Ad Hoc Advisory Committee on
Freestanding ASCs and Charity Care

Draft Report

Level of Service

Paragraphs (2) and (3) of Subdivision (d) of 10 NYCRR section 709.5 require ambulatory surgery centers (ASCs), whether freestanding or hospital-based, to provide charity care and services to the underserved, as evinced by:

> (2) written documentation that the proposed service or facility will enhance access to services by patients, including members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services (for example, low income persons, racial and ethnic minorities, women and handicapped persons) and/or rural populations;
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> (3) written documentation that the facility's hours of operation and admission policies will promote the availability of services to those in need of such services regardless of their ability to pay. This shall include, but not be limited to, a written policy to provide charity care and to promote access to services regardless of an individual's ability to pay. *Charity care* shall mean care provided at no charge or reduced charge for the services the facility is certified to provide to patients who are unable to pay full charges, are not eligible for covered benefits under Title XVIII or XIX of the Social Security Act or are not covered by private insurance;

Although this regulation makes clear that ASCs are to provide charity care, it does not specify a percentage or other measurable indicator for these efforts, nor for other services to the Medicaid population.[1]

In administering this regulation over the years, the Department and the PHHPC have in general sought a minimum charity care level of two percent of projected cases and a Medicaid level of five percent from proposed operators of freestanding (i. e., not hospital-based) ASCs. While we have found that few applicants propose more than two percent for charity care, it is not

[1] In addition to the charity care obligations of ASCs set forth in section 709.5, the New York State Health Care Reform Act of 1996 (HCRA) assesses charges of 9.63% on revenues of freestanding ASCs obtained from commercial insurers and HMOs and 7.04% on revenues from the State share of Medicaid and from Worker's Compensation and other governmental payers. These contributions support hospitals and other eligible providers (not ASCs) in the provision of uncompensated care and other "safety net" services.

uncommon for some ASCs to propose and eventually attain a higher volume of services to Medicaid clients. This is most true of certain single specialty ASCs (e. g., ophthalmology) and in areas with high levels of enrollment in Medicaid managed care plans. We are hopeful that this favorable trend will continue with the further implementation of Medicaid Redesign and the Affordable Care Act (ACA).

Nevertheless, there remain a significant number of freestanding ASCs that fail to reach their projected number of cases for the underserved, especially for charity care, as they approach the end of their five-year limited life certification period. This Committee has sought to identify the obstacles to attainment of these ASC targets and to consider how to tailor our application of section 709.5 to the review of proposed and actual ASC performance under the current changing circumstances of the health care system.

From statements made to the Committee over the past several months by ASC operators, consumer advocates, Federally Qualified Health Centers (FQHCs) and other stakeholders, the Committee has been made aware of the practical aspects of reaching and serving uninsured and Medicaid clients, especially of how the services and characteristics of individual ASCs and the circumstances of the service area and health care market in which each operates may affect the individual facility's success in serving these populations. For example, single specialty ASCs offering endoscopy or ophthalmology are likely to serve an older clientele, a large portion of whom are 65 or over and eligible for Medicare; hence, it may be reasonable to expect a lower volume of Medicaid and charity care cases from these providers than from ASCs offering more general surgical services. Similarly, an ASC operating in an area of high Medicaid enrollment may experience considerable success in collaborating with Medicaid managed care plans but have difficulty in reaching even a minimal number of uninsured individuals. On the other hand,

ASCs in some areas of the State report that they have been unable to enter into contracts with Medicaid managed care plans because of the plans' preference for working with hospital-based ASCs and reluctance to enter into agreements with multiple freestanding providers. It is also reasonable to expect that the success of the Affordable Care Act and Medicaid Redesign in reducing the number of uninsured in New York State will make it increasingly difficult for ASCs to find and serve uninsured clients.

In view of these circumstances and the likelihood of continuous change in the health care system for some time to come, the Committee concludes that there is no specific minimum or optimum proportion of Medicaid and charity care cases that can be prescribed uniformly for ASCs in meeting the requirements of section 709.5. However, we believe that the lack of specificity in section 709.5 actually affords the PHHPC and the Department the flexibility to evaluate each ASC according to the totality of its proposed and actual volume of services to the underserved, whether Medicaid, charity care or a combination of the two. We recommend that this assessment of effort for individual ASCs be undertaken with regard to the nature and scope of the services proposed, the organization and delivery of health care services in the ASC's service area and the distribution of insured, uninsured and Medicaid clients in the community.

Assessment of Effort - Prospective

The adequacy of an individual ASC's effort to serve the underserved may be evaluated prospectively, in the review of the initial CON application, and retrospectively, when the facility is near the completion of its initial five-year, limited life operating period. In both instances, each ASC should be evaluated according to its proposed surgical services and the features of the health care system and mix of insured, Medicaid and uninsured individuals in its service area.

