RESPONSE OF FIRSTHEALTH OF THE CAROLINAS, INC. TO PETITION BY CAPE FEAR VALLEY HEALTH SYSTEM TO ADJUST THE ACUTE CARE BED AND OPERATING ROOM SERVICE AREAS FOR HOKE COUNTY IN THE 2010 SMFP

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FirstHealth of the Carolinas, Inc. ("FirstHealth") files this response in opposition to the petition filed on July 6, 2009 by Cape Fear Valley Health System ("CFVHS") to adjust the acute care bed and operating room service areas for Hoke County in the 2010 State Medical Facilities Plan ("SMFP"). FirstHealth has previously responded to the portion of CFVHS' petition that proposes an adjustment to the MRI service areas for Hoke County in the 2010 SMFP. For the reasons stated below, changing service areas is a complicated process that has significant public policy implications for state-wide health planning. If the SHCC determines that the issue of service areas merits attention, then it should convene a work group to examine the issue thoroughly and make recommendations for *all* multi-county groupings in the SMFP, and for *all* services in the SMFP that are subject to multi-county groupings.

Background

At the present time, Hoke County has no hospital, operating rooms or MRI scanner. Hoke County and Moore County have been combined as a multi-county service area for purposes of acute care beds, operating rooms, and MRI because, for many years, FirstHealth Moore Regional Hospital provided the largest number of inpatient days of care to residents of Hoke County. *See* Proposed 2010 SMFP, Chapter 9. CFVHS is seeking to change the Moore-Hoke service area to a Cumberland-Hoke service area on the basis of a one-year change. CFVHS is further asking that Moore County be designated a single county for purposes of acute care beds, operating rooms, and MRI. According to the information CFVHS provides in its petition, for the first time, CFVHS provided more inpatient days of care in FY2008 to Hoke County residents than did FirstHealth Moore Regional. This is based on data that Thomson Reuters released in April 2009. CFVHS' petition discusses only the Moore-Hoke service area and does not propose to make changes to any other multi-county service area. There are, of course, several other multi-county service areas in North Carolina identified in the draft 2010 SMFP; specifically, 12 multi-county acute care bed service areas as described in Figure 5.1; 12 multi-county operating room service areas as described in Figure 6.1; 27 multi-county linear accelerator service areas as described in Table 9G; and 12 multi-county MRI service areas as described in Table 9K. PET scanners are grouped according to Health Service Areas, which is another form of multi-county grouping. Lithotripsy services are grouped according to mobile hospital sites, which establish multi-county service areas. Inpatient rehabilitation beds are also grouped according to Health Service Area.

FirstHealth has filed a CON application proposing to develop an 8-bed hospital in Hoke County. CFVHS has filed its own CON application proposing to develop a 41-bed hospital near the Hoke-Cumberland border in Cumberland County. Service areas cannot be changed while a CON application is under review, as the CON Section must apply the SMFP in effect at the time the application is submitted. Decisions on these applications will be due in late November 2009. These applications have been deemed competitive by the CON Section and litigation may follow the Agency's decision.

As explained in the following points, the SHCC may wish to defer making any changes in the service areas until the CON process and any appeals have been completed.

Reasons why FirstHealth opposes the petition

FirstHealth opposes CFVHS' petition for the following reasons:

1. CFVHS' acute care bed petition is based on only one year's worth of data that purports to show inpatient days in the aggregate, excluding newborns.[1] The Moore-Hoke service area has been in place since the 2004 SMFP, when the State Health Coordinating Council decided to convert to single county acute care bed service areas. Regardless of what the FY2008 Thomson Reuters data shows in the aggregate, FirstHealth Moore Regional still provides a very significant amount of care to Hoke County residents. In this regard, it is important to consider discharges at the service line level using Thomson Reuters FY2008 Inpatient DRG data. Comparing FY2008 Hoke County discharges at the DRG service line level and including all obstetrics-related DRGs for CFVHS and FirstHealth Moore Regional, FirstHealth had more discharges of Hoke County residents in:

