

# **Patient Migration Trends Impacting Hospitals, Physicians, Communities, and 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.*

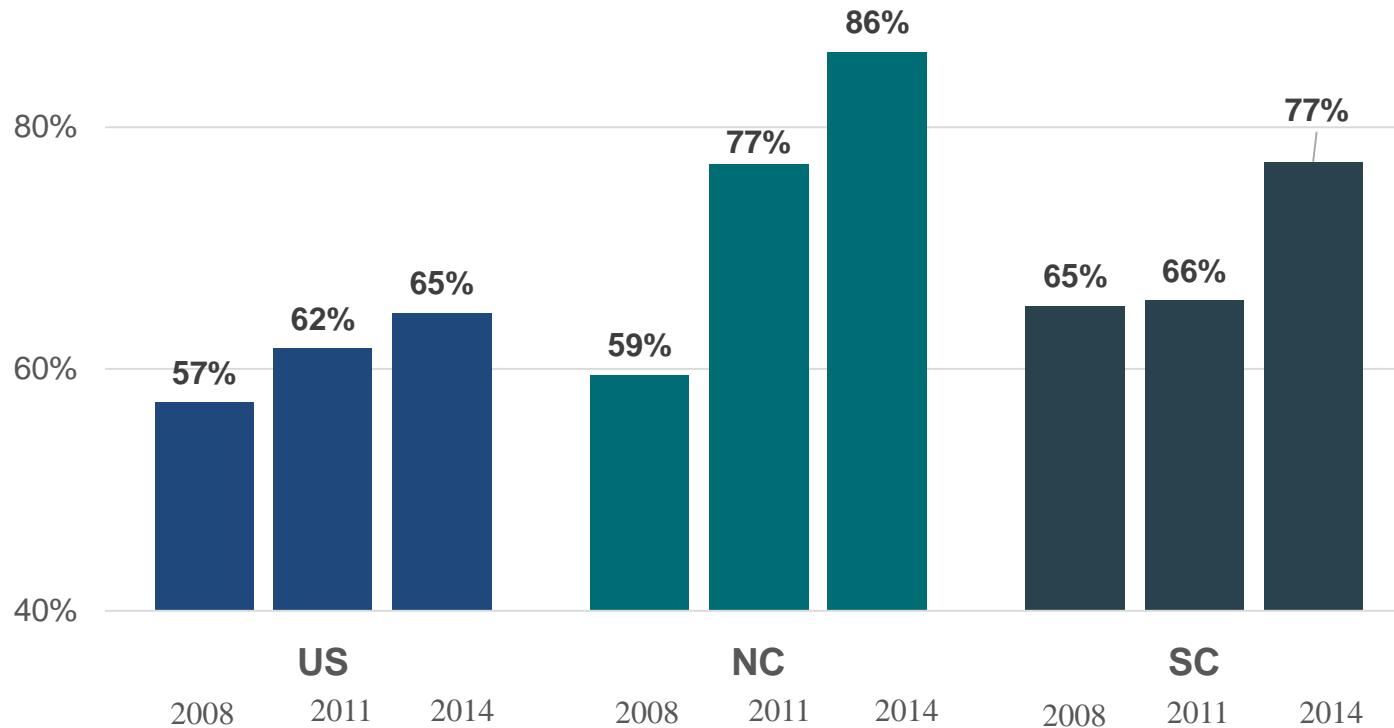
*I want to express my personal appreciation to Amy Craddock and Tom Dickson who supplied data and helped me refine today's presentation.*

# Medical Care is a Highly Constrained “Economic Ecosystem”

- Medicare, Medicaid, & TRICARE use annual government price fixing formulas.
  - Medicare Physician payments are calculated at 50% of the cost of service; No operating margin component!
  - For physician specialists, NC Medicaid is 72-78% of NC Medicare.
- Most physician private insurance contracts are indexed to the Medicare Resource Based Relative Value Scale (RBRVS)
- Hospital integration, physician alignment, insurance-related narrow networks, benefit managers, steerage, out of network issues, episodes of care and bundled payments, ACOs, CINs, provider at-risk contracts, etc. create economic constraints for patients, physicians, and hospitals.