In their initial applications, ASCs should propose a targeted volume of Medicaid and charity care cases that reflects their individual services and service area circumstances and which meets the requirements of section 709.5. To aid prospective ASCs in reaching a volume of Medicaid and charity care cases appropriate for their services and service areas, we recommend that their CON applications include the following:

- Contracts with two or more Medicaid managed care plans (if contracts cannot be executed before the ASC receives PHHPC establishment approval, letters of intent from the plans will suffice).
- Documentation of preliminary contacts with FQHCs, provider associations, advocacy groups for the underserved, DSRIP Performing Provider Systems (PPS's), local health departments or other organizations to develop referral and other collaborative arrangements to bring ambulatory surgery services to Medicaid and charity care clients.
- A plan and associated staffing to conduct outreach to underserved groups, develop referral arrangements with FQHCs and other primary care providers and navigate patients through the scheduling of appointments, surgery and post-surgical follow-up.

The Department and the PHHPC will review the individual ASC's proposed volume of Medicaid and charity care cases to determine if it is reasonable, given the applicant's proposed services and circumstances, and in keeping with the intent of section 709.5 for the provision of access to ambulatory surgical care by the underserved. We are confident that this differential approach will be both rigorous enough to result in better access to ASC care by Medicaid and charity care clients and flexible enough to result in attainable volumes of such cases by individual ASCs.

Assessment of Effort – Retrospective

An ASC for which there are no quality concerns or outstanding enforcement actions and which has achieved its targets for Medicaid and charity care cases can expect to proceed to indefinite certification at the end of its initial five-year limited life approval period. However,

for those ASCs that fail to attain the Medicaid and charity care caseloads projected at the time of initial CON approval, the Department will need to determine whether the facility's initial targets are still applicable or whether they should be adjusted based on other considerations. It seems likely, for instance, that the multiple changes occurring in the organization and financing of health care services under DSRIP, in the expansion of coverage under the Affordable Care Act, and in the delivery of reinvigorated primary and preventive care services through PPS arrangements may combine to affect ASCs in ways that confound their best efforts to meet their obligations to Medicaid and uninsured populations. Accordingly, we recommend that in reviewing the efforts of ASCs that experience such difficulties in their initial five years, the Department take into account the effects of these health system changes and other factors that may have affected the individual ASC's performance, as documented by the applicant. These considerations may include but should not be limited to:

- A preference by FQHCs and other primary care providers in the ASC's service area for other arrangements for surgical services, such as with local hospital-based ASCs or with PPS's in which the ASC is not a member;
- Higher-than-expected growth in ACA and Medicaid coverage in the service area, resulting in fewer numbers of uninsured individuals who would otherwise be eligible for charity care;
- Outreach activities and systematic efforts by the ASC to publicize its services to underserved groups that nevertheless have not drawn sufficient numbers of charity care patients;
- Consolidation of ambulatory surgery services, whether hospital-based or freestanding, into PPS's to which the applicant ASC has been unable to gain entry;
- Compensatory activities by the ASC that make up for a low volume of charity care cases, such as:
  - Services to a significantly higher-than-expected volume of Medicaid managed care clients;

- Incursion of a high percentage of bad debt attributable to services to individuals covered by policies with high co-pays and deductibles under the ACA.

Consideration of these and other factors will enable the Department to evaluate the five-year efforts of ASCs in a more individualized and discriminating manner.

Conclusion

We recommend the continued case-by-case review of proposed and actual ASC performance in providing charity care and care to Medicaid clients but with the consideration of each ASC's circumstances and experience, as described in this report. The Committee believes that this more nuanced approach will prove a practical and effective means of setting reasonable, attainable expectations of ASCs in their efforts to meet the requirements of section 709.5.

We wish to express our thanks to the individuals and organizations who attended the Committee's several meetings and contributed to our consideration of this important issue. Their accounts of difficulties and successes in bringing ASC services to the uninsured and the Medicaid population have largely informed this report and will aid the PHHPC and the Department in evaluating ASC applications and performance with greater fairness and precision. We also wish to note the support voiced by individual ASC operators and the New York State Association of Ambulatory Surgery Centers (NYSAASC) for the provision of ASC services to the uninsured and Medicaid clients, over and above the contributions these facilities make to the HCRA pools that support the health care safety net. We suggest that the NYSAASC work with the Community Health Centers Association of New York State (CHCANYS) to help ASCs develop working relationships with FQHCs and other community-based providers of primary care serving Medicaid clients and the uninsured. We are also hopeful that the willingness and commitment of freestanding ASC's to extend services to these underserved groups will cause

Medicaid managed care plans, PPS networks and other entities to see these providers as potential partners in their own efforts to bring appropriate surgical services to their clients.