May 31,2011 Comments from Novant Health, Inc.
Regarding WakeMed Cary Hospital, Inc.
Acute Care Bed Addition (22 Beds)
Certificate of Need Application (J-8661-11)
Submitted April 15, 2011 for May 1, 2011 Review

In accordance with N.C.G.S. Section 131E-185(a1)(1), Novant Health, Inc. submits the following comments regarding the CON Application of WakeMed Cary Hospital, Inc. (J-8661-11).

I. Introduction

The following applications were submitted in response to the need determination identified in the *2011 State Medical Facilities Plan* (*2011 SMFP*) for 101 acute care beds in Wake County:

- J-8660-11: WakeMed to spend $57.5 million to add 79 beds at its main Raleigh campus.
- J-8661-11: WakeMed Cary to spend $2.1 million to add 22 beds.
- J-8667-11: Rex Healthcare to spend $278.8 million to add 11 beds, replace 115 acute care beds, and change in scope for Project ID J-8532-10 (cardiovascular renovation expansion project).
- J-8669-11: Rex Healthcare to spend $136.6 million to build a separately licensed 50-bed hospital in Holly Springs.
- J-8670-11: Rex Healthcare to spend $102.2 million on a separately licensed 40-bed hospital in Wakefield.
- J-8673-11: Holly Springs Hospital, LLC to build a 50-bed $77.7 million hospital in Holly Springs.

WakeMed Cary Hospital (WMC) proposes to add 22 medical/surgical acute care beds at its existing facility in Cary (referred to herein as "WMC Application" or "this Application" or the "Application"). If approved, WMC will have an inventory of 178 acute care beds.

II. CON Review Criteria

G.S. 131E-183 (3)

The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

The WMC Application is non-conforming to Criterion (3) because it overstates the need for the proposed new 22 acute care beds. The WMC Application also contains some inconsistencies, which are noted below.

A. Acute Care Volume in Project Year 3 is Increasing when Volume is Shifting to a New Hospital in Harnett County

On page 47, WMC assumes that "once the new hospital in Lillington opens in late 2012, 40% of WakeMed Cary's market share in Angier and 75% of its market share in Lillington would shift to the new hospital." As a result, WMC reduces its Harnett County market share from 3.5% to 3.0% in FFY 2013 and from 3.5% to 2.4% starting in FFY 2014.

The following table shows the projected utilization of WMC by county through FY 2015.

WakeMed Cary Hospital
Projected Inpatient Discharges by County
October 2010 – September 2015

County	FFY 2011	FFY 2012	FFY 2013	FFY 2014	FFY 2015
Wake	9,256	9,625	9,990	10,350	10,715
Johnston	313	325	337	348	360
Harnett	423	437	388	**320**	**330**
Service Area Subtotal	9,992	10,387	10,715	11,018	11,405
Inmigration	765	796	821	844	874
Total	10,757	11,183	11,536	11,862	12,279

Source: CON Application J-8661-11, page 47

It should be noted in the previous table that WMC projects its utilization in FY 2015 (Project Year 3) will increase in Harnett County. WMC's aggressive use rate methodology, discussed below, ensures that volume continues to grow despite a reduced market share in Harnett County and a volume shift to Harnett County Central Campus beginning in FFY 2014 and continuing each fiscal year.

WMC projects its discharges to increase by 3.5% in FY 2015, as shown in the following table.

WakeMed Cary Hospital Projected Acute Care Bed Utilization
October 2010 – September 2015

Oct-Sept	2011	2012	2013	2014	2015
Discharges	10,757	11,183	11,536	11,862	12,279
% Change		4.0%	3.2%	2.8%	**3.5%**

Source: CON Application Project I.D. #J-8661-11, Pages 47 and 85

As will be discussed in more detail below, WMC's projections are overstated due to its use of age-specific use rates.

B. Acute Care Volumes Are Not Adjusted for Shifting Volume to the New Hospital in Johnston County

On page 59, WMC acknowledges a decline in emergency department utilization as a result of the new freestanding ED in Clayton. However, WMC does not project any decrease in inpatient utilization as a result of the 27 new inpatient acute care beds which opened at Johnston Memorial Hospital-Clayton in 2011. If ED utilization decreased from 2009 to 2010 as a result of the freestanding ED opening in 2009, it is reasonable to assume that inpatient utilization at Johnston Memorial Hospital-Clayton will impact inpatient admissions WMC. No such adjustment was made to the WMC projected acute patient day utilization. Therefore, the WMC's projected utilization is overstated and unreasonable.

C. Age-Specific Use Rate Projections Overstate Future Utilization

WakeMed chose to use a methodology that relies on age group-specific discharges, population, and use rates. Age groups are: 0-17, 18-44, 45-64, and 65+. See WMC CON Application at pages 38-39.

Furthermore, despite having used age group-specific population and age group-specific inpatient discharge data to calculate age group-specific discharge use rates, WakeMed uses non-age specific market share which also could impact projected utilization. There is no acknowledgement of that assumption (or inconsistency) in the WakeMed acute bed methodology and assumptions.

It is reasonable to assume that the sum of projected utilization for the four age groups equal total projected utilization for all age groups. Consequently, the sum of projected discharges for the four age groups shown in Table 4 (page 43) will equal total projected discharges for the total population in a given year.

As shown in the following table, utilizing age specific inpatient discharge use rates to project future inpatient discharges results in an unprecedented increase in total population inpatient discharge use rates for the three-county defined service area for WMC. See the table directly below.

