Meeting opened with presentation of need methodologies for ASF in other states.

State ASF methodologies reviewed and presented were:

- Delaware
- Connecticut
- Michigan
- North Carolina
- Maryland

Participants discussed varying state methodologies, strengths and weaknesses. Participants also identified and discussed information provided and where additional follow up and research may be needed for clarification.

Participants also discussed data sources among different states. Types of methodologies were discussed, including population based, facility based and planning area (geographic) based methodologies.

Most states seem to follow a fundamental methodology.

Bart: We need to agree on a general approach to the methodology. Do we want a methodology to be place based (what the facility is doing, and what its needs are irrespective of what is happening outside of that facility) versus a planning area (a geographic based methodology that is the typical approach)

Frank: Or, you could have a combination of the two, place and facility based.

Jody: Is there going to be a separate methodology for endoscopy?

Bart: It’s all on the table. Never had a great feel for how we treat single specialty decisions – LASIK, endoscopy, dental, weight loss.

Frank: Seems that the determining factor has been surgical vs non-surgical, but the definition of surgery isn’t necessarily well-defined. That may be why you have that gray area of ASFs versus GI labs, for example, or pain centers. But I think that needs to be discussed.

Bart: Department’s goal is clarity, ease of use.

Zosia: Can we look at the general questions?
Questions:

1. Mixed use

Emily does not like mixed use definition – some required clarity. It is important to understand what it means.

Right now we count the # of minutes – should we have a discussion of mixed use?

Bart: We can agree that “mixed use” means inpatient and outpatient, but is it fair to define an OR as mixed use if (for example) it only does 1 operation a week?

Frank: Better definition as long as it is quantifiable, time usage included in definition

Bart: Time usage would need to be assigned. We need to understand that OP are and can be very different (OP can be in a facility 24/7, whereas the same is not true of ASF). Notion would be that it may/may not be used; assign some usage for mixed use that gets included as outpatient. Is that data collected by hospitals; information may not be included in all cases

Make sure we understand that status difference between inpatient/outpatient

Need to understand this (above) concept

Keep as placeholders – here are the elements

Time

Type of procedure

Character of population

2. ASF or ASC?

Not certain that a distinction should be made. As long as it’s consistent with statutory language.

3. Specialty ASF

Should they be CoN reviewable or not? What is the intent here? Are there going to be single specialty surgery centers that will be exempt? What is the methodology that should be used for GI rooms?

Bart: Not the department’s intent. The department is interested in pain management – done by injection – is it a surgical procedure? LASIK, ophthalmic stuff – does it fall into the surgical definition?
What is a single specialty?

What do we look at when we try to define these?

Jody: Wants to make sure we balance exemptions. When can we calculate use rates, is everything included in this?

Bart: The only way we’re going to get data is by surveys. We can poll licensed ASF. Part of the problem is not knowing what the usage rate is – undefinable data sources.

Group defines specialty offices, and specialty areas identified as problematic:
  GI
  Pain
  Dental
  Eyes
  Gastric bypass (maybe not, too much “spill room”)
  Podiatric – tends to be single specialty
  Pediatric – should be separated from these – ages 15 and under
    Pediatric Level II – all ASC perform service regardless of age?
    Service provided to child depends on what facility deems “safe”

We don’t want to exclude these from some kind of review, but we might need a different method for what we look at. Methodology will essentially be a general representation of utilization.

Bart: Start conceptual thinking about methodology. What does the group think about the notion of planning areas? Should we stay with planning areas?

Frank: Yes, but as is currently the case, you have the ability to make modifications from a place-based approach to accommodate migration because right now, the methodology says you start with the planning area but then you look at utilization based on actual facility utilization which includes migration.

Jody: We see huge variances in use rates by planning area and that’s due to migration.

Frank: They can be three times higher in one area than another, and that’s purely driven by migration.

Remainder of Group: No position.

