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Healthcare Planning

NORTH CAROLINA STATE HEALTH COORDINATING COUNCIL

COMMENTS REGARDING PETITION TO AMEND NEED METHODOLOGY FOR FIXED CARDIAC CATHETERIZATION EQUIPMENT

Duke University Health System, Inc. d/b/a Duke Raleigh Hospital hereby submits these comments regarding the petition from Rex Healthcare to modify the need methodology for cardiac catheterization equipment in Wake County in the 2017 State Medical Facilities Plan.

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Rex's proposal would lead to the unnecessary duplication of existing services for a treatment modality with declining volumes statewide, and calls for a significant change to the methodology when circumstances do not warrant it.

There is no need for a statewide methodology adjustment

Rex submitted a petition to adjust the local need for cardiac catheterization equipment in 2015. Having had that petition denied, it now tries to convert a purely local situation into a statewide issue to justify a change to the methodology. Rex acknowledges that its change would "only impact a minority of the hospitals across the state"; in fact, a review of the 2016 SMFP shows that there is not a single other service area or provider that would have been affected by Rex's proposed change this year. A statewide change – especially one that would reflect a major philosophical change in the approach to the need determination – is therefore not justified.

DUHS Comments Regarding Petition To Amend Need Methodology
For Fixed Cardiac Catheterization Equipment

Statewide cardiac catheterization volumes have been decreasing steadily over the past several years:

Year	Statewide Weighted Fixed Procedures
2008 (from 2010 SMFP)	119,910
2009 (from 2011 SMFP)	115,865
2010 (from 2012 SMFP)	115,017
2011 (from 2013 SMFP)	114,567
2012 (from 2014 SMFP)	112,060
2013 (from 2015 SMFP)	109,885
2014 (from 2016 SMFP)	106,185

Despite this significant and continuous decrease, Rex now proposes a statewide change in methodology to address what is, in essence, a local business issue: Rex hired a cardiology practice that previously made use of the capacity available at all of the hospitals in Wake County. Then after hiring those physicians, Rex insisted that they relinquish their privileges at other hospitals and limit their practice to Rex Hospital, thereby creating a manufactured crisis of capacity. Rex's growth in recent years has resulted from this concerted recruitment of physicians within Wake County, not from the addition of providers to the market or any long-term utilization increase in the service area.

There is ample capacity in the service area to meet patient needs. All of the hospitals in Wake County with catheterization lab capacity have open medical staffs, and physicians who find any scheduling difficulties at Rex Hospital are free to seek privileges and schedule procedures at other facilities – just as they used to. In fact, North Carolina Heart and Vascular physicians continue to maintain privileges at 7 hospitals, including 3 hospitals that are not part of the UNC system (Granville Medical Center, Sampson Regional, and Wilson Medical Center). See www.ncheartvascular.com/hospitals. Rex's arguments regarding the challenges of practicing at other hospitals are belied by this practice's maintenance of privileges at several hospitals outside of Wake County. This is especially true for outpatient diagnostic procedures that do not require interventional and inpatient care – the procedures that Rex's physicians have identified as the ones potentially delayed due to Rex's capacity constraints.

Other petitions cited by Rex are not comparable.

Rex identifies several other petitions that have previously been granted. However, the great majority of the petitions Rex cites as comparable were for local need adjustments, not statewide methodology changes of the kind Rex seeks now.

The statewide methodology changes identified by Rex were the result of concerted efforts by a convened work group with input from all stakeholders. The operating room methodology is instructive: the SHCC modified the methodology to account for "chronically underutilized" facilities operating at less than 40% of capacity. In contrast to Rex's proposal here, the operating room methodology does not jettison the long-standing CON principle of encouraging efficient use of existing capacity in a service area. The operating room methodology remains service

area, not facility, based. Notably, even if the cardiac catheterization methodology included a similar adjustment, and the equipment and volumes at WakeMed Cary and Duke Raleigh were excluded as utilized below 40% of capacity, the machines required for Rex's service area would be 12.09, with an existing inventory of 13. Rex's proposal would therefore create a very dramatic change in the approach to need determinations for this equipment.

Conclusion

For all the foregoing reasons, Rex's petition, reflecting a local situation created by its own business decisions, does not justify a wholesale change to the methodology for determining need for cardiac catheterization equipment, and should be denied.