

18-027

ORIGINAL

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

AUG 20 2018

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name: Aghapy Surgical Center		
Street Address: 200 Fox Glen Court		
City and Zip Code: Barrington, Illinois 60010		
County: Lake	Health Service Area: 8	Health Planning Area: N/A

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: Aghapy Surgical Center, S.C.
Street Address: 200 Fox Glen Court
City and Zip Code: Barrington, Illinois 60010
Name of Registered Agent: George N. Atia
Registered Agent Street Address: 107 Green Bay Road
Registered Agent City and Zip Code: Wilmette, Illinois 60091
Name of Chief Executive Officer: George N. Atia, M.D.
CEO Street Address: 200 Fox Glen Court
CEO City and Zip Code: Barrington, Illinois 60010
CEO Telephone Number: 847-382-7165

Type of Ownership of Applicants

☐ Non-profit Corporation	☐ Partnership
☒ For-profit Corporation	☐ Governmental
☐ Limited Liability Company	☐ Sole Proprietorship
☐ Other	

- Corporations and limited liability companies must provide an Illinois certificate of good standing.
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Amber Fallico
Title: Director of Clinical Operations
Company Name: The Illinois Center for Digestive and Liver Health Barrington
Address: 200 Fox Glen Court, Barrington, Illinois 60010
Telephone Number: 847-382-7165
E-mail Address: amber@icdlh.com
Fax Number:

Additional Contact [Person who is also authorized to discuss the application for permit]

Name: Daniel J. Lawler
Title: Attorney
Company Name: Barnes & Thornburg LLP
Address: One North Wacker Drive, Suite 4400, Chicago, Illinois 60606
Telephone Number: 312-214-4861
E-mail Address: dlawler@btlaw.com
Fax Number: 312-759-5646

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION**This Section must be completed for all projects.****Facility/Project Identification**

Facility Name: Aghapy Surgical Center		
Street Address: 200 Fox Glen Court		
City and Zip Code: Barrington, Illinois 60010		
County: Lake	Health Service Area: 8	Health Planning Area: N/A

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: George N. Atia, M.D., S.C.		
Street Address: 200 Fox Glen Court		
City and Zip Code: Barrington, Illinois 60010		
Name of Registered Agent: Emily Atia		
Registered Agent Street Address: 107 Green Bay Road		
Registered Agent City and Zip Code: Wilmette, Illinois 60091		
Name of Chief Executive Officer: George N. Atia, M.D.		
CEO Street Address: 200 Fox Glen Court		
CEO City and Zip Code: Barrington, Illinois 60010		
CEO Telephone Number: 847-382-7165		

Type of Ownership of Applicants

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Telephone Number: 312-214-4861
E-mail Address: djlawler@btlaw.com
Fax Number: 312-759-5646

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]

Name: George N. Atia, M.D.
Title: Owner
Company Name: Aghapy Surgery Center, S.C.
Address: 200 Fox Glen Court, Barrington, Illinois 60010
Telephone Number: 847-382-7165
E-mail Address: gnatia@aol.com
Fax Number:

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: AHF Investments, LLC
Address of Site Owner: 107 Green Bay Rd, Wilmette, IL 60091
Street Address or Legal Description of the Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: Aghapy Surgical Center, S.C.
Address: 200 Fox Glen Court, Barrington, Illinois 60010
☐ Non-profit Corporation ☐ Partnership ☒ For-profit Corporation ☐ Governmental ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Other
- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. - Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (<http://www.hfsrb.illinois.gov>).

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT**1. Project Classification**

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The applicants, George N. Atia, M.D., S.C., and Aghapy Surgery Center, S.C., propose an ambulatory surgical treatment center ("ASTC") to provide gastroenterology services with two procedure rooms and eight recovery stations at 200 Fox Glen Court, Barrington, Illinois 60010.

The ASTC will serve the existing patients of Dr. George Atia, and other gastroenterologists who practice with him. The historical patient volume used to support this project is currently being performed in hospitals. A significant percentage of the procedures are for Medicaid patients who do not have easy access to gastroenterology services at existing facilities in the area. The proposed ASTC will allow these procedures to be performed at lower cost and provide better access to patients in an out-patient setting.

The project square footage is 4850 gsf and the project cost is \$75,000. The low cost of the project is due to the facility being located in the existing physician practice of the applicant Dr. George N. Atia, M.D., S.C. d/b/a Illinois Center for Digestive and Liver Health in a building that was initially designed to ASTC licensing standards and which currently meets those standards, so no construction or modernization costs are associated with this project.

This project is classified as a substantive project because it is to establish a new health care facility.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees	\$40,000	\$35,000	\$75,000
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$40,000	\$35,000	\$75,000
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$40,000	\$35,000	\$75,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$40,000	\$35,000	\$75,000
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No Purchase Price: \$ _____ Fair Market Value: \$ _____
The project involves the establishment of a new facility or a new category of service ☒ Yes ☐ No If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100. Estimated start-up costs and operating deficit cost is \$ _____ None _____.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: ☒ None or not applicable ☐ Preliminary ☐ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): <u>December 31, 2019.</u>
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): ☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies ☒ Financial Commitment will occur after permit issuance.
APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable: Not Applicable as applicants are not existing facilities and have no outstanding permits. ☐ Cancer Registry ☐ APORS ☐ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted ☐ All reports regarding outstanding permits Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS **ATTACHMENT 9**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization**Not Applicable: the project does not involve inpatient services.**

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available**. Include **observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME:		CITY:			
REPORTING PERIOD DATES:		From:		to:	
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other (Identify)					
TOTALS:					

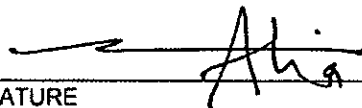
CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of George N. Atia, M.D., S.C. * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

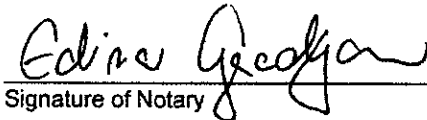
NOTE: The applicant George N. Atia, M.D., S.C., is solely owned by Dr. George N. Atia who is the only person authorized to sign on its behalf.

X 
SIGNATURE

George N. Atia, M.D., S.C.
PRINTED NAME

Sole Owner
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of July 2018


Signature of Notary



*Insert the EXACT legal name of the applicant

Not Applicable
SIGNATURE

X George N. Atia
PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

CERTIFICATION

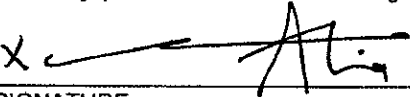
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- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

NOTE: The applicant Aghapy Surgical Center, S.C., is solely owned by Dr. George N. Atia who is the only person authorized to sign on its behalf.

This Application is filed on the behalf of Aghapy Surgical Center, S.C. * In accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

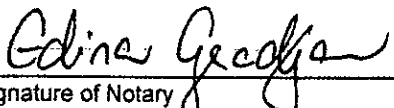
NOTE: The applicant Aghapy Surgical Center, S.C., is solely owned by Dr. George N. Atia who is the only person authorized to sign on its behalf.

X 
SIGNATURE

George N. Atia, M.D.
PRINTED NAME

Owner
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 9th day of July 2018


Signature of Notary



*Insert the EXACT legal name of the applicant

Not Applicable
SIGNATURE

X
PRINTED NAME

PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this _____ day of _____

Signature of Notary

Seal

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)**PURPOSE OF PROJECT**

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space**

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. This must be a narrative and it shall include the basis used for determining the space and the methodology applied.
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
 - c. The project involves the conversion of existing space that results in excess square footage.
 - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110. Appendix B. A narrative of the rationale that supports the projections must be provided.

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE: NOTE: No shell space is associated with this project.

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.
3. Evidence that the shell space is being constructed due to:
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data is available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Non-Hospital Based Ambulatory Surgery

1. Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service	
☐	Cardiovascular
☐	Colon and Rectal Surgery
☐	Dermatology
☐	General Dentistry
☐	General Surgery
☒	Gastroenterology
☐	Neurological Surgery
☐	Nuclear Medicine
☐	Obstetrics/Gynecology
☐	Ophthalmology
☐	Oral/Maxillofacial Surgery
☐	Orthopedic Surgery
☐	Otolaryngology
☐	Pain Management
☐	Physical Medicine and Rehabilitation
☐	Plastic Surgery
☐	Podiatric Surgery
☐	Radiology
☐	Thoracic Surgery
☐	Urology
☐	Other _____

2. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	

1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

SECTION VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable [Indicate the dollar amount to be provided from the following sources]:

<u>\$75,000</u>	a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion.
<u> </u>	b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
<u> </u>	c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts.
<u> </u>	d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.

_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT-34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 38.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI. CHARITY CARE INFORMATION

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

“Charity Care” means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT 39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS

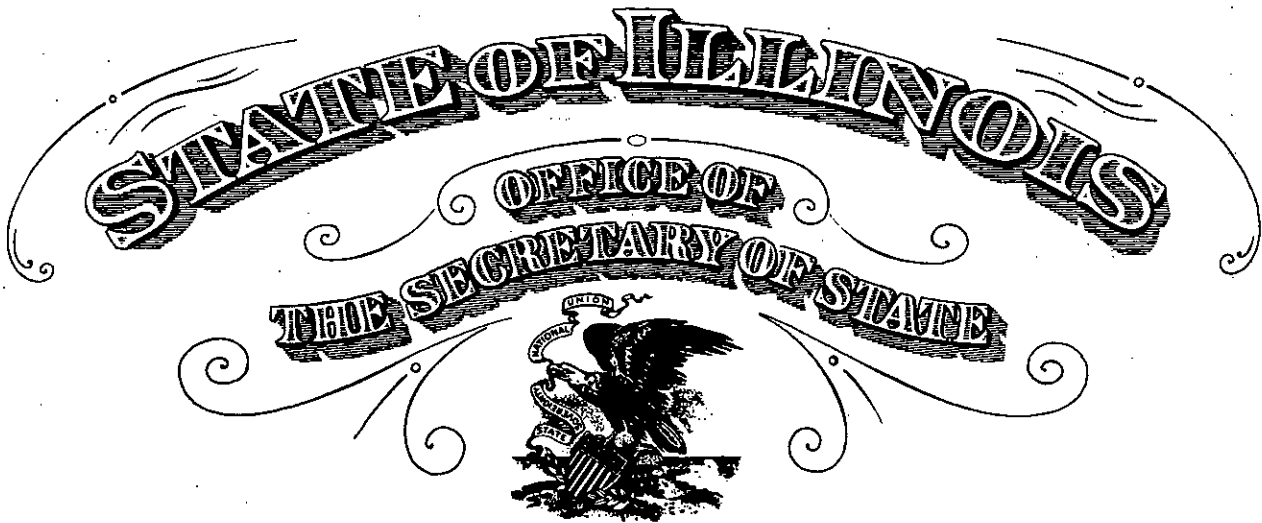
ATTACHMENT NO.		PAGES
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ATTACHMENT 1

Applicant Ownership Information

Included with this attachment are the following:

- (1) The Illinois Certificate of Good Standing for the applicant Aghapy Surgical Center, S.C. an Illinois professional service corporation that will own and operate the proposed ASTC.
- (2) The Illinois Certificate of Good Standing for the applicant George N. Atia, M.D., S.C., an Illinois professional service corporation which owns Aghapy Surgical Center, S.C.



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

GEORGE N. ATIA M.D., S.C., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JANUARY 30, 2002, ADOPTED THE ASSUMED NAME THE ILLINOIS CENTER FOR DIGESTIVE AND LIVER HEALTH BARRINGTON ON FEBRUARY 10, 2014, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 3RD day of APRIL A.D. 2017 .

Jesse White

SECRETARY OF STATE



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

AGHAPY SURGICAL CENTER, S.C., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 26, 2018, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 29TH
day of APRIL A.D. 2018 .***

Jesse White

SECRETARY OF STATE

Authentication #: 1811900416 verifiable until 04/29/2019

Authenticate at: <http://www.cyberdriveillinois.com>

ATTACHMENT 2

Site Ownership Information

The proposed ASTC will be located at 200 Fox Glen Court, Barrington, Illinois. The premises is owned by AHF Investments, LLC, which leases the premises to Dr. George N. Atia who owns the applicant George N. Atia M.D., S.C. A copy of the lease agreement for the premise is included with this Attachment 2.

MEDICAL EQUIPMENT AND FIXTURES LEASE AGREEMENT

Date of Lease Agreement: October 1, 2007

Term of Lease Agreement: February 1, 2007 –

Location of Leased Premises: 200 Fox Glen Court Barrington, IL 60010

Lessor: AHF Investments, LLC.

Lessee: George N. Atia MD SC

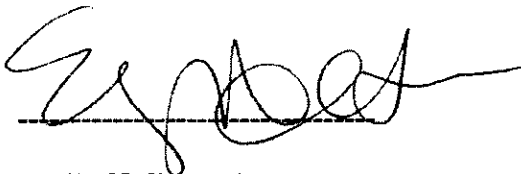
Purpose: Provision of Surgical Equipment

Rent: The Lessee shall pay the Lessor the base rent for equipment, the sum of \$18,000.00 each month, monthly in advance until the end of the lease. All rent due under the terms of this lease shall be paid on the 1st of October 2007 and on the 1st day of each and every month thereafter until this Lease ends.

Witness the hands of the parties hereto, as of the Lease stated above.

LESSOR:

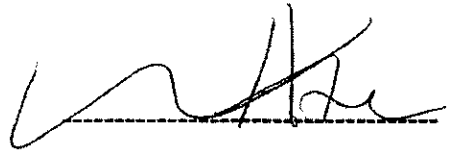
LESSEE:



Emily Halim-Atia

Managing Member

AHF Investments, LLC



George N. Atia

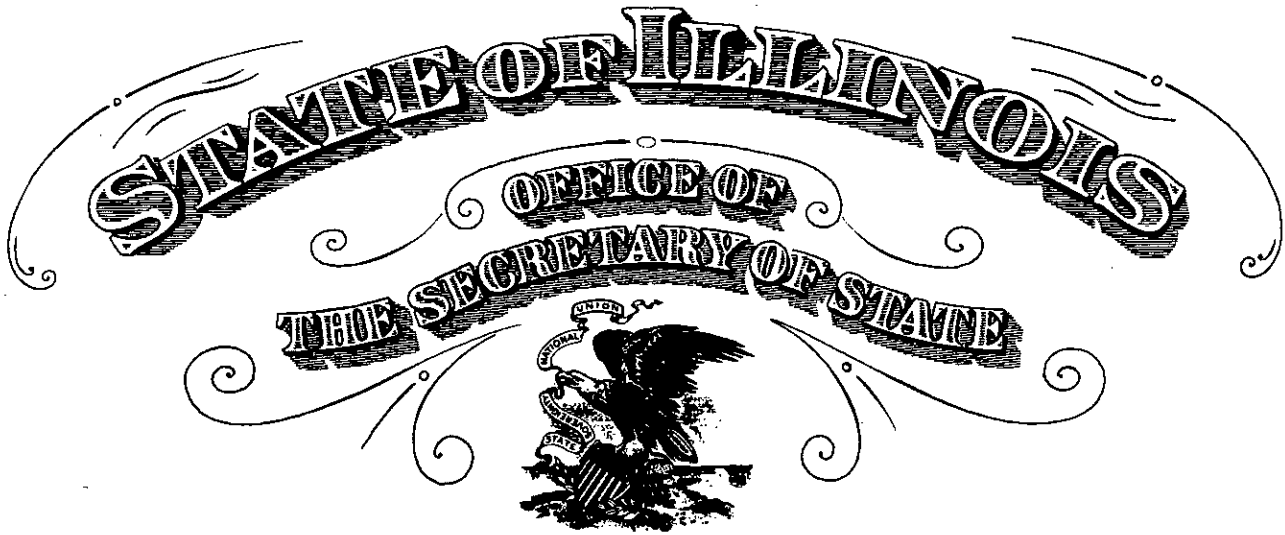
President

George N. Atia MD SC

ATTACHMENT 3

Operating Identity/Licensee

Included with this attachment is certificate of good standing of Aghapy Surgical Center, S.C., which will be the operating identity and licensee of the proposed facility.



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

AGHAPY SURGICAL CENTER, S.C., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON MARCH 26, 2018, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

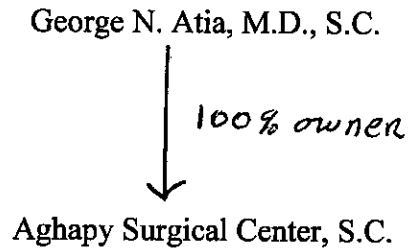


***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 29TH
day of APRIL A.D. 2018 .***

Jesse White

SECRETARY OF STATE

ATTACHMENT 4
Organizational Relationships



ATTACHMENT 5

Flood Plain Requirements

Confirmation that the site of the proposed ASTC complies with the requirements of Illinois Executive Order #2006-5 is shown on the FEMA flood plain map and the applicants' attestation included with this Attachment 5.

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Avery:

I hereby certify and attest that the property located at 200 Fox Glen Court, Barrington, Illinois, 60010 is not located in a special flood hazard area and complies with Illinois Executive Order 2006-05.

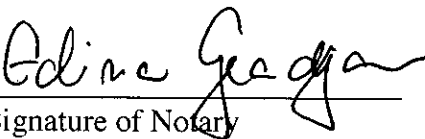
Sincerely,

x 

George Atia, M.D., S.C.

Notary:

Subscribed and sworn to before me this 9th day of JULY, 2018.


