MINUTES

HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES

THURSDAY, OCTOBER 6, 2011

10:00 a.m.

Room 544, Legislative Office Building

The House Select Committee on Certificate of Need and Related Hospital Issues met on Thursday, October 6, 2011, at 10:00 a.m. in Room 544 of the Legislative Office Building. Representatives Avila, Boles, Brandon, Collins, Current, Hollo, Randleman, Steen, and Torbett attended.

Representative Torbett presided. He welcomed members and audience and gave information on upcoming meetings. Shawn Parker, Committee Counsel, addressed questions from previous meeting that were answered concerning the ethical regulations of the SHCC: The state health coordinating council is not considered a covered board under the state ethics act, instead the regulations of their ethics falls under executive order 10, which has been issued by Governor Perdue, and it imposes certain disclosure requirements and conflict of interest standards. What it requires is that prior to each meeting members are reminded of their duty to act in the best interest of the public without regard to their professional, institutional, or financial interest. Before conducting any business, each member must disclose any professional or institutional interest in any matter coming before the SHCC or a SHCC subcommittee. The chair would determine whether the member must be recused. Before conducting any business each member must disclose any financial benefit, the term is slightly different than what would be in the state government ethics act that he or she or his or her spouse may derive in a manner before the SHCC or a subcommittee. If the member indicates they derive a benefit they must recuse themselves. They may deliberate on the matter unless the chair decides that the deliberation would not be in the best interest of the committee.

Representative Torbett asked the committee to adopt the minutes from the previous committee meeting. Representative Randleman made the motion, seconded by Representative Steen. The motion carried unanimously.

PRESENTATIONS

AC3, Drexel Pratt, Director of the Division of Health Service Regulation (see attached).

Overview and Inventory of Regulated Facilities, CON Review Statistics, Jeff Horton, Chief Operating Officer, division of Health Service Regulation, DHHS (see attached)

Representative Avila: Back on page 12 where we talked about the dialysis clinics, there was recently some work done and they are questioning whether just three days a week is sufficient and I was wondering has that trickled into any discussions in terms of capacity as far as the state is concerned?

Jeff Horton: Not to my knowledge. Three days a week is still the standard of care.

Representative Avila: Just being knit picky on this. On page 16, I don't get my numbers to add up. Because when you do the non –competitive and the competitive you only get 123 and you are saying there were 156 reviewed, where do we lose that, what kind of classification did the difference fall into?

Jeff Horton: We had 156 total received, actually, the 11 competitive reviews were 45 applications, and then that actually would be added to the 112 applications. Actually that would be 157.

Representative Current: In deciding, let me see if I can put it a way that clarifies what I am saying. In my county, town of Mount Holly area, our hospital applied for an emergency facility and then the hospital across the river contested that and so forth and I think it has been decided, but my question is who makes the decision you need any emergency room facility in Mount Holly or is that purely based on the fact that somebody applies for it?

Jeff Horton: Yes, a need for the offsite and emergency department, like you are talking about, is not in the state medical facilities plan. There is no determination in the plan for that, per se. The hospital would have to make the case and say we believe there is a need for it and then they would have to demonstrate that need and tell us why they think it is and it would have to conform to the criteria and the law.

Representative Current: You touched on something I also wanted to get a little more clarification on. In the case of a hospital, I think Hillsboro is getting ready to build one, is that correct?

Jeff Horton: Yes.

Representative Current: Now if the mission of certificate of need is to affect the cost of health care in North Carolina, would certificate of need have the authority or the committees behind it and so forth, to decide whether you need a hospital period, based on access or the other factors and so forth, up front?

Jeff Horton: Well the state medical facilities plan would determine if there is a need for acute care hospital beds. That's where the need originates from and then the plan is published every year and is signed by the governor, usually before the end of the calendar year, and its effective January 1 of the next year and that will have the need determinations in it. So if there are new hospital beds in it that would typically drive somebody building a hospital or either taking those beds and adding it to an existing hospital in the same county. Now another that hospitals can do is there may not be a need determination for hospital beds in a certain county, but let's say they want to take some beds from their big facility and just relocate those beds to another part of the county. They can do that, but they have to have a certificate of need, and again, we look at the criteria that they have to meet all the review criteria. A big part of that, I will tell you, that when reviews are done, when folks are relocating services within the county, we often look at what population are they serving. A big part of the law is medically underserved individuals. You have to show that you are serving that population, so if they want to relocate something to another area, we typically look are they still going to serve medically underserved

individuals where they want to move their beds to. So we look at things like that just to make sure that they are leaving some folks high and dry somewhere.

