Further Development of State Health Plan Standards for General Surgical Services: COMAR 10.24.11

May 18, 2017

MHCC | MARYLAND HEALTH CARE COMMISSION

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Where We Are Currently

CON required to establish any ambulatory surgical facility or ASF (2+ operating rooms)

CON required to add operating rooms (ORs) in any setting

In either case, finding a need for the project is based on OR capacity assumptions

- **Achieve a specified OR hour volume level to get consideration**
- **Demonstrate an ability to reach specified OR hour volume within a specified time**

Where We Are with Draft Changes – April 2017

CON exemption to establish an ASF through the addition of a second OR or the consolidation of two one-OR centers

CON exemption to establish two-OR ASF by a hospital converting to a freestanding medical facility

Finding a need for a second OR requires achievement of a specified OR hour volume level to get consideration

In all exemption cases, a demonstration of an ability to reach specified OR hour volume within a specified time is required

Questions from April 21, 2017 Commission Discussion

- How are ORs used in Maryland with reference to the SHP's current capacity assumptions?
- How does Maryland compare with other states with respect to use of hospital and non-hospital settings for outpatient surgery?
- How does payer mix differ by surgery setting? Can Medicaid MCOs increase use of non-hospital settings?
- What is the geographic distribution of ASFs and POSCs?
- What is the likely impact of shifting outpatient surgery to ASFs from hospitals and the implications for total cost of care and system savings?
- What are the implications of policy changes on regulatory oversight of dedicated inpatient ORs?

Questions from April 21, 2017 Commission Discussion

- What, if any, limitations on location of expanded or new ASFs relative to the current location of the ASF(s) or the hospital should be established?
- How do MHCC charity care requirements overlap with HSCRC requirements and are such requirements consistent across regulated services?

How are ORs used in Maryland with reference to the SHP's current capacity assumptions?

Average OR Hours per OR per Year, Hospital Mixed-Use Operating Rooms, 2008 - 2015

Average OR Hours per OR	2008	2009	2010	2011	2012	2013	2014	2015
Under 500	3	2	3	2	2	2	3	4
500 - 699	2	1	2	2	1	4	2	2
700 - 899	1	1	1	3	2	1	3	4
900 - 1,099	0	1	2	3	4	4	3	4
1,100 - 1,299	4	7	7	8	9	7	5	8
1,300 - 1,499	11	11	9	5	11	10	11	10
1,500 - 1,699	11	9	9	10	6	5	9	7
1,700 - 1,899	8	7	6	6	6	8	5	4
1,900 - 2,375 *	4	6	6	6	5	2	5	3
2,376 or higher	0	0	0	0	0	2	0	1
Total Number of Reported Hospitals	44	45	45	45	46	45	46	47

Source: MHCC Annual Hospital Supplemental Survey Note: Assumes 25 min. turnaround time for OR cases.

* According to SHP, a hospital mixed-use OR is assumed to have full capacity use of 2,375 hours per year and an optimal capacity of 80% of full capacity, which is 1,900 hours per year.

How are ORs used in Maryland with reference to the SHP's current capacity assumptions?

Average OR Hours per OR per Year, Non-Hospital Operating Rooms, 2008 - 2015

[Includes only facilities open for full year]

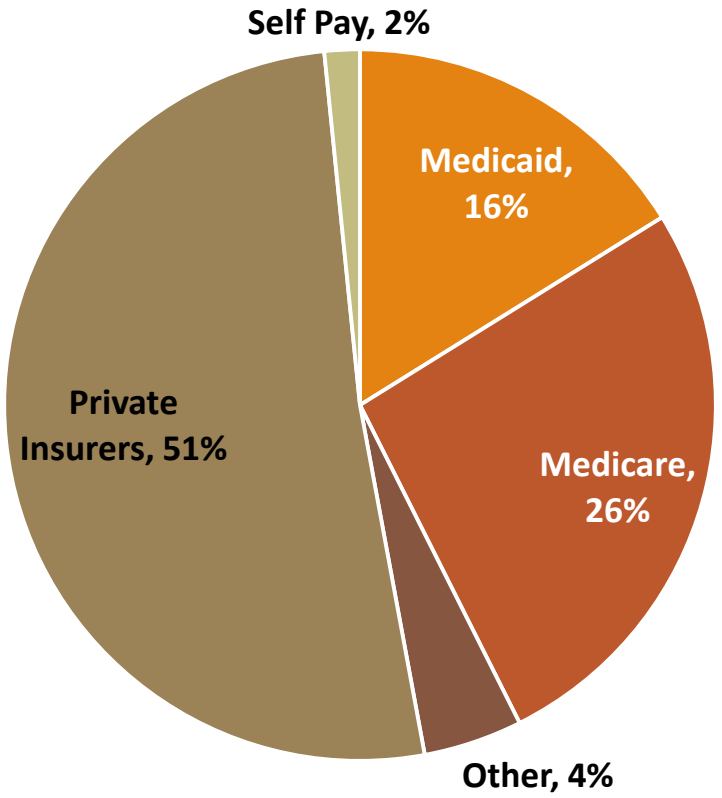
Average OR Hours per OR	2008	2009	2010	2011	2012	2013	2014	2015
Below 100	29	25	26	23	24	26	24	24
100 - 299	44	34	30	30	29	23	31	27
300 - 499	19	20	22	30	23	17	10	13
500 - 699	13	25	15	12	18	24	15	15
700 - 899	19	12	19	24	16	11	22	20
900 - 1,099	14	15	20	16	17	18	13	17
1,100 - 1,299	15	17	15	12	12	12	18	12
1,300 - 1,499	13	13	10	14	13	19	15	17
1500 - 1631	11	6	4	7	6	8	9	7
1632 - 2040 *	11	11	13	10	17	19	24	21
2041 or higher	13	22	20	21	25	24	24	27
Total Number of Reported Non-Hospital Surgical Facilities	201	200	194	199	200	201	205	200