Signature of Notary

SEAL:



ATTACHMENT 6

Historic Resources Preservation Act Requirements

Included with this attachment is the letter from the Illinois Department of Natural Resources dated September 6, 2017 finding that there are no historic, architectural or archaeological sites within the project area is attached.



Illinois Department of Natural Resources

One Natural Resources Way Springfield, Illinois 62702-1271
www.dnr.illinois.gov

Bruce Rauner, Governor
Wayne A. Rosenthal, Director

FAX (217) 524-7525

Lake County

Barrington

CON - Interior Rehabilitation to Establish an Ambulatory Surgical Treatment Center, Illinois Center for
Digestive and Liver Health Barrington

200 Fox Glen

SHPO Log #014081817

September 6, 2017

Claire Reed

Barnes & Thornburg LLP

One North Wacker Dr., Suite 4400

Chicago, IL 60606-2833

Dear Ms. Reed:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact David Halpin, Cultural Resources Manager, at 217/785-4998.

Sincerely,

Rachel Leibowitz, Ph.D.

Deputy State Historic

Preservation Officer

ATTACHMENT 7

Itemization of Project Costs

Items	Cost
Consulting and Other Fees	
CON Application Fee	\$2,500
CON consulting fees	\$50,000
Attorney's fees	\$22,500
TOTAL PROJECT COSTS	\$75,000

ATTACHMENT 9

Cost Space Requirements

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept/Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
ASTC	\$40,000	3,350		0		3,350	0
Total Clinical	\$40,000	3,350		0		3,350	0
Nonreviewable							
Administration, Waiting Room, Reception, Medical Records, Other	\$35,000	1,500		0		1,500	0
Total Nonclinical	\$35,000	1,500		0		1,500	0
TOTAL	\$75,000	4,850		0		4,850	0

ATTACHMENT 11

Background of Applicants

1. The applicants do not own or operate any health care facilities.
2. Included with this attachment is the applicants' certification that they do not own or operate any health care facilities and, therefore, no adverse action has been taken against any facility owned or operated by the applicants during the three years prior to the filing of this application.
3. The attached letter also provides the applicants' authorization permitting HFSRB and IDPH access to any documents necessary to verify the information submitted, including but not limited to official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable, and the records of nationally recognized accreditation organizations.
4. The applicants have not previously submitted any applications for permit within the last calendar year.

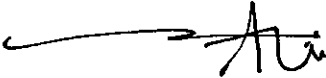
Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761
Attn: Courtney Avery

Dear Ms. Avery:

This letter is to certify that the applicants George N. Atia, M.D., S.C. and Aghapy Surgical Center, S.C. do not own or operate any health care facilities and, therefore, no adverse action has been taken against any health care facility owned and/or operated by the applicants during the three years prior to the filing of the Certificate of Need permit application to establish an ambulatory surgical treatment center at 200 Fox Glen Court, Barrington, Illinois.

Also, George N. Atia, M.D., S.C. and Aghapy Surgical Center, S.C. authorize the Illinois Health Facilities and Services Review Board and Illinois Department of Public Health ("IDPH") to have access to any documents necessary to verify the information submitted in the Certificate of Need application, including, but not limited to: (i) official records of IDPH or other State of Illinois agencies; (ii) the licensing or certification records of other states, when applicable; and (iii) the records of nationally recognized accreditation organizations.

Respectfully submitted,

X 

George N. Atia, M.D.

On behalf of George N. Atia, M.D., S.C. and Aghapy Surgical Center, S.C.

Notary:

Subscribed and sworn to me this 9th day of July, 2018



Notary Public

Seal:



ATTACHMENT 12

Purpose of the Project

1. *Document that the project will provide health services that improve the health care or well-being of the market area population to be served.*

The applicants propose an ASTC to provide gastroenterology services with two procedure rooms and eight recovery stations at 200 Fox Glen Court, Barrington, Illinois 60010. The ASTC will serve the patients of Dr. George Atia, and other gastroenterologists who practice with him, whose procedures that are currently being treated in hospital facilities. A significant percentage of their procedures are for Medicaid patients who do not have easy access to gastroenterology services at existing outpatient facilities. The proposed ASTC will allow these procedures to be performed at lower cost and in closer proximity to many of the patients. The ASTC will provide much-needed gastroenterology services and endoscopy screenings to the community.

The proposed ASTC will be located in the lower level of the George N. Atia M.D., S.C. medical practice and will be easily accessible to Dr. Atia's patients. The upper level of the building is a medical office building in which Dr. George Atia and other gastroenterologists who practice with him see patients. Dr. George Atia has been an Illinois-licensed physician and surgeon for approximately twenty years, primarily serving residents in the northwest suburban Chicago region. His medical corporation employs two other physicians and surgeons—Dr. Antwan Atia and Dr. Stacy McKelvey.

Dr. Atia's medical practice treats a relatively high percentage of Medicaid patients of over 14%. Medicaid patients do not have access to outpatient facilities because the procedures are not financially viable in an office setting due to the low reimbursement levels and most ASTCs, which can charge a facility fee, still do not accept Medicaid patients. Consequently, most Medicaid patients in need of gastroenterological surgical procedures most have the procedures done in a hospital. The proposed project will provide Medicaid patients with the convenience of an outpatient setting for their surgical procedures.

2. *Define the planning area or market area, or other relevant area, per the applicant's definition.*

The proposed ASTC will be located at 200 Fox Glen, Barrington, Illinois. The project's site is located within Health Service Area 8. The applicants propose a geographic service area ("GSA") that includes all zip codes that are within a forty-five minute drive time radius surrounding the site. Maps showing the project site and proposed GSA are included with this attachment.

3. *Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.*

The proposed ASTC will provide gastroenterology services, including cancer screenings, not currently available in the area to low-income Medicaid beneficiaries. The applicants' current patient mix includes approximately 14.5% Medicaid patients. By contrast, the 2016 ASTC facility profiles show that ASTCs in the area treated only 259 Medicaid patients out of 55,743 total patients, or less than one half of one percent. The applicant proposes to establish the ASTC to expand access to care for Medicaid patients in the area.

The proposed project will also provide cost savings to the Medicare program, as Medicare patients represent approximately 20% of the applicants' surgical procedures, as well as to providing cost savings to commercial payors. *See, Medicare Cost Savings Tied to Ambulatory Surgery Centers*, Ambulatory Surgery Center Association ("ASCA") and Berkeley, University of California, and *Commercial Insurance Cost Savings in Ambulatory Surgery Centers*, ASCA, included with this attachment.

4. *Cite the sources of the documentation.*

- 2016 ASTC Facility Profiles.
- *Medicare Cost Savings Tied to Ambulatory Surgery Centers*, ASCA and Berkeley, University of California
- *Commercial Insurance Cost Savings in Ambulatory Surgery Centers*, ASCA

5. *Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.*

The proposed ASTC will address the need and improve access to much-needed gastroenterological procedures and cancer screenings for residents of the service area. As noted above, the applicants have focused on providing services for Medicare and Medicaid beneficiaries, accounting for almost 40% of the practice's patients

6. *Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.*

The medical practice of the applicant George N. Atia, M.D., S.C., currently serves 14.5% Medicaid patients and 48% Medicare, and expects to continue to serve the same patient mix in the proposed ASTC. Consequently, the applicants expect to attain this same level of Medicaid and Medicare patients upon licensing of the facility as an ASTC.

ATTACHMENT 13

Alternatives

- 1) ***Identify all of the alternatives to the proposed project: Alternative options must include:***
 - A) ***Proposing a project of greater or lesser scope and cost;***
 - B) ***Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;***
 - C) ***Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and***
 - D) ***Provide the reasons why the chosen alternative was selected.***
- 2) ***Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. For every alternative identified, the total project cost and the reasons why the alternative was rejected must be provided.***

A. Proposing a project of greater or lesser scope and cost;

The proposed ASTC is intended to provide services to the applicant's existing patient volume which justifies the two procedure rooms and eight stations requested. A project of smaller scope would not be sufficient to serve existing patients. A project of larger scope is not needed and would be more costly.

B. Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

Existing area ASTCs limit access to Medicaid patients whereas the proposed project will be accessible to Medicaid patients and is intended to treat a relatively large percentage of Medicaid patients. Also, because the building in which Dr. Atia currently practices was built to ASTC licensing and Life Safety standards, the current location is the least costly alternative by far as it requires no new construction or modernization. To develop the proposed ASTC at an alternate site would increase the project cost by many millions of dollars as new construction would be required.

C. Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project;

As noted above, existing area ASTCs limit access to Medicaid patients whereas the proposed project will be accessible to Medicaid patients and is intended to treat a relatively large percentage of Medicaid patients. Also, some of the area hospitals do not accept applicant's higher volume of Medicaid patients and one of the hospitals does not

accept a number of the Medicaid managed care plans which the applicant accepts. There would be no cost to this alternative.

By establishing an ASTC, the applicants will be able to provide much-needed gastroenterology services to individuals residing in the surrounding area, including Medicaid beneficiaries, and the project cost of establishing the ASTC is only \$75,000.

- 3) *The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.*

The applicant will provide the same quality of care in the proposed ASTC that is currently provided to patients.

ATTACHMENT 14

Project Scope, Utilization, and Unfinished/Shell Space

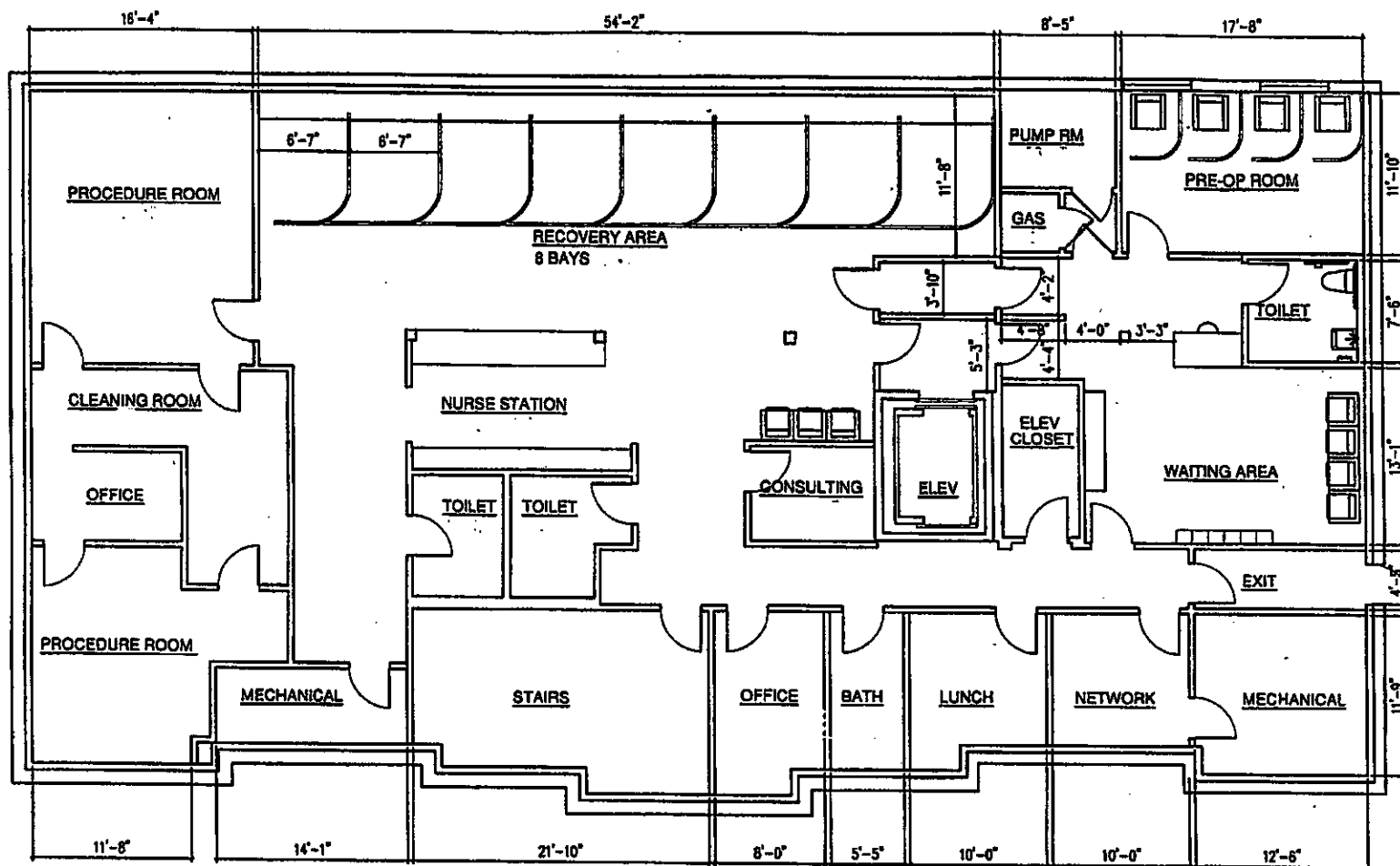
Size of Project

The Applicants propose to establish an ASTC with two procedure rooms and eight recovery stations. Pursuant to Section 1110, Appendix B of the Review Board's rules, the standard is 1660 to 2200 dgsf per procedure room.

Size of Project					
Department/Service	Rooms Proposed	Proposed BGSF	State Standard	Difference	Met Standard?
ASTC	Clinical	3,350	1660-2200 dgsf/rm (3,320-4,400 dgsf for two rooms)	(1050)	Yes
	Non-clinical	1,500	N/A		N/A
Total		4,850			

The State Board's guidelines regarding total departmental square footage ("DGSF") for a proposed ambulatory surgical treatment center ("ASTC") are shown in the above chart. The project meets the Board's Standards for the size of the project.

The existing floor plan of the facility is attached.



1 EXISTING BASEMENT FLOOR PLAN
 SCALE: 1/8" = 1'-0"

SK7

WNA
 WILLIAM A. NICHOLS ARCHITECTS
 ARCHITECTURE PLANNING INTERIOR DESIGN
 273 531 0045

200 FOX GLEN COURT

MEDICAL CLINIC
 SF CALCULATION

3.08.18

1/8"



48

#14

ATTACHMENT 15

Project Services Utilization

The projected utilization of services for which the Review Board has utilization standards is included in the table below. A narrative of the rationale supporting the utilization projections follows the table.

UTILIZATION					
	Dept./Service	Historical Utilization (Surgical Hours)	Projected Utilization	State Standard	Met Standard?
Year 1	ASTC		3,390 hours	3,000 hours	YES
Year 2	ASTC		3,390 hours	3,000 hours	YES

The applicants anticipate performing 4,520 procedures in the first year after completion, and at least that many procedures in the second year after project completion. The applicants anticipate that each procedure will average 45 minutes (0.75 hours) hours, resulting in 3,390 hours per treatment room by the second year of operation. This satisfies the state standard of 3,000 surgical hours per room for two rooms.

ATTACHMENT 16

Unfinished or Shell Space

The project has no shell space.

ATTACHMENT 25

Non-Hospital Based Ambulatory Surgery

1. Service to GSA Residents

The proposed ASTC will serve the geographic service area consisting of 45 minutes normal travel time of the ASTC. Attached is a chart showing the patient origin by zip code for patients treated by physicians referring to the proposed facility for the latest 12-month period. The patient zip codes are based on their residence as of the time of treatment. The chart shows that at least 50% of admissions will be residents of the geographic service area.

2. Service Demand – Establishment of an ASTC

The physician referral letters providing the number of patients referred for treatments to existing hospitals in the area in the past 12 months is attached. The total number of patients referred in the past 12 months and the projected number of referrals to the proposed ASTC during the first full year of operation are as follows:

12-month Period: July 2017-June 2018

TOTAL HOSPITAL PROCEDURES IN 12-MONTH PERIOD				
	Good Shepherd	St. Joseph	IMMC	Total
Dr. G. Atia	471	2869	137	3477
Dr. A. Atia	1667	329	16	2012
Dr. S. McKelvey	1285	201	11	1497
Total	3423	3399	164	6986

TOTAL HOSPITAL PROCEDURES TO BE REFERRED TO ASTC	
	Total
Dr. G. Atia	2250
Dr. A. Atia	1300
Dr. S. McKelvey	970
Total	4520

3. Treatment Room Need Assessment

The applicants propose to establish an ASTC with two procedure rooms. The target utilization is 1,500 hours per room, or 3,000 hours for two procedure rooms. The applicants project 4,520 surgical procedures in the first year after completion and estimates that the average length of time per procedure will average 0.75 hours for a total of 3,390 surgical hours. The applicants project at least 4,520 surgical procedures in the second year after project completion, or 3,390 surgical hours, meeting the annual minimum utilization for two procedure rooms which meets the state standard.

4. Service Accessibility

The proposed ASTC will improve access to gastroenterology services for patients in the GSA, especially for Medicaid and Medicare patients. According to the 2016 ASTC facility profiles, there were 14 ambulatory surgical treatment centers in Health Service Area 8 that served 55,743 total patients in 2016. Only 259 of those patients were Medicaid beneficiaries, and Medicaid accounted for only 0.1% of the net revenue by payor source for ASTCs in the Health Service Area.

The applicant's current payor mix includes approximately 14.5% Medicaid patients and 48% Medicare patients. ASTC services are less-costly than hospital outpatient surgical procedures, where the current Medicaid and Medicare procedures are being performed, so that the proposed project will reduce costs to both Medicaid and Medicare.

In addition, ASTCs are less expensive and more efficient than hospital outpatient departments. An analysis conducted by Healthcare Bluebook and HealthSmart on behalf of the Ambulatory Surgery Center Association found that out-of-pocket costs and deductibles were reduced for commercially insured patients at ASTCs in comparison to hospital outpatient departments, further promoting access to care. A copy of the analysis is included with this application.

