COMMENTS ON PETITION FOR AN ADJUSTMENT TO A NEED METHODOLOGY

Comments in Support of Petition for an Adjustment to the Need Methodology for Acute Care Beds

COMMENTER

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INTRODUCTION

UNC Health appreciates the opportunity to comment on the petition filed by Duke University Health System, Inc. (Duke) to adjust the need methodology for acute care beds by removing neonatal beds from the acute care bed need methodology in Chapter 5 of the *2023 State Medical Facilities Plan* (*2023 SMFP*). Based on its detailed review, UNC Health urges the State Health Coordinating Council (SHCC) to approve this petition with minor modifications discussed below.

COMMENTS

Duke proposes a change which will serve to carve neonatal beds out of the acute care bed need methodology. This proposed change parallels the treatment of C-Section rooms in Chapter 6 of the *SMFP*, which are excluded from the operating room need methodology.

Specifically, as stated in its petition, Duke proposes adding the following language to the acute care bed need methodology:

> *NOTE: The need methodology excludes dedicated neonatal beds and associated inpatient days of care from the calculation of need determinations. A dedicated neonatal bed shall only be used to accommodate: 1) neonates (newborn from birth **to one month**); and/or 2) patients transferred from another hospital at which the patients were receiving inpatient neonatal care (for example, patients transferred between Level IV NICU beds at one hospital and Level II neonatal beds at another hospital).*

[**emphasis added**].

While UNC Health supports the change proposed by Duke, UNC Health believes that the proposed language should be modified to clearly address infants who require a NICU stay that would exceed one month (see emphasized language above). Specifically, in order to avoid any confusion in the application

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[1] The University of North Carolina Health System, formerly known as UNC Health Care, is now known as UNC Health.

of Duke's proposed change and to clearly address infants who may require a NICU stay exceeding one month, UNC Health proposes that the note be revised to reference the definitions found in the Criteria and Standards for Neonatal Services as follows:

> *NOTE: The need methodology excludes dedicated Neonatal beds (as defined in 10A NCAC 14C .1401(8))[2] and associated inpatient days of care from the calculation of need determinations. Neonatal beds shall only be used to provide Neonatal services,[3] as defined in 10A NCAC 14C .1401(11).*

Or, in the alternative, UNC Health proposes the following modification to the note proposed by Duke:

> *NOTE: The need methodology excludes dedicated neonatal beds and associated inpatient days of care from the calculation of need determinations. A dedicated neonatal bed shall only be used to accommodate: 1) neonates (newborn from birth to one month)* ***<u>and infants</u>****; and/or 2) patients transferred from another hospital at which the patients were receiving inpatient neonatal care (for example, patients transferred between Level IV NICU beds at one hospital and Level II neonatal beds at another hospital).*

[**<u>revised language</u>**].

Please note that the modifications proposed by UNC Health are in keeping with the intent of Duke's petition – to carve neonatal beds out of the acute care bed need methodology. The minor modifications are proposed simply to eliminate any confusion related to the treatment of infants who may require a NICU stay exceeding one month.

As discussed below, UNC Health supports the approval of Duke's petition to remove neonatal beds from the acute care bed need methodology in Chapter 5 of the *2023 SMFP* for the following reasons:

- Neonatal beds differ from other types of acute care beds;
- Neonatal beds are not interchangeable with other categories of acute care beds; and,
- There is a need for separate treatment of neonatal beds.

The current acute care bed need methodology, found in Chapter 5 of the *2022 SMFP*, does not distinguish between the various types of inpatient services that can be provided in acute care beds. As such, all categories of acute care beds – general acute care, intensive care, adult, and pediatric and neonatal beds – are considered the same (as "acute care beds") under the current acute care bed need methodology, even though the levels of care provided in these beds, as well as the needs of patients receiving care in these beds, can vary dramatically.

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[2] A "neonatal bed" refers to a licensed acute care bed used to provide Level II, III, or IV neonatal services. *See* 10A NCAC 14C .1401(8).

[3] "Neonatal services" means any of the Level I, Level II, Level III, or Level IV services defined in this Rule. *See* 10A NCAC 14C .1401(11).

Neonatal beds,[4] which are currently considered the same as other categories of acute care beds under the acute care bed need methodology, are unique and differ from other categories of acute care beds. Neonatal beds are highly specialized and serve a specific vulnerable population. Not only are neonatal beds reserved exclusively for newborn infants with major health problems or special care needs, but they also require specialized staffing and support services. In addition, neonatal patients may have lengthy inpatient stays as critically ill infants many spend weeks (or even months) in a neonatal unit.

Further, while neonatal patients may transition through the various levels of neonatal care, this unique patient population cannot be easily accommodated in available acute care beds in other areas of a hospital. Notably, the physical facility requirements for neonatal beds are not consistent with those for other acute care beds. Not only are neonatal patients accommodated in different physical beds than adult or pediatric patients, but also, the physical plant requirements for neonatal beds differ from that of other acute care beds with regard to square footage, bathroom access, and security. By way of example, neonatal units require controlled access, infant security systems, and must be physically situated so as to allow for efficient access to labor and delivery services as well as the emergency department. As such, neonatal beds have less flexibility in terms of the types of patients who may fill these beds. Given these differences, adults and pediatric patients may not be admitted to dedicated neonatal beds. Likewise, it is often not possible or feasible to admit neonatal patients to space for other acute care patients, given that such space is not required to meet the physical facility requirements for neonatal beds.

In the past, rather than trying to compete for need determinations for acute care beds, providers have typically sought to add neonatal beds by petitioning the SHCC for special need adjustments for additional neonatal beds. These special need petitions for neonatal beds – such as the one filed by WakeMed in 2008 and subsequently approved by the SHCC – have been driven in part by the unique nature of neonatal beds and the fact that in a competitive acute care bed review, applications for neonatal beds are often at a comparative disadvantage. As noted above, neonatal beds serve a limited patient population and may result in lengthy inpatient stays. This translates into a comparative disadvantage given that the CON Section is predisposed to award acute care bed need allocations to applicants proposing the least costly alternative and/or those that propose to improve access (serve the greatest number of patients). Moreover, and as addressed in Duke's petition, while providers may convert other existing acute care beds to neonatal beds, such an alternative (particularly in the current market) may not be deemed to be the most effective in light of the operational needs of the facility and the ongoing demands associated with the ongoing COVID-19 pandemic.

As detailed above, neonatal beds are unique and differ from other categories of acute care beds and, as such, warrant different treatment. Moreover, as noted in Duke's petition, carving neonatal beds out of the acute care bed need methodology would not unnecessarily duplicate health resources as providers would still be required to file a CON application to develop acute care beds, including neonatal beds. In addition, providers also would have to meet licensure requirements and demonstrate compliance with applicable facility, staffing, and support criteria.

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[4] A "neonatal bed" refers to a licensed acute care bed used to provide Level II, III, or IV neonatal services. *See* 10A NCAC 14C .1401(8). This definition is consistent with the Hospital License Renewal Application form, which identifies Level II-IV neonatal beds as included in a hospital's licensed acute care bed inventory. Note: Bassinets accommodating neonatal patients requiring standard Level I care are not considered licensed acute care beds (10A NCAC 13B .3102).

Summary

UNC Health believes that the change proposed by Duke in its petition – to carve neonatal beds out of the acute care bed need methodology – is appropriate and should be approved with the minor modifications suggested herein. Not only is the proposed change consistent with the principles of the CON law, but it will also serve to improve patient access to these critical services and flexibility for providers, while maintaining a reasonable and appropriate level of regulation.

Thank you for your time and consideration.