

Certificate of Need – ASF Rules
Notes for Stakeholder Meeting – April 13, 2016
WAC 246-310-270

Meeting commenced at 9:05AM with introductions, agenda overview, ASF Workgroup Issue/Topic and Consensus Tracking document review. There were no comments with respect to the agenda or the consensus document.

Kathy Hoffman presented the results and associated report of the recently completed ASF survey.

Group was generally surprised by the wide variance in data tracking systems and minute tracking between facilities, although some attendees anticipated this result. This result will present some challenges when we move to discussion of need methodology calculation.

Susie: Kathy, one of the questions we had is, what exactly do you plan to do with this? What is the final product? You don't really seem to have... (Unintelligible).

Jan: I think that the purpose was to inform us as to how people had data, because we had been sending out surveys annually to collect information so that we could plug it in to our current methodology. And so, if we're finding that the information isn't being collected in a way that is useful to us, we may have to re-think how we develop the methodology that we are developing.

Kathy: I think the other piece to that was, there was conversation about revising our current survey. And we didn't know what the data reporting capabilities were for existing ASCs. So, we wanted to get a feel for what those capabilities were, correct?

Jan: Right.

Kathy: And so this sort of gave us a sense of what we're working with. And what we're working with is a wide variety of data reporting capabilities. That is going to influence the way we craft our survey and as Jan has noted, our methodology, as well.

Jan: Did you see a difference in reporting between those that were Medicare certified and those that were not Medicare certified?

Kathy: The entities that weren't Medicare certified were primarily cosmetic plastics. The reporting was a little different, and they scheduled by procedure, which could include multiple procedures, sometimes lasting a couple of hours based on how many procedures were going into the surgery. (To Susie): Does that answer your question Susie?

Susie: It answers the question but I guess the proof is in the pudding about where we move forward based on this.

Kathy: This is just an informational document designed to, as Jan said, to help us understand what is happening with ASCs right now.

Zosia: And so the result is surveys may not be the best way to get the information we need about hours and things? What is the other alternative? Is it creating some forecasting methodology?

Jan: It is possible that that is what we'll have to do. Or maybe come to some sort of consensus on making some assumptions.

Jody: Or who is in and who is out.

Frank: Yes, and we've already crossed the bridge of what other data sources are out there and alternatives, or surveys, and we decided that there aren't any.

Nick: It feels like the tables are somewhat stacked against us; we've researched what is out there, and there's nothing out there that is nationwide, and now we've done a survey of ASF and reporting capability, and we've identified that there is so much variance in what they can report that survey data may be even tougher. So, are we going at this blind or is there some other source that we haven't thought of.

Frank: Not sure if we're going at this blind. The survey was to help inform us and to reiterate what Jan said, I think it helps to tell us where our deficits are currently and on a going-forward basis tells us probably where we are going to have to make assumptions... (Unintelligible). That would be my perception.

Jan: Another thing that might inform us would be to maybe have a surgery scheduler from an ASC, a hospital and identify a couple of types of ambulatory surgery centers that come to a meeting and say to us, when you are scheduling a day or a week worth of surgeries, what is the process that you go through to identify the timing and how many surgeries that you are going to be scheduling in a day. That also might be something that would help us in terms of identifying, maybe, the room capacity or something of that nature. Does that seem like that might be helpful? Because they are the ones that are involved in doing that

Frank: It might be, although Kathy's already broached that subject in her survey, and found that there is significant variability, and when we count something like minutes and then minutes per case, those are going to be noisy calculations because they are not at all precise. I think Kathy's conclusion was that, there may be a standard, but there is so much variability across that standard depending on the type of surgery center that she surveyed that there is going to be a lot of noise with that data, and I think we just need to recognize that.

Jody: Kathy, is it fair to say that those that are seen as extensions of the providers practice are where you saw the most variability?

Kathy: I didn't ask the question as to whether they were an extension of a providers practice. Is that what you are assuming?

Jody: As soon as I read this, that is what I assumed because they are just treating it like a practice, based on the scheduling responses. It almost seems to me that we need to go back and make decisions about what is in and what is out.

Susie: Well certainly from my reading of it didn't think there was anything wrong in the scheduling. Just very logical variance.

Group: Yes, right.

