SURGICAL SERVICES
STANDARD ADVISORY COMMITTEE (SSSAC) MEETING

Tuesday, July 12, 2005

Michigan Library and Historical Center
702 West Kalamazoo Street
Lake Ontario Room
Lansing, MI 48915

APPROVED MINUTES

I. Call to Order.

Chairperson Miller called the meeting to order at 9:02 a.m.

a. Members Present and Organizations Represented:

Cheryl Miller, Trinity Health (Chairperson)
Eric Barnaby, Foote Health System (Alternate) (Arrived at 9:07 a.m.)
Evelyn Bochenek, RN, MSN, Sparrow Hospital
Lowell Bursch, MD, Spectrum Health (Arrived at 9:10 a.m.)
Charles Dobis, Michigan Ambulatory Surgery Association (Left at 1:47 p.m.)
Toshiki Masaki, Michigan Manufacturers Association
Richard Mata, Michigan State AFL-CIO
Rand O'Leary, Borgess Medical Center
Krishna Sawhney, MD, Henry Ford Health System
Debra Stephenson, BSN-RN, MBA, CNOR, McLaren Health Care
Walter Whitehouse, Jr., MD, The Saint Joseph Mercy Health System
Robert Wolford, Michigan Medical Group Management Association
George Yoo, MD, Barbara Ann Karmanos Cancer Institute

b. Members Absent and Organizations Represented:

John Fox, MD, Priority Health
Kim Meeker, RN, BSN, MBA, Foote Health System

c. Staff Present:

Lakshmi Amarnath
Larry Horvath (arrived at 10:27 a.m.)
John Hubinger
John Kowalski
Andrea Moore
Stan Nash
Brenda Rogers
Matt Weaver

d. General Public in Attendance:

There were approximately 37 people in attendance.

II. Review of Agenda and Distributed Materials.

Chairperson Miller reviewed the agenda and the distributed materials. Motion by Dr. Sawhney, seconded by Dr. Whitehouse, to accepted the Agenda as presented. Motion Carried.

III. Review of Minutes – June 30, 2005.

Motion by Dr. Sawhney, seconded by Ms. Bochenek, to accept the Minutes as presented. Motion Carried.

IV. Declaration of Conflicts of Interest.

No conflicts were noted.

V. Presentation by Representative Roger Kahn, MD.

Representative Kahn provided an oral and written overview (Attachment A) of his issues/recommendations. He will provide the reference to the Pennsylvania data to Chairperson Miller for the Committee to review further. Discussion followed.

VI. Medicaid ASC Issues - Update.

Mr. John Kowalski, Medicaid Office, provided an oral and written response (Attachment B) to the Committee's issues. Discussion followed.

Break from 10:35 a.m. – 10:45 a.m.

VII. Rural Consideration/Allowance for Volumes and Timeframes.

Public Comment:
Mr. Larry Horwitz, Economic Alliance, addressed the Committee.

Ms. Amy Barkholz, MHA, provided an overview of the proposed rural amendment (Attachment C) to the Standards. Discussion followed.

Public Comment:
Mr. Tim Heinrich, Memorial Medical Center of West Michigan.
Ms. Yvonne Ulmer, Ionia Memorial Community Hospital.

Discussion followed. The Committee requested that Ms. Barkholz bring revised proposed language to the August 17th Meeting.

VIII. Informal Workgroup – Update.

Chairperson Miller gave an overview of the progress of the workgroup. A subcommittee of the workgroup will have a conference call on July 21st. A full recommendation from the workgroup is expected at the August 17th Meeting.

Lunch Break from 12:05 p.m. to 12:45 p.m.

IX. Benchmarks for Performance/Best Practices.

Chairperson Miller gave an overview of the articles provided on this issue and asked that the Committee review them for the August 17th Meeting.

X. Minimally Invasive Impact on OR Utilization.

Dr. Whitehouse provided an overview of his facility's adjustments over the last 10 years with the introduction of minimally invasive procedures. He reported that some procedures were longer and some procedures were shorter, that the changes equaled out and did not make a large difference over the 10 years. Discussion followed.

XI. On/Off Sterile Corridor Issues Including Endo/Cysto and Radiology/Angiography.

Mr. Horvath gave an overview of the Department's sterile corridor issues. He stated that the Department will be proposing language to establish Standards for dedicating ORs. Discussion followed.

XII. Technology Impact on ORs.

The issue of intraoperative MRI's was discussed.