# Hospitals within Health Systems

*Today, many hospitals have joined integrated networks to gain economies of scale, contracting and information technology expertise , and to more effectively leverage network offerings.*

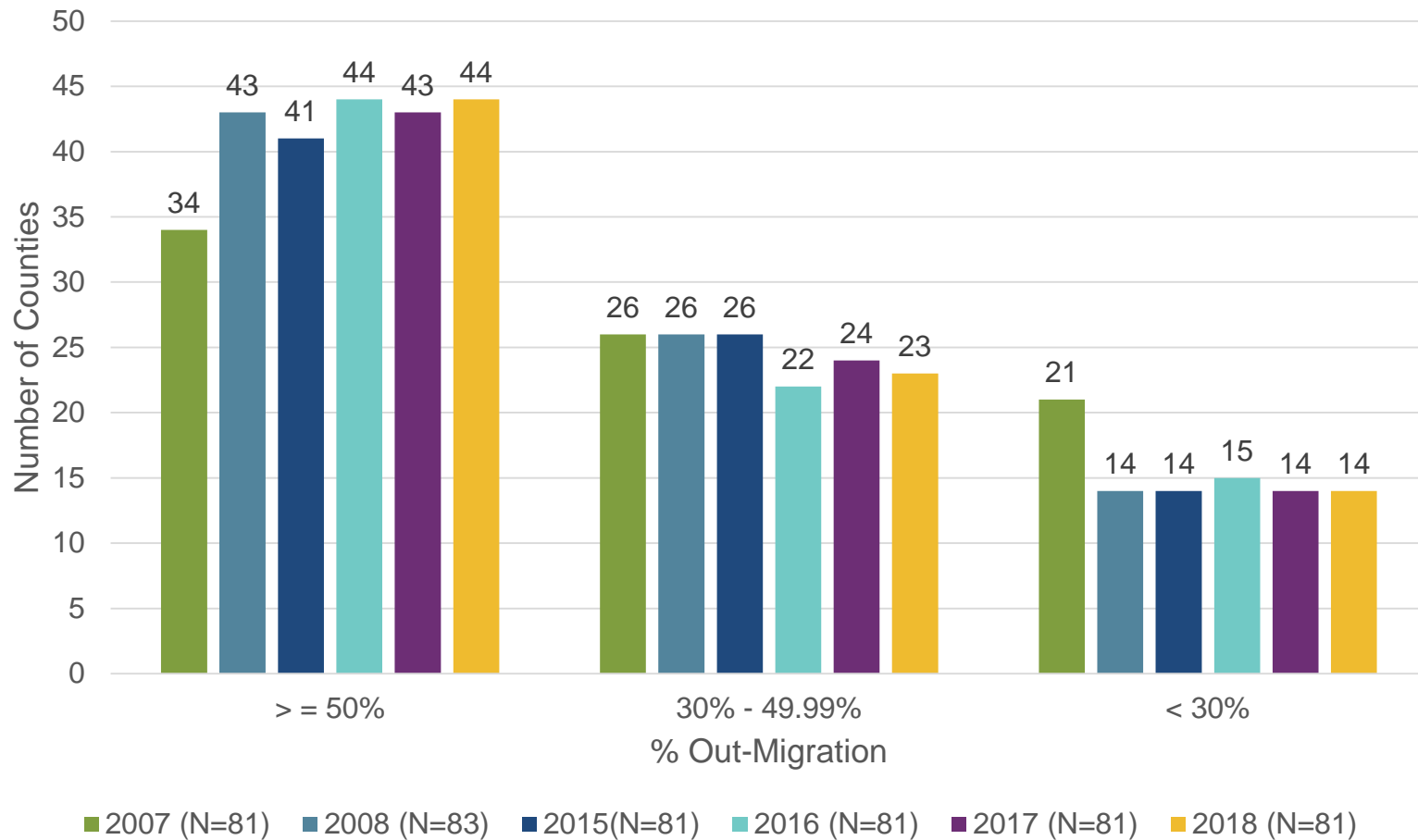


**Sources: American Hospital Association, 2016 Hospitals Statistics