SURGICAL SERVICES
STANDARD ADVISORY COMMITTEE (SSSAC) MEETING

Wednesday, August 17, 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 9:00 a.m.

A. Members Present and Organizations Represented:

Cheryl Miller, Trinity Health (Chairperson)
Kim Meeker, Foote Health System
Evelyn Bochenek, RN, MSN, Sparrow Hospital
Lowell Bursch, MD, Spectrum Health
Charles Dobis, Michigan Ambulatory Surgery Association (Arrived at 9:30 a.m., Left at 1:44 p.m.)
Carolyn Skaff, Michigan Ambulatory Surgery Association (Arrived at 1:45 p.m.)
Toshiki Masaki, Michigan Manufacturers Association (Arrived at 9:06 a.m., Left at 12:40 p.m.)
Richard Mata, Michigan State AFL-CIO (Left at 2:30 p.m.)
Rand O'Leary, Borgess Medical Center
Sally Bertoia, Henry Ford Health System (Alternate)
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:

Krishna Sawney, MD, Henry Ford Health System

C. Staff Present:

Lakshmi Amarnath
Larry Horvath
John Hubinger
Stan Nash
Brenda Rogers
Gaye Tuttle
Kate Wandtke
Matt Weaver

D. General Public in Attendance:

There were approximately 45 people in attendance.

II. Review of Agenda and Distributed Materials.

Chairperson Miller reviewed the Agenda and distributed materials. Motion by Dr. Whitehouse, seconded by Ms. Bochenek, to accept the Agenda as presented. Motion carried.

III. Declaration of Conflicts of Interest.

No conflicts were noted.

IV. Review of Minutes – July 12, 2005

Motion by Ms. Stephenson, seconded by Mr. O'Leary, to accept the Minutes as presented. Motion carried.

V. Informal Workgroup – Update and Recommendation.

Ms. Kathy Jo Uecker, Healthcare Midwest, and Ms. Julie Greene, Michigan Medical Group Management Association, provided an oral overview of the proposed "Combined CON-approved list." Discussion followed. Ms. Meeker requested a list of the deleted codes. Ms. Greene will provide the list of deleted codes to the SAC.

A. Public Participating in Discussion
- Mr. Terry O'Rourke, Hackley Hospital (Attachment A)
- Ms. Amy Barkholz, Michigan Health and Hospital Association

Break from 10:26 a.m. to 10:35 a.m.

A. Public Participating in Discussion (cont.)
- Mr. Jim Budzinski, Sparrow Hospital
- Mr. Colin Ford, Michigan State Medical Society

B. SAC Action

Chairperson Miller requested a vote of the following to narrow down the list of options for defining standards for surgical procedures.

1. Combine two CMS lists + Adjunct list + Done in OR + 10% (in OR) + 10(2)
2. Same as #1, except delete 10(2)
3. Recommendation of workgroup two CMS + Adjunct list + 10% exemption + 10(2)
4. Status Quo + 10(2)
5. Done in OR + 10(2)
6. Two CMS lists + 10% + 10(2)
7. Two CMS lists + Adjunct list + 10(2)

Option 1 carried with 10 votes, option 2 received 1 vote and option 3 received 3 votes, out of 14 total votes.

C. Public Participating in Discussion
- Ms. Julie Greene, Michigan Medical Group Management Association
- Ms. Barbara Jackson, Economic Alliance
- Mr. Mark Mailloux, University of Michigan Health System
- Mr. James 'Chip' Falahee, Bronson Methodist Hospital
- Mr. Robert Meeker, Spectrum Health Systems
- Mr. Matt Jordan, Kheder and Associates

Motion by Mr. Mata, seconded by Dr. Bursch, to accept option one as stated. Motion carried.

Break for lunch – 12:40 p.m. – 1:16 p.m.

C. Public Participating in Discussion (cont.)
Ms. Amy Barkholz, MHA
Mr. Mark Mailloux, University of Michigan Health System
Mr. Robert Meeker, Spectrum Health System

After further discussion, the SAC asked the Department to provide language applying the concept to projection and excess capacity (historical volume).

VI. Renovation/Relocation

Mr. Jim Budzinski, Sparrow Health System, gave overview of language presented at June 2, 2005 meeting. Discussion followed.