XIII. Burn, Trauma, and Open Heart Cases.

Chairperson Miller gave an overview of the proposed concept. Discussion followed.

Public Comment:

Ms. Penny Crissman, Crittenton Hospital, addressed the Committee.
Mr. Larry Horwitz, Economic Alliance, addressed the Committee.

XIV. Review of Issues for Evaluation:

Chairperson Miller updated the final list of issues as follows:

- Procedure Rooms – sterile corridor, volumes counted/not counted
- Endo/Cysto Rooms
- Sterile Corridor issues
- Surgical Procedure – definition, office/OR/procedure room, radiology rms vs. operating suite
- Dedicated Trauma/Open Heart Rooms - ½ credit, no volume credit
- Renovations of an OR - non-sub review
- Rural Counties - considerations for volumes and timeframes
- Medicaid participation – definition needs further clarification
- Minimally invasive procedures
- Hour requirements for an FSOF
- Project Delivery Requirements
- Expansion – commitments vs. historical data
- PA 683 – Minimum Design Standards
- Procedure for dedication of an OR
- Separate licensure of facilities with common ownership

Mr. Barnaby will provide draft language on the issue of separate licensure of facilities with common ownership at the August 17th Meeting.

XV. Future Meetings and Agenda Planning:

Future Meeting Dates
Wednesday, August 17, 2005
Tuesday, September 20, 2005
Wednesday, October 12, 2005
Thursday, October 20, 2005

Chairperson Miller provided the following items as the tentative agenda items for the August 17th Meeting:

- Renovation/Relocation
- Recommendation from Informal Workgroup
- 2005 Planning Assumptions
- Physical Distinction of ORs under Single License
- Volume Requirements/Thresholds
- Separate licensure of facilities with common ownership
- Rural Consideration Language
- Response to the Presentation of Dr. Kahn
- Open Heart Designation

XVI. Public Comment.

None.

XVII. Adjournment.

Motion by Mr. Wolford, seconded by Mr. Mata, to adjourn the meeting at 2:52 p.m. Motion Carried.

DIST. 94 MTG
7-12-05
By Rep. Kahn

Attachment A

7/12/05 1

To the Surgical Advisory Committee
From Roger Kahn, MD, State Representative
Re Ambulatory Surgical Centers and Public Policy

Dear Committee Members:

I am Roger Kahn a practicing cardiologist from Saginaw, Michigan. I have been in practice since 1979. I also serve Michigan as State Representative from the 94th District (Saginaw) and am Vice Chairman of two Appropriations Committees: The Department of Community Health and The Department of Human Services. I am one of only two State Representatives also serving on the policy side where I am a member of the Health Policy Committee. I also am a Clinical Associate Professor of Medicine for MSU.

In those capacities as legislator and doctor I see, every day, issues regarding the cost and quality of health care. I chair a subcommittee of the Health Policy Committee on Access to Health Care. In healthcare there is an interdependent relationship between access, cost and quality, as you know. CON is a critical tool in maintaining all three. You and your committee are therefore an integral part of the delivery of care to our citizens. You bear a heavy responsibility. I thank you for your service. I am honored and privileged to be before you today.

I want to be clear in this document and also clearly state that I support CON as one of our strongest tools to deliver good care to Michigan at a time when the demand for care, cost escalation, and questions about quality all threaten the continuation of the American health care system. Our CON program should provide integration with other state programs like Medicaid and also be designed to address demand, cost, quality assurance and also licensure issues.

In that regard, I am particularly concerned about increased numbers of free standing surgical outpatient facilities (FSOFs) and the ability of our economy, state, businesses and citizens to withstand another round of certain cost escalation if we have uncontrolled proliferation of FSOFs. The 2004 AHA (Michigan Hosp Assoc.) Survey noted that Pennsylvania's ambulatory surgery usage per 1000 was 32% higher than the U.S. average. Pennsylvania then had no CON. 48 new surgical centers opened there in 2003. That growth raises cost and quality concerns and demonstrates the pressure you will see for ambulatory surgical center expansion. Almost all of that pressure will come from providers not patients.

I support new outpatient facilities that address an unmet need for our citizens and I support competition in medicine. I also support appropriate movement of health care delivery to the outpatient sector in so far as it addresses lack of access and controls cost and maintains quality.

