

Certificate of Need – ASF Rules

Notes for Stakeholder Meeting – October 14, 2015

WAC 246-310-270

Meeting opened at 9:12AM

Meeting opened with introductions, brief discussion of prior meeting and notes; location of meeting material updates and future scheduled meetings on DOH Certificate of Need rule activity webpage.

Participants reviewed topics developed at the September 16, 2015 meeting, opting to retain the order of topics as originally developed.

Planning Areas

- Frank: Currently 54 planning areas; many counties. In larger metro areas there are sub-counties, the most extensive of which is King County, and this is divided into 5 sub-planning areas. Has no issues with current planning area, but would want sub-county planning areas to be defined by zip code and updated/posted by department regularly. There is no published set of planning areas at the sub-county level, and there is some amount of variation between what analysts prepare and what a consultant may prepare. We've looked at this topic before, and not sure if there is a better set of definitions, open to discuss, but they seem to work.
- Christine: Has a considerable number of people coming in who would not be considered any part of the population because they are out of state and other things, so struggle with planning area in all CoN definitions. Swedish has same problem.
- USPS zip codes are used as are USPS zip code definitions; sub-regions are also based on USPS zip codes and updated randomly. Generally, fairly stable, just want to make sure information is verifiable and updated on a periodic basis. Certain counties are growing faster than others, zip codes created, just need to be updated.
- OFM population data does not consider in/out migration
- Frank: OFM population series used for county definitions; for sub-counties, proprietary demographic information is used – primarily Claritas – there just needs to be agreement that the most recent available data is used in the methodology by the department.
- In/out migration – how do we fix that?
- Christine: Pull data from most current, available sources. The question is trying to project any population increase in the other areas, what am I needing? We use OFM, but we don't really know what to use as the fundamental way to project those numbers. Hard to project because it is not a linear projection.

- Frank: Starts out as a placed-based methodology, that's the county, but by the time you are done with it, it's really facility based. In/out migration isn't obviously easy adjustment, but because you are picking up facility level data in the counts of volumes and counts of minutes, to the extent that there is in/out migration, the facility data is picking it up. It isn't picking up time series or changes in that facility data, so it's just a snapshot of time. If there are dynamics of migration changing, the methodology is not picking that up. But that's true of most DOH methodologies. No "dynamism" with in/out migration. Should be language in rule that allows an output to point to exceptions, new programs that haven't been picked. . Methodology picks up in/out migration quantitatively. But it is just a snapshot in time.
- Kathy: Any ideas about how to address the lack of dynamic movement in the methodology?
- Frank: If they can point to time series data that shows changes in volumes, and as part of that changes in their volumes coming in from out of the area, then that could be the basis of, for example, asking for an exception. Historically, the department does not accept that kind of information but if it is material, it should be allowed.
- Nick: Would there be some sort of vetting process?
- Frank: All internal data; no vetting process. Up to the department to validate. Data is not like CHARS (public/verifiable) that looks at migratory trends and anyone can assess how many patient days are being used.
- Participants would like sub-county areas to be explicitly defined by zip code. Any updates to zip code would ideally be updated and posted to CoN or DOH website regularly. Updating is important to participants to account for specialty procedures, in/out migration.

Projection Horizon

- Frank: Current is 3 years post project start up; recommends 5 years post actuals, meaning when the data are available; if there is 2013 data available, then 5 years post 2013 would be the forecast horizon. Might be good rationale for difference between expansion vs new facility. Indicates that in much larger capital projects like hospitals, there is explicit recognition that they are higher cost capital projects and they should have a longer ramp-up period. In the case of ASF, the same argument applies – maybe take 5 and 10 years. Suggests 10 years because population growth is the only variable that's changing.
- Christine: If you are starting from zero with a real estate transaction, it can take a while. Heard of ASF that open on the day at their projection, are already full and need more capacity.
- Emily: It's worth thinking about, but there are a lot of ASC projects that are CoN approved ASC as opposed to de novo projects, and maybe there is a reason to think about those projects differently.