WakeMed Cary County Specific Expected Inpatient Discharges
Sum of Four Age Groups and Total Calculated Discharge Use Rate
October 2010 – September 2016

WakeMed Base Data: Thomson Reuters Discharge Data* - Sum of Age Groups	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Wake	73,940	76,883	79,805	82,674	85,595	88,548
Population	947,459	974,978	1,002,495	1,030,015	1,057,534	1,085,054
Total Use Rate	78.0	78.9	79.6	80.3	80.9	81.6
Johnston	16,682	17,305	17,947	18,580	19,220	19,854
Population	178,933	184,266	189,599	194,933	200,269	205,601
Total Use Rate	93.2	93.9	94.7	95.3	96.0	96.6
Harnett	12,110	12,522	12,928	13,337	13,757	14,185
Population	119,459	122,761	126,085	129,398	132,717	136,032
Total Use Rate	101.4	102.0	102.5	103.1	103.7	104.3
Total Three Counties	102,732	106,710	110,680	114,591	118,572	122,587
Population	1,245,851	1,282,005	1,318,179	1,354,346	1,390,520	1,426,687
Total Use Rate	82.5	83.2	84.0	84.6	85.3	85.9

Source: WMC Application, pages 41-42; NC OSBM Population Data
* Exclusions: Normal Newborns (795) and Rehab (945-946)

Please note that the previous table shows discharge use rate increases in all three counties in the defined service area each fiscal year through FFY 2016. **This is an unreasonable assumption since total county-specific inpatient discharge use rates have decreased continuously since FFY 2007 for every county in the defined service area as shown in the following table.**

WakeMed Cary County-Specific Historical Inpatient Discharges
Sum of Four Age Groups and Total Calculated Discharge Use Rate
October 2006 – September 2010

WakeMed Base Data: Thomson Reuters Discharge Data* - Sum of Age Groups	FY 2007	FY 2008	FY 2009	FY 2010
Wake	67,593	69,966	71,940	71,286
Population	823,616	856,927	882,344	907,314
Total Use Rate	82.1	81.6	81.5	78.6
Johnston	16,335	16,607	15,991	16,104
Population	154,635	160,062	165,111	170,151
Total Use Rate	105.6	103.8	96.8	94.6
Harnett	11,318	11,331	11,613	11,721
Population	105,310	108,490	112,003	115,579
Total Use Rate	107.5	104.4	103.7	101.4
Total	95,246	97,904	99,544	99,111
Population	1,083,561	1,125,479	1,159,458	1,193,044
Total Use Rate	87.9	87.0	85.9	83.1

Source: WMC Application, pages 39-40; NC OSBM Population Data
* Exclusions: Normal Newborns (795) and Rehab (945-946)

As shown in the previous table all three counties in the WMC service area experienced annual decreases in total inpatient discharge use rates from FFY 2007 through FFY 2010. For example, the Wake County inpatient discharge use rate declined from 82.1Inpatient Discharges per 1,000 Population in FFY 2007 to 78.6Inpatient Discharges per 1,000 Population in FFY2010, over the four-year period.

Age and population growth are two variables discussed which impact the inpatient use rates on page 57 of the Application. WakeMed assumes that the aging population and the higher use rates by age equals increased total utilization. However, as reflected in the previous table directly above, the opposite is in fact true. From FFY 2007 to FFY 2010 even as the baby boomer generation began entering the 65+ age cohort, total inpatient discharge use rates went down. On page 59, WakeMed discusses the economy's impact on changes in utilization, however, the 65+ population, which utilizes more services, has health coverage through Medicare, so the 65+ age group that experiences high inpatient use rates has health insurance and is not as impacted by changes in the economy. While the economy has had an impact on inpatient utilization, it is not the only factor which has had an impact on inpatient utilization, as evidenced by the decreases in inpatient use rates prior to FFY 2009 and FFY 2010.

In addition to the economy and age, technology, prevention, pharmaceuticals, health status and many other variables impact inpatient utilization. As shown in Attachment 1, many of Wake County's key health indicators, including Age-Adjusted Stroke Death Rates, have improved, which also supports continued decreases in inpatient utilization rates.

Continuous change in the provision of health care services results in shifts from inpatient to outpatient care. The Affordable Care Act of 2010 includes many provisions for improved preventive care and end of life care, as well as significant penalties for readmissions. All of which will also impact future inpatient utilization volumes.

Based upon historical trends the expectation is for either no growth in annual inpatient discharge use rates or potential decreases in annual inpatient discharge use rates. Therefore, the use of increasing inpatient use rates in the WakeMed methodology is unreasonable and overstates projected inpatient hospital discharges, which results in overstated, unreasonable, and unsupported patient days for WMR and WMC.

D. WakeMed Cary Unlicensed Observation Beds

1. In 2004, WMC was Approved to Add 42 Acute Care Beds and Close 40 Acute Care Beds Relocated to the New Bed Tower

On April 29, 2005, the CON Section approved an addition of 42 acute care beds at WMC. A new bed tower was added to the WMC facility, and WMC delicensed 40 existing acute care beds in Nursing Units 1East and 2East.

According to Table II.1 (page 12), WMC uses 19 of the delicensed beds as observation beds in Nursing Unit 1EastA. The remaining 21 delicensed beds are used as offices, storage, a SIM lab, waiting rooms, and dialysis beds.

On page 13, WMC proposes to add 22 new acute care beds to Nursing Unit 1EastA, which according to Table II.1 (page 12) is the site of 19 unlicensed observation beds. Those unlicensed 19 observation beds will be replaced with 22 new acute care beds.

2. Number of Unlicensed Observation Beds

Based on information presented on pages 12 and 13 of the Application, WMC has **31** unlicensed observation beds: 19 observation beds on Nursing Unit 1EastA + a 12-bed chest pain observation unit.