5. Unnecessary Duplication

The facility will be located at 200 Fox Glen Court, Barrington, Illinois. A map of the proposed facility's market area is attached. A list of zip codes located, in total or in part, within 45 minutes normal travel time of the site of the proposed facility as well as 2015 census estimates for each zip code is provided in the attached table.

A list of all existing and approved health care facilities located within the Geographic Service area that provide the surgical services proposed by the project is attached.

6. Maldistribution

The project will not result in unnecessary duplication. The population of the GSA and names and locations of facilities that provide the proposed service are attached.

7. Impact on Area Providers

As noted earlier, few of the ASTCs in the Health Service Area service Medicaid beneficiaries. The Applicant's payor mix will include 17% Medicaid beneficiaries, patients who likely otherwise would not have access to ASTC services in the area. Because fewer of the ASTCs provide services to Medicaid beneficiaries, the Applicant would not have as much an impact on other providers in the region.

Also, none of the proposed patient volume is coming from any existing ASTC. Consequently, the proposed project will have no impact on existing ASTCs.

8. Staffing

The Center for Digestive and Liver Health will be staffed in accordance with all State and Medicare staffing requirements. It will be staffed as follows:

- 1 Administrator/Director of Clinical Operations
- 1 PA/NP
- 3 Registered Nurses
- 3 other health professionals
- 12 other non-health professionals

9. Charge Commitment

In accordance with Criterion 1110.235, the following procedures will be performed at the proposed following charges (excepting professional fee):

Procedure List and Charges		
CPT Code	Description	Charge
43235	EGD brushing washing including collection of specimen	1250
43236	EGD with submucosal injection	1500
43239	EGD	1500
43249	EGD with biopsy	1500
43250	EGD with removal of tumor hot snare	750
43251	EGD with removal of tumor snare	1600
43255	EGD with control bleed	1500
44377	EGD sm intestine with biopsy	1250
44378	EGD sm intestine with control bleed	1250
45330	Sigmoidoscopy	500
45331	Sigmoidoscopy with biopsy	750
45334	Sigmoidoscopy with control bleed	1300
45380	Colonoscopy	1800

45381	Colonoscopy with submucosal injection	1750
45382	Colonoscopy with control bleed	1800
45384	Colonoscopy with removal tumor, polyp	1600
45385	Colonoscopy with snare	2100
45398	Colonoscopy with banding	2100
46221	Hemorrhoidectomy	1750
46600	Endoscopy including collection of specimen(s) by brushing or washing	500
46930	Destruction of internal hemorrhoid(s)	1500
47000	Liver biopsy	1200
76942	Ultrasonic guidance for needle placement	650
91035	Bravo	1650

A letter from the applicant committing to maintain the above charges for the first two years of operation is included with this attachment.

10. Assurances

Included with this attachment is the applicant's letter certifying that the proposed facility shall implement a peer review program in accordance with Criterion 1110.235 and will achieve target utilization by the end of the second year of operation.

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761
Attn: Courtney Avery, Administrator

**RE: Physician Referral Letter
Aghapy Surgical Center, Barrington**

Dear Ms. Avery:

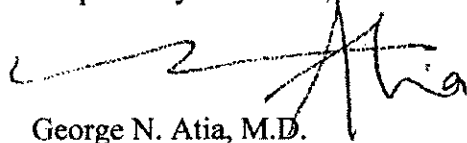
I am a physician licensed to practice medicine in Illinois and specialize in gastroenterology. My office address is 200 Fox Glen Court, Barrington, Illinois 60010.

In the 12-month period from July 2017 to June 2018, prior to the submission of the application for permit to establish an ambulatory surgical treatment center, the Aghapy Surgical Center, I have referred and performed the following number of patient procedures to IDPH-licensed hospitals located in the geographic service area of the proposed surgical center, and a list of the patient zip codes will be provided:

Hospital Name	Total Patient Procedures
Advocate Good Shepherd Hospital	471
St. Joseph Health Centers and Hospital	2,869
Illinois Masonic Medical Center	137
TOTAL	3,477

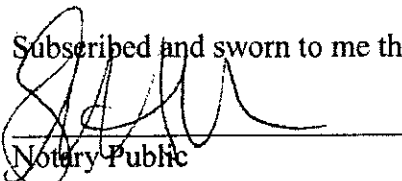
I anticipate that I will refer at least 2,250 of the above referrals to Aghapy Surgical Center within a 24-month period after project completion. I verify that these patient referrals have not been used to support another pending or approved certificate of need application for gastroenterology services.

Respectfully submitted,

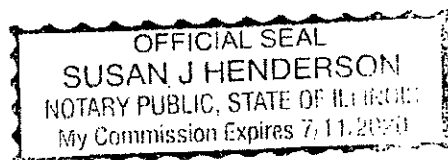

George N. Atia, M.D.

NOTARY:

Subscribed and sworn to me this 15 day of August, 2018.


Notary Public

Seal:



Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761
Attn: Courtney Avery, Administrator

**RE: Physician Referral Letter
Aghapy Surgical Center, Barrington**

Dear Ms. Avery:

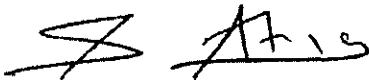
I am a physician licensed to practice medicine in Illinois and specialize in gastroenterology. My office address is 200 Fox Glen Court, Barrington, Illinois 60010.

In the 12-month period from July 2017 to June 2018, prior to the submission of the application for permit to establish an ambulatory surgical treatment center the Aghapy Surgical Center, I have referred and performed the following number of patient procedures to IDPH-licensed hospitals located in the geographic service area of the proposed surgical center, and a list of the patient zip codes will be provided:

Hospital Name	Total Patient Procedures
Advocate Good Shepherd Hospital	1,667
St. Joseph Health Centers and Hospital	329
Illinois Masonic Medical Center	16
TOTAL	2,012

I anticipate that I will refer at least 1,300 of the above referrals to Aghapy Surgical Center within a 24-month period after project completion. I verify that these patient referrals have not been used to support another pending or approved certificate of need application for gastroenterology services.

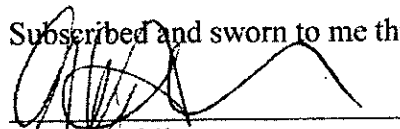
Respectfully submitted,



Antwan N. Atia, M.D.

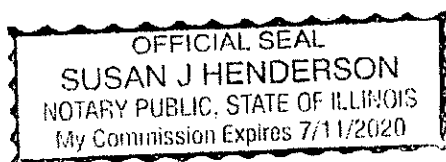
NOTARY:

Subscribed and sworn to me this 15 day of August, 2018.



Notary Public

Seal:



Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761
Attn: Courtney Avery, Administrator

**RE: Physician Referral Letter
Aghapy Surgical Center, Barrington**

Dear Ms. Avery:

I am a physician licensed to practice medicine in Illinois and specialize in gastroenterology. My office address is 200 Fox Glen Court, Barrington, Illinois 60010.

In the 12-month period from July 2017 to June 2018, prior to the submission of the application for permit to establish an ambulatory surgical treatment center the Aghapy Surgical Center, I have referred and performed the following number of patient procedures at IDPH-licensed hospitals located in the geographic service area of the proposed surgical center, and a list of patient zip codes will be provided:

Hospital Name	Total Patient Procedures
Advocate Good Shepherd Hospital	1,285
St. Joseph Health Centers and Hospital	201
Illinois Masonic Medical Center	11
TOTAL	1,497

I anticipate that I will refer at least 970 of the above referrals to Aghapy Surgical Center within a 24-month period after project completion. I verify that these patient referrals have not been used to support another pending or approved certificate of need application for gastroenterology services.

Respectfully submitted,

SMcKelvey MD

Stacey L. McKelvey, M.D.

NOTARY:

Subscribed and sworn to me this 15 day of August, 2018.

[Signature]
Notary Public

Seal:



Aghapy Surgical Center

Zip Codes of patients for referring physicians Dr. George Atia, Dr. Antwan Atia
and Dr. Stacey McKelvey (Zip Codes with only one patient excluded)

Zip Code	Count
60010	732
60014	585
60013	427
60047	394
60640	333
60660	308
60657	297
60084	249
60102	247
60050	212
60614	196
60156	182
60613	177
60618	172
60626	168
60051	159
60021	154
60067	139
60042	131
60142	118
60110	115
60610	113
60625	113
60647	113
60012	108
60645	92
60641	81
60074	78
60659	66
60073	59
60639	58
60118	54
60622	53
60202	51
60097	46
60169	41
60634	41
60192	39
60646	39
60123	37
60107	35

Zip Codes w/in 45min Travel Time	Population (est 2015)
60002	24,340
60004	50,639
60005	29,942
60007	33,952
60008	22,043
60010	44,331
60012	10,960
60013	26,242
60014	48,868
60015	27,356
60016	61,096
60018	29,351
60020	9,875
60021	5,455
60025	39,525
60026	14,376
60030	36,649
60031	37,800
60035	29,806
60041	9,192
60042	8,603
60044	9,715
60045	20,514
60046	35,013
60047	42,330
60048	28,966
60050	31,809
60051	24,769
60056	55,803
60060	38,138
60061	26,352
60062	40,344
60067	37,899
60068	37,608
60069	8,572
60070	16,147
60071	3,520
60072	910
60073	61,118
60074	39,757
60081	9,874
60083	10,676

Zip Codes w/in 45min Travel Time	Population (est 2015)
60084	15,695
60085	71,051
60089	41,594
60090	38,014
60093	19,447
60097	10,623
60098	32,354
60099	31,147
60101	39,918
60102	32,813
60103	42,429
60106	20,083
60107	41,320
60108	23,213
60110	39,334
60118	15,681
60120	50,564
60123	48,890
60124	20,912
60126	47,403
60131	18,125
60133	38,488
60136	7,338
60140	15,224
60142	27,080
60143	10,435
60152	12,943
60156	28,900
60157	2,097
60160	25,656
60163	5,217
60164	22,035
60169	34,164
60171	10,299
60172	24,793
60173	12,361
60174	31,747
60176	11,834
60177	22,869
60180	1,582
60184	2,296
60191	14,469
60192	16,695
60193	39,839

Zip Codes w/in 45min Travel Time	Population (est 2015)
60194	19,164
60195	4,915
60631	28,255
60634	74,093
60656	28,526
60706	23,452

Source: The above-referenced data was obtained from the U.S. Census Bureau using American Fact Finder available on the internet at:

<https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>.

The census data is the most recent data available for the State of Illinois by zip code. The data is from the 2015 American Community Survey - Five Year Population Estimates.

11003

TOTAL POPULATION

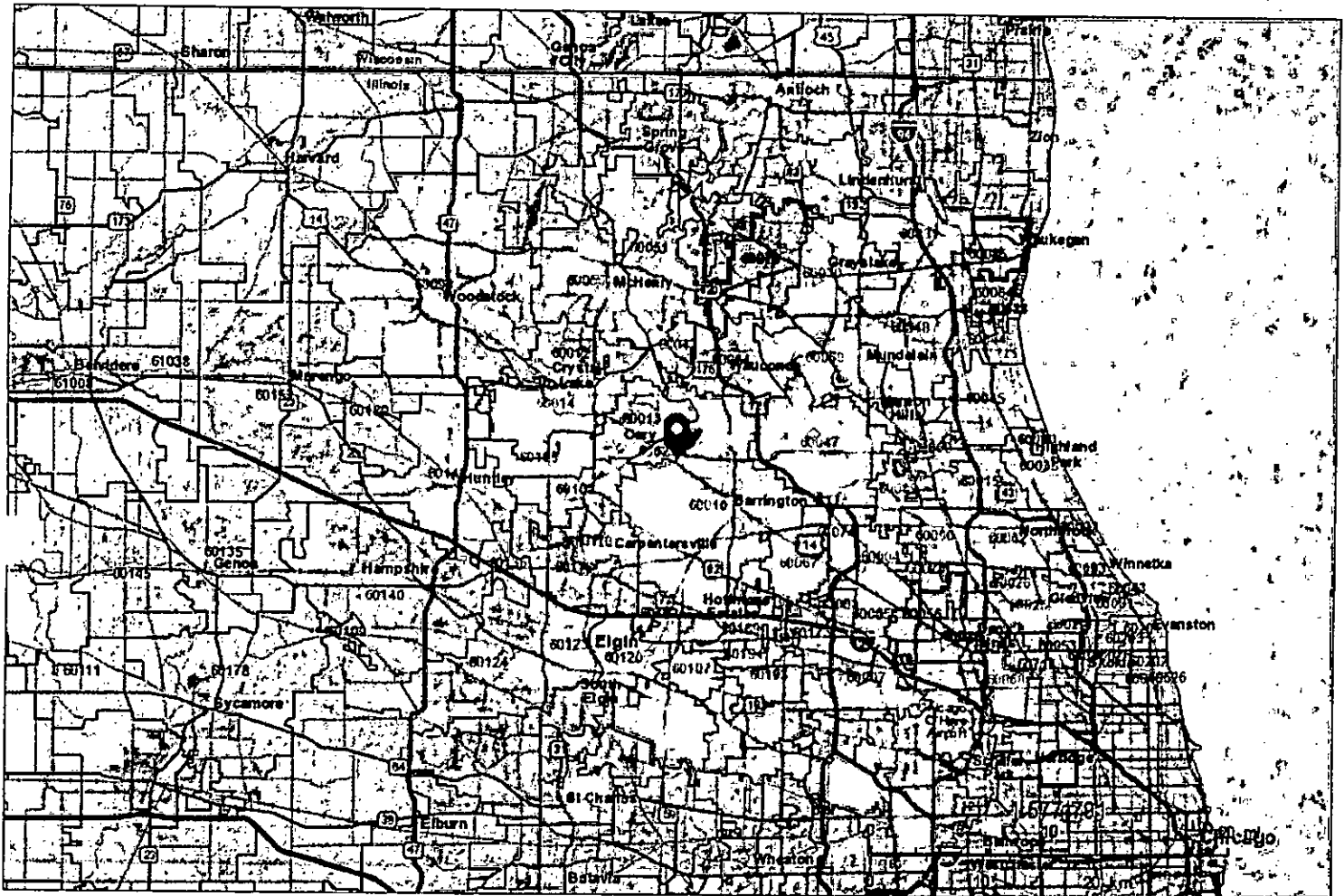
Universe: Total population

2011-2015 American Community Survey 5-Year Estimates

Criterion 1110.1540 – Geographic Service Area Need

Thematic Map of Estimate; Total

Geography by: 5-Digit ZCTA



Legend

Data Classes

- ☐ 910 - 12,943
- ☐ 14,376 - 23,452
- ☐ 24,340 - 35,013
- ☐ 36,649 - 50,639
- ☐ 55,803 - 74,093

2015 Boundaries

- ☐ 5-Digit ZCTA

Supporting documentation on code lists, subject definitions, data accuracy, and statistical testing can be found on the American Community Survey website in the Data and Documentation section.

Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the American Community Survey website in the Methodology section.

Tell us what you think. Provide feedback to help make American Community Survey data more useful for you.

Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census

Advocate Condell Ambulatory Surgical Treatment Center	825 South Milwaukee	Libertyville	IL	60048
Lindenhurst Surgery Center	1050 RED OAK LANE	LINDENHURST	IL	60046
NORTH SHORE ENDOSCOPY CENTER	988 Carriage Park Avenue	LAKE BLUFF	IL	60144
Presence Mercy Center	1325 North Highland Avenue	Aurora	IL	60506-1458
Delnor Community Hospital	300 Randall Road	Geneva	IL	60134-0000
Centegra Hospital - Huntley	10400 Haligus Road	Huntley	IL	60142
Presence Saint Joseph Hospital	77 North Airlite Street	Elgin	IL	60120-0000
Sherman Hospital	934 Center Street	Elgin	IL	60120-0000
Advocate Good Samaritan Hospital	3815 Highland Avenue	Downers Grove	IL	60515-0000
Adventist Hinsdale Hospital	120 North Oak Street	Hinsdale	IL	60521-0000
Central DuPage Hospital	Hospital Road	Winfield	IL	60190-0000
St. Alexius Medical Center	1555 Barrington Road	Hoffman Estates	IL	60169
Adventist Glen Oaks Medical Center	701 Winthrop Avenue	Glendale Heights	IL	60139-0000
Alexian Brothers Medical Center	800 Biesterfield Road	Elk Grove Villa	IL	60007-0000
Elmhurst Memorial Hospital	York Rd & Roosevelt Rd	Elmhurst	IL	60126-0000
Northwest Community Hospital	800 West Central Road	Arlington Heights	IL	60005-0000
Adventist LaGrange Memorial Hospital	5101 Gilbert Avenue	LaGrange	IL	60525-0000
VHS Westlake Hospital	1225 W Lake St	Melrose Park	IL	60160-0000
Loyola University Medical Center/Foster G. McGaw	2160 South 1st Avenue	Maywood	IL	60153-0000
Rush Oak Park Hospital	520 South Maple Street	Oak Park	IL	60304-0000
Loyola Health System at Gottlieb	701 West North Avenue	Melrose Park	IL	60160-0000
Presence Resurrection Medical Center	7435 West Talcott Avenue	Chicago	IL	60631-0000
Loretto Hospital	645 South Central Avenue	Chicago	IL	60644-0000
Shriner's Hospitals for Children	2211 North Oak Park	Elmwood Park	IL	60707
VHS West Suburban Medical Center	622 North Austin Ave	Oak Park	IL	60302-0000
Presence Our Lady of Resurrection Medical Center	5645 West Addison Street	Chicago	IL	60634-0000
Advocate Lutheran General Hospital	1800 Parkside Dr	Park Ridge	IL	60068-0000
Presence Holy Family Hospital	100 North River Road	Des Plaines	IL	60016-1278
Glenbrook Hospital	2100 Pfingsten Road	Glenview	IL	60025-0000
Skokie Hospital	9600 Gross Point Road	Skokie	IL	60076-0000
Saint Mary Of Nazareth Hospital	2233 West Divison Street	Chicago	IL	60622-0000
St. Elizabeth's Hospital	1431 North Claremont	Chicago	IL	60622-0000
Swedish Covenant Hospital	5145 North California Avenue	Chicago	IL	60625-0000
Advocate Illinois Masonic Medical Center	836 West Wellington	Chicago	IL	60657-5193

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#25

Thorek Memorial Hospital	850 West Irving Park	Chicago	IL	60613-0000
Ann & Robert Lurie Children's Hospital of Chicago	2300 Childrens Plaza	Chicago	IL	60614-0000
Presence Saint Joseph Hospital	2900 North Lake Shore W	Chicago	IL	60657-0000
Centegra Hospital - Woodstock	3501 Doty Road	Woodstock	IL	60098-0000
Centegra Hospital - McHenry	4201 Medical Center Drive	McHenry	IL	60050-0000
Advocate Good Shepherd Hospital	100 Haverton Way	Barrington	IL	60010-0000
Advocate Condell Medical Center	801 South Milwaukee Avenue	Libertyville	IL	60048-0000
Northwestern Lake Forest Hospital	660 North Westmoreland	Lake Forest	IL	60045-0000
Highland Park Hospital	718 Glenview Avenue	Highland Park	IL	60035-0000

66

#25

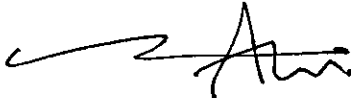
Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761
Attn: Courtney Avery, Administrator

RE: Charge Commitment

Dear Ms. Avery:

Pursuant to 77 Ill. Admin. Code 1110.1540(j), a statement of all charges, except for any professional fees, is attached to this letter. I hereby commit that the attached charge schedule will not be increased, at a minimum, for the first two (2) years of operation following the establishment and opening of the proposed ASTC, which will be located at 2475 Dean Street, St. Charles, Illinois.