- Bart: Shorter horizons for those types of projects? What should the planning horizon look like and the difference between an expansion project and an out of the ground project? What are the things that you think should drive that difference other than cost? Should the cost of the project impact the planning horizon in the context that it's a 6 million dollar investment to recapture so you are looking further into the future to establish the need versus someone who has an 800K expansion project. Should that influence the horizon?
- Frank: Cost and time are both factors. Start date in the current planning horizon "floats" with each project. Might be easier to just say 5 years post actuals for existing projects and maybe 10 years post actuals for new projects, the difference being the implementation period for an expansion is very much more rapid than a new project that's going to take 2 -3 years once you start to get it in place, and then the new project is going to cost significantly more so you want, more reasonably, a longer amortization period for that to ramp up reasonably well.
- Bart: Those would be the two things that justify why you picked 10. 5 afterwards because it would be easier and cheaper, but when are we expecting a project to implement the construction phase and complete it for an add. Currently, if you haven't provided information that your facility can build, and if you don't have a plan, you aren't going to get a CoN anyway. That shouldn't be a factor anyway, but design and construction can be a factor (typical is 10% done at time of application); design is typically complete 6 months after awards of CoN, sometimes complete 12 month after CoN. 18 months is a reasonable timeline for design/build. So, adding 2 years to projection horizon is reasonable. 5 years for expansion and 7 for green build are defensible. How can we justify further 3 year projection? This might be difficult for large buildouts to be financially feasible within 3 years if built too big. (25.09)
- Frank: The difference now in applications is that if you are building a new project you have to show financial feasibility within 3 years of project completion, the applicant will typically generate the volumes to show that, whereas those volumes may not be realistic. Longer forecast period might allow more realistic set of volume assumptions so that applicants aren't going from nothing to, for instance, 6,000 procedures in 3 years.
- Bart: Does that have to do with projection horizon or does that have to do with patient volume supporting financial feasibility?
- Frank: Typically financial feasibility.
- Bart: That's the subtlety. Patients that are projected to show financial feasibility may be in-migration, but we can't quantify that. A 10 year projection will always show need. It's appropriate to give different planning horizons. Need to justify specific years.
- Christine: There are also discussions around facility fees, as well. Unless it's medical necessity, it's being forced into a much more ambulatory type of world.
- Frank: Some of the difference in planning horizon can be thought of as in acute care where there is one forecast period for expansions and there is a different forecast

period for new projects. The rationale isn't so much financial feasibility narrowly defined because the rationale in that same set of analyses is still 3 years post-implementation under financial feasibility, but the new facilities are given 15 years to show need for their project, the argument being larger cost projects ought to have a longer window in which they can plan for the future. The same argument applies here, although it's perhaps not as material because we're not talking about 100M or 50M project for a hospital, it's going to be 1M or 5M, but the argument is the same, maybe a shorter difference between conversions or expansions.

- Bart: Agrees. Difference between new and expansion. But how do we get from 5 to 10?
- Frank: 5 seems too short if it's post-actuals, if it's post-implementation that's one thing, but if it's post-actuals, that really cuts off a couple of years before you start the project.
- Bart: The first couple years of projections are really passed.
- Jody: Would be interested in seeing how methodology gets tweaked before setting planning horizon.
- Bart: What we're getting at is what does planning horizon do. If we're going to differentiate between expansions and out of the ground, what are the underlying arguments that you want to have to support that? We know they can't get started as quickly, but how long is that? We need to reach some reasonable consensus of what is the difference between simply the timing – do you buy there's a difference between a 2M expansion or an expansion that is significant, that would be adding 3 ORs to an existing 2 ORs, and the capital expenditure looks really close to an entity building a brand new, out of the ground 2 OR facility. It's hard to draw a hard line here.
- General: Lots of things to think about here.
- When we start doing projection methodology, we start tweaking parts of it, and it becomes outcome driven rather than based on foundational principle of projection horizon.
- Can't do a methodology without some sort of foundational concepts around projection horizon.

Capacity

- Frank: Are there things that we should exclude from the ASF methodology? Currently GI and pain clinics are sort of in but they are really not. The department requires a CoN for these but there is no need methodology and so effectively, they are out. Suggest that first we talk about what is out and perhaps as a corollary to that, we discuss whether we want to deal differently with single specialty facilities, like eye surgery centers or things like that as separate need methodologies, but maybe the first thing we should discuss what's in versus what's out.
- Jody: Do we mean leave out of the methodology or leave out for certificate of need review? Need some clarity. Jan, I think you folks told me years ago that you folks are regulating what is on CMS's lists of approved ASC procedures.