Assuming that there are 31 unlicensed observation beds at WMC, removal of 19 unlicensed observation beds as a result of this project will leave 12 unlicensed observation beds at WMC (31-19 = 12).

On page 13 of the Application, WMC states that it "will still have 18 delicensed beds available if it needs to bring them into service for observation patients at a later date." That statement is misleading because there are no actual delicensed beds at WMC. There are spaces in which previously-licensed beds were replaced with offices, a SIM lab, waiting rooms, and dialysis beds.

During the most recent three fiscal years, WMC has reported different numbers of unlicensed observation beds, as shown in the following table.

WakeMed Cary Hospital Unlicensed Observation Bed Inventory
October 2007 – September 2010

	FY 2008	FY 2009	FY 2010
Unlicensed Observation Beds	35	22	35

Source: WakeMed Cary 2009-2011 LRAs

The previous table shows that in FFY 2010, WMC has 35 unlicensed observation beds.

Assuming that there are 35 unlicensed observation beds at WMC, removal of 19 unlicensed observation beds as a result of this project will leave 16 unlicensed observation beds at WMC (35-19 = 16). WMC has a 12-bed chest pain observation unit, but fails to identify the location of the remaining 4 unlicensed observation beds.

In order for the CON Section to evaluate completely the Application, there must be an accurate and correct identification of WMC's inventory of unlicensed observation beds and the location of each of those beds.

3. Utilization of Unlicensed Observation Beds

The following table shows WMC's reported utilization of its unlicensed observation beds during the last three fiscal years.

WakeMed Cary Hospital Observation Bed Utilization
October 2007 – September 2010

	FFY 2008	FFY 2009	FFY 2010
Unlicensed Observation Beds	35	22	35
Observation Patients not Admitted as Inpatients	4,693	5,183	4,967
ADC	12.9	14.2	13.6
Annual Occupancy Rate	36.7%	64.5%	38.9%

Source: Annual LRAs for WakeMed

The previous table shows the number of observation patients who were **not** admitted to WMC as inpatients in each of the last three fiscal years. The previous table shows that in FY 2010, WMC used less than 40% of its unlicensed observation bed capacity.

For comparison purposes, in Table III.1.17 (page 64 of the Application) WMC presents its utilization of its observation unit and Chest Pain Center, as shown in the following table.

WakeMed Cary Hospital
Outpatient Utilization of Observation Unit & Chest Pain Center
October 2007 – September 2010

	FFY 2008	FFY 2009	FFY 2010	FFY 2011 YTD
Cases				
Chest Pain Center			565	200
Observation Unit	1,817	2,131	2,084	453
Total			2,649	653
ADC				
Chest Pain Center			1.5	2.2
Observation Unit	5.0	5.8	5.7	4.9
Total	5.0	5.8	7.3	7.1

Source: CON Application J-8661-11, page 64

There is no explanation provided by WMC for the disparity in the observation patient data shown in the previous table and reported in the annual LRA, respectively.

WMC states on page 63 that it "compiled the average daily census (ADC) of outpatients utilizing the observation unit and the Chest Pain Center. These are patients who are not expected to require inpatient care when they are admitted to these units."

On page 63 of the Application, WMC states that "approximately 5.7 outpatient observation patients per day in FFY 2010 were admitted to the observation unit and 1.5 per day were admitted to the Chest Pain Center."

Please note that WMC does not define the number of unlicensed observation beds in its "observation unit."

In addition to the data and inventory disparities, the WMC Application leaves unanswered some important questions:

- What percentage of patients is admitted to an acute care bed from an observation bed?
- How many patients are admitted each day from an observation bed to an acute care bed?

Without those answers, it is not possible to evaluate independently whether WMC is using its observation beds effectively and efficiently. That independent evaluation is necessary to determine whether WMC has an actual and documented need for the proposed 22 new acute care beds.

E. Thomson Acute Care Data Set Used by WakeMed Cary includes Substance Abuse and Mental Health Inpatient Discharges

1. Over-inclusive Thomson Acute Care Discharge Data Set

WMC opts to use county discharge data from a Thomson database as the basis for its methodology. That data is used by WMC to:

- Determine acute care discharge volume
- Calculate use rates
- Determine historical market share and patient origin
- Project market share and patient origin.

It is important to recognize that the Thomson database used by WMC in its April 2011 CON Application (for 22 new acute beds) includes mental health and substance abuse (DRGs 880-887 and 894-897) inpatient discharge records.[1]

Page 46 of the *2011 SMFP* makes clear that "[r]ecords that are coded as **substance abuse, psychiatric** or rehabilitation **discharges are excluded**" from the days of care used in the Acute Care Bed Need Methodology. [**Emphasis** added.]

WMC defines a three-county service area. The following table shows a comparison of

[1] CON Application J-8661-11, pages 39 - 40, note (a)

county discharge data used by WMC as the basis for its methodology, and the Thomson data with substance abuse and mental health discharges excluded.

WakeMed Cary Hospital Comparison of Service Area Discharge Data
October 2009 – September 2010

County	WakeMed Base Data: Thomson Reuters Discharge Data*	Acute Care Need Methodology: Thomson Reuters Discharge Data**	Numerical Difference	Percent Difference
Wake	71,286	67,971	3,315	4.9%
Johnston	16,104	15,345	759	4.9%
Harnett	11,721	11,349	372	3.3%
Total	99,111	94,665	4,446	4.7%

Source: CON Application J-8661-11, page 43; Thomson Reuters Inpatient Acute Care Database
* Exclusions: Normal Newborns (795) and Rehab (945-946)
**Exclusions: Mental Health and Substance Abuse (880-887 and 894-897), Rehab (945-946), Normal Newborns (795)

The previous table shows that there is nearly a 5% difference between base data used by WMC and the Thomson data that excludes substance abuse and mental health inpatient discharges. That is a statistically significant difference. This difference causes the WakeMed Cary future acute patient day projections to be unreasonable and unreliable from Step 2 through Step 9 of WakeMed Cary's need method, set forth at Application pages 38-49. Thus, WakeMed Cary fails to demonstrate the need for 22 new acute beds.

