# Hospital and Patient Trends Impacting the State Medical Facilities Plan

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*This presentation is a general overview meant to provide members of the SHCC with basic information. Any data errors present are unintentional. Nothing said during this presentation should be construed as either an endorsement or a criticism of the providers mentioned.*

*I want to express my personal appreciation to the Healthcare Planning staff and others who supplied data and helped me refine today's presentation.*

# CON Law and Process

- The State Medical Facilities Plan (SMFP) is governed by three Basic Principles: Safety and Quality, Access, and Value.
- NC SMFP need methodologies are patient utilization “centric,” not hospital, physician, or corporate determined. The SMFP is annually reviewed and modified. A transparent petition process provides the opportunity for modification of the SMFP methodology and for local adjustments when the statewide process is inadequate. There is ample opportunity for public input as part of NC’s process.
- The CON process compels very careful spending and prioritization of capital projects.  The result is better projects without duplication of services that cannot be supported by patient service volumes.

# Medical Care is a Highly Constrained "Economic Ecosystem"

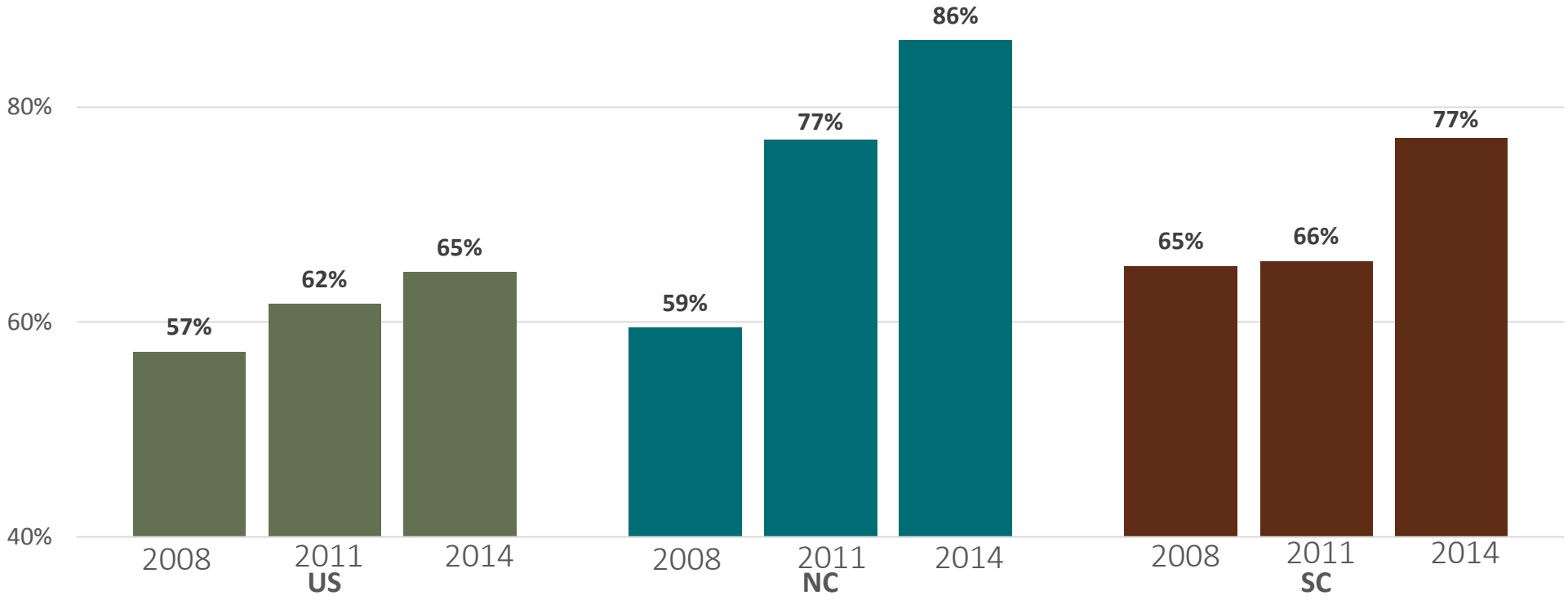
- Medicare, Medicaid, & TRICARE use annual government price fixing formulas.
  - Medicare Physician payments are calculated at 50% of the cost of service; No operating margin component!
  - For physician specialists, NC Medicaid is 72-78% of NC Medicare.
- Most physician private insurance contracts are indexed to Medicare.
- Hospital integration, physician alignment, insurance-related narrow networks, benefit managers, steerage, out of network issues, episodes of care and bundled payments, ACOs, CINs, provider at-risk contracts, etc.. create economic constraints for patients, physicians, and hospitals.

