Market Based Solutions and Elimination of Anti-Competitive Practices in Health Care (LRC)(2013)

Cost Savings and Justification for Changes to CON Law
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Change CON Law to Allow Ambulatory Surgery Centers

The current planning methodology used to regulate operating rooms fails to account for surgery cases performed in procedure rooms of licensed facilities and fails to provide price competition that benefits patients.

Changes to the NC CON law to allow additional single-specialty ASCs would provide tremendous cost savings in future years.

Changes to the NC CON law to eliminate the regulation of "diagnostic centers" would allow for routine imaging services to be provided at lower costs to patients.

North Carolinians Have Limited Access to ASCs

	Year 2012
US Total Medicare Certified ASCs Projected for 2012*	6314
US Total Population	313,914,040
ASCs per 100,000 Population in US	2.01
North Carolina 2012 ASCs	114
NC Total Population	9,752,073
ASCs per 100,000 Population in NC	1.17
Variance US and NC numbers of ASC per 100,000 pop.	-0.84
Additional ASCs needed for NC to be on Par with US	82
Total NC ASCs Existing Plus those Needed	196

* REPORT TO CONGRESS: Medicare Ambulatory Surgical Center Value-Based Purchasing Implementation Plan reports 5175 ASSCs in 2008 and 5.1% compound annual growth for 2003 to 2008

Why Change CON Law Now?

The 2012 Medicare facility reimbursement rates are 43 percent lower than the hospital reimbursement rates. Medicaid, the State Health Plan, and commercial insurances reimburse ASC facilities at substantially lower rates than hospitals. Patient co-payments are also lower for ambulatory surgery centers.

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

2011 Procedure Volumes and Top Physician Specialties At ASCs

Highest Procedure Volumes by Specialty Performed in NC Surgical ASCs

Ophthalmology	57,345
Orthopaedic Surgery	32,134
Otolaryngology	24,381
General Surgery	8,597
Obstetrics and GYN	6,626
Plastic Surgery	2,746

Highest Volumes of Non-Surgical Procedures Performed in NC Surgical ASCs

Pain Management	20,760
Yag Lasers	5,563

Top 6 Physician Specialties on ASC Medical Staff (This is not a measure of physician ownership)

Orthopaedic Surgery	338
Anesthesia	294
Ophtalmology	246
Obstetrics and GYN	244
Otolaryngology	182
General Surgery	178

Rationale for Changing CON Law to Allow CON Applications for Single-Specialty ASCs