Respectfully submitted,

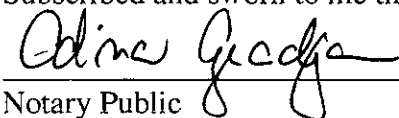
X 

George N. Atia, M.D.

2

NOTARY:

Subscribed and sworn to me this 9th day of July, 2018.


Notary Public

Seal:



Procedure List and Charges		
CPT Code	Description	Charge
43235	EGD brushing washing including collection of specimen	1250
43236	EGD with submucosal injection	1500
43239	EGD	1500
43249	EGD with biopsy	1500
43250	EGD with removal of tumor hot snare	750
43251	EGD with removal of tumor snare	1600
43255	EGD with control bleed	1500
44377	EGD sm intestine with biopsy	1250
44378	EGD sm intestine with control bleed	1250
45330	Sigmoidoscopy	500
45331	Sigmoidoscopy with biopsy	750
45334	Sigmoidoscopy with control bleed	1300
45380	Colonoscopy	1800
45381	Colonoscopy with submucosal injection	1750
45382	Colonoscopy with control bleed	1800
45384	Colonoscopy with removal tumor, polyp	1600
45385	Colonoscopy with snare	2100
45398	Colonoscopy with banding	2100
46221	Hemorrhoidectomy	1750
46600	Endoscopy including collection of specimen(s) by brushing or washing	500
46930	Destruction of internal hemorrhoid(s)	1500
47000	Liver biopsy	1200
76942	Ultrasonic guidance for needle placement	650
91035	Bravo	1650

Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

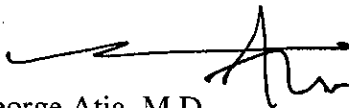
RE: Illinois Center for Digestive and Liver Health

Dear Ms. Avery:

In accordance with 77 Ill. Admin. Code 1110.1540(k), I attest that a peer review program will be implemented that evaluates whether patient outcomes are consistent with quality standards established for ambulatory surgical treatment center services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

In addition, by the second year of operation after the project completion date, the annual utilization of the surgical treatment rooms will meet or exceed the utilization standards set forth in the Illinois administrative code. Documentation to support this certification is included with this Certificate of Need application.

Respectfully submitted,

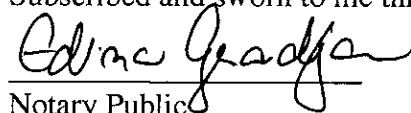
x 

George Atia, M.D.

Owner, George N. Atia, M.D., S.C. and Aghapy Surgical Center, S.C.

NOTARY:

Subscribed and sworn to me this 9th day of July, 2018



Notary Public

Seal:





Medicare Cost Savings Tied to Ambulatory Surgery Centers

ASCA
Ambulatory Surgery Center Association

Produced with cost
savings analysis from

Berkeley
UNIVERSITY OF CALIFORNIA

70

#25

Acknowledgements

Dr. Brent Fulton, Assistant Adjunct Professor and Research Economist, and Dr. Sue Kim, Research Scientist, both from the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, University of California-Berkeley, conducted the cost savings analysis presented in this report.

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EXECUTIVE SUMMARY

Even in today's divisive political environment, there's at least one important area of consensus among policymakers: the threat posed by rising health care costs to both our national economy and the federal and state governments' balance sheets. This concern is particularly acute in the Medicare program, where costs are expected to rise dramatically as new treatments are developed and a generation of Baby Boomers enters retirement. Burgeoning health care costs, it seems certain, will be near the top of Washington, DC's agenda for years to come.

As they work to reduce health care costs and extend the solvency of programs like Medicare, policymakers will confront tough choices in the months and years ahead. Yet, they must also be alert for reforms that cut costs while maintaining quality services for beneficiaries. This analysis by Professor Brent Fulton and Dr. Sue Kim of the University of California at Berkeley explores one possible way for policymakers to generate substantial Medicare savings without reducing services or quality of care.

This study examines ambulatory surgery centers (ASCs). ASCs are technologically advanced medical facilities that provide same-day surgical procedures, including important diagnostic and preventive services like colonoscopies. Today, more than 5,300 Medicare-certified ASCs serve communities throughout our nation. These ASCs perform many of the same procedures as hospital outpatient departments (HOPDs). ASCs, however, are able to provide care much more efficiently and without the often costly overhead associated with hospitals. According to an industry calculation, the Medicare program currently reimburses ASCs at 58 percent of the HOPD rate, meaning that Medicare—and the taxpayers who fund it—realize savings every time a procedure is performed in an ASC instead of an HOPD.

When one considers the millions of same-day surgical procedures performed in ASCs through the Medicare program each year, the nationwide savings add up quickly. In this study, University of California at Berkeley's Professor Brent Fulton and Dr. Sue Kim analyze the numbers to determine how much ASCs save the Medicare program and its beneficiaries. They begin by analyzing government data to identify how much money ASCs saved Medicare in recent years, and then, forecast how much more ASCs will save Medicare in the future. The key findings are the following:

- During the four-year period from 2008 to 2011, ASCs saved the Medicare program and its beneficiaries \$7.5 billion. ASCs saved Medicare and its beneficiaries \$2.3 billion in 2011 alone.

- \$6 billion of these savings were realized by the federal Medicare program. The remaining \$1.5 billion went directly to Medicare beneficiaries. In other words, Medicare patients nationwide saved \$1.5 billion thanks to the less expensive care offered at ASCs.
- ASCs have the potential to save the Medicare program and its beneficiaries up to \$57.6 billion more over the next decade.
- Beneficiaries themselves also stand to save considerably in future years. Because Medicare reimburses ASCs at a lower rate than HOPDs, patients also pay a smaller coinsurance amount in an ASC. The authors use the example of cataract surgery, noting that a Medicare beneficiary will save \$148 on his or her coinsurance by electing to undergo surgery in an ASC instead of a hospital.



These findings have important implications for policymakers' ongoing discussion about how to most effectively reduce health care costs and the national budget deficit. The clearest implication is that, while public officials may indeed confront tough choices in the years ahead, the choice to encourage ASC use within the Medicare program is an easy decision. These findings suggest that ASCs offer a "win-win" for patients and the Medicare system, since they provide substantial savings without any corresponding reduction in quality or benefits.

While the future savings offered by ASCs are easily attainable, however, they are not inevitable. Indeed, a discrepancy in Medicare reimbursement policy could jeopardize the savings ASCs provide. Medicare uses two different factors to update ASC and HOPD payments—despite the fact that the two settings provide the same surgical services. ASC payments are updated based on the consumer price index for all urban consumers (CPI-U), which measures changes in the costs of all consumer goods; HOPD rates, meanwhile, are updated on the hospital market basket, which specifically measures changes in the costs of providing health care, and so, more accurately reflects the increased costs that outpatient facilities face.

Since consumer prices have inflated more slowly than medical costs, the gap in ASC and HOPD reimbursement

rates has widened over time. If the reimbursement rate for ASCs continues to fall relative to their HOPD counterparts, ASC owners and physicians will face increasing pressure to leave the Medicare system and allow their facilities to be acquired by nearby hospitals. When an ASC is acquired by a hospital, the Medicare reimbursement rate jumps roughly 75 percent. This threatens to turn the cost-saving advantage of ASCs into a perverse market incentive that drives ASCs from the Medicare program.

Already, the widening disparity in reimbursement has led more than 60 ASCs to terminate their participation in Medicare over the last three years. If the reimbursement gap continues to widen, more ASCs will leave the Medicare program. As a result, more Medicare cases will be driven to the HOPD, causing costs to both the Medicare program and its beneficiaries to rise.

Thus, realizing the full potential savings that ASCs offer will likely require policymakers to step in and halt this continuing "slide" in ASC reimbursement rates. Because Medicare saves money virtually every time a procedure is performed in an ASC instead of an HOPD, any policies that reduce the widening reimbursement gap between ASCs and HOPDs, and that otherwise encourage the migration of cases from the hospital setting into ASCs, will increase total savings for the Medicare program and its beneficiaries.

I. AN INTRODUCTION TO AMBULATORY SURGERY CENTERS

Only 40 years ago, virtually all surgeries and diagnostic procedures were performed in hospitals. Today, however, standalone facilities known as Ambulatory Surgery Centers (ASCs) provide outpatient surgical care in an atmosphere removed from the competing demands that are often encountered in an acute care hospital.

ASCs, as this report details, offer patients a cost-effective alternative to hospital outpatient departments (HOPDs). The first ASC opened in 1970, and today, there are more than 5,300 Medicare-certified ASCs in the United States. The overwhelming majority of these ASCs are at least partially owned by physicians, which allows for better control over scheduling, as procedures are not often delayed or rescheduled due to staffing issues or competing demands for operating room space from emergency cases.

ASC surgeons perform a diverse range of procedures, many of them diagnostic or preventive in nature. For example:

- ASCs perform more than 40 percent of all Medicare colonoscopies, contributing to a decade-long decline in colorectal cancer mortality.
- The ASC industry also led the development of minimally invasive procedures and the advancement of technology to replace the intraocular lens, a procedure that is now used nearly one million times each year to restore vision for Medicare patients with cataracts. Once an inpatient hospital procedure, it can now be performed safely at an ASC at a much lower cost.

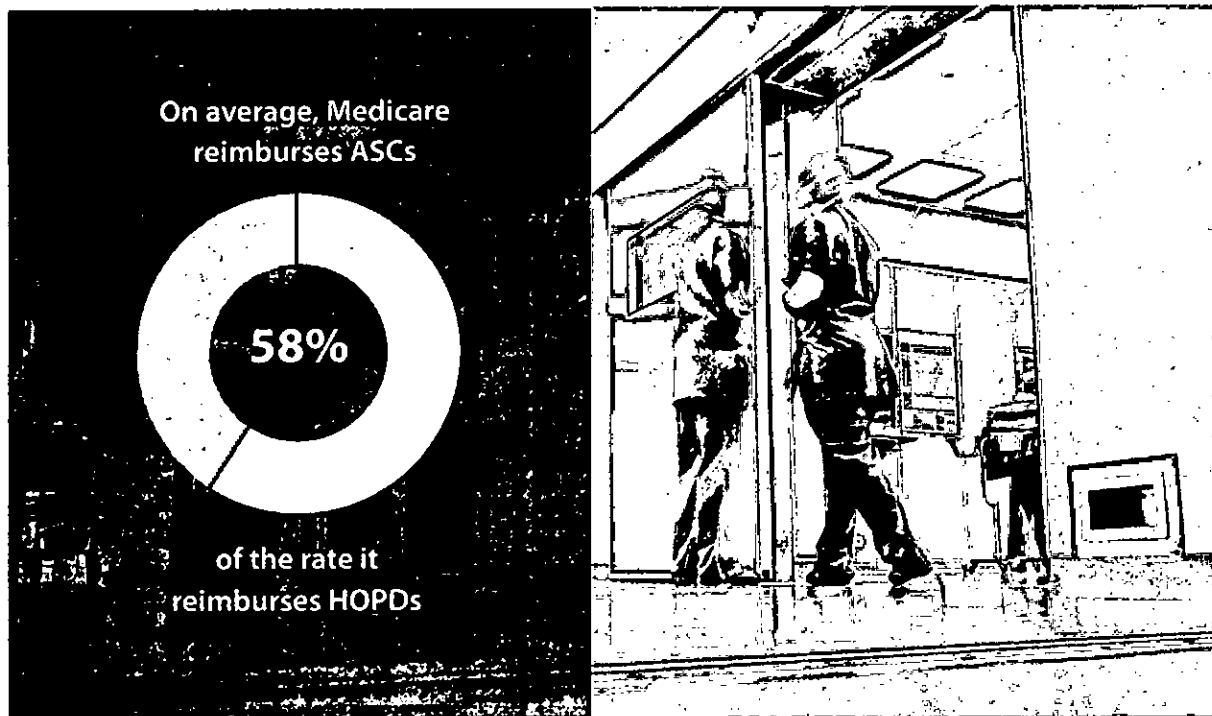
Ambulatory Surgery Centers are modern health care facilities focused on providing a range of same-day surgical care, the same types of procedures that were once performed exclusively in hospitals. Today, as a result of medical advancements and new technologies—including minimally invasive surgical techniques and improved anesthesia—a range of procedures can be performed safely and effectively on an outpatient basis.

II. ASCS: SAVING THE SYSTEM

The more than 5,300 Medicare-certified ASCs in the United States today provide identical services to those performed at HOPDs throughout the country. ASCs are able to perform these surgeries much more efficiently than HOPDs. ASCs do not incur the often substantial administrative and overhead costs associated with a hospital. This enables ASCs to provide these services at substantially less cost to the Medicare program—and to its beneficiaries—than their hospital counterparts.

Today, Medicare reimburses ASCs at an average of 58 percent of the rate it reimburses HOPDs for the same procedures.

The savings that accrue over time, even for individual procedures, are significant. For example, in 2011, Medicare beneficiaries (excluding Medicare Advantage beneficiaries) had 1,709,175 cataract surgeries, of which, 1,120,388 were performed in ASCs and the other 588,787 in HOPDs. The parallel reimbursements per surgery were \$951 for an ASC and \$1,691 for an HOPD, meaning that every time a patient elected to receive treatment in an ASC, the Medicare program saved \$740. When applied across the 1,120,388 cataract surgeries performed in ASCs during 2011, the total savings for this single procedure reached \$829 million.



These findings are illustrated in the following chart.

Descriptor	Annual Change	Total (2008—2011)	2008	2009	2010	2011
Number of procedures per 1,000 Medicare beneficiaries	5.6%		573.9	587.3	600.3	674.9
Procedures (million)						
ASC	4.7%	19.5	4.7	4.7	4.8	5.4
HOPD	5.9%	22.3	5.3	5.3	5.4	6.3
Physician office	7.7%	45.5	10.4	10.8	11.3	13.0
Total # of procedures	6.6%	87.3	20.4	20.8	21.5	24.7
ASC share*	1.5%	22.3%	22.9%	22.7%	22.3%	21.7%
Savings (\$billion) **						
Program	16.6%	\$6.0	\$1.2	\$1.4	\$1.5	\$1.9
Beneficiaries	14.8%	\$1.5	\$0.3	\$0.4	\$0.4	\$0.5
Total***	16.3%	\$7.5	\$1.5	\$1.8	\$1.9	\$2.3

Notes:

*The ASC share reported in the table is influenced by (or weighted for) high-volume procedures, such as cataracts. The analysts also calculated the ASC share based on a simple average across the 120 procedures. The ASC shares for 2008 to 2011 were 30.4%, 31.0%, 31.4% and 31.8%, respectively, each year, and averaged 31.1% over the four years.

**Savings are reported in nominal dollars.

***Totals may not sum and percentages may not total to 100% due to rounding.

Future Savings

The ASC industry is certain to continue generating savings to both the Medicare program and its beneficiaries over the next decade. The magnitude of these savings, however, will hinge on whether, and how much, the ASC share of surgeries grows within the Medicare program. That growth rate will, in turn, depend on market trends, demographic factors and how policymakers act—or decline to act—to encourage the use of ASCs within the Medicare program.

To estimate the savings Medicare would realize from having more procedures performed in ASCs from 2013 to 2022, Professor Fulton and Dr. Kim applied the methodology above to six scenarios. These six scenarios, which incorporate different assumptions about both the growth of ASC share and the overall growth of Medicare procedure rates, provide a range of possible savings offered by ASCs in the next decade.

