the CON laws regarding ASC's and diagnostic centers. He noted that North Carolina has fewer ASC's per 100,000 population than the national average. Medicare facility reimbursement rates are 43% lower for ASC facilities than for hospitals. A review of common outpatient procedures showed a variance between hospital-based outpatient surgery and ASC's in excess of 30%. Potential Medicaid savings to the State from a change in the CON law, depending on the number of ASC's built range from $16 million if 50 ASC's are added, to $33 million if 100 new ASC's are built. Under the same scenario, the State Health Plan could realize savings ranging from $53 million to $114 million in amounts paid for outpatient surgical procedures. Cumulative cost savings to the State for both Medicaid and the State Health Plan range between $70 million and 147 million depending on the number of cases and the shift of cases to ASC's.

Mr. French also addressed the issue of eliminating the requirement of CON for diagnostic centers. According to Mr. French, the CON law restricts competition and limits patient access to lower cost outpatient imaging. Differentials in reimbursement between hospital-based imaging and outpatient imaging range from 1.56 to 3.49 for various imaging modalities. Finally, Mr. French provided a rebuttal to the concerns raised by the North Carolina Hospital Association at the February 18, 2014 meeting, specifically regarding cross-subsidization, physician self-referral, emergency department coverage, and the lack of free markets in health care.

Dr. Richard Bruch, Consultant with Triangle Orthopedic Associates, spoke to the Committee about the effects of federal legislation on cost and delivery of health care services. He addressed the concept of "bundled payments" as part of the proposed physician Medicare/Medicaid payments for the next decade. In orthopedics, for example, a bundled payment cover surgery and all follow up care. Dr. Bruch stated that to achieve optimal patient care a patient must be served in the correct, cost effective setting. He noted that currently 72% of surgeries in North Carolina are outpatient and 77% of those surgeries are done in a hospital outpatient setting. Additional freestanding ASC's would help provide patient care in the correct setting and be more cost effecting. Dr. Bruch also addressed the WellPoint Advanced Imaging study that showed that self-referring groups were better utilizers than non self-referrers. Non self-referring physicians ordered more studies per patient. Further, the fact of MRI ownership did not change Medicare MRI ordering. In North Carolina: when orthopaedists own their advanced imaging equipment referral patterns are normal. Both Medicare/Medicaid and commercial insurers pay less for imaging studies performed in the physician's office than in a hospital setting.

Dr. Dan Murrey, CEO of OrthoCarolina, spoke to the Committee about what was wrong with healthcare in the United States. The US pays far more than other countries for healthcare and yet this additional spending is not effective. Some of the causes include a lack of integration and coordination of care and misaligned incentives. Solutions include integrated practice units around patient conditions, coordinated care across providers, and alternative care environments. Alternative care environments include using urgent care instead of the emergency department, office injection suites instead of surgical centers, ASC's instead of hospital-based operating rooms, and outpatient imaging instead of inpatient imaging. Incentives need to reward value not volume. Bundling payments can lower overall costs and reduce waste. CON programs make it hard to achieve these goals because they limit competition. They increase costs through application and appeals expenses. Protecting the revenues of CON holders does not justify the program. Physician ownership of facilities and equipment does not lead to overutilization.

The focus of the meeting next turned to CON's for diagnostic centers. Martha Frisone, Interim Section Chief, CON, DHSR, told the Committee that a diagnostic center is a freestanding facility, program or provider including physicians' offices, clinical labs, radiology centers and mobile diagnostic clinics, where the total cost of all the medical diagnostic equipment used costing $10,000 or more exceeds $500,000. A facility must apply for a CON when the total cost of equipment meets the threshold.

Dr. David Levin, spoke to the Committee on the issue of physician self-referral of patients and its effect on the use of imaging. Dr. Levin referenced a number of studies, dating from the mid 1990's to the present showing increased use of imaging by physicians after acquisition of MRI's, CT scanners, and other imaging equipment with its concomitant increase in health care costs. Included in his presentation were the MedPAC 2009 Report to Congress and a 2012 GAO report, "Higher Use of Advanced Imaging Services by providers who Self-Refer Costing Medicare Millions".