A. Public Participating in Discussion
Ms. Julie Greene, Grand Valley Surgical Center
Mr. Robert Meeker, Spectrum Health System
Mr. Mark Mailloux, University of Michigan Health System
Mr. Terry O'Rourke, Hackley Hospital

Motion by Dr. Whitehouse, second by Dr. Fox, to keep Standards as they currently exist for replacement, renovation and relocation. Motion carried.

VII. Rural Considerations/Allowances for Volumes and Timeframes.

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

A. Public Participating in Discussion:
Ms. Barbara Jackson, Economic Alliance, addressed the Committee.

Motion by Dr. Whitehouse, seconded by Dr. Bursch, to accept the proposed language, with an upper limit of five ORs (applicable facilities with 4 or fewer ORs would be potentially eligible). Motion carried.

VIII. Physical Distinction of ORs under Single License.

Chairperson Miller reviewed definition of a physical distinction of ORs from Jeff McManus, Engineering Section, BHS, MDCH, as follows: "Surgical and/or delivery suites that are considered for the Certificate of Need purposes to be distinctively separate from one another shall be arranged and service agreements in effect so that staff or patients do not need to travel through one suite to reach the other. Each suite shall include all necessary support facilities to be self-supporting, including: scrub sinks, staff locker/lounge/toilets, sub-sterile facilities, anesthesia workrooms, equipment storage, and housekeeping closets." Discussion followed.

A. Public Participating in Discussion:
Mr. Bob Meeker, Spectrum Health
Mr. James Falahee, Bronson Methodist Hospital

The second informal workgroup will review this language further.

IX. Separate Licensure of facilities with common ownership.

Ms. Kim Meeker gave overview. Ms. Meeker will provide proposed language to the Department and to the SAC prior to the September 20, 2005 Meeting.

A. Public Participating in Discussion
Mr. Mark Mailloux, University of Michigan Health Systems

X. Open Heart Designation

Chairperson Miller gave overview of Open Heart Designation. Discussion followed.

Motion by Dr. Whitehouse, seconded by Ms. Stephenson, to defer to the informal workgroup. Motion carried.

XI. Response to the Presentation of Dr. Kahn

Tabled to September 20, 2005 Meeting.

XII. 2005 Planning Assumptions (Volume Requirements/Thresholds)

Tabled to September 20, 2005 Meeting and deferred to the informal workgroup.

XIII. Agenda Planning and September 20, 2005 Meeting

No discussion.

XIV. Future Meetings: September 20, 2005, October 12, 2005 and October 20, 2005

XV. Adjournment

Motion by Mr. Rand O'Leary, seconded by Dr. Whitehouse, to adjourn the meeting at 3:40 p.m. Motion carried.

Attachment A

HackleyHospital
Personalized healthcare, close to home
1700 Clinton St.
Muskegon, MI
49443-3302
231.726.3511 phone
800.825.4677 toll-free
www.hackley.org

August 8, 2005

To: Members and Alternates of the SSSAC, Procedures Workgroup, MDCH staff and others

Good morning, my name is Terrence O'Rourke. I am the Vice President of Business Development at Hackley Hospital in Muskegon. I have 35 years of executive experience in hospitals of various size in the Midwest. This includes ASC experience in Grand Rapids.
As part of my new responsibilities, I began monitoring CON Commission activities, focusing on the SSSAC meetings since early June.

One of the current major tasks of the SSSAC is to define a surgical procedure. Specifically, what procedures should be eligible to meet the volume threshold for a new FSOF. A multidisciplinary workgroup has done the arduous work of reviewing some 14,000 CPT codes and narrowing the list to just under 5,000 codes. They should be complimented for this move in the right direction, particularly tightening the "adjunct" list.

Unfortunately, current CONs for FSOFs are using **any** CPT code, including several office procedures. Because of surgeon efficiency and patient convenience, these procedures logically will continue to be performed in the office as part of a single office visit. To allow these procedures to be counted towards the ASC volume requirement, coupled with an absence of effective monitoring leaves a wide open opportunity for abusing the intent of the CON regulations.

