Petition to the State Health Coordinating Council Regarding Cardiac Catheterization Equipment Adjusted Need Determination For the 2012 State Medical Facilities Plan

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STATEMENT OF REQUESTED CHANGE

Iredell Health System requests the following special need adjustment to the *2012 State Medical Facilities Plan* (*Plan*).

Chapter 9, Cardiac Catheterization, should be changed as follows:

Table 9U. Fixed Cardiac Catheterization Equipment Adjusted Need Determination

Based on information submitted in a Special Needs Petition, it is determined that there is a need for one additional shared fixed cardiac catheterization laboratory in Iredell County in a program that provides both diagnostic and therapeutic (interventional) cardiac catheterizations.

Cardiac Catheterization Service Area	HSA	Fixed Cardiac Catheterization Adjusted Need Determination	CON Application* Due Date	CON Beginning Review Date
Iredell	III	1*	TBD	TBD

*Applicants must use existing equipment and show evidence that therapeutic catheterization procedures have been provided for the past 12 months.

REASONS FOR THE PROPOSED CHANGES

Overview

Iredell County's most active cardiac catheterization laboratory has reached 120 percent capacity and is still growing. Yet, the *Proposed 2012 State Medical Facilities Plan* ("Plan") shows no need for expanded capacity in Iredell County. The 2012 Plan should be adjusted to show a need determination in Iredell County. This proposed adjustment would address The Basic Principles of the *Plan,* yielding a solution that meets the tests of quality, access and value.

Value - Role of Cardiac Catheterization

Cardiac catheterization is the definitive tool for diagnosis and, in many cases for repair, of damaged heart vessels. The equipment is expensive and operation requires exceptionally skilled technicians, nurses and physicians. Thus, capacity, including equipment and staff, should be used judiciously and efficiently.

Appropriate use of cardiac catheterization includes:

- Identification of the extent and severity of coronary artery disease and evaluation of left ventricular function;
- Assessment of the severity of valvular or myocardial disorders such as aortic stenosis and/or insufficiency, mitral stenosis and/or insufficiency, and various cardiomyopathies to determine the need for surgical correction;
- Collection of data to confirm and complement noninvasive studies;
- Determination of the presence of coronary artery disease in patients with confusing clinical presentations or chest pain of uncertain origin;
- Repair of certain types of heart defects and stenotic heart valves; and
- Opening blocked arteries or inserting stents to strengthen arteries and improve blood flow.

A program that offers diagnostic and interventional / therapeutic procedures can reach a broader cross section of persons in need. Because such a program can repair damaged vessels, physicians and patients are more likely to choose it.

Access - Cardiac Disease in the Iredell Health System Service Area

The primary service area for Iredell Health System includes Iredell County, and parts of Alexander, Davie and Wilkes Counties.

According to the 2011 Update from the American Heart Association[1], the overall national death rate from cardiovascular disease was 251.2 per 100,000 residents in 2007. Heart disease accounted for one in every three (2.9) deaths in the United States. A more recent NC Justus-Warren Heart Disease and Stroke Prevention Task Force reported North Carolina cardiovascular disease accounted for one in every 3.2 deaths[2]. Rates are higher among black and white males, among black females, and among certain high risk groups.

Risk factors include obesity, hypertension, diabetes and metabolic syndrome. All of these risk factors are high in the Iredell Health System service area. According to the Centers for Disease Control, for 2000 to 2006, age adjusted, smoothed heart disease death rates for persons 35+ were 417 per 100,000 for Iredell County. Iredell County residents were hospitalized for heart disease at a rate of 70 per 100,000. Alexander rates were 77, and Wilkes rates were 84.[3] The 2010 Behavioral Risk Factor Surveillance Survey (BRFSS) shows that 25 to 39 percent of Iredell adults are obese and 18 to 32 percent of adults in Alexander and Catawba Counties meet obesity criteria.[4] Overweight is a separate BRFSS category, which, when added to the obesity, brings community risk up to 80 percent in Iredell County and 88 percent in Alexander and Catawba Counties. BRFSS reports group smaller rural counties into large categories like "Western North Carolina." In the aggregate, 11.7 percent of Western North Carolina residents have been told they have diabetes.

According to the National Health Interview Survey[5], in 2009, 12 percent of U.S. adults had been told by a physician they had heart disease. North Carolina Center for Health Statistics reports heart disease death rates per 100,000 residents in Iredell County, based on four year averages (2005 through 2009) ranked in the third highest quartile for the state. Iredell and nearby counties have higher cardiovascular death rates than most of western and central North Carolina.

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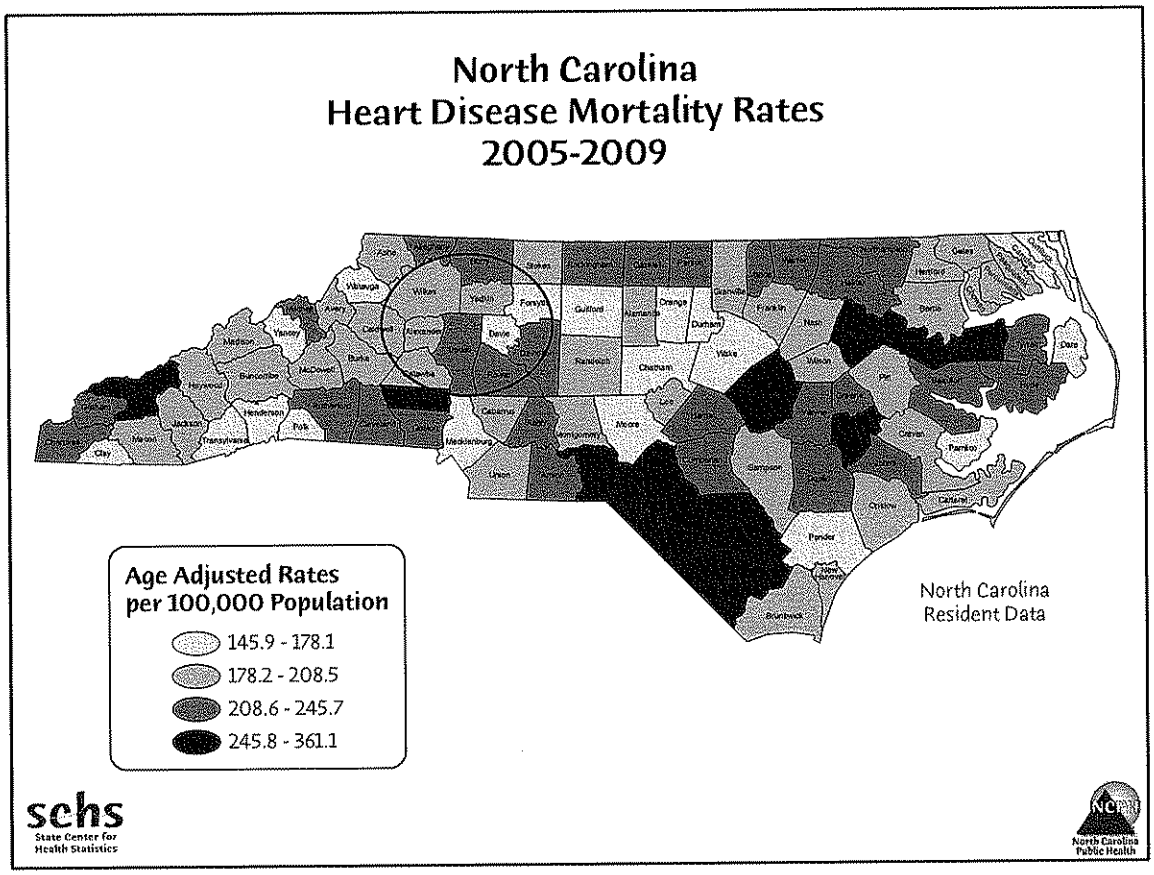
[1] Roger, V.L et al, Heart Disease and Stroke Statistics, 2011 Update, A Report from the American Heart Association, *Circulation*. 2011;123:e18-e209.) http://circ.ahajournals.org/content/123/4/e18.full.pdf accessed July 20, 2011.

[2] Houston, Sarah L, The Burden of Cardiovascular Disease in North Carolina July 2010 Updatehttp://www.startwithyourheart.com/resources/508SWYH_BurdenofCVDinNCJuly2010.pdf ,

[3] Centers for Disease Control, and Prevention, US Department of Health and Human Services http://apps.nccd.cdc.gov/giscvh2/Results.aspx accessed July 20, 2011

[4] http://www.schs.state.nc.us/SCHS/brfss/2010/ired/topics.html#hd Derived Variables and Risk Factors 2010 BRFSS data for North Carolina, Body Mass Index Grouping accessed July 25, 2011.

[5] NCHS Summary Health Statistics for US Adults: National Health Interview Survey: 2009. http://www.cdc.gov/nchs/data/series/sr_10/sr10_249.pdf accessed 6/29/2011



Today, the three primary counties have 239,000 people. According to SAS and the State Office of Budget and Management, by 2015, the three primary counties will have 256,000 people.

Population in Iredell Health System Primary Service Area

County	Jul-10	Jul-11	Jul-12	Jul-13	Jul-14	Jul-15
Davie	41,378	41,932	42,483	43,034	43,586	44,136
Alexander	37,254	37,459	37,644	37,807	37,956	38,088
Iredell	160,107	162,785	165,460	168,136	170,813	173,489
Total	**238,739**	**242,176**	**245,587**	**248,977**	**252,355**	**255,713**

Source: North Carolina OSBM

As illustrated in Attachment 1, the IHS cardiac service area extends beyond the primary service area into Wilkes and north to Alleghany and Ashe Counties. Demographics include very rural populations in the northern parts of Iredell, Statesville, Mocksville and Taylorsville and suburban commuters in southern parts of the county. Iredell Health System serves both.

Access - Cardiac Catheterization Equipment in Iredell Health System Service Area

Iredell, Davie and Alexander Counties have five hospitals. One hospital, Alexander, is not in service. Three hospitals offer cardiac catheterization in fixed laboratories. Only one, Iredell Memorial Hospital (IMH) in Statesville, is part of a cardiac care program offering a coordinated continuum of care from primary care in a hospital-supported community health center, to certified preventive and rehabilitation programs and full time dedicated catheterization laboratory staff. IMH service area counties north and east of Iredell do not offer cardiac catheterization. The *2012 Plan* reports that Wilkes Regional has a cardiac catheterization laboratory, but Wilkes reported no equipment and no procedures on its 2011 Hospital License Renewal report.

Iredell Memorial's one cardiac catheterization laboratory operated at 96 percent annual capacity for the most recent 12 months, and in May and June 2011, it operated at 120 percent capacity. Attachment 2 shows monthly and annual totals.

Access, Quality, Value- Cardiac Catheterization at Iredell Memorial

Equipment

Iredell Memorial opened its cardiac catheterization laboratory in 1989, before the North Carolina General Statute required a CON for cardiac catheterization equipment. In 2008, after two years of careful planning and protocol development, Iredell Memorial began offering therapeutic catheterizations. Approximately 30 percent of IMH catheterizations now involve therapeutic procedures. Because IMH did not require a Certificate of Need for its cardiac catheterization equipment, it is not subject to the Special Certificate of Need Rule 10A NCAC 14C.1604, which requires a facility that does interventional (therapeutic) procedures to provide open heart surgery.

Iredell Memorial Hospital is upgrading its cardiac catheterization equipment to state of the art technology. New equipment will be in service by the end of this calendar year. However, the upgrade will not address capacity issues. Short term, IHS is also arranging to contract for mobile cardiac catheterization services. At best, a mobile unit is an interim solution. It will not likely be available every day and it will be located on a mobile pad outside the hospital.

Iredell Memorial also has an angiography/electrophysiology laboratory. That equipment is located adjacent to the cardiac catheterization laboratory and shares the same recovery space. The equipment is capable of handling cardiac catheterizations, but IMH is restricted from using it for cardiac catheterization by conditions on the equipment's Certificate of Need. Presently, that equipment is under used. It provides about 360 procedures per year, up from 91 procedures in fiscal year 2010. Iredell Memorial angiography procedures dropped significantly in 2010, when surgeons elected to do some procedures in the operating room, and a part time invasive radiology group cut back on its schedule. Recently, a new interventional radiologist, Steve Harlan, MD acquired privileges and another physician, Charles DeBernardenis, MD, expanded his scope of practice to include vascular angiography. Although the program is growing, the angiography equipment will have capacity to serve cardiac catheterization patients.

Program

Cardiac Catheterization

IMH is part of Iredell Health System (IHS). The IHS cardiac program meets all American Heart Association/American College of Cardiology STEMI Guidelines and lacks only open heart surgery to have a comprehensive tertiary heart program. Open heart involves a small proportion of the population, representing only 10.4 cases per 10,000 North Carolina residents in 2009[6]. Cardiac catheterization, by contrast, occurred at a rate of 98 cases per 10,000 residents in 2010.[7] The Board of Trustees for Iredell Health System has focused on cardiac care components needed more frequently by service area residents, including cardiac catheterization and very active primary preventive and rehabilitative cardiac programs. The IHS cardiac rehabilitation program is Medicare Certified and grew 23 percent between 2008 and 2010, reaching more than 3,000 people with 6,357 visits last year. In 2010, IHS diabetic care management program served 1,160 patients. In addition to a network of its own primary care physicians IHS also supports the primary care program at the local community health center.

The Iredell Memorial Hospital cardiac catheterization program has earned respect among physicians and patients. Demand for cardiac catheterization services grew rapidly in 2011, as the community began to understand the program's quality, additional physician capabilities and capacity to offer full service cardiac catheterization. The number of diagnostic equivalent catheterizations increased from 806 for 12 months ending in September 2010 to 1,440 procedures for the 12-month period ending in June 2011. The catheterization program is already operating with extended hours, often as late as 8 PM and 9 PM. Several times a month, patients are rescheduled to the next day. In fiscal year 2010, according to data from Thompson Reuters Market Expert, Iredell Memorial provided 24 percent of the inpatient cardiac catheterizations in the primary service area.

Iredell Memorial trends indicate that demand for cardiac catheterization would support and sustain a second fixed IMH laboratory as early as spring 2013. Attachment 2 contains a linear trend forecast based on the last 14 months.

These projections show that IMH could meet required benchmarks for the added shared fixed laboratory in the first year, and the number of diagnostic equivalent procedures may reach full capacity for a second full cardiac catheterization laboratory in two years. The fixed plus shared fixed benchmark would be 1750 cardiac catheterization procedures (1500 +250). However, recognizing that trend lines can change over time, Iredell Health System is conservatively asking only for permission to use existing equipment in a shared fixed mode.

[6] Procedures (cases) from 2011 SMFP divided by NC population per State Office of Budget and Management (9742/9,424,782 times 10,000.

[7] Proposed 2012 State Medical Facilities Plan Table 9N plus Table 9Q (64,856 + 29,210) / 9,572,454 residents 2010) * 10,000).

Iredell Health System is unique in many ways. Its Iredell Memorial is the only hospital in the county that has a significant staff assigned to work exclusively with the cardiac catheterization program. Five nurses, six technologists and two clerks give the program more than 101 collective years experience in cardiac catheterization. Nine (9) Board Certified cardiologists are skilled in invasive cardiology and two of them are trained for interventional, therapeutic cardiology. Nurses who staff our monitored beds are specially trained to care for cardiac catheterization patients. Laboratory and pharmacy staffs are integrated with the program. To assure maximum safety for therapeutic catheterization patients, staff routinely participates in emergency procedure drills with the open heart surgery hospitals in Charlotte and Winston-Salem. Open heart staff at one of those hospitals is always on standby alert when Iredell Memorial conducts therapeutic procedures. Our local emergency transport staff is similarly integrated into the patient safety program.