2. Higher County Discharge Use Rate per 1,000

Each of the three counties in the defined WakeMed Cary Service Area is similarly affected: over-inclusive acute care discharge volume (that incorrectly includes substance abuse and mental health inpatient days) results in a higher use rate per 1,000 for each county, as shown in the following table.

WakeMed Cary Hospital Comparison of Service Area Discharge Use Rate per 1,000
October 2009 – September 2010

County	WakeMed Base Data: Thomson Reuters Discharge Data*	Acute Care Need Methodology: Thomson Reuters Discharge Data**	Numerical Difference	Percent Difference
Wake County				
Discharges	71,286	67,971	3,315	4.9%
Total Population	919,938	919,938		
Use Rate per 1,000	77.5	73.9		4.9%
Johnston County				
Discharges	16,104	15,345	759	4.9%
Total Population	173,600	173,600		
Use Rate per 1,000	92.8	88.4		5.0%
Harnett County				
Discharges	11,721	11,349	372	3.3%
Total Population	116,118	116,118		
Use Rate per 1,000	100.9	97.7		3.2%
Total Service Area				
Discharges	99,111	94,665	4,446	4.7%
Total Population	1,209,656	1,209,656		
Use Rate per 1,000	81.9	78.3		4.7%

Source: CON Application J-8661-11, pages 43 and 57; Thomson Reuters Inpatient Acute Care Database
* Exclusions: Normal Newborns (795) and Rehab (945-946)
**Exclusions: Mental Health and Substance Abuse (880-887 and 894-897), Rehab (945-946), Normal Newborns (795)

The previous table shows that use rates used by WMC are nearly 5% higher than the use rates calculated using Thomson data that excludes substance abuse and mental health discharges. That is a statistically significant difference. This difference causes the WakeMed Cary future acute patient day projections to be unreasonable and unreliable from Step 2 through Step 9 of WakeMed Cary's need method, set forth at Application pages 38-49. Thus, WakeMed Cary fails to demonstrate the need for 22 new acute beds.

N.C.G.S. 131E-183 (4)

Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

Each applicant has a burden of presenting, evaluating, and demonstrative that the least costly or most effective alternative has been proposed. Since this application shows the project is not needed under Criterion 3, it is not the least costly or most effective alternative under Criterion 4.

In addition, WMC has at least two alternative methods of meeting the needs of patients at WMC, which methods are less costly and more effective than the proposed addition of 22 new acute care beds. One alternative is to make more effective use of its unlicensed observation beds – an alternative that does not require a capital expenditure. A second alternative is to make more effective use of its unlicensed observation beds, which would permit WMC to add fewer than 22 new acute care beds – an alternative that requires a lower capital expenditure.

WMC did not identify either alternative – despite the fact that clinical observation units have emerged as a viable solution to pressing problems facing US hospitals: capacity constraints in the emergency department, lack of inpatient beds, and the movement toward greater reliance on outpatient services by CMS and other payors.

The observation unit setting is geared toward patients who require more management or attention than can be given in the traditional ED, but do not need the length or level of services provided in the inpatient setting. Observation units can help avoid unnecessary and costly inpatient admissions by aggressively diagnosing and treating patients' symptoms, allowing them to go home in a timely manner. These units help improve quality and regulatory compliance.

ED physicians frequently admit patients presenting with chest pain or other chronic conditions because of malpractice fears; if a patient is sent home too soon and something goes wrong, the blame may fall back on the physician and the hospital. Admitting a patient to the hospital who does not need to be there can result in considerable expense and use up bed space that could go to other patients. Observation units allow clinicians to provide care better, cheaper and faster. It is a no-lose situation for the hospital. For example, even when a patient is admitted to the hospital from the observation unit - which occurs in about 25 percent of cases nationwide - length of stay is typically shorter than that of a patient admitted directly from the ED to inpatient status.

Observation care also can help hospitals increase the case-mix multiplier that helps CMS determine reimbursement for inpatient services. With proper management, observation units keep healthier patients requiring shorter lengths of stays out of the hospital. As a result, the hospital's case mix comprises sicker patients needing more intensive care. CMS will increase reimbursements to reflect care for these patients.

The number of patients treated at hospitals that are classified as "observation" patients is increasing as CMS and private insurers establish stricter criteria for hospital admissions each year in an effort to ensure that only the sickest people are treated in costly, resource-intensive medical centers.

For the reasons discussed, the WMC Application does not conform to Criterion (4).

N.C.G.S. 131E-183 (5)

Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

As discussed above, WakeMed Cary fails to satisfy Criterion 3 because its projections are unreasonable and unsupported. Since the volume projections are integral to the financial projections, WakeMed Cary's unreasonable volumes cause the project to be financially infeasible, and therefore non-conforming with Criterion 5.

G.S. 131E-183 (6)

The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

As discussed in the context of Criterion (3) above, WMC uses a data set that is over-inclusive and results in overstated, unreasonable, and unreliable projections. Overstated projections are evidence of an unnecessary duplication of existing health service capabilities and facilities.

