

# Hospital and Patient Trends Impacting the State Medical Facilities Plan

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

# CON Law and Process

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

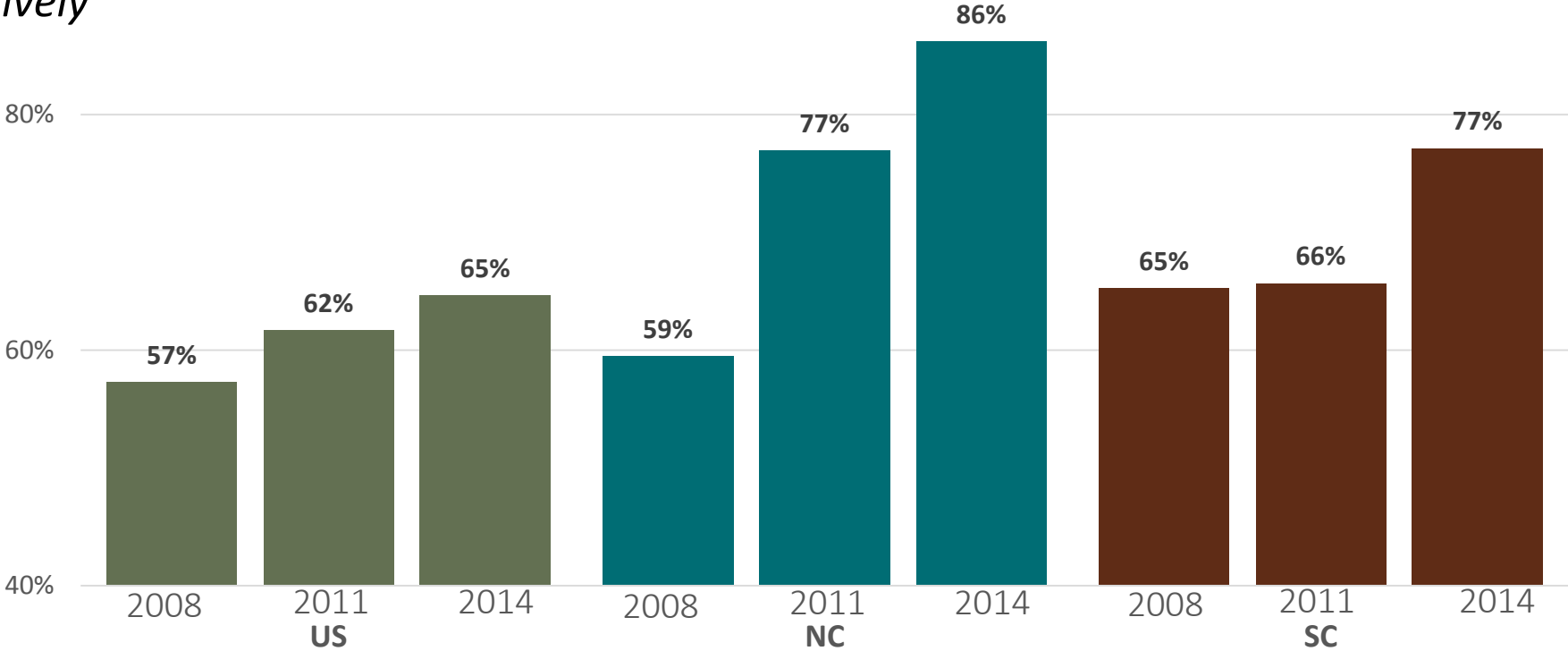
# Medical Care is a Highly Constrained Market: CMS Physician Payments

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- Medicare, Medicaid, Tri-Care use annual government price fixing formulas.
  - MPFS set at 50% of service cost; No operating margin component
  - NC Medicaid is 78% of NC Medicare
- Most private physician contracts are indexed to MPFS.
- Steerage, narrow networks, benefit managers, high deductible policies, out of network issues, episodes of care / bundling, ACOs, CINs, etc.. all create economic restraints for patients and physicians.
- Hospital payments are on different CMS formulas. These are very complex and beyond the time to discuss today. My simplified view: No operating margin, no mission.
- Government mandated “volume to value” payments and “population health” goals and penalties require tight physician/hospital integration and “deep pockets” to manage cost and risks.