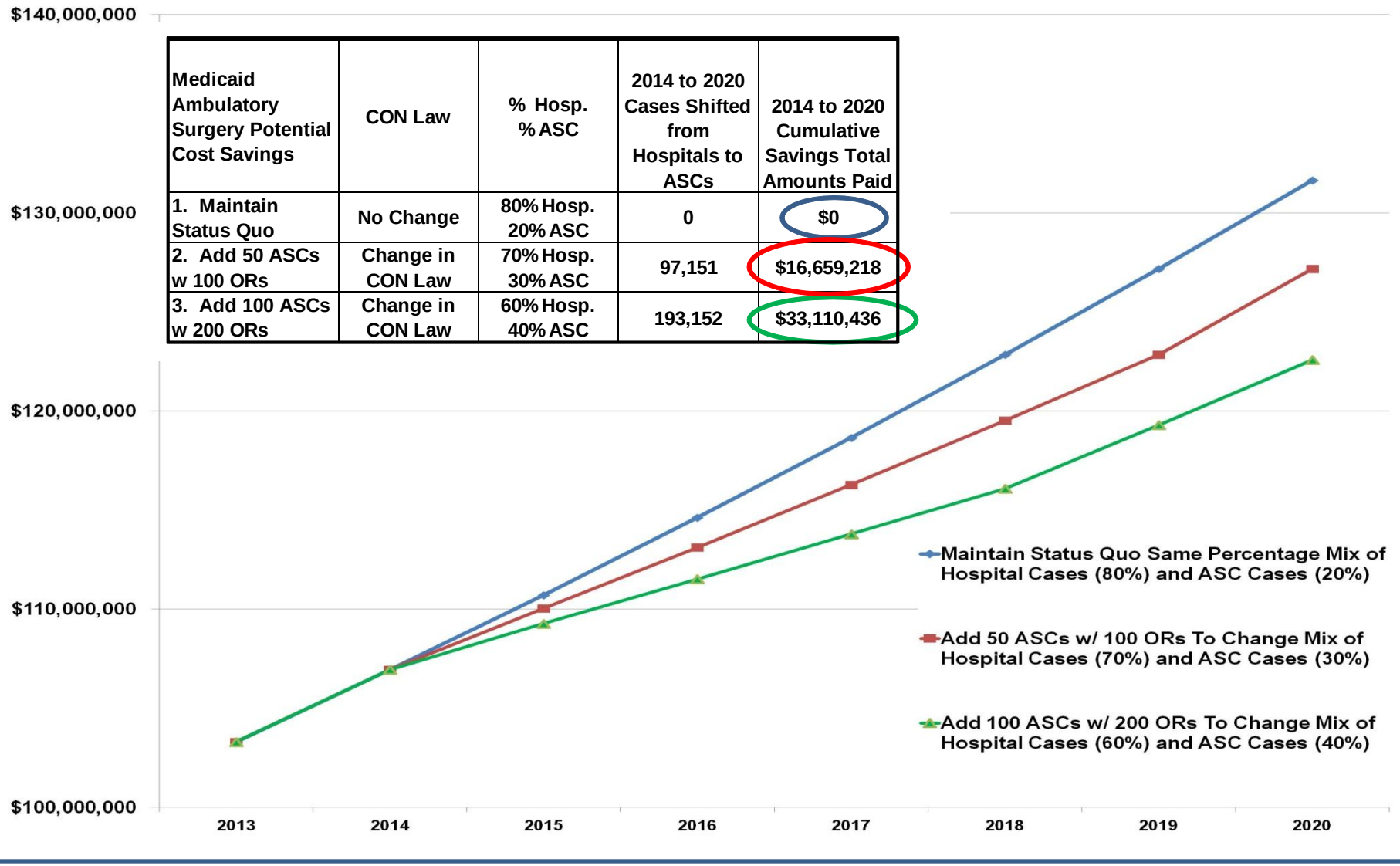
- ✓ Ambulatory surgical centers provide tremendous cost savings to patients, insurance companies and government payors
- ✓ ASCs enable surgeons to be more efficient
- ✓ Proposals can be submitted by physicians, hospital-owned physician groups or other legal entities including joint ventures
- ✓ This change will increase competition and patient access
- ✓ ASCs will be required to provide specific levels of care to Medicaid and Charity patients and to provide annual reports
- ✓ This change in the CON law will support the future recruitment of physician specialists to North Carolina
- ✓ This change will increase investment in facilities, create jobs and expand the tax base

NC Medicaid Ambulatory Surgery
Actual Cases and Amounts Paid

	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 Amount	$165.12	$160.99
Percentage Variance of Hospital and ASC Paid Amount	36.31%	32.63%

Medicaid Ambulatory Surgery Projections; Three Scenarios for Total Combined Annual Paid Amounts for Hospital Cases and ASC Cases

Medicaid Ambulatory Surgery Potential Cost Savings	CON Law	% Hosp. % ASC	2014 to 2020 Cases Shifted from Hospitals to ASCs	2014 to 2020 Cumulative Savings Total Amounts Paid
1. Maintain Status Quo	No Change	80% Hosp. 20% ASC	0	$0
2. Add 50 ASCs w 100 ORs	Change in CON Law	70% Hosp. 30% ASC	97,151	$16,659,218
3. Add 100 ASCs w 200 ORs	Change in CON Law	60% Hosp. 40% ASC	193,152	$33,110,436