Group shifts to discussion of what type of facilities could potentially be in/out of methodology. As we try to decide what methodology will include, the survey could help us there. But maybe we should focus on bucketing since we know that eye centers are very different from GI labs, which are very different from surgery centers, and now we know plastic surgery centers are very different from other providers. So it might help to understand the buckets, and then structure the survey around that. Is that what Jody meant by what is in and what is out? (Jody: That's what I meant).

Group reviews survey report more closely. Kathy walks group through each section, explains method, how survey was conducted; described development of themes based on survey responses after coding and analysis; described statistics. Jody: request to run cross tabs on data, specifically as to identifying CN approved ASC vs non-CN approved ASC. Might take out some of the variance (Tape 1, 20:22). Some of the variability might come from using the ASC to support the practice as opposed to the practice supporting the ASC.

Bart: Quick follow up: If they are all licensed, still the major purpose of that entity is surgery. So it's really surgery, not office-based surgery. So what information would be different?

Frank: In some markets you have ASCs that are extensions of a physician's clinic and those are used much less routinely than a pure surgical facility and you'd expect when they are used less as a surgical facility, their practices might be more variable, at least that's what I've seen.

Bart: And they've set themselves up structurally in way that their ASC is legally separate from their general practice? Most of them that have surgical activity that is associated with their clinical practice, if it didn't hit that bar of it being sort of 50 or 51% of your business generated by surgery, either by patient volume or dollars, you wouldn't be subject to licensure, you would be considered an office-based practice. And so, they wouldn't be in this data set at all. So, there are those places, but what from I've seen, typically they come to us and make the argument, "I'm not required to be licensed," because they prefer not to be, as an ambulatory surgery center unless they cross that threshold where the surgery center is the driver of patient volumes or revenue.

Jody: How does that impact the CN definition?

Bart: We survey the exempt entities for volumes, but the data set used for this survey was taken from ILRS to identify licensed only ambulatory surgery centers. It's different from what we do to get our rates - we survey everybody.

Jody: What I'm asking is, if someone falls below that threshold, do they need an exemption from CN?

Bart: Everybody has either an exemption or a CN. When we did that huge data run, where we wanted to see every ASC that we're aware of, and they have exemptions which meant they are group practices, so their primary purpose was not doing surgery, it was a clinical practice that surgery happened to be a part of, and it was within the group so that individual physicians, all of those...

Jody: So are you saying that these are not part of the survey?

Bart: They are not part of *this* data survey. This survey is out of the 193 licensed ambulatory surgery centers. Not all are CN approved. But in order to be licensed, their primary purpose was surgery, not surgery being an incidental activity under a clinical practice.

Zosia: So it still would be interesting to see, of the 193 which are CN exempt and which aren't.

Kathy: I've got a list for you.

Discussion of the 193 active ASC pulled from ILRS for survey: entities who have represented to DOH that their primary purpose is surgery and the definition of "primary purpose" is 50% or greater of their patients seen or the revenue generated by that entity is surgery. So, not incidental to an office based practice. There may be some entities that voluntarily license. Discussion of accreditation, type of anesthesia, and definition of "primary purpose." This might make the data a little hard to read. All we can get out of ILRS is case count, how many surgical procedures entities expect to do because it sets their fees. But ILRS does not track CN survey responses; rely on ILRS to fill in survey gaps. Confirm that annual CN ASC survey goes to all ASC, licensed or not. Discussion of when CN would apply, when exemptions would apply, how many unlicensed ASC are being surveyed.

Discussion: Where are the non-licensed ASC and how many are there? Maybe 50 – not certain. Can an entity be Medicare certified and not licensed? Technically, yes. But department does not believe there are many – business model would be difficult. Discussion of how many entities are CN exempt, but not in ILRS. Number is very low.

Susie: Isn't maybe part of the question not just the number of surgery centers, unlicensed in this case, but the actual number of surgeries? I think you are going to find that number [to be] very small. If there are 50, then I'm guessing you are not missing many.

Bart: And with all of those, we wouldn't be missing many. How well are we capturing what we should use as a reasonable use rate? We're not missing a lot, and is it statistically significant? Our annual survey has a pretty good response rate. CN has not been incorporated into ILRS, so everything we have is on spreadsheets, project trackers. We'll field that and see if there is any significant gap.

Group continues to discuss survey responses, data representations, and discusses variability. Kathy will cross-tab survey by CN, by buckets. Cross-tabbing will help us figure out what questions we need to focus on for the methodology. Will also help us figure out minutes, hours of operation.

Susie: I really don't know why I feel the need to say this again, and I know you put a lot of work into this, but I'm just not sure where we go with it in terms of its practical value. So I'll listen carefully.