# Hospitals within Health Systems

*Today, most hospitals have joined systems for scale economies and to position network offerings more effectively*



Sources: American Hospital Association, 2016 Hospitals Statistics Book

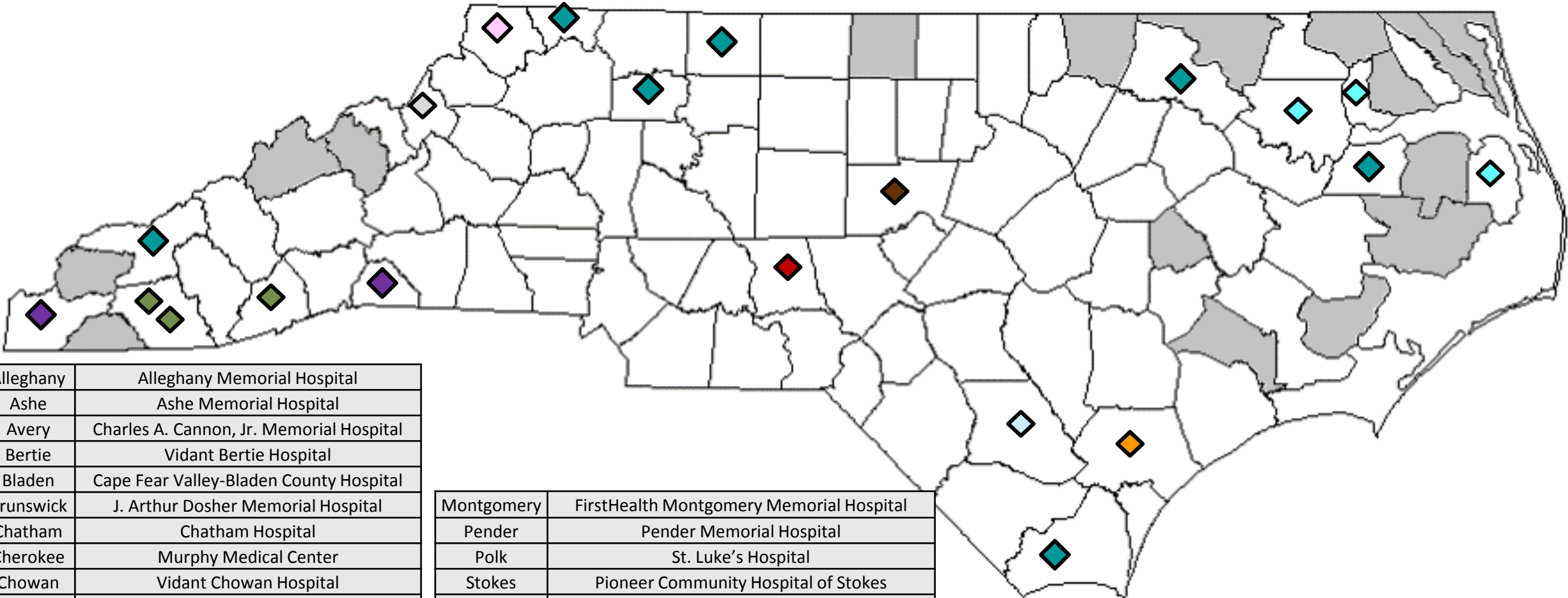


# North Carolina Has 100 Counties

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- 14 have 2 full service hospitals / systems.
- 66 have 1 full service hospital.
- 16 have no hospital.
- 21 critical access hospitals (3 insolvent now).
- Large integrated hospital and university systems with employed physicians are very common.
- Large private practice or corporate single-specialty and multi-service line corporations with employed physicians are growing.