Representative Current: On the back page you are talking about how much the state spends in your attorney general's effort. I'm just curious to know how much money might be spent by the entities that desire certificate of needs to address the changes in the decisions. Do you have any idea how much money, because that comes from, say in the case of a hospital that wants to expand or something; those are reflected in healthcare costs?

Jeff Horton: We don't collect that data, that is typically something hospital work out with their law firms and we don't have access to that data.

PRESENTATION

Climate and Conditions for Hospital Operations, Hugh Tilson, Sr. Vice-President, North Carolina Hospital Association (see attached)

Representative Current: Talking a little bit about the Medicaid disproportionate situation, is that still in existence?

Hugh Tilson: Yes sir it is. So Medicaid pays hospitals a base rate and it is on the outpatient side 80% of cost and one the inpatient about 50% of cost. The federal government has a program called the disproportion share program that allows us to draw down federal funds to help offset those losses. The net of those losses are now about 74% of our cost of caring. So even with that it doesn't offset our entire cost of caring for Medicaid patients.

Representative Current: Now does that include the cost of Medicare services that are not paid by the government and charity and Medicaid, uncompensated portion of what they pay the hospitals?

Hugh Tilson: No sir. That's just the Medicaid portion.

Representative Current: I'm surprised to see obstetrics over here in the losing column. If that is the case, why do I see hospitals continually building and improving their birthing centers, it seems to never end?

Hugh Tilson: I'd be happy to get some hospital folks up here to really answer the question. I'd be happy to tell you my impression of it and that is when you go to the hospital there are very few positive interactions. You are usually sick, having an intervention, but having a baby is a good thing. So hospitals want to make that as positive as an experience as possible so that you have a positive experience at the hospital for the rest of your medical care. It is an important patient intervention. It's the right thing to do, we need to make it as comfortable as possible, but from a financial standpoint. The other thing is about half the babies in North Carolina are paid for by Medicaid. So you see a lot of effort to try to get those commercially insured babies being born at your hospital as well.

Representative Current: My experience has been that all of these young ladies that have babies that do have commercial insurance. They pay the cost to the hospital and the physician care before they ever are delivered has been my observation. You mentioned something about the hospitals serving people and then worrying about collecting. I want to know where you can go, every doctor I go see for whatever, the first thing we talk about is how it's going to be paid for. I have an assistant that works in our office that is having a baby in December, paying it out of pocket, and she has made arrangements for the hospital to be paid and the doctor to be paid before that baby ever comes into the world. I know in my office we take patients and don't worry about getting paid until it's done and we've got a pretty good accounts receivable. The point I want to make is that I don't know that I agreed with what you said about all this care being done out here in the field without compensation being talked about before it's ever done.

Hugh Tilson: I think you are going to see more of that with that balance of being a business and a charitable organization. If you can schedule things in advance, I think you are going to see more people talking about how you're going to pay for it. But there are an awful lot of things in a hospital that you can't schedule in advance. Those are the types of things I'm talking about when you show up in the emergency department , you need an MRI, you need an emergency heart surgery, you need all those type things, we're not going to ask how are you going to pay for it. If you show up and need to have your knee scoped or you need any of those type things, we can schedule in advance, we are increasingly asking those questions.

Representative Avila: It's just sort of like a theoretical supply and demand. On one hand you are saying that we are having more and more people needing these services, yet we have in place a program that limits the services. I'm not sure that the review process and the agreement to expand are keeping up this need to expand. Is that logical?

Hugh Tilson: Need to defer to someone who actually does this for a living to answer that question, but my impression is that because the planning process plans years out, it anticipates what is going to be there. Process is designed to reflect your question, whether it does it or not, my hospitals seem to believe it does and that we are very comfortable with that.

North Carolina Certificate of Need Law in the 21st Century, Noah H. Huffstetler III, Partner, Nelson Mullins (see attached)

Question from Representative Avila: When we talked about supply and demand and we heard Hugh make the statement that you plan far in advance and here you've got an expansion that has been hung up in discussion for three years. It's not working. You are planning for growth, but you are not providing the facilities at the rate that you need them, because the system can hang it up forever. It definitely needs to be reworked if your objective is to review, plan ahead, and build accordingly.

