Certificate of Need – ASF Rules

Notes for Stakeholder Meeting – November 19, 2015

WAC 246-310-270

Meeting commenced at 9:15AM with introductions, and brief agenda overview.

Frank Fox presented an analysis of use rate options. Frank also provided a discussion sheet that was distributed to workgroup attendees. Frank shared the following information:

Resources analyzed:

• NCHS (National Center for Health Statistics, data from 2006):

  The NCHS ambulatory surgical facility data is very dated, but functional. This survey has been discontinued, and has been succeeded by the NHAMC. Since the survey has been discontinued, no further analysis was conducted.

• NHAMC (National Hospital Ambulatory Medical Care survey – 2010 survey data):

  **Strengths**: Relatively recent data (2010). Consists of aggregated/procedure code data; very granular. Contains hospital and department level information.

  **Weaknesses**: Because flat files are downloaded directly from website, works best with statistical software such as SPSS or STATA. Data is not overly accessible to the routine user – can’t drop into Excel. Provides counts of cases, but no population data, so use rates could not be calculated.

• MEPS (Medical Expenditure Panel Survey):

  **Strengths**: Robust annual survey at the patient and provider level; 2013 data is very granular at the provider and patient level, as well as use rates. Allows user to get down to the procedure code level. Allows user to obtain encounter level data, and then look at the demographic characteristics of it. We can get aggregate use rates.

  **Weaknesses**: Does not separate procedures by persons, can’t identify and separate multiple procedures in one surgery. So, if a person has multiple procedures, can’t parse that out. Example: ENT procedures are listed at the encounter level.

Frank F.: None of these data sources get down to the level that we need. In some cases they meet some of our needs, and in other cases they met other needs. However, none of them meet all of our needs.

This is not to say that the ideal data source isn’t available or “out there,”
but it isn’t easy to locate.

What’s the second best approach? We can always use CHARS, but its counterpart on the outpatient side does not exist. What are the things we should be thinking about in terms of methodology and what kind of information is needed to operationalize it? I created the handout with the intent that it would be a platform for discussion. The springboard is really, what criteria do we want information to meet? I class these criteria as relevant, accurate and complete, non-disruptive to providers, simple; can be made publically available data, transparent and timely. I would overlay these criteria on any kind of discussion about information we’d need.

Suggested data elements:

- Number of ORs, set-up and in use, by facility
- Information that distinguishes ORs by major type of use, including general surgery, and surgeries/procedures in special purpose rooms, e.g., eye surgery ORs, endoscopy suites, pain management rooms, dedicated open heart ORs, C-section, cystoscopy and trauma surgery rooms
- Total number of cases, defined for inpatient or outpatient cases
  - Where appropriate, separated for special purpose rooms, as defined above
- Total number of minutes, defined for inpatient or outpatient cases
  - Where appropriate, separated for special purpose rooms, as defined above
- Responses provided on an annual basis for all licensed surgery facilities
- Defined coverage period, e.g., most recent prior year
- Defined submission period
- Submission of survey responses a requirement conditioned on new and on-going licensure
- The department timely compiles data, prepares it and releases a “standard” electronic data set, that includes the above-defined data elements.
- Annual compilation, preparation and release of data sets

These are my preliminary thoughts on structure and compilation of data for an ASC methodology.

Group Discussion:

Bart: When we talk outpatient, how do we define outpatient cases? By billing codes?

Frank: Yes. The difficulty for hospital data is that they don’t have information by OR; they can tell the department how many ORs they have, but they can’t say, these 5 ORs were used 40% of the time for inpatient and 60% of the time for outpatient. They can tell you the number of ORs, and they can tell you inpatient cases and inpatient minutes, or outpatient cases and outpatient minutes, and then there is some calculation made as to the number of inpatient/outpatient cases.
Bart: Is there some kind of allocation for reported use? Whole or portion of OR use. Key element of what we’re talking about. Does everyone agree that these classes of patients – inpatient and outpatient - is straight forward?

Emily: I think the principle of needing to understand OR utilization in terms of outpatient and inpatient is important. How we do that isn’t as straightforward.