# Critical Access Hospitals



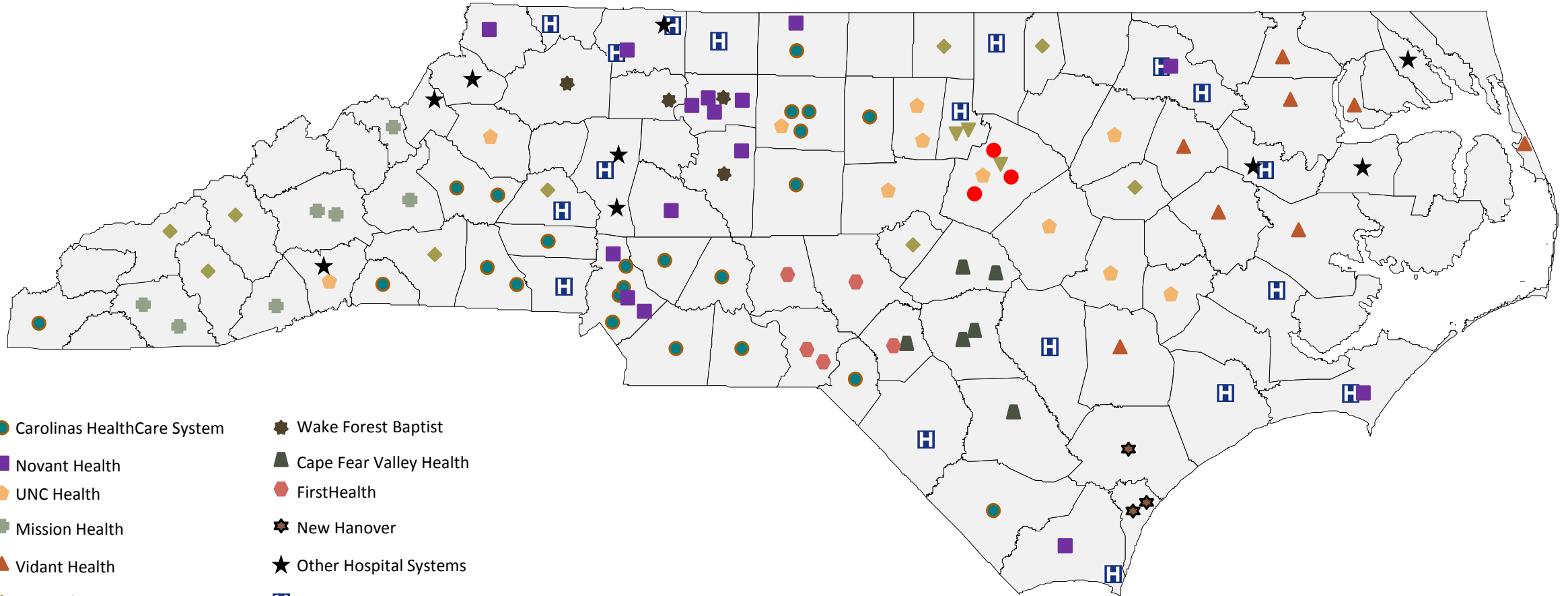
Alleghany	Alleghany Memorial Hospital
Ashe	Ashe Memorial Hospital
Avery	Charles A. Cannon, Jr. Memorial Hospital
Bertie	Vidant Bertie Hospital
Bladen	Cape Fear Valley-Bladen County Hospital
Brunswick	J. Arthur Doshier Memorial Hospital
Chatham	Chatham Hospital
Cherokee	Murphy Medical Center
Chowan	Vidant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