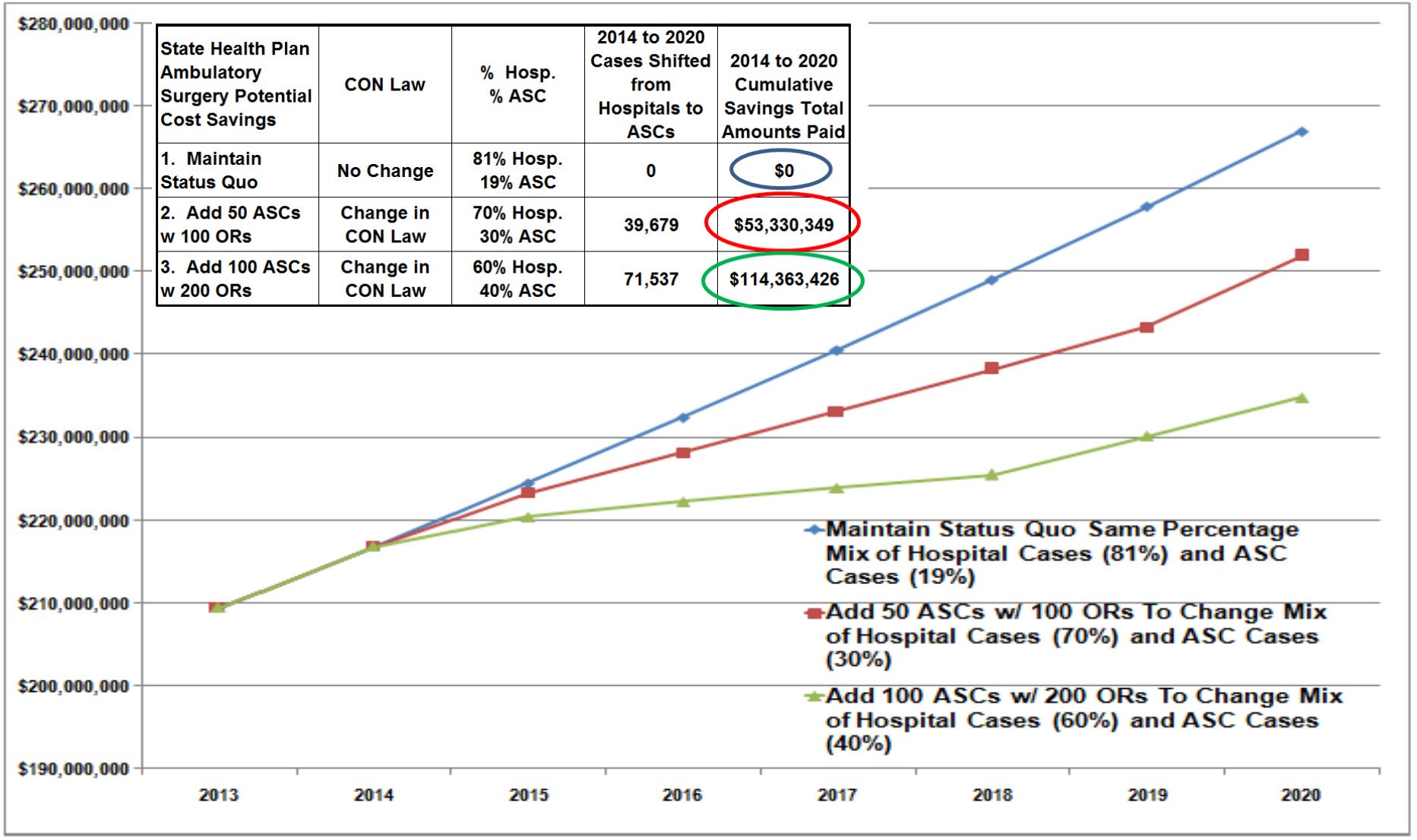
NC State Health Plan Ambulatory Surgery Cases and Amounts Paid (SHP Enrollment 663,000 Persons)

	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 Amounts	$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	

State Health Plan Ambulatory Surgery Projections; Three Scenarios for Total Combined Annual Paid Amounts for Hospital Cases and ASC Cases

State Health Plan Ambulatory Surgery Potential Cost Savings	CON Law	% Hosp. % ASC	2014 to 2020 Cases Shifted from Hospitals to ASCs	2014 to 2020 Cumulative Savings Total Amounts Paid
1. Maintain Status Quo	No Change	81% Hosp. 19% ASC	0	$0
2. Add 50 ASCs w 100 ORs	Change in CON Law	70% Hosp. 30% ASC	39,679	$53,330,349
3. Add 100 ASCs w 200 ORs	Change in CON Law	60% Hosp. 40% ASC	71,537	$114,363,426



Medicaid and State Health Plan
Estimated Savings Following Change in CON Law

	2014 to 2020
Scenario 1 - No Changes to CON Law , Ambulatory Cases Remain at 80% Hospitals and 20% ASCs	Scenario 1
Total Medicaid + SHP Amounts Paid	Cumulative $2,520,532.219
Savings	$0
Scenario 2 - Add 50 ASCs w 100 ORs (2 per ASC) Changes Ambulatory Cases to 70% Hospitals and 30% ASC	Scenario 2
Total Medicaid + SHP Amounts Paid	Cumlative $2,450,542,562
Savings	$69,989,568
Scenario 3 - Add 100 ASCs with 200 ORs (2 per ASC) Changes Ambulatory Cases to 60% Hospitals and 40% ASCs	Scenario 3
Total Medicaid + SHP Amounts Paid	Cumlative $2,172,694,165
Savings	$147,473,862

Cumulative Cost Savings Range Between $70 Million and $147 Million Depending on the Number of ASCs and the Shift of Cases

Key Factors Regarding Changes To CON Law for Single Specialty ASCs

Must meet all licensure and accreditation standards and Medicare Conditions of Participation

Must establish transfer agreements with local hospitals

Will be required to provide access for Charity Care and Medicaid patients on par with existing hospitals and ASCs and consistent with written policies

Must submit annual reports of Charity Care and Medicaid utilization

Will not be permitted to be developed in counties of less than 100,000 persons unless the project is supported by the local hospital

Elimination of CON Regulation of Diagnostic Centers

The CON definition of diagnostic centers is poorly understood, often ignored and rarely enforced.