As discussed in the context of Criterion (4) above, WMC has at least two alternative methods of meeting the needs of patients at WMC, which methods are less costly and more effective than the proposed addition of 22 new acute care beds. Having less costly and more effective alternative methods for meeting the needs of patients at WMC are evidence of an unnecessary duplication of existing health service capabilities and facilities.

For the reasons discussed, the WMC Application does not conform to Criterion (6).

G.S. 131E-183 (18a)

The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

The proposed WakeMed Cary project is not needed, is not the least costly or most effective alternative, is not financially feasible and unnecessarily duplicates existing services. Based on these multiple failures, the WakeMed Cary project is non-conforming with Criterion 18a.

The proposed Novant Holly Springs Hospital is the only project which will introduce a new health care competitor into the Wake County market. Novant Health, the parent organization of Holly Springs Hospital has a long history of providing accessible care, cost efficient operations and high quality care.

The enhanced competition offered by the Novant Holly Springs Hospital brings a new approach in community hospital design that will be less costly to construct initially, less expensive to operate and maintain, and less costly to expand or renovate, and less disruptive to the ongoing provision of hospital-based services during expansion or renovation. The design incorporates the state of the art AIA recommendations for infection control (includes biohazard control, hand washing, infection control risk assessments, construction materials), electronic medical records, therapeutic environments (environment of care, green design and sustainability), IT/Healthcare technology and communications (includes patient documentation, imaging), safety and security, dimensional consideration (includes space planning), energy and cost-effectiveness.

In addition, Novant's continued commitment to increasing efficiencies has made Novant a leader in the field. Novant will bring this experience and disciplined approach to the operation of the proposed Holly Springs Hospital to provide a competitive alternative which will have a positive impact upon the cost effectiveness, quality, and access to the services proposed.

In addition, Novant Medical Group has a long successful history of providing high quality, cost effective services to residents of Triad, Coastal, and Triangle Regions of North Carolina, the Greater Charlotte Region (including North & South Carolina), and in northern Virginia . This experience and dedication to accessible community-based patient care is critical to expanding choice in the Wake County market.

IV. CON Criteria and Standards for Acute Care Beds – 10A NCAC 14C .3800

10A NCAC 14C .3803(a)-Projected ADC at Target Occupancy Rates

As discussed in detail in the context of Criterion (3) above, WakeMed relies on over-inclusive base year inpatient discharge data (that incorrectly includes discharges for inpatient substance abuse and mental health patients). This results in overstated WMC future inpatient day volume projections. Furthermore, the applicant's projected growth for acute inpatient days at WakeMed Raleigh results in significantly unsubstantiated growth rates, which are unsupported, unexplained, and unreliable. This is discussed below.

1. Acute Care Utilization is Declining at WakeMed Raleigh Based On License Renewal Application Data for the Last Six Fiscal Years

The following table shows acute care utilization reported by WMR in its annual Hospital License Renewal Applications (LRAs) over the last six fiscal years.

WakeMed Raleigh Acute Care Bed Utilization
October 2004 – September 2010

Oct-Sept	2005	2006	2007	2008	2009	2010	CAGR 2005-2010	CAGR 2007-2010	CAGR 2008-2010
Days of Care	154,054	163,947	172,630	177,004	174,046	167,614	1.7%	-1.0%	-2.7%
% Change		6.4%	5.3%	2.5%	-1.7%	-3.7%			
Licensed Beds	515	515	515	515	515	575			
ADC	422.1	449.2	473.0	484.9	476.8	459.2			
Occupancy	82.0%	87.2%	91.8%	94.2%	92.6%	79.9%			

Source: Annual LRAs for WakeMed

The previous table shows that days of care at WMR have declined in the last two fiscal years, the most recent decline of nearly 4% from FFY 2009 to FFY 2010. Those declines result in a negative CAGR of acute inpatient days for FFY 2007-FFY 2010 and FFY 2008-FFY 2010, respectively. WMR added 60 acute care beds on June 3, 2010. In view of declining volume and a sizeable acute bed inventory addition in FY 2010, it is unreasonable for WMR to request an increase of 79 new acute care beds with a capital expenditure of $57.5 million.

Furthermore, WMR does not provide any new data to show that trends in the first six month of FFY 2011 have changed. WakeMed does not provide any updated calendar year comparisons to show that 2011 has resulted in the reversed trends projected in the Application. The only updated data provided by WakeMed is on page 68 regarding ED patients that have left without being seen.

2. Projected WakeMed Growth Rates Are Unreasonable

As discussed in the previous section and shown in the following table, the historical inpatient day CAGR for WMR was negative from FFY 2007 through FFY 2010 and from FFY 2008 through FFY 2010

WakeMed – Inpatient Day CAGR – All Inpatient Facilities

Historical Inpatient Day Growth Rates									
Oct-Sept	2005	2006	2007	2008	2009	2010	CAGR 2005-2010	CAGR 2007-2010	CAGR 2008-2010
WMR	154,054	163,947	172,630	177,004	174,046	167,614	1.7%	-1.0%	-2.7%
Annual Growth Rate		6.4%	5.3%	2.5%	-1.7%	-3.7%			
WMC	31,765	33,482	35,815	38,496	40,927	44,469	7.0%	7.5%	7.5%
Annual Growth Rate		5.4%	7.0%	7.5%	6.3%	8.7%			
Combined	185,819	197,429	208,445	215,500	214,973	212,083	2.7%	0.6%	-0.8%
Annual Growth Rate		6.2%	5.6%	3.4%	-0.2%	-1.3%			