Noah Huffstetler: I agree, I think you hit the nail on the head. It is true that the state plan looks at a planning horizon, a couple of years in the future. What we often see is by the time that planning

horizon arrives, it's already obsolete. Even if you are planning that far in the future, if the thing is going to be held up in court for 5 years, you are going to delay the ability of folks to meet needs. The BRAC program in the Cumberland Hoke County is leading to a tremendous influx of families and both First Health located in Pinehurst and Cumberland located in Fayetteville have applied to build hospitals in that community and they are still held up in court and likely will be for a while. That is one area where we can make the program refocused more on the needs of the people it's supposed to serve.

Representative Brandon: Who is in charge of the certificate of need on the review process, particularly the competitor part? If there are 10 people applying for the certificate and they all 10 qualify, how does that decision get made to just one person getting it?

Noah Huffstetler: Unlike other states who have a board of people who make these decisions, in North Carolina, we have the decision made by a single project analyst with the oversight and the supervision of either the chief of the CON section or that chief's deputy. Two people are making the decision. Typically the person with oversight, who is responsible, does not read the whole application. These applications are hundreds of pages long. In the situation that you hypothesize with ten applicants, you could have ten applications, each of which 400 pages long, and an agency file that would fill up several volumes where they have commented in favor of their application against the other. Really, there is only one person who reviews all that. His or her decision is reviewed and approved by someone higher up in the CON section, but it is not a board or commission that makes those decisions. It's basically one person.

Representative Current: Complement presenter on appraisal of state health coordinating council, you did that eloquently and objectively. How it's appointed and the make -up and ethics. You make the comment that everybody had agreed that there needed to be an emergency room in Mount Holly. I just am going to use this as an example. I'm a Gaston County man and I think that if we are going to build one, I'd like for Caromont to have it, obviously. Which brings a second question, I picked up the paper yesterday morning and I think there were two maybe three full page ads of advertising in our newspaper in Gaston County for physicians to go see that are physicians of the Charlotte Hospital that I won't reference. I'm sitting here saying to myself how is this in the best interest of the public that you say that the certificate of need is supposed to be serving. We're spending all this money trying to take patients away from each other, and that is what this emergency room situation is about, is how to cut off the flow of patients from Gaston County to Charlotte and then Charlotte wants to get our people coming to their hospitals. It would seem to me that what we should be seeking is some type of scenario that is really in the best interest of the people.

Representative Steen: I think these reform measures are something that we need to take a strong look at. I think they are very practical and hopefully we can go down that road. You mentioned the medical care commission and SHCC, what is the interaction between those two groups?

Noah Huffstetler: They are separate groups with separate authorities. The medical care commission adopts certain rules for the practice of medicine, for example, in North Carolina and it is under its auspices that hospital revenue bonds are issued. The full faith and credit of the state is not pledged for

those bonds, but the medical care commission assists the community hospitals, and this is available only for not for profit hospitals, in being able to issue the finances they need for new projects. They don't make the CON decision. In the original CON law, the one that was declared unconstitutional and reenacted, it was the medical care commission that made those decisions. Under the present law, the state health coordinating council, which has no common representation with the medical care commission, is the entity that makes the decision about where a facility can be built. Then you go to the medical care commission if you want to get state sponsored funding for that project.

Representative Steen: You mentioned the AC3 hospitals, the acute care with the academics. How much have academic hospitals increased market share since that law was enacted in 1977?

Noah Huffstetler: It is impossible to say, I do have a slide here that shows that they are doing extraordinarily well in terms of their operating performance and metrics. (See attached) The original purpose of policy AC3 was a valid one. It was to recognize that these academic institutions may have a need for teaching or research purposes that cannot be justified in the terms of the number of patients they are going to have and, therefore, shouldn't have to go through the regular process. What we have seen is, in Wake, Forsythe, and all these other places across the state, head to head competition between academic medical centers and ordinary hospitals over issues that don't have anything to do with research and some kind of esoteric technology. In Forsyth County the state medical facilities plan says that it has 7 too many operating rooms in the county and so none of the non -academic hospitals were permitted to expand their facilities, but yet North Carolina Baptist was permitted to build a new 8 operating room ambulatory surgery facility to do kind of tonsillectomies and ear plugs and the other things that are normally done in ambulatory surgery facilities, even though none of the private hospitals could do that. As long as they weren't competing head to head, I think it was fair and appropriate for the academics to have some special provisions, but if they are going to be doing head to head competition, as indeed they are here in Wake County, I think you need to level the playing field between academics and the other guys.

Representative Torbett reminded members that the next meeting will occur on October 20th, at 6pm Western North Carolina Agricultural Center in Fletcher, NC and adjourned the meeting.

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Representative John Torbett, Co-Chair Presiding Viddia Torbett, Clerk

Representative Fred Steen, Co-Chair