North Carolina Medical Society
Surgical Facility Task Force

Presentation of Consensus Items
March 23, 2013*

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Chair

*non-substantive edits for clarity on March 17, 2015.

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Executive Summary

The Task Force was convened to make recommendations to address pending controversies within the medical community related to regulation of surgical facilities in our state. It was comprised of an evenly balanced group of physicians who had previously demonstrated leadership within their specialties and communities.

Using an anonymous voting procedure that focused on 12 general policy statements, and acknowledging the importance of proceeding with reform only where broad support could be achieved, the Task Force decided to make its recommendations in the form of consensus statements.

A consensus was reached on the following policy statements:

Consensus FOR

- Critical Access Hospitals should receive additional protection from potential competing surgical capacity.
- Surgical capacity that is built under the minimum dollar threshold for a "new institutional health service" (i.e., the CON threshold) should be subject to reasonable facility licensure standards, and should be eligible to apply for and receive a facility license if those standards are met.
- Each owner of licensed surgical capacity in North Carolina should be required by state law to do their pro rata share of surgical care that is uncompensated from any source.
- Each individual serving on the State Health Coordinating Council should comply fully with the State Government Ethics Act provisions that otherwise apply to members of non-advisory state government boards and commissions.
- Facility licensure should be available to any owner of surgical capacity in North Carolina.

Consensus AGAINST

- Existing hospitals and ambulatory surgical centers should receive a preference over others in public policy and regulatory decisions related to the development of new surgical capacity in North Carolina

NCMS Surgical Facility Task Force Charge

The purpose of the Surgical Facility Task Force is to make recommendations to address and resolve pending controversies within the medical community related to the regulation of surgical facilities in our state.

Among the issues to be discussed and resolved:

1. The current certificate of need and facility licensure requirements favor hospitals and some incumbent providers, making it impractical for physician groups to develop licensed surgical facilities, generally weakening physician groups financially, and making it difficult for them to compete in recruitment and to comply with emerging mandates.
2. If the current certificate of need and facility licensure requirements were significantly altered, physician-owned and single-specialty surgical facilities could potentially engage in counterproductive competitive practices, such as cherry-picking insured patients, leaving the hospitals multi-specialty surgical facilities to care for a disproportionate share of the indigent population. This would weaken the hospitals financially, undermine the resources available to support various unprofitable services within hospitals, and undermine the health care safety net.

The NCMS Board of Directors would like to receive any recommendations from this Task Force as early as practical in 2013.

Guiding Principles for NCMS Surgical Facility Task Force Proceedings

1. Doing what is best for patients:
    a. quality of care, patient safety;
    b. access to needed care;
    c. controlling costs.
2. Helping physicians do their jobs:
    d. access to facilities and equipment they require;
    e. efficiency in performing their duties;
    f. ability to compete fairly within the system;
    g. ability to be reasonably compensated for services rendered;
    h. enabling physicians to meet the needs of their communities.

Explanation of Voting and Consensus Procedures

At its first meeting, the Task Force made two decision related to is work:

1. All votes would be taken using an online, anonymous format, and

2. All recommendations would be consensus-driven.

After the initial meeting of the Task Force, members were presented with 12 separate policy statements about the regulation of surgical facilities and asked to vote “for” or “against” each statement.

To determine if a consensus could be achieved, a second meeting was convened, during which each of the 12 policy statements was presented along with the vote totals for that statement. The Task Force members discussed their respective views on the policy statement. Following the discussion, before any consensus was declared, those voting on the minority side had to be willing to withdraw their objections. Otherwise, no consensus. This gave each individual in the minority the power to veto a consensus.

In each instance where a consensus is presented in this report, those in the minority withdrew their objections.

A consensus approach affects the interpretation of this report in two ways. First, a consensus is much harder to achieve than a majority, giving consensus items a greater weight than recommendations made based on a majority vote. Second, items where no consensus is reached are given no weight, even where they were supported by a majority.

4. Critical Access Hospitals should receive additional protection from potential competing surgical capacity~~, regardless of cost or quality differences that may be offered by competing surgical capacity~~.

Online Vote: 10-6
The above vote was taken on the unedited version of this statement.
Consensus was achieved on the edited version.