The analysts divided the scenarios into two subsets. For subset A, they assumed that the number of procedures per 1,000 Medicare beneficiaries would remain constant at the 2010 rate. For subset B, they assumed that the 2011 rate would increase by 3 percent annually for each procedure.⁵ Within each subset, the analysts examined three scenarios:

1. The ASC share of each procedure in 2011 will remain constant between 2013 and 2022. *This is a baseline assumption that assumes ASC share does not grow at all in the coming decade.*
2. The ASC share of each procedure will increase by 2 percent per year from 2013 through 2022, equivalent to the average increase across procedures from 2008 through 2011.⁶ The analysts capped the share for any given procedure at 90 percent to avoid implausible assumptions.
3. The ASC share growth for each procedure will vary depending on that procedure's historical share growth rate. The analysts assumed three growth rates and, again, capped the share for any single procedure at 90 percent.
 - The "low" group included procedures that had negative or no growth in the share of procedures performed at ASCs during 2008–2011. The analysts assumed that the ASC share of these procedures will increase 1 percent annually from 2013–2022. This group included approximately 30 percent of the procedures.
 - The "middle" group included procedures that had up to 5 percent growth in share of procedures performed at ASCs during 2008–2011. It was assumed that the ASC share of these procedures will increase 5 percent annually from 2013–2022. This group included approximately 43 percent of the procedures.
 - The "high" group included procedures that had greater than 5 percent growth in share of procedures performed at ASCs during 2008–2011. This group had a median ASC share growth rate of about 11 percent annually during 2008–2011. The analysts projected that the ASC share of these procedures will increase 10 percent annually from 2013–2022. This group included approximately 27 percent of the procedures.

The estimated savings are tabulated in the following table. The savings analysis and predictions for each individual procedure are tabulated in the appendix.

5 The number of procedures per 1,000 Medicare beneficiaries significantly increased between 2010 and 2011 (see table on page 9). For the lower-savings estimates (subset A), the lower 2010 rate was used as a baseline. For the higher-savings estimates (subset B), the 2011 rate was used as the baseline.

6 The 2% annual average increase is based on a simple average across the 120 procedures, meaning the average is not influenced by (or weighted for) for high-volume procedures, such as cataracts.

Projected Savings (\$Billion)	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013-2017	2018-2022	2013-2022
A. Volume of Procedures per 1,000 Medicare Beneficiaries Remains Constant and:													
A1. ASC share remains constant	\$2.3	\$2.5	\$2.8	\$3.0	\$3.2	\$3.3	\$3.5	\$3.7	\$4.0	\$4.2	\$13.7	\$18.7	\$32.5
A2. ASC share increases at 2% annually	\$2.4	\$2.7	\$3.0	\$3.3	\$3.6	\$3.8	\$4.1	\$4.4	\$4.8	\$5.2	\$14.9	\$22.5	\$37.3
A3. ASC share increases either 1%, 5% or 10% annually (depending on the procedure)	\$2.5	\$2.8	\$3.1	\$3.5	\$3.8	\$4.2	\$4.6	\$5.0	\$5.5	\$6.0	\$15.7	\$25.3	\$41.0
B. Volume of Procedures per 1,000 Medicare Beneficiaries Increases by 3% Annually and:													
B1. ASC share remains constant	\$2.8	\$3.1	\$3.5	\$3.9	\$4.3	\$4.7	\$5.1	\$5.5	\$6.0	\$6.6	\$17.6	\$27.9	\$45.5
B2. ASC share increases at 2% annually	\$2.9	\$3.3	\$3.8	\$4.3	\$4.8	\$5.4	\$5.9	\$6.6	\$7.4	\$8.2	\$19.1	\$33.4	\$52.6
B3. ASC share increases either 1%, 5% or 10% annually (depending on the procedure)	\$3.0	\$3.5	\$4.0	\$4.6	\$5.2	\$5.8	\$6.6	\$7.4	\$8.3	\$9.4	\$20.2	\$37.5	\$57.6

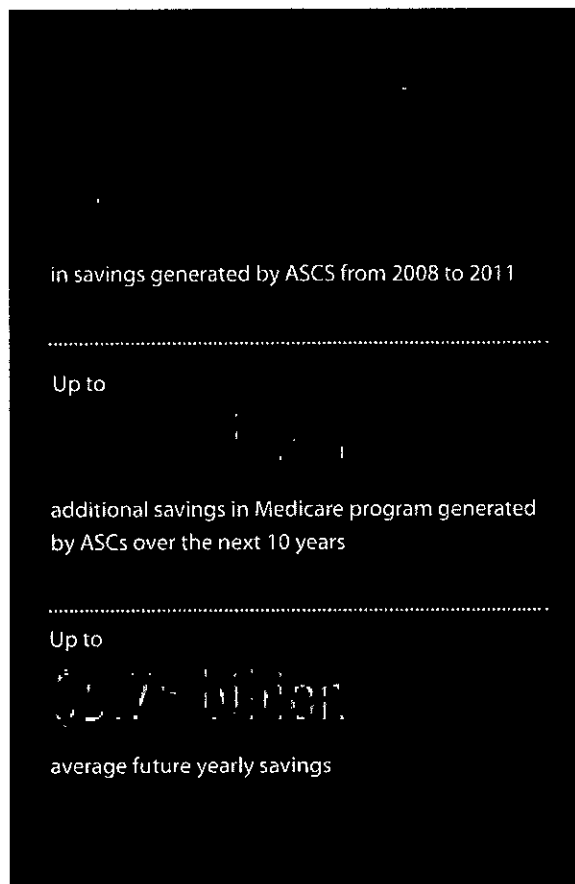
Note: Savings are reported in nominal dollars. In all scenarios, the Berkeley analysts inflated the reimbursement amounts over time using a forecasted Consumer Price Index for All Urban Consumers, which averaged 2.4% from 2013–2022.

Conclusions

ASCs saved the Medicare program and its beneficiaries \$7.5 billion over the four-year period from 2008 to 2011. Even under the most conservative assumptions, the future savings generated by ASCs are substantial.

- Under the baseline scenario, which assumes that neither ASC share nor Medicare procedure volume will grow over the next decade, ASCs will save the Medicare program an additional \$32.5 billion during that time.
- As the share of procedures performed in ASCs grows within the Medicare program, so do the savings. If ASC share within the Medicare system increases even slightly, as in scenarios B2 and B3, the savings could exceed \$57.6 billion over 10 years—an average savings of \$5.76 billion each year.
- Medicare beneficiaries also save money by choosing ASCs, since a lower Medicare reimbursement rate means that patients, in turn, pay a smaller coinsurance. While the forward-looking portion of this study does not examine coinsurance rates for each procedure, it is clear that the savings realized by the Medicare program imply additional savings for beneficiaries. Using the example of cataract surgeries: a Medicare beneficiary will pay coinsurance of \$338.20 for such a surgery to be performed in an HOPD, but only \$190.20 for that same surgery in an ASC—a \$148 savings that goes directly to the patient.

Further, the above estimates are quite conservative. Even the most “optimistic” scenario assumes that ASC share growth per procedure grows only modestly more quickly than historical averages, and that Medicare volume grows at a modest, and historically consistent, rate. If policy decisions or other factors cause either growth rate to accelerate further, the savings generated by ASCs within the Medicare system would certainly exceed the \$57.6 billion estimated here.



A final note: although this study examined only data from the Medicare program, ASCs typically also charge private payers, including those in the Medicare Advantage program, less than their HOPD counterparts. Thus, similar cost savings also exist in the commercial health insurance market and in the Medicare Advantage program. We believe it is important to quantify these private-side savings as well and encourage others to examine this subject in future studies.

IV. POLICY IMPLICATIONS AND CONSIDERATIONS

An aging population, along with inflation in health care costs, means that the federal government's expenditures through the Medicare program are projected to increase substantially in the coming years. Consequently, policymakers in Washington, DC, are exploring potential ways to reduce projected Medicare outlays and extend the program's solvency. We believe that this study offers an important contribution to that discussion. Two specific policy concerns stand out.

AVOIDING ASC TO HOPD CONVERSIONS

Our first and most important observation is that, while the future savings offered by ASCs are easily attainable, they are not inevitable. Because they provide identical services to HOPDs but do so at an average of 58 percent of the reimbursement rate that the Medicare program pays HOPDs for those services, ASCs represent a source of value to the program and the taxpayers who fund it. A discrepancy in the way Medicare reimbursement rates are updated, however, threatens to marginalize ASCs' role within the program.

CMS currently applies different measures of inflation to determine the adjustments it provides to its payment systems for ASCs and HOPDs each year. For ASCs, that measure is the CPI-U, which is tied to consumer prices. The index for HOPD reimbursements, on the other hand, remains tied to the hospital market basket, which measures inflation in actual medical costs. Since consumer prices have inflated more slowly than medical costs, the gap in ASC and HOPD reimbursement rates has widened over time. As the reimbursement rate for ASCs continues to fall relative to their HOPD counterparts, ASC owners and physicians will face increasing pressure to leave the Medicare system and allow their facilities to be acquired by nearby hospitals.

When an ASC is acquired by a hospital, in what is known as "an ASC to HOPD conversion," the Medicare reimbursement rate jumps roughly 75 percent and all savings to the Medicare program and its beneficiaries are promptly lost. The

continuing reduction in reimbursement led more than 60 ASCs to terminate their participation in Medicare over the last three years. If policymakers allow this gap in reimbursements to continue widening, the cost-saving advantage that ASCs offer could morph into a perverse market incentive that drives ASCs from the Medicare program.

Some in Congress have introduced legislation, which is titled the "Ambulatory Surgical Center Quality and Access Act," that aims to fix this problem. This bill would correct the imbalance in reimbursement indices and ensure that ASC reimbursements do not continue to fall relative to their HOPD counterparts. Additionally, it would establish an ASC value-based purchasing (VBP) program designed to foster collaboration between ASCs and the government and create additional savings for the Medicare system in the process.

ASCs AS PART OF BROADER COST-SAVINGS EFFORTS

Many of the policy options aimed at reducing Medicare costs that are being considered in Congress today involve important "trade-offs," where reduced outlays come at the expense of retirees' benefits. Often-discussed options such as raising the Medicare retirement age or increasing cost-sharing, for example, generate savings as a direct result of reducing the amount of benefits delivered by the Medicare program. The savings offered by ASCs, however, do not involve such trade-offs; they make it possible for the Medicare program, and its beneficiaries, to realize significant savings without any corresponding reduction in benefits.

There are more than 5,300 Medicare-certified ASCs throughout the country, all of which represent an important source of efficiency for the Medicare program and the taxpayers who fund it. We recommend that policymakers explore all potential options for encouraging further growth of ASC share within the Medicare system.

APPENDIX: METHODOLOGY AND CHART OF INDIVIDUAL PROCEDURE SAVINGS

The following table shows detailed statistics for the 120 procedures. In the table, the procedures are first sorted by the annual ASC share increase assumptions in Scenarios A3 and B3, which were 1, 5, and 10 percent annually (see Column “% ASC Share Growth Assumptions for A3 and B3”). Within the 1, 5, and 10 percent buckets, the procedures are then sorted based on the savings they generated in 2011 (see Column “Savings 2011”).

The table shows the average annual change in the ASC share from 2008 through 2011, the 2011 ASC share of procedures and projected ASC share in 2022 if the share increases by 2 percent annually or in the range of 1 to 10 percent annually. In addition, it shows the 2011 and projected 2022 volume per 1,000 Medicare beneficiaries. Most importantly, those columns are followed by two sets of three columns that show the projected savings estimates in 2022 when the number of procedures per 1,000 Medicare beneficiaries remains constant and when the number of procedures per 1,000 Medicare beneficiaries increases by 3 percent per year. Within each set, the ASC share assumptions are based on the assumptions presented in the table on page 11.

The first row of the table illustrates that cataract surgeries (HCPCS 66984) alone generated a savings of \$829 million in 2011. In 2011, the ASC share of this procedure was 56 percent, and that share either increases to 62 or 69 percent depending on the scenario. Depending on whether the number of cataract surgeries per 1,000 Medicare beneficiaries increases and the share of procedures performed in ASCs, the projected savings for Medicare and its beneficiaries range from \$1.5 billion to \$2.95 billion in 2022.

The last row of the table shows column totals and averages (see page 9). In 2011, there were \$2.3 billion in savings for the 120 procedures, and the projected savings in 2022 range from \$4.2 billion to \$9.4 billion, depending on the scenario.

No.	HCPCS	HCPCS Description	Savings 2011 (\$million)	Average Annual ASC Share Change 2008-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures for 2022 (# per 1,000 Medicare Beneficiaries)*	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			% ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) (\$million)	A2. Savings for 2022 (ASC share increases 2% per year) (\$million)	A3. Savings for 2022 (ASC share increase varies) (\$million)	B1. Baseline: Savings for 2022 (ASC share remains constant) (\$million)	B2. Savings for 2022 (ASC share increases 2% per year) (\$million)	B3. Savings for 2022 (ASC share increase varies) (\$million)		
1	66984	Cataract surg w/1st stage	\$829	-3.56%	56%	69%	62%	54.9	76.0	\$1,500	\$1,870	\$1,670	\$2,370	\$2,950	\$2,650	1%	\$740
2	66982	Cataract surgery complex	\$63	-0.96%	52%	65%	59%	4.4	6.1	\$116	\$144	\$129	\$180	\$224	\$201	1%	\$740
3	64483	Inj foramen epidural l/s	\$60	-3.02%	35%	44%	39%	20.6	28.5	\$106	\$132	\$119	\$173	\$215	\$193	1%	\$229
4	62311	Inject spine l/s (cd)	\$53	-13.67%	26%	33%	29%	24.1	33.4	\$73	\$91	\$82	\$152	\$188	\$169	1%	\$229
5	66821	After cataract laser surgery	\$43	-2.96%	43%	54%	48%	16.2	22.4	\$86	\$107	\$96	\$124	\$154	\$138	1%	\$169
6	29881	Knee arthroscopy/surgery	\$25	-0.25%	39%	48%	43%	2.0	2.7	\$51	\$64	\$57	\$71	\$89	\$79	1%	\$903
7	28285	Repair of hammertoe	\$22	-0.22%	37%	46%	41%	2.4	3.3	\$38	\$47	\$43	\$64	\$79	\$71	1%	\$681
8	43235	Upper GI endoscopy diagnosis	\$21	-0.18%	34%	43%	38%	6.1	8.5	\$38	\$47	\$42	\$59	\$73	\$66	1%	\$268
9	64622	Destr paravertebral nerve l/s	\$18	-4.98%	35%	44%	40%	3.6	5.0	\$28	\$34	\$31	\$52	\$64	\$58	1%	\$386
10	52000	Cystoscopy	\$16	-0.03%	8%	10%	9%	24.4	33.8	\$33	\$41	\$37	\$47	\$58	\$52	1%	\$224
11	62310	Inject spine c/t	\$14	-13.54%	30%	37%	33%	5.5	7.6	\$18	\$23	\$20	\$39	\$49	\$44	1%	\$229
12	29848	Wrist endoscopy/surgery	\$11	-0.10%	51%	63%	57%	0.7	0.9	\$20	\$25	\$23	\$32	\$40	\$36	1%	\$903
13	29823	Shoulder arthroscopy/surgery	\$10	-2.73%	28%	35%	31%	0.7	0.9	\$14	\$17	\$16	\$29	\$36	\$32	1%	\$1,460
14	63650	Implant neuroelectrodes	\$9	-20.87%	24%	29%	26%	1.2	1.7	\$10	\$12	\$11	\$26	\$32	\$29	1%	\$846
15	20680	Removal of support implant	\$7	-1.14%	26%	32%	29%	1.1	1.5	\$14	\$17	\$15	\$21	\$27	\$24	1%	\$720
16	28296	Correction of bunion	\$7	-0.91%	41%	50%	45%	0.5	0.7	\$15	\$18	\$17	\$20	\$25	\$23	1%	\$1,002
17	52005	Cystoscopy & ureter catheter	\$7	-0.11%	25%	31%	28%	0.9	1.3	\$12	\$15	\$13	\$19	\$24	\$22	1%	\$794
18	45381	Colonoscopy submucous inj	\$7	-4.10%	43%	54%	48%	1.5	2.0	\$7	\$9	\$8	\$19	\$23	\$21	1%	\$281
19	36561	Insert tunneled cv cath	\$6	-1.43%	7%	8%	7%	2.6	3.7	\$12	\$15	\$13	\$17	\$21	\$19	1%	\$927
20	29875	Knee arthroscopy/surgery	\$5	-1.21%	46%	57%	51%	0.3	0.4	\$8	\$10	\$9	\$14	\$17	\$15	1%	\$903
21	30520	Repair of nasal septum	\$5	-0.30%	30%	37%	34%	0.6	0.8	\$8	\$9	\$8	\$14	\$17	\$15	1%	\$773
22	52281	Cystoscopy and treatment	\$5	-0.75%	9%	11%	10%	2.7	3.7	\$11	\$13	\$12	\$14	\$17	\$15	1%	\$530
23	58558	Hysteroscopy biopsy	\$4	-2.25%	13%	17%	15%	1.1	1.5	\$7	\$9	\$8	\$10	\$13	\$12	1%	\$696
24	65426	Removal of eye lesion	\$3	-0.03%	59%	73%	66%	0.2	0.2	\$5	\$6	\$6	\$8	\$10	\$9	1%	\$736
25	64626	Destr paravertebral nerve c/t	\$3	-7.96%	38%	48%	43%	0.8	1.2	\$4	\$5	\$5	\$8	\$10	\$9	1%	\$229
26	14041	Skin tissue rearrangement	\$3	-2.49%	13%	16%	15%	1.0	1.4	\$5	\$6	\$6	\$7	\$9	\$8	1%	\$519
27	43251	Operative upper GI endoscopy	\$2	-0.85%	35%	44%	39%	0.6	0.9	\$4	\$5	\$4	\$6	\$8	\$7	1%	\$268
28	64627	Destr paravertebral n add-on	\$2	-0.43%	39%	48%	43%	1.9	2.6	\$3	\$3	\$3	\$6	\$8	\$7	1%	\$80
29	44361	Small bowel endoscopy/biopsy	\$2	-1.36%	53%	66%	60%	0.3	0.5	\$4	\$5	\$4	\$6	\$7	\$6	1%	\$307
30	62264	Epidural lysis on single day	\$2	-17.63%	29%	36%	32%	0.4	0.5	\$2	\$2	\$2	\$5	\$6	\$5	1%	\$386