    - cardiology
    - dermatology
    - endocrinology
    - gastroenterology
    - general medicine
    - general surgery
    - hematology
    - nephrology
    - neurology
    - open heart
    - orthopaedics
    - otolaryngology
    - psychiatric/drug abuse
    - pulmonary
    - rheumatology
    - thoracic surgery
    - urology
    - vascular surgery

    Please see Attachment 1 to this response.[2] The most significant areas where CFVHS has more discharges than FirstHealth Moore Regional is in the obstetrics-related DRGs. CFVHS is essentially asking the SHCC to make a major planning change because CFVHS provided more obstetrics-related services to Hoke County residents than did FirstHealth Moore Regional in FY2008.

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[1] CFVHS notes that its acute inpatient days of care provided to Hoke County residents has been increasing. *See* Petition, page 3. This is not relevant. The test applied in the SMFP is "the largest number of inpatient days of care to the residents of the county that has no hospital." *See* Proposed 2010 SMFP, Chapter 9. The test is not whether the provider's inpatient days of care have been increasing.

[2] The chart on page 3 of the CFVHS petition indicates that only newborn inpatient days were excluded from CFVHS' calculations, which suggests that other obstetrics-related DRGs were included in CFVHS' calculations.

According to the data supplied on page 3 of CFVHS' petition, over the last four fiscal years, FirstHealth Moore Regional provided more (approximately 42%) of the acute inpatient days of care to Hoke County residents than did any other single provider. In only one of these four years has CFVHS provided more acute inpatient days of care to Hoke County residents than did FirstHealth Moore Regional. With respect to surgical cases, CFVHS' chart on page 5 of its petition indicates that in FY2007 and FY2008, Cumberland County surgical providers handled more Hoke County surgical cases than did Moore County surgical providers. However, CFVHS does not mention that during part of this time period, FirstHealth Moore Regional was without neurosurgical coverage which impacted surgical volumes. FirstHealth has hired four neurosurgeons so this situation has been corrected.

Before the SHCC makes a significant change to the SMFP, it should have the benefit of more data over a longer period of time, not just a one year snapshot worth of data that may not be indicative of a long-term change in usage patterns. The SHCC must also be certain that the data used to support any changes have been checked thoroughly for accuracy and is complete before any changes are made to service areas. The SHCC should also be certain that the change is truly representative of multiple DRGs and that a particular service line is not "skewing" the data. As discussed above, the most significant differences between FirstHealth and CFVHS relate to obstetrics-related discharges.

If the SHCC decides that the issue of multi-county service areas needs attention, a work group, composed of a cross-section of representatives, should be formed to study the issue of multi-county service areas thoroughly. FirstHealth notes that Wake Forest University Baptist Medical Center, Duke, UNC and Carolinas have all submitted comments to the Medical Facilities Planning Section in which they recommend that the Acute Care Bed Need Methodology Work Group be reconvened. This work group could study whether service areas need to be changed.

Upon review, the work group might recommend that the methodology used to create multi-county service areas should be changed. For example, acute care bed and MRI multi-county service areas are now based on inpatient days of care. It should be noted that when a hospital actively works to decrease lengths of stay that patients and the health care system will experience lower costs. However, a methodology based on patient days may unintentionally "reward" providers that are not actively working to decrease lengths of stay or that have inefficient discharge policies, which results in more inpatient days of care and greater costs to the patient and health care system. One of the basic principles of the SMFP is to promote cost-effective alternatives to inpatient care and to reduce average length of stay. The work group may therefore determine that a methodology based on patient days is not the best metric to employ in developing multi-county service areas.

The work group might recommend that multi-county service areas should be based on number of admissions, number of discharges, acuity levels, charity care or some other measure. The work group might decide to use a combination of measures. The work group might also determine that any changes made to multi-county service areas should be based on an analysis of several years' worth of data, such as a three or five year average. This would help ensure that any changes are based on long-term patterns and not just on aberrations. It might also be relevant to consider the views of the residents of the county without the hospital, so they have some say in the county (and thus the hospital) with which they are combined. Consistent with Policy Gen-3 and the Basic

Principles that are the underpinning of the SMFP, the work group might also want to consider how changing service area groupings could potentially impact charges to patients or charity care to the medically underserved.