10 – Agree	6 – Disagree	Skipped
Other rural hospitals should as well	Hospitals should not be protected to receive inflated fees for surgery (both for the facility and their anesthesia services) to cover other areas of financial losses. The hospitals should work on correcting their other expenses more directly to balance them. The CAHs deserve some protection, but this sentence is worded such that I must disagree.	Definition of critical access would need to be refined, otherwise this will become the loophole to avoid any meaningful reform

Staff note (03/17/2015)
The removal of protections provided only to Critical Access Hospitals is not proposed in H200. There is, however, more general protection in H200 for hospitals in approximately 72 counties that have fewer than 100,000 residents (i.e., a limitation on the exemption from CON for ORs).

7. Surgical capacity that is built under the minimum dollar threshold for a "new institutional health service" (i.e., the CON threshold) should be subject to reasonable facility licensure standards, and should be eligible to apply for and receive a facility license if those standards are met.

Online Vote: 14-3

14 – Agree	**3 - Disagree**
Threshold should be removed for majority owned physician facilities.	Not be subject to, but eligible to apply if they wish, ok.

Staff note (03/17/2015):

Under the current law, surgical capacity that is built under the $2M threshold for a "new institutional health service" is not subject to licensure standards, and is ineligible to be considered for a facility license. Many of these facilities are equivalent to fully-capable operating rooms and do, in fact, meet the current OR standards. CON is the only barrier to these facilities being eligible for a facility license, and the Task Force reached a consensus that this should be changed. This issue is addressed by H200 (2015).

3. Existing hospitals and ambulatory surgical centers should receive a preference over others in public policy and regulatory decisions related to the development of new surgical capacity in North Carolina.

Online Vote: 2-15

2 - Agree	15 - Disagree
	This is a public health issue and the best should be available to our patients. The current CON law is so difficult for smaller facilities to obtain a CON that it has been heavily weighted toward hospitals and ASCs already and perhaps there needs to be a "leveling of the playing field" so to speak for all. This likely would improve overall health care and help contain costs. The present CON system has favored the existing CON Certificate holders compared to most physicians and many hospitals. Laws should encourage competition rather than limit. This is the only way to bring down healthcare costs. They already have a near monopoly.

CONSENSUS

Staff note (03/17/2015)

The CON program, as implemented by the NC Division of Health Service Regulation, provides a strong preference for existing hospitals and ASCs over potential competitors. This preference is found in the “procedure room loophole”, which allows only existing hospitals and ASCs to build “procedure rooms” as fully capable operating rooms (not limited use minor procedure rooms) without first obtaining a CON. Meanwhile, physician groups who want to compete with the existing providers cannot use the loophole because they would be denied a facility license and a Medicare provider number unless they have a CON. No provider number, no facility fee. Existing providers already have a provider number, and therefore can collect a facility fee for cases performed in their procedure rooms. The State Medical Facilities Plan (SMFP) identifies communities across the state that “need” new ORs. If there is no need in the annual SMFP, new providers cannot enter the market. The procedure room loophole is addressed in H200.

9. Each owner of licensed surgical capacity in North Carolina should be required by state law to do their pro rata share of surgical care that is uncompensated from any source.

Online Vote: 15-2

15 – Agree	**2 - Disagree**
However, they must be allowed to enter into a private contract with that patient and have the freedom to negotiate rates with the patient based on patient ability to invest in their own health. The 7% charitable care standard in the NC State Medical Facility Plan for the Physician owned ASC demonstration project is appropriate. Should be reflected by the % of patients in that category in their practice.	Perhaps a better option would be a credit or incentive based on indigent/uncompensated care provided.

CONSENSUS

Staff note (03/17/2015)

There is no requirement in state law or federal that any hospital do their pro rata share of uncompensated care. Federal laws like EMTALA are a bigger burden on emergency physicians than hospitals (since hospitals cannot perform a screening exam or provide any type of emergency care). The community service burden imposed on not-for-profit hospitals through tax policy and the ACA may be satisfied in many ways and may involve only limited uncompensated care. Neither requires that a specific amount of uncompensated care be provided. There are well-publicized and long-running disputes between hospitals in NC over whether each is doing its share of uncompensated care. State law does, however, require GI endoscopy centers to demonstrate a commitment to uncompensated care as part of their CON application. H200 would require new ASCs (not hospitals or existing ACSs) to provide 7% of its care to self-pay and Medicaid patients, demonstrated each year, as a condition of licensure.