- Jan: Right. Endoscopies are surgical procedures that are, as are pain procedures, identified as surgical procedures, so those would be covered under certificate of need. I think there is reason to not have them in generic methodology so long as the procedures that are being proposed by the applicant don't include those procedures. If you are developing a methodology for general use, and an applicant is going to be proposing to provide those services within their ASC or ASF, then there should be a way that the capacity of those types of ASFs that are providing those similar types of services are included in the methodology. But if you are only limiting yourself to this, maybe it's a two-step process – have something for general surgical procedures and a second for specialty procedure need.
- Jody: So we're talking about out of the methodology, not out of certificate of need.
- Bart: Out of the methodology for general purpose, multi-specialty, let's use it that way.
- Frank: They are out of the methodology now. Endos are out of the methodology.
- Bart: Yes, we have the same problem with eyes, eating disorders, pain management. What Jan is saying is should we develop multiple types of application approaches. Some of the methodologies might be for unique single specialties, but conceptually the methodology is still the same.
- Christine: What about multispecialty that includes specialty? What would we do if we combine a bunch of different services, such as pain, ophthalmology, ortho, a variety of stuff. Would certain of this list have their own methodology and then we would roll them up at the bottom?
- Frank: On the application, if it's just purely an eye center applying for CoN, then that's what it's applying for, and its competitors would be other eye centers. The difficulty is in the details, where you get the use rates for eye centers. But that's just a data problem, and there's data out there for use as a use rate for eye centers. Under the current methodology, you could run the methodology just for eye centers.
- Jan, Bart: Yes, that's what we're saying. If that's the only thing that you are going to be doing, then yes. It's the multi-purpose ASF that also are including those that are in those unique categories.
- Jody: Because we can see use rates for just about everything, you can just go down a checklist, and if you're doing this, you can check this and add the use rate in. It would not have to be separate methodologies, you could just have what's in and what's out.
- Jan/Bart: Yes, that's what we're saying. You could use the same method, just substitute the data. Don't want to get too carried away with what the single specialty environment is.
- Emily: Taking a step that would lead toward recognizing that some single specialties only perform procedures a few days a week – that would be a very positive thing in bringing us toward having a methodology that reflects reality. Different OR time for different procedure types.
- Bart: Right, now they are just lumped in and counted as a surgery center and we exclude gastro.

- Frank: Makes more sense if you have specialty centers like that that they perform different days of the week and their case times are fundamentally different than what we think are typically case times for ASF. Theoretically that data is out there.
- Jody: Conversely, to assume that hospitals only operate 37 hours a week per week is a huge misnomer.
- Jan: Those are the things that you identify as default.
- Jody: Hours per week is not a default; hospital ORs are operating at 60 hours a week. The methodology assumes that we're only going 37 hours. The default is the minutes per case, but the hours are not in the default. If we want to recognize that some ASF are not operating 40 hours a week we should recognize that a lot of hospital OR are going 60 hours per week. Actual OR time should be counted.
- Bart: Have we reached some kind of consensus that we should give some thought to single specialty providers and how they project either independently or they become an add to a multi-specialty facility that is also going to include single specialty services.
- Frank: Clearly define specialty services
- Group defines single specialty: eye surgery, endoscopy, pain centers, dental, pediatric
- Christine: Can we be consistent with CMS definitions? What else comes from CMS other than the definitions of surgery that can help us? DOH facility guidelines have their own definitions for surgery that are different than previous versions and definitions are changing. Definitions are overlapping - we need to be cognizant of this.
- Emily: Going back to Frank's question on single-specialty: does it make sense to include plastic surgery centers? As I understand it, they have set ups very similar to ophthalmic centers – usually small, operate clinic 4 days a week, surgery 1 day a week. If they are being counted as operating five days a week for surgery (intelligible). (50.59)
- Group discussion re pediatrics – how to define. What is the cut-off point? Projection method is based on population identified. Sometimes there is cross-over.
- Bart: Projection method will be based on that definition or where the population data breaks off, whether it's 0 – 14 or something else. This is where the population data breaks off. Are there pediatric specialty ASF, where do they reside, and what are the age ranges served? Need to establish a cut-off for ASF; need to understand that pediatric will include incidental coverage codes.
- Frank: Some do, 5+ 12+
- Bart: If the applicant asks for specialty, this will be different from the general that includes some amount of specialty. We'll need to break out what of that into supply. Think of the supply side on this.
- Group: For single specialty, we want different methodologies, potentially different or added, and we're just going to recognize that in our methodology.
- Frank: Hospital ORs: how should these be counted: exclude special purpose rooms, but need to understand which OR are viable as ASF alternatives. If rooms are used

exclusively as OR, are there substitutes for ambulatory surgery rooms? Hospitals are reporting almost everything as mixed use.