Jody: We needed this because there are gaps in our knowledge. I actually think it was really, really helpful.

Susie: Maybe because this is what we do it's more familiar to us (unintelligible). I don't want to belabor that point, but I just want to say it again.

Kathy: Do you have information you can share with the group about the minute tracking and that kind of thing? Like the questions we asked on the survey?

Susie: No, it's more anecdotal knowledge on our part, we haven't done a survey. I'm just wondering whether this is extremely useful in this process.

Jody: Are all of your members licensed? Do you know what the percentage is?

Susie: I'm sure someone does, but I don't.

Bart: This confirmed a bunch of things for us, there are a couple of takeaways. We can see there are distinctions, some consistencies when we look at the type of facility especially with the minutes. But you

can't compare the really different types of facilities. It confirms ideas we had early on, we think we need to make these different piles because of the methodology and one size won't fit all. That's why we went through this survey to find out whether it would confirm that or are there consistencies that we're not aware of, and it does not seem to do that for us.

Frank: This survey convinced me that the noise that we're getting back in the response number of minutes from the annual survey is fairly significant.

Bart: Or when we add it all up and get 62, does that mean that 62 is what we should use across all facilities? Because it's wrong for the plastics and it's wrong for gastro. So, what real value does taking that average have for us?

Jan: Or do you identify for those that are the gastros and endos you use the 30, as the basis for identifying the number of rooms versus if you have a multi-purpose ASC then you might use the 62 as the average because you are going to have some on both sides. There still would be some space in between for folks for doing that.

Nick: I think that average for a multi-purpose would be specific to those services they provide, not necessarily that overall number of 62. So, if they do only gyno, podiatry, ophthalmology, not that that would ever be a mix, but that would be the average for that site, because they are going to have to apply for a new CN if they chose to add a service. Right? Or at least give an exemption and identify that they are changing their services provided.

Discussion: Program generally hasn't taken that rigid an approach. If you did ophthalmology, and then added plastic, then we'd need to do a CN. More recently, CN are much more specific. If you are applying for an ASC that the department might be doing something differently regarding methodology – endos is a prime example - like peds, or eyes, or dental, the methodology is done differently than just applying the straight methodology because of the unique nature of the equipment, services, etc. . If you expand those specialty ASC into a general, multi-purpose ASC, then yes, there would need to be another CN review because you are going from one or two buckets to a new bucket.

****BREAK****

Next agenda item: Jan and Kathy present on quarterly hospital reports for various hospitals that report to the department through CHARS. Just looking to see what was being reported – many data elements, but of interest to us is total inpatient surgeries and outpatient surgeries. We can look at this as a measure of what is going on between the two. On the year-end report, these are rolled up and reported as surgery minutes. Captures number of inpatient surgeries as well as number of outpatient case counts. This is what is currently being reported to CHARS. Also of interest: outpatient surgeries outnumber the inpatient. Total surgery minutes are taken off the cost center reports – group noticed a little (or big) quirk with Swedish. The point is, this is what's available in CHARS. The purpose of wanting to have an understanding of this, assuming some reasonable level of accuracy, is whether it is supportive of how we would want to parse out what the total operating capacity is or would be for a hospital.

Discussion: Hypothetical: Assume 10 OR. If 60% of cases are outpatient, then maybe we should count six. Theoretically, want to split the percentages based on the actual resource use, and that would be minutes, but minutes don't get reported in either of these two surveys or reports, and secondarily, outpatient surgery visits are pretty noisy – data would have to be cleaned before use – endoscopies are counted in this data. Depends on how they are reported. If endo is subject to review, could we add an

element to endoscopy? Could assign surgery time based on time and buckets. Currently, year-end reports and cost reports aggregate surgery minutes. These numbers are pretty stable. Does the data creating noise include C-sections, endoscopies? For purposes of determining proportionate amount of OR space, we could drill down to all of the buckets.

Fundamental question: Hospital says they have 10 OR. Currently, we don't have much of a way to say, how much of that OR space should be attributed to outpatient OR other than just asking? Most hospitals report their OR as mixed use.