Jeffrey James, CEO of Wilmington Health, was the final speaker of the day. Wilmington Health is a 160 provider multispecialty group practice with 20 locations serving 6 counties in eastern North Carolina. It is an Accountable Care Organization and a Medicare Shared Savings Participant. Among its facilities is a leased MRI, owned CT and a single specialty endoscopy center. Data from the practice shows decreased use and cost in CT and MRI.

At the end of the meeting Senator Apodaca requested the Committee to send their comments and suggestions for recommendations and legislation to staff by March 25, 2014 to be incorporated into the Committee's report to the Legislative Research Commission.

FINDINGS AND RECOMMENDATIONS

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FINDINGS

1. North Carolina is following the national trend toward greater consolidation of hospitals and health care providers and increased acquisition by hospitals of physician's practices.

Nationally, hospital merger and acquisition activity has increased almost 50% since 2009. Data presented to the Committee showed that only 22 of more than 120 hospitals in North Carolina remain independent. The rest have affiliated or been acquired by one of 19 larger systems operating in the State. The increased consolidation among hospitals gives them greater market power. As a result, they have increased leverage in negotiating reimbursement rates with health plans, plus access to additional facility fees. Hospital merger and acquisition activity has led to increased out of pocket expenses for insured, and higher pharmaceutical costs. The increased acquisition of physician practices also leads to a decrease in patient choice and higher costs.

2. Increased competition among health care providers and greater price transparency for services can help control increasing health care costs and offer patients greater access to health care services.

In 2005, North Carolina changed its Certificate of Need (CON law to allow gastrointestinal endoscopy rooms to become licensed as ambulatory surgical centers (ASC's) without obtaining a CON if they were in existence, or a building permit had been issued for construction, on or before August 31, 2005. Since 2005, 56 new licensed ASC's with endoscopy rooms have opened. The costs for endoscopies performed in ASC's are reimbursed by Medicare at 58% of the reimbursement rate for hospital based procedures. Total cost savings to date are estimated at $300 million dollars. According to Dr. Peter Donaldson of Digestive Health Specialists, the increased competition helps to hold down costs and charges by health care providers. Dr. Donaldson also noted that the change in the CON law provided patients with greater access to affordable colonoscopy screening. Increased screenings results in a lower death rate from colorectal cancers.

The State of Georgia has also changed its approach to the regulation of ASC's removing most of the capital restrictions on the development of new ASC's. Georgia law imposes a 2% to 4% charity care requirement on non-hospital ASC's. The number of ASC's in Georgia, including physician-owned, hospital-owned, joint partnership, and for profit, is up to 341. North Carolina has 111. According to Dr. Stan Plavin, President of Ambulatory Anesthesia of Atlanta, and Andrew King, Acumen Healthcare, the increased

competition has brought down pricing. Georgia's healthcare costs are 15% lower than those in North Carolina. This is due in part to 2012 Medicare facility rates being 43% lower than hospital rates.

3. The methodology used to develop projections of need for ASC's for the annual State Medical Facilities Plan (SMFP) is flawed. The need projections favor existing ASC's and hospital based outpatient surgery and act as a barrier to entry for new, freestanding ASC's.

An "operating room" is defined in the CON statutes as "…a room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room." G.S. 131E-176 (18c). Procedure rooms, which also are rooms used for the performance of surgical and other procedures, are not defined in statute, and no CON or facility license is required. If, however, a procedure room is located in a licensed facility, a facility fee may be charged for the use of the room. Procedure rooms may be built to full operating room standards and there is no limitation on the types of procedures that may be done in them.

The methodology for determining need for new operating rooms does not include procedure rooms. According to the Division of Health Service Regulation, there are 2,874 procedure rooms located in hospitals and 44 located in ASC's across the State. The lack of regulation for procedure rooms creates a strong incentive for licensed facilities to build procedure rooms instead of operating rooms. Given that the number of surgeries conducted in procedure rooms are not reported to DHSR, this surgery volume is not used in determining the need for additional operating rooms. The skewed data tends to artificially suppress the need for additional operating rooms in the SMFP.

4. Eliminating need determinations for the development of new freestanding ASC's has the potential to significantly reduce health care costs and increase access to health care services for the citizens of the State.