However, when the potential for total costs associated with procedure explosion threatens to outstrip any saving from the reduction in price for an individual service, I become very concerned. When inappropriate procedure explosion occurs total medical expenditures rise and payors are economically damaged. In Pennsylvania between 2000 and 2003 outpatient surgical and diagnostic procedures grew from 9% to 20% of all procedures performed in that state. The causes of this included: self-referral, patient demand, defensive medicine, and the AVAILABILITY of technology alone, which is almost always associated with increased utilization (Health Affairs report). To quote Mark Twain " To the man with a hammer, the world is full of nails."

Economically damaged payors will withdraw from the health care arena and leave patients uninsured or underinsured. Uninsured and underinsured patients defer needed care because of out of pocket costs, become sicker and only then, when desperate, present to a hospital where their delay in seeking care leads to more expensive care, worse outcomes and an increase in the hospital's burden of uncompensated care. Both the patient and the hospital are damaged in this process. This downward spiral is a proper focus for CON. As stated in the MI Legislative Service Bureau's Backgrounder Volume 6, Issue4-2002 "an often unstated but widely practiced (in the U.S.) objective of CON programs is the preservation of facilities providing a high level of indigent care".

We live in an environment where Medicaid is paying hospitals well below their cost (about70% of costs) for the provision of services. This makes any business model catering to serve Medicaid patients or private pay patients undesirable for the freestanding surgical facility. The obvious result, therefore, is that hospitals will be competing for their only profitable customers with the FSOFs and possibly left to eat the cost of their losing customers since the federal EMTALA laws require hospitals but NOT the freestanding surgery centers, to treat all comers (So much for competitiveness and a level playing field). We should, therefore, be very certain that diverting services from hospitals

is associated with some overwhelming public good because there will surely be public harm as hospitals restrict services to the poor and vulnerable in an effort to remain afloat while enduring further reductions in their paying customer mix. Florida is one state that has used CON to ensure access for indigent patients and presumably blunt this threat. There, interestingly, the provision of a certain amount of indigent care is a requirement for new facilities, I have been told.

A subsidy of indigent care in this manner is characterized as a "tax by regulation" in the health policy literature. The "tax" is built into charges for a variety of services to cover the cost of service to patients who do not have the means to pay. CON is believed to enable this practice by reducing price competition among providers. It does so by limiting the supply of services to what is actually needed in a particular service area. This devalues price as a volume and income strategy.

Alternatively to cutting services, the hospitals can further raise prices to insurance companies and cost shift losses to those who pay for insurance. This is part of what we have today in American medicine and the auto companies, for example, are paying the bill. As a result the auto companies have more invested in health care ($1500 per vehicle) than steel and labor combined. These health care costs destroy their competitiveness, and lead to sales losses, plant closures, and relocations which exacerbate the problem anew. Incidentally, the foreign automakers have about a $1500 cost advantage per vehicle. It isn't labor that is hurting our auto company's competitiveness. It is health care.

Michigan's population is flat. So as we increase the number of surgical facilities we depress the number of cases done per facility (see Hammer above). That depresses the experience and expertise of the support personal in those outpatient units and also in the hospital units as hospital volume shrinks. Since case volume is one of the factors leading to quality outcomes, this is a clear chilling effect on the maintenance of quality results.

Therefore, unless there is a clear indication of the need for more operating rooms in an area of population growth, CON should NOT permit additional ORs. What is an area of population growth? In my opinion (professional opinion) most patients will drive approximately 30 miles (minutes) for service. If there is inadequate service to meet CLEAR volume needs within a 30-mile radius, then an additional OR is not justified. I believe that CON has a statutory criterion for "demonstrating need IN (my caps) the area to be served."

I have five specific suggestions for the work of the committee:

1. CON standards should be tightened so that demonstration of need is based on actual experience not on projections of future activity. The CON standards for MRI set a good example. These standards require applicants to base their indication of need in a local area on actual experience in the recent past. In short, surgeons should be able to indicate future use (cases) in a FSOF. That use should be based on their demonstrated (prior) numbers of facility-based surgeries.

   Parenthetically, the CON standards for CT should be revised and the current structure should be avoided in any new FSOF standards, as CT standards require only a "documented projection" of the number of procedures expected to be performed within one year after initiation of operation. Unfortunately "projections" are not required to have a basis in either reality or community need.

2. CON should only count surgical procedures appropriately done in surgical facilities. Procedures done in a doctor's office should not count toward satisfying facility volume requirements since the standard of care does not require them to be done in an outpatient facility or a hospital. A workable way of determining appropriateness would be to use the Medicaid list of surgical procedures for which the state pays a facility fee. I have no objection for counting the RARE office procedure that has a special consideration that requires it to be done in a facility.