Book**

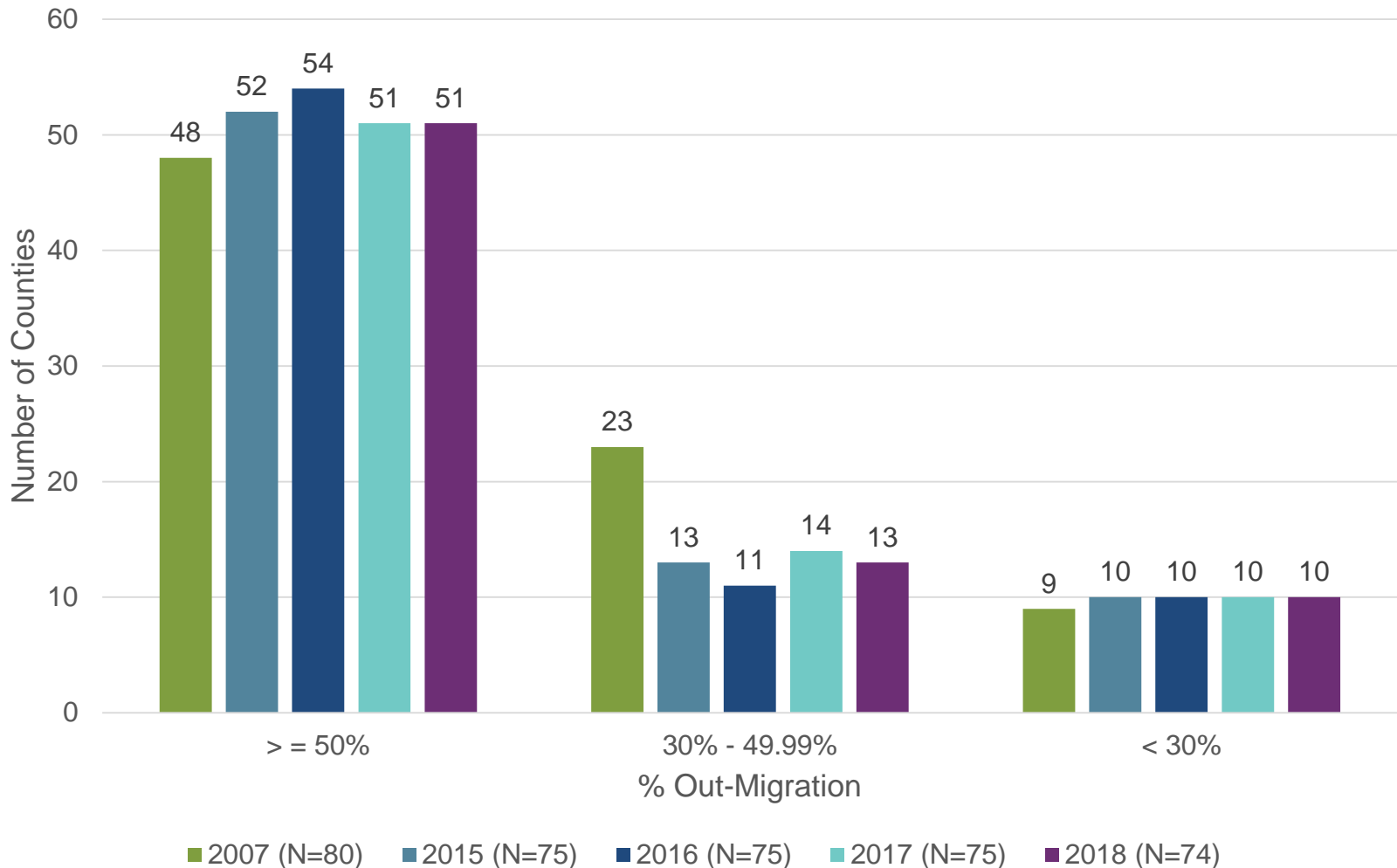
# North Carolina Has 100 Counties

- 15 have 2 full service hospitals / systems. One county has 3 systems.
- 66 have 1 full service hospital.
- 18 have no hospital.
- 19 critical access hospitals (4 recent insolvencies).
- 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.

