

**Comment on WakeMed's Petition for No Adjusted Need Determination for
Cardiac Catheterization Equipment in Wake County**

COMMENTER

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In response to WakeMed's petition, Rex Healthcare (Rex) provides the following comments for the Agency's and SHCC's consideration. Rex believes that WakeMed's petition is wholly improper and should not be approved. As stated in Chapter 2 of the *Proposed 2015 SMFP*:

"People who believe that unique or special attributes of a particular geographic area or institution give rise to resource requirements that differ from those provided by application of the standard planning procedures and policies may submit a written petition requesting an adjustment be made to the need determination given in the North Carolina Proposed State Medical Facilities Plan." (Emphasis added)

WakeMed's petition does not request an adjustment to the application of the standard planning procedures and policies. The *Proposed 2015 SMFP* shows no need for cardiac catheterization equipment in Wake County, which is what is requested by the petition. Thus, the petition, even if it were approved, would not "adjust" anything. Even if the SHCC were ultimately to determine that there should not be a need determination for cardiac catheterization equipment in Wake County in the *2015 SMFP*, the petition should not be approved, because it only already affirms what is in the *Proposed 2015 SMFP*. Approving the petition also has the potential to set a precedent that might be followed by other petitioners, in which case the Agency would be inundated with petitions that would have to be reviewed by staff, taking time that is needed for other work to provide an Agency report for a petition that asks for no change to the need determination. For these reasons alone, Rex asks that the WakeMed petition be denied, and that its petition be noted as improperly filed, which will hopefully prevent others from pursuing a similar course in the future.

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Notwithstanding the improper nature of the petition, the following discussion will address each specific point made in the petition.

1. WakeMed's first point in its petition discusses the relative surplus of cardiac catheterization units in Wake and other counties. First, it seems disingenuous for WakeMed to discuss the surplus of cardiac catheterization units in Wake County when its equipment is the cause of more than one-half of the surplus. Next, given the fact that most counties with fixed cardiac catheterization units have only one provider (as most counties are smaller with only one hospital) and usually only one cath lab, it is logical that most would have a surplus of less than one. Wake County, as the county with the second highest population in the state, is certainly much different than those smaller counties with one provider. But even when considering similarly-sized Mecklenburg County, which also has 17 existing fixed cardiac catheterization units and a similar surplus, the surplus is spread more evenly across the providers—and no provider has a deficit.

Moreover, if there was not a deficit in the county, a need would be generated through the standard methodology and Rex would not need to file a petition for an adjusted need determination. The inability of WakeMed and Duke Raleigh to fully utilize their equipment should not prevent Rex's physicians from providing the care their patients need. As stated in Rex's petition, the SHCC's rationale when approving the Duke Raleigh petition for an additional linear accelerator in 2013 was clearly centered on the need at the well-utilized provider, not the underutilization at other providers.

This point also contradicts several petitions filed by WakeMed itself.

- In 2008, the Wake County service area showed a surplus of 105 acute care beds, yet WakeMed petitioned for 18 additional beds in the 2009 *SMFP*, for which a need was subsequently determined.
- In 2010, Wake County showed a surplus of 0.54 operating rooms, yet WakeMed petitioned for four additional operating rooms.
- In 2012, Wake County showed a surplus of 8.13 operating rooms, yet WakeMed petitioned for two additional operating rooms.

Clearly, WakeMed believes that petitioning for additional capacity when existing capacity is underutilized is a reasonable approach.

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2. WakeMed's second point discusses the declining volume of cardiac catheterizations in the state. Rex acknowledged this fact in its own petition; however, it is the unique circumstances outlined in Rex's petition that are driving the utilization at Rex. Given the fact that, as WakeMed asserts, so many providers and geographies are experiencing declining cath volumes, while Rex's volume is increasing so dramatically, Rex believes this is a compelling reason for the adjusted need determination, because of the special (i.e. different, unique) circumstances it is experiencing, which cannot be remedied through the standard need methodology.
3. The third point discusses the fact that some cardiologists are privileged at more than one facility in Wake County. While this is true, it is clear that the preferred facility for those cardiologists to practice is Rex, based on the volume increase there. Moreover, as noted in WakeMed's statement, with such highly utilized equipment, if a patient has to have his or her cardiac cath procedure performed at another hospital, he or she may have to be treated by a different physician. Most importantly, as discussed thoroughly in Rex's petition, a cardiac catheterization is typically part of an entire series of diagnostic and therapeutic tests associated with cardiac health; being able to perform them all but the cardiac cath at the same facility is not conducive to the continuity of care.
4. The final point made by WakeMed concerns the potential impact to WakeMed of an additional unit of cardiac catheterization equipment at Rex. The most obvious problem with this point is that it contradicts the previous point made by WakeMed – if there are physicians that practice at both Rex and WakeMed, and if the physicians that practice at WakeMed have a different payor mix than those that practice at Rex, it is logical to assume that enabling those physicians to practice at Rex would, using WakeMed's premise, improve the payor mix at WakeMed and negatively impact the payor mix at Rex.

Next, the differences cited by WakeMed in the payor mix for cardiac catheterization service are minimal, particularly for Medicaid and charity care. As reported by WakeMed, it provided 8% Medicaid and 9% charity care, which is not substantially different from Rex's 5% Medicaid and 6% charity care. Interestingly, WakeMed did not provide the payor mix for WakeMed Cary, which is likely much different from WakeMed's New Bern Avenue campus as well. In addition, the data are only for inpatient

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cases, which typically are one-half or less of the total cases. Multiple other factors also are the likely causes in the differences in payor mixes, including the demographics of the population in proximity to the hospitals, WakeMed's voluntary status as a Level I Trauma center and provider of air ambulance services, and its historical legacy as the "county" hospital.

Finally, WakeMed is asking the SHCC to base its decision on the potential (and highly speculative) impact on its financial condition. While the SHCC or the CON Section cannot withdraw a CON that has been issued (as has been discussed numerous times in SHCC meetings), the provider itself is certainly able to decrease its capacity if it is no longer needed. Hospitals do this quite frequently by delicensing acute care beds or converting them to other uses. The evolution of healthcare has never been taking place more quickly, and such an issue as where physicians desire to practice medicine and treat their patients has always been beyond the ability of the SHCC to develop policies to address. The *SMFP* speaks to the fact that the SHCC and the *SMFP* cannot be used as a policy tool to ensure the survival of a hospital in Chapter 5, Basic Principle 3.