# Medical Care is a Highly Constrained "Economic Ecosystem"

- Hospital payments are on different CMS formulas. These are very complex and beyond the time to discuss today. A critical access hospital is a federally designated facility which receives very modest extra government funding intended to keep "the doors open."
- Government mandated "volume to value" payments and "population health" goals and penalties require tight physician/hospital integration and "deep pockets" to manage cost and risks. Downside risk creates the possibility of provider financial failure and community loss of access.
- In many counties, the local hospital is the largest employer, and is viewed as a vital community asset.
- My simple view: No operating margin, no mission.

# Hospitals within Health Systems

*Today, many hospitals have joined integrated networks to gain economies of scale, contracting and information technology expertise , and to more effectively leverage network offerings.*



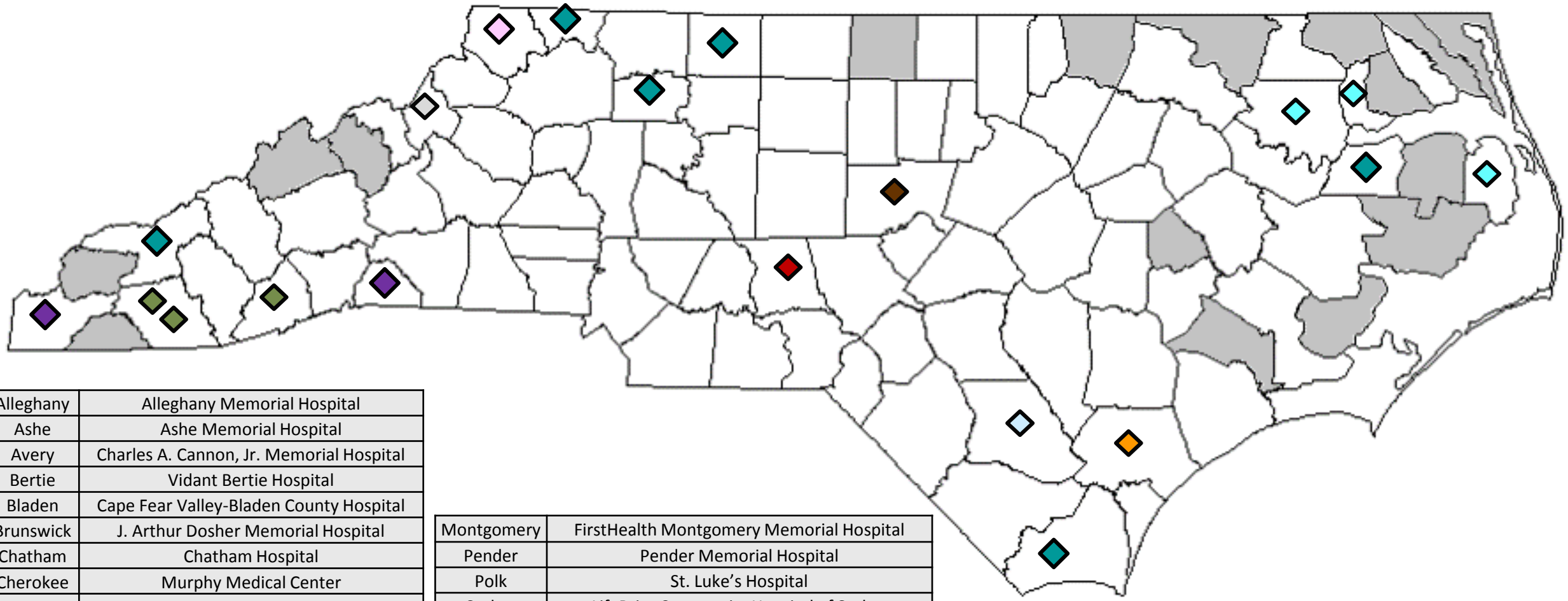

*Sources: American Hospital Association, 2016 Hospitals Statistics Book*

Nothing Compares NORTH CAROLINA

# North Carolina Has 100 Counties

- 14 have 2 full service hospitals / systems. One county has 3 systems.
- 67 have 1 full service hospital.
- 18 have no hospital.
- 19 critical access hospitals (4 recent insolvencies).
- Large integrated hospital and university systems with employed physicians are very common.
- Large private practice or corporate single-specialty and multi-service line corporations with employed physicians are growing.