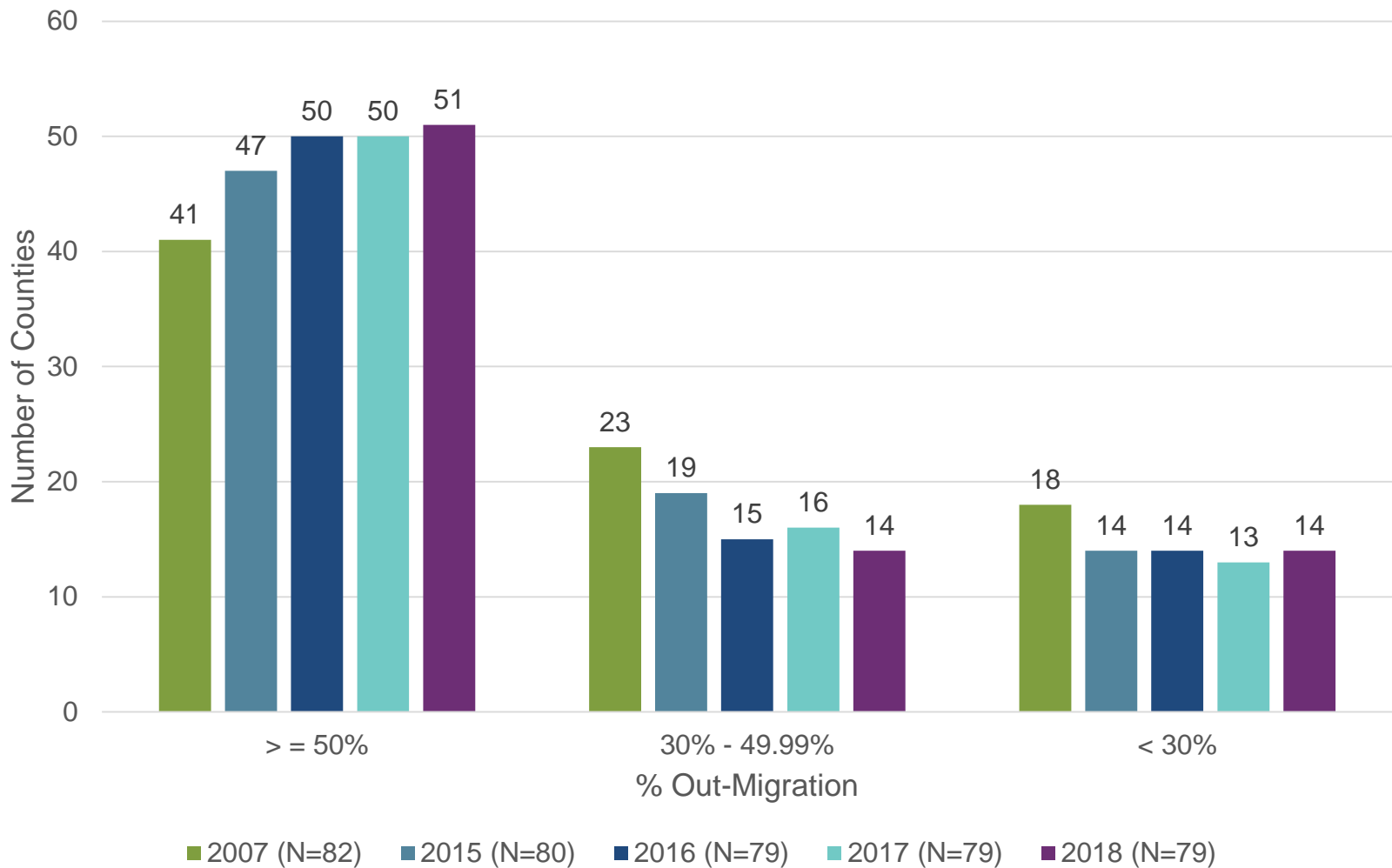
# Out-Migration of General Acute Care Inpatient Admissions: 2007, 2008, 2015-2018