In the case of Hoke County for example, Thomson Reuters data show that CFVHS is significantly more expensive than FirstHealth Moore Regional in several areas:

Hoke County
All FY2008 Emergency Department Visits

	Visits	Total Charges	Charge per Visits	Variance
Hoke County ED Patients				
CFVMC	4,602	$6.7 million	$1,464	
FMRH	4,883	$6.0 million	$1,236	15.6% Less
All ED Patients				
CFVMC	83,676	$130.5 million	$1,561	
FMRH	48,467	$60.0 million	$1,238	20.7% Less

Source: Emergency Department Data, Thomson Reuters, March 2009.

FY2008 Emergency Department Visits
Primary Diagnosis Comparison

		Average Charge		
Primary Dx	Description	CFVMC	FMRH	FMRH Variance
3829	Otitis media NOS	$427	$168	-61%
4659	Acute URI NOS	$544	$218	-60%
462	Acute pharyngitis	$673	$273	-59%
4660	Acute bronchitis	$1,362	$643	-53%
07999	Viral infection NOS	$746	$368	-51%
5990	Urinary tract INF NOS	$2,032	$1,042	-49%
49392	Asthma NOS w exacer	$1,329	$733	-45%
0340	Strep sore throat	$719	$436	-39%
7840	Headache	$2,387	$1,458	-39%
78703	Vomiting alone	$1,368	$904	-34%
7806	Fever	$1,067	$720	-33%
7242	Lumbago	$1,363	$1,046	-23%
8470	Neck sprain	$1,871	$1,474	-21%
7802	Syncope & collapse	$2,487	$2,787	12%

Source: Emergency Department Data, Thomson Reuters, March 2009.

As the previous table indicates, for the most commonly diagnosed diseases in the Emergency Department, FMRH has a lower charge in 13 of the 14 common Primary Diagnosis Codes included in the Thomson Reuters report. No acuity adjustments are needed for these diagnosis codes and an acuity adjustment cannot account for a 61% increase in charges for a middle ear infection. The average variance from CFVMC average charge to the FMRH average charge is 40.0 percent.

If the work group recommends that changes should be made to the multi-county service areas, the work group should also determine how often it will need to re-evaluate the issue, i.e., annually, every three years, etc. Providers will need to have some certainty so that they can plan their CON activities accordingly. For example, if a provider is uncertain whether a service area might change, the provider might refrain from investing the time, effort and expense associated with preparing a CON application. This in turn might disadvantage residents of the area who could benefit from the proposed service.

Finally, the work group might also recommend that multi-county service areas are no longer necessary and should be abolished entirely.

All of these variations show that the issue of multi-county service areas is complex and therefore deserves careful study before any changes are made. At the earliest, changes might be implemented in the 2011 SMFP, but there is not sufficient time left in 2009 to thoroughly study the issue in time for the 2010 SMFP.

2. CFVHS' petition and the proposal contained in the petition are incomplete and designed solely to benefit CFVHS. There are, of course, several other multi-county service areas in North Carolina besides Moore-Hoke service area identified in the draft 2010 SMFP; specifically, 12 multi-county acute care bed service areas as described in Figure 5.1; 12 multi-county operating room service areas as described in Figure 6.1; 27 multi-county linear accelerator service areas as described in Table 9G; and 12 multi-county MRI service areas as described in Table 9K. PET scanners, lithotripsy services, and inpatient rehabilitation beds are also subject to multi-county groupings. The SHCC has responsibility for developing a health plan for the entire State. If the SHCC determines that any changes need to be made to the Moore-Hoke service area, it must also review all other multi-county service areas to ensure consistency in the development of the SMFP. Likewise, the SHCC must also review all services that are subject to multi-county groupings. The SMFP covers many services in addition to acute care beds, operating rooms and MRI. The SHCC should not make selective changes that will benefit one provider that happens to be involved in a competitive CON review. Indeed, should the FirstHealth application be approved, Hoke County would become its own service area and presumably CFVHS' petition would become moot. Again, a work group that would study *all* of the multi-county service areas and *all* affected services is preferable to a piecemeal change that benefits only one provider in a competitive CON review.