Source: MHCC Annual Ambulatory Surgery Survey Note: Assumes 25 min. turnaround for OR cases.

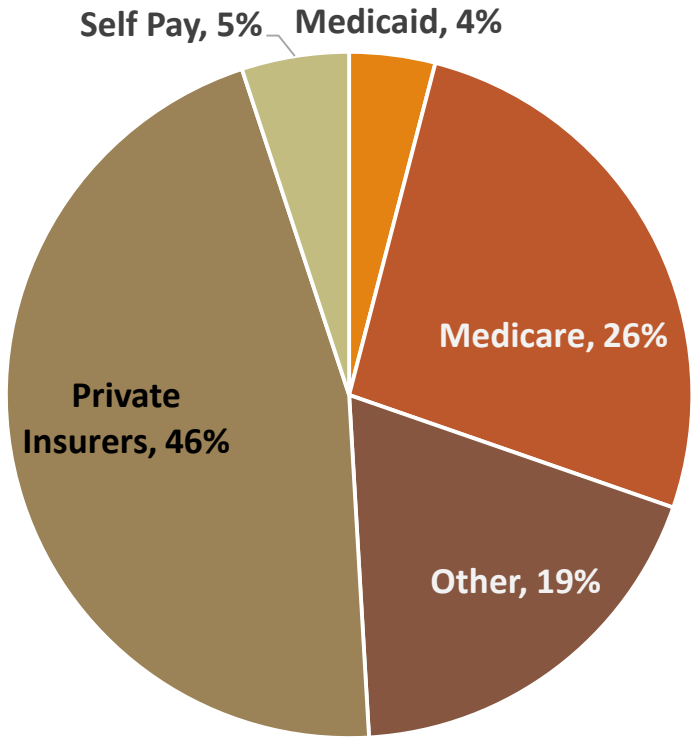
According to SHP, a dedicated outpatient OR is assumed to have full capacity use of 2,040 hours per year and an optimal capacity of 80% of full capacity, which is 1,632 hours per year.

How does payer mix differ by surgery setting?