Discussion: The split between inpatient/outpatient may be driven by financial reasons. But that would work – it's a proxy. Right now, if you go back and look at the surveys, by and large all of the hospitals are going to say the rooms are mixed use. For the most part, either an inpatient or outpatient surgery could have taken place in a surgery suite. Our question is, how much of that room is pure outpatient and how much is inpatient? Current methodology has a way to deal with mixed use, and ultimately the preference would go to dedicated outpatient. Seems simpler to create a methodology that asks what are outpatient procedures, and default time for each? Just something to think about. This data might help to inform us. Need to know what is "inside" the number, whether hospitals keep data that is OR specific. Most hospitals don't do this, but they will differentiate between inpatient and outpatient. If we ask this, puts hospital and department in an awkward place of moving to an "attestation" concept as opposed to a data driven system. Want to be fair, and want to be able to verify what is reported the best way we can based on what data is available. Don't want to put people in the position of having to attest to use, department would prefer to say that based on our accepted standards that we use to approve new, we apply that same standard to you [existing facility] based on what you did, and then you get an allocated number of OR. Annual updating is important. Shift toward outpatient use is interesting. We may see more outpatient use in hospitals just naturally occurring.

Suggestion above is capacity neutral. Presumption that hospitals build OR capacity because they are pressing their need, do it at will, running and operating their sweet spot.

Bart: If 60% of your actual surgeries are outpatient, whatever number of ORs you've built and are operating, 60% of them are going to be allocated to outpatient surgery. If the reality is that that you have twice as many ORs, the exact same thing is going to happen – you'll get twice as many ORs allocated as the number of surgeries in the ASC that was approved for 5 that only has volumes today that are needed. Same thing for the hospitals – we're counting the idle capacity. Most hospitals don't build excessive OR capacity. Something happens to cause it.

Susie: I have to ask you, are you assuming that surgery centers, that ASCs do overbuild?

Bart: No. Because we're not talking about ASCs.

Frank: You wouldn't think it prudent for anyone to do that. No one wants to build idle capacity.

Susie: You carefully seemed to jump over that.

Frank/Jody: We see a lot of idle capacity out there. And you wonder why.

Bart: No, no, that's not what I'm assuming at all.

Susie: That's the thing. A [unintelligible] building an ASC is unlikely to add two extra ORs just for the fun of it.

Bart: The reality is that the initial CN is based on a reasonable projection of use, and you expect that to materialize. So idle capacity is surprising, and may be a result of our methodology. That can happen when you use default minutes. This is just an approach.

Nick/Frank: We've been successful at identifying minutes in ASF survey by type/specialty. May be able to similarly break it down the same way for hospitals. CHARS data is split by revenue codes, and this is how they are reported. Could break it down into buckets by ICD-9 codes similar to ASF survey so we're doing some sort of apples to apples comparison.

Group: What are the buckets? Is it fair to be able to ask hospitals about dermatology? And we're specifically talking about outpatient surgery? Do we need to ask anything about inpatient surgery? No. Kathy's buckets are way too distinct; but for hospitals, may need fewer. Getting outpatient surgery by minutes would be very helpful. Most hospitals utilize EPIC so the level of detail we need is readily available, but the challenge is to define the buckets. Minutes will parse out inpatient/outpatient. If there is any trending around surgical capacity of a hospital, what we might see is remodeling of space for the addition of surgical capacity. We don't see an entity lose patients. As we look at numbers, it is presumed that number [reported] is some reflection of what surgery is. Inpatient/outpatient minutes depend on the market you are in. Quarterly data isn't really helpful. Currently survey asks for information about current outpatient surgeries in facilities and we ask for minutes. If minutes are not reported, department assigns them. Do the same for inpatient. But what you see is that those line items are zeroed out. It's all mixed use.

Group shifts to discussion of how to craft the hospital survey. First, need to define the buckets that we want minutes reported for. Are there any buckets that we need that we don't see, any that are reasonable on the hospital side that we don't see? We feel we have a representation of what the ASC are doing – need to be able to do a reasonable comparison on both sides. Also need to make it clear to hospitals that this is different from the annual reporting that they do. Should use the buckets we will use in methodology – we can ask for more, but it may not be material. Should outpatient surgery buckets be the same as ASC buckets? Yes.

Agreement that GI, endo and pain are separate buckets. Eyes should be separate too – very different room. Dental? See very little of this in hospitals, primarily an emergency procedure.

Brief discussion of dental ambulatory surgical center.