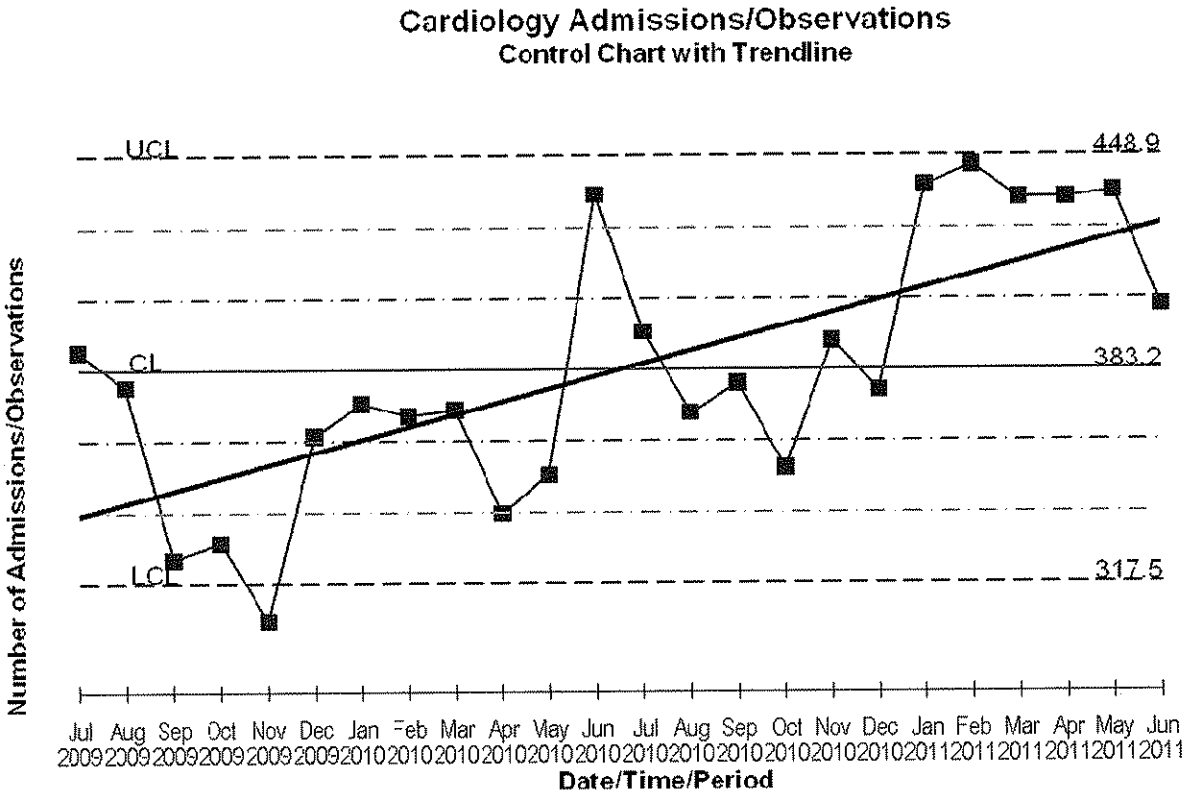
Iredell Memorial is also the only county hospital that offers both a CMS Certified Cardiac Rehabilitation program and a Diabetes Care Management program staffed by professionals who are certified by the American Diabetes Association.

As the only non-profit hospital in the county, Iredell Memorial is also the primary charity care provider. It is one of only seven hospitals in the state given special recognition by the NC Justice Center for its high charity care levels.[8] Seventy-five percent of Iredell Memorial cardiac catheterization patients are self pay or beneficiaries of government programs (Medicare, Medicaid and Champus). Many insured patients have high deductibles and copayments that require charity adjustments.

Cardiology

The entire cardiac program at Iredell Memorial is growing. Cardiology admissions/observations increased by almost 100 a month from July a year ago; and the trend is upward.

[8] http://www.ncjustice.org/?q=node/446



Quality

Iredell Health System is fully committed to the elements of a safe, high quality cardiac catheterization program; IHS has formal arrangements with providers of open heart surgery services in Winston and Charlotte, and rigorous internal rules requiring emergency back-up for every scheduled therapeutic procedure. IHS developed its policies and procedures for therapeutic catheterizations to conform to the quality protocols and recommendations of The Joint Commission and the American College of Cardiology. Today, Iredell Memorial meets or exceeds STEMI standards. All cases are subjected to peer review. Together, these make physicians comfortable referring patients to IHS. Ambulance transfer reports for the county show Iredell Memorial destinations out rank either of the other two hospitals two to one. Please see Attachment 5.

Iredell Health System cardiac care inpatient quality trends are upward as well. According to the NC Hospital Quality Center online chart, IHS has made significant progress with its 30-day outcomes for heart attack patients, gaining special recognition by the North Carolina Hospital Quality Center (Attachment 6). Both in-hospital mortality and readmissions dropped about 10 percent on the most recent three-year trend chart.[9] IHS heart attack readmission rates are lower than the state average. Heart attack treatment scores for IHS stayed between 95 and 100 percent of optimal for the most recent 12-month reporting period.[10]

[9] http://www.nchospitalquality.org/scatter.lasso?condition_id=1&district_id=3 accessed July 24, 2011.

[10] http://www.nchospitalquality.org/trend.lasso

Limitations of the 2012 *Plan* Methodology

Recent Data

The *Proposed 2012 State Medical Facilities Plan* methodology does not calculate need for more cardiac catheterization equipment in Iredell County.

The *Plan's* cardiac catheterization methodology defines capacity for a fixed cardiac catheterization laboratory as 1,500 annual diagnostic equivalent procedures. A therapeutic catheterization counts for 1.75 diagnostic equivalents and a need occurs when county utilization reaches 90 percent.[11] With utilization at 1,400+ diagnostic equivalent procedures, IMH should trigger a need for a second cardiac catheterization laboratory. It does not. First, the *Plan's* methodology uses 2011 Hospital License Renewal data, which cover the year ending September 2010. Iredell Memorial's rapid growth occurred since then. Second, the methodology treats IMH and two chronically underused cardiac catheterization labs as if their services were identical.

Iredell Memorial reported 806 diagnostic equivalent procedures for 2010 on its Hospital Licensure Renewal application. But utilization increased dramatically in FY 2011, with a running 12-month total of 1,440 diagnostic equivalent procedures by June 2011. Diagnostic catheterizations increased 45 percent and therapeutics increased five-fold. Overall, between May 2010 and April 2011, Iredell Memorial cardiac catheterization procedures increased 76 percent. Unfortunately, the *Proposed 2012 Plan* does not reflect this.

Using procedures from 2009-2010 as the basis for need, for a CON that would be filed in 2012, for a project that most likely cannot be approved and developed prior to 2013, puts a lag in supply in locations where demand for service is growing. The *Plan's* methodology makes no allowance for growth in the three-year interval.

Chronically Under Used Equipment in Service Area

Chronically underused equipment in the county precludes this *2012 Plan*, and likely most future Plans from showing a need for additional cardiac catheterization capacity at Iredell Memorial.

The *2012 Plan* defines Iredell County as the cardiac catheterization service area for Iredell Memorial Hospital. Two other Iredell County hospitals have chronically underutilized cardiac catheterization equipment. In 2010, Davis Regional Medical Center and Lake Norman Regional Medical Center used 10 and 5 percent of their respective capacity.[12] Davis did 155 procedures on its equipment in 2010; Lake Norman reported 77 procedures for its catheterization lab. Neither has developed strong physician or support staff capacity for cardiac catheterization. However, the *2012 Plan* methodology accords the same capacity to cardiac catheterization equipment at these two hospitals as to Iredell Memorial's.

[11] Page 196-197 on line

[12] Source: 2011 North Carolina Hospital Licensure Renewal applications, Davis and Lake Norman hospitals

Shared – Fixed Solution

The 2012 Plan methodology for shared fixed labs targets only counties that have no cardiac catheterization capability. Permitting use of a shared fixed laboratory to build capacity in smaller increments in a county that has both fixed lab capacity and evidence of growing demand for cardiac catheterization services follows the same logic as permitting a shared fixed where no prior capacity existed. In fact, permitting a qualified existing angiograph laboratory to absorb cardiac catheterization program growth would be more cost effective than showing a need for one more unit of fixed cardiac catheterization equipment.

Summary

In Iredell County's unique circumstances, the *Proposed 2012 Plan* methodology masks the need in the Iredell Health System service area today. The *Plan* has no built in mechanism to accommodate for chronically underused capacity. Consequently, the only way for the *2012 Plan* to reflect the real need in the Iredell Health System service area is to adjust the 2012 Plan to identify a Special Need for Iredell County. Identifying need for a shared fixed laboratory in a facility that offers therapeutic catheterizations is a conservative way to increase access; and would require applicants to demonstrate that they have the quality program foundations to support expanded utilization. Iredell Memorial would use the shared fixed lab only for diagnostic cardiac catheterizations and angiography procedures. It would do therapeutic interventional catheterizations on the existing catheterization equipment.

ADVERSE EFFECTS ON PROVIDERS AND CONSUMERS OF NOT MAKING THE REQUESTED CHANGE

Among residents of the IMH service area, outmigration for cardiac catheterization has been significant. Until Iredell Health System started its program in 2008, no hospital in the county offered therapeutic cardiac catheterization. Cardiac catheterization use in the county was low because referring physicians did not want to subject their patients to the risk of being transferred out mid-procedure for a therapeutic intervention. Nor did they want to subject patients to the extra costs associated with two hospital admissions for cardiac catheterization, one for diagnosis and another for interventional therapy. Consequently, most of Iredell Health System's primary service area residents traveled an hour or more to Winston-Salem, Charlotte, or Hickory, or they deferred care. High heart attack rates in the area testify to the amount of deferred care.

In rural communities, people will often avoid care rather than travel long distances to urban centers to get treatment. As a result, disease advances from mild to serious, often going untreated and resulting in premature deaths. The cardiac mortality rates in Iredell Health System service area communities suggest this has occurred.

Though Iredell Health System has responded and developed a comprehensive cardiac care program, it has now reached limits on its response capacity. Simply extending cardiac catheterization lab hours late into the night will not meet patient care requirements. The program already operates until 8 and 9 PM. If the special need is not approved, some patients will be forced out of the service area to get comparable quality care, unless Iredell Health System finds enough mobile unit capacity to fill the gap. Even so, extended use of mobile equipment is not a good solution.

Other hospitals in the county do not have the staff to provide comparable service, or the policies to provide comparable charity care. Hence, referring physicians and patients will have only the out-of-county solution if Iredell Memorial cannot respond. Out-of-county care is not only stressful at the time of the procedure, it often results in breaks in care coordination; transition breaks in pharmaceutical regimens; and patient imposed breaks in follow up.

If IHS continues the expensive and inconvenient mobile program, it will have increased operating costs and fewer resources available for charity care.

ALTERNATIVES TO THE REQUESTED CHANGE CONSIDERED AND REJECTED

Mobile Units

Mobile cardiac catheterization laboratories represent one solution for absorbing short term growth. IHS is about to contract with a mobile provider for interim capacity. However, options are limited. In North Carolina, the mobile must have a CON. Iredell Health System surveyed the approved providers and found only First Health and DLP Partners, LLC have available capacity. However, supply may be limited to one to two days a week.

DLP Partners could place capacity at Iredell Memorial and operate it as a service. Staff would work for DLP and be subject to DLP protocols. This split management would move staff focus away from patient care to deal with different company allegiances. Some staff would work for Iredell Memorial. Others would work for DLP. Thus, what appears to be a solution to the CON barrier creates an operational problem that may have risks to the patient and certainly would cause interruptions for the physicians and other caregivers.

With the exception of the unique DLP arrangements, mobile units are by nature positioned outside the hospital. Going in and out in inclement weather, or even good weather is less than ideal for a person whose health is already compromised by advancing coronary disease. The solution also requires extra staff for transporting patients, and because the post procedure patient requires RN monitoring until the sheath is removed, the transport involves extra nursing staff.

Renting these units is itself expensive, because the transaction requires two overheads, that of IHS and that of the mobile provider.

Other Providers

Iredell Health System seriously considered the possibility that other programs would grow and absorb the demand. This is not happening. Equipment alone does not build a program. IHS meticulously built its therapeutic (interventional) program, working closely with other successful community hospital programs in Virginia, New Hampshire, Kansas and elsewhere. All of these have excellent outcomes and do not offer open heart surgery. IHS also worked with two national consulting firms, and locally with Wake Forest Baptist University Medical Center, Forsyth Medical Center, and Carolinas Health Care to design and refine its program. Other county providers have not made this investment. It would be inappropriate, and in violation of The Joint Commission requirements, for Iredell Memorial to refer patients to a facility with a lower standard of care.

It is also unreasonable to bank on hope that others will build their programs to Iredell Memorial standards. The other two hospitals in the county have had cardiac catheterization equipment for almost as long as Iredell Memorial. Yet, their program volume has remained low since they opened. In 2006, the most active of the past five years, Davis reached 25 percent capacity and Lake Norman reached 14 percent. Neither of the other two hospitals has the protocols, staff, nor organized training programs that IHS put in place to assure that Iredell Memorial sustains its very high quality outcomes. Both other hospitals are for-profit and have a different mission with regard to providing charity care. Iredell Memorial alone has a generous charity care program, intentionally designed to make care accessible to persons at highest risk of deferring needed care. Also, it alone has invested in the certified primary prevention and rehabilitation programs.

Out-of-county programs have excellent quality protocols and charity policies, but distance from patient homes and urbanized locations both represent actual or perceived barriers to many residents of this service area. The out of county programs are not linked back to the prevention and wellness programs that Iredell Health System has installed in its service area communities.

Additional Cardiac Catheterization Laboratory

Although trends suggest that Iredell Memorial cardiac catheterization demand will justify a second cardiac catheterization laboratory, Iredell Health System believes it more prudent to build its program with existing capacity. This requires less capital and permits the hospital to conserve resources in a time of shrinking payments for services.

If the 2012 *Plan* were adjusted to include determination of need for another fixed catheterization laboratory in the county, the *Plan* would risk permitting more capacity than is needed, which would result in unnecessary duplication of services. A new lab, like a shared fixed lab, could do only diagnostic catheterizations. Thus restricted, a second fixed cardiac catheterization lab would likely be underutilized.

EVIDENCE OF NON-DUPLICATION OF SERVICES

This requested change will cause no unnecessary duplication of services. This petition asks to determine need for a shared fixed cardiac catheterization laboratory. Because all hospitals in the county have fixed equipment, but some are chronically underused, a successful applicant should be required to show that its own equipment operated at 80 percent of capacity as reflected on the most recent Licensure /Renewal Application on file with the Division.

The shared fixed requirement would permit use of existing equipment. Existing equipment would involve space that is operational and staff that is in place. The level of heart disease in the service area, the increasing age of area residents, continued development of a primary care network in rural communities, and the highly organized program at Iredell Memorial all contribute to the likelihood that need in Iredell County for quality cardiac catheterization in cardiac program that offers diagnostic and therapeutic catheterizations, primary care, preventive care and rehabilitation and sustains excellent outcomes will sustain and expand.

Labor and support services are larger components of the cost and quality in a cardiac catheterization program, than the equipment. Labor and support are in place and can absorb additional procedures with minimal increase in staff. The project envisioned by Iredell Memorial would not increase capital expenditures or actual equipment inventory in North Carolina.

Restricting applicants to use of existing equipment; requiring demonstrated quality outcomes; and requiring a history of therapeutic and diagnostic, cardiac catheterization, would prevent costly duplication of support program components.

Finally, a special need determination would allow a quality provider to make better use of existing equipment and eliminate the need for an expensive mobile unit. Hence, it would actually reduce duplication of services.

EVIDENCE OF NORTH CAROLINA MEDICAL FACILITIES PLAN BASIC GOVERNING PRINCIPLES

Overview

Inclusion of a special need that permits conversion of existing equipment to a shared fixed lab meets the three basic principles of the *2012 Plan*, especially if the equipment is in a program that has demonstrated quality outcomes in both therapeutic and diagnostic catheterizations. Iredell County deserves access to the best quality, access and value in cardiac catheterization services.