ASC's provide significant cost savings to the State Medicaid program, to insurance companies and to patients. The 2013 Medicare facility reimbursement rates are 43% less than hospital reimbursement rates. According to data provided by David French, Strategic Healthcare Consultants, Medicaid, the State Health Plan, and commercial insurance companies reimburse ASC's at substantially lower rates than hospitals. Patient copayments are also lower at ASC's.

Looking at actual cases and amounts paid for 2011 and 2012, the variance between hospital and ASC paid amounts was 36.31% and 32.63% respectively. Mr. French projected cumulative savings to Medicaid for the years 2014 through 2020 to be $16,659,218, assuming 50 new ASC's were built and the utilization mix of hospital to

ASC procedures shifted from 80%/20% to 70%/30%. If 100 new ASC's were developed and the utilization mix shifted to 60%/40%, those savings are projected to reach $33,110,436.

Data for the State Health Plan (SHP) for 2011 and 2012 showed a variance between hospital and ASC paid amounts of 68.62% and 63.54% respectively. In 2012, 81% of outpatient surgeries for enrollees of the SHP were performed in hospitals and 19% in ASC's. Mr. French projected cumulative savings to the SHP for the years 2014 through 2020 to be $53,330,349 if 50 new ASC's were added and the utilization mix shifted to 70%/30%. Savings were projected at $114,363,428 if the number of new ASC's reached 100 with a utilization mix of 60%/40%.

Combining the above savings estimates for both Medicaid and the SHP shows potential cumulative savings to the State for 2014 through 2020 ranging between $69,989,568 and $147,473,862.

5. Eliminating the CON regulation of Diagnostic Centers would allow for imaging services to be provided at lower costs to patients. High cost imaging technology would still be subject to CON review where the imaging equipment cost exceeded the capital threshold of $750,000 for major medical equipment.

Diagnostic Centers are freestanding facilities, program, or providers in which the total cost of all the medical diagnostic equipment used that cost $10,000 or more exceeds $500,000. G.S. 131E-176(7a). The capital cost threshold of $500,000 has not changed since1993, when it was first enacted.

According to David French, Strategic Healthcare Consultants, the current CON regulations restrict competition and limit patient access to lower cost imaging at freestanding centers. The average revenue differential for various imaging modalities ranges from 1.56 to 3.49 per procedure when comparing hospital outpatient imaging and diagnostic centers. The capital cost restrictions also discourage physicians and diagnostic centers from updating their equipment lest they cross over the $500,000 threshold.

Jeff James, CEO of Wilmington Health provided the Committee with data drawn from their multispecialty group practice, from 2010 to the present, showing a significant decrease each year in imaging costs at their facility. The decrease in costs and numbers of patients treated for CT scans was particularly significant.

6. North Carolina does not have a definition of charity care as it relates to healthcare providers nor does it establish any requirements for levels of charity care to be provided by health care providers. ASC's should be

required to provide charity care to patients at levels comparable to those provided by hospitals for their outpatient surgeries.

Hospitals must provide treatment to all who present themselves to the Emergency Department regardless of ability to pay under the federal Emergency Medical Treatment and Labor Act (EMTALA). Hospitals also provide a substantial amount of care to patients covered under Medicare and Medicaid. Reimbursement under Medicare and Medicaid frequently do not cover the cost of providing medical services to these patients. Other healthcare providers are not subject to EMTALA and may or may not treat the large numbers of Medicare/Medicaid patients. However, physicians often provide charity care in their practices and to those they treat at hospitals. Hospitals also have access to other revenue sources not available to physicians, such as foundations and grants. Hospitals do not pay property taxes and receive substantial sales tax refunds that help offset loss of revenue from charity care.

North Carolina does not require hospitals or other healthcare facilities to provide a specific level of charity care. Further each facility has its own policies and eligibility requirements for charity care which makes comparisons difficult. This past year, the General Assembly enacted S.L.2013-382 that will require hospitals and ASC's that file IRS Form990 to report charity care and community benefits.

If the General Assembly decides to decrease the CON regulatory burden on ASC's, it should also require, as a condition of licensure, that ASC's provide a minimum level of charity care equivalent to that provided by hospitals in the local community.