Projected Inpatient Day Growth Rates									
Oct-Sept	2011	2012	2013	2014	2015	2016	CAGR 2010-2016		
WMR	178,831	185,191	191,542	186,239	189,727	194,453	2.5%		
Annual Growth Rate	**6.7%**	3.6%	3.4%	-2.8%	1.9%	2.5%			
WMC	44,857	46,633	48,105	49,465	51,203	52,963	3.0%		
Annual Growth Rate	0.87%	4.0%	3.2%	2.8%	3.5%	3.4%			
WMN				11,537	14,409	16,087			
Annual Growth Rate					24.9%	11.6%			
Combined				247,241	255,339	263,503	**3.7%**		

Source: Annual LRAs and pages 54 and 55 in Application

Projected compound annual growth (CAGR) in inpatient days in the Application for all WakeMed inpatient facilities exceeds 3.7% as shown in the previous table. However, historical CAGR for all WakeMed inpatient facilities was negative from FFY 2008 to FFY 2010, and was only 0.6% for FFY 2007 to FFY 2010. Even with the addition of 60 additional acute care beds in June 2010, total patient days at all WakeMed inpatient facilities decreased from FFY 2009 to FFY 2010.

In addition, from FFY 2010 to FFY 2011 WakeMed has projected a 6.7% increase in patient days at WakeMed Raleigh as shown in the previous table. The WakeMed Raleigh Application was submitted April 15, 2010, more than six months into FFY 2011, however **WakeMed provided no updated FFY 2011 data to substantiate this level of growth at WakeMed Raleigh from October 2010 through March 2011**.

WakeMed has utilized unreasonable and unsubstantiated projections in its use rate methodology, as previously discussed, resulting in significantly overstated projected growth rates for future inpatient utilization and should be denied.

The systemwide acute inpatient utilization for WakeMed is based upon unreasonable and unsupported assumptions and incorrect base data for the projections. Thus, as a result is project acute inpatient days are overstated and unsubstantiated. Evaluation of the projected utilization under the performance standard set forth in this Rule is impossible.

Thus, the WakeMed Cary project should be found non-conforming with this performance standard.

VII. Comparative Factors

The Agency Findings in the competitive review in 2007 for Medical Park Hospital-Clemmons and NCBH Davie County Hospital Replacement facility provide comparative factors that should be considered in the review of the WakeMed, WakeMed Cary, and Rex Hospital, Rex Wakefield Hospital, the Rex Holly Springs Hospital, and the Novant Holly Springs Hospital CON Applications all filed on April 15, 2011 in response to a need determination in the 2011 SMFP for 101 New Acute Beds in Wake County. These factors include: Geographic Access, Facility Design, Scope of Services, Staffing, Charges/Revenues, Operating Costs, Access by Underserved Groups, Coordination with Existing Healthcare System, and Community Support. In addition, the Agency Findings for the eight competing CON Applications filed on August 15, 2008 to seek approval for the 41 new acute beds and the 4 new ORs identified in the 2008 SMFP for Wake County. That application included one set of comparative factors for the operating rooms and a separate set of comparative factors for the new acute beds. The Agency used the following comparative factors for the new Wake County ORs: Geographic Accessibility, Demonstration of Need, Financial Feasibility, Coordination with Existing Health Care System, Access by Underserved Groups, Revenue, Operating Expenses, and Documentation of Physician Support. The comparative factors used by the Agency for the new Wake County acute beds were the same eight factors used by the Agency for the Wake County operating room comparison in 2008.

GEOGRAPHIC ACCESS

The WakeMed Cary proposes to expand capacity at its hospital in Cary. As noted in the Novant and Rex Holly Springs Hospital CON Applications, it can take 30 minutes or more to get from Holy Springs and town south of there (such as Fuquay-Varina) due to traffic jams, no direct local access to the Interstate highway, and population growth that has basically grown in a manner that has outpaced the road infrastructure leading out of southern Wake County. Thus, new beds in Cary is not a preferred alternative for many residents of Holly Springs, Fuquay-Varina, and others in southern Wake County communities below Cary. The Novant Holly Springs Hospital is seeking approval for a 50-bed community hospital in southern Wake County, where currently there are no acute inpatient beds and no operating rooms. Today, about 12% of the Wake County population resides in southern Wake County and 0% of the Wake County acute beds are located there today. Thus, the Novant Holly Springs Hospital project is superior in terms of creating enhanced geographic access for the proposed new acute beds in Wake County.

DEMONSTRATION OF NEED

As discussed above in these comments the WakeMed Cary acute patient day projected utilization for 22 new acute beds is based on incorrect base data (that includes substance

abuse and mental health inpatient days) and is also unreasonable, unsupported, and unreliable under Criterion (3). Thus, WakeMed Cary did not adequately demonstrate the need for the 22 new acute beds at WMC.

The Novant Holly Springs Hospital has adequately demonstrated that the patient days and surgical cases projected to be performed at Novant's HSH are reasonable and has adequately demonstrated that the population it proposes to serve has the need for the 50 new acute beds and 3 ORs in southern Wake County in the HSH service area. Thus, Novant's HSH is comparatively superior in terms of demonstration of need.

FINANCIAL FEASIBLITY

As discussed above in the Criterion (3) section of these comments, WakeMed Cary fails to satisfy Criterion (3) because its projections are unreasonable, unreliable and unsupported as discussed above in these comments. Since volume projections are integral to the financial projections, WakeMed Cary's unreasonable volumes cause the project to be financially infeasible.

ACCESS BY UNDERSERVED GROUPS

The Project Year 2 percentages of each applicant's projected percentage of entire hospital services to be provided to Medicare and Medicaid recipients, as stated in the applicants' responses to Question VI.14 are set forth in the table below.