Safety and Quality

The proposed special need will improve quality of care in Iredell County and communities around it by making a quality program available to more people on a more convenient schedule. The following quality elements are already in place in Iredell Health System:

- A cardiac catheterization program that meets or exceeds all the Practice Guidelines set by the American Heart Association Task Force and the American College of Cardiology for the Management of Patients with ST-Elevation Myocardial Infarction (STEMI) throughout its hospital/health care system.
- At least two board-certified cardiologists trained in interventional therapeutic procedures and nine board-certified invasive cardiologists.
- Participation by board-certified cardiologists in the diagnosis and follow up treatment and rehabilitation plan for patients.
- Standby emergency transport and open heart back up capacity at tertiary care institutions within 30 minutes travel time.
- A nursing and cardiac catheterization technology staff who work only in the cardiac catheterization lab.
- Regular staff training and protocol development that incorporates new cardiac research findings.
- A program that sustains a door to revascularization time for STEMI cases of 45 minutes. (STEMI guideline is 30 minutes from diagnosis to departure to facility capable of interventional cardiac catheterization and 90 minutes door to needle.)[13]
- A program that attains top scores on the CMS Medicare heart attack care quality index.

The special need would also permit Iredell Memorial to substitute full time service, located inside the hospital, adjacent to the other cardiac catheterization laboratory for rented mobile equipment located outside the hospital that may be available only part time. At minimum, communication, a critical component of quality, would be easier. Staff would spend more time in patient care and less time in patient transport.

[13]AHA/ ACC Guidelines Circulation. *2004; 110: 588-636* http://circ.ahajournals.org/content/110/5/588.full accessed July 23, 2011.

Access

Iredell Health System is the safety net health care provider for Iredell County and the IHS service area. It has one of seven hospitals recognized by the North Carolina Justice Center for exceptional charity care policies. See Attachment 4. It accepts all persons without regard to age, race, sex, religion or ability to pay and its mission includes a focus on improving health of the residents of the county.

Iredell County is in the upper third quartile of heart disease mortality for the state. Service area heart disease statistics point to sustained high need for cardiac catheterization.

The proposed special need will improve access in the IMH service area, because it will open capacity in a facility in Iredell County that has no programmatic access barriers and a fixed cardiac catheterization laboratory is operating at 120 percent capacity at the time of this petition. Several times a month, schedules are so tight that unexpected therapeutic cases must remain in the holding area to be worked in to an open slot later in the day.

The Iredell Health System cardiac catheterization program has a track record of excellent access:

- Turn-around time between patients is an efficient 47 minutes.
- Operating hours are officially 7:30 to 4:30 PM, with procedures scheduled to start as early as 8 AM and as late as 4 PM. However, patients are routinely in the lab as late as 6 PM, sometimes to 8 PM and 9 PM. Now, about four days a month, diagnostic patient schedules are moved forward a day, because emergency procedures take their slots.
- Iredell Memorial far exceeds the STEMI guidelines of fewer than 90 minutes door to needle time. Iredell Memorial has achieved 45 minute average door to revascularization time.

With regard to persons in need of cardiac catheterization, the special need in Iredell County will permit something not guaranteed with a mobile solution. It will provide an opportunity to assure that cardiac catheterization capacity is consistent every day, inside the hospital.

Iredell Health System has made the full commitment to a heart program. In this regard, it meets the access tests of:

- Full service program, including primary, preventive and rehabilitation programs for persons with low income or under insurance.
- Active wellness program specifically for persons with diabetes and heart problems.

Value

IHS can offer the county a unique value advantage. It can expand cardiac catheterization capacity using shared fixed equipment and make no capital expenditure. The existing Iredell Memorial angiography/EP laboratory has unused capacity and could absorb demand.

The angiography/EP laboratory at Iredell Memorial has the same technology as a cardiac catheterization laboratory. Its use is restricted by conditions on the Certificate of Need that authorized it.

This very efficient use of capital requires a special need, outside the *Proposed 2012 Plan methodologies.* It involves a shared fixed laboratory in a county that has fixed cardiac catheterization equipment. As such, it would also require modifications to the Special Rules for Cardiac Catheterization, 10 NCAC 14C.1600, including an adjustment for the chronically underused equipment in the primary service area.

A special need for a shared fixed laboratory in Iredell County that required applicants to show that existing cardiac catheterization equipment meets capacity utilization standards will meet the value test. Incremental costs would be minimal. Iredell Memorial could offer the service with no additional capital cost and with minimal incremental staffing. Moreover, better use of existing capacity would contain total hospital and health system operating costs. This will permit the hospital to continue meeting its commitment to low income underinsured persons in the face of price compression on the part of all payors.

CONCLUSION

Showing a need for one shared fixed cardiac catheterization laboratory in the *2012 Plan* will address a critical health care disparity in Iredell County.

It will permit Iredell Memorial Hospital to promote safety and quality in the delivery of health care services while permitting equitable access and maximizing health care value for resources expended. Iredell Memorial has recruited and developed a highly skilled team, whose work is integrated with open heart surgery programs at Wake Forest University Baptist Medical Center, Forsyth Medical Center, and Carolinas Medical Center.

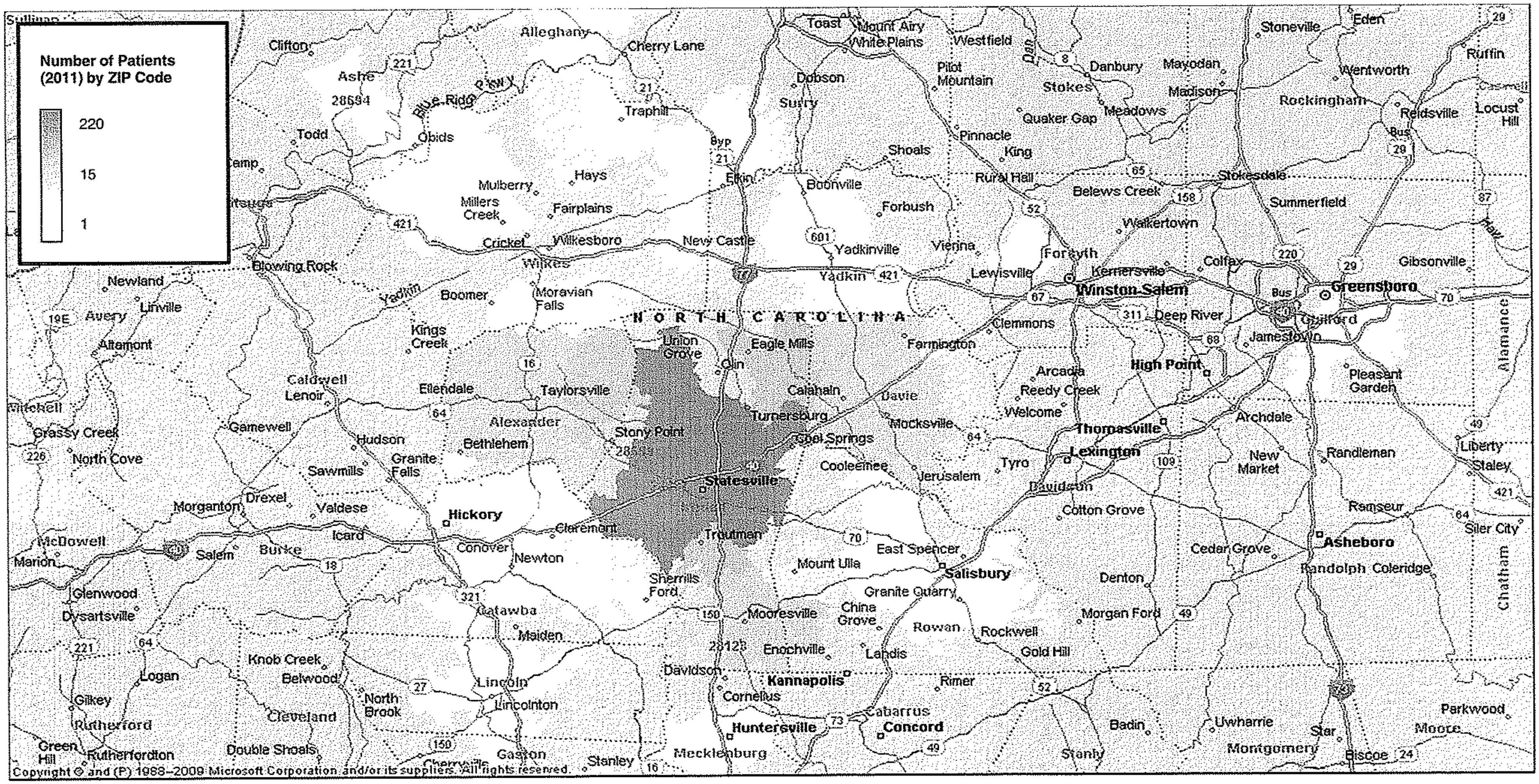
IHS has made the human capital investment in program and can get economies of scale in management, third party contracting, provider certification and quality management. These are as significant in the cost of a program as the capital cost of the equipment. IHS Board of Trustees has been cautious and deliberate in its decision to pursue this opportunity. The IHS program is developed; the need exists in the service area; and it makes sense to act now. There is no likelihood that a future Plan methodology will show need without approval of this special need petition.

ATTACHMENTS

Prepared with assistance from **PDA**, *Inc., Raleigh, NC*

Attachment 1

Cardiac Catheterization Patient Origin in Calendar Year 2011



Attachment 2

Iredell Health System

F:\Client Projects\Iredell 11\Cath Petition\Working Documents\Petition\Exhibits\[Cath Procedures Exhibit.xlsx]June June2011 (3)

Cardiac Catheterization Procedures Historical and Forecast for Iredell Memorial

ACTUAL PROCEDURES YE JUNE 2011

	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11
Diagnostic Cath	49	70	55	79	86	60	62	61	81	71	91	94
Interventional Cath	18	36	19	32	22	25	37	23	31	26	33	30
Total	67	106	74	111	108	85	99	84	112	97	124	124

Source: Tim Jones Cardiac Cath logs Iredell Memorial Hospital
Note: May 11 from 2 weeks of data

Annual DX Equivalents	1,440
Annual Capacity Per SMFP	1500
IMH Percent Capacity -1 lab	96%
Percent Change, July 10-June 11	85%

ACTUAL PROCEDURES YE JUNE 2012

	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
Diagnostic Cath	86	88	90	92	94	96	98	100	102	104	106	109
Interventional Cath	33	34	35	36	37	38	39	39	40	41	42	43
Total	124	122	125	128	131	134	137	140	143	146	149	152

Source: Linear forecast from 14 months data, May-10 through June-11

Annual DX Equivalents	1,967
IMH Percent Capacity -2 labs	65.6%

ACTUAL PROCEDURES YE JUNE 2013

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Diagnostic Cath	111	113	115	117	119	121	123	125	127	129	131	133
Interventional Cath	44	45	46	47	48	49	50	50	51	52	53	54
Total	155	158	161	164	167	170	172	175	178	181	184	187

Source: Linear forecast from 14 months data, May-10 through June-11

Annual DX Equivalents	2,494
IMH Percent Capacity -2 labs	83.1%

ACTUAL PROCEDURES YE JUNE 2014

	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Diagnostic Cath	133	135	137	139	141	143	145	148	150	152	154	156
Interventional Cath	54	55	56	57	58	59	60	61	62	62	63	64
Total	187	190	193	196	199	202	205	208	211	214	217	220

Source: Linear forecast from 14 months data, May-10 through June-11

Annual DX Equivalents	2,709
IMH Percent Capacity -2 labs	90.3%

ACTUAL PROCEDURES YE JUNE 2015

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Diagnostic Cath	160	162	164	166	168	170	172	174	176	178	180	182
Interventional Cath	66	67	68	69	70	71	72	73	73	74	75	76
Total	226	229	232	235	238	241	244	247	250	253	256	259

Source: Linear forecast from 14 months data, May-10 through June-11

Annual DX Equivalents	3,548
IMH Percent Capacity -2 labs	118.3%

Attachment 3

7. **Specialized Cardiac Services** (for questions, call 855-3865 [Medical Facilities Planning])

(a) Cardiac Catheterization	Diagnostic Cardiac Catheterization ICD-9 37.21, 37.22, 37.23, 37.25	Interventional Cardiac Catheterization- ICD-9 00.66, 99.10, 36.06, 36.07, 36.09; 35.52, 35.71, 35.96	Electro-physiology 37.26, 37.27, 37.34, 37.70, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.95, 37.96, 37.97, 37.98, 37.99, 00.50, 00.51, 00.52, 00.53, 00.54
1. Number of Units of Fixed Equipment	1		
2. Number of Procedures* Performed in Fixed Units on Patients Age 14 and younger	Ø	Ø	Ø
3. Number of Procedures* Performed in Fixed Units on Patients Age 15 and older	153	Ø	13 { 12 PACERS, 1 AICD }
4. Number of Procedures* Performed in Mobile Units	155	Ø	Ø

*A **procedure** is defined to be one visit or trip by a patient to a catheterization laboratory for a single or multiple catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, and/or EP catheterizations performed within that visit.

Name of Mobile Vendor: MEDCATH

Number of 8-hour days per week the mobile unit is onsite: 5 DAYS/WK (NOV 2009 - MAY 2010) 8-hour days per week.
(Examples: Monday through Friday for 8 hours per day is 5 8-hour days per week. Monday, Wednesday, & Friday for 4 hours per day is 1.5 8-hour days per week) DURING INSTALLATION/RENOVATION

(b) Open Heart Surgery	Number of Machines/Procedures
1. Number of Heart-Lung Bypass Machines	
2. Total Annual Number of Open Heart Surgery Procedures Utilizing Heart-Lung Bypass Machine	
3. Total Annual Number of Open Heart Surgery Procedures done without utilizing a Heart-Lung Bypass Machine	N/A
4. Total Open Heart Surgery Procedures (2. + 3.)	
Procedures on Patients Age 14 and younger	
5. **Of total in #2**, Number of Procedures on Patients Age 14 & younger	
6. **Of total in #3**, Number of Procedures on Patients Age 14 & younger	

Scans Performed on Mobile CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast	N/A	X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	

10d. Other Imaging Equipment

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Dedicated Fixed PET Scanner	Ø			
Mobile PET Scanner	Ø			
PET pursuant to Policy AC-3	Ø			
Other Human Research PET Scanner	Ø			
Ultrasound equipment	2	1586	1939	3525
Mammography equipment	1	Ø	1465	1465
Bone Density Equipment	Ø			
Fixed X-ray Equipment (excluding fluoroscopic)	2	4606	12,217	16,823
Fixed Fluoroscopic X-ray Equipment	2	233	485	718
Special Procedures/ Angiography Equipment (neuro & vascular, but not including cardiac cath.)	1	97	58	155
Coincidence Camera	Ø			
Mobile Coincidence Camera Vendor:	Ø			
SPECT	Ø			
Mobile SPECT Vendor:	Ø			
Gamma Camera	2	415	449	864
Mobile Gamma Camera Vendor:	Ø			

* PET **procedure** means a single discrete study of one patient involving one or more PET scans. PET **scan** means an image-scanning sequence derived from a single administration of a PET radiopharmaceutical, equated with a single injection of the tracer. One or more PET scans comprise a PET procedure. **The number of PET procedures in this table should match the number of patients reported on the PET Patient Origin Table on page 27.**

10e. Lithotripsy

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed	Ø			
Mobile	1	Ø	50	50

Lithotripsy Vendor/Owner:
PIEDMONT STONE

7. **Specialized Cardiac Services** (for questions, call 855-3865 [Medical Facilities Planning])

(a) Cardiac Catheterization	Diagnostic Cardiac Catheterization ICD-9 37.21, 37.22, 37.23, 37.25	Interventional Cardiac Catheterization- ICD-9 00.66, 99.10, 36.06, 36.07, 36.09; 35.52, 35.71, 35.96	Electro-physiology 37.26, 37.27, 37.34, 37.70, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.95, 37.96, 37.97, 37.98, 37.99, 00.50, 00.51, 00.52, 00.53, 00.54
1. Number of Units of Fixed Equipment	1	-0-	-0-
2. Number of Procedures* Performed in Fixed Units on Patients Age 14 and younger			
3. Number of Procedures* Performed in Fixed Units on Patients Age 15 and older	77		
4. Number of Procedures* Performed in Mobile Units			

*A **procedure** is defined to be one visit or trip by a patient to a catheterization laboratory for a single or multiple catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, and/or EP catheterizations performed within that visit.