List for survey consists of GI, endo, pain, eyes and dental. The bucket that contains everything could be "other" or "all other." GI and endoscopy are synonymous. Discussion of why orthopedics aren't separated out – procedurally, not all that different from general surgery. Dividing line is not a bright one. Resource requirements are very similar to general surgery. Should we exclude pain? In applications, do they assert that there is something unique about the way they build their suites that is self-limiting? Yes, built to different licensure specifications so you couldn't have a pain procedure room used for anything else – they use procedure rooms instead of ORs. There's a distinction between pain procedures – injections vs fusing vertebrae. So should we be classifying differently? Variances in different types of surgery within buckets. We could identify by ICD-10, but that would really complicate things. We've carved out simple buckets based on OR environment.

We would ask hospitals, based on the above buckets, concepts of procedures, can you give us general average minutes on these? Nick suggests making sure to clearly define the buckets – define GI, but make

sure to call it endo, pain, eye and dental. Craft definitions in ways that make it easy for hospitals to grab codes, minutes associated with codes, and calculate what average is. Very similar to what was done for the ASC survey. Large buckets – don't want to have to re-survey. Are we going to ask about turnaround? That seems to really vary by procedure and specialty. The data gathered from the hospital survey would get what we need to calculate use rates, capacity/supply, but we'll need estimates of productivity so we can do our projections. Default productivity = capacity. Right now we rely on 37.5 weeks, not sure if we want to stay with that assumption, unsure of how detailed we want to get.

If we ask people the length of time it actually takes to do some of these procedures, doesn't that back into setting a default capacity of an OR once we decide how many hours a day it could be considered available? What about turnaround? If we don't ask that on the either side, then should we go to a default? What about ASC that operate two days a week? If a CN approved ASC is operating two days a week, something went wrong, could have stemmed from methodology. Perhaps they anticipated more physicians? No one would build a full center and only operate at 40%. But from a capacity standpoint, we still count it at the full five days a week. Don't have to, but we do. We should consider this as we re-write the rule. How do we handle it when someone isn't operating at capacity? We addressed this in the kidney dialysis rules – if you aren't able to hit the expected capacity projections, which you should be able to do, we're not going to have you prevent someone else from coming in, so we're going to count you as though you are operating at capacity. Not taking anything away from you, but we have minimum expected utilization.

Susie: Prefers to go to Association with the proposed hospital buckets.

Zosia: It would be helpful to have more detailed minutes. It usually takes a week to get the minutes and summary.

Kathy: Dept already does that. There is almost a transcript of the meeting and a summary of the meeting and transcript that goes out after each meeting.

Zosia: I mean a more detailed proposal regarding the survey.

Bart: Last time we went out a draft survey.

Discussion of timing of survey, feedback regarding buckets. This is a foundational issue with this group – we talked about this on the 14th of October. Now we've broken this down to four/five buckets. Another question to ask what is when do you schedule your last surgery and what are the days you operate? That will help us with the volume. Should we use the defaults we have in our methodology as the questions? Frame questions around the numbers we have in the current methodology.

Nick: Just want to confirm – we're going to get some sort of single-pager that identifies here are the buckets that we considered, here are the types of facilities that are going to fall within those buckets, so our all-other or general is going to include podiatry, ENT, ortho, some of these others. Pain, eye, dental all broken out, that way we can take that back, you can get feedback, I can get feedback on the buckets, and then from there, develop what our questions are for our survey. Do we want to talk about pediatrics?

Susie: What do you do with a surgery center that is multi-specialty?

Group: Goes into all other. Parse out what we think are the obvious outliers, and everybody else is an ASC.

Pediatric discussion. What age is pediatric? 0-14? Depends on who is defining pediatric, exceptions to general concepts of pediatric care. Appears to be difficult to define it just at 18. Some kids with significant problems don't transition to adult care, but small number. Most ASC send kids to hospitals, and depends on procedure. Seeing more ASC serving 12 and above. We don't survey for age cohorts. Methodology currently includes everyone – "population" – do we need to develop a separate methodology for pediatrics? We're not missing the procedure in cases and minutes, and developing a use rate. If a particular entity asserts that they are going to service a particular population, we've approved uniqueness in the past, but there isn't anything in the rule that says we'll deny an application if you don't serve children. Want to give the opportunity for someone to assert that argument, like an exception? Jan shared a recent ASC decision serving age 12 and over, made population adjustment, included 10 and above – ended up being .01 OR. Not significant. Count of OR drives the need. Do we want to know if they serve pediatric patients, and what the volume is? Should we even ask the question or allow applicant to address pediatrics without prompting? Most ASC aren't excited about treating kids under the age of 14. For the types of the procedures we're talking about here, kids would be referred to hospitals. Good group to ask is anesthesiologists.