RECOMMENDATIONS

1. The Committee on Market-Based Solutions and Elimination of Anticompetitive Practices in Healthcare recommends the enactment of 2013-MGz-140 (see APPENDIX D).

The bill would (1) eliminate need determinations and policies from the State Medical Facilities Plan that limit the number of single specialty ambulatory surgical operating rooms that may be approved for a CON, (2) require persons seeking a CON for single specialty ambulatory surgical operating rooms to make a written commitment to provide charity care and services to Medicare/Medicaid patients and (3) eliminate CON requirements for diagnostic centers

2. The Committee on Market-Based Solutions and the Elimination of Anti-Competitive Practices in Healthcare recommends further study of ways to improve the State's healthcare delivery system including whether further repeal of facilities and services covered by the CON law, such as psychiatric and substance abuse services, would increase competition, temper health care cost increases, and improve access to health care for the citizens of the State.

Appendix A

COMMITTEE MEMBERSHIP

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2013-2014

President Pro Tempore of the Senate Appointments:

Senator Thomas M. Apodaca , Co-Chair

Senator Donald Davis
Senator Jim Davis
Senator Ralph Hise
Senator Louis Pate
Senator Robert Rucho

Speaker of the House of Representatives Appointments:

Representative Marilyn Avila, Co-Chair

Representative William Brisson
Representative Donny Lambeth
Representative Nathan Ramsey
Representative John Szoka

Appendix B

COMMITTEE CHARGE

Market Based Solutions and Elimination of Anti-Competitive Practices in Health Care - The LRC Study Committee on Market Based Solutions and Elimination of Anti-Competitive Practices in Health Care shall study federal and state barriers to a market-based health care delivery system, compare hospital-based operating room and ambulatory surgical centers as a venue for the provision of surgical services, study North Carolina's certificate of need program in comparison with other states, and study other related certificate of need issues.

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Specifically, the study shall include:

(1) A study of barriers to a market-based health care delivery system from the federal level, including:
  (a) Federal health care laws.
  (b) Federal regulation of health care service delivery.
  (c) Federal reimbursement issues.

(2) A study of barriers to a market-based health care delivery system at the State level including:
  (a) State health care laws.
  (b) State regulation of health service delivery.
  (c) State reimbursement issues.
  (d) The impact of the certificate of need program on smaller community hospitals.

(3) A comparison of same day surgery offered by hospital-based or hospital-owned operating rooms and nonhospital-based ambulatory surgical centers. The comparison shall include the following factors: cost, quality of care, availability, and charity care.

(4) A study of the North Carolina certificate of need law in comparison to other states both with and without certificate of need programs.

(5) A review of restrictive covenants in physician employment agreements. This may include:
  (a) Their impact on health care costs.
  (b) Their impact on health outcomes.
  (c) Whether they restrict access to medical services.

(6) Any other issues pertinent to this study.

Senate Members		**House Members**	
Sen. Apodaca	Chair, Ex Officio	Rep. Avila	Chair
Sen. Don Davis		Rep. Brisson	
Sen. Jim Davis		Rep. Lambeth	
Sen. Hise		Rep. Ramsey	
Sen. Pate		Rep. Szoka	
Sen. Rucho		Rep. Tim Moore	Ex Officio

STATUTORY AUTHORITY

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NORTH CAROLINA GENERAL STATUTES
ARTICLE 6B.

Legislative Research Commission.

§ 120-30.17. Powers and duties.

The Legislative Research Commission has the following powers and duties:

(1) Pursuant to the direction of the General Assembly or either house thereof, or of the chairmen, to make or cause to be made such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner.

(2) To report to the General Assembly the results of the studies made. The reports may be accompanied by the recommendations of the Commission and bills suggested to effectuate the recommendations.

(3), (4) Repealed by Session Laws 1969, c. 1184, s. 8.

(5), (6) Repealed by Session Laws 1981, c. 688, s. 2.

(7) To obtain information and data from all State officers, agents, agencies and departments, while in discharge of its duty, pursuant to the provisions of G.S. 120-19 as if it were a committee of the General Assembly.