Group discussion included whether to move forward with afternoon session since volume of information provided in morning session was substantial; consensus was to keep going, but create a list of topics for further discussion. Each topic will have substantial discussion, and will likely be interwoven.
Ana suggested that another thing that might be helpful at this preliminary stage is to make the list and then talk about some of the advantages and disadvantages of different ways of looking at it as opposed to sort of selecting or advocating for any one of us for one thing. “I think we might not be there yet so maybe, for those who are sort of intimately involved in a very technical methodology it would be helpful to not necessarily advocate for one thing, or if you feel comfortable doing that, great, but have a more open discussion about the merits of the different options.”

Topics developed were:

1. Planning area-
   a. Need to have some
   b. Need to recognize in/out migration
   c. If we have, clearly defined

2. Projection horizon
   a. Timeline
   b. Zero, 3 yr, 4 yr, 5 yr
   c. Are there differences in green build or expansion?

3. Capacity-What’s included
   a. ? should ALL ORs be counted
   b. ? how do we consider single specialty
   c. ? how do we consider within the physical confines of a hospital
   d. Is there a difference in physical confines vs connected via skyway/tunnel
   e. ? how do we consider mixed use ORs.
   f. Dedicated Peds vs Adult
   g. Dedicated ORs in general? Is it limited to how they are being used or could be used?
   h. How do you count an existing provider that does not return a survey (if used) and is not in ILRS (Integrated Licensing and Regulatory System)? Are they counted at all? Use last reported?

4. Exception/Not ordinarily
   a. Define?

5. What is in/out of methodology

6. In/out migration

7. Case definition (how surgical procedure is defined)
   a. Case could have multiple procedures
   b. Minutes- is that information collected
   c. How hard is it for providers to collect that information?
   d. If minutes used-need to define

8. Mixed use ORs
   a. Define
b. In or out of methodology
c. Data on their use
d. Need to meaningfully contribute to outpatient use.

9. Data and data sources
   a. Verifiable
   b. Published
   c. Current information
   d. Across all providers
   e. 3rd party?
   f. DoH publish projections
   g. SCOPE?
   h. State level or National level?

10. Single specialty
    a. Separate methodologies?
    b. If separate—need to define single specialty
    c. Potential use of the room—does that make a difference?

11. OR use expectations
    a. Minimum use standard of existing CoN approved before new approved.
    b. Maximum use standard
    c. Is there a difference between a new facility and an exempt converting to a non-exempt?
    d. Is there a maximum # of surgeries/cases that would be counted in the method?

LUNCH BREAK – 11:55AM

RECONVENE – 1:00PM

1. Planning area

   Modified, population based—should reflect utilization and migration, but planning areas are important.
   Some in group supported this idea as long as it is similar to what we have now.
   Jody and Frank agree that current planning areas work.
   Bart indicated that we commonly use zip codes, whole counties, or a combination of counties.
   Place based—look at PA definitions
   Consider in and out migration
   PA strengths—data information for population
   Makes it clear to applicants re methodology—capacity in planning areas
   Need something like PA because then you can (illegible) access
   We can add criteria—a minimum demographic population base—can combine counties
Alternative? Facility based? To not have well-described – like Michigan – “here’s my service area”
We used to use this in dialysis, “but it was a disaster”

Simple methodology but high risk for competitor who is trying to grow their business for financial opportunities
Disconnect supply/demand and cannot beef up standards about access/cost
Hard for HOPD to expand – create HOPD demand (????)

2. Projection Horizon

X need today versus need X years from now?
How far into the future should we project?
Establishes the number of ORs or connected to financial feasibility/anticipated growth rate
0,3, year, 4, years, or 5 years
Green built or addition – different criteria for expansion versus ground up?
Clarity around projections – 2 types of projections – revenue versus need
Forecast is currently 3 years
If zero projection horizon, means there is pent-up access already
Normally there is a horizon, self-defeating if you go out too many years – try to pick up something representative near term
Projecting too far out is also problematic

3. What is included in capacity?

Group agrees this is an important topic
Supply side is what department considers to be capacity
If all OR capacity should be considered in need methodology?
Should we consider capacity in single specialty environments vs multi-specialty environments?
How do we consider capacity within hospitals and are there any differences?
How ORs could be used versus how they are used?
Mixed use?
Hospital versus ASF?
Dedicated pediatric vs adult?
Dedicated OR in general?
If ORs are removed, take out minutes that contribute to use rate.