****LUNCH BREAK****

Pediatric discussion: what would we add to the matrix? We really don't need to parse out pediatrics – address as an exception.

CONCENSUS: Add something in the rule to address pediatrics as an exception. Something in the rule that would allow the provision of pediatric ASC services to be considered as an exception beyond numeric need. (Tape 2, 1:52)

Kathy: Hoping to work through existing methodology piece by piece. What about the methodology works and does not work?

Frank: The methodology works; the wrinkle is the survey data. Sometimes you have it and sometimes you don't, and if you don't, you can't use anything. Otherwise, methodology is pretty straightforward.

Jan: Right now we have a minimum of 2 OR for approval. Medicare does not have that particular standard.

No one in group indicated a need for constraint of 2 OR minimum. Jan gave perspective on reason for 2 OR requirement – one available while other is being cleaned/turned over. Would there be an explosion of people applying for a 1 OR site? Can't see that this would occur.

CONCENSUS: Reduce OR threshold to 1 from 2.

Bart: Why do we need to project inpatient surgeries?

Jan: Because the way that the methodology works, it impacts the number of ORS available to perform outpatient surgeries. The methodology was developed at a time when we reviewed any addition of OR capacity, whether it was inpatient only, mixed use or outpatient.

Bart: I can understand that, because now if you want to do inpatient additions, you would want to project them. But how does it impact, you would look at the last worksheet page, how does projected inpatient...

Frank: It has no effect. It's the preceding step that matters, when you compare the counted minutes that are projected demand versus those that are estimated as supply.

Do we need to continue to project inpatient capacity? We have a step that projects in patient capacity, not sure how it applies. Pull up the spreadsheet so we can see what function the step has. Frank/Jody: It does not have a function.

Frank: Particularly now when we go strictly to outpatient as opposed to including mixed use and outpatient. You could take that piece out of it.

Bart: It seems to me that a lot of what happens in this is for that purpose – you need to make a determination of inpatient (unintelligible). This methodology helped you decide, what's the total surgical capacity, both in and out patient? So half of it is projecting something we don't do.

Beth pulls up a methodology template for group to review. We're still using mixed use OR in methodology, but we'd have to call them something else in new rule. But if we did this allocation thing we talked about earlier, there would be no need for differentiation between dedicated outpatient and mixed use, you would just need estimated outpatient. So, you would collapse the separation of those calculations into just one. That is, if you are going to say capacity is the same – there might be a reason to keep.

If we want to retain mixed use concept, we need to ask, does the combination of the inpatient and outpatient use in a single OR fall within the constraints of the minimum use possibility established by our standards? (Tape 2, 10:58) Discussion of minutes, mixed use, assignment of minutes. Would we ask this in the survey – do hospitals limit their mixed use OR? Are those rooms operating 44 hours a week or some less or more time than that? If they are hospital based, what number are they operating at 68,850 or are they operating at 94,250? It's a capacity question. What's the length of each surgery, do you do outpatient surgeries, after 3 or 4pm?

Christine discusses how Harborview schedules surgeries, both in and out patient. If a trauma case comes in, surgeries will go on well after 3pm.

Maybe stop using the term "mixed use" and replace with "hospital based"? Maybe data could be collapsed into one total? Discussion of specific cells in methodology worksheet – after Step A where capacity is calculated, the remainder of the methodology could collapse because after that, all that really matters is outpatient surgeries. Jan asserts that inpatient surgeries will impact the hospital's ability to perform outpatient surgeries. The survey might help us flush out and understand the ratio. The ratio will hit Step A in the worksheet, and after that, the differentiation of in/out patient won't make much difference because everything becomes outpatient since you've already adjusted for the inpatient split. We're going to discount, hypothetically, 70% of the surgeries are done as an outpatient and 30% are done on inpatient – we're going to discount 30% of the ORs for being inpatient. Would not need to call them inpatient or mixed use, we would just identify the minutes, of outpatient surgery that's exactly what is being proposed. And use rates would be driven strictly off of outpatient cases. Use rate would go down significantly. Use rate goes down, we would be projecting fewer ORs.

Should we do a test? Just run it and see what happens. Frank volunteers.