Frank S, Frank F. and Lisa: Discussion of inpatient/outpatient designation. Doing procedure in hospital is sometimes based on acuity and risk; the medical necessity will be lost in the data and could create bias. Looking at the array of ICD-9 or ICD-10 codes, outpatient cannot be identified. Assume that inpatient is a proxy for a case that needs more time and a different kind of surgical intervention. Scheduler would know of the time needed for the case, and will have an idea of what kinds of cases will be done in a particular room. So, if there are more procedures performed a that room that are inpatient and fewer that were outpatient at the end of the day because we know the patients will go home, does that make it an outpatient room?

Frank F: Include in the data all IDC10 code data? Huge record dump on department. Class providers by what they tell us they do.

Christine: This list isn’t hard to produce. Granularity of medical necessity is more granular than we need to be.

Data systems vary greatly across facilities. Be careful what we ask for. Define the difference between the insurance definition of medically necessary and health care provider definition of medically necessary. Hard to do. We sort side step the whole issue of medical necessity.

EX: 10 ORs: Are there special use rooms that are dedicated? (25.06)

What about an agreed upon standard? Weighting or minutes or a combination? Default minutes are currently used in methodology. Need to define what those minutes are. Is there a common element in how we track minutes? What about an assumption of room turn? Need to develop a common understanding of when to start tracking minutes. We should be able to see what procedures are done by ASC and minutes associated with those procedures.

Lisa: But I bill by procedure code, not minutes.

Bart: What do we ask people to report? If we are getting reports from hospitals, we are going to have to do something different with hospitals because first we have to determine capacity. Utilization does not accurately predict capacity of an OR. What is the target of efficient utilization of each OR? Capacity could be mistaken. (35.05)
Emily: When we talk about capacity, to the extent that ASC procedures are done more efficiently and turn-around times are faster, is that, sort of, superior capacity in a day in an ASC OR somehow captured relative to a hospital operating room because I think that would be important. (36:00)

All: Capacity vs. utilization discussion: Want to parse out certain case types from methodology where substantial differences can be seen in the data. Specifically those where turnover is less than in the hospital.

Emily: Sounds like there is a difference in how data is captured and how to account for it.

Christine: Data must be something that is already captured or compliance will suffer.

We can at least use a procedure code that is apples to apples.

Frank F: We can at least put cases into buckets: ask for procedure code level information.

Bart/Frank: We have a multispecialty surgical center and we ask them what they are doing. We don’t want to see procedures dumped into one big bucket. Defining the buckets – should we make them larger? We’ve agreed we want to use a use rate for ASC. Should we use bigger buckets or procedure code information? Have we identified the method of doing a use rate? We’ve identified that we want to include use rate as part of our projection model. A use rate of what? We’ve agreed that specialties should have different methodology. So, we need to know the use rate for eyes, etc. Use rates for multi-specialty will be different buckets. Define the buckets for providers, or provide their procedures in the survey by ICD-9 or CPT 4, and algorithms used to create data, and the specialties and sub-specialty information sets. Department thinks ICD-9 or CPT 4 is a level of data detail that is beyond what we need. Might run into PCI information problem – gathered too much data.

Lisa/Frank: Inpatient/observation vs outpatient. Discharge information discussion.

Bart: What do we count in a hospital as OR? We’ve agreed that projections will be based on use rate. Of the data we know we can identify, how do we want to use that to create a use rate? If we do X survey asking X questions, will we get what we need? Where and how much existing supply is there – another piece we need to solve. Understanding the use rate for the procedure isn’t impacted by where the procedure took place. Example: most coronary interventions that are PCIs are outpatient, but we do not allow them to be done anywhere else as outpatient. That does not mean that the patient stayed more than 24 hours; makes no difference if they were stented and stayed one day or if they were stented and stayed more than 24 hours. Now we need to go further and ask how many of those hip or back procedures, for whatever reason, had a complexity that said it really wasn’t enough, and if we really want to make that decision are there enough procedures that really weren’t appropriate to be outpatient and should have been inpatient, and somehow credit the supply side as an outpatient. Eventually adjust use rate and adjust supply of OR. But this isn’t a significant population. (53:00)
Medical reasons that person sought surgery in hospital as an outpatient, but was admitted, how do we count that? A percentage of patients fit this example.

