Maryland Ambulatory Surgery Association

August 23, 2012

Mr. Paul Parker
Director, Center for Hospital Services
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Parker:

On behalf of the Maryland Ambulatory Surgery Association (MASA) I'd like to thank you for the opportunity to comment on the Maryland Health Care Commission's proposed repeal and replacement to the State Health Plan for Facilities and Services: General Surgical Services established in COMAR 10.24.11. Please consider the following comments on the proposed changes that so greatly concern the ASC industry. My comments follow the structure of the proposed chapter.

.03 Issues and Policies

It was recommended that the Commission include a table that depicts the utilization of operating and procedure rooms within the hospital setting, in order to compare the overall utilization rates of the state's inventory of all surgical facilities. Without the information it is difficult to see the increased usage for the state's inventory of operating and procedure rooms regardless of settings.

In addition, please note that over the past two decades technology has drastically impacted what defines an appropriate setting for numerous surgical procedures, dramatically increasing the number of cases that can now be performed safely and more cost-effectively in the ASF and POSC settings.

The discussions throughout the document fail to mention that the system in place for billing charges for services rendered in the hospital setting versus the ASF's give the illusion of higher overhead costs for the hospital-based facilities. In fact, the hospitals generally pay less for the supplies, due to their overall buying power. The ASF is limited to billing a global fee for the entire procedure, whereas the hospital typically bills for each minute of time in the operating room and recovery phase, as well as, line items each supply with mark-up.

.05 Standards

A. General Standards

(2) Charity Care Policy

(i) Determination of Eligibility for Charity Care-need to clarify within 2 days to include the verbiage "following receipt of completed application". A facility cannot make an informed decision if the patient has not supplied sufficient documentation to substantiate an application.

(ii) Notice of Charity Care Policy- Unlike the hospital whose charity care cases are generated through the ER or inpatient population, ASF's cases are generated out of the surgeon's practice. An ASF is, therefore, better seen as a secondary facility provider while a hospital can be seen as a primary facility provider. ASFs receive ambulatory patients for elective surgery referred by privileged surgeons, while hospitals receive both ambulatory and non-ambulatory patients for elective and non-elective surgery who have self-referred to that facility. Unlike hospitals, an ASF does not maintain a call schedule and never refers a patient to a surgeon.

If the surgeon does not offer his services for charity cases or his patient population does not include qualified indigent persons, the ASF will not necessarily receive requests for such. Unlike a hospital, whose service area is determined in part by its geographic location, the ASF's service area is strictly determined by the make-up of its surgeon's practice(s). To require a facility to "provide public notice of Charity Care Policy" when they can't necessarily meet the needs of the qualified individuals is comparable to false advertising.

During the workgroup's discussion the ASC Association provided testimony that in order to provide charity care to a qualified patient; the surgeon, laboratory, primary care physician and frequently cardiologist and other specialists must also be willing to provide the financial assistance as well. ASF's do not operate laboratories or pre-

operative testing facilities. ASFs are, however, required by both CMS, the state and accrediting bodies to obtain preoperative labs, exams and clearance in order to safely perform surgical procedures. ASFs are dependent on other providers for those services and should not be required to be financially responsible for those services the ASFs do not provide."

To require a policy be in place and meet specific criteria for eligibility is certainly reasonable, but to require policies that may not be achievable is not acceptable.

(4) Transfer Agreements

This requirement is already required by the state for licensure, as well as accrediting bodies for ASCs, and therefore not necessary to include in this document. In reality, regardless of the hospital listed in an agreement, Emergency Medical Services deliver patients to the closest hospital accepting patients at the given moment.

.06 Operating Room Capacity and Needs Assessment

C. (4) Impact on hospital(s). If the concern of the Commission is truly to avoid excess capacity in operating rooms, then it is reasonable to require determination of the impact on all facilities including ASF's.

Thank you for the opportunity to participate in this process.

Sincerely,

Andrea M. Hyatt, President
Maryland Ambulatory Surgery Association