- Jody: 60% of OR use is outpatient. That's what the data shows.
- Emily: Counting mixed use as existing capacity is difficult.
- Do we have capacity for outpatient?
- Christine: As outpatient surgery shifts, OR use in hospitals will change.
- Jan: There was a time that we regulated all hospital ORs; keep in mind the age of the current rule.
- Bart: Need to quantify what the need is for outpatient surgery in both the hospital and ASF environments because appropriateness of setting varies from patient to patient. The department is concerned with the concept that the only capacity available is in a hospital OR. The department asks for assistance in understanding what is happening in the hospitals. There are a certain number of cases that can be outpatient, but there are other times the same case may need to be inpatient. Environment depends on the patient.
- Christine: Real life example: at Harborview, even though average is 60% outpatient, it's really much less than that. Closer to 30 – 35% of which large subject would qualify for medically necessary to still happen within the hospital confines. There are many other drivers making us more interested in moving out of the hospital from patient/provider/financial drivers. If we took a third out of our OR, would we shut down any of those? Right now they are mixed. The answer is no; we would still continue to run all of our OR, even if we feel pretty strongly a methodology would show we would meet demand for outpatient OR as well. By the methodology, it would show we're adding capacity for whatever that is, but in the end we aren't closing anything either because it would be a reduction of hours vs closing the capacity because we still need to meet the demand of the inpatient services for whatever is medically necessary. So #4 in WAC is hard – the definition between inpatient and outpatient.
- Jody: Harborview has a hugely disproportionate share of Medicaid as well, so if we're looking at access, they are taking outpatient cases that other providers don't want to take.
- Lisa: But isn't ambulatory surgery 24 hours or less?
- Christine: A subset exists at Harborview for ambulatory but medically necessary to we expect them to be discharged within 24 hours. For some reason the surgery has to be performed in the hospital whether they are admitted or not. Has to do with status – observation status.
- Bart: Do something with the ICD-9 codes that are designated ambulatory surgery procedures, but discharge does not happen after 24 hours? When you discount hospital ORs case need goes way down. Wholesale approach to this issue does not make sense
- Jan: Another idea is that hospitals report quarterly outpatient surgery business.
- Jody: Does it make sense if we aligned capacity what is really happening on the outpatient side? Do we want that much idle capacity? Methodology shows a lot of idle

capacity, produces a lot of idle capacity in hospitals. If the department is okay with that, then use actual hospital data (OR use time). Hospitals are driving need. Should we back out hospital capacity data and align with ASF? This might bring balance; look accurately at both sides – need an inventory. What is our policy on this?

- Christine/Jody: Idle capacity is your own cost. Does not help. Don't want to drain volume out of hospitals.
- Emily: We're looking at this from a hospital perspective; as hospital capacity being the more expensive capacity. Struggle to look at this through the lense of what makes sense to the hospital, have to interject what makes sense to the patient.
- Bart: Jody is asking for a fundamental policy. There is always idle capacity – that's ok. Would have a problem with idle capacity if the overall cost of a system defeated the hospital's primary mission. The policy is that there is going to be a balance; people's access to quality, affordable care it what interests the department. Create a methodology that is fair to both sides. Idle capacity is okay, but the department is not okay with it if the cost of idle capacity trickles down to consumers. Hospitals have a lot of incentives to control costs.
- Emily: WASCA would have an issue with a methodology that made it difficult for ASC to be established in this state.
- Emily/Jody: Look accurately at both sides. To understand the ASF that are operating at limited capacity but which are counted at full capacity, need to do an inventory.
- Bart: Common interest is to control costs. Hospitals have an interest in controlling costs, as well.
- Zosia: Agrees. Hospitals have a huge interest in keeping costs down. Also, all hospitals will operate differently, so we'll need to look at hospitals differently.
- Bart: Common data set, trying to know what percentage of discharges pend in once day, Example: mixed use, 15 OR entity. Affects outpatient surgical capacity. What percent of surgical procedures are actually discharged on the same day? If less than 10% are actually outpatient, are they discharged on the same day? If less than 10% are actually outpatient, can we actually count all 15 OR? Are OR hours directed by a surgery schedule or something else? Do hospitals staff OR regardless of surgery?
- Universal rooms?
- Frank: Difference in OR minutes is based on the hospital. Volume is a good predictor but it isn't the only predictor.
- Bart: Remember we're looking forward – can we isolate actual outpatient and align that with hospital services, and then take that capacity that they use to support those procedures and incorporate that into our projection model.
- Frank: How do we count data and are cases a good predictor of OR volume?
- Jody: Should we create a baseline, where we understand the market share of the hospitals in the planning area for outpatient, we hold that constant and then we just project into the future.