# Critical Access Hospitals



| | |
|---|---|
| Alleghany | Alleghany Memorial Hospital |
| Ashe | Ashe Memorial Hospital |
| Avery | Charles A. Cannon, Jr. Memorial Hospital |
| Bertie | Vidant Bertie Hospital |
| Bladen | Cape Fear Valley-Bladen County Hospital |
| Brunswick | J. Arthur Dosher Memorial Hospital |
| Chatham | Chatham Hospital |
| Cherokee | Murphy Medical Center |
| Chowan | Vidant Chowan Hospital |
| Dare | The Outer Banks Hospital |
| Macon | Angel Medical Center |
| | Highlands-Cashiers Hospital |

| | |
|---|---|
| Montgomery | FirstHealth Montgomery Memorial Hospital |
| Pender | Pender Memorial Hospital |
| Polk | St. Luke's Hospital |
| Stokes | LifeBrite Community Hospital of Stokes |
| Swain | Swain Community Hospital |
| Transylvania | Transylvania Regional Hospital |
| Washington | Washington County Hospital |

*Note: Counties in grey do not have a hospital. In addition, Franklin and Yadkin Counties also have no hospital.*

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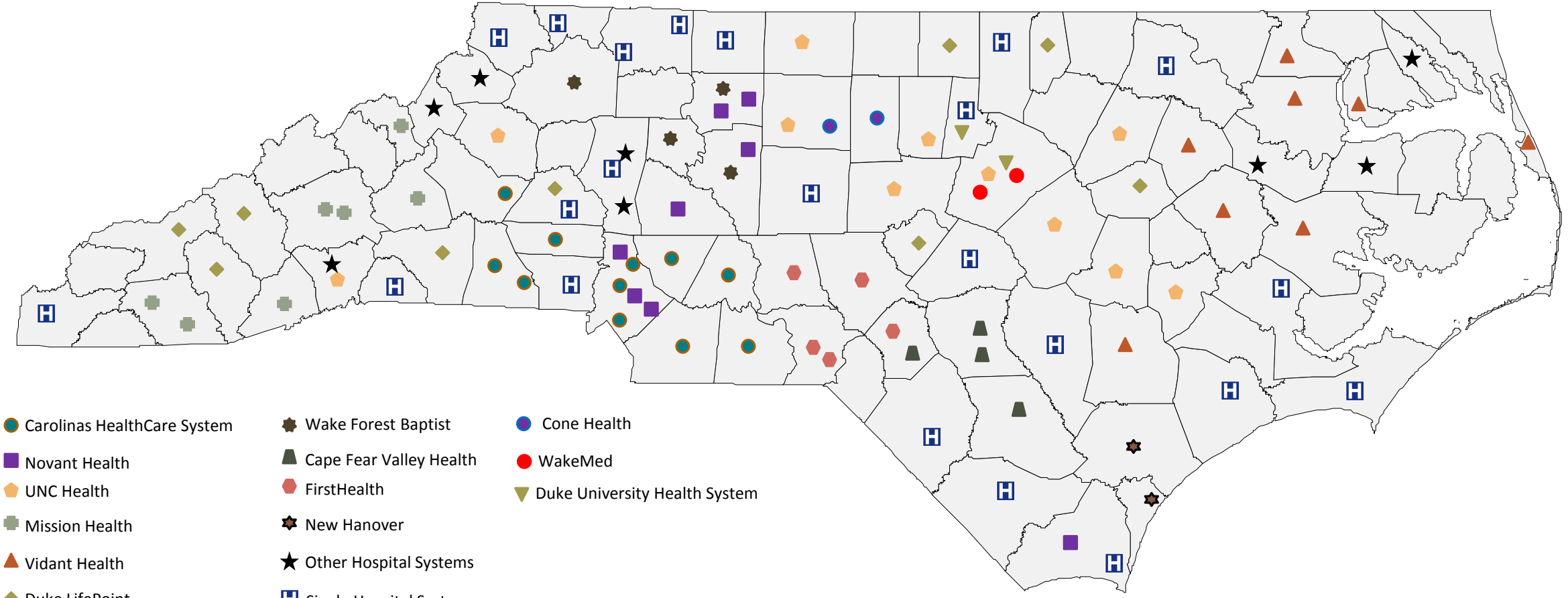
# North Carolina Hospital Systems 2018