The $500,000 capital cost threshold for the total cost of equipment in a non-hospital location was established in 1993 and has never been updated. No other state has a diagnostic center category with such a low dollar threshold.

High cost imaging technology such as MRI scanners and PET scanners and other imaging equipment that individually cost more than $750,000 would still be required to obtain CON approval.

The Current CON Regulation of Diagnostic Centers

Restricts competition and limits patient access to lower cost outpatient imaging

Average Revenue (Blended) per Procedure Comparing Hospital and Outpatient Imaging Center Technical Component Reimbursement			
Modality	Hospital Reimbursement	Outpatient Imaging Center Reimbursement	Average Revenue Differential
CT	$626.66	$245.83	2.55
Ultrasound	$241.23	$87.01	2.77
Radiography	$106.45	$44.55	2.39
Mammography	$121.44	$78.07	1.56
Nuclear Medicine	$634.71	$181.72	3.49

Discourages physicians and imaging centers from replacing outdated imaging equipment

How Elimination of CON Regulation of Diagnostic Centers Can Reduce Utilization and Save Money

Allows physicians and imaging centers to obtain digital imaging equipment that provides better images that can be transmitted to other facilities to eliminate the need for duplicative procedures.

Allows patients and physicians to expedite routine diagnostic procedures (x-ray, ultrasound, mammography, nuclear medicine and CT) and implement treatment more quickly.

Allows physician to have better options to order low cost imaging procedures such as x-ray or ultrasound as an alternative to higher cost CT or MRI.

Misleading Arguments from Hospital Officials

"Cross Subsidization" - profitable services such as orthopaedic surgery must subsidize money-losing services such as maternity. This argument is false because most hospitals have:

- **Nonprofit status and no property taxes saves hospitals hundreds of millions**
- **Access to money from foundations and grants**
- **Sales tax refund of over $300,000 million per year**
- **Skyrocketing patient charges of 400% to 1000% for costs of treatments and drugs**

"Physician Self Referral" - physician ownership of surgery centers or imaging equipment leads to unnecessary procedures. This has no merit:

- **Surgery centers and imaging centers are subject to the Medicare conditions of participation, accreditation standards, quality assurance and utilization review**
- **Hospitals employ or contract with an increasing number of physicians and are encouraging these physicians to refer to hospital-owned services**
- **Numerous hospitals have been named in lawsuits and are being investigated by the U.S. Justice Department for pressuring physicians to raise inpatient admissions and paying kickbacks to physicians**

Misleading Arguments from Hospital Officials

"ED Call Coverage" - once surgeons obtain ownership in an ambulatory surgery center they will no longer provide call coverage for the hospital emergency departments. This is a false concern:

- **Current CON regulations require physicians to have hospital privileges**
- **Medical staff by-laws for hospital privileges define emergency department call coverage requirements**
- **Some hospitals have created their own problems by building satellite emergency departments and imposing greater call coverage obligations on physicians**

"No Free Market in Healthcare" – even without CON, insurance contracts, EMTALA and Medicare would interfere with healthcare competition. This is misleading:

- **Patients increasingly want to compare prices and have greater choices**
- **The FTC and U.S. Justice Department report that CON laws create barriers to entry and expansion, to the detriment of health care competition and consumers**
- **Hospital mergers and acquisitions of physician practices in North Carolina restrict patient choice and limit competition**

Quality of Care

ASCs and hospitals serve different patient populations which makes it difficult to compare quality measures.

There is no dispute that surgery schedules at ASCs are much less likely to be disrupted as compared to hospitals where emergency cases must be accommodated.

ASCQR is the quality reporting system implemented by CMS where ambulatory surgery centers report quality of care data for standardized measures to receive the full annual update to their ASC annual payment rate.

Changing the CON law to allow additional licensed ASCs would provide a much better regulatory structure for quality measurement as compared to the current scenario that allows unregulated procedure rooms to be added in existing licensed facilities.

Thank you

Questions