Applicant	Projected % of Hospital Services to Medicare Recipients in Year 2	Projected % of Hospital Services to Medicaid Recipients in Year 2
WakeMed Cary	33.44%	11.20%
Novant Holly Springs Hospital	31.15%	11.61%

With regard to Medicare recipients, Novant HSH and WakeMed project a similar Medicare payor mix percentage, with a difference between the two of less than two percentage points. Novant HSH projects a slightly higher percentage of hospital services to be provided to Medicaid recipients.

In addition, the WakeMed Charity Care policy which is applicable at WakeMed Cary is found in Exhibit 40, pages 555-558. It specifies 100% discount off of charges for qualified individuals with annual household incomes less than 200% of the annual federal poverty level. It appears that the WakeMed Charity Care policy may take into consideration certain assets, beyond household income, in determining eligibility, since the policy asks for information about tax value of property, address listed on car registration, and rent receipts. The WakeMed Charity Care policy covers qualified individuals with annual household incomes greater than 200% FPL and up to 300% FPL with a sliding scale of discounts of the hospital charges. For example, if household income is 250% of FPL, the patient may be eligible for a 60% discount of charges and if

the annual household income is 300% of FPL the patient may be eligible for a 20% discount of charges. Annual household income for a family of four at 300% FPL is $67,050 in 2011.

By comparison, Novant's policies on Charity Care, Uninsured Discount, Catastrophic Discount & Payment Plan provide services for patients with limited financial resources, commensurate with community standards, as well as the availability of capacity to provide those services. Those four Charity Care-related are found in Novant HSH CON Application Exhibit 12 and will apply when HSH opens. For example, based on the government's 2011 Federal Poverty Level (FPL) definitions, a family of four with annual income of $67,050 is eligible for a full Charity Care write-off of all charges with the completion of a simple one-page form that is attached to the Novant Charity Care policy. Novant's Charity Care policy does not include an assets test beyond annual household income. Recently, the Health Access Coalition of North Carolina at the North Carolina Justice Center (www.ncjustice.org) authored a study analyzing the charity care policies of North Carolina's hospitals. The study shows that not all hospital charity care policies are alike; some are significantly more generous than others. Novant's charity care policy was specifically acknowledged for both its generosity (100% discount for a family of four living on annual household income at or below 300% of the FPL; and the policy also exceeds the Living Income Standard in all counties where Novant operates) and its transparency (i.e., Novant's Charity care policy is one of only a few healthcare systems in North Carolina that posts its Charity Care policy online).

These charity policies are the framework or portal by which access to services is enhanced for medically underserved populations. Based on the features of the WakeMed and Novant Charity Care policies, it appears that Novant has the more generous charity care policy, which will serve to enhance access for the populations that it proposes to serve in the Holly Springs market.

GROSS REVENUE

Below is a comparison of Year 3 Inpatient Gross Revenue per Inpatient Day using the information provided by the applicants' responses to Question X.3:

- WakeMed Cary's Inpatient Gross Revenue Per Inpatient Day is $8,134 in Year 3
- Novant HSH's Inpatient Gross Revenue Per Inpatient Day is $6,516 in Year 3

Novant HSH projects the lowest Year 3 Inpatient Gross Revenue per Inpatient Day compared to WakeMed Cary and the other four applicants in the third year of operation Thus, Novant HSH is comparatively superior to WakeMed Cary and the other applicants on this factor.

NET REVENUE

Below is a comparison of Year 3 Net Revenue per adjusted patient day using the information provided by the applicants' responses to Question X.3:

- WakeMed Cary's net revenue per adjusted patient day is $2,177 in Year 3
- Novant HSH's net revenue per adjusted patient day is $2,728 in Year 3

WakeMed Cary's net revenue per adjusted patient day is lower than that of Novant Holly Springs Hospital.

OPERATING EXPENSES

Below is a comparison of Year 3 operating costs per adjusted patient day using the information provided by the applicants' responses to Question X.3:

- WakeMed Cary's operating costs per adjusted patient day are $1,870 in Year 3
- Novant Holly Springs Hospital's operating costs per adjusted patient day are $2,464 in Year 3

Novant's HSH, as a proposed new hospital, projects a higher operating expense per adjusted patient day than WakeMed Cary, which is an existing Wake County provider. Of the three competing applications for new community hospitals (Novant HSH, Rex Hospital Holly Springs, and Rex Wakefield Hospital), Novant Holly Springs Hospital projects the lowest operating expense per adjusted patient day.

COMMUNITY SUPPORT

At the time the WakeMed Cary CON Application was filed on April 15, 2011, there appear to be about 110 community letters of support included in Exhibit 49. See pages 835-955, Exhibit 49. These letters include expressions of support from WakeMed employees, local businesses, WakeMed patients, and the Apex and Cary Chambers of Commerce. About 40-45 of these 110 community support letters express support for both the WakeMed Cary 22-bed CON Application and for the WakeMed Raleigh 79-bed application. See pages 906-955. Two letters also express support only for the WakeMed Raleigh application at pages 931 and 943.