Percent of Total Surgery Charges at Hospital Outpatient, CY 2015



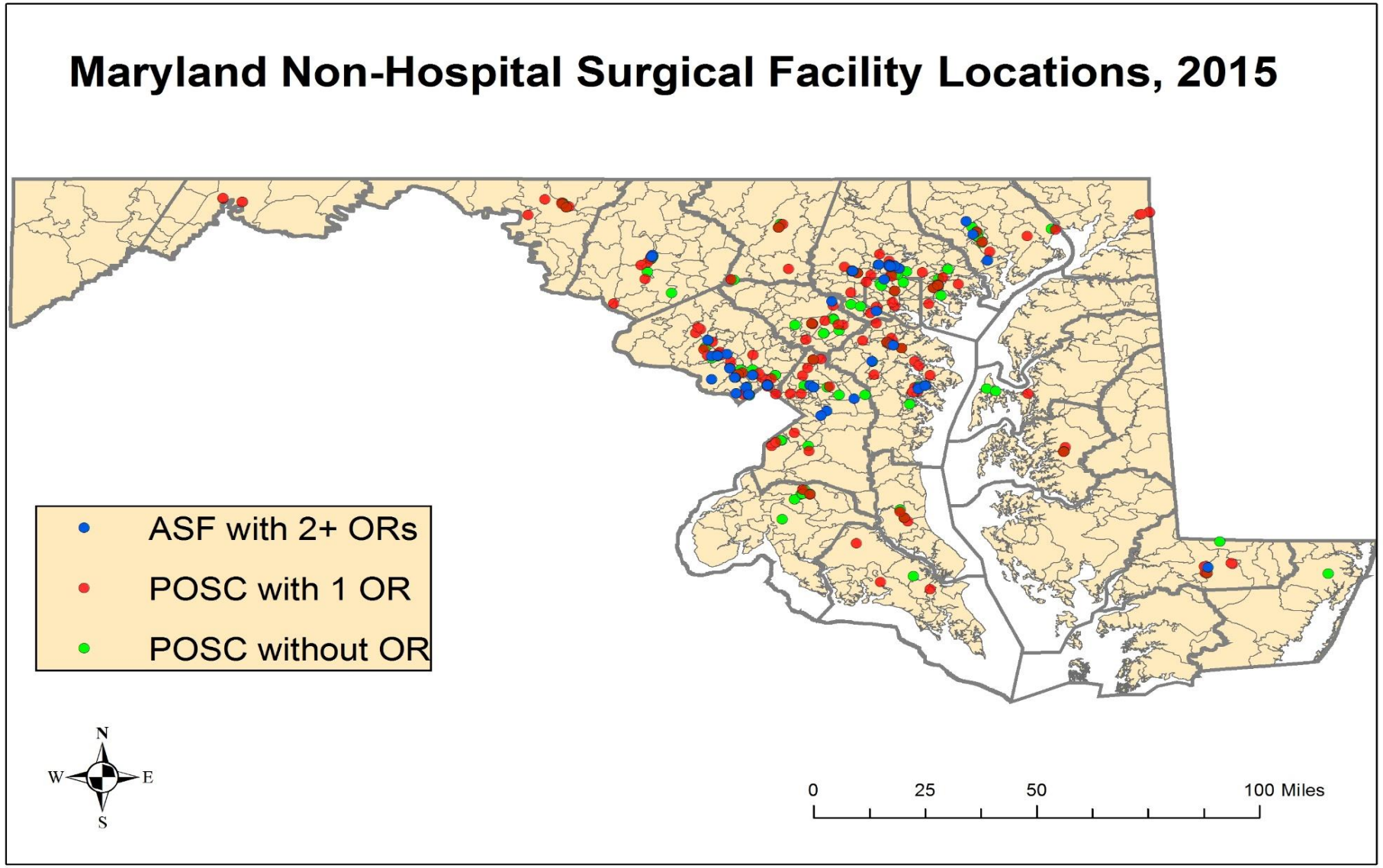
Percent of Total Net Revenue at Non-Hospital Surgical Facilities, CY 2015



Includes all facilities, with and without operating rooms

Note: For Hospital, 'Other' includes Government program, Worker's compensation, Charity and others;
For Non-Hospital, 'Other' also includes some plans that are not clarified in the survey.

What is the geographic distribution of ASFs and POSCs?



Data Source: MHCC Annual Ambulatory Survey, 2015

Commissioner Preferences

Minimize regulatory barriers for development of surgical capacity in the non-hospital setting for all persons, including hospitals, consistent with existing statute

- **Reconsider use of capacity assumptions in need determination**
- **Facilitate ability of hospitals to establish ASFs**

Policy Priority: Maximize ability to perform outpatient surgery in the lowest charge setting, the ASF. Hours of time in which ORs are used should be, at best, a secondary consideration

Policy Changes Reflecting Commissioner Preferences

1. Eliminate use of OR capacity assumptions in consideration of need for ASF projects for CON and exemption reviews. Require demonstration of efficiency by applicant.

2. Retain exemption reviews as proposed in the April, 2017 draft – expansion of POSCs, consolidation of POSCs, and ASFs for FMFs – without use of OR capacity assumption

3. Add a exemption review process allowing for hospitals to establish ASFs without increasing overall OR capacity they operate.

Policy Implications of Changes

Maryland may see growth in proportional use of non-hospital setting for outpatient surgery and in number two-OR ASFs and hospital-owned or controlled ASFs

Shifting OR capacity and use from hospitals to hospital ASFs is likely to reduce charges paid for outpatient surgery. It may not result in significant system savings. Hospitals will still need to retain revenue in GBR for fixed costs and overhead associated with surgical facilities in place. The SHP could require a showing of system savings as a requirement for project approval.

Hospital ASFs are unlikely to have the same payer mix as the hospital. They will be incentivized to minimize surgery for Medicaid and uninsured patients.

Process Going Forward

Review Commission preferences, policy options, and implications with surgical services Work Group. Continue to dialogue with HSCRC staff on policy implications. WG will meet June 1, 2017.

Develop new draft proposed SHP chapter for consideration by Commission at July 2017 meeting.

Consider desired legislative changes related to CON regulation of surgery.