- Nick: We can't assign a constant because the market is shifting so quickly. Organizations are having to adapt to shifts in the provision of future care. Shifts will be market specific. Inpatient/outpatient, almost 10% decrease in inpatient volume. New technology is driving those changes. Aspiration is to provide care at a level such that we can invest in that shift. Cannot maintain services in the way they used to. The goal is to provide care and continue to remain viable. Hospitals will be competing with ASF and it's possible that inpatient OR may "go dark." Procedure counts might allow us to do it at an established level.
- Discussion of freestanding, HOPD, ASC and rates. Existing capacity. Want level playing field among the parties.
- Jody: If hospitals shift OR offsite, are those new ORs or are they added? What kind of CoN will they need? ASC or DOR?
- Bart: Will those be HOPDS or ASC? The department is more concerned with patient experience than caring about the ownership of the ASC. From a CoN perspective, moving to outpatient by hospitals IS expanding capacity in the planning area.
- Emily: Conversion of HOPD to ASC is the same as exempt
- Bart: Want OR capacity to be done in the more affordable environment.

BREAK

- Frank: Dedicated OR: cardio vascular OR should be excluded.
- Emily: Conversion of ORs from HOPD to ASC is no longer being used. What about "shelled" ORs? Up to hospital to declare that "shelled" space.
- Frank: If shelled, it would not count.
- Zosia: Should we continue to use survey? For ASF, hospitals, if we are going to be data dependent we need to be able to identify and verify the data source.
- Bart: Continue to do surveys.
- Lisa: Is there any way to track when you run procedures, if it is inpatient/outpatient? And also the discharge part? Where did the patient go when they were discharged? We track this for quality reporting. Is that a way to separate patients out?
- Christine: Would need to see what that data pull looks like. Definitions might be difficult. Not totally accurate.
- Zosia: There are some process pieces that are difficult. Opportunity to make a more robust survey system. There are better survey methods in the works, correct? This might level the playing field between types of applicants. As to the level playing field, is that the goal of the CoN process?
- Bart: Yes, CoN should be equally accessible for all types of owners applying for an ASF CoN. System as fair as possible.
- Christine: Shout out for clarity and simplicity.

- Jody: Zosia’s question about the survey, verifiable and published. This is what gets us into court. What about the ESRD data set? Published once per year, everyone attests to it, etc.
- Bart: Difference is robust data set.
- Jan: Hospitals report data quarterly (outpatient and inpatient) separately. These are cases. Report minutes at year end. Rolled up into just the one. Volume is a good predictor of surgical capacity, variation of care minutes across providers.
- Jody: Differences in surveys, minutes and cases are calculated differently. OB is in, GI is in, just the number of patients, databases are not aligned.
- Biggest glitch with current methodology is the data. Data integrity.
- Ana: Is there any data that isn’t accessible? Maybe we should start there.
- Bart: No.
- Emily: Threshold – if x% of mixed use is outpatient, then it should be counted as OR. Retrospective – not asking them to set priorities for specific ORs
- Bart: Should we count ASF ORs that are only used, for example, one day a week as a full OR? If business decision leads to using OR at less than full capacity, would this prevent new players from coming in? Should we reconcile both sides?
- Frank: Exempt facilities typically only use their ORs minimally. CoN approved ASC - use 1500 cases or more per year. There is variability in optimal capacity.
- Bart: CoN approved multi-specialty ASF – some, but not much variability.
- Lisa: Business discussion – would open ORs if needed on other days, but won’t open unless patients needed it. Open to fill capacity we need right now. Don’t keep rooms open when you aren’t using rooms. Single specialty look and operate differently.