For example, some pending CON applications are based on office procedures such as CPT code #20610 - Arthrocentesis Aspiration/Injection Major. Most orthopaedic surgeons do this procedure as part of a single office visit now, and will continue to do so in the future even if a FSOF is constructed. It is maximally efficient for the surgeon, and a great convenience to the patient to use the office rather than reschedule the patient at the ASC, do the additional paperwork, and incur the additional facility charge. To do so would waste valuable health care resources, while raising employer/insurer cost. Much to the credit of the workgroup, this particular CPT code (20610) has been removed from the their recommended list.

Review of the 2003 Surgical Database published by MDCH shows that there are an estimated 35

 Attachment A

FSOFs in Michigan, with a mix of not for-profit and for-profit ownership. In the past 9 months in Michigan, there have been at least 14 CON applications filed for FSOF/ASCs. Six have been approved, with eight more pending review. More LOIs are filed weekly, the latest being one in Muskegon County. Many of these are based on meeting volume requirements with office based procedures. The very fact these procedures have been done for decades in the office with good quality and lower cost, should argue persuasively for them not to be eligible for "the count" for CON-FSOF approval purposes.

Attached is a simplified analysis of the cost impact of a new FSOF facility in an area that has available surgical capacity in area hospitals or existing FSOFs. Hospital or existing FSOF operating margin declines because it is not possible to reduce total expenses (variable expense is reduced, but not fixed expense) to correspond with the loss of net revenue. Other hospital or existing FSOF prices will be raised to compensate for the deficit. The conclusion is simple – additional, unneeded capacity will lead to an increase in the overall cost of health care.

I agree with the automotive industry and labor representatives who are concerned about rising health care cost ultimately impacting employment levels in Michigan. Absent a compelling qualitative reason, permitting office procedures in the CON volume count is contrary to good public policy.

In my view, Section 10.2 of the Surgical Services Standards makes good sense. It's intent is seriously undermined if the new FSOF applications are permitted to count office-based procedures.

In **conclusion**, I commend the workgroup and the SSSAC for their intense effort and the narrowing of the approved list of procedures. My recommendation is to keep the CMS inpatient and ASC list. Either the limited 10% list (for which procedures must be individually justified) or the adjunct list should be dropped.

Most importantly, MDCH and the legislature should **declare a moratorium now** on approving pending CON applications and LOIs until the new surgical standards can be enacted. At that time, all existing and future CON/FSOF applications should be subject to the new standards.

Respectfully,

Terrence M. O'Rourke
Vice President – Business Development

Attachment A

ABC Community Hospital / FSOF
Statement of Operations

This pro forma shows the estimated impact on operations based on a 30% reduction in outpatient surgery.
The Year 1 column includes revenue and expenses before the 30% reduction.
The adjustment column shows the loss of net revenue and the related variable costs, for example wages & supplies.

	Year 1	*Adjustment*	*Adjusted Year 1*
Net Operating Revenue			
Net patient service revenue	$ 136,452,000	$ (4,903,000)	$ 131,549,000
Other revenues	1,047,000		1,047,000
Total Net Operating Revenue	137,499,000	(4,903,000)	132,596,000
Operating Expenses			
Salaries & Wages	55,604,000	(1,282,000)	54,322,000
Employee Benefits	16,898,000	(549,000)	16,349,000
Purchased Services	19,632,000		19,632,000
Medical Supplies	20,441,000	(1,062,000)	19,379,000
Other Supplies	1,312,000		1,312,000
Depreciation	8,207,000		8,207,000
Interest	1,335,000		1,335,000
Bad Debt Expense	6,839,000	(247,000)	6,592,000
Other	5,862,000		5,862,000
Total Operating Expenses	136,130,000	(3,140,000)	132,990,000
Income From Operations	$ 1,369,000	$ (1,763,000)	$ (394,000)
Operating Margin	1.00%		-0.30%

MHA
MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

Attachment B

TO: Members of the CON Standard Advisory Committee for Surgical Services

FROM: Amy Barkholz, Senior Director, Advocacy

DATE: August 17, 2005

SUBJECT: **Proposed Language for Small and Rural Facilities**

Thank you for the opportunity at your last meeting to explain how surgical services are provided in small and rural facilities and why the current CON standards for surgical services should be amended to better facilitate cost-efficient, high-quality patient care in these communities.

The basic tenet of our argument is that many rural hospitals currently experience pressure in their surgery departments and it makes good sense from a cost, quality and access perspective to expand their capacity. When patients can't get the surgical services they need at their local community hospital, they must seek them at more distant facilities. This adds cost and diminishes patient satisfaction.

