Acute Care Services Committee
Recommendations to the NC State Health Coordinating Council
June 1, 2022

The Acute Care Services Committee met twice this year, on April 12th and May 10th.

Topics reviewed and discussed included:

- policies and methodologies for all acute care chapters;
- petitions regarding Neonatal Intensive Care Unit beds and Policy AC-5, as well as a request for a new ESRD policy;
- clarifying language for Policy AC-6;
- a comparison between hospital licensure and Hospital Industry Data Institute (HIDI) acute care bed days of care data; and
- preliminary drafts of need projections generated by the standard methodologies in the Acute Care Services chapters, based on information currently available.

The following is an overview of the Committee's recommendations for Acute Care Services for the *Proposed 2023 SMFP*.

Chapter 5: Acute Care Hospital Beds

- The Agency received two petitions regarding acute care hospital beds.

  Duke University Health System petitioned to remove Level II, III and IV NICU beds from the acute care bed need methodology. The Agency received two comments in support of this petition, one comment from the Petitioner in response to one of the comments, and one comment requesting further study. In hospitals with NICUs, NICU Levels II through IV beds are a portion of the total acute care bed complement. However, NICU beds are specifically designed to meet the needs of neonates. Serving neonates in any other type of bed is both impractical and medically inappropriate. Almost a third of hospitals in the state operate bassinets for normal newborns, and most of them report providing NICU Level II or III services. The Agency reviewed the change in acute care bed need determinations that would have occurred if NICU beds had been removed from the 2022 SMFP need methodology calculations. There would have been more need determinations in two service areas and fewer needs in four other service areas. Decreases in those services areas indicate that a portion of the beds in their need determinations were attributable to NICU bed utilization. The Committee agreed with the Agency recommendation to approve the petition.

  Blue Ridge HealthCare Hospitals petitioned to remove Policy AC-5 (Replacement of Acute Care Bed Capacity). The Agency received one comment requesting further study. Beginning with the 1997 SMFP, Policy AC-5 required CON to evaluate acute

care bed utilization according to specific occupancy thresholds when considering proposals to construct new space for existing beds. Beginning with the 2014 SMFP, a new statute was enacted that exempts from CON review the construction of new space for existing beds on main campuses only. However, across the State, 11 hospitals have licensed acute care beds located on non-main or satellite campuses. The Agency agreed with the Petitioner that the main campus may bear the burden of meeting threshold requirements in AC-5 for projects to develop a satellite, which could be problematic in areas of high population growth. Also, as noted by the Petitioner, removing occupancy threshold requirements for replacements on satellite campuses by eliminating Policy AC-5 would not exempt these projects from CON review. The Agency recommended approving the Petition, and the Committee concurred.

- Every three years the staff uses patient origin data to reevaluate the acute care bed service areas. There will be one change beginning in the 2023 SMFP. Warren County, which had been grouped with Vance County only, will now be in a multi-county service area with the Durham/Caswell service area and with Vance County.

- The Committee reviewed Licensure and HIDI acute days of care for discrepancies exceeding ±5%. Staff will work with the Sheps Center, HIDI, and the hospitals during the summer to improve discrepant data. Resolution of discrepant data may change need determinations. Staff will notify the Committee if need projections change.

- The Committee also reviewed data collected regarding the Hospital Care at Home program to assess whether any of those days of care were included in inpatient days of care reported on the License Renewal Applications. Hospital Care at Home utilization should not be reported on the LRA nor included in need determination calculations. Hospitals reported providing a total of 5,888 days of care via hospital care at home but reported only 7 of those days on the LRA. Therefore, there is no concern that hospital care at home days of care have been included in the utilization data for the need determination calculations.

- Finally, the Committee addressed continuing effects of the COVID-19 pandemic on bed need. Initial calculations showed that the state had a need for 1,481 additional beds. This number is about three to four times more than in a typical year. Analysis showed that the large number of needs was partly due to the fact that the overall average length of stay increased by about 20-25% from 2020 to 2021. This increase is unprecedented, but not expected to be permanent. Rather, it is most likely related to the lengthier stays of COVID patients. Therefore, in addition to removing NICU data in response to the Duke petition, the Committee approved an adjustment to the growth rate multiplier. Specifically, need determination calculations used the county growth rate multiplier from the 2021 SMFP, which reflects the 2015-2019 pre-pandemic reporting years.