3. New facilities should not take cases from current facilities and leave existing facilities no longer able to meet CON minimum volume requirements. I urge the committee to maintain section 10(2) which maintains the general approach of CON in determining the need for additional facilities. This should apply to all applicants and no one should be able to rely on surgical data from their own or someone else's facility if so doing will lead a current, existing facility to fall below the CON minimum for cases or hours. Only excess utilization should be used to justify additional capacity.

4. Service volumes and type should be part of a CON review and applications ought to be denied if approval would draw patients from and threaten the survival of a facility that serves substantial numbers of indigent patients.

5. A provision for accountability ought to be part of the application process and this should include and require a mechanism for credentialing and privileging. It should also require a peer review provision.

In conclusion, I hope the committee finds these suggestions worth discussing and implementing. I will be glad to support as a physician and as a legislator a revised CON standard for Surgical Services that allows for additional capacity when there is demonstrated need. GM's position document on CON given on February 12, 2002 stated: Improving health care quality will reduce costs. Quality is provided by delivering the right services for the right patients at the right time. Quality means preventing overuse, under use, and misuse by reducing unnecessary, duplicative and wasteful services. I agree.

Thank you,

Roger Kahn

Distribute @ mtg
7-12-05
SSSAC

Attachment B

From: Kowalski, John M.
Sent: Monday, July 11, 2005 4:50 PM
To: Freebury, Tom (MDCH); Kemp, Edmund
Cc: Fitton, Stephen; Whited, Kathy
Subject: Re: FW: Medicaid Questions

I'll try to clarify item #2 below.

We currently do not enroll ASCs or FSOPs such as free-standing radiology/oncology centers. We do pay physician services provided in both of these facilities. The problem we have is with our invoice processing system which does not allow a physician or other non-facility entity to bill for facility charges except as a part of the global procedure. This would not typically reimburse facility charges adequately and is an issue when the physician is a contractor rather than an employee or owner of the facility.

We do intend to enroll such facilities to be consistent with Medicare and commercial payers. To accomplish this, two things need to occur in our processing system: (1) We switch to APCs as a payment methodology for ASCs and (2) We can modify the programming in our payment system to accept facility charge billing from a non-facility provider for both ASCs and free-standing radiology/oncology centers. Our systems people have told us that the programming changes needed in our current processing system will require significant time to implement and test. It may not be feasible until our new MMIS system is in place.

I hope this helps to clarify some of the issues we are trying to work out.

Questions asked by SAC:

1. The term "Medicaid" is ambiguous given that most traditional Medicaid has been rolled into various managed care plans. Please provide a clarification of what is included in "Medicaid."
2. What is the basis for the refusal to contract with FSOFs/ASCs? (It is the understanding of the CON Section, that Medicaid contracts with FSOFs, not with ASCs. Is this correct?)

Distribute @ Mtg SSSAC 7-12-05

Attachment C

MHA
MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

TO: Surgical Services Standard Advisory Committee Members

FROM: Amy Barkholz, Senior Director, Advocacy

DATE: July 12, 2005

SUBJECT: **Proposed Rural Amendment to Surgical Services Standards**

The Michigan Health & Hospital Association recently approved a proposal from the MHA Council on Small or Rural Hospitals to support changes to the existing CON standards for surgical services to reflect the unique circumstances of rural providers seeking to expand surgical services capabilities. Due to the relatively small number of operating rooms, staffing difficulties, and recruitment challenges, the MHA recommends allowing rural facilities a small volume reduction and additional time to meet these volume requirements.

The current standards require applicants seeking to add more ORs to meet the following requirements:

All existing ORs must continue to do at least 1200 cases per year or 1600 hours of use (freestanding surgical facilities must do 1800 hours). Applicants must demonstrate that the new OR performs to these volume levels by the second twelve months of operation and annually thereafter.

The MHA recommends the following amendment:

An applicant proposing to add one or more operating rooms at an existing surgical service that is a licensed hospital that provides 24-hour emergency services and is located in a non-urban county or a county of less than 120,000 population on January 1, 2005 shall perform 1,500 hours of use or 1,125 cases per year per operating room in the fifth twelve months of operation and annually thereafter. *(NOTE: This proposal was supported by the MHA Council on Small or Rural Hospitals on 2/23/05 and approved by the MHA Legislative Policy Panel on 5/26/05.)*

The purpose of the proposed changes is to recognize the unique recruiting, staffing, and access challenges faced by hospitals in rural communities.

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