No.	HCPCS	HCPCS Description	Savings 2011 (\$million)	Average Annual ASC Share Change 2008-2011	Baseline: 2011 ASC Share of Procedures	Projected ASC Share for 2022 (2% increase per year)	Projected ASC Share for 2022 (share increase varies)	2011 Volume of Procedures (# per 1,000 Medicare Beneficiaries)	Projected Volume of Procedures (# per 1,000 Medicare Beneficiaries)*	Volume per 1,000 Medicare Beneficiaries Remains Constant			Volume per 1,000 Medicare Beneficiaries Increases By 3% per Year			% ASC Annual Share Growth Assumption for A3 & B3	Reimbursement Difference Between ASCs and HOPDs 2011
										A1. Baseline: Savings for 2022 (ASC share remains constant) (\$million)	A2. Savings for 2022 (ASC share increases 2% per year) (\$million)	A3. Savings for 2022 (ASC share increase varies) (\$million)	B1. Baseline: Savings for 2022 (ASC share remains constant) (\$million)	B2. Savings for 2022 (ASC share increases 2% per year) (\$million)	B3. Savings for 2022 (ASC share increase varies) (\$million)		
31	13132	Repair of wound or lesion	\$2	-4.69%	6%	7%	6%	5.3	7.4	\$2	\$3	\$3	\$5	\$6	\$5	1%	\$140
32	62319	Inject spine w/cath U/s (cd)	\$2	-18.47%	30%	38%	34%	0.4	0.5	\$2	\$2	\$2	\$4	\$6	\$5	1%	\$386
33	64520	N block lumbar/thoracic	\$1	-13.74%	23%	29%	26%	0.6	0.8	\$1	\$2	\$2	\$3	\$4	\$4	1%	\$229
34	64450	N block other peripheral	\$1	-1.62%	1%	2%	1%	10.2	14.1	\$1	\$1	\$1	\$3	\$4	\$3	1%	\$226
35	11042	Deb subq tissue 20 sq cm/<	\$1	-14.48%	1%	1%	1%	28.9	40.0	\$1	\$2	\$2	\$2	\$3	\$2	1%	\$82
36	20552	Inj trigger point 1/2 muscl	\$1	-7.74%	1%	2%	1%	8.3	11.5	\$1	\$1	\$1	\$2	\$2	\$2	1%	\$163
37	43239	Upper gi endoscopy biopsy	\$143	0.58%	45%	55%	76%	32.8	45.5	\$243	\$303	\$416	\$409	\$509	\$700	5%	\$268
38	45380	Colonoscopy and biopsy	\$107	1.11%	48%	59%	82%	21.8	30.2	\$197	\$245	\$336	\$306	\$380	\$523	5%	\$281
39	45385	Lesion removal colonoscopy	\$82	2.10%	46%	58%	79%	17.2	23.9	\$162	\$202	\$278	\$236	\$293	\$403	5%	\$281
40	45378	Diagnostic colonoscopy	\$66	0.27%	40%	49%	68%	16.2	22.4	\$157	\$195	\$268	\$190	\$236	\$324	5%	\$281
41	29826	Shoulder arthroscopy/surgery	\$38	1.27%	33%	40%	56%	2.2	3.1	\$53	\$66	\$91	\$110	\$137	\$188	5%	\$1,460
42	G0105	Colorectal son; hi risk ind	\$30	2.48%	52%	64%	88%	6.3	8.7	\$54	\$68	\$93	\$85	\$105	\$145	5%	\$249
43	64721	Carpal tunnel surgery	\$25	1.01%	40%	50%	68%	3.0	4.2	\$50	\$62	\$85	\$72	\$90	\$124	5%	\$577
44	64623	Destr paravertebral n add-on	\$24	4.03%	36%	44%	61%	8.1	11.2	\$31	\$39	\$53	\$69	\$86	\$118	5%	\$229
45	G0121	Colon ca scan not hi risk ind	\$24	2.22%	45%	56%	77%	5.8	8.0	\$42	\$52	\$72	\$68	\$84	\$115	5%	\$249
46	29827	Arthroscop rotator cuff repr	\$23	3.71%	32%	39%	54%	1.4	1.9	\$44	\$55	\$75	\$66	\$82	\$112	5%	\$1,460
47	29880	Knee arthroscopy/surgery	\$21	1.64%	41%	51%	71%	1.5	2.1	\$44	\$55	\$76	\$59	\$73	\$100	5%	\$903
48	45384	Lesion remove colonoscopy	\$19	0.93%	42%	52%	71%	4.5	6.3	\$40	\$49	\$68	\$56	\$69	\$95	5%	\$281
49	67904	Repair eyelid defect	\$17	3.55%	63%	79%	90%	1.2	1.7	\$32	\$40	\$46	\$48	\$60	\$69	5%	\$603
50	64484	Inj foramen epidural add-on	\$16	3.71%	34%	42%	58%	11.2	15.6	\$23	\$29	\$40	\$46	\$58	\$79	5%	\$117
51	26055	Incise finger tendon sheath	\$16	1.20%	44%	55%	76%	1.9	2.7	\$28	\$35	\$49	\$46	\$58	\$79	5%	\$517
52	43248	Uppr gi endoscopy/guide wire	\$14	0.86%	53%	67%	90%	2.6	3.6	\$25	\$31	\$42	\$39	\$49	\$66	5%	\$268
53	29824	Shoulder arthroscopy/surgery	\$11	0.45%	33%	42%	57%	1.0	1.4	\$15	\$19	\$26	\$32	\$40	\$55	5%	\$903
54	49505	Prp i/hem init reduc >5 yr	\$11	2.77%	15%	19%	26%	1.9	2.7	\$23	\$28	\$39	\$30	\$38	\$52	5%	\$997
55	67917	Repair eyelid defect	\$10	3.72%	60%	74%	90%	0.8	1.0	\$18	\$23	\$27	\$28	\$35	\$43	5%	\$603
56	23412	Repair rotator cuff chronic	\$10	3.46%	33%	41%	56%	0.6	0.8	\$20	\$25	\$34	\$27	\$34	\$47	5%	\$1,426
57	14060	Skin tissue rearrangement	\$9	0.50%	18%	22%	30%	2.6	3.6	\$18	\$22	\$30	\$25	\$31	\$43	5%	\$519
58	55700	Biopsy of prostate	\$8	2.92%	12%	14%	20%	5.1	7.0	\$17	\$21	\$29	\$24	\$30	\$42	5%	\$393
59	66180	Implant eye shunt	\$8	3.44%	52%	65%	89%	0.3	0.4	\$16	\$20	\$27	\$22	\$27	\$38	5%	\$1,303
60	43450	Dilate esophagus	\$8	1.82%	54%	67%	90%	1.9	2.7	\$8	\$11	\$14	\$22	\$27	\$36	5%	\$198

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61	25447	Repair wrist joint(s)	\$7	1.12%	47%	58%	80%	0.4	0.5	\$14	\$17	\$23	\$21	\$26	\$36	5%	\$1,184
62	43249	Esoph endoscopy dilation	\$7	1.08%	30%	38%	52%	2.2	3.1	\$12	\$15	\$20	\$19	\$24	\$33	5%	\$268
63	66170	Glaucoma surgery	\$6	4.40%	61%	76%	90%	0.4	0.5	\$13	\$16	\$19	\$18	\$23	\$27	5%	\$736
64	29822	Shoulder arthroscopy/surgery	\$6	2.28%	36%	45%	61%	0.5	0.7	\$10	\$13	\$17	\$18	\$23	\$31	5%	\$903
65	14040	Skin tissue rearrangement	\$6	1.83%	16%	20%	27%	2.1	2.9	\$13	\$16	\$22	\$18	\$23	\$31	5%	\$519
66	28270	Release of foot contracture	\$5	3.02%	28%	35%	48%	0.8	1.1	\$9	\$12	\$16	\$15	\$19	\$26	5%	\$681
67	15260	Skin full graft een & lips	\$5	4.70%	18%	22%	31%	1.5	2.0	\$10	\$12	\$17	\$14	\$18	\$25	5%	\$519
68	45383	Lesion removal colonoscopy	\$5	1.36%	36%	45%	62%	1.3	1.8	\$10	\$13	\$18	\$14	\$17	\$24	5%	\$281
69	66711	Ciliary endoscopic ablation	\$5	1.70%	79%	90%	90%	0.3	0.4	\$7	\$8	\$8	\$14	\$16	\$16	5%	\$539
70	67924	Repair eyelid defect	\$5	3.72%	61%	76%	90%	0.3	0.5	\$9	\$11	\$13	\$13	\$17	\$20	5%	\$603
71	52353	Cystouretero w/lithotripsy	\$4	4.90%	13%	16%	21%	0.8	1.2	\$8	\$10	\$14	\$12	\$15	\$21	5%	\$1,126
72	67028	Injection eye drug	\$4	3.19%	1%	1%	2%	54.4	75.4	\$6	\$8	\$11	\$11	\$14	\$19	5%	\$169
73	52234	Cystoscopy and treatment	\$4	1.27%	19%	24%	33%	0.7	0.9	\$7	\$9	\$13	\$11	\$13	\$18	5%	\$794
74	64718	Revise ulnar nerve at elbow	\$4	3.70%	36%	45%	62%	0.5	0.7	\$6	\$8	\$11	\$11	\$13	\$18	5%	\$577
75	28308	Incision of metatarsal	\$3	1.92%	38%	48%	65%	0.4	0.5	\$5	\$7	\$9	\$10	\$12	\$17	5%	\$681
76	26123	Release palm contracture	\$3	1.37%	47%	58%	80%	0.2	0.3	\$8	\$10	\$13	\$10	\$12	\$17	5%	\$897
77	26160	Remove tendon sheath lesion	\$3	0.77%	44%	55%	75%	0.4	0.6	\$6	\$8	\$11	\$10	\$12	\$17	5%	\$517
78	67950	Revision of eyelid	\$3	2.29%	64%	80%	90%	0.2	0.3	\$5	\$7	\$7	\$9	\$12	\$13	5%	\$603
79	52224	Cystoscopy and treatment	\$3	4.95%	8%	11%	14%	1.3	1.9	\$7	\$9	\$12	\$9	\$12	\$16	5%	\$794
80	52310	Cystoscopy and treatment	\$3	0.06%	9%	11%	16%	1.8	2.5	\$6	\$8	\$10	\$9	\$11	\$15	5%	\$530
81	67961	Revision of eyelid	\$3	1.27%	55%	69%	90%	0.2	0.3	\$5	\$6	\$9	\$9	\$11	\$14	5%	\$603
82	52235	Cystoscopy and treatment	\$3	2.23%	14%	18%	24%	0.7	1.0	\$6	\$7	\$10	\$9	\$11	\$15	5%	\$794
83	66986	Exchange lens prosthesis	\$3	0.17%	63%	78%	90%	0.2	0.2	\$5	\$6	\$7	\$8	\$10	\$12	5%	\$740
84	64479	Inf foramen epidural c/t	\$3	0.16%	31%	38%	53%	1.1	1.5	\$5	\$6	\$9	\$8	\$10	\$14	5%	\$229
85	66250	Follow-up surgery of eye	\$2	1.83%	37%	46%	64%	0.3	0.4	\$4	\$5	\$7	\$6	\$7	\$10	5%	\$539
86	14061	Skin tissue rearrangement	\$2	1.01%	16%	19%	27%	0.7	0.9	\$4	\$5	\$7	\$6	\$7	\$10	5%	\$519
87	17311	Mohs 1 stage h/n/hf/g	\$1	3.76%	1%	2%	2%	14.8	20.5	\$2	\$2	\$3	\$3	\$4	\$5	5%	\$162
88	13121	Repair of wound or lesion	\$1	0.48%	6%	7%	10%	2.8	3.8	\$1	\$1	\$1	\$2	\$2	\$3	5%	\$95
89	15823	Revision of upper eyelid	\$41	6.61%	68%	85%	90%	2.4	3.4	\$84	\$105	\$111	\$117	\$146	\$155	10%	\$671
90	50590	Fragmenting of kidney stone	\$13	10.88%	18%	23%	52%	1.5	2.1	\$25	\$31	\$72	\$36	\$45	\$103	10%	\$1,265

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91	67042	Vit for macular hole	\$13	7.78%	42%	53%	90%	0.7	0.9	\$26	\$32	\$55	\$36	\$45	\$77	10%	\$1,234
92	52332	Cystoscopy and treatment	\$10	5.10%	13%	16%	36%	2.6	3.6	\$15	\$18	\$42	\$27	\$34	\$78	10%	\$794
93	67041	Vit for macular pucker	\$9	7.36%	40%	50%	90%	0.5	0.6	\$19	\$24	\$42	\$24	\$30	\$54	10%	\$1,234
94	65855	Laser surgery of eye	\$8	10.98%	22%	28%	63%	4.0	5.6	\$18	\$23	\$52	\$24	\$30	\$68	10%	\$257
95	67900	Repair brow defect	\$8	7.23%	68%	85%	90%	0.4	0.6	\$14	\$18	\$19	\$24	\$30	\$32	10%	\$801
96	31255	Removal of ethmoid sinus	\$8	11.19%	39%	49%	90%	0.6	0.8	\$17	\$21	\$38	\$22	\$28	\$51	10%	\$933
97	67036	Removal of inner eye fluid	\$6	10.53%	38%	47%	90%	0.4	0.5	\$13	\$16	\$31	\$18	\$23	\$43	10%	\$1,234
98	31267	Endoscopy maxillary sinus	\$6	11.09%	37%	46%	90%	0.5	0.7	\$11	\$14	\$26	\$18	\$22	\$44	10%	\$933
99	30140	Resect inferior turbinate	\$6	16.88%	39%	48%	90%	0.5	0.7	\$12	\$15	\$28	\$16	\$20	\$37	10%	\$773
100	67108	Repair detached retina	\$6	11.99%	34%	43%	90%	0.4	0.5	\$11	\$14	\$29	\$16	\$20	\$42	10%	\$1,234
101	47562	Laparoscopic cholecystectomy	\$5	11.18%	6%	7%	16%	1.8	2.5	\$11	\$14	\$32	\$16	\$19	\$44	10%	\$1,442
102	66761	Revision of iris	\$5	5.24%	27%	34%	78%	2.2	3.1	\$11	\$13	\$31	\$15	\$19	\$43	10%	\$237
103	67040	Laser treatment of retina	\$5	8.70%	33%	41%	90%	0.3	0.4	\$10	\$12	\$27	\$13	\$17	\$36	10%	\$1,234
104	52204	Cystoscopy w/biopsy(s)	\$5	7.61%	19%	24%	55%	0.8	1.1	\$9	\$11	\$25	\$13	\$16	\$37	10%	\$794
105	20610	Drain/inject joint/bursa	\$4	18.62%	0.5%	1%	1%	153.1	212.0	\$8	\$10	\$24	\$12	\$14	\$33	10%	\$149
106	31256	Exploration maxillary sinus	\$4	8.96%	37%	46%	90%	0.3	0.4	\$7	\$9	\$18	\$12	\$14	\$28	10%	\$933
107	31276	Sinus endoscopy surgical	\$4	22.38%	33%	41%	90%	0.4	0.5	\$10	\$12	\$27	\$11	\$14	\$31	10%	\$933
108	64640	Injection treatment of nerve	\$4	75.05%	13%	16%	36%	1.8	2.4	\$6	\$8	\$18	\$10	\$13	\$29	10%	\$437
109	67255	Reinforce/graft eye wall	\$3	6.57%	50%	63%	90%	0.3	0.3	\$4	\$6	\$8	\$9	\$12	\$17	10%	\$706
110	69436	Create eardrum opening	\$3	11.68%	40%	50%	90%	0.3	0.5	\$6	\$8	\$14	\$7	\$9	\$17	10%	\$522
111	45330	Diagnostic sigmoidoscopy	\$2	15.64%	17%	21%	48%	1.3	1.7	\$5	\$6	\$14	\$7	\$9	\$20	10%	\$324
112	68815	Probe nasolacrimal duct	\$2	9.08%	51%	64%	90%	0.2	0.3	\$4	\$5	\$6	\$7	\$9	\$12	10%	\$603
113	46221	Ligation of hemorrhoid(s)	\$2	59.92%	11%	14%	33%	1.7	2.4	\$4	\$5	\$11	\$6	\$8	\$18	10%	\$296
114	67840	Remove eyelid lesion	\$2	15.10%	8%	10%	24%	1.4	2.0	\$4	\$4	\$10	\$5	\$6	\$15	10%	\$422
115	45331	Sigmoidoscopy and biopsy	\$1	5.08%	34%	43%	90%	0.7	0.9	\$3	\$3	\$7	\$4	\$5	\$11	10%	\$175
116	67210	Treatment of retinal lesion	\$1	10.61%	7%	9%	21%	2.9	4.0	\$3	\$4	\$9	\$4	\$5	\$11	10%	\$169
117	67228	Treatment of retinal lesion	\$1	11.58%	7%	9%	20%	2.3	3.2	\$2	\$3	\$6	\$3	\$4	\$8	10%	\$169
118	11642	Exc face-mm malig+marg 1.1-2	\$1	7.98%	3%	4%	10%	3.5	4.9	\$2	\$2	\$4	\$3	\$4	\$8	10%	\$226
119	64480	Inf foramen epidural add-on	\$1	17.51%	29%	36%	83%	0.8	1.0	\$2	\$2	\$5	\$3	\$3	\$8	10%	\$117
120	51700	Irrigation of bladder	\$0.5	29.91%	3%	4%	10%	4.0	5.5	\$1	\$1	\$3	\$1	\$2	\$4	10%	\$99
Total or Mean**			\$2,307	3.46%	32%	40%	52%	5.62	7.78	\$4,203	\$5,231	\$6,013	\$6,604	\$8,212	\$9,383	N/A	\$589

NOTES:

*Increases volume per 1,000 Medicare beneficiaries by 3% annually.