All: Some patients don’t meet criteria to do outpatient surgery, and have to have surgery in hospital. The number isn’t very high. If 2 out of 100 have this happen, do we need to be so precise? Depends on the surgery. This goes back to are there exceptions. The methodology won’t be able to take care of it all. This is why simple is preferred to complex. We want to have the right amount of ASC in communities, and be sensitive that we don’t impact hospitals capacity to do routine outpatient procedures in a way that would compromise their financial health. There’s a small slice of patients who have to have surgery performed in hospital, and hospitals can handle it. They can handle capacity at will. Is that such a high demand that if we include in capacity, knowing that a portion of those surgeries could be performed there, have we overbuilt the ASF and disrupted planned and orderly development with idle capacity?

Under out current model, you’ll never impact the procedures of a hospital. You’re not going to take the inappropriate option. Even if hospitals report as outpatient, it may be a surgery that was driven there; okay to count unless it’s a huge number. We run a small risk of overbuilding. We can create a use rate, and the use rates are kind of in buckets – certain types of eye surgeries that a patient needs to go to the hospital for, still use it in utilization calculations. If there is a huge number of those procedures, we run a low risk of overbuilding in freestanding ASF.

How much overcapacity has a reasonable impact on cost of care?

General agreement: surveys are the way to go; “bucket level” tells us what you do; create buckets around general surgery (everything other than certain procedures, all else); create global kinds of use rates. Use rates would be set by data. Each reporting period would change.

Instead of buckets, how about CPT-4 or ICD-10. Otherwise, department has to create buckets. Use 3-digit ICD-10. Process will be a lot more difficult than it sounds. Identified very few specialties that we’ve carved out, should we ask at that level? If an eye center had to develop a use rate that was used to predict the number of procedures in a certain period of time, what would be used? One idea was a data dump that could be rolled into buckets. Department does not have the resources to handle that. There are standardized grouping methodologies that could be applied or resourced by department to take data that is being referred to, run through and will result in a “care family.” Likely one person would track data; surveys are slow in being returned. Response rate is low.

**BREAK**

Nick spoke briefly about Wisconsin info center:

Reached out to the Wisconsin Hospital Association, specifically the WHA Info Center.

Wisconsin collects the following data quarterly:
Inpatient discharge data (as we do with CHARS)
Emergency room hospital data from hospitals
Ambulatory surgery data from hospitals
Other hospital outpatient data
Data from freestanding ambulatory surgery centers, according to Wisconsin statutes.

Not enough information to report further at this point.

Discussion resumed with respect to data collection.

Difficult for some providers to report based on size. Some report CPT-4.

All: Other states have mandatory reporting. For this group, well beyond the scope of what we’re trying to tackle. From hospital perspective, we can cull from Wisconsin’s questions and process. For instance, Wisconsin delineates facility by revenue code. Supply and capacity are two very different conversations. Case vs procedure is a big distinction.

Bart: A little confused about supply and capacity so we can keep them separate. What specifically do we want to talk about? Where does that lead us?

Christine: Is there a way to figure out categories of the data and test it? Subspecialty is not represented. Is that a large number?

Frank: CPT 4 might be easier for ASF, but have to confirm that hospitals use CPT-4. There is a crosswalk, but it’s “not pretty.”

All: Is it fair to ask hospitals to report their use in these big buckets? It seems like there is potential for hospital data to be complex. Data can be filtered, and data elements through the array would filter out, however, not sure if hospitals could do this. And, ASC might not have robust data that can be filtered. For all procedures you (hospitals) do, group them for us. Currently, we don’t ask about surgery types. We don’t want to create a rule based on exceptions – we’re trying to lessen the complexity of this. What about remote ASC, where it’s flexible and they can do whatever is required at that time – procedures are based on what surgeons are doing in that particular region at that time. Want to keep it simple, but we want valid measures, too. This is why it may be preferable to do a data dump with the classification of CPT-4s attached to it or something similar, averaged over a year. We don’t need quarterly data, annual would be better. Hospital/ASC might attach different codes, so department would have to seek consistency.  (1:36)

The way the department might look at the data would be different than the providers. The department would have to provide codes, or let the providers provide the codes with the department creating the definitions rather than alpha names. If you provide alpha characters, they won’t provide consistent data. We want to try to aim for consistency from ASC and hospitals attempting to write some kind of common code that can be equally compared;
alternatively, is it better to get the raw data and have it analyzed by one group? Let the department worry about the homogeneity of data and the processing of it.