Montgomery	FirstHealth Montgomery Memorial Hospital
Pender	Pender Memorial Hospital
Polk	St. Luke's Hospital
Stokes	Pioneer Community Hospital of Stokes
Swain	Swain Community Hospital
Transylvania	Transylvania Regional Hospital
Washington	Washington County Hospital
Yadkin	Yadkin Valley Community Hospital

*Note: Counties in grey do not have a hospital*

# North Carolina Hospital Systems 2017

As of February 9, 2017



- Carolinas HealthCare System
- Novant Health
- ⬠ UNC Health
- Mission Health
- ▲ Vidant Health
- ◆ Duke LifePoint
- ▼ Duke Health
- WakeMed

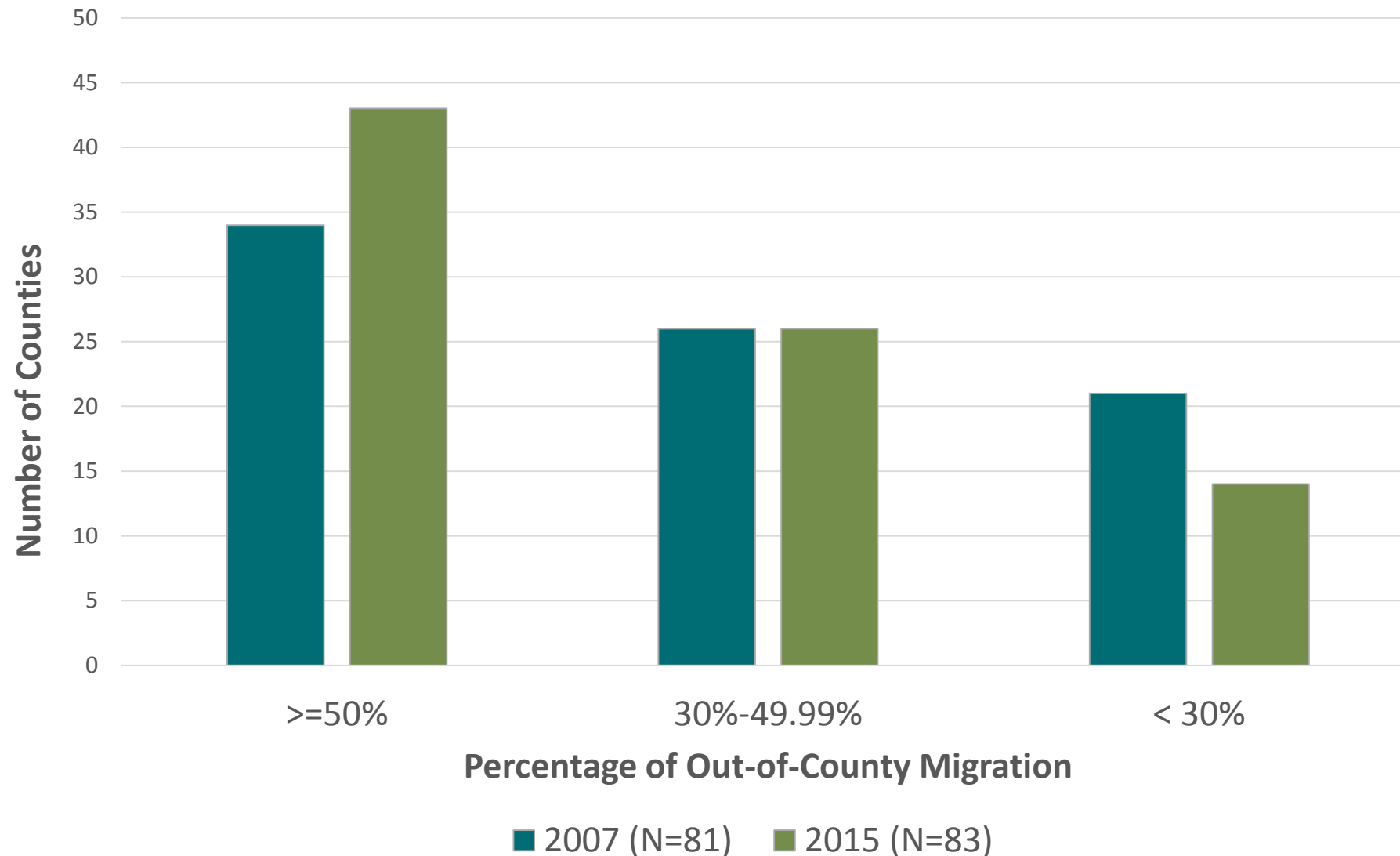
- ★ Wake Forest Baptist
- ▲ Cape Fear Valley Health
- ⬠ FirstHealth
- ★ New Hanover
- ★ Other Hospital Systems
- ⊠ Single Hospital Systems