3. It is not clear that there is a problem at the present time that needs to be fixed. CFVHS is the only provider that has asked for a change in multi-county groupings. CFVHS states that one reason the SHCC should change the service areas is because it would "allow the development of expanded services for residents of Hoke County in Hoke County...by allowing those residents to continue to use resources at Cape Fear Valley." *See* Petition, page 6. Residents of Hoke County already have access to the services of CFVHS both inside and outside of Hoke County. For example, CFVHS operates Hoke Family Medicine in Hoke County. CFVHS has recently filed a CON application to develop a diagnostic center in Hoke County. CFVHS has also recently filed a CON application proposing a 41-bed hospital near the Hoke-Cumberland border. CFVHS maintains in that application that its proposed hospital will offer excellent access for Hoke County residents. The Moore-Hoke service area alignment did not preclude CFVHS from filing this application. If the application is approved, CFVHS proposes to serve not only Hoke residents but also the population growth due to the Department of Defense's Base Realignment and Closure (BRAC) program. It is also worth noting that CFVHS asked for this change in the service areas after it had filed a CON application proposing to build a hospital. CFVHS announced its plans to build its 41-bed hospital about two weeks after FirstHealth announced its plans.

4. The fact that there are competitive CON applications currently under review in which the applicants propose to build hospitals that would serve Hoke County residents also weighs in favor of the SHCC deferring the service area realignment issue until after all appeals related to this review are completed. The CON application and appeal process, which are clearly defined in the CON Law, should be allowed to run their course without a provider gaining an "advantage" through a change in service areas. If the FirstHealth application is approved, Hoke County will become its own service area, and CFVHS' petition will become moot. Likewise, if the CFVHS application is approved, CFVHS may decide to move forward with its project at its proposed location in Cumberland County and therefore, a change in service areas would not be needed by CFVHS. A change in service areas, in close proximity to a competitive CON review in which litigation is a distinct possibility, may draw the SHCC into a CON dispute, which the SHCC normally prefers to avoid.

Conclusion

FirstHealth respectfully submits that the CFVHS petition should be denied. If the SHCC determines that the issue of multi-county service areas needs attention, a work group should be formed and the issue should be thoroughly considered before any changes are made.

Hoke County
FY2008 Discharges
FMRH and CFVMC

DRG Service Line	FMRH Discharges	CVFVMC Discharges
CARDIOLOGY	247	179
DENTISTRY	2	3
DERMATOLOGY	23	14
ENDOCRINE	36	35
GASTROENTEROLOGY	155	92
GENERAL MEDICINE	107	91
GENERAL SURGERY	109	93
GYNECOLOGY	17	29
HEMATOLOGY	29	20
HIV	2	2
NEONATOLOGY	21	102
NEPHROLOGY	72	38
NEUROLOGY	77	55
NEUROSURGERY	3	4
NORMAL NEWBORNS	45	302
OB/DELIVERY	68	390
ONCOLOGY MEDICAL	12	13
OPEN HEART	17	12
OPHTHALMOLOGY	2	3
ORTHOPEDICS	122	48
OTHER	0	0
OTHER OB	13	60
OTOLARYNGOLOGY	11	4
PSYCH/DRUG ABUSE	86	56
PULMONARY	156	121
RHEUMATOLOGY	5	2
THORACIC SURGERY	12	7
TRAUMA	4	9
UROLOGY	16	9
VASCULAR SURGERY	26	21
Grand Total	**1,495**	**1,814**

Source: Thomson Reuters FY 2008 IP DRG