12. Each individual serving on the State Health Coordinating Council should comply fully with the State Government Ethics Act provisions that otherwise apply to members of non-advisory state government boards and commissions.

Online Vote: 15-2

15 – Agree	**2 - Disagree**
DUH!	I do not know all the provisions of the State Government Ethics Act, but in general this seems like a reasonable request.
What is this about, actually?	Would essentially remove all healthcare representatives from SHCC.

Staff note (03/17/2015)

This issue is not addressed in H200.

6. Facility licensure should be available to~~, and required of,~~ any owner of surgical capacity in North Carolina.

Online Vote: 14-3
The above vote was taken on the unedited version of this statement.
Consensus was achieved on the edited version

14 – Agree	**3 - Disagree**
The ability to obtain OR licensure needs to be made more easily achievable in our state. Should be standard, and not opposed by any competitor. Available, but not required.	Facility licensure is not currently required specific to "surgical capacity" beyond the licensure required for private office practice in general.

Staff note (03/17/2015)
The owner of a procedure room, who is not already the owner of an operating room, will not be considered eligible by DHSR to receive a facility license. Without a facility license, the entity will not be considered eligible by DHSR to receive a Medicare number. Without a Medicare number, the entity will not receive a facility payment for cases performed in the procedure room. The Task Force reached a consensus that all surgical capacity in the state should be eligible for licensure. H200 would accomplish this.

11. Each physician who is ~~an owner of~~practicing in licensed surgical capacity in North Carolina should ~~be required by state law~~maintain hospital privileges in their specialty, comply with that hospital's medical staff bylaws, rules and regulations and NC Medical Board requirements related to ~~participate equitably in~~ the fulfillment of unassigned call responsibilities~~schedule of any hospital where he/she maintains privileges~~.

Online Vote: 8-9
The above vote was taken on the unedited version of this statement.
The Task Force requested another online vote of the edited version; see Supplement on p.13.

8 – Agree	**9 - Disagree**
Or they should be able to enter into agreements with those with said privileges to cover their equitable share of call, as long as those covering have the same core skills that said surgeon is using. If the surgeon is performing procedures that others cannot cover within standard of care, than they MUST participate.	State laws should not dictate hospital and ASC staff by-laws. Currently just about evry ASC requires physicians who use their facility to have some type of hospital privileges so patients with complications can be admitted as appropriate from the surgical center if needed. Each individual hospital system addresses unassigned call and the physician responsibilities for that call. Most by-laws allow physicians to "age out" of call at some point. Also I think this question should be directed at physicians who use surgical facilities and not necessarily physicians who "own" the facilities as they often are two different entities.
I would suggest that the wording be modified to say any physician who is credentialed to work in a licensed surgical facility (ASC) be required to have full hospital privileges and unassigned call responsibility subject to the bylaws of that facility. The wording difference is subtle but yours implies he has to take call if he has hospital privileges mine suggests he has to have those privileges.	Rules are already in place for determining call responsibility required to maintain hospital privileges. No extra burden should be applied to owners of surgical capacity. Each capacity may determine the requirement for hospital privileges for participating surgeons which in turn carries relevant call schedule responsibility.
I am on the fence on this issue.	Totally unrelated. Obviously this was thought up by hospitals as a way to "control" a surgeon. "If you don't take the call the hospital wants, then the hospital (competitor) can take away your facility." Unbelievable we would be asked this question!
	Hospital bylaws define on call responsibilities, some physicians have met their required minimum years of service and should not be required to go back on call.

SEE PAGE 13

1. The State of North Carolina should have a facility planning system (i.e., CON program) that applies to all surgical capacity (excluding surgical capacity used exclusively for Level 1 procedures, as defined by the NC Medical Board, where among other limitations the anesthesia is local, topical, digital block, or none).

Online Vote: 8-9

8 – Agree	9 – Disagree
But not as restrictive.	The reason I disagree is that the only fair way to subject all facilities to this centralized planning system is to allow all such facilities to have an opportunity to obtain a CON for their facility. NC CON law has been usurped by the hospitals to maintain their monopoly. The State Planning (Central Planning, the State Government telling patients and doctors what they need) will always be flawed. Current system is anti competitive, redoing the system would be harder than just eliminating it.