As of January 25, 2018




**NOTE: Where another symbol is combined with an H it represents a single hospital system affiliated with a system for shared services or purchasing only.**

*Source: North Carolina Hospital Association, 2017*

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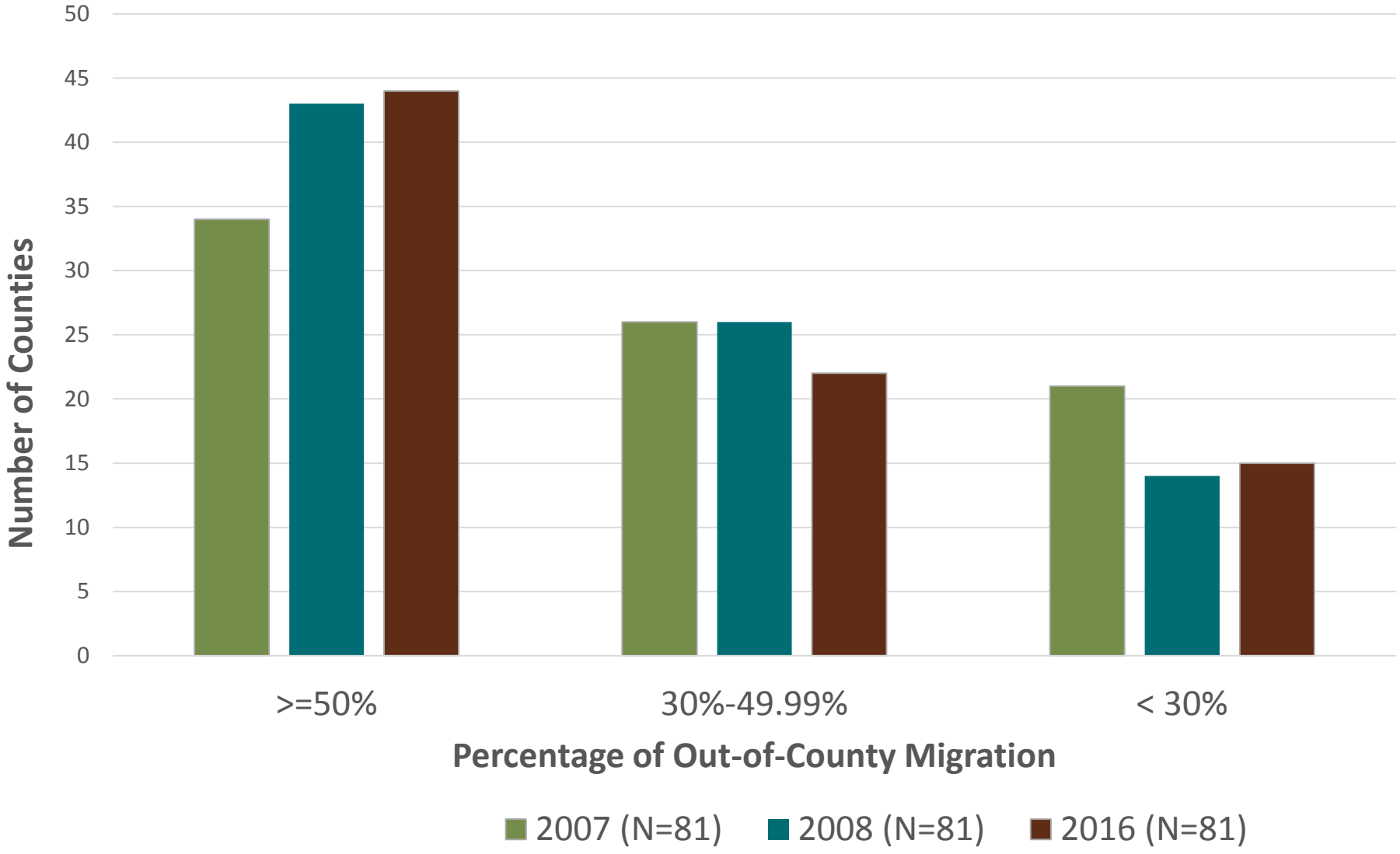
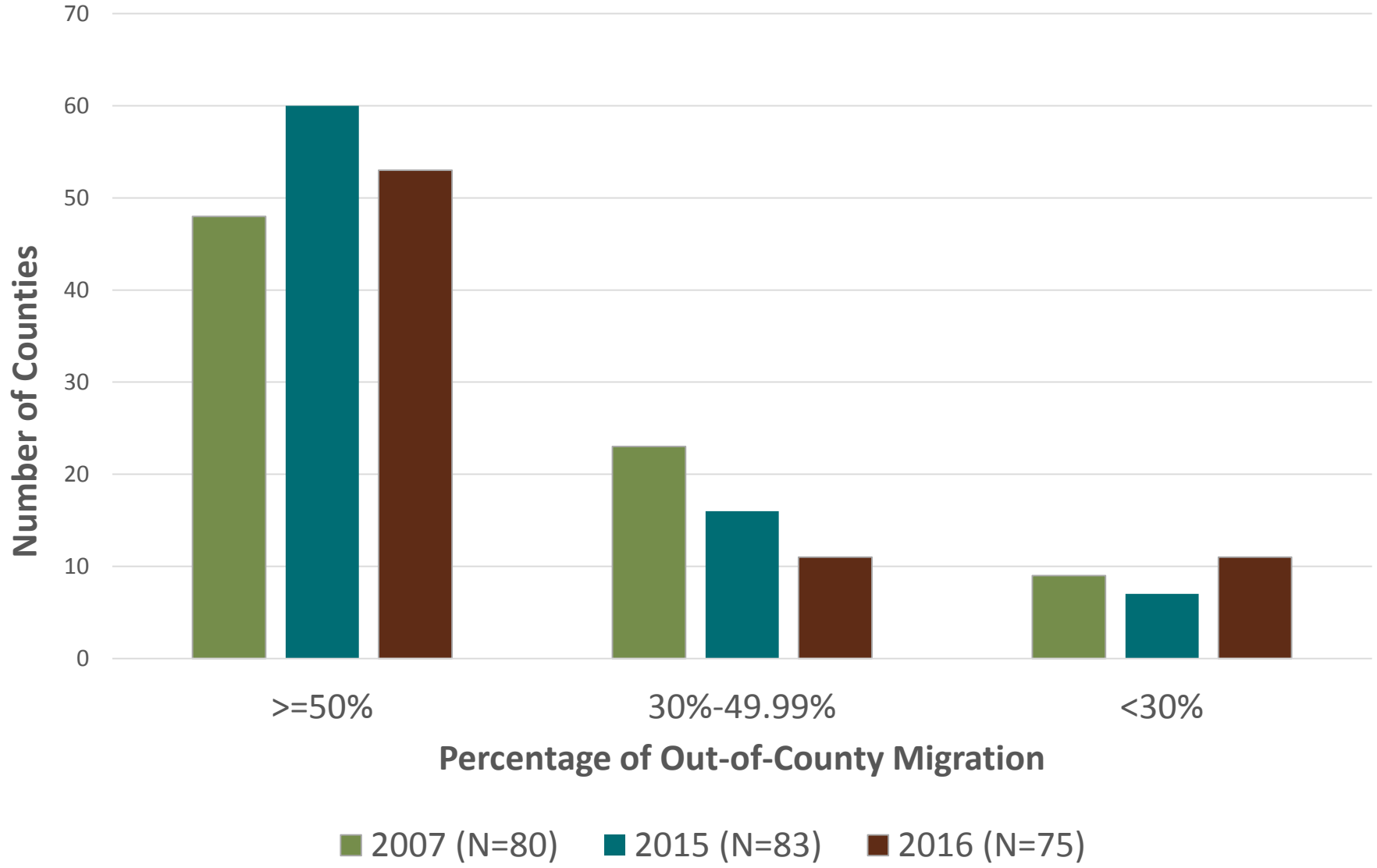
# Percentage of Out-of-County Migration of General Acute Care Inpatients: 2007, 2015, and 2016