Name of Mobile Vendor: _____

Number of 8-hour days per week the mobile unit is onsite: _____ 8-hour days per week.
(Examples: Monday through Friday for 8 hours per day is 5 8-hour days per week. Monday, Wednesday, & Friday for 4 hours per day is 1.5 8-hour days per week)

(b) Open Heart Surgery	Number of Machines/Procedures
1. Number of Heart-Lung Bypass Machines	N/A
2. Total Annual Number of Open Heart Surgery Procedures Utilizing Heart-Lung Bypass Machine	N/A
3. Total Annual Number of Open Heart Surgery Procedures done without utilizing a Heart-Lung Bypass Machine	N/A
4. Total Open Heart Surgery Procedures (2. + 3.)	N/A
Procedures on Patients Age 14 and younger	
5. **Of total in #2**, Number of Procedures on Patients Age 14 & younger	N/A
6. **Of total in #3**, Number of Procedures on Patients Age 14 & younger	N/A

Scans Performed on Mobile CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	

10d. Other Imaging Equipment

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Dedicated Fixed PET Scanner	-0-	-0-	-0-	-0-
Mobile PET Scanner	1	-0-	201	201
PET pursuant to Policy AC-3				
Other Human Research PET Scanner				
Ultrasound equipment	6	1,614	3,828	5,442
Mammography equipment	3		9,987	9,987
Bone Density Equipment	1		891	891
Fixed X-ray Equipment (excluding fluoroscopic)	3	8,962	6,938	15,900
Fixed Fluoroscopic X-ray Equipment	2	685	1,293	1,978
Special Procedures/ Angiography Equipment (neuro & vascular, but not including cardiac cath.)	1	1,277	1,498	2,775
Coincidence Camera	-0-			
Mobile Coincidence Camera Vendor:	-0-			
SPECT	-0-			
Mobile SPECT Vendor:	-0-			
Gamma Camera	2	1,106	2,183	3,289
Mobile Gamma Camera Vendor:	-0-			

* PET **procedure** means a single discrete study of one patient involving one or more PET scans. PET **scan** means an image-scanning sequence derived from a single administration of a PET radiopharmaceutical, equated with a single injection of the tracer. One or more PET scans comprise a PET procedure. **The number of PET procedures in this table should match the number of patients reported on the PET Patient Origin Table on page 27.**

10e. Lithotripsy

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed	-0-	-0-	-0-	-0-
Mobile	1	-0-	30	30

Lithotripsy Vendor/Owner:

Stone Institute

7. **Specialized Cardiac Services** (for questions, call 855-3865 [Medical Facilities Planning])

(a) Cardiac Catheterization	Diagnostic Cardiac Catheterization ICD-9 37.21, 37.22, 37.23, 37.25	Interventional Cardiac Catheterization- ICD-9 00.66, 99.10, 36.06, 36.07, 36.09; 35.52, 35.71, 35.96	Electro-physiology 37.26, 37.27, 37.34, 37.70, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.95, 37.96, 37.97, 37.98, 37.99, 00.50, 00.51, 00.52, 00.53, 00.54
1. Number of Units of Fixed Equipment			
2. Number of Procedures* Performed in Fixed Units on Patients Age 14 and younger			
3. Number of Procedures* Performed in Fixed Units on Patients Age 15 and older			
4. Number of Procedures* Performed in Mobile Units			

*A **procedure** is defined to be one visit or trip by a patient to a catheterization laboratory for a single or multiple catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, and/or EP catheterizations performed within that visit.

Name of Mobile Vendor: N/A

Number of 8-hour days per week the mobile unit is onsite: N/A 8-hour days per week.
(Examples: Monday through Friday for 8 hours per day is 5 8-hour days per week. Monday, Wednesday, & Friday for 4 hours per day is 1.5 8-hour days per week)

(b) Open Heart Surgery	Number of Machines/Procedures
1. Number of Heart-Lung Bypass Machines	0
2. Total Annual Number of Open Heart Surgery Procedures Utilizing Heart-Lung Bypass Machine	0
3. Total Annual Number of Open Heart Surgery Procedures done without utilizing a Heart-Lung Bypass Machine	0
4. Total Open Heart Surgery Procedures (2. + 3.)	0
Procedures on Patients Age 14 and younger	
5. **Of total in #2**, Number of Procedures on Patients Age 14 & younger	0
6. **Of total in #3**, Number of Procedures on Patients Age 14 & younger	0

7. **Specialized Cardiac Services** (for questions, call 855-3865 [Medical Facilities Planning])

(a) Cardiac Catheterization	Diagnostic Cardiac Catheterization ICD-9 37.21, 37.22, 37.23, 37.25	Interventional Cardiac Catheterization- ICD-9 00.66, 99.10, 36.06, 36.07, 36.09; 35.52, 35.71, 35.96	Electro-physiology 37.26, 37.27, 37.34, 37.70, 37.71, 37.72, 37.73, 37.74, 37.75, 37.76, 37.77, 37.79, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.89, 37.94, 37.95, 37.96, 37.97, 37.98, 37.99, 00.50, 00.51, 00.52, 00.53, 00.54
1. Number of Units of Fixed Equipment	1		
2. Number of Procedures* Performed in Fixed Units on Patients Age 14 and younger	-		
3. Number of Procedures* Performed in Fixed Units on Patients Age 15 and older	617	108	
4. Number of Procedures* Performed in Mobile Units	0	0	

*A **procedure** is defined to be one visit or trip by a patient to a catheterization laboratory for a single or multiple catheterizations. Count each visit once, regardless of the number of diagnostic, interventional, and/or EP catheterizations performed within that visit.

Name of Mobile Vendor: N/A

Number of 8-hour days per week the mobile unit is onsite: 0 8-hour days per week.
(Examples: Monday through Friday for 8 hours per day is 5 8-hour days per week. Monday, Wednesday, & Friday for 4 hours per day is 1.5 8-hour days per week)

(b) Open Heart Surgery	Number of Machines/Procedures
1. Number of Heart-Lung Bypass Machines	0
2. Total Annual Number of Open Heart Surgery Procedures Utilizing Heart-Lung Bypass Machine	0
3. Total Annual Number of Open Heart Surgery Procedures done without utilizing a Heart-Lung Bypass Machine	0
4. Total Open Heart Surgery Procedures (2. + 3.)	0
Procedures on Patients Age 14 and younger	0
5. **Of total in #2,** Number of Procedures on Patients Age 14 & younger	
6. **Of total in #3,** Number of Procedures on Patients Age 14 & younger	

Scans Performed on Mobile CT Scanners *(Multiply # scans by Conversion Factor to get HECT Units)*

	Type of CT Scan	# of Scans		Conversion Factor		HECT Units
1	Head without contrast		X	1.00	=	
2	Head with contrast		X	1.25	=	
3	Head without and with contrast		X	1.75	=	
4	Body without contrast		X	1.50	=	
5	Body with contrast		X	1.75	=	
6	Body without contrast and with contrast		X	2.75	=	
7	Biopsy in addition to body scan with or without contrast		X	2.75	=	
8	Abscess drainage in addition to body scan with or without contrast		X	4.00	=	

10d. Other Imaging Equipment

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Dedicated Fixed PET Scanner	1	59	377	436
Mobile PET Scanner	0			
PET pursuant to Policy AC-3	0			
Other Human Research PET Scanner	0			
Ultrasound equipment	2	1,925	5,155	7,080
Mammography equipment	2	99	8,347	8,446
Bone Density Equipment	1		942	942
Fixed X-ray Equipment (excluding fluoroscopic)	3	8,162	26,413	34,575
Fixed Fluoroscopic X-ray Equipment	4	533	1,780	2,313
Special Procedures/ Angiography Equipment (neuro & vascular, but not including cardiac cath.)	1	0	0	0
Coincidence Camera	0			
Mobile Coincidence Camera Vendor:	0			
SPECT	2	795	1,425	2,220
Mobile SPECT Vendor:	0			
Gamma Camera	0			
Mobile Gamma Camera Vendor:	0			

* PET **procedure** means a single discrete study of one patient involving one or more PET scans. PET **scan** means an image-scanning sequence derived from a single administration of a PET radiopharmaceutical, equated with a single injection of the tracer. One or more PET scans comprise a PET procedure. **The number of PET procedures in this table should match the number of patients reported on the PET Patient Origin Table on page 27.**

10e. Lithotripsy

	Number of Units	Number of Procedures		
		Inpatient	Outpatient	Total
Fixed				
Mobile	1		111	111

Lithotripsy Vendor/Owner:
PIEDMONT STONE

Attachment 4

NC HEALTH ACCESS COALITION

NC Justice Center
Opportunity and Prosperity for All

in depth

Vol 2 No 2 • February 2010

How Charitable are North Carolina Hospitals?

A Look at Financial Assistance Policies for the Uninsured

BY ADAM LINKER, HEALTH POLICY ANALYST

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EXECUTIVE SUMMARY

- Hospitals serve as critical safety-net providers for people seeking medical care. In fiscal year 2008, North Carolina hospitals provided $694 million in free care.
- All 112 hospitals in North Carolina maintain websites, and 72 hospitals, or 63 percent, currently post some information about financial assistance policies online.
- Out of 112 hospitals 39, or 35 percent, post comprehensive charity care policies online.
- Several hospitals and hospital systems deserve special recognition for providing charity care levels that exceed the cost of living for their region, including Novant Health, UNC Health Care, University Health Systems of Eastern North Carolina, Iredell Memorial Hospital, The Outer Banks Hospital, High Point Regional Health System and Margaret R. Pardee Memorial Hospital.
- Every hospital in the state should post a comprehensive charity care policy online, including income eligibility levels, asset limits, and catastrophic discounts.
- Hospitals should strive to provide free care to families earning less than 200 percent of federal poverty level and provide some discount to families earning less than 300 percent of federal poverty level. Hospitals should consider benchmarking charity care policies to a reasonable cost-of-living index like the Living Income Standard.

Background on hospital charity care

MEDICAL DEBT BURDENS many low- and middle-income families in North Carolina. Most families in the state and around the country receive health insurance benefits through work, which leaves them especially vulnerable during a recession, when unemployment is high. Although some economic indicators show that the economy is creeping toward recovery, North Carolina's unemployment rate still exceeds 10 percent. Because the state has shed thousands of jobs, North Carolina had the nation's largest jump in the percentage of the population without insurance from 2007 to 2009. According to one estimate the recession has increased the number of uninsured in North Carolina to nearly 1.8 million.[1]

When people lose health insurance or purchase inadequate coverage with high deductibles, they are more likely to struggle with medical debt. There is some evidence that trouble paying medical bills is a widespread problem. One of the most comprehensive studies of medical debt nationwide found that

more than 62 percent of all bankruptcies in 2007 were related to medical debt and that 92 percent of medical debtors had bills in excess of $5,000.[2]

Hospitals stand at the center of the state's health care system. Especially during times of economic distress, many uninsured and underinsured patients seek medical treatment in hospital emergency rooms. Hospitals, especially nonprofit hospitals, provide an enormous amount of free care in North Carolina. Many hospitals in the state operate as critical safety-net providers to families in economic free fall.

There are some obligations on hospitals to provide free care to all North Carolinians. Federal law – specifically the Emergency Medical Treatment and Active Labor Act – requires that hospital emergency rooms provide at least some care regardless of a patient's ability to pay. Many hospitals also are granted nonprofit status; most North Carolina hospitals are nonprofit. Nonprofit status allows hospitals to issue tax-exempt bonds and reap millions in sales tax and property tax exemptions.

Although hospitals do not gain nonprofit status based solely on providing charity care, community benefit is one overarching consideration when deciding whether a hospital deserves a nonprofit designation. The most direct community benefit that hospitals provide is charity care. Charity care is free care given to patients without any expectation of payment. It is distinct from other community benefits such as grants to community health clinics.

Nonprofit hospitals in North Carolina are at the forefront of providing, publicizing, and reporting community benefit programs and services. The North Carolina Hospital Association (NCHA) maintains a website where all major hospitals in the state are beginning to post their charity care policies.[3] In addition, the NCHA is gathering and posting standardized reports on what community benefits North Carolina hospitals are providing to the state.

The NCHA reports that hospitals provided $694 million in free care to indigent patients in fiscal year 2008. That is a critical benefit to struggling families. And just as hospitals provide an important benefit to the state, the state provides tax benefits to nonprofit hospitals. In fiscal year 2006-2007, for example, hospitals received more than $213 million in sales tax breaks alone.[4]

Again, there is not a direct trade-off between tax benefits and community benefits. But along with tax exemptions and nonprofit status come certain expectations of transparency and accountability. Every hospital in North Carolina maintains a website, and every hospital has adopted a charity care policy. The NCHA recommends that every hospital post its charity care policy online.

While the NCHA asks that every hospital post a charity care policy it does not provide guidance on what specific information should appear online. As consumer advocates, the NC Health Access Coalition believes that every hospital should note the existence of a charity care policy along with specific contact information where patients can seek financial counseling. In this report we recognize all of the hospitals that provide some charity care information online.

Furthermore, we believe that hospitals should at least provide income guidelines for determining whether or not a patient qualifies for charity care. Many factors are included in financial assistance determinations, but income is the first step in screening patients for charity care. If a hospital provides free care to all uninsured patients under 100 percent of the federal poverty level, for example, that policy should appear on the hospital's website.

The more information a hospital provides online the better. We hope that every hospital in the state will post financial counseling contact numbers, income guidelines, asset tests, and catastrophic discounts to keep patients, physicians, and advocates fully informed.

Transparency of hospital charity care policies in North Carolina

Out of 112 hospitals in the state, the websites of 72 list some charity care information online as requested by the North Carolina Hospital Association. Several of the hospitals that list information online only note the existence of a charity care policy along with a phone number for financial assistance. Other hospitals include more details but do not list specific income ranges and charity care discounts.

Out of 112 hospitals, 39 provide what we call a "comprehensive" policy online. These hospitals post qualifying income guidelines for financial assistance. This helps patients understand their potential financial obligations before seeking hospital care. Some of these hospitals also include catastrophic discounts and interest-free payment policies on their websites. (See attached chart for complete list of charity care policies.)

Several large hospitals still include only rudimentary information online. These organizations should work to provide as much financial assistance information as possible to patients.

Nonprofit hospitals have a clear obligation to provide information to taxpayers on financial assistance policies because North Carolina residents provide tax benefits to these health care providers. But for-profit hospitals should also post charity care policies online. Tenet Healthcare Corporation, for example, operates two hospitals in North Carolina. Tenet settled a lawsuit in 2005 where the company agreed to provide certain benefits to uninsured patients. Those provisions should appear on the websites of Tenet hospitals.

Because hospitals can post charity care policies at any time patients should check regularly for changes. We will reissue this report in six months to track any updates to hospital charity care policies.

Adequacy of hospital charity care policies in North Carolina

An examination of posted charity care policies shows that financial assistance programs vary widely across the state. We can see that Winston-Salem- and Charlotte-based Novant Health has the most sound and clear policy of any hospital system in North Carolina. At Novant any uninsured patient with an income less than 300 percent of the federal poverty level, or $66,150 for a family of four, qualifies for a 100 percent discount on hospital bills. This policy recognizes the realities of modern family finances.