If we go to a longer planning horizon, does this matter? You have the inpatient and mixed use OR capacity, and those are going to take precedent over the outpatient OR capacity because the outpatient

surgeries can be done other places, but the inpatient surgeries can't, so if you have more inpatient surgeries regardless of type and length, that impacts the number of outpatient surgeries that can be performed in the inpatient ORs that are used for both. All agree. Or, we could approach it another way – look at the all of the hospitals in the planning area inpatient minute trend, and subtract out five years into the future what we think their inpatient minutes would be as a percentage of their total ORs and then use that as your available outpatient (unintelligible).

The benefit of what we're talking about here is that we're talking about actual minute as opposed trying to determine what the proper estimate is across everything because minutes vary from facility to facility. Would want to make sure we update minutes annually, and consider that some facilities operate on a fiscal year – this would create some challenges. Can convert to calendar year. Survey goes out typically in March, but the lag may be long for some facilities. Discussed what happens when an outpatient surgery becomes an inpatient surgery – does not happen often. Define what minute are – from administration of anesthesia start and stop.

Jody: In order to figure out if we want to change anything in WAC 246-310-270(9)(a)(i) and (ii), we are going to wait to see the result of the hospital survey the group is developing – whether they can be merged, combined, etc.

Bart: But we're also agreeing to the built-in notion of (9)(a)(i), that we're going to make an assumption about a single operating room's capacity, and that our methodology is going to be based on that – everybody agree with that? (Tape 2, 37:00)

Frank: But we don't know if capacity varies between hospitals and freestanding ASCs.

Jody: But we agree conceptually.

Bart/Frank: Right. And we're going to do a survey and we're going to align with their like-type ambulatory surgical procedures in a hospital that have similar times to freestanding ambulatory surgical facilities and will create the new minute calculation for us. So, if we find that there are differences, what would be an explanation of why a like-type surgery in a hospital was different than it would be in a freestanding ambulatory surgical center?

Jody/Frank: Hours of operation; sometimes eye centers have very quick turn times. If you look at that same procedure in a hospital ASC, those turn times aren't going to be that fast, but that's because the hospital ASC does a multitude of other things, and they are not focused on the efficiencies of turning over the eye cases.

Bart: So, moving on to WAC 246-310-270(9)(a)(ii), we need to confirm the number. And we're talking about maybe having that different for hospitals and ambulatory surgery centers.

Frank: If it turns out that way, And similarly, we're talking about the capacity number for the ASCs differing across the buckets.

Discussion of different hours currently in rule for hospitals and ASC (44 hours per week in a hospital vs. 37.5 hours per week in an ASC, or WAC 246-310-270(9)(a)(i) vs (9)(a)(ii)). Want to test if this is something we want to keep.

Frank: There is no rounding up on this methodology; so if we're allowing less than 2 OR minimum, you still have to show need for at least one.

Remainder of the methodology speaks to calculations.

Christine: So if we lower this to one [OR], who would have to apply?

Jan: It depends. The doctor's offices would not need to apply if the OR are in the physicians' offices operated as an integral part of their clinical practice. There may be instances where a doctor's office would need to [apply] because they have separated [the OR] from their clinical practice and want to run it separately. Then they will qualify, whether they are having one OR or two ORs or whatever, but that's choice that they make when they are doing that. I don't see any difference. The reason for them going through review has nothing to do with whether they have one or two ORs. It has to do with how the ambulatory surgery center is operated in conjunction with the clinical practice.

Susie: Question to clarify. So everywhere there is inpatient referenced, you are proposing to remove it.

Frank: Right, because really the methodology is now just two buckets, its outpatient and everything else. Even though they are using the term "inpatient" that's not really what it's doing anyway. And now we're proposing to just make it outpatient only.

Jody: If we could get some results before the next meeting, I'd be willing to take some of your old methodologies and just say, with the adjustments, here is what we would be seeing. It seems like it would be nice if we could come in understanding if there are going to be consequences or its doing what we think it should be. Can share ahead of time so we can contrast and compare.

General agreement: Wait and see mode on the methodology now.

Nick: So what questions do know based on our discussions so far that we have to survey for?

Jody: Bucket, minutes, and I think we want to know that we want to inform AI – hours of operation, turnaround. A lot of the hospitals I work with, each OR has scheduled hours and each OR is different. Room 1 for 15 hours a day, Room 2 goes 14 hours a day, so it could be a little more complicated. Is that true for the ambulatory surgery centers as well?

Susie: (unintelligible) No operations... (Unintelligible)

Jody: But I think those are the three things.