5. Procedure rooms, as defined by the NC DHHS Division of Facility Services, should be exempt from facility planning and licensure laws applicable to operating rooms.

Online Vote: 7-10

7 – Agree	**10 - Disagree**
As currently defined I agree with this. But if we can enact some effective and meaningful reform to the CON law, then this might need to change. We have major problems in NC if our doctors are required to compete in the CON and licensure arena just to be allowed to perform office based surgeries. God would really impact our plastic surgeons.	As long as the CON law is in place, a facility should not be able to indirectly augment their room capacity by use of "procedure rooms" when these are used equivalently with actual operating rooms.

2. The State of North Carolina should have a facility licensure system that applies to all surgical capacity (again, excluding surgical capacity used exclusively for Level 1 procedures).

Online Vote: 11-6

11 - Agree	**6 -Disagree**
Licensure allows the facility to treat Medicare and Medicaid patients, so having ability to achieve licensure allows more facilities to care for these patients.	There are other very good accreditation organizations already performing this task and I think it would be too burdensome and onerous for the state to do. However, I feel that all facilities performing surgery should be accredited by some entity. This statement is somewhat general. What is the standard in states where there is no CON restriction? Physicians should be able to obtain licensure if they meet licensing requirements, only, with no CON. Physicians already burdened with Obamacare, Medicare, EMRs, another hoop to go thru to do office procedures would be overly burdensome. Has a problem been identified or is this a solution looking for a problem to solve?

NO CONSENSUS

8. Physicians who propose to build licensed, single specialty ambulatory operating rooms for their practice should be exempt from the need formula that is applicable to operating rooms, provided they can demonstrate financial viability and appropriate utilization of the new capacity.

Online Vote: 11-6

11 – Agree	**6 – Disagree**
Agree with the exemption, however, financial viability should not be subject to regulatory determination just as the opening of a private practice is not. What is meant by "appropriate utilization," a vague term? With no spending threshold, and no ability for a competitor to oppose. Low cost surgery is going to be a driving force in the new environment.	Why only single specialty??? When "single specialty" gets preferred treatment, it opens door to charges of collusion.

NO CONSENSUS

10. Each owner of licensed surgical capacity in North Carolina should be required by state law to do their pro rata share of surgical care that is compensated by Medicare and Medicaid.

Online Vote: 13-4

13 – Agree	**4 - Disagree**
TRICARE pts should also be included.	No state law should force physicians to take Medicaid and/or Medicare patients or any other specific insurance plan as this begins to micromanage practices. Medicaid and Medicare are issues separate from CON licensure and should not be a part of discussions regarding CON.
Should be reflected by the % of those patients in their practice.	Oppose this due to scenario of plastic surgeons, if their facilities become licensed, how can they meet this standard?

SUPPLEMENT

The following statement was presented to the Surgical Facility Task Force as an online poll following its second and final meeting. It is a modification of the unassigned call issue. See page 11 of this report.

Each physician practicing in a licensed surgical facility in North Carolina should maintain hospital privileges in their specialty, comply with that hospital's medical staff bylaws, rules and regulations and NC Medical Board requirements related to the fulfillment of unassigned call responsibilities.

Online Vote: 11-1

11 - Agree	**1 - Disagree**
	The facility itself has to have a an admission agreement with a hospital, according to N.C. Licensing Requirements. A particular hospital has no authority, nor "should have" no authority to influence the operations of an unrelated healthcare facility. It is just as irrational for an ASC to control the operations of an unrelated hospital facility. This is the whole point of having the NCMS represent physicians - to remove inappropriate political control of physicians. This is simple "Hospital Speak". If hospitals have billions of dollars in cash reserves, physicians have no reason to feel guilty and hospitals can arrange or compensate their on-call physicians as their business model dictates.
however, I do not believe NCBME has a position statement re unassigned call, they do have a position re providing call or call back up on already established patients	

MAJORITY

Staff note (03/17/2015)

This majority statement evolved out of former statement 12. The debate focused on the level of control a hospital should have over a physician's unassigned call schedule. A strong majority was obtained after the second and final Task Force meeting. A consensus could not be pursued because the discussion and withdrawal of objections could not be accomplished unless the Task Force were to meet again in a face-to-face setting. Today, there is no requirement in state law, and no proposed legislation to require, that the above consensus item be implemented. H200 does not currently address this issue.