# Percentage of Out-of-County Migration of Inpatient Surgical Patients: 2007, 2015, and 2016

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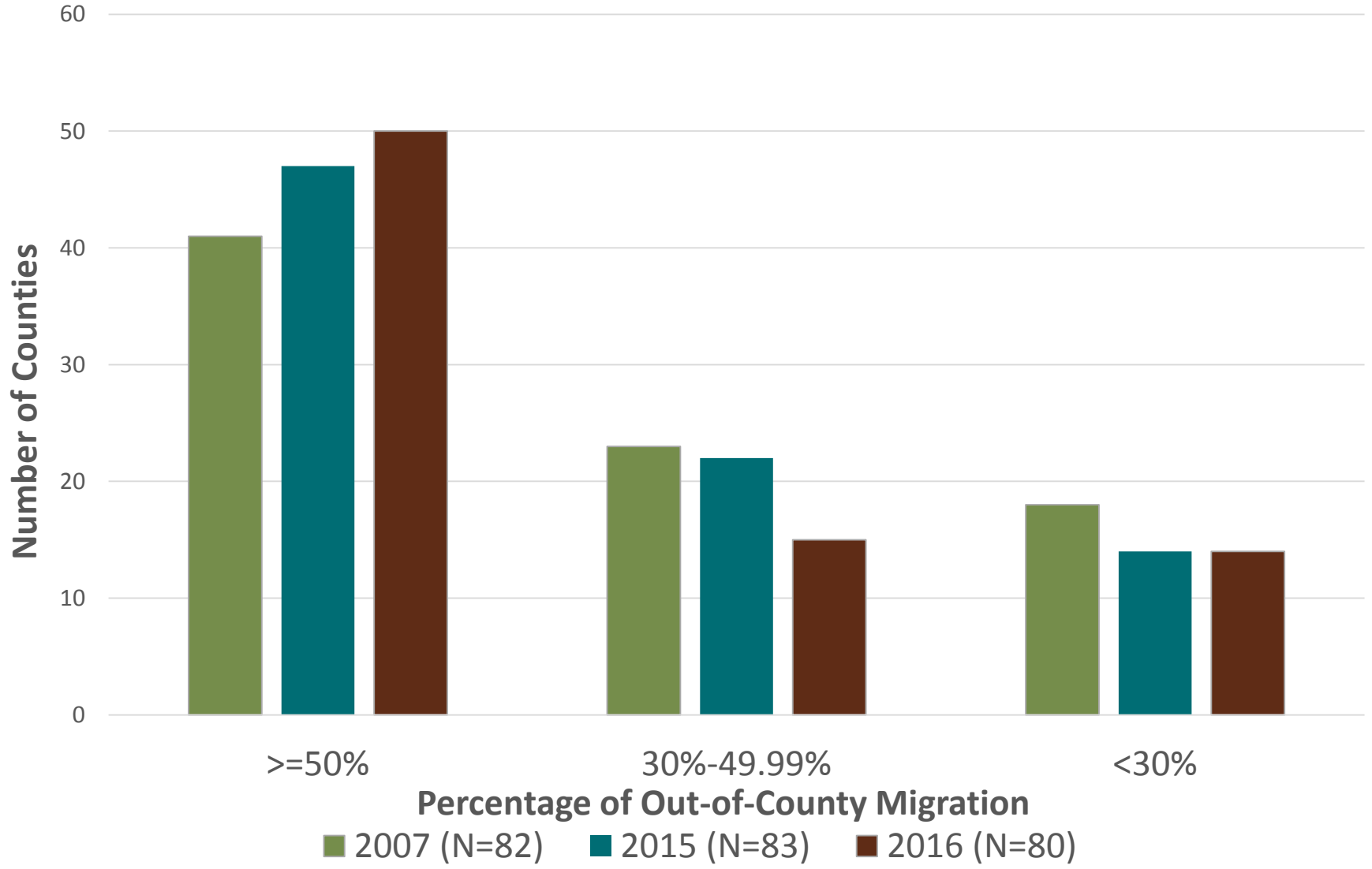
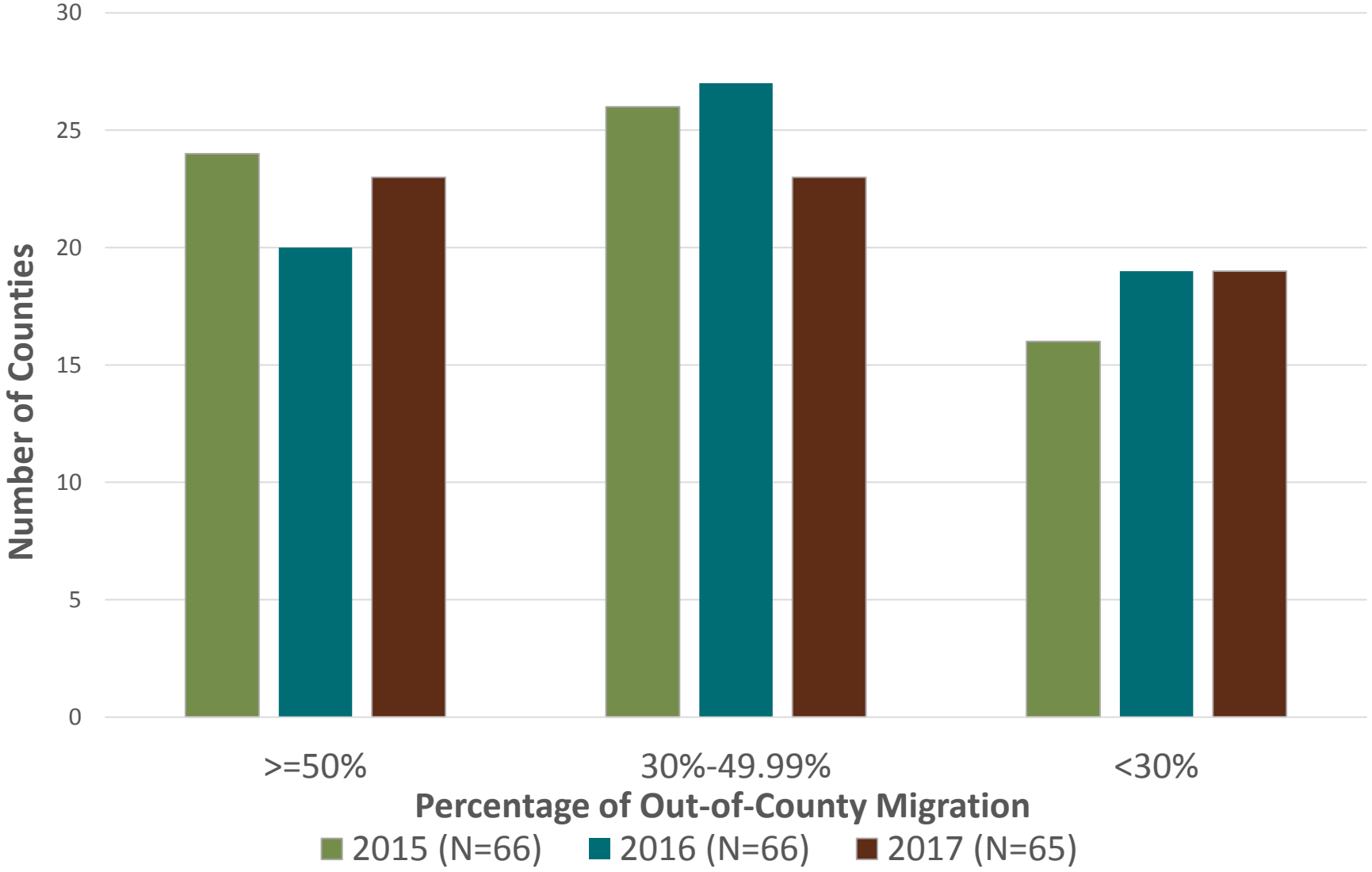
# Percentage of Out-of-County Migration of Ambulatory Surgical Patients: 2007, 2015, and 2016