Bart: Follow up for clarity – if we focus on outpatient, ORs that are not dedicated or mixed use whether they are in a hospital or not are all treated the same, does everybody agree with that? (referring to WAC 246-310-270(9)(a)(i). (General agreement, yes). Whether that OR is in a hospital or not, those assumptions should not be any different. (Tape 2, 51:00)

Jody: But that's a dedicated OR.

Bart: Yes, but ultimately we're going to come up with allocating how much of that OR space is dedicated in that facility and it should be reflective of the same capacity that a freestanding can do a similar type of procedure in. That was my question. Why would we treat the procedure that occurs in a hospital, time wise, any different in a hospital vs ambulatory surgery? One example is that there might be some comorbidities associated with the patient that might have made a difference in the care needing to go on longer.

Jody: Or the rooms might be used longer or the turnaround time is different. Because operating as a mixed use OR operating in a much larger environment. It's still mixed use, but we're just assuming that we're separating out the percentage of its capacity that is dedicated. But in reality, it operates in a mixed use environment. So we have to acknowledge that, and it might be operating for 60 hours a week, not 37, and the turnaround time might be 30% not 20%. But that is the reality of how cases are being scheduled.

Christine: If you look at the research papers, in ambulatory surgery centers the minutes in the cases often are slightly less, but the overall schedule of the rooms, from one patient to the next is less than in a hospital, and that's documented.

General agreement to test the methodology.

Jody: If an ASC responds and says, we operate two days a week, eight hours a day, is their capacity going to be based on that, or are we going to say 60/850?.

Idle capacity discussion. Unless dept wants to handle modifications to that schedule based on an organization's desire to increase its available operating time, don't see how we can do that - has to be full time 60/850. Hypothetical discussion about ASF operating at less than capacity: would there be an opportunity in the rules to make that case? Yes, want the opportunity. There is a piece that applies to capacity, but on the need side, need to acknowledge that an entity does not operate five days a week? Argument was made at past meetings that fewer days equals greater efficiency, but majority of group prefers a bit of give and take. The business decision to limit capacity may affect others opportunity to prove need. There is a difference between electing to operate two days a week or if something else is driving that. We can ask, have you elected not to operate at full capacity? Is that because they don't want to or if they can't? What happens when we get to .2 OR can be approved in a planning area then? Makes new entry difficult. CN fundamental assumption is that you intend to meet these operational standards of fully meeting capacity. Once that capacity is full, someone is going to ask for more. But that isn't what is happening.

Susie: When you do a specialty kind of surgery and there's a limited need for it, you may not be able to fill up four days a week. But you still have a very legitimate reason for that capacity not looking like it is being met.

Bart: Does our bucket construct address that?

Nick: In some regards, yes. But the idle capacity piece needs to have some serious discussion in order to truly address how you are going to determine that for CN. If we apply for a 10 OR ASC somewhere, how are you going to say, well no, if we can come back and say, of those you have counted as one full FTE with X amount of minutes, they are actually operating this, and this site is operating this and this and this. I could see a legal argument that says, how did you not account for that? So, that's my struggle right now. How do we account for that and how do you limit what that approval allows them to do. If they intend to operate it two days a week, and they tell you they intend to operate it two days a week, do you give them that full allotment of time?

Jody: The problem is we'd never be able to reconcile that.

Christine: We all want the flexibility to increase and/or decrease to control costs.

Jody: We could take a look at the last three years of data, and count what they are actually doing. For the past three years, if they are only open one day a week, why are we treating them as if they are open and accessible five days a week?

Christine: Not trying to limit them from making changes but just accounting for historic (unintelligible) in the methodology based on survey data.

Nick: So it's an adjustment the department would make in the methodology or the need determination in that planning area based on the actual number of utilized ORs based on three years historical trended survey data that would change.

Trending discussion. Strengths and weaknesses of trending. Bart describes difference between three and five years trending outcomes. The concept of trying to establish a capacity cap, difficulties some businesses encountered with a cap – what we thought we approved didn't happen for a variety of reasons. We could use average of three years, similar to the capacity we assign in hospice, same concept. Bart describes the way the hospice methodology works, compares how this might apply to ASF methodology, but we need to model this. May be more of a policy driven issue – if capacity isn't being used and it appears there is demand, then should we count full capacity?

All agree we need to model methodology and see how it works.

Agreement to cancel May 10 meeting to allow time for survey. Department will follow up with single page document re survey buckets, etc.