It is important that charity care policies not bankrupt a hospital. Hospital administrators often note that without a margin there is no mission. In other words, a hospital that is forced to close its doors can no longer deliver any community benefits. But it is also crucial that these policies account for the cost of living in different communities. In general, 200 percent of the federal poverty level, or $44,100 per year for a family of four, is required to maintain a minimally comfortable life without saving or paying hefty medical bills.

All hospitals in the state should strive to set the free care minimum at 200 percent of the federal poverty level. We recognize that 200 percent of federal poverty level is an unobtainable target for some rural hospitals that operate on thin margins. And for large, wealthy hospital systems in expensive parts of the state a goal of 200 percent of federal poverty level is not ambitious enough. But this number provides a good guide for how much it costs for a family to subsist in most regions of the state.

While providing a 100 percent discount for uninsured families making less than 200 percent of the federal poverty level is important, it is also critical that financial assistance policies provide some help for those making higher incomes – at least up to 300 percent of the federal poverty level. Well-insured patients get a discount on hospital bills because insurance companies negotiate payment rates for particular services. Uninsured and underinsured patients should get a similar advantage.

Designing a charitable charity care policy

Hospitals should consider benchmarking charity care policies to how much it costs for an average family to live in the region where the hospital is

located. Federal poverty level has major shortcomings for understanding how much a family must spend to survive. The federal poverty level for a family of four, for example, is $22,050 per year. That amount is insufficient to cover the costs of transportation, day care, housing, and food in North Carolina. It's not even close.

A more sophisticated – although still conservative– measure of family expenses is the Living Income Standard (LIS) produced by the North Carolina Justice Center's Budget & Tax Center.[5] This calculation constructs county-level budgets for four representative family types. The budgets are built from seven essential expenses – housing, food, childcare, health care, transportation, taxes, and other necessities. Excluded from the budget are savings, cell phones, restaurant meals, entertainment, cable television, and gifts.

The LIS budget leaves no room for large medical bills. Families making a living income are still only living on the edge. One trip to the emergency room could tip these families into financial ruin. Mitigating the number of families facing foreclosure or bankruptcy due to bills for inpatient care is one of the most important community benefits hospitals can provide.

Consulting the LIS shows that families in most counties require a minimum income level of 200 percent of federal poverty level to pay for necessities. There are, however, numerous counties of the state that require a higher income level to live – those near Charlotte; in the Triangle area of Raleigh, Durham, and Chapel Hill; in the Triad area near Greensboro, High Point, and Winston-Salem; and in the coastal plains surrounding Wilmington. There are also lower cost areas in the state where families can live on less than 200 percent of federal poverty level.

It is not our recommendation that North Carolina hospitals peg charity care policies to the LIS. But the LIS provides a reasonable guide for how much it costs to live in different regions of the state. And hospitals should consider using a cost-of-living index to establish financial assistance policies.

Many hospitals in North Carolina clearly recognize the shortcomings of the federal poverty guidelines and set financial assistance policies much higher than 100 percent of the federal poverty rate.

As noted previously, Novant sets its 100 percent discount rate at 300 percent of federal poverty guidelines. Novant's policy also does well when compared to the LIS. In Mecklenburg County, where Novant runs the well-regarded Presbyterian Hospital, the LIS for a two adult and two child family is 220.7 percent of the federal poverty level.

Currently, of the 39 hospitals that list comprehensive charity care policies online, 22 provide a 100 percent discount to uninsured families earning 200 percent of federal poverty level or more. Most of those hospitals are owned by a few nonprofit systems, including Novant, Duke University, and WakeMed Health & Hospitals.

A few hospitals are even more generous and provide discounts that match the LIS for a two adult and two child family for the county in which the hospital is located. Novant's policy exceeds the LIS in every county where the system operates. UNC Health Care provides a 100 percent discount at 250 percent of federal poverty guidelines, which is more generous than Orange County's LIS of 236.7 percent of federal poverty guidelines for a two adult and two child household.

In Henderson County, where the LIS is 189.8 percent of federal poverty level, Margaret R. Pardee Memorial Hospital in Hendersonville has a charity care policy that provides a 100 percent discount at 220 percent of federal poverty level. Iredell Memorial Hospital, where the LIS is 200 percent of federal poverty level, provides a 100 percent discount at 192 percent of federal poverty level. And University Health Systems of Eastern Carolina provides a 100 percent discount

increased to 200.7 percent

at 200 percent of federal poverty level, which exceeds the LIS for the region where the system operates.

Other large nonprofit hospital systems provide the full discount at 200 percent of federal poverty level but fall short of matching the region's cost-of-living requirements. Duke University Medical Center provides a 100 percent discount at 200 percent of the federal poverty level, but the LIS in Durham County is 227.2 percent of federal poverty level, and in Wake County, where Duke also operates a hospital, the LIS is 246.6 percent of federal poverty guidelines. WakeMed, which operates several hospitals in Wake County, provides the same discount rate as Duke.

Eight hospitals that post charity care policies online provide a 100 percent discount at 150 percent of the federal poverty level. Another six hospitals posting charity care policies provide a 100 percent discount at 125 percent or 120 percent of federal poverty level. Only one hospital posting a comprehensive policy, Southeastern Regional Medical Center, has a charity care policy matching the federal poverty level.

It is heartening that a majority of hospitals in North Carolina post notice of a charity care policy online. We applaud those hospitals that post comprehensive policies online for their openness and accountability. Novant Health, UNC Health Care, University Health Systems of Eastern Carolina, Iredell Memorial Hospital, The Outer Banks Hospital, High Point Regional Health System, and Margaret R. Pardee stand out as providing excellent charity care policies. Other hospitals like Duke University Medical Center and WakeMed Health & Hospitals have good policies that could be strengthened in the future.

Conclusion

It is encouraging that a majority of North Carolina hospitals post some charity care information online, although fewer than half of the state's hospitals post comprehensive policies. This step would help struggling families understand discount programs at nearby hospitals before seeking care.

Hospitals that have posted policies online should be commended. Many of the large nonprofit hospitals in the state have fair policies that provide free care to patients with incomes less than 200 percent of the federal poverty level. The charity care policies of a few hospitals even take into account the cost of living in nearby communities.

In North Carolina high unemployment is causing people to lose insurance at high rates. Many uninsured patients seek care at free clinics and hospital emergency rooms. Hospitals are filling an important role as safety-net providers contributing a large amount of free care. Charity care should not bankrupt a hospital, but policies must be available to the public and should consider the living costs of families. The North Carolina Hospital Association has made impressive strides toward meeting these goals. With encouragement, North Carolina hospitals could serve as national models of openness and accountability.

Recommendations:

- All hospitals should post comprehensive charity care policies online. The policies should include information on asset limits, income guidelines, and catastrophic discounts.

  IMH policy posted and in compliance

- Most hospitals should move toward providing a 100 percent discount to families earning less than 200 percent of the federal poverty level and some discount to families earning less than 300 percent of the federal poverty level.

  100 percent discount at 200.7% of fpl with charity discounts up to 351% of fpl

- Hospitals should consider adopting a more nuanced measure of poverty – such as the Living Income Standard – to calculate charity care policies.

  Using Living Income Standard in calculation

- Hospitals should thoroughly screen patients, including those entering through the emergency room, to check eligibility for public programs or charity care discounts.

  Patients are provided charity info at time of service and during collection process

HOSPITAL CHARITY CARE POLICIES

HOSPITAL	Is some charity care information available online?	Is comprehensive policy available on website?	Financial assistance policy	LIS Budget for four-person family (two adults, two children) as % of FPL
Alamance Regional Medical Center	Y	N		200.40%
Albemarle Hospital	Y	N		201.60%
Alleghany Memorial Hospital	Y	N		182.90%
Angel Medical Center	Y	N		189.20%
Annie Penn Hospital	Y	Y	100% at 125% FPL; discount up to 200% FPL	180.80%
Anson Community Hospital	Y	N		175.10%
Ashe Memorial Hospital	Y	Y	100% discount at 150% FPL	179.90%
Beaufort County Hospital	N	N		189.60%
Bertie Memorial Hospital	Y	Y	100% discount for less than 200% FPL and bills over $5,000	185.90%
Betsy Johnson Regional Hospital	Y	N		189.70%
Bladen Healthcare	N	N		181.90%
Blowing Rock Hospital	N	N		207.70%
Blue Ridge Regional Hospital	Y	N		196.60%
Brunswick Community Hospital	Y	Y	100% discount at 300% FPL	203.80%
Caldwell Memorial Hospital	Y	Y	100% discount at 125% FPL	183.90%
Cannon Memorial Hospital	N	N		193.80%
Cape Fear Valley	N	N		189.10%
CarolinaEast Medical Center	Y	N	some discount for less than 200% FPL	187.50%
Carolinas Medical Center	Y	N		220.70%
Carolinas Medical Center Mercy	Y	N		220.70%
Carolinas Medical Center Northeast	Y	N		214.80%
Carolinas Medical Center Pineville	Y	N		220.70%
Carolinas Medical Center Union	Y	N		214.20%
Carolinas Medical Center University	Y	N		220.70%
Carteret County General Hospital	Y	Y	100% discount at 125% FPL; discount up to 300% FPL	195.60%
Catawba Valley Medical Center	Y	Y	100% discount at 150% FPL; discount up to 250% FPL	183.90%
Central Carolina Hospital	N	N		195.70%
Chatham Hospital	Y	N		220.60%
Chowan Hospital	Y	Y	100% discount at 200% FPL	195.70%
Cleveland Regional Medical Center	N	N		197.70%
CMC Lincoln	Y	N		196.60%
Columbus Regional Healthcare System	Y	N		184.70%
Community Care Partners	Y	N		189.80%
Crawley Memorial Hospital	N	N		197.70%
Davie County Hospital	Y	N		191.10%
Davis Regional Medical Center	N	N		200.70%
Duke Raleigh Hospital	Y	Y	100% discount at 200% FPL; discount up to 300% FPL	246.60%
Duke University Hospital	Y	Y	100% discount at 200% FPL; discount up to 300% FPL	227.20%
Duplin General Hospital	N	N		181.90%
Durham Regional Hospital	Y	Y	100% discount at 200% FPL; discount up to 300% FPL	227.20%
FirstHealth Montgomery Regional Hospital	N	N		187.60%
FirstHealth Moore Regional Hospital	N	N		194.80%
FirstHealth Richmond Memorial Hospital	N	N		185.90%
Forsyth Medical Center	Y	Y	100% discount at 300% FPL	199.70%
Franklin Regional Medical Center	N	N		215.00%
Frye Regional Medical Center	N	N		183.90%
Gaston Memorial Hospital	Y	N	some discount for Gaston County residents	206.60%
Grace Hospital	Y	Y	100% discount at 120% FPL; discount up to 250% FPL	182.30%
Granville Health System	Y	N	discount between 200% FPL and 300% FPL	194.10%
Halifax Regional Medical Center	Y	N		185.10%
Harris Regional Hospital	Y	Y	100% discount at 150% FPL; discount up to 300% FPL	194.60%
Haywood Regional Medical Center	N	N		181.20%
Heritage Hospital	Y	Y	100% discount at 200% FPL	191.00%
High Point Regional Health System	Y	Y	100% discount at 200% FPL; discount up to 400% FPL	208.20%
Highlands-Cashiers Hospital	N	N		191.10%
Hoots Memorial Hospital	N	N		189.10%
Hugh Chatham Memorial Hospital	Y	Y	100% discount at 150% FPL; discount up to 200% FPL	181.00%
Iredell Memorial Hospital	Y	Y	100% discount at 192% FPL	200.70%
J. Arthur Dosher Memorial Hospital	Y	N		203.80%
Johnston Memorial Hospital	N	N		213.80%

HOSPITAL CHARITY CARE POLICIES (cont.)

HOSPITAL	Is some charity care information available online?	Is comprehensive policy available on website?	Financial assistance policy	LIS Budget for four-person family (two adults, two children) as % of FPL
Kings Mountain Hospital	N	N		197.70%
Lake Norman Regional Medical Center	N	N		200.70%
Lenoir Memorial Hospital	N	N		187.40%
Lexington Memorial Hospital	Y	N		186.80%
Margaret R. Pardee Memorial Hospital	Y	Y	100% discount at 220% FPL; discount up to 400% FPL	189.80%
Maria Parham Medical Center	Y	N		188.20%
Martin General Hospital	N	N		182.50%
Medical Park Hospital	Y	Y	100% discount at 300% FPL	199.70%
Mission Hospital	Y	N		189.80%
Morehead Memorial Hospital	N	N		180.80%
Moses Cone Hospital System Greensboro	Y	Y	100% at 125% FPL; discount up to 200% FPL	208.20%
Murphy Medical Center	N	N		176.00%
Nash Healthcare System	Y	Y	100% at 150% FPL; discount up to 250% FPL	193.00%
New Hanover Regional Medical Center	Y	N	some discount for less than 200% FPL	214.00%
North Carolina Baptist Hospital	Y	N		199.70%
Northern Hospital of Surry County	N	N		181.00%
Onslow Memorial Hospital	N	N		184.60%
Our Community Hospital	N	N		185.10%
Park Ridge Hospital	N	N		189.80%
Pender Memorial Hospital	N	N		189.20%
Person Memorial Hospital	N	N		182.80%
Pitt County Memorial Hospital	Y	Y	100% discount for less than 200% FPL and bills over $5,000	187.50%
Presbyterian Healthcare	Y	Y	100% at 300% FPL	220.70%
Presbyterian Hospital Huntersville	Y	Y	100% at 300% FPL	220.70%
Presbyterian Hospital Matthews	Y	Y	100% at 300% FPL	220.70%
Pungo District Hospital Corporation	N	N		189.60%
Randolph Hospital	N	N		198.50%
Rex Healthcare	Y	Y	100% at 250% FPL; some co-pays required	246.60%
Roanoke-Chowan Hospital	Y	Y	100% discount for less than 200% FPL and bills over $5,000	184.40%
Rowan Regional Medical Center	Y	Y	100% at 300% FPL	201.30%
Rutherford Hospital	N	N		193.50%
Saint Luke's Hospital	Y	Y	100% at 150% FPL; discount up to 400% FPL	196.00%
Sampson Regional Medical Center	Y	N		181.70%
Sandhills Regional Medical Center	N	N		185.90%
Scotland Memorial Hospital	N	N		193.10%
Southeastern Regional Medical Center	Y	Y	100% at 100% FPL; discount up to 300% FPL	188.60%
Stanly Regional Medical Center	Y	Y	100% at 150% FPL discount up to 300% FPL	192.60%
Stokes-Reynolds Memorial Hospital	N	N		191.10%
Swain County Hospital	Y	Y	100% discount at 150% FPL; discount up to 300% FPL	187.00%
The McDowell Hospital	Y	N		192.90%
The Outer Banks Hospital	Y	Y	100% discount for less than 200% FPL	218.40%
Thomasville Medical Center	Y	Y	100% at 300% FPL	186.80%
Transylvania Community Hospital	Y	N		185.90%
UNC Hospitals	Y	Y	100% at 250% FPL; some co-pays required	238.60%
Valdese General Hospital	Y	Y	100% at 120% FPL; discount up to 200% FPL	182.30%
WadeMed Cary Hospital	Y	Y	100% at 200% FPL; discount up to 300% FPL	246.60%
WakeMed	Y	Y	100% at 200% FPL; discount up to 300% FPL	246.60%
Washington County Hospital	N	N		191.40%
Watauga Medical Center	N	N		207.70%
Wayne Memorial Hospital	Y	N		183.60%
Wilkes Regional Medical Center	N	N		185.90%
Wilson Medical Center	Y	N		196.10%

1 See "North Carolina's Increase in the Uninsured: 2007-2009" March 2009, a report prepared by the North Carolina Institute of Medicine and the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Available online at http://www.nciom.org/data/DS_2009-01_UninUnemp.pdf.

2 See "Medical Bankruptcy in the United States, 2007: Results of a National Study", The American Journal of Medicine, August 2009. Available online at: http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.