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

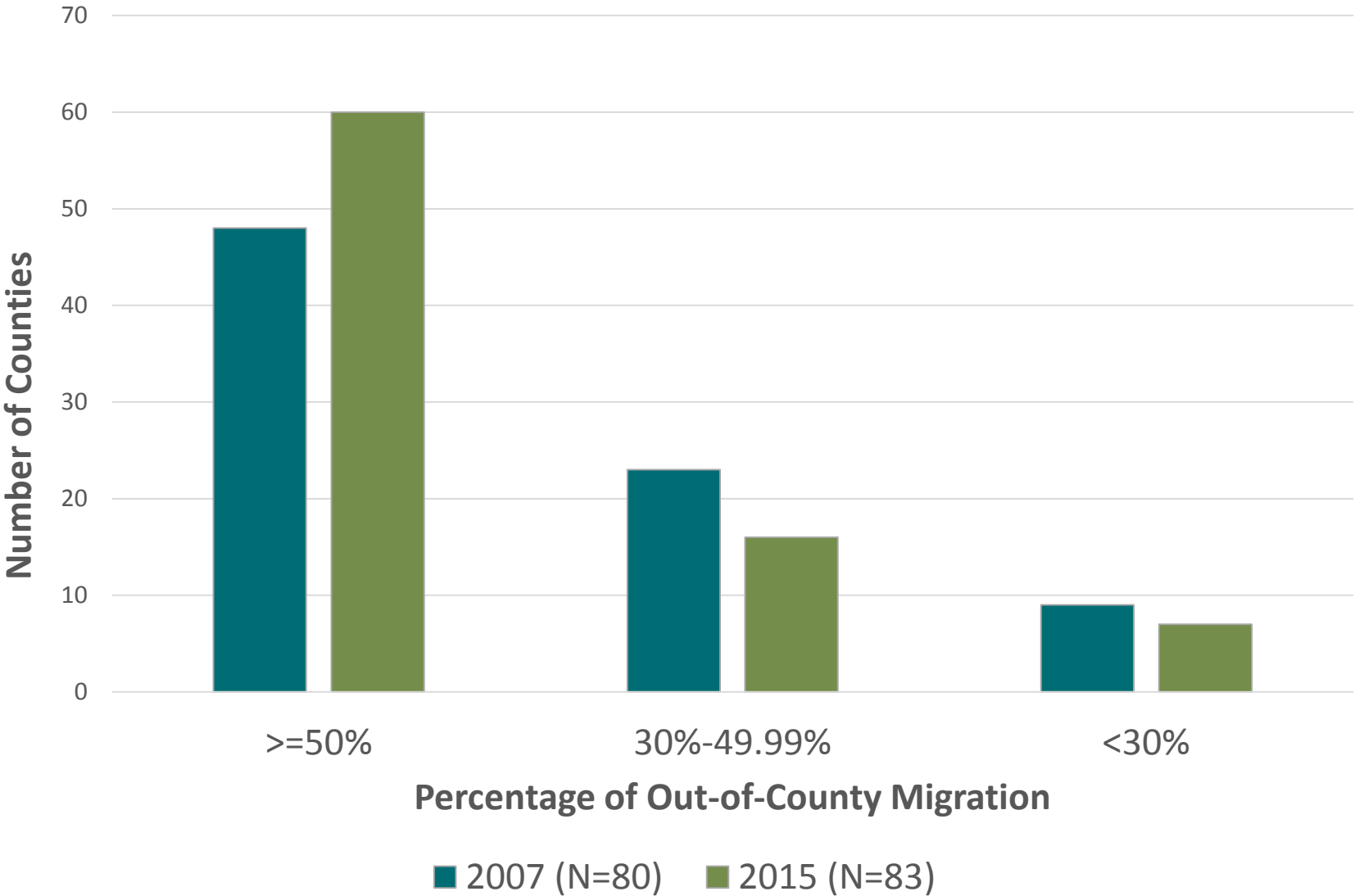
Source: North Carolina Hospital Association, 2017