  The tables presented at the May Acute Care Services Committee meeting had not yet been incorporated into the database due to time constraints. In preparation for today's

meeting, the staff has incorporated the data into the database and posted additional versions of Table 5A. These tables show the adjusted growth rate multipliers used in the need determination calculations. One table includes NICU days of care and the other does not.

These newly posted tables reflect the incorporation of the data into the Access database, as it would have appeared for the May Acute Care Services Committee meeting. Final need determinations reflect the exclusion of NICU beds. As a result, the bed needs increased from 424 to 468, in the following service areas:

- 7 in Anson
- 31 in Buncombe/Graham/Madison/Yancey
- 65 in Cabarrus
- 6 in Duplin
- 48 in Gaston
- 54 in Hoke
- 164 in Mecklenburg
- 28 in Scotland
- 21 in Union
- 44 in Wake

The addition of the bed need in Wake County was the only change. Even with the growth rate multiplier adjustment, the needs in some service areas are unexpected. As always, anyone who believes that the projected needs are out of line with the actual needs may file a summer petition to remove, add, reduce, or increase a need determination.

Chapter 6: Operating Rooms

- Every three years staff revises the OR service areas. There are two changes beginning in the 2023 SMFP:
  - Graham County, which was a part of the Jackson/Graham/Swain service area only will now also become a part of the Buncombe/Madison/Yancey service area.
  - Currituck County, which had been a part of a multi-county service area with Dare County will no longer be. It will now only be a part of the service area with Pasquotank, Camden, Gates & Perquimans counties.

- Application of the current need methodology resulted in no need determinations for ORs.

Chapter 7: Other Acute Care Services

- Chapter 7 covers Burn ICU beds, open heart surgery services, bone marrow transplants, and solid organ transplants.

- Staff suggested a revision to Policy AC-6 (Heart-Lung Bypass Machines for Emergency Coverage). This policy establishes a need determination for a second heart-lung bypass machine for emergency coverage for any hospital that has only one machine. The narrative of Chapter 7 states that there is no need determination methodology for heart-lung bypass machines but does not discuss the potential for a need determination pursuant to Policy AC-6. The limited conditions applicable to Policy AC-6 do not necessitate a need determination, because only the hospital with one machine could be approved for a second machine. Therefore, staff recommended a revision to the Policy to state that a hospital that wants to acquire a second machine for the purposes of emergency coverage can submit a CON application; a need determination is not required. Similarly, revisions to the Chapter narrative further clarify that requesting any additional machines other than the second one for emergency coverage would require a summer petition.

- There are no need determinations for any services covered in Chapter 7.

Chapter 8: Inpatient Rehabilitation Services

- Application of the standard methodology indicated no need for additional inpatient rehabilitation beds anywhere in the state.

Chapter 9: End-Stage Renal Disease (ESRD) Dialysis Facilities

- The Agency received one petition for ESRD facilities.

  Liberty Healthcare and Rehabilitation Services petitioned to create a policy to allow the development or expansion of an outpatient dialysis facility at a nursing home. As of 2018, CMS began allowing these services in nursing homes, provided the treatment is administered and supervised by personnel who meet the criteria for training and competency verification set forth in the Federal regulations. They must also provide the services through a written agreement between the nursing home and the ESRD facility. Services may include in-center dialysis, as well as home hemodialysis and peritoneal dialysis. The Committee recognizes the value to the patients of providing these services in a nursing home setting but did not conclude that a policy is the best approach at this point. Rather, the summer petition process is currently available to achieve the goals of the petition. Therefore, the Committee supported the Agency's recommendation to deny the petition.

- Application of the county need determination methodology resulted in no need determinations anywhere in the state. The facility need determination methodology calculations showed needs for 400 dialysis stations across 72 dialysis facilities throughout the state.

Committee Recommendation Regarding Acute Care Services:

The Committee recommends that the State Health Coordinating Council approve Chapters 5 through 9, Acute Care Facilities and Services, with the understanding that staff is authorized to continue making necessary updates to the narratives, tables, and need determinations.