3 Information is available under "Community Benefits Report" at www.ncha.org.

4 Tax refund information is available on the North Carolina Department of Revenue's website at http://www.dornc.com/publications/abstract/2008/table35b.pdf.

5 For a more thorough explanation of the Living Income Standard see "Making ends meet on low wages: the 2008 North Carolina Living Income Standard" available online at http://www.ncjustice.org/?q=node/243.

NC JUSTICE CENTER'S

Health Access Coalition

Adam Searing, *Project Director*
adam@ncjustice.org

www.nchac.org

Supported by funding from
COMMUNITY CATALYST'S HOSPITAL ACCOUNTABILITY PROJECT
www.communitycatalyst.org

NORTH CAROLINA JUSTICE CENTER

Opportunity and Prosperity for All

224 S. Dawson Street • P.O. Box 28068 • Raleigh, NC 27611
919/856-2570 voice • 919/856-2175 fax • www.ncjustice.org • contact@ncjustice.org

Notice of Availability of Financial Assistance

Iredell Memorial Hospital will provide a reasonable amount of its services free or at a discounted charge to persons who are uninsured, underinsured or can not otherwise pay for all of their medical care. Under its Financial Assistance Program, the Hospital will provide medically necessary services on a "first-come-first-serve" basis until, at a minimum, its annual budget for free and discounted services has been reached. Eligibility will be limited to persons whose family or household net worth is less than $75,000 and whose household or family income is within the ranges detailed below:

Family Size	Discounts for Annual Income Less Than the Amount Below: 100%	80%	60%	35%
1	21,860	27,325	32,790	38,255
2	29,530	36,915	44,295	51,680
3	37,190	46,490	55,785	65,085
4	44,860	56,075	67,290	78,505
5	52,530	65,665	78,795	91,930
6	60,190	75,240	90,285	105,335

For family units with more than 6 members, the annual incomes above will be increased based upon federal guidelines

If you think you are eligible for this Program, please contact the Financial Counselor at 704-878-4573. An application and financial information will be required. An eligibility determination will be made within two weeks after your application is completed. Any financial assistance provided under this Program is conditional upon your applying for any government assistance for which you may qualify (i.e. Medicaid, Vocational Rehabilitation, etc).

Some services such as physician fees (anesthesiologist, pathologist, radiologist, surgeon, etc) are separate from hospital charges and may not be eligible for discounts.

Federal and state laws require hospitals to seek payment for care provided. This means we could ultimately turn unpaid bills over to a collection agency or legal action, which would affect your credit status. **Therefore, it is important that you apply for these discounts if you are eligible.**

Aviso de disponibilidad de asistencia financiera

Iredell Memorial Hospital proporcionara a las personas que no esten aseguradas, que tengan seguros limitados o que no puedan pagar de ningun otro modo la atencion medica que reciben, una parte razonable de sus servicios de forma gratuita o con un cargo reducido. A traves de su Programa de asistencia financiera, el hospital proporcionara los servicios necesarios desde el punto de vista medico "por orden de llegada" hasta que, como minimo, se cubra su presupuesto anual para servicios gratuitos y con descuento. La elegibilidad estara limitada a personas cuyo valor neto del hogar o familia sea menor a $75,000 y cuyos ingresos familiares o del hogar esten dentro de los limites detallados a continuacion:

Tamano de la familia	Descuentos por ingresos anuales menores al monto que aparece a continuacion: 100%	80%	60%	35%
1	21,860	27,325	32,790	38,255
2	29,530	36,915	44,295	51,680
3	37,190	46,490	55,785	65,085
4	44,860	56,075	67,290	78,505
5	52,530	65,665	78,795	91,930
6	60,190	75,240	90,285	105,335

Para unidades familiares con mas de 6 miembros, los ingresos anuales precedents se aumentaran segun las pautas federales

Si cree que es califica para este Programa, pongase en contacto con el Asesor financiero por el 704-878-4573. Necesitara una solicitud e informacion financiera. La determinacion de elegibilidad se realizara dentro de un plazo de dos semanas luego de completada su solicitud. Toda asistencia financiera proporcionada bajo este programa dependera de su solicitud de asistencia gubernamental para la cual pueda calificar (es decir, Medicaid, rehabilitacion profesional, etc.).

Algunos servicios tales como los honorarios de los medicos (anestesistas, patologos, radiologos, cirujanos, etc.) son independientes de los cargos hospitalarios y pueden no ser elegibles para descuentos.

Las leyes estatales y federales exigen que los hospitales procuren el pago de los servicios proporcionados. Esto significa que en ultima instancia podriamos enviar las facturas impagas a una agencia de cobro o iniciar acciones legales, lo que afectaria su estado de credito. **Por lo tanto, es importante que solicite estos descuentos si es elegible.**

North Carolina Hospital Community Benefits Report

Hospital Name	**Iredell Memorial Hospital**
Time Period	**FY 2010**
Community Benefits	
A. Estimated Costs of Treating Charity Care Patients* 5.12% of Total Expenses	6,763,698
B. Estimated Unreimbursed Costs of Treating Medicare Patients*	12,823,568
C. Includes an adjustment in this period's Medicare revenues for extraordinary adjustments[1] of:	0
D. Without this Medicare adjustment, Medicare Losses would have been (B + C):	12,823,568
E. Estimated Unreimbursed Costs of Treating Medicaid Patients*	3,680,844
F. Includes an adjustment in this period's Medicaid revenues for extraordinary adjustments[1] of:	1,828,909
G. Without this Medicaid adjustment, Medicaid Losses would have been (E + F):	5,509,753
H. Estimated Unreimbursed Costs of Treating Patients from Other Means-Tested Government Programs*	423,415
I. This includes an adjustment in this period's Other Means-Tested Government Programs revenues for extraordinary adjustments[1] of:	0
J. Without this adjustment, Other Means-Tested Gov. Programs Losses would have been (H + I):	423,415
K. Community Health Improvement Services & Community Benefit Operations	718,403
L. Health Professions Education	122,778
M. Subsidized Health Services[2]	372,923
N. Research Costs	0
O. Cash and In-kind Contributions to Community Groups	381,027
P. Community Building Activities[3]	35,065
Q. Total Community Benefits[1] with Settlements and Extraordinary Adjustments (A + B + E + H + K + L + M + N + O + P)	**25,321,721**
R. Total Community Benefits[1] without Settlements and Extraordinary Adjustments (A + D + G + J + K + L + M + N + O + P)	**27,150,630**
Bad Debt Costs	
S. Estimated Costs of Treating Bad Debt Patients*	**6,721,403**

Notes:

(1) *Notes about prior period adjustments*

(2) *Notes about Subsidized Health Services*

(3) *Notes about Community Building Activities*

.itional Information:

Grant monies received to support any community benefit activities. These amounts have not been netted from Total Community Benefits.

URL with additional information about this community benefits report

Other Notes

*** Footnotes:**

The costing methodology or source used to determine payer costs is:

___ The ANDI methodology, which uses a facility-wide ratio of cost to charges as described in NCHA Community Benefits Guidelines.

_X_ An internal cost accounting system, adjusted for community benefit reporting.

___ An internal cost accounting system, adjusted for community benefit reporting, for all items except bad debt and charity care, which use in internal cost-to-charge ratio approach that is based on the methodology specified in the NCHA Community Benefits Guidelines.

___ An internal cost-to-charge ratio approach that is based on the methodology specified in the NCHA Community Benefits Guidelines.

All costing methodologies do not double-count expenses reported in other community benefit items. For example, amounts reported in Subsidized Health Services do not also appear in Medicaid losses.

Last modified on April 22, 2011 10:36 AM

North Carolina Hospital Associatic

Serving North Carolina Hospitals & Health Systems

Hospital Community Benefits Report

Downloads

NCHA Community Be

North Carolina communities are unique. The hospitals that serve these communities are equally so. Each was built and is operated to serve a specific group of neighbors. That uniqueness extenc policies for assisting patients with financial challenges. These policies, combined with each community's dem influence the amount of the local hospital's charity care and other community benefits. Economic conditions a communities differ, prompting different hospital standards for charity care. There is also no one-size-fits-all so segmenting between charity care and bad debt.

North Carolina hospitals want their communities to know their financial assistance policies and what benefits t The hospitals have voluntarily submitted their financial assistance policies along with their community benefit Understanding the assistance policies is vital to reasoned comparison of hospital community benefit reports.

This site pairs hospitals' community benefit reports with their financial assistance policies. Just click on the re alongside each hospital name. The financial data was self-reported by hospitals using guidelines developed b members. It has not been validated by NCHA or by another independent resource.

For details about quantifying community benefit, please see the NCHA Community Benefit Guidelines. NCHA work with hospitals to standardize definitions and data sources to improve community benefit reporting.

This site includes all general acute care hospitals in North Carolina. It also includes several other types of hos volunteered to share their community benefit report.

For more information, or to report a problem, please send email to communitybenefits@ncha.org.

Fiscal Year: 2010 View

Hospital	Community Benefits Report	Financial Assistance Policy
Alamance Regional Medical Center	View Report	View Policy
Albemarle Hospital	View Report	View Policy
Alleghany Memorial Hospital	View Report	View Policy
Angel Medical Center	View Report	View Policy
Annie Penn Hospital	View Report	View Policy
Anson Community Hospital	Not Available	View Policy
Ashe Memorial Hospital	Not Available	View Policy
Beaufort County Hospital	Not Available	Not Available

Bertie Memorial Hospital	View Report	View Policy
Betsy Johnson Regional Hospital	View Report	View Policy
Bladen Healthcare, LLC	View Report	Not Available
Blowing Rock Hospital	View Report	View Policy
Blue Ridge Regional Hospital	View Report	View Policy
Brunswick Community Hospital	View Report	View Policy
Caldwell Memorial Hospital	View Report	View Policy
Cannon Memorial Hospital	View Report	View Policy
Cape Fear Valley	View Report	Not Available
CarolinaEast Medical Center	View Report	View Policy
Carolinas Medical Center	View Report	View Policy
Carolinas Medical Center-Mercy	View Report	View Policy
Carolinas Medical Center-NorthEast	View Report	View Policy
Carolinas Medical Center-Pineville	View Report	View Policy
Carolinas Medical Center-Union	View Report	View Policy
Carolinas Medical Center-University	View Report	View Policy
Carolinas Rehabilitation	View Report	View Policy
Carteret County General Hospital	View Report	View Policy
Catawba Valley Medical Center	View Report	View Policy
Central Carolina Hospital	Not Available	Not Available
Chatham Hospital	View Report	View Policy
Chowan Hospital	View Report	View Policy
Cleveland Regional Medical Center	View Report	View Policy
CMC-Lincoln	View Report	View Policy
Columbus Regional Healthcare System	View Report	View Policy
Community Care Partners	Not Available	View Policy
Crawley Memorial Hospital	Not Available	Not Available
Davie County Hospital	View Report	View Policy
Davis Regional Medical Center	Not Available	Not Available
Duke Raleigh Hospital	View Report	View Policy
Duke University Hospital	View Report	View Policy
Duplin General Hospital	View Report	Not Available

Durham Regional Hospital	View Report	View Policy
FirstHealth Montgomery Memorial Hospital	View Report	View Policy
FirstHealth Moore Regional Hospital	View Report	View Policy
FirstHealth Richmond Memorial Hospital	View Report	View Policy
Forsyth Medical Center	View Report	View Policy
Franklin Regional Medical Center	View Report	View Policy
Frye Regional Medical Center	Not Available	Not Available
Gaston Memorial Hospital	View Report	View Policy
Grace Hospital	View Report	View Policy
Granville Health System	View Report	View Policy
Halifax Regional Medical Center	View Report	View Policy
Harris Regional Hospital	Not Available	View Policy
Haywood Regional Medical Center	Not Available	Not Available
Heritage Hospital	View Report	View Policy
High Point Regional Health System	View Report	View Policy
Highlands-Cashiers Hospital	View Report	View Policy
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Iredell Memorial Hospital	View Report	View Policy
J. Arthur Dosher Memorial Hospital	View Report	View Policy
Johnston Memorial Hospital	View Report	Not Available
Kings Mountain Hospital	View Report	View Policy
Lake Norman Regional Medical Center	Not Available	Not Available
Lenoir Memorial Hospital	View Report	View Policy
Lexington Memorial Hospital	View Report	View Policy
Margaret R. Pardee Memorial Hospital	View Report	View Policy
Maria Parham Hospital	View Report	View Policy
Martin General Hospital	Not Available	Not Available
MCHS - Greensboro Operations	View Report	View Policy
Medical Park Hospital	View Report	View Policy
Mission Hospital	View Report	View Policy
Morehead Memorial Hospital	View Report	View Policy
Murphy Medical Center	View Report	View Policy

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Annie Penn Hospital	View Report	View Policy
Anson Community Hospital	View Report	View Policy
Ashe Memorial Hospital	View Report	View Policy
Beaufort County Hospital	View Report	Not Available

Bertie Memorial Hospital	View Report	View Policy
Betsy Johnson Regional Hospital	View Report	View Policy
Bladen Healthcare, LLC	View Report	Not Available
Blowing Rock Hospital	View Report	View Policy
Blue Ridge Regional Hospital	View Report	View Policy
Brunswick Community Hospital	View Report	View Policy
Caldwell Memorial Hospital	View Report	View Policy
Cannon Memorial Hospital	View Report	View Policy
Cape Fear Valley	View Report	Not Available
CarolinaEast Medical Center	View Report	View Policy
Carolinas Medical Center	View Report	View Policy
Carolinas Medical Center-Mercy	View Report	View Policy
Carolinas Medical Center-NorthEast	View Report	View Policy
Carolinas Medical Center-Pineville	View Report	View Policy
Carolinas Medical Center-Union	View Report	View Policy
Carolinas Medical Center-University	View Report	View Policy
Carteret County General Hospital	View Report	View Policy
Catawba Valley Medical Center	View Report	View Policy
Central Carolina Hospital	Not Available	Not Available
Chatham Hospital	View Report	View Policy
Chowan Hospital	View Report	View Policy
Cleveland Regional Medical Center	View Report	View Policy
CMC-Lincoln	View Report	View Policy
Columbus Regional Healthcare System	View Report	View Policy
Community Care Partners	View Report	View Policy
Crawley Memorial Hospital	Not Available	Not Available
Davie County Hospital	View Report	View Policy
Davis Regional Medical Center	Not Available	Not Available
Duke Raleigh Hospital	View Report	View Policy
Duke University Hospital	View Report	View Policy
Duplin General Hospital	View Report	Not Available
Durham Regional Hospital	View Report	View Policy

FirstHealth Montgomery Memorial Hospital	View Report	View Policy
FirstHealth Moore Regional Hospital	View Report	View Policy
FirstHealth Richmond Memorial Hospital	View Report	View Policy
Forsyth Medical Center	View Report	View Policy
Franklin Regional Medical Center	Not Available	View Policy
Frye Regional Medical Center	Not Available	Not Available
Gaston Memorial Hospital	View Report	View Policy
Grace Hospital	View Report	View Policy
Granville Health System	View Report	View Policy
Halifax Regional Medical Center	View Report	View Policy
Harris Regional Hospital	View Report	View Policy
Haywood Regional Medical Center	Not Available	Not Available
Heritage Hospital	View Report	View Policy
High Point Regional Health System	View Report	View Policy
Highlands-Cashiers Hospital	View Report	View Policy
Hugh Chatham Memorial Hospital	View Report	View Policy
Iredell Memorial Hospital	View Report	View Policy
J. Arthur Dosher Memorial Hospital	View Report	View Policy
Johnston Memorial Hospital	View Report	Not Available
Kings Mountain Hospital	View Report	View Policy
Lake Norman Regional Medical Center	Not Available	Not Available
Lenoir Memorial Hospital	View Report	View Policy
Lexington Memorial Hospital	View Report	View Policy
Margaret R. Pardee Memorial Hospital	View Report	View Policy
Maria Parham Hospital	View Report	View Policy
Martin General Hospital	Not Available	Not Available
MCHS - Greensboro Operations	View Report	View Policy
Medical Park Hospital	View Report	View Policy
Mission Hospital	View Report	View Policy
Morehead Memorial Hospital	View Report	View Policy
Murphy Medical Center	View Report	View Policy
Nash Health Care System	View Report	View Policy

 » *Joe Carlson and Melanie Evans*

A financial counselor, right, talks to a patient needing assistance at Mercy Hospital Clermont, which devoted 5.7% of total expenditures to charity care in 2009.