4. Exceptions/Not Ordinarily

270(4) – define?
Department may write some rules that are limiting – this would be designed to provide flexibility where exceptional circumstances exist, i.e. change in standard for delivery of care that isn’t account for in rule.
Department to address the “known circumstances” but sometimes there are unknowns – that’s where these exemptions come in.
Address technology changes.

5. In/out – Mixed use?

Hold for future meeting.

6. In/out migration

Why would you have migration? No need to in and out because that indicates there is no access. Access is not properly structured.
Regionalized services?
Not entirely realistic because a lot of tertiary services are regionalized – need to be for one reason or another.
Outpatient procedures – we have in/out migrations
  We can have a methodology that accounts for this or not
Migration out can tank an application for a new facility – what causes that? Referrals, lack of access not enough infrastructure in PA for services
Do we want to identify out-migration and return it to community to planning are when people out migration?
Frank: Should we establish a threshold for use rate?
Problem with tying services to zip codes – does that matter?
Bart: CoN likes access to services within communities where people live
For out-patient services, we hope folks can stay in the communities.
Turnover time is not reported in survey; assumptions factor in turnover time
Important to fairly define OR utilization.

7. Case Definitions

Cases vs procedures vs minutes
“Case” could have multiple procedures tied to it
Also difference in minutes – define minutes – when surgery stopes/starts, when anesthesia starts/stops
“Patient in and patient out” – don’t bill by minutes – patient arrival/departure
Turn time is in assumption
Anomaly – what about people who aren’t using a whole day and limited number of cases? What about a case that lasts 8 minutes?
8. Mixed use OR

Need definitions/thresholds

Should this be in or out of the methodology?
Data issues – do they compile data on their use
Need to meaningfully contribute to outpatient use
Need to make sure that these ORs meaningfully contribute to outpatient OR supply.

9. Data./Data Sources

Department prefers to use verifiable data.
Available and accessible and verifiable – department prefers CHARS
Jody: data should be published annually
Even if it is something department has to collect and publish
Frank: should include current information
Across all providers
Jody: In an ideal world, dept would publish projections that could be used for a year
Do we want to create a data collection file?
SCOPE = collected only ASF data
Frank: State level or national level sets?

10. Single Specialty

Separate methodology for multi-specialty?
Endoscopy single use because it is the only use they can have and physical construction of room has to be very specific.
Plus or minus pressure, square foot clearance, electrical hookups – physical design may change.
Frank: What do we do with existing supply?
Misleading data by including endoscopy
Potential use of room, i.e. can it be used for more purposes versus should it be? Does that make a difference?
GI labs and eye centers = their rooms can’t do anything else?
Department seeing more and more movement away from specialty rooms
Older concepts we relied on (not including gastro rooms with general surgery) room wouldn’t support
We’re not going to design out what is there
What about a cosmetic surgeon who adds ENT - surgery suite will be very different.
Unique attributes of room are gone
But then what do you do with supply of existing rooms?
Single specialty – separate methodology?
If separate, need to define single specialty

11. OR Use Expectations

    Benchmarks for utilization
    Can underutilization or current facilities be a barrier to new applicants?
    New ASC versus exempt facilities?
    Emily: Possibly grandfather some exempt facilities?
    Bart: If you don’t intend to use that OR, maybe you should be exempt. There is a middle
    ground between exemption and CoN.
    Jody/Bart: Reverse – want to look at CoN approved facilities to see if threshold would
    allow more surgery centers into the market.
    Jody: Under new rules – prospective
    Frank: Minimum use may differ for existing and future provider
    Minimum occupancy standards
    Dept looks at internal demand vs external demand
    Minimum use standard
    Maximum use standard
    Is there a difference between a new facility and an exempt converting to a non-
    exempt?
    Good area for discussion.

    END