Bart: We need to survey providers and ask them how difficult it would be to provide a data dump that represents all of the surgical procedures you have performed, with certain data elements.

Data would be provided between specific dates, clear data points, work with both associations to assure it gets out to everyone and clear in what we’re asking. Survey on the survey, or random sample? Easier for department to survey all entities, then look at response rate for trend in failure to respond. We can examine the response rate.

First survey question to ASCs might be, if we create a rule that asks a specific question as to data, can you provide it to us?

Issue: Different codes for reporting: ASC use CPT-4 for reporting; hospitals use ICD-9, soon ICD-10; hospitals do not use CPT-4 for outpatients.

Survey questions to hospitals would be similar, can you provide us data that delineates inpatient utilization and outpatient utilization of your ORs and that is for purposes of determining how much supply, or how you parse out overall supply. Can you provide data that delineates between inpatient and outpatient?

We need to establish a use rate – for hospitals, what are the hospitals doing that is similar to ASC surgeries?

Jan: What information is being submitted to the department already on the financial side, or the use side of the data through CHARS? What about the patient data side? We don’t ask hospitals for their data.

Bart: For developing use rate, we only need outpatient procedures; to figure out the allocation of the ORs, I need them both. Can all ASF provide us a CPT code database. We can work with the hospitals and survey them as well, because it sounds like some of their outpatient procedures are going to be coded with something other than a CPT code and we’ll need to do a crosswalk to align the databases and develop a use rate.

Hospitals may need a specific list of codes. Ask for ICD-9 code groups and CPT-4 code groups instead of referring to specific procedures to reduce/avoid confusion. (1:49) Can you give us X for ICD-9 procedures codes? Happening in OR, pretty clear. Procedure, not so clear.

Frank: Questions to ask might be do hospitals carry CPT codes for outpatients, and do they carry CPT codes for inpatient. If the answer is no for either, how do you bill?

We know that ASC does CPT-4, but not sure if hospitals do.

Kathy: Health Care Authority might be able to provide some of this information – what data do they have?
Discussion of state wide rate vs. planning area rate. Do we want to make the assumption that population use rates are normalized in their need for procedures? If you only look at use rate of a planning area, is it low because the population is healthy or are they migrating to another planning area? Large in-migration allows you to overbuild what you expect for the population of that planning area. If in the future an existing facility wants to build a facility in the area where the out-migration emanates and you have a methodology recognizing that use rate, building would be allowed. Build the capacity there, and it impacts the people who built capacity for that in-migration in an adverse way.

Can look at statewide rate and planning area rate if we ask for zip codes. This is very similar to the bed-need methodology. Need to be careful with this. Currently, department relies on provider data that incorporates a certain amount of in-migration already. Is patient origin data needed? (2:03)

Are there other specialty facilities that are capturing the data? Department does not prefer to ask entities for data that won’t be used. If we aren’t going to do anything with patient origin data, uncertain why we’d ask for it. Ask for zip code information to calculate use rates allowing for in and out migration analysis. Currently, department does not do this. Adds a level of complexity. Presume that migration will continue, so need to provide enough capacity in one planning area to accommodate. However, if we don’t recognize potential of in-migration. (2:05)

Bart: Ask for CPTs and tie those to zip codes for us. We need to know, if it’s not a canned report, what is the level of difficulty to pull this information for the provider? If the rule is worth enough for the department to adopt, and creates this additional burden for you, that burden is important to the department. (2:11)

Need to ask for surgery minutes…but there are many definitions. What do we think the answer to turnaround is?

For hospitals, it’s billing codes. Patient in room, start procedure and the clock start when the procedure is actually being performed. If reimbursed by procedure, then how are hospitals able to bill this way? Hospitals bill by units of service in an OR, or increments of time.

Jan: In our current rule, the definition of billing units is the time lapse from administration of anesthesia until surgery is completed.

Group: This does not account for turnaround time.