Short of the mark

A Modern Healthcare analysis of Form 990s shows some very profitable hospitals offering little subsidized care

IMH 2008

A crush of new information about hospital finance is finally starting to roll in and the results suggest that some highly profitable hospitals are skimping on subsidized care to the needy while others with narrower margins appear more generous.

After more than a decade of discussion and preparation, the most comprehensive public disclosure of what not-for-profit hospitals do to earn significant tax breaks has begun, with more disclosures to follow in coming months. Even if healthcare reform succeeds in shrinking the ranks of the uninsured and fewer people need what's now referred to as charity care, the results are destined to be parsed and analyzed for years to come.

A *Modern Healthcare* analysis found widely uneven distribution in the levels of charity care given to the poor by various hospitals. Many of the charitable healthcare providers also acknowledged billing patients who, in retrospect, probably should have qualified for free care.

"Hospitals, if they're not-for-profits, should act like a charity," said Sen. Chuck Grassley, one of the most vocal critics in the debate about whether tax-exempt hospitals do enough for their communities. "I expect nonprofit hospitals to fulfill their not-for-profit status by providing whatever charity care is needed."

However, the Iowa Republican was quick to add that he finds the early results of the tax forms encouraging, and that the forms appear to prove that outlays of charity care ought not to be the only factor by which not-for-profits are judged because different communities have different needs, and because setting minimum levels can discourage those who can do more.

A majority of U.S. hospitals operate as private charities, a status that affords significant federal, state and local tax breaks worth an estimated $12 billion annually by one widely cited, but dated, estimate produced by Congress' Joint Committee on Taxation in 2002.

The nation's roughly 2,900 not-for-profit hospitals that operate in communities rich and poor, populous and remote, have received the financial and competitive advantage of tax breaks. The trade-off was that hospitals give back to communities through vaguely defined "community benefit" activities, including subsidies for low-income patients, but also money-losing endeavors such as research and physician training.

But limited oversight and poor disclosure of those community benefits sparked congressional hearings, inquiries and sharp criticism as reports emerged during the past decade of aggressive billing and collection practices for the uninsured.

Enter the Internal Revenue Service. In 2009, for the first time, hospitals were forced to file a form called the Schedule H with their annual Form 990 tax disclosures as a way to finally quantify community benefit activities.

And it turns out that some hospitals and systems do significantly more than others, according to an analysis by *Modern Healthcare* of 156 Form 990s and Schedule Hs from 20 large health systems that were among the first to face a filing deadline. The analysis looks at tax year 2009 because hospitals have up to 11½ months to file their taxes with extensions.

On average, the results show, each hospital devoted 2.5% of all its expenses to providing charity care—an estimate based on the cost of providing the care, not the marked-up retail price billed to patients. Once losses on Medicaid and subsidies for other services were included, the figure rose to 8.3%.

90% fall below proposed standard

The analysis found that nine out of 10 respondents in the survey failed to provide enough free and discounted care to earn tax breaks under a proposal from Grassley that would have forced the hospitals to devote 5% of their expenditures to giving out subsidized care for the poor.

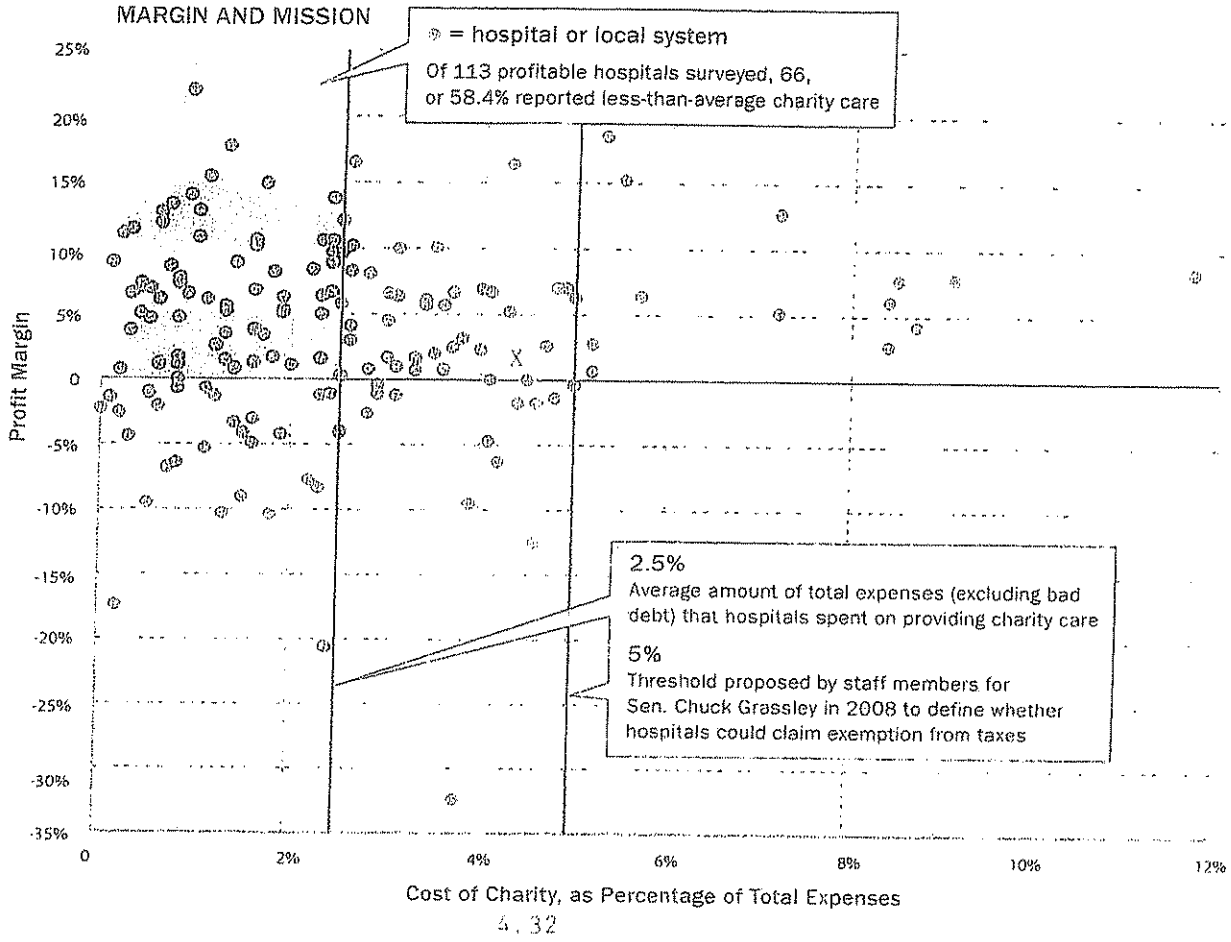
Grassley, in an interview about the *Modern Healthcare* results, backed away from the 5% proposal. Yet despite the industry's position that the threshold would threaten the financial stability of many hospitals, all 15 hospitals in the sample that met the 5% threshold ended the year with a profit.

In another closely watched section of the tax forms, hospitals had the option to quantify how much of their unpaid bills could be attributed to patients who probably would have qualified for financial assistance. Some within the industry argue such losses should be recognized as subsi-

See **COVER STORY** *on p. 14*

NOT-FOR-PROFIT HOSPITAL DISCLOSURES

MARGIN AND MISSION

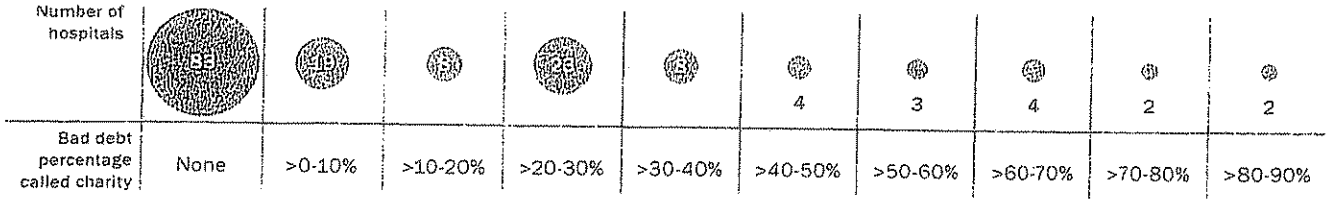


1.64

4.32

CHARITY OR DEBT

Many hospitals surveyed told the IRS that a portion of their bad debt—owed by patients who were billed but didn't pay—would have qualified for charity care



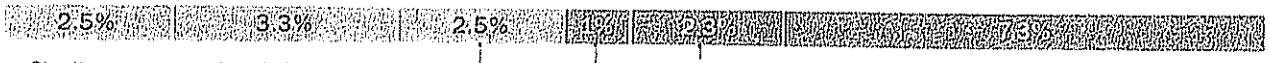
STACKING IT ALL UP

10.13

8.3% of total expenses is the average that hospitals devoted to community benefits recognized by the federal government.

11.50 plus

10.6% of total expenses is the average that hospitals devoted to items not recognized by as community benefit by the federal government.



Charity care at cost 4.32

Unreimbursed Medicaid expenses 3.84 1.97

"Community building" activities NA in 2008

Bad debt, at cost 3.61

Unreimbursed Medicare expenses, at cost 7.89

"Other benefits" including research, medical resident education and clinical services on which the provider takes a financial loss

Source: Modern Healthcare analysis of IRS Form 990 tax disclosures for 156 hospitals filing for tax year 2009

MODERN HEALTHCARE GRAPHIC/ERIC SEMELROTH

COVER STORY *from p. 6*

dized care, but consumer researchers and advocates say the findings suggest troubling hospital collection policies with significant consequences for those already financially vulnerable.

How aggressive are collections?

"It's not OK to try using commercial collection practices and get credit for that as charity care," said Melissa Jacoby, a law professor at the University of North Carolina at Chapel Hill, who studies medical bills and consumer bankruptcy. Jacoby said the new disclosure raises questions about how aggressively hospitals sought to collect unpaid bills from low-income patients.

Results of the analysis are not representative of all tax-exempt hospitals but do offer a comparison of community benefits at some of the nation's largest health systems. For Congress and policymakers, new disclosure provides previously unavailable information that will allow the closest scrutiny to date of the benefit tax-exempt hospitals provide to nearby communities.

"There's all these unfair social problems that the health system is grappling with," said Nancy Kane, a professor of management at the Harvard School of Public Health, who has testified before Congress on the value of hospitals' tax exemption.

She said the Schedule H will help lawmakers write better policies "to make sure that those that have a high social burden aren't getting competitively disadvantaged by it."

While meeting the social burden didn't appear to distress the hospitals in the *Modern Healthcare* sample that reported above-average levels of charity care, a majority of profitable hospitals did provide less free care than the average.

The most common type of hospital in the profit-charity analysis were those that posted a net profit and gave out lower-than-average levels of charity care. And of the 61 hospitals that gave out above-average levels of charity care, 75% of them turned a profit.

Take Mercy Hospital Clermont. The 111-bed acute-care hospital lies on the outskirts of Cincinnati, in Batavia, Ohio, where a Ford Motor Co. factory, Batavia Transmission, closed in 2008 and contributed to high levels of unemployment and lack of insurance coverage in the region.

TAD BUTLER

Mercy Hospital Clermont displays a copy of its charity-care policy in its emergency department.

The system offers free care to residents who earn less than two times the federal poverty level, and discounted care for those up to 400% of poverty—including patients with insurance. That cost the hospital more than $4.1 million, or 5.7% of its total expenditures, in 2009.

"What we like to say is, the mission of caring for the poor and underserved is as vibrant today as it was 150 years ago, when the Sisters of Mercy and the Franciscan Sisters came over from Ireland and Germany in wooden boats," James May, president and CEO of Mercy Health Partners of Southwest Ohio, said in reference to the regional system's original religious sponsors.

Yet Mercy Hospital Clermont, which is part of Catholic Health Partners, still posted a 6.5% profit margin in 2009.

The Schedule H required expanded disclosure of hospitals' billing and collection efforts. The IRS asked hospitals to estimate for the first time how much they billed to patients who were unable to pay under guidelines for free and discounted care.

Among those reviewed by *Modern Healthcare*, 83 reported no unpaid bills attributable to patients eligible for subsidized care.

At Sacramento, Calif.-based Sutter Health, which owns or operates 22 hospitals in Northern California and one in Hawaii, hospitals did not credit any of $73.7 million in reported bad debt to patients who qualified for charity care. "If we know it's eligible, it wouldn't be bad debt," Bill Gleeson, a spokesman for the system, said in an e-mail.

Other hospitals and systems, however, estimated needy patients accounted for a significant share of unpaid bills—including a dozen that said bills sent to those considered eligible for subsidized care made up at least half of bad debt costs.

St. Peter's Hospital, a 487-bed Albany, N.Y., hospital owned by Catholic Health East, estimated needy patients accounted for $2.6 million, or 82%, of its $3.2 million in bad debt. Elmer Streeter, a St. Peter's spokesman, said the hospital is dedicated to finding patients coverage and has an active program to promote its financial aid.

BJC HealthCare reported that 81% of its

See **COVER STORY** *on p. 16*

FINANCE >> *Joe Carlson and Melanie Evans*

1% to charity care

But Mayo Clinic says tax forms distort the picture

By one widely watched measure of whether a tax-exempt hospital does enough for the public to justify its tax exemption, the famed Mayo Clinic doesn't. Mayo's two dozen hospitals devoted a meager 1% of their expenses in 2009 on subsidies for those unable to afford medical care, according to tax forms designed to let policymakers and the public monitor and compare such giving.

But the design of the public tax forms makes getting at that number a laborious chore, and Mayo's executives contend that it overshadows the $1 billion the system spent to subsidize research, education and other services that federal officials also deem community benefit.

"If this form leads to a cookie-cutter approach, it will have failed those who it was designed to help," said Melinda Hatton, general counsel for the American Hospital Association. "With a system like Mayo, aren't we all getting more benefit than you can imagine out of the medical research and training that they're doing?"

An in-depth examination of Mayo's various tax forms indicates that the system posts above-average profits and below-average levels of free and subsidized care for indigent residents and Medicaid recipients.

See **MAYO** *on p. 16*

COVER STORY *from p. 14*

unpaid bills in 2009—amounting to $63 million—were sent to households without the income to pay for some or all of the debt.

Comparing these numbers across systems is complicated by the fact the IRS did not specify how to come up with the number. *Modern Healthcare*'s analysis found that the methods, which also are reported on the Schedule H, varied widely.

The BJC estimate was calculated using commercial databases to analyze income by ZIP code and address for the system's unpaid bills, said Tracy Mahler, BJC's director of tax services. The unpaid bills stem primarily from its St. Louis hospitals that serve poorer neighborhoods, she said, and other hospitals or systems may not serve similarly low-income communities.

Dave Aplington, deputy general counsel for BJC, said the system has sought to more aggressively identify those who qualify for financial assistance and has an interest in conserving resources that would be wasted trying to collect money that cannot be collected.

The 'misery factor'

Consumer debt researchers and patient advocates say reported billing of low-income patients is worrying.

Outstanding bills can mean financial and emotional stress for low-income households, and damage to credit scores can be costly, said Mark Rukavina, executive director of the Access Project, a healthcare advocacy not-for-profit. "The misery factor there is significant."

Hospitals increasingly seek to independently verify whether patients qualify for financial aid, and charity-care policies should identify information that allow hospitals to "presumptively" write off patients' bills, said Keith Hearle, president of Verite Healthcare Consulting. That can include enrollment in other social services for low-income households.