(8) To call witnesses and compel testimony relevant to any matter properly before the Commission or any of its committees. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Commission and its committees as if each were a joint committee of the General Assembly. In addition to the other signatures required for the issuance of a subpoena under this subsection, the subpoena shall also be signed by the members of the Commission or of its committee who vote for the issuance of the subpoena.

(9) For studies authorized to be made by the Legislative Research Commission, to request another State agency, board, commission or committee to conduct the study if the Legislative Research Commission determines that the other body is a more appropriate vehicle with which to conduct the study. If the other body agrees, and no legislation specifically provides otherwise, that body shall conduct the study as if the original authorization had assigned the study to that body and shall report to the General Assembly at the same time other studies to be conducted by the Legislative Research Commission are to be reported. The other agency shall conduct the transferred study within the funds already assigned to it.

Appendix D

LEGISLATIVE PROPOSALS

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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H **D**

BILL DRAFT 2013-MGz-140 [v.1] (03/28)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
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Short Title:	LRC Recs. on Certificate of Need Laws.	(Public)
Sponsors:	Representative Avila.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT EXEMPTING DIAGNOSTIC CENTERS FROM CERTIFICATE OF NEED REVIEW AND AMENDING CERTIFICATE OF NEED LAWS PERTAINING TO SINGLE-SPECIALTY AMBULATORY SURGERY OPERATING ROOMS AND OPERATING ROOMS WITHIN AMBULATORY SURGERY FACILITIES AND ACUTE CARE HOSPITALS, AS RECOMMENDED BY THE LEGISLATIVE RESEARCH COMMISSION ON MARKET-BASED SOLUTIONS AND ELIMINATION OF ANTI-COMPETITIVE PRACTICES IN HEALTH CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-175 is amended by adding new subdivisions to read:

"(13) That the relocation of a hospital's operating rooms to a location separate from the campus upon which the hospital's inpatient acute care beds and emergency department are located results in a costly and unnecessary economic burden to the public.

(14) That the demand for ambulatory surgery is increasing due to advances in technology and anesthesia, and single-specialty ambulatory surgery operating rooms are recognized as a highly effective means of expanding access while achieving cost savings regardless of the availability and potential underutilization of hospital-based operating rooms."

SECTION 2. G.S. 131E-176(9b) reads as rewritten:

"(9b) 'Health service facility' means a hospital; long-term care hospital; psychiatric facility; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for the mentally retarded; home health agency office; chemical dependency treatment facility; ~~diagnostic center;~~ hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility."

SECTION 3. G.S. 131E-176(16)u. reads as rewritten:

"(16) 'New institutional health services' means any of the following:

…

u. The construction, development, establishment, increase in the number, or relocation of an operating ~~room~~ room, including a single-specialty ambulatory surgery operating room, or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating ~~room~~ room, or single-specialty ambulatory surgery operating room, or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.

…."

SECTION 4. G.S. 131E-176(24c) reads as rewritten:

"(24c) ~~Reserved for future codification.~~"Single-specialty ambulatory surgery operating room" means a designated operating room located in a licensed ambulatory surgical facility that is used to perform same-day surgical procedures in one of the single-specialty areas identified by the American College of Surgeons. For the purpose of this subdivision, 'same-day surgical procedures' includes pain injections by orthopedists, physiatrists, and anesthesiologists."

SECTION 5. Article 9 of Chapter 131E is amended by adding a new section to read:

"**§ 131E-178l. Need determinations and approvals for ambulatory surgical facilities.**

(a) The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of single-specialty ambulatory surgery operating rooms that may be approved for a certificate of need. However, the Department shall not approve an application for a single-specialty ambulatory surgery operating room in any ambulatory surgical facility within (i) a county in which a licensed critical access hospital, as defined in 42 C.F.R. 400.202, as amended, is located or (ii) a county with a population of less than 100,000 as of July 1, 2014, unless the application includes written support from each licensed acute care hospital within that county.

(b) The Department shall not approve an application for the relocation of a hospital's operating rooms to a location separate from the campus upon which the hospital's inpatient acute care beds and emergency department are located if approval would result in the hospital obtaining reimbursement for surgery procedures at a rate higher than the rate paid to ambulatory surgery centers under a government-sponsored health insurance or medical assistance program."