# Percentage of Out-of-County Migration of MRI Procedures (Fixed Equipment Only): 2015 - 2017



# Total Hospitals in North Carolina, 2015

**106**

**"Top 5"**

Within the top 15, the top 5 are the Academic Medical Center Teaching Hospitals

**"Big 15"**

The top 15 hospitals, ranked by ADC, in urban and suburban counties in North Carolina

**"Other 91"**

Mostly smaller and rural hospitals in North Carolina

| Big 15 Hospitals | 2015 ADC | % Occupancy |
|---|---|---|
| **Duke University Medical Center** | **745** | **80.7** |
| **Carolinas Medical Center** | **742** | **91.2** |
| **UNC Medical Center** | **649** | **89.7** |
| **Wake Forest Baptist Medical Center** | **636** | **79.3** |
| **Vidant Medical Center** | **622** | **79.5** |
| Novant Health Forsyth | 576 | 70.0 |
| Mission Hospital | 517 | 73.8 |
| Moses H Cone Memorial Hospital | 501 | 64.5 |
| New Hanover Regional Medical Center | 490 | 75.7 |
| WakeMed – Raleigh Campus | 462 | 78.7 |
| Cape Fear Valley Medical Center | 453 | 92.4 |
| Novant Health Presbyterian | 379 | 62.8 |
| UNC Rex Hospital | 337 | 89.7 |
| CHS NorthEast | 286 | 64.0 |
| First Health Moore Regional Hospital | 246 | 78.9 |