**The reported totals are for savings. The remaining columns are simple means across the 120 procedures, for which the mean is not influenced by (or weighted for) high-volume procedures, such as cataracts. Savings are reported in nominal dollars. N/A: not applicable.

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Medicare Cost Savings Tied to Ambulatory Surgery Centers



Produced with cost savings analysis from

Berkeley
UNIVERSITY OF CALIFORNIA

Commercial Insurance Cost Savings in Ambulatory Surgery Centers



Healthcare **Bluebook**™



HealthSmart®



Executive Summary

A review of commercial medical-claims data found that U.S. healthcare costs are reduced by more than \$38 billion per year due to the availability of ambulatory surgery centers (ASCs) as an appropriate setting for outpatient procedures. More than \$5 billion of the cost reduction accrues to the patient through lower deductible and coinsurance payments. This cost reduction is driven by the fact that, in general, ASC prices are significantly lower than hospital outpatient department (HOPD) prices for the same procedure in all markets, regardless of payer.

The study also looks at the potential savings that could be achieved if additional procedures were redirected to ASCs. As much as \$55 billion could be saved annually depending on the percentage of procedures that migrate to ASCs and the mix of ASCs selected instead of HOPDs.

Finally, the study explores additional cost savings that would result if certain inpatient procedures, such as total joint replacements, continue to migrate to ASCs.

This study supplements an earlier review of Medicare costs by researchers at the University of California-Berkeley that showed that ASCs reduce Medicare costs by \$2.3 billion annually. *Ambulatory Surgery Center Association, Medicare Cost Savings Tied to ASCs, (2013),* <http://www.advancingsurgicalcare.com/medicarecostsavings>.

Introduction and Purpose

The Medicare price differential for common outpatient services delivered in the hospital outpatient department (HOPD) vs. ambulatory surgery center (ASC) environment is well known and documented. On average, Medicare reimburses ASCs at 53 percent of the rate it reimburses HOPDs for the same procedure. The payment gap between services delivered at ASCs rather than HOPDs reduced the Centers for Medicare and Medicaid Services' (CMS) costs by more than \$7 billion between 2007 and 2011¹.

While CMS payment rates are publicly available, commercial carrier payment rates are not. Therefore, less is known about the price differences and associated savings that exist between the ASC and HOPD environments for those employers and patients covered by commercial insurance (employer-sponsored insurance or private insurance purchased on the public exchanges and elsewhere).

The following analysis provides an estimate of the significant savings that ASCs currently provide to commercially insured patients, along with potential savings available to the commercially insured population, when shifting care to an ASC setting. This analysis was conducted in a partnership between Healthcare Bluebook, the Ambulatory Surgery Center Association (ASCA) and HealthSmart, a leading provider

of third-party administrative services for self-funded employers.

Specifically, the paper discusses each of the following:

1. the estimated cost savings generated by ASCs in the commercially insured U.S. population;
2. the estimated additional cost reductions to be achieved if more cases were to be performed in ASCs;
3. the additional value created as traditional inpatient procedures migrate to ASC settings (e.g., total knee replacements); and
4. examples of HOPD and ASC price disparities within and across regions.

The ASC model was developed in 1970, and Medicare approved payments to ASCs for more than 200 procedures in 1982. Steady growth in the number of ASCs and the number of surgical procedures performed in the outpatient setting, including HOPDs, has continued since. This shift toward outpatient procedures has accelerated due to advancements in medical practice and technology that have reduced the need for overnight hospital stays.

¹ Department of Health and Human Services, Office of Inspector General. (2014, April). *Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates For Ambulatory Surgical Center Approved Procedures to Ambulatory Surgical Center Payment Rates.*

Retrieved April 11, 2016, from <http://oig.hhs.gov/oas/reports/region5/51200020.pdf>



Today, many common surgeries are performed as outpatient procedures, and most patients, except those with complicated health conditions, can be served in the outpatient setting. Common ASC procedures include colonoscopies, cataract surgeries, tonsillectomies and arthroscopic orthopedic surgeries. CMS currently approves and reimburses 3,837 procedure codes in the ASC setting, and commercial populations are constantly expanding these boundaries. In fact, some ASCs are performing total joint replacements and other traditionally inpatient procedures with excellent outcomes.

While all HOPDs are hospital owned, most ASCs are at least partially owned by physicians, often in conjunction with hospitals and/or management companies. Sixty-five percent of the more than 5,400 Medicare-licensed ASCs in the U.S. are wholly owned by physicians and operate as small businesses.

A study published in *Health Affairs* analyzed data from the National Survey of Ambulatory Surgery and discovered that procedures performed in ASCs are more efficient, taking 25 percent less time than those performed in hospitals². This efficiency, and corresponding cost-effectiveness, is due largely to the ASCs' focus on a limited number of procedures, their owner/operator culture and specialized nursing and support staff. Because ASCs specialize in providing outpatient surgery, they are able to deliver patient-care services efficiently and conveniently. For example, operating rooms are turned over quickly and are not interrupted by emergency cases. This enables physicians

to commence their procedures in a timely manner and use their time more productively. Consequently, ASCs tend to be more convenient and cost effective than HOPDs while still providing excellent care.

² Munnich, E. L., & Parente, S. T. (2014). Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up. *Health Affairs*, 33(5), 764-769.

Patients Often Pay Dramatically Different Amounts for the Same Care in the Same Community

Healthcare prices vary dramatically even within the same insurance network and city. For example, in Charleston, West Virginia, the price of a cataract surgery, including payments to the anesthesiologist and physician, can vary from \$2,684 to \$8,662 depending on the facility where the surgery is performed (Figure 1). In this case prices vary by more than 300 percent, primarily due to the amount charged by the facility – not the physicians. These facility prices vary by almost 600 percent and total more than 70 percent of all dollars spent for cataract surgery in Charleston, WV.

Payments to anesthesiologists vary, partially due to the time component of anesthesia billing, but these payments are the smallest

portion of the total cost and are dwarfed by payments to facilities.

Payments to physicians are a more significant portion of total cost, but physicians performing the most expensive cataract surgeries are paid approximately the same as physicians performing the least expensive surgeries. Thus, it is the choice of facility that drives the total price variation.

The consistency of payments to physicians indicates that most physicians are unable to differentiate themselves when negotiating payment rates from insurance companies and, hence, are paid similar rates. Facilities, on the other hand, vary significantly in their service

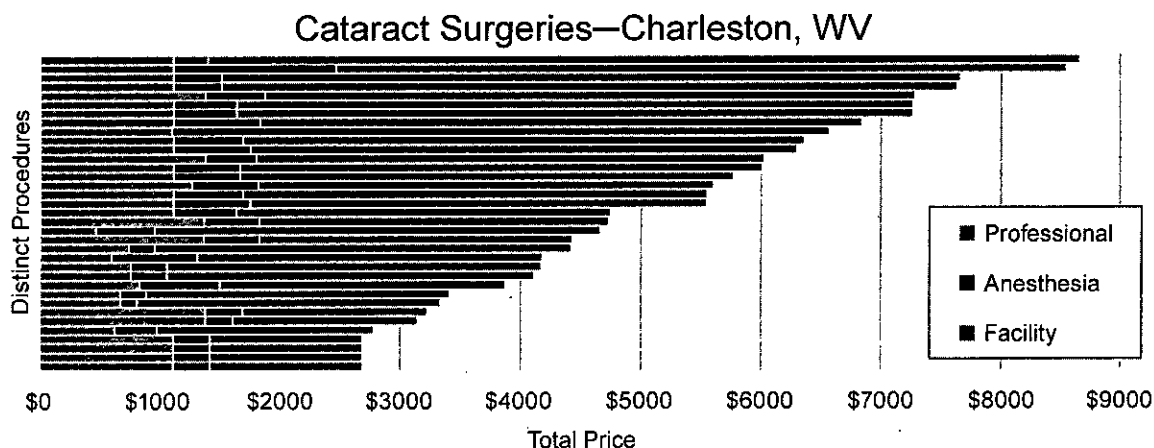


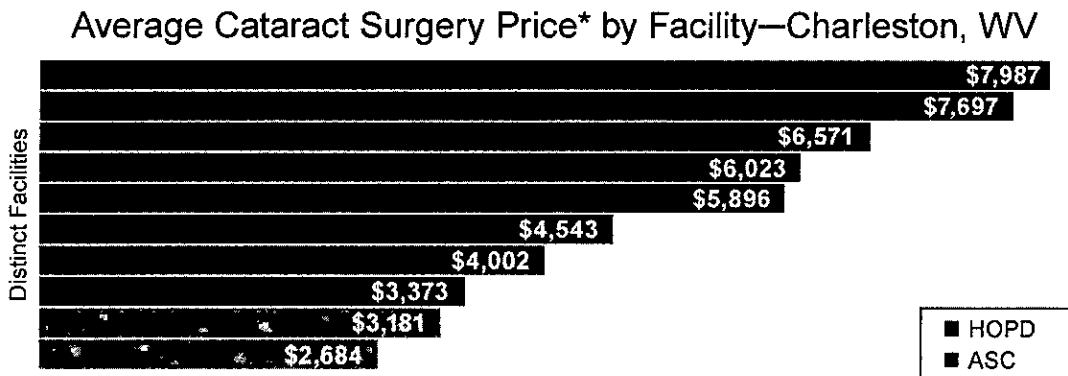
Figure 1

offerings and market power and, therefore, have significantly different negotiated rates with insurance companies.

For example, Hospital A provides emergency, inpatient and outpatient care. Hospital B offers everything Hospital A offers and also operates the only children's hospital in the metropolitan area. Due to this exclusive service line, Hospital B has better negotiating leverage with an insurance company. Importantly, this leverage applies not only to services uniquely performed in the children's hospital, but also to outpatient surgeries, such as cataract surgery, that are performed in other facilities in the area. Since the entire hospital is either in or out of network, all services are negotiated together, allowing Hospital B to demand higher reimbursement for procedures even though equally good, lower-priced alternative sites of service exist in that market area.

Since any ASC will offer fewer services than both Hospital A and B, those ASCs will have less negotiating leverage with commercial carriers and, therefore, often will receive lower reimbursement rates than either Hospital A or B if they want to be included in the insurer's network. While the efficiency inherent in the ASC model explains why ASCs can continue to exist when receiving significantly lower payments, it is the market power of hospitals that widens these price disparities^{3,4}.

As a result of these factors, the total price of a procedure performed at an ASC is generally significantly lower than the total price of the same procedure performed in an HOPD. For example, the average price of cataract surgery at an ASC in Charleston, West Virginia, is \$2,932, including the physician and anesthesiologist payments, while the average price at an HOPD is \$5,762 (Figure 2). In this example,



* Includes allowed amounts for all claim components: anesthesia, professional and facility.

Figure 2

³ Neprash, H.T., BA, Chernew, M.E., PhD, Hicks, A.L., MS, Gibson, T., PhD, & McWilliams, M., MD, PhD, (2015, October). Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. *Journal of the American Medical Association*.

⁴ The Robert Wood Johnson Foundation, Martin Gaynor, PhD & Robert Town, PhD. (2012, June). *The impact of hospital consolidation – Update*.

Retrieved April 20, 2016, from <http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.htm>

the average price for a cataract surgery at the least expensive facility was \$2,684, including the payments to anesthesiologists and physicians. At the most expensive facility, the average price was \$7,987. ASCs are at the low end of the spectrum and HOPDs are at the high end.

This commercial price differential between the ASC and HOPD environments is persistent across metropolitan areas (Figure 3), insurance carriers and procedure categories, with the degree of price variability related to local market factors.

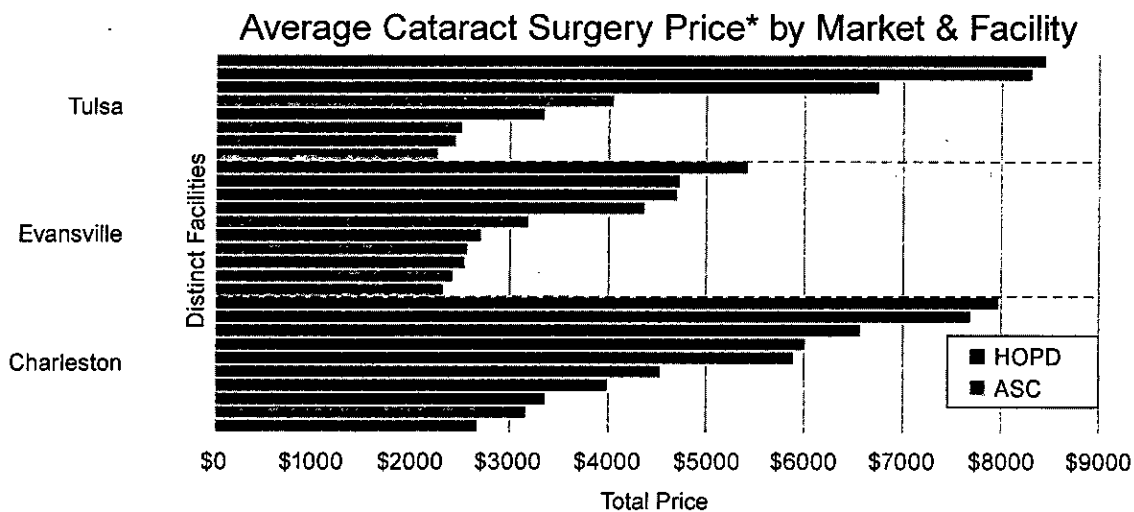
Summary of Methodology

All analysis was conducted using a sample of de-identified commercial claims data for calendar year 2014 from HealthSmart. This data represents more than 400,000 lives across all regions of the U.S. The CMS list of ASC-eligible procedure codes, with a few additions reflecting those prevalent in a

commercial population (pediatric-related codes, OB/GYN-related codes, etc.), was used to identify the spending on procedures that can be performed in an ASC.

Total price of service was included in the analysis (facility fees, professional fees and anesthesia fees, where relevant). Based on the commercial population considered, these services accounted for about 19 percent of total medical spend, or \$890 per person for the year. All prices are calculated using the "allowed" amount, which reflects the actual amount a provider received after any discounts were applied.

Thirteen high-volume outpatient procedures were used as proxies to analyze the price differential between the ASC and HOPD environments and estimate the percentage of spending that could be saved by performing the procedures in ASCs instead of HOPDs. An adjustment was made to account for the fact that some high-risk patients are not candidates



* Includes allowed amounts for all claim components: anesthesia, professional and facility.

Figure 3



for ASC-based care (patients with high comorbidities are traditionally directed to an HOPD in order to be closer to critical-access care). This adjusted percentage was applied to the \$890 ASC-eligible spend per person and then scaled by the commercially insured U.S. population to estimate the national savings potential.

All estimates are based on the calendar year 2014 data. No adjustments were made to account for population aging or increasing utilization of ASC-eligible services. (See Appendix A: Methodology and Appendix B: Adjustments for ASC Ineligibility for a more detailed explanation of the methodology.)

Current ASC Use Reduces Private Healthcare Costs by \$38 Billion Annually

The lower cost of care in ASCs relative to HOPDs saves employers and consumers tens of billions of dollars a year. For the commercially insured population in the U.S., an

estimated \$37.8 billion is saved annually by using ASCs. Stated differently, if all of the procedures currently performed in ASCs for the commercially insured population in the U.S. were performed in HOPDs, the cost of those procedures would increase by \$37.8 billion in just one year.

Potential Cost Reductions Attributed to ASCs

Despite the savings detailed above, for commercially insured populations, only 48 percent of procedures commonly performed in ASCs are actually performed in ASCs. If the remaining 52 percent were performed at ASC price points, an additional \$41 billion in healthcare costs could be saved annually.

As a practical matter, ASCs would not be the appropriate setting for a small percentage of patients (e.g., those with serious health issues) currently treated in HOPDs. For example, patients on dialysis (0.1 percent of Americans) are not ASC eligible for certain procedures. When ASC-ineligible cases are accounted for, the total potential annual savings from performing the surgeries in ASCs instead of HOPDs is \$38.2B. (This assumes 3 percent of relevant cases are ASC ineligible. See Appendix B: Adjustments for ASC Ineligibility.)

The average ASC price, however, is a blend of both lower-priced and higher-priced ASCs. The optimal migration of cases would shift cases from HOPDs to the local low-price ASCs. If patients were directed to low-price ASCs only, the potential annual savings increases from \$38.2 billion to \$55.6 billion.