Data

- Frank: There is no uniform data set. How do we make the current method better: The annual survey with a better response rate and more explicit definitions of what the department is asking for might help. Second best approach is what should be done. Data should be:
 - Annual
 - Greater response rate
 - Better consistency
 - Published at a set time every year
- Zosia: How many surveys go out? When?
- Jan: Currently send out surveys once a year in March. Process-wise, this isn’t working very well. Acute care/PCI survey/hospice survey are models to consider. A handful of surveys are problematic.
- Zosia: Process wise, seems like one of the challenges is response rates. Maybe one way to address that is to develop a process that is more streamlined, and you know

you'll get the data on March 1st, because that seems to be a challenge. If you're going to continue to collect surveys, then this seems like an area for improvement.

- Nick: Thinking of capacity already in practice, including a multispecialty suite that has capacity, on the data and data sources side, Frank's idea of a second best approach, because there is no single source of data, although we're hopeful that there may be in this all-payer claims data base (but that's years away), and thinking of Zosia's comment, is a level playing field what the goal is or is need what the goal is, and verifying need. If we have the ability to demonstrate in a single specialty that we can say what data sources are available to help you in defining here's what we use to determine where we want to place our building. When we chose to build here, why did we chose to do that and what data sources were available. Using one individual specialty and trying to create a scenario around that one may help us to develop various other individual methodologies that we can roll into a better need methodology. I think as soon as you hit multispecialty, there's a variability question that will make the range low to extraordinarily high. Are there utilization rates for single specialty?
- Frank/Nick: Discussion of developing a way to show need based on specialty use. Have to use the second best approach; multi-specialty created need/use rate discrepancies. Frank goes to national data sets, no published data sets available the state, but NCHS has a very good statistical database that has it down to single specialty levels. Can we apply the NCHS metrics by use rate level for developing a need methodology? Does that give us enough to go forward with?
Jody: Issue is on the supply side. The data sources are fine; our issue is supply and capacity.
- Frank: Single specialty are pretty straight forward. National data can tell us if they are operating at capacity.
- Nick: When approving OR – with the assumption that they “could” operate at 1.0, even if they report 0.2 OR. National data sets – NCHS – may not be totally sufficient, but can we apply these metrics to develop a methodology? What resources can we leverage to identify national norms since we don't have anything that we can use regionally or locally?
- Bart: Issue with national data might give you a case per 1000 population, but does not tell you anything about what the capacity is and how it's being utilized.
- Jody: Or how we deal with in and out migration in a specific market.
- Nick: National data then, is insufficient. What do we have? Just the survey? If that's the focus, what can we do with the survey that would help us develop a methodology?
- Jody: Suggest that at the next meeting, participants come back with suggestions of questions to ask.
- Discussion: Problems with surveys: blank cells, no response, inconsistent data.

- Bart: Look at it differently: There is some national data that can help us with use rates. We can get that. Then we need to get survey data. Most of incomplete data is from licensed facilities. If we decide we have an alternate data source for part of it, if minutes of use of surgical procedures, we have national data as well. What we really don't have is that whole capacity concept. Looking at the number of cases, minutes, etc. will help to determine need – how long has the facility been open? Does the entity have the capability to be open?
- Jody: Alternate use data – survey has to be narrower but this might understate/overstate actual population and migration. Using national data understates capacity in Pierce/King counties, and overstates in rural areas. We have to account for in/out migration. If we used a normalized rate, we'd say there's too much capacity in Pierce.
- Nick: Make adjustments to use rates, based on national rate that captures specialties we want. Argument is that if we applied use rates and they are wrong, have we done a disservice?
- Frank/Jody/Nick: Metro v. non-metro use rates
- Bart/Frank/Christine/Jody: Can rely on national rate that captures the specialties we want. Program wants to see services near the people who need the care, so in rural communities we want to see someone do it but typically it isn't cost effective so it does not materialize...how do we account for that migration? We know there's a narrow case capacity. How do we account for the surplus? Use CHARS – use migration statistics out of CHARS and use inpatients as a proxy for (unintelligible). It's a good proxy, would be reflective of the most closest available. Do it zip code based. This is a conceptual model that we want to capture notes on.
- NCHS bundled rate data has stuff we want to take out; if you wanted to take an aggregate rate or take out certain cases.
- Are we using CHARS definitions?
- Aggregate patient days for migration. CHARS helps with understanding migration patterns and trends. CHARS is all inpatient data, gathered by survey, describing trends in migration. Helps describe overall demand in a planning area.