Jan: Also, when we’re talking about the annual capacity of an operating room in a hospital that isn’t dedicated to outpatient surgery, they [the rule, WAC 246-310-270(9)] identify it as 94,250 minutes. They are assuming you get that number by assuming that the room is scheduled 42 hours per week, 51 weeks per year, and there is a 15% loss in time for preparation and cleanup and 15% time loss to schedule flexibility. That’s how this was calculated, and there is a similar calculation for ASF.
Group: Inpatient and outpatient cleanup isn’t really a measure of efficiency. An outpatient surgery is shorter, so cleanup and turnover will occur more often. Procedures that take a long time are fewer, so cleanup time is shorter; in outpatient setting, there are more cleanups, might be shorter cleanups. Transition times will be different. Standard contemplates cleanup over a year and frequency of cleanup. More time is dedicated to cleanup in ASF. Sometimes cleanup may be longer than actual procedure. There is a great deal of variability. Current rule is a default in the event that total minutes aren’t reported.

Some ASF aren’t open five days per week, and capacity is less. Will have to sort through this at a later date. Concept is the same – what is effective and efficient use of OR capacity? If demand does not require you to operate 5 days a week, then we have to compensate for that. Underlying assumption, if the facility is not being used at capacity, that isn’t the desire of the provider. If you don’t have the patients, then you aren’t going to keep facility open. Do we go forward with this philosophy? For CoN purposes, there is interest in effectively and efficiently using CoN capacity. (2:27)

All: Hospital capacity discussion.

**LUNCH BREAK**

Resume 1:16PM

Off-agenda item: revised expansion language for WAC 246-310-020. Newest version distributed to group. Brief discussion; return to agenda.

Conversation resumes regarding cases vs. procedures.

**Consensus:** We are looking at procedures, not cases.

Beth: Clarify case vs procedure – example of Lasik, right eye and left eye. Is that two procedure codes or one?

Lisa: One case, two procedures.

Not clear what department gets back in surveys currently; needs to be clarified.

Jan: One thing to add – whether there should be a minimum number of rooms at an approved facility. Currently, two is the minimum. Part of that was going from an exempt to a non-exempt facility, and the dynamics of scheduling surgeries of whatever type. One room will be in the process of being cleaned and the other can be used for surgery. That’s part of the discussion regarding turnaround.

Emily: One thing we might want to talk about if we’re going to have an OR minimum is whether or not it makes sense to exempt existing one-room OR ASCs from review, so if they are underutilizing (unintelligible) (8:37)

Ana: Can you circulate a Word version of the expansion language?
Bart/Kathy: Yes

Bart: We’re going to get on the survey right away. What other things might we ask? What is the current “state of the state” in terms of minutes? Should we use this as the chance to ask, on average, what is the number of minutes that we can expect? Not asking them to break it out to minutes for every CPT code.

Frank F: Are you sure? You do need minutes per case for sub-aggregates.

All: Is that information available nationally? There’s nothing out there in peer review literature. Benchmarks? Medicare? Are minutes part of how Medicare develops their reimbursement model for procedures – if part of the resource intensity drill down gets to that level. They globally talk about that’s how they set their rates. We could ask about a resource analysis – does that include surgeon time since we can assume the surgeon is there through the whole procedure.

Frank F: One thing that would be useful to ask is how do you define minutes? Or checkboxes with options that include definitions.

Bart: Or craft questions with a preface of, “Please help us understand how your ORs are utilized.” We know that there is pre-procedure preparation, procedure, post-procedure cleaning and prep for next procedure. Are you able to put us in buckets for us? From the time you were told “get the OR ready” to where you say, bring the patient in. Pre-op associated with the OR only, not other prep.

Lisa: So you are looking at the time the patient enters the OR to the time the patient leaves the OR, then the next patient enters.

Frank S: OR scheduling program will help you do that, also averages based on provider and procedure.

All: Even if they provide estimates, it will help us with discussion of how we are going to treat these ASF and how we will calculate capacity. Will help us rebuild numbers. Current WAC does not reflect current minutes. So question to add to survey would be, “Tell us generally what they think their minutes are rather than procedures.” Like to know how room is utilized. To keep the room active, there’s more to it than patient and turn-over. How do you factor in the variables? How long does it take to clean up? Hospital rooms operate 24 hours a day, and ASC less. Does it make a difference? What we’re trying to do is figure out capacity of OR. If you have an extra two hours outside of surgical time, we will say that in a room based on the minutes of procedures, we expect X number of procedures in a day. Does not impact capacity. May have an efficient cleanup crew or not, but those things might impact your cost of operation, not capacity.