Migrating a meaningful number of patients to lower-cost ASC settings would, undoubtedly, also have the added benefit of causing HOPDs

Annual Savings from Procedures Performed in ASCs	
% of Common ASC Procedures Currently Performed at ASCs	48%
Current Annual Savings	\$37.8 B
Potential Additional Annual Savings	\$38.2 B
Potential Additional Annual Savings from Optimal Migration to ASCs	\$55.6 B

to consider price reductions in order to maintain their market share. While this study did not attempt to model the competitive reactions of HOPDs if confronted with a significant loss of patient volume, fundamental economic principles as well as a recent study that looked at the impact of reference-based pricing on patient choices concluded that hospitals did, in fact, lower their pricing for certain procedures in response to a loss of market share to competing ASCs⁵.

Potential Savings Can Grow if ASCs Can Perform More Complex Procedures

With advances in surgical techniques, pain management and post-surgical care, more procedures traditionally performed in the inpatient setting are being shifted to ASCs. This creates an expanding frontier for reducing healthcare costs. As an example, total hip and total knee replacements, which currently account for about 1.5 percent of total medical spend, are now being performed safely in ASCs in a limited number of markets. The potential savings are significant. Assuming that the price differential and the rate of ASC ineligibility due to comorbidities for total joint replacement will be commensurate with other outpatient procedures, \$3.2 billion could be

saved by moving total hip and knee replacements to ASCs. (See Appendix A: Methodology.)

Projected National Cost Reductions

To realize the potential cost reductions highlighted above, several things need to happen. On the supply side, ASC capacity will have to double in order to support the migration from HOPDs.

On the demand side, patients must be educated and incentivized to choose ASCs for their outpatient procedures. As premiums rise and adoption of high-deductible health plans increases, patients have greater incentives to reduce their costs by choosing ASC-based care, but education is lacking. Though health-care transparency has made significant advancements in recent years, most patients are still unaware of the lower costs that ASCs offer.

Even modest changes in market share produce massive savings for the entire health system. For example, if an additional 5 percent of current HOPD cases were moved to ASCs annually over the next ten years, \$113.8 billion would be saved compared to current utilization rates (Table 1). This assumes that the annual potential ASC savings is currently \$41.4 billion:

Ten-Year Savings Projection

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
Potential Savings	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$413.7 B
Percent of Savings Captured	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	28%
Savings	\$2.1 B	\$4.1 B	\$6.2 B	\$8.3 B	\$10.3 B	\$12.4 B	\$14.5 B	\$16.5 B	\$18.6 B	\$20.7 B	\$113.8 B

Table 1

⁵ Robinson, J., et. al. (2015, March). Reference-Based Benefit Design Changes Consumers' Choices And Employers' Payments For Ambulatory Surgery. *Health Affairs*.



\$38.2 billion from current ASC-eligible procedures above plus \$3.2 billion from total knee and hip replacement.

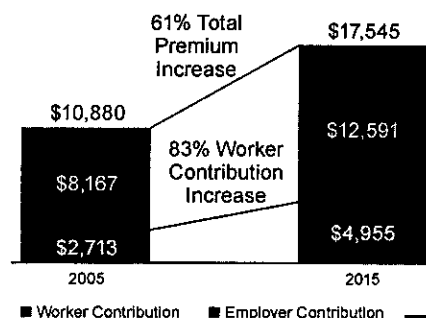
For ASC eligible procedures in this study, patients were responsible for 15 percent of the cost on average. That would mean \$17.1 billion in reduced costs for patients over the next ten years (Figure 4). If 3 percent or 8 percent of HOPD cases were moved to ASCs annually, ten-year savings would be \$68.3 billion and \$182 billion respectively (Table 2).

Projected National Cost Reduction	
Plan Sponsor Savings	\$96.7 B
Patient Savings	\$17.1 B
Total Savings	\$113.8 B

Figure 4

These estimates do not account for inflation or upward trends in medical spending. They also do not take into account the potential that HOPD pricing will decrease in order to compete with ASCs, which would create further outpatient savings. As referenced above, in the CalPERS reference pricing program, high-priced providers will reduce prices to be competitive and attract price-sensitive consumers.

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2005-2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2015



Reducing Costs for Employers and Employees

From 2005 to 2015, average health insurance premiums for employer-sponsored family coverage increased 61 percent, from \$10,880 to \$17,545 per year. To combat these rising costs, employers have increasingly adopted Consumer Driven Health Plans (CDHP) and account-based plan types, shifting costs to employees. This has driven the average employee's share of healthcare spending up 81 percent in the same time period, from \$2,713 to \$4,955⁶ annually. This highlights the need for programs like price transparency that can help patients identify better value providers within their networks so that employers and their employees both can lower costs.

Ten-Year Savings Projections

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
Savings at 3% Additional Capture	\$1.2 B	\$2.5 B	\$3.7 B	\$5.0 B	\$6.2 B	\$7.4 B	\$8.7 B	\$9.9 B	\$11.2 B	\$12.4 B	\$68.3 B
Savings at 5% Additional Capture	\$2.1 B	\$4.1 B	\$6.2 B	\$8.3 B	\$10.3 B	\$12.4 B	\$14.5 B	\$16.5 B	\$18.6 B	\$20.7 B	\$113.8 B
Savings at 8% Additional Capture	\$3.3 B	\$6.6 B	\$9.9 B	\$13.2 B	\$16.5 B	\$19.9 B	\$23.2 B	\$26.5 B	\$29.8 B	\$33.1 B	\$182.0 B

Table 2

⁶ Henry J. Kaiser Family Foundation. (2015, September). *Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2015*. Retrieved April 10, 2016, from <http://kff.org/health-costs/report/2015-employer-health-benefits-survey/>

For example, in Charlotte, NC, the average ASC price for a knee arthroscopy was \$6,118, while the average HOPD price was \$12,493, more than twice as expensive. That means \$6,375 is saved on average in Charlotte, NC, when a patient chooses an ASC for a knee arthroscopy. How those savings are divided between the payer and the patient depends on the plan design.

For a knee arthroscopy in Charlotte, NC, if a patient has a Silver Plan as defined by the Affordable Care Act, with a \$2,700 deductible, 80 percent coinsurance and \$5,000 maximum out of pocket, the patient would save \$1,275—more than the median family's weekly income. The remaining \$5,100 would be saved by the payer. For self-funded employer-sponsored insurance, that is \$5,100 directly to the bottom line for the employer.

Applying the same plan design to the earlier example of cataract surgery in Charleston, WV, a patient would save \$566 by choosing an ASC instead of an HOPD. This is a significant savings in a geographic area where annual income per capita is less than \$35,000⁷. The payer would realize an additional savings of \$2,264.

Estimating Savings for Self-Insured Populations

For employers that self insure, it is reasonably straightforward to estimate the potential cost reductions from ASCs for their covered employees. With \$890 in ASC-eligible spending per commercially insured person and 20.6 percent savings opportunity from moving all

ASC-eligible cases from HOPDs to ASCs, \$183 in potential ASC savings exists per commercially insured person. A self-funded employer with 1,000 employees is normally covering more than 2,000 lives, when employees and dependents are counted, which means a potential ASC-based savings of more than \$366,000 for the employer and employees.

Conclusion

Billions of dollars spent each year on commercially insured outpatient surgeries and procedures can be reduced, without compromising quality, if more cases migrate to ambulatory surgery centers. While a small percentage of patients have health conditions that require outpatient care to be received in proximity to a full-service hospital should complications arise, most patients can receive the same level of care at lower cost by seeking treatment in an ASC. Advances in medical technology and pain control are allowing increasingly complex procedures, such as total joint replacements, to be performed in an outpatient setting.

Policymakers, insurers, employers and beneficiaries all have a shared interest in reducing healthcare costs, and the \$38 billion in annual savings identified in this study highlight the role that ASCs already play in controlling these costs. Strategies should be implemented to generate additional savings by ensuring that the most efficient site of service for outpatient care is selected whenever possible. In particular, innovative plan design and increased consumer awareness of the benefits of receiving care in an ASC can save thousands of dollars per procedure.

⁷ United States Census Bureau. (2014). *2010–2014 American Community Survey 5-Year Estimates*. Retrieved April 30, 2016, from <http://www.census.gov/>



About the authors/organizations

Ambulatory Surgery Center Association (ASCA)

ASCA is the national membership association that represents ASCs of all specialties and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to all the patients they serve.

Healthcare Bluebook

Healthcarebluebook.com, headquartered in Nashville, TN, is a leading provider of health-care price and quality transparency solutions to employers, third-party administrators (TPA), health plans and provider organizations. Healthcare Bluebook products help employers and employees save money by enabling consumers to understand local health-care prices, compare providers on price and quality and shop for care anywhere in the U.S.

HealthSmart

For more than 40 years, HealthSmart has offered a wide array of customizable and scalable health-plan solutions for self-funded employers. HealthSmart's comprehensive service suite addresses individual health from all angles. This includes claims and benefits administration, provider networks, pharmacy, benefit-management services, business intelligence, onsite employer clinics, care management, a variety of health and wellness initiatives and Web-based reporting.

Appendix A: Methodology

Data Source

All analysis was conducted using a national sample of de-identified commercial claims for calendar year 2014.

Estimating Potential ASC Savings for the Commercially Insured U.S. Population

The estimated potential ASC savings for the commercially insured U.S. population is calculated as:

Equation 1

Addressable Spend per Commercially Insured Person \$890	X	Percent Savings from ASCs 20.6%	X	Commercially Insured Population 208.6M
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Estimating the Addressable Spend per Commercially Insured Patient

The addressable spend is the expenditure on any procedure that could be performed in an ASC for an ASC-eligible patient, whether that patient is ASC eligible or not. (Adjustments for ASC ineligibility are made later in the process. See Appendix B: Adjustments for ASC Ineligibility.) All prices are calculated using the allowed amount, which is the actual amount a provider receives after any discounts are applied.

CMS currently covers 3,837 procedure codes in the ASC setting. Procedure codes from select Healthcare Bluebook ShopSmart™ procedures were added to the CMS list to produce a complete ASC-eligible procedure code list. These procedure codes were used to identify procedures in one

year of medical-claims data. For each procedure performed in an ASC or HOPD, the total anesthesia, professional and facility payments were included as part of the procedure price. All office-based, inpatient-based and emergent care was excluded. When the total payments from this process were divided by the total members in the represented population, the annual addressable spend per person was \$890.

Estimating Percent Savings from ASCs

To estimate the percent savings from ASCs, thirteen high-volume procedures were used as proxies to represent all ASC procedures. These procedures were selected for their high volume and standardization. The average ASC price was calculated for each procedure in each metropolitan market across the U.S.

The potential ASC savings is the sum of the differences between the price of each HOPD case and the average ASC case price for that metropolitan market and procedure combination. Market and procedure combinations with limited data volume were excluded.

Equation 2

$$\text{potential ASC savings} = \sum_{m,p,h} \text{cost}_{m,p,h} - \text{average_ASC_price}_{m,p}$$

m = market
p = procedure
h = HOPD case

To produce the ASC savings as a percentage, the potential ASC savings was divided by the total spend for all analyzed markets and procedures and multiplied by one hundred.

Equation 3

$$\text{percent savings from ASCs} = \sum_{m,p,h} \frac{\text{potential ASC savings}}{\text{total spend}} \times 100$$

Estimating Potential Savings from Total Hip & Total Knee Replacements

To estimate potential savings from moving total hip and knee replacements to the ASC setting, Equation 1 from above was used, but with \$73.59 as the addressable spend per commercially insured person. This represents 1.5 percent of total medical spend per commercially insured person. The 20.6 percent savings opportunity was not changed because there are not currently enough markets offering ASC-based joint replacement to use as a representation of the entire U.S. However, the savings opportunity may be as much as double this estimate based on markets that currently have ASC-based total joint replacements.

Appendix B: Adjustments for ASC Ineligibility

Some patients will not qualify for treatment in an ASC setting due to comorbidities or other complicating factors. To account for this, potential ASC savings were estimated using three assumptions for what percent of the commercially insured population is ASC ineligible: 1 percent, 3 percent and 7



percent. These percentages were selected based on prevalence rates for three common conditions that may make patients ineligible for care at an ASC for some procedures (Table 3).

Seven percent ASC ineligibility is the upper limit of this sensitivity analysis since it is the sum of the prevalence rates of all three conditions, which are not independent and which don't necessarily disqualify patients from ASC-based care. For example, a patient with a body mass index (BMI) of 41 could still be cared for in an ASC for most if not all procedures performed in an ASC. However, a patient with a BMI of 45 would qualify for fewer procedures in an ASC setting.

Three percent was selected as the expected rate of ASC ineligibility in a commercially insured population. This, however, could still be an overestimation, so we have also included the one-percent ASC-ineligibility threshold.

For each of these ASC-ineligibility rates, a corresponding number of cases per market/procedure combination were assumed to be performed at the average HOPD price and excluded from the migration calculation. See Table 4 for the sensitivity impact on estimated savings.

Common Conditions that Effect ASC Eligibility

Condition	Prevalence (% of U.S. Population)	Notes
Latex Allergy	< 1%	Some ASCs are not equipped with a latex-free operating room.
CKD (with Dialysis)	0.1%	Not a disqualifying condition for all procedures performed in ASCs.
BMI > 40	6.3%	Patients with BMI > 45 are almost always ASC ineligible. Not all patients with BMI between 40 and 45 are ASC ineligible.

Table 3

Effect of ASC-Ineligibility on Potential Savings

	Savings as % of Total Addressable Spend	Potential Annual Savings
0% ASC Ineligible	22.1%	\$41.0 B
1% ASC Ineligible	21.6%	\$40.1 B
3% ASC Ineligible	20.6%	\$38.2 B
7% ASC Ineligible	18.6%	\$34.5 B

Table 4

Appendix C: Savings Examples

Procedure prices in most U.S. markets can vary by as much as 500 percent. In most cases, when present, ASCs provide the best value.

Procedure	Market	Lowest Price Provider Type	Lowest Price	Average ASC Price	Average HOPD Price	Average Price Difference
Cataract Surgery	Charleston, WV	ASC	\$2,684	\$2,932	\$5,762	\$2,830
Cataract Surgery	Evansville, IN	ASC	\$2,450	\$3,316	\$6,992	\$3,676
Cataract Surgery	Tulsa, OK	ASC	\$2,248	\$2,249	\$3,833	\$1,335
Knee Arthroscopy	Fayetteville, NC	ASC	\$5,924	\$7,658	\$11,575	\$3,917
Knee Arthroscopy	Charlotte, NC	ASC	\$5,664	\$6,118	\$12,493	\$6,375
Knee Arthroscopy	Tulsa, OK	ASC	\$2,627	\$2,844	\$4,807	\$1,963
Knee Arthroscopy	Phoenix, AZ	ASC	\$2,355	\$2,972	\$4,306	\$1,334

Attachment 34

Availability of Funds

There are no costs associated with this project other than filing, consulting and attorneys fees which have or will be paid out of operations of Dr. George N. Atia's physician practice.

Attachment 35

Financial Viability Waiver

All of the projects capital expenditures are completely funded through internal sources.

Attachment 37

Economic Feasibility

A. Reasonableness of Financing Arrangement

Included with this attachment is a notarized statement of the applicant attesting that the total estimated project costs and related costs will be funded in total with cash and equivalents.

B. Reasonableness of Project and Related Costs

There are no new construction or modernization costs associated with this project.

C. Projected Operating Costs

The projected direct annual operating costs by the second year following project completion is \$533 per case.

D. Total Effect of the Project on Operating Costs

There are no projected annual capital costs for the first full year at target utilization as the only costs associated with the project are filing, consulting and attorneys fees associated with this application.

ATTACHMENT 38

Safety Net Impact Statement

The proposed ASTC will not have an adverse impact on essential safety net services in the community. The project will provide outpatient gastroenterology services to Medicaid patients that are not currently available in the community. To the applicants' knowledge, the project will not adversely impact the ability of another provider or health care system to cross-subsidize safety net services.

The applicants do not currently own or operate any health care facilities and, therefore, there are no methodologies specified by the Review Board for reporting historical amounts of charity care or Medicaid information. In addition, the applicant Aghapy Surgical Center, S.C., is a newly formed entity for purposes of this project. The applicant George N. Atia, M.D., S.C. estimated charity care and Medicaid information is set forth in the table below.

ATTACHMENT 39

Charity Care Information

The applicants are not existing health care facilities and, have no historical charity care reported.

Daniel J. Lawler
Partner
(312) 214-4861
daniel.lawler@btlaw.com

August 16, 2018

VIA OVERNIGHT DELIVERY

Courtney R. Avery
Administrator
Illinois Health Facilities and Services
Review Board
525 West Jefferson Street
2nd Floor
Springfield, IL 62761

Re: Aghapy Surgical Center, Barrington

Request for Expedited Review

Dear Ms. Avery:

Enclosed is a Certificate of Need to establish a single specialty ambulatory surgical treatment center in Barrington, Illinois for gastroenterology surgery services, and check in the amount of \$2,500 for the filing fee.

The project is unique in that the only project related costs are for filing, consulting and legal fees as the location of the proposed ASTC is in a building that was built to ASTC licensing standards, though the facility is not currently licensed as an ASTC. In addition, while the facility will be physician-owned it will be provide services to a relatively high percentage of Medicaid patients. Finally, all of the patient volume supporting the proposed project is based on historical referrals to licensed hospitals.

For the above reasons, we respectfully request expedited review of the project and scheduling on the Review Board's October meeting.

Sincerely,
Barnes & Thornburg, LLP



Daniel J. Lawler