*Source: Truven, 2016*

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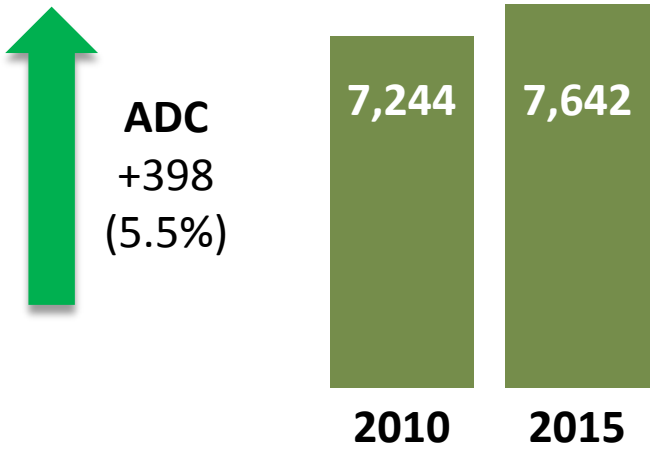
# NC Healthcare Urbanization, ADC from NC residents, 2010-2015

## "Big 15"




- From 2010 to 2015, 13 of the 15 grew census.
- From a patient origin perspective, 243 of the 398 (61%) ADC growth came from rural counties, despite slower population growth in rural counties versus urban counties.
- Big 15 hospitals averaged an occupancy rate of 78% in 2015.

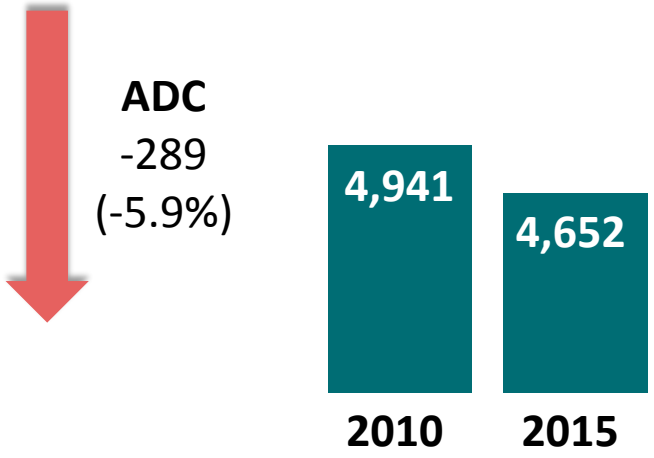
| | Avg. ADC |
|---|---|
| **2010** | 483 |
| **2015** | 509 |

* Per hospital

NOTE: Neonates defined by DRG; 2015 data Jun YTD annualized; Excludes IP Behavioral Health, IP Rehab.

# NC Healthcare Urbanization, ADC from NC residents, 2010-2015

## "Other 91"




- Since 2010, 62% of hospitals experienced a decline in census, despite an average population growth of 3.5% and 4.9% in rural and suburban counties, respectively.
- 6 hospitals in rural counties closed or transitioned to OP (Valdese Hospital, Franklin Regional, Our Community, Vidant-Pungo, Yadkin Valley, FirstHealth-Hamlet).
- The Other 91 hospitals averaged an occupancy rate of 43% in 2015. In order to maintain patient access, SHCC policies need to avoid damaging these vulnerable hospitals.

| | Avg. ADC |
|---|---|
| **2010** | 54 |
| **2015** | 51 |

* Per hospital

NOTE: Neonates defined by DRG; 2015 data Jun YTD annualized; Excludes IP Behavioral Health, IP Rehab.

# Hospital Trends Impacting the SMFP

- 67 of NC counties have 1 hospital;  19 Critical Access Hospitals are currently operational;  18 NC counties do not have an operational hospital now.
- Medical care is a highly constrained economic ecosystem (market).
- Integrated hospital systems and physician groups are a megatrend.
- Patients are choosing to receive their care in more centralized facilities. The “Big 15” are providing more care. Many of the “Other 91” struggle. The “Top 5” are NC’s Academic Medical Centers.

# Hospital Trends Impacting the SMFP

- SHCC policies need to avoid damaging the “Other 91” if patient access is to be maintained in many of our NC counties. Our most specialized hospitals also need adequate facility capacity to meet patient’s site of care choices and needs.
- For many reasons, the 20th century health care delivery model is no longer sustainable. Patient and physician preferences, as well as changing government and insurance payment levels, models, and policies increasingly require a transition to a 21st century health care delivery paradigm.