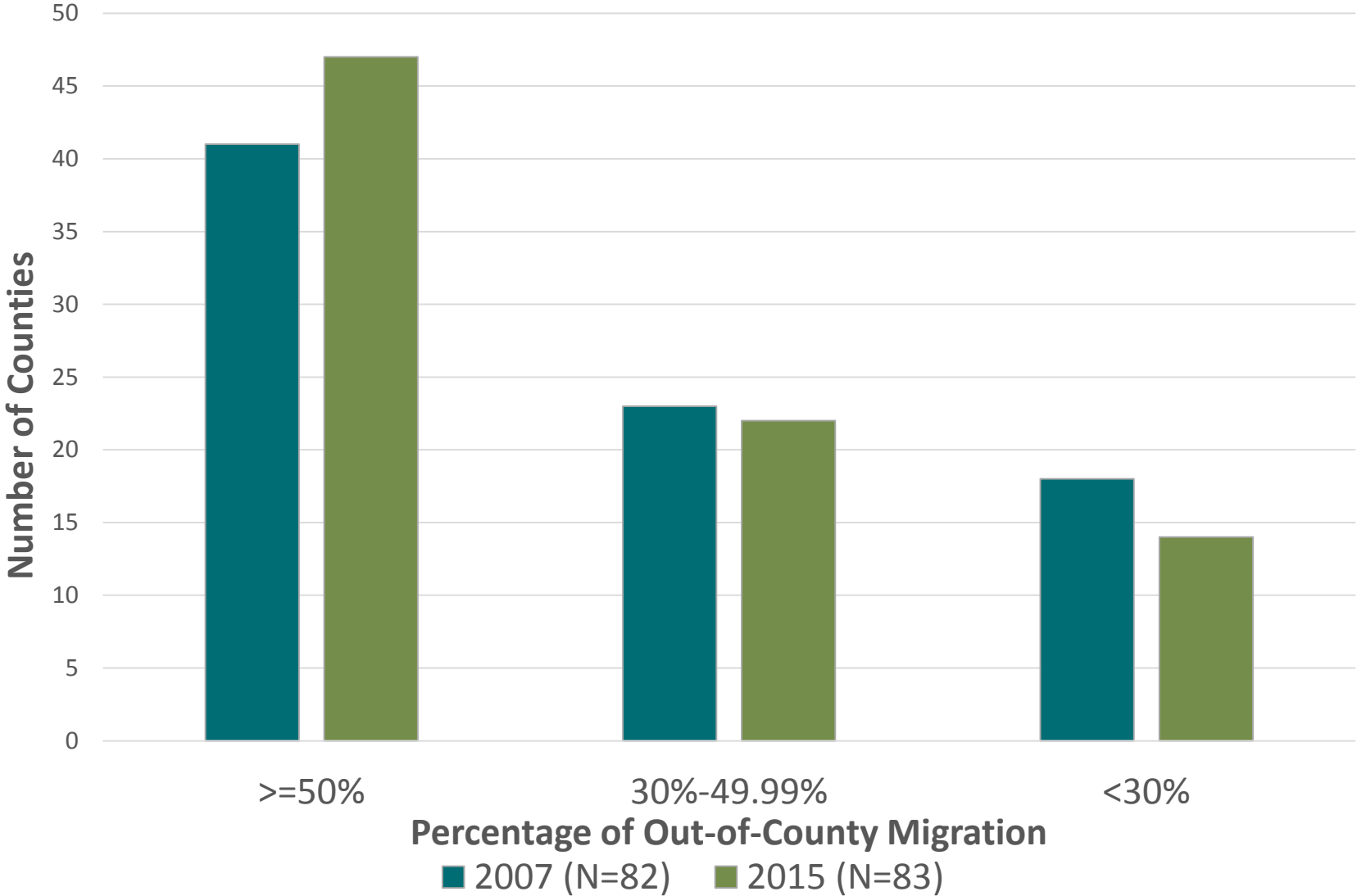
# Percentage of Out-of-County Migration of General Acute Care Inpatients, 2008 and 2015