Melinda Hatton, senior vice president and general counsel of the American Hospital Association, disagreed that the blame for the issue rests with the hospitals.

"I don't think that those high numbers reflect a lack of diligence on the part of hospitals, but just that there are many reasons why someone who is eligible for financial assistance might not apply," she said. "It's not always the fault of a hospital." «

MAYO *from p. 14*

One hospital, Mayo Clinic Methodist in Rochester, Minn., earned a 22% profit margin while putting 0.9% of its total expenses toward charity care—less than half the average 2.5% *Modern Healthcare* found in a sample of 156 respondents. Even after adding in unreimbursed Medicaid costs, the hospital still spent about half the average, with Methodist's 2.7% of expenses compared to the list's overall average of 5.3%.

But if the documents create a perception that the organization is greedy, Mayo officials said that's a flaw in the forms. "Does it make sense as a tax-compliance document? Yes. As a public document? No," said Christie Lohkamp, tax director for the Mayo Foundation system. "Research and education really is a big part of what we do ... The average person thinks of patient care, but we have three pieces to our mission. The Schedule H is very much skewed toward one of them."

All U.S. tax-exempt hospitals are required to file IRS Form 990, a public document that goes into voluminous detail about hospital finances and operations. For tax year 2009, the IRS overhauled the forms to improve disclosure of subsidized medical care and other services as policymakers debate what not-for-profits should do in exchange for significant tax breaks.

Modern Healthcare spent several months gathering and analyzing the detailed Schedule H forms of 156 hospitals and regional systems.

The Schedule H reveals more than ever about hospital community-benefit activities, but it also conceals seemingly important information because of choices the IRS made about how hospitals ought to report their data.

Rules for reporting mean some systems must consolidate multibillion-dollar operations on one disclosure. Others must file each hospital separately, which may not capture ways in which systems may offset greater demand for subsidies at one hospital with more profitable operations elsewhere. It depends on each system's corporate structure.

Anyone wanting to know exactly how much community-benefit activity Mayo performs annually as a health system must first locate and then scrutinize 22 separate Form 990s. In response to a request for all of its Form 990s that included a Schedule H, Mayo sent a total of 1,571 pages of tax forms encompassing $7 billion in hospital revenue. By comparison, the Cleveland Clinic, with 11 hospitals, consolidates its $5.7 billion in revenue on a single form of just 145 pages.

IRS officials declined repeated requests for interviews for this project over the period of three weeks in February and March.

By tabulating data from all 22 of Mayo Clinic's hospital tax forms, *Modern Healthcare* found that the system actually devotes more of its resources to activities considered community benefit than its peers. It just didn't come in the category of subsidized healthcare. The tax forms show that the system spent just over $1 billion on research and education, but only $180 million on charity care and unreimbursed costs for Medicaid beneficiaries.

All told, Mayo devoted 11% of its expenditures to activities the IRS considers legitimate community benefits, compared with the 8.3% average for total expenditures dedicated to all forms of community-benefit spending found in the magazine's survey. «

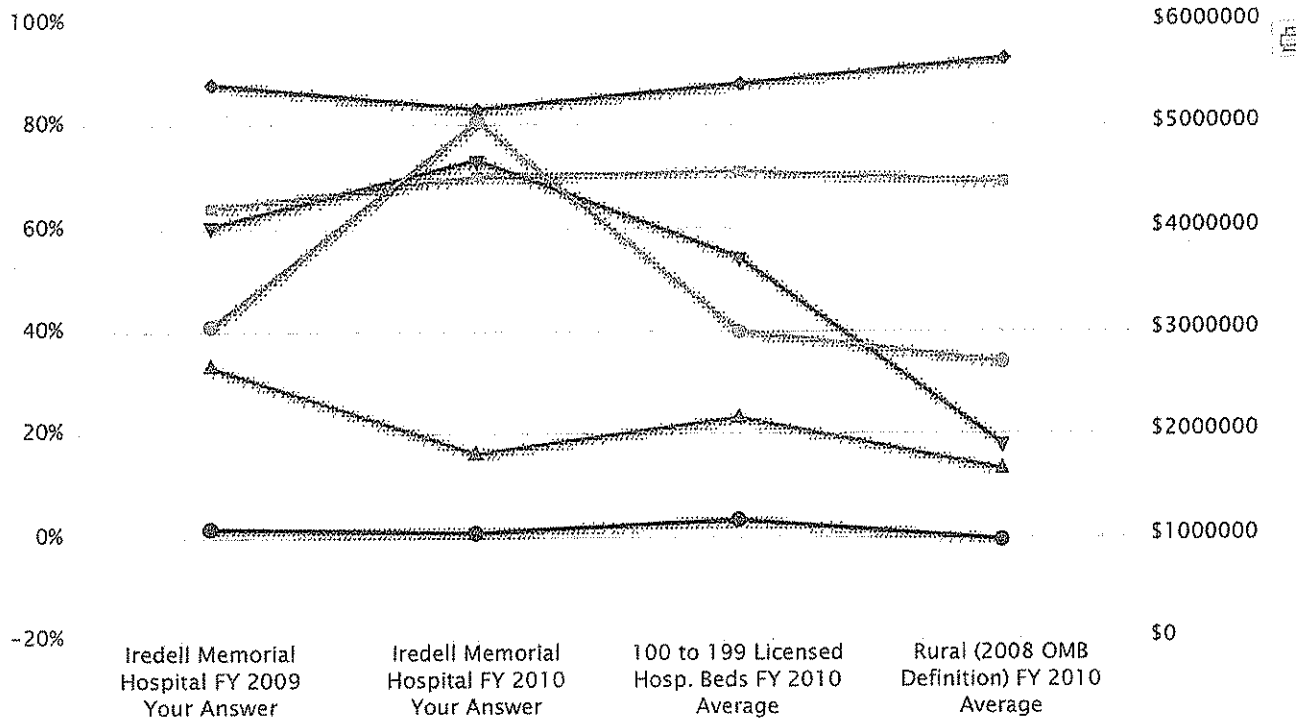
How we did it

Modern Healthcare obtained tax forms for each hospital under 20 health systems with fiscal years ending Dec. 31 and the highest total revenue in the magazine's most recent Hospital Systems Survey.

The 20 systems in the survey are:

Adventist Health System/Sunbelt*
Advocate Health and Hospitals Corp.
Allina Health System
Aurora Health Care
Banner Health
BJC HealthCare
Catholic Health East
Catholic Health Partners
Cleveland Clinic
Intermountain Healthcare
Mayo Clinic
Fairview Health Services
New York-Presbyterian Healthcare System
North Shore-Long Island Jewish Health System
Providence Health & Services
Sentara Healthcare
SSM Health Care Corp.
Sutter Health
Texas Health Resources
University Hospitals**

*Winter Park, Fla. **Cleveland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$5000000
$4000000
$3000000
$2000000
$1000000
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Iredell Memorial Hospital FY 2009 Your Answer
Iredell Memorial Hospital FY 2010 Your Answer
100 to 199 Licensed Hosp. Beds FY 2010 Average
Rural (2008 OMB Definition) FY 2010 Average
Operating Margin
Estimated Pct Medicare Costs Paid*
Percent of estimated Medicaid costs paid
Growth in estimated costs of charity care from last year
Estimated Costs of Providing Charity Care
Estimated Costs of Self-Pay (Uninsured) Bad Debt

Attachment 5

Iredell County Emergency Medical Services

Monthly Activity Report for January 2011

In January EMS ran 1474 calls with a year to date call volume of 1,474.
55.8% were dispatched as emergency calls

Calls per EMS Base and by Time of Day

BASE	Calls	8 am - 8 pm	8:01 pm - 7:59 am
Harmony	91	65	26
Trinity VFD	143	114	29
Statesville	658	439	219
Troutman	156	120	36
Mooresville	423	278	145
Lake Norman VFD	86	65	21

Average Response Times per EMS Base (time dispatched to time on scene)

County Wide	10 min 00 sec
Harmony	8 min 24 sec
Trinity VFD	12 min 12 sec
Statesville	9 min 30 sec
Troutman	11 min 06 sec
Mooresville	9 min 12 sec
Lake Norman VFD	9 min 24 sec

Top five response categories (% of calls)

General Sickness	19.70%
Fall Victim	15.50%
Standby at Post	14.10%
Traffic Accident	6.70%
Respiratory Distress	5.90%

Patient Not Transportated by EMS Data

Cancelled Prior to Arrival	4.7%
Patient Deceased at Scene	0.5%
No Patient Found	0.9%
Patient Refused Care	17.8%
Standby at Post	13.1%
Special Event Standby	0.00%
Transported by Rescue (ALS)	0.10%
Transported by Rescue (BLS)	0.40%
Transported by Flight Service	0.30%

Patient Transported by EMS Data

Not Entered	40.2%
Iredell Memorial Hospital	29.1%
Davis Regional Hospital	9.90%
Lake Norman Regional	19.40%
Presbyterian Hospital (Huntersville)	0.50%
Presbyterian Hospital (Main)	0.00%
Carolinas Medical Center	0.30%
Wake Forest Medical Center	0.60%
Forsyth Memorial Hospital	0.10%

Iredell County Emergency Medical Services

Monthly Activity Report for February 2011

In February EMS ran 1471 calls with a year to date call volume of 2,945.
57.6% were dispatched as emergency calls

Calls per EMS Base and by Time of Day

BASE	Calls	8 am - 8 pm	8:01 pm - 7:59 am
Harmony	89	63	26
Trinity VFD	154	127	27
Statesville	709	483	226
Troutman	159	127	32
Mooresville	390	257	133
Lake Norman VFD	56	44	12

Average Response Times per EMS Base (time dispatched to time on scene)

County Wide	9 min 48 sec
Harmony	9 min 24 sec
Trinity VFD	12 min 0 sec
Statesville	9 min 6 sec
Troutman	10 min 18 sec
Mooresville	8 min 54 sec
Lake Norman VFD	9 min 12 sec

Top five response categories (% of calls)

General Sickness	18.40%
Standby at Post	15.50%
Fall Victim	12.50%
Respiratory Distress	8.30%
Traffice Accident	7.60%

Patient Not Transportated by EMS Data

Cancelled Prior to Arrival	5.4%
Patient Deceased at Scene	0.7%
No Patient Found	0.8%
Patient Refused Care	16.4%
Standby at Post	14.2%
Special Event Standby	0.00%
Transported by Rescue (ALS)	0.40%
Transported by Rescue (BLS)	0.30%
Transported by Flight Service	0.40%

Patient Transported by EMS Data

Not Entered	39.3%
Iredell Memorial Hospital	31.1%
Davis Regional Hospital	10.10%
Lake Norman Regional	17.40%
Presbyterian Hospital (Huntersville)	0.80%
Presbyterian Hospital (Main)	0.00%
Carolinas Medical Center	0.70%
Wake Forest Medical Center	0.30%
Forsyth Memorial Hospital	0.10%

Iredell County Emergency Medical Services

Monthly Activity Report for March 2011

In March EMS ran 1413 calls with a year to date call volume of 4,358.
60.3% were dispatched as emergency calls

Calls per EMS Base and by Time of Day

BASE	Calls	8 am - 8 pm	8:01 pm - 7:59 am
Harmony	60	31	29
Trinity VFD	130	104	26
Statesville	653	422	231
Troutman	169	125	44
Mooresville	424	282	142
Lake Norman VFD	69	47	22

Average Response Times per EMS Base (time dispatched to time on scene)

County Wide	9 min 24 sec
Harmony	9 min 06 sec
Trinity VFD	12 min 12 sec
Statesville	9 min 18 sec
Troutman	9 min 48 sec
Mooresville	9 min 12 sec
Lake Norman VFD	8 min 30 sec

Top five response categories (% of calls)

General Sickness	18.60%
Fall Victim	14.20%
Standby	12.80%
Traffice Accident	9.00%
Respiratory Distress	6.60%

Patient Not Transportated by EMS Data

Cancelled Prior to Arrival	5.1%
Patient Deceased at Scene	1.1%
No Patient Found	0.9%
Patient Refused Care	18.0%
Standby at Post	11.8%
Special Event Standby	0.10%
Transported by Rescue (ALS)	0.00%
Transported by Rescue (BLS)	0.00%
Transported by Flight Service	0.30%

Patient Transported by EMS Data

Not Entered	39.4%
Iredell Memorial Hospital	30.3%
Davis Regional Hospital	11.00%
Lake Norman Regional	17.10%
Presbyterian Hospital (Huntersville)	0.80%
Presbyterian Hospital (Main)	0.10%
Carolinas Medical Center	0.50%
Wake Forest Medical Center	0.40%
Forsyth Memorial Hospital	0.10%

Iredell County Emergency Medical Services

Monthly Activity Report for April 2011

In April EMS ran 1441 calls with a year to date call volume of 5,799.
63.1% were dispatched as emergency calls

Calls per EMS Base and by Time of Day

BASE	Calls	8 am - 8 pm	8:01 pm - 7:59 am
Harmony	106	74	32
Trinity VFD	127	108	19
Statesville	688	454	234
Troutman	157	118	39
Mooresville	405	264	141
Lake Norman VFD	87	64	23

Average Response Times per EMS Base (time dispatched to time on scene)

County Wide	9 min 18 sec
Harmony	8 min 48 sec
Trinity VFD	11 min 36 sec
Statesville	8 min 42 sec
Troutman	9 min 00 sec
Mooresville	9 min 12 sec
Lake Norman VFD	8 min 30 sec

Top five response categories (% of calls)

General Sickness	15.20%
Fall Victim	14.30%
Standby	13.90%
Traffice Accident	10.50%
Chest Pain	6.00%

Patient Not Transportated by EMS Data

Cancelled Prior to Arrival	5.0%
Patient Deceased at Scene	1.2%
No Patient Found	0.7%
Patient Refused Care	19.1%
Standby at Post	12.9%
Special Event Standby	0.00%
Transported by Rescue (ALS)	0.00%
Transported by Rescue (BLS)	0.00%
Transported by Flight Service	0.80%

Patient Transported by EMS Data

Not Entered	41.5%
Iredell Memorial Hospital	31.3%
Davis Regional Hospital	9.90%
Lake Norman Regional	16.40%
Presbyterian Hospital (Huntersville)	0.30%
Presbyterian Hospital (Main)	0.10%
Carolinas Medical Center	0.10%
Wake Forest Medical Center	0.30%
Forsyth Memorial Hospital	0.00%

Attachment 6

Iredell, North Carolina

Heart Disease Death Rates, Total Population, Ages 35+, 2000 – 2006

Race/Ethnicity	Rate*
Total Population	**417**
American Indian and Alaska Natives	Insufficient Data
Asian and Pacific Islanders	180
Blacks	504
Hispanics	118
Whites	405

* Rate per 100,000 age-adjusted and spatially smoothed

Distribution of Total Population, Ages 35+, 2006

Race/Ethnicity	Percentage	Number
American Indian and Alaskan Natives	0.24%	184
Asian and Pacific Islanders	1.16%	898
Blacks	11.51%	8,939
Hispanics	2.93%	2,274
Whites	86.75%	67,349
Others	0.34%	264

Footnote:
* Percentages do not add up to 100% because the race/ethnicity categories are not mutually exclusive.

County Demographics

Rural — Urban Status[1]	Micropolitan
Total Population, All Ages,2006[2]	146,206
Total Population, Ages 35+,2006[3]	77,634
Percent of Families Below Poverty,2006[4]	11%
Percent of Persons 25 years or older with High School Diploma or more,2002[2]	78%
Median Household Income,2006[4]	$45,408
Percent of Persons without Health Insurance, 2005[5]	18%

Footnote:
1. 2006, NCHS urban — rural classification scheme for counties.
2. United States Census Bureau / Area Resource File.
3. United States Census Bureau.
4. United States Census Bureau / Small Area Income & Poverty Estimates.
5. United States Census Bureau / Small Area Health Insurance Estimates.