While not all rural hospitals are experiencing growth, those that are growing and seeking to expand face more challenges than their urban and suburban counterparts because they have fewer ORs to spread the excess capacity around, a less flexible and smaller workforce to absorb the additional hours, and more recruitment challenges. In many instances, it actually costs less and improves quality to operate more rural ORs during peek hours than to operate fewer for longer hours because of labor costs and available support staff.

Unlike many other CON standards, the current surgical volume levels are the same for rural and urban facilities. **The attached draft language provides an adjustment to the volume levels for small and rural facilities for the reasons outlined above and in earlier testimony. The language also seeks to address the concerns raised by the SAC at the last meeting.**

The draft language reduces the volume from 1,200 annual cases per operating room to 900 (or the hourly equivalent) for facilities located in rural and micropolitan counties and for facilities located in very small communities defined by the legislature as being eligible for the federal critical access hospital program. The 900 number was based on testimony that an average surgeon performs about 300 cases per year in a rural area. Therefore, it reduces the volume level for small/rural hospitals by one additional surgeon – from 1,200 to 900 hours.

SPENCER JOHNSON, PRESIDENT
CORPORATE HEADQUARTERS ◆ 6215 West St. Joseph Highway ◆ Lansing, Michigan 48917 ◆ (517) 323-3443 ◆ Fax (517) 323-0946
CAPITOL ADVOCACY CENTER ◆ 110 West Michigan Avenue, Suite 1200 ◆ Lansing, Michigan 48933 ◆ (517) 323-3443 ◆ Fax (517) 705-8620
www.mha.org

Attachment B

The proposed language only applies to existing facilities seeking to expand services because it was less appropriate from a cost perspective to lower the existing volume threshold for applicants seeking to start new facilities. The provisions only apply to small/rural facilities seeking to add one additional operating room. Finally, the language requires applicants to meet the same project delivery requirements within the same period as other applicants.

Please contact me at (517) 703-8616 or abarkholz@mha.org if you have any comments or questions.

Attachment B

Proposed Surgical Services
Small / Rural Lanugage

Amend section 5 of standards as follows: [New language is in **bold** and underlined]

Section 5. Requirements for approval for surgical services proposing to expand an existing surgical service

Sec. 5. (1) An applicant proposing to add one of more operating rooms at an existing surgical service shall demonstrate each of the following:

(a) all existing operating rooms in the existing surgical facility have performed an average of at least:

(i) 1,200 surgical cases or

(ii) in a hospital, 1,600 hours of use or in an FSOF or ASC, 1,800 hours of use per year per operating room for the most recent 12-month period for which verifiable data is available to the Department.

(b) All operating rooms, existing and proposed, are projected to perform an average of at least:

(i) 1,200 surgical cases or

(ii) in a hospital, 1,600 hours of use or in an FSOF or ASC, 1,800 hours of use per year per operating room in the second twelve months of operation, and annually thereafter.

(2) Subsection (1) shall not apply if the proposed project involves adding a second operating room in a licensed hospital site located in a rural **or micropolitan** county that currently has only one operating room.

(3) Subsection (1) shall not apply if the proposed project involves an applicant that meets all of the following criteria:

(a) the applicant is located in a rural or micropolitan county or the applicant is located in a city, village, or township with a population of not more than 12,000 and in a county with a population of not more than 110,000 as defined by the most recent federal decennial census;

(b) the applicant proposing to expand an existing surgical service is adding no more than one (1) additional operating room;

(c) all existing operating rooms in the existing surgical facility have performed an average of at least:

(i) 900 surgical cases (or in a hospital, 1,200 hours of use or in an FSOF or ASC, 1,350 hours of use) per year per operating room for the most recent 12-month period for which verifiable data is available to the Department.

(ii) all operating rooms, existing and proposed, are projected to perform an average of at least 900 surgical cases (or in a hospital, 1,200 hours of use or in an FSOF or ASC, 1,350 hours of use) per year per

Attachment B

operating room in the second twelve months of operation, and annually thereafter.

(4) If the number of surgical cases, or hours of use, projected under subsection (1) or **(3)** includes surgical cases, or hours of use, performed at an existing surgical facility(s), an applicant shall demonstrate that it meets the requirements of Section 10(2).