SECTION 6. G.S. 131E-182 reads as rewritten:

"(a) The Department in its rules shall establish schedules for submission and review of completed applications. The schedules shall provide that applications for similar proposals in the same service area will be reviewed together.

(a1) The Department shall not schedule a review prior to February 1, 2015, for certificate of need applications that propose to establish a licensed ambulatory surgery facility for the provision of single-specialty ambulatory surgery procedures or to

establish a single-specialty ambulatory surgery operating room within an existing ambulatory surgical facility.

(b) An application for a certificate of need shall be made on forms provided by the Department. The application forms, which may vary according to the type of proposal, shall require such information as the Department, by its rules deems necessary to conduct the review. An applicant shall be required to furnish only that information necessary to determine whether the proposed new institutional health service is consistent with the review criteria implemented under G.S. 131E-183 and with duly adopted standards, plans and criteria.

(b1) The application form for a certificate of need to establish an ambulatory surgery facility for the provision of single-specialty ambulatory surgical procedures or to establish a single-specialty ambulatory surgery operating room within an existing ambulatory surgical facility shall require the applicant to provide all of the following:

(1) A written commitment, plan, and policies and procedures for serving indigent and medically underserved populations.

(2) The projected charges for the 20 most common surgical procedures to be performed in the proposed operating room.

(3) Demonstration that is performing or reasonably expects to perform at least 800 single-specialty ambulatory procedures per licensed single-specialty ambulatory operating room per year.

(b2) The application form for a certificate of need to establish, relocate, or replace operating rooms within an ambulatory surgery facility or acute care hospital shall require the applicant to provide all of the following:

(1) A commitment that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least seven percent (7%) of the total revenue collected for all surgical cases performed in the facility or proposed facility.

(2) For each of the first three full fiscal years of operation:

a. The projected number of self-pay surgical cases.

b. The projected number of Medicaid surgical cases.

c. The total projected Medicare allowable amount for the self-pay surgical cases to be served in the facility or proposed facility. This projection shall be determined by multiplying the projected amount of the Medicare allowable amount per self-pay surgical case, and the projected number of self-pay surgical cases.

d. The total projected amount of Medicare payments the facility expects to receive for surgical procedures performed on patients who are Medicaid recipients. This projection shall be determined by multiplying the projected amount of the Medicare allowable amount per Medicaid surgical case, and the projected number of Medicaid surgical cases.

e. The projected revenue to be collected from the projected number of self-pay surgical cases.

f. The projected revenues to be collected from the projected number of Medicaid cases.

g. The projected total revenue to be collected for all surgical cases to be performed in the facility or proposed facility.

(3) A commitment to report utilization and payment data for services provided by the ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2.

(c) An application fee is imposed on an applicant for a certificate of need. An applicant must submit the fee with the application. The fee is not refundable, regardless of whether a certificate of need is issued. Fees collected under this section shall be credited to the General Fund as nontax revenue. The application fee is five thousand dollars ($5,000) plus an amount equal to three-tenths of one percent (.3%) of the amount of the capital expenditure proposed in the application that exceeds one million dollars ($1,000,000). In no event may the fee exceed fifty thousand dollars ($50,000)."

SECTION 7. G.S. 131E-184(a) is amended by adding a new subdivision to read:

"(10) To develop, acquire, or replace an institutional health service that obtained certificate of need approval prior to the effective date of this act as a diagnostic center, unless a new institutional health service other than those described in G.S. 131E-176(16)b. is offered or developed in the building."

SECTION 8. Nothing in this act shall be construed to reflect any legislative intent with respect to the circumstances under which Medicare or Medicaid certification may be obtained for a provider of ambulatory surgery services.

SECTION 9. This act is effective when it becomes law. Section 6 of this act expires on the effective date of administrative rules adopted consistent with the provisions of this act regarding (i) the number of single-specialty surgery procedures performed or projected to be performed by applicants seeking to establish a licensed single-specialty ambulatory surgery operating room and (ii) the establishment, relocation, or replacement of operating rooms within ambulatory surgery facilities or acute care hospitals.