What about a person who is identified with an infectious something? All patients are treated the same; but some should not be in the clinic until the issue is under control.
What about going back to the current rule? Should we try to re-create these hours? Try to rebuild the numbers with new data – might be an approach to fix what we already have? We would send out the survey saying “Here’s what we’re doing now. What of these assumptions make sense currently?” For example, how many hours per week does your OR operate? We can decide what we think the efficient use of ORs should be. We can say, here is what the current expectation is, and show us what the reality is around procedures, and if that is true, how many procedures would we expect to see out of the effectively and efficiently used OR? We need to know how long the procedures are taking – we could ask for a sampling of the procedures that are out-patient, and how long they take. There will be variance among providers, and we could take average. So, an eye procedure might run in a range. Averages can be undependable when there is a small sampling; we should base numbers on state-wide averages for buckets as opposed to planning areas. Assume that specialties do the same basic scope of procedures. Multiple procedure facilities will confuse this, that’s why we need procedure code information. How would survey be sent out?

Jan/Bart: Varies – email presents challenges, so does telephoning. Department hopes that WASCA and WSHA would send out notice to members in an effort to get a better rate of return. If response is incomplete, but above what would arguably be above what a statistically accurate sampling would be, we’re good. We can follow up with telephone contact if needed.

**Consensus as to survey focus:** Procedures, location, and time.

Discussion: ORs operating at less than capacity expectations. The reason for operation at less than capacity is not by choice, but by market? Hospitals don’t shut down; ASF sometimes do. Every time a procedure is done in an environment that is not surveyed, use rate is impacted. But, the use rate the department is interested in is the one that is normalized where the procedures are being done within these ambulatory surgery centers, whether it’s CoN, proxy or hospital. We expect that the current trend is going to go into the future. Assumption: we’ll set defaults on what we think efficient use of OR is. Now we need to fill in the gaps. If we think defaults have changed, we’ll change them in the rule. Question of what are your operating hours really isn’t of use to department; what is relevant is what are the procedures you’re doing, what is the time associated with that.

**Consensus:** The difference between a case and a procedure is that a case may represent someone who received multiple procedures. How long is it between cases? Time the patient entered the OR and time the patient left the OR is how it should be measured.

Complication: Billable events at CPT-4 code level. Multiple procedures that are happening to a patient, you’ll see case minutes. Ex: orthopedic patient receiving 3 procedures; you’ll see complimentary orthopedic procedures that take 50 minutes to perform. You will see total minutes, not minutes per procedure.

Case vs. minutes discussion #2: Patient enters the room and patient exits the room. (1:00) Example: Some people came in and were out in 15 minutes, some where it took an hour, divide
those up and that is the number we can use for trying to set capacity of individual OR. Starting to collect data, then figure out how to use it. Know what they are doing, where they are coming from and how long it takes them to complete procedures. What else do we need to know?

Frank F: Mix of OR – more to hospitals, and maybe some of the ASC that are general practice. May see endo and eyes, but not often.

Frank S: Some have OR and a procedure room. Different construction standards. You have orthopedic and pain. How will we carve out pain because they are closely associated specialties?

Jan: We’re trying to be too fine on what it is we’re trying to measure. It does not have to be perfect. Trying to come up with every scenario isn’t going to work. If you are doing pain procedures, you’ll make your own assumptions on how long that will take. There is going to be some flexibility built into the methodology. It isn’t going to be so precise that we know in two months we’ll need four, but in a year we’ll need exactly 10.

Christine: Data will speak to this. We’ll be able to see the variance.

Surgery suite vs. procedure room discussion. Procedure can be surgical by definition. For CoN purposes, it is an OR. Might not look like the same surgical environment, but it’s still an OR and we count those (like GI labs and pain programs). Hybrid OR? Survey perspective and capacity perspective are different.

Survey will include the following questions (concepts):

- Provide CPT-4 coding
- Can the provider tie patient zip codes to procedure codes (patient origin data)
- Minutes/time it takes to do their average procedure (case level – patient in room/patient exit room)

Draft questions will go to workgroup for review and response.

Agreement to cancel December 10 meeting.