Exceptions

- Jody: There are always exceptions. Need to leave room for exceptional circumstances. Rule currently says “not ordinarily.”
- Bart: Agrees that flexibility for applicants important.
- Exceptions should be well-defined. Typically applies in the absence of the projection of numeric need.

In/Out of Methodology

- Frank: Could potentially avoid having to survey exempt facilities if we use nationally recognized use rates, carving out for certain things.
- Bart: Could use licensing survey for that. How do we count minutes in the OR? Explicitly state that we want minutes in OR is out of commission per patient.
- Discussion of how to survey between entities – hospital, ASC – procedures, times, licensed, focus on procedure time, discharge time, turnaround time. Turn-around time is different for different facilities. Probably get most of this data from national sources Turn-around time impacts capacity – what leads us to not have to do surveys – not rely on this data because we'll have other verifiable sources (NCHS). Just a use rate, and that's all we're looking at. Best available.
- Emily: It's important to know this – turnaround would be different for different facilities. Would want to see the difference in turnaround time between mixed use and outpatient. Does turnaround time impact capacity?
- Lisa: Issue with using NCHS 2008 data – too old. Healthcare environment has changed; is data still relevant?
- Alignment of FGI guidelines and CoN process.
- General discussion of licensing process, and CoN process.
- We get use rate by survey, but if we get that from a national database source.
- Don't have to survey hospital, but need to survey ASF – maybe able to get minutes from national data
- General (broadly applied) consensus: We don't count capacity as exempt from CoN ambulatory surgery centers; alignment of FGI/CoN connection

Case Definition

- Frank: Have to count cases, minutes – collected through survey information. Hospitals collect it, CoN exempt units may or may not collect it, CoN approved units collect it – that appears to be the quality differentiation between the different survey responses. To the extent that we have specialty carve outs then we'd have to do this same kind of thing for all of the specialty centers as well.
- Bart/Frank: Does national data give us case count according to procedure or is it going to be ICD-10? Suspect it's going to be procedure based.
- Bart: Cases vs. procedure. Procedure should be easy to count. Outpatient more likely that only one procedure/case is involved; inpatient more likely to have multiple procedures/cases. 5-6 procedures per case.
- Christine: Things are coded multiple ways – driven by primary procedure. Group data might be tougher than you think to gather. An example is endoscopy: there is an endoscopy code and a biopsy code. Two codes but one is dependent upon the primary code.

- Bart: Picking up additional procedures affects surgery time? What other ambulatory procedures have multiple codes?
- Lisa/Emily: Ophthalmic surgery. Eye: bilateral is two procedures – glaucoma and cataract in one case (two procedures).
- Bart: Case definition will be tied to data/data source. Procedure v. case based data – part is case definition
- Topic items #7 and #9 should be grouped together for purposes of further discussion and development.

Mixed Use

- Bart: One of our areas of consensus: talking about hospital ORs – agreement that group needs more understanding as to how hospital ORs are being used. Mixed use OR being used for outpatient is not the same as an ambulatory OR. What is different and how should we incorporate them into our methodology?
- Frank: Case types in many cases are similar.
- Emily: Mixed use OR is not always available for outpatient procedures in the same way that dedicated outpatient OR in a hospital or ASC is. When we're thinking about capacity we need to recognize and account for that difference.
- Frank: Not sure how this works operationally.
- Bart: As soon as an OR becomes mixed use OR, it becomes different than an ambulatory outpatient OR. If $\frac{1}{2}$ of the capacity of a mixed-use OR is outpatient and $\frac{1}{2}$ is inpatient, can we agree that the $\frac{1}{2}$ outpatient is an equivalent for capacity purposes as a freestanding ASF. Can we agree on this conceptually?
- Emily: Isn't that the context that we talk about mixed use OR capacity for outpatient surgery?
- Frank: In that regard, then any hospital's OR has capacity for outpatient surgery. It has capacity to do that.
- Jan: If you aren't scheduling that OR for 100% inpatient or 100% outpatient, there has to be a mechanism in which you account for or delineate between the two and that is the amount of capacity that will be counted. Whether you can schedule it or not is not the point but it is then counted one way or the other as capacity for the methodology.
- Frank: It's not a bright line. It's increasingly amorphous.
- Nick: Timing of surveys. They are multi-purpose rooms. Depending on fluctuation and volume of inpatient/outpatient, it may be totally different one week to the next. From a supply perspective it's an OR. We envision a flexible OR.
- Emily: It's a retrospective transparency.
- Jan: It's not changing how you use that OR; it's how we count them for purposes of projecting additional OR capacity.