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



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



# Total Hospitals in North Carolina, 2015

106



## “Other 91”

91 smaller and mostly rural hospitals in North Carolina



## “Big 15”

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



## “Top 5”

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

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

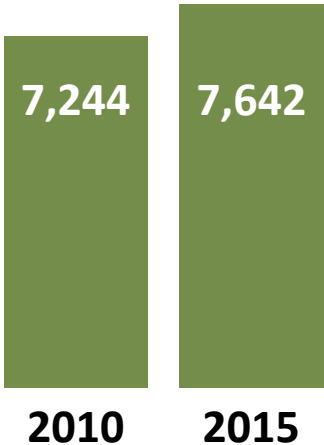
Source: Truven, 2016

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

## “Big 15”



ADC  
+398  
(5.5%)



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



Avg. ADC	
2010	483
2015	509

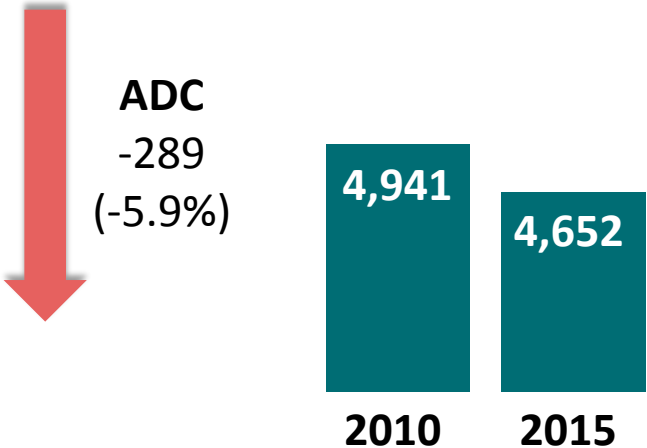
\* Per hospital

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

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

## “Other 91”

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



Avg. ADC	
2010	54
2015	51

\* Per hospital

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

# Hospital Trends Impacting the SMFP

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- 66 of NC counties have 1 hospital; 21 Critical Access Hospitals exist. 16 NC counties do not have a hospital now.
- Medical care is a highly constrained economic market.
- Integrated hospital systems and physician groups are a megatrend.
- Patients are choosing to receive their care in more centralized facilities. The “Big 15” are providing more care. Many of the “Other 91” struggle. The “Top 5” are NC’s Academic Medical Centers.
- SHCC policies need to avoid damaging the “Other 91” if patient access is to be maintained in many of our NC counties. Our most specialized hospitals also need adequate facility capacity to meet patient’s site of care choices and needs.
- Changing payment models and government policies require a transition to a 21<sup>st</sup> century health care delivery paradigm. For many reasons, the 20<sup>th</sup> century health care delivery model is unsustainable.