# Out-Migration of Inpatient Surgical Cases: 2007, 2015-2018

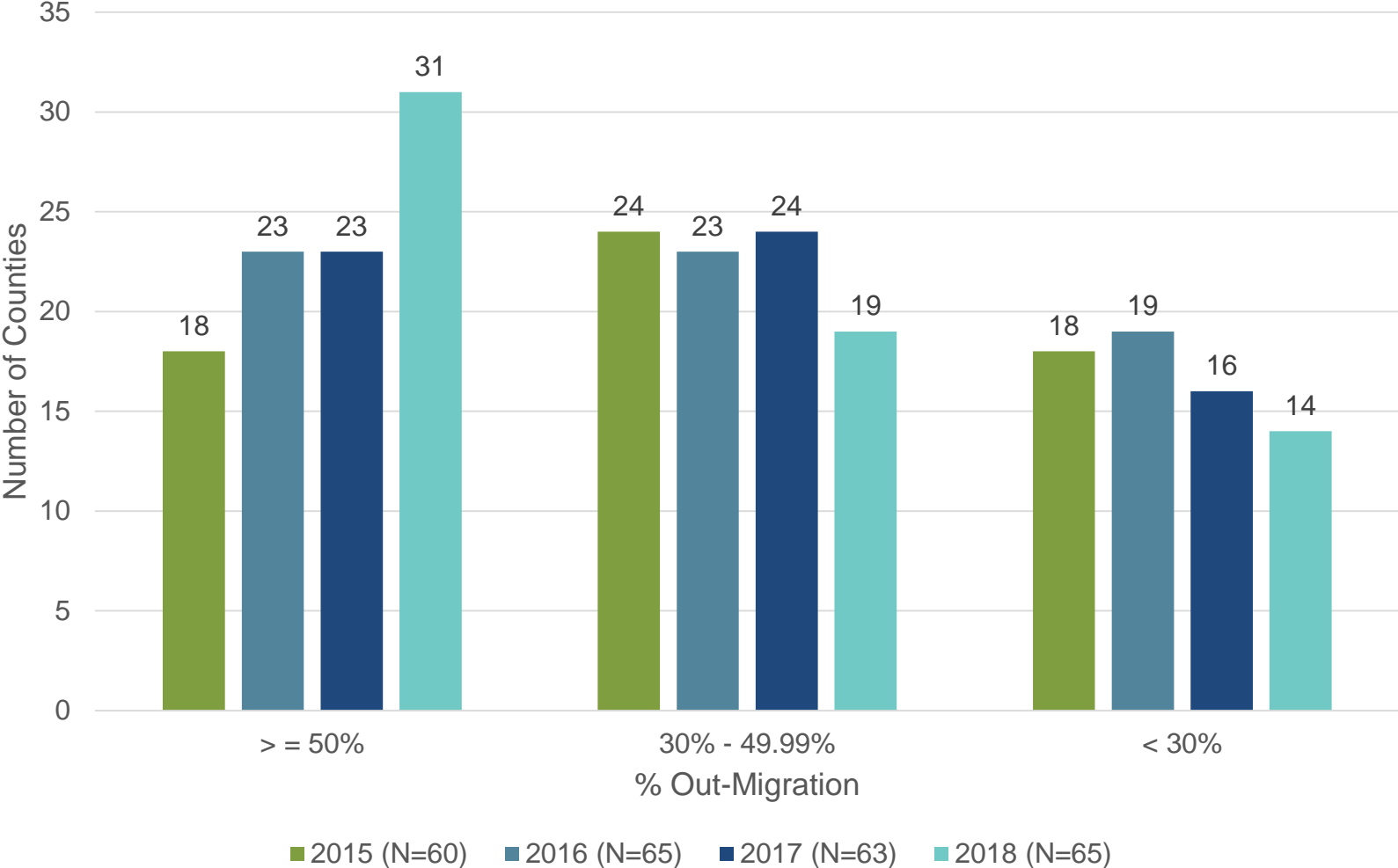


# Out-Migration of Ambulatory Surgical Cases: 2007, 2015-2018





# Out-of-County Migration of Fixed MRI Patients: 2015-2018

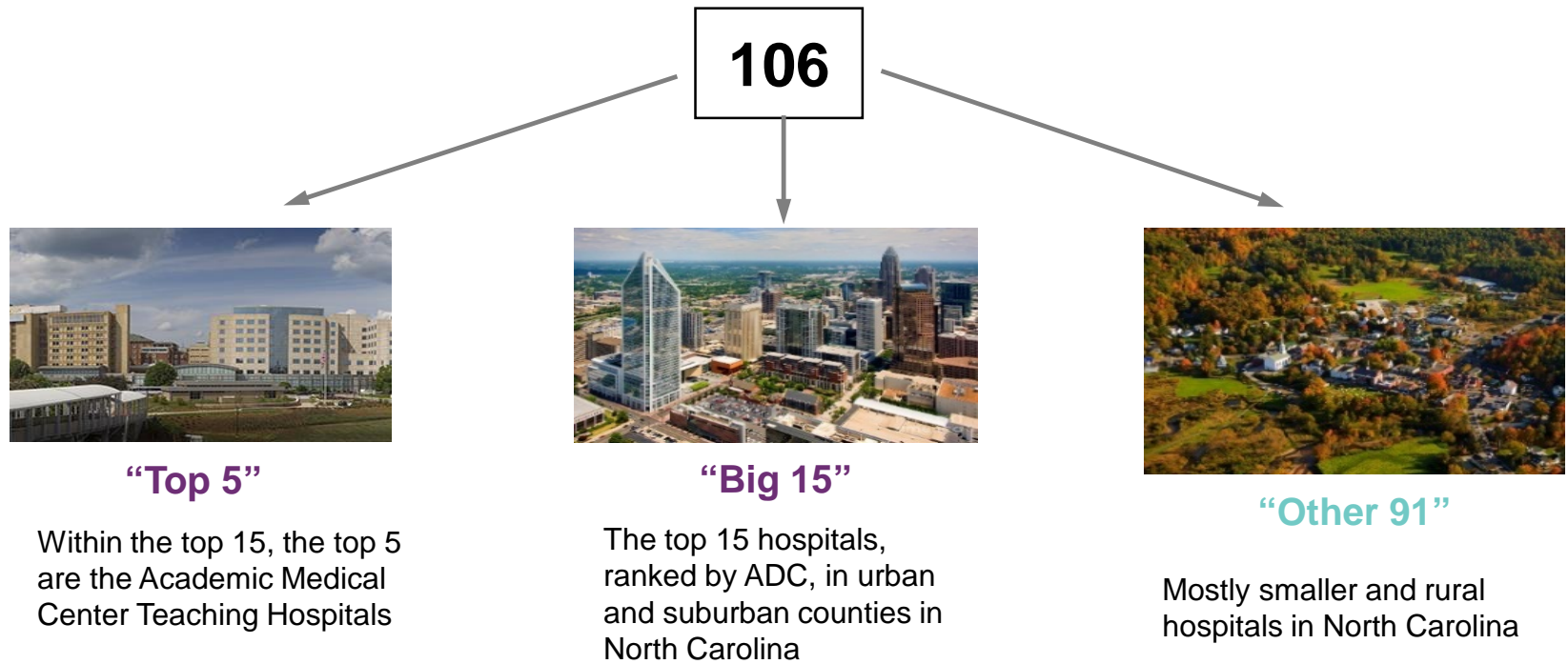


# Why are patients migrating out of county?

*There is surprisingly little reliable hard data. Commonly discussed reasons include:*

1. Access to specialized care and perceptions of quality and service
2. Integrated health systems
3. Various restrictive insurance networks
4. Most are not migrating for lower cost care
5. Etc...

# Total Hospitals in North Carolina, 2018



*Source: 2019 License Renewal Applications*

# Big15 Hospitals in North Carolina, 2018

Big 15 Hospitals	2018 Average Daily Census	% Occupancy
Carolinas Medical Center	858	84.9
Duke University Medical Center	801	85.3
UNC Medical Center	673	83.1
North Carolina Baptist Hospital	637	79.3
Vidant Medical Center	619	73.0
Novant Health Forsyth	594	68.6
Mission Hospital	530	74.9
New Hanover Regional Medical Center	494	76.3
Cone Health	460	59.2
Cape Fear Valley Medical Center	454	86.5
WakeMed	438	69.9
Novant Health Presbyterian	348	61.3
UNC Rex Hospital	314	71.5
Atrium Health Cabarrus	290	64.8
First Health Moore Regional Hospital	244	72.3

*Source:  
2019  
License  
Renewal  
Applica-  
tions*

# Trends Impacting the SMFP

- 67 NC counties have 1 hospital; 19 Critical Access Hospitals are currently operational; 18 NC counties do not have an operational hospital now.
- Medical care is a highly constrained economic ecosystem (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.

# Trends Impacting the SMFP

- 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.
- For many reasons, the 20th century health care delivery model is no longer sustainable. Patient and physician preferences, as well as changing government and insurance payment levels, models, and policies increasingly require a transition to a 21st century health care delivery paradigm.

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