- Frank: For hospitals, an OR is an OR. It's true that certain cases will have different time requirements, and different resource requirements, but that's why most hospitals report them as mixed use cases.
- Bart: That's not why they report them as mixed use. They report them as mixed use because they know in the ambulatory surgery methodology, they get counted as an outpatient capacity and it results in a no-need calculation under the current methodology. We need to be fundamentally transparent and understand that this is the reality. No interest in eliminating hospitals existing OR capacity. Market has changed for a lot of surgical procedures that used to be inpatient. We don't want to write a rule that compromises the hospitals.
- Group consensus (apply broad definition of consensus here) that mixed use is different from OR to ASF, and we need to further discuss how we should incorporate that into methodology. Business has changed. Many hospital OR rooms are identified as mixed use. If we rely on data from 2008, many of the procedures done then as inpatient are now outpatient, and we may be losing some capture rates.
- Nick: Wisconsin collects ASC data – Wisconsin Hospital Association – might be another data source for ASC. Population metrics are similar between WA and WI, and could be representative of use rate. Illinois has something very similar. Wisconsin is the leader in this type of data collection. May be able to rely on it for comparable use rate.

OR Use Expectations

- Frank: Should facilities have to reach certain thresholds? Currently 80% occupancy standards, nothing about minimum volume threshold – something to consider. Are you requesting approval for 1500 or 1000 procedures per year? Issue of what is a good utilization benchmark or standard in the rule and for the applicant is a good starting point.
- Emily: Actual utilization vs. actual capacity conversation.
- Emily/Frank: Days open data should be collected, but unsure how this data should be used. What is a good utilization benchmark or standard? What will data be used for?
- Does methodology look at supply?
- Bart: Expectation that the OR be used at capacity. If the facility has made a decision not to operate 5 days per week, should they still be counted as providing that capacity in the community?
- Frank: Yes, unless you want to manage each one.
- Bart: Parallel with ESRD. Volume standards. If you don't reach capacity after a certain period of time, your lack of performance won't block out potential new capacity, based on lack of performance. That is, you are a 2 OR facility, we count you at 2 ORs for X number of years. If utilization doesn't measure up after X number of years, you are counted at whatever percentage of utilization.
- Methodology assumes actual utilization

- Validate what is the minute use for OR capacity – is 68,000 minutes still right?
- Bart: Any expectations regarding what to do, counting ORs that “go dark” after a shift to hospital owned ASF – would those “dark ORs” be counted in capacity?
- Frank: What about unused capacity? Symmetrical transparency for OR use inpatient and outpatient. Both hospitals and ASF should report unused capacity.
- Bart: Do we set OR use expectations. If that isn’t met, do we count that unutilized capacity against a new entrant or expansion project? How do we deal with it?
- Frank/Nick: How to count OR discussion – approved vs operational. Approved for 6, running 4, report 6 on survey.
- Frank: Let’s agree that we should look at this more thoroughly.

Other

- Emily: Follow up question regarding whether the department has authority to require surveys to be completed.
- Bart: We might have authority to require it. What is the reasonable enforcement mechanism?

General Consensus Areas

Keep planning area the same

Project horizon: projection should differ for expansion vs out of the ground; 5 vs 10 years, clear articulation as to the why of the year

Capacity: clearly define single specialty services, floated ideas, GI, pain, dental, pediatrics (0-14), plastics

- Definitions for procedures, etc. based on an existing sources/documentation so we aren’t reinventing the wheel
- Hospital OR are somehow different, need to be understood and at what capacity they should be counted, and this subject needs exploration.

Data: Consistent, reliable data

- Annual, increase response rates, where available should be published.
- If we use survey, should be annual, increase response rates of those surveyed, make sure we have clearly defined data elements.
- May be national data sources that people would be willing to defer to as establishing credible data for us. Might be able to get some use rates from a national data source. We would adjust it based on CHARS as a proxy. If we’re going to do any kind of adjustments for migration, CHARS hospital inpatient data would be the source that we use.

Mixed Use

- Different from OR to ASF, and we need to further discuss how we should incorporate that into methodology.

Close

Case definitions and data collection (Items 7 and 9) for next meeting.

Nick will prepare high level bullet points, and examples of what is in the Wisconsin data

Frank will prepare something with respect to NCHS