At the time the Novant Holly Springs Hospital CON Application was filed on April 15, 2011, there were about 375 letters of support from Novant Medical Group-Triangle patients and residents of southern Wake County and surrounding communities including Holly Springs, Fuquay-Varina, Apex, Cary, New Hill, Garner, Willow Springs, Lillington (Harnett County), and Angier(Harnett County). In addition, Novant HSH Exhibit 16 includes letters and resolutions of support from the Mayor of Holly Springs (page 1781), the Town Council of Holly Springs (page 1603), the Fuquay-Varina Board of Commissioners (page 1604), and Senator Richard Y. Stevens of the North Carolina General Assembly (page 1606). Also, during the comment period approximately two

thousand additional community letters of support for the Novant Holly Springs Hospital were submitted to the CON Agency. These 2,001 letters of support are from residents of Holly Springs, Angier, Apex, Raleigh, Cary, Fuquay-Varina, Garner, New Hill, and Willow Springs. In total, the Novant Holly Springs Hospital project has demonstrated support with 2,376 community members support letters (375 +2001) and physician support letters representing 100 individual physicians, for a total of 2,476 expressions of support. It is clear that the Novant Holly Springs Hospital proposal has broad, deep, and sustained support from the communities that it proposes to serve.

DOCUMENTATION OF PHYSICIAN SUPPORT

Based on the physician letters of support in the WakeMed CON Application at Exhibit 49, it appears there are about 180 letters of support from primary care, medical specialist, and surgical physicians, with offices in Wake, Johnston, Franklin, Harnett, Vance, and other surrounding counties. See the WakeMed Cary CON Application at pages 647-834, Exhibit 49. Identical letters of support from the Wake Radiology radiologists, the Wake Emergency Physicians, and the Cary Cardiology cardiologists are included in both the WakeMed Cary and the WakeMed CON Applications.

The Novant Holly Springs Hospital CON Application includes a HSH Chief of the Medical Staff letter, Medical Director/physician letters of support for services at HSH including Normal Newborn Nursery/Neonatal Level I, GI Endoscopy, Radiology, CT Scans, Emergency Medicine, Anesthesiology, Surgical Services, Inpatient Care Specialists/Hospitalists, Intensive Care Unit, Pathology, and Obstetrics, as well as physician support letters from primary care, medical specialist, and surgical physicians. Of the eleven Medical Director/Chief of Service letters for HSH, seven are from physicians practicing in the Triangle area today (Neonatal, GI Endoscopy, Radiology, Pathology, Anesthesia, Surgery, and CT Scans). These are found in Exhibit 14 of the Novant HSH CON Application. This exhibit also includes physician letters of support representing 42 individual primary care physicians (family practice, internal medicine, pediatrics) practicing in Wake, Durham, and Franklin counties, including three physician practices with offices in Holly Springs today. Novant HSH Exhibit #14 also includes physician letters of support representing 15 individual medical specialists including cardiology, gastroenterology, hepatology, medical oncology, neurology, pathology, pulmonology, and radiology. These physicians or their groups have offices in Wake, Durham, Franklin, Harnett, Moore, Orange, and Alamance Counties, including four practices with offices in Cary, NC. Finally, Exhibit 14 in the Novant HSH CON Application includes surgeon letters of support representing 32 individual surgeons, including ENT, general surgery, orthopedics, obstetrics and gynecology, and vascular surgery. These surgeons have offices in Wake, Durham, Franklin, and Orange counties, including three practices with offices in Apex or Cary.

Together these Novant HSH physician and medical director letters of support represent 100 individual physicians, the majority of whom practice in the Triangle area today, including Wake County. Each of their signed letters express a plan to seek medical staff privileges at Novant HSH, a commitment to admit patients to Novant HSH, an intent to

refer appropriate patients to the Novant HSH, an intent to perform surgery a Novant HSH, a commitment to refer appropriate patients to other physicians and specialists on the Novant HSH medical staff for imaging studies, surgery, or emergency department care, or to perform the duties of medical director/chief of service for certain clinical service lines at HSH. See pages 1454-1594 in Exhibit 14 of the Novant HSH CON. The Novant HSH physician support letters demonstrate sufficient and necessary support for the proposed 50-bed community hospital.

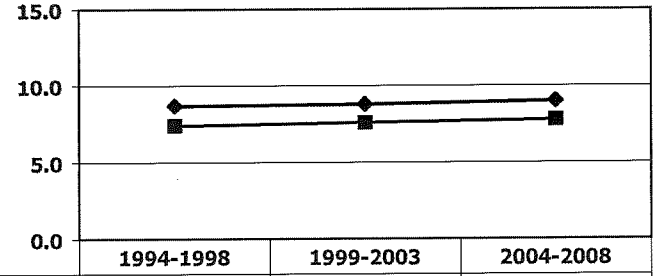
File: CommentsNovantOnWakeMedCaryFINAL.05.30.2011.doc

refer appropriate patients to the Novant HSH, an intent to perform surgery a Novant HSH, a commitment to refer appropriate patients to other physicians and specialists on the Novant HSH medical staff for imaging studies, surgery, or emergency department care, or to perform the duties of medical director/chief of service for certain clinical service lines at HSH. See pages 1454-1594 in Exhibit 14 of the Novant HSH CON. The Novant HSH physician support letters demonstrate sufficient and necessary support for the proposed 50-bed community hospital.

File: CommentsNovantOnWakeMedCaryFINAL.05.30.2011.doc

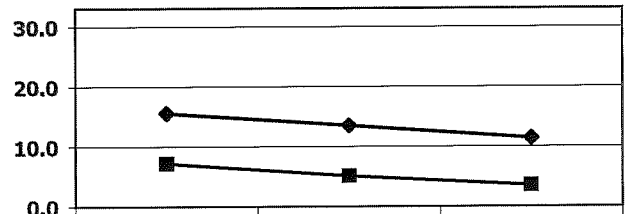
NORTH CAROLINA STATEWIDE AND COUNTY TRENDS IN KEY HEALTH INDICATORS: WAKE COUNTY

Percentage of Resident Live Births Classified As Low Birthweight (2,500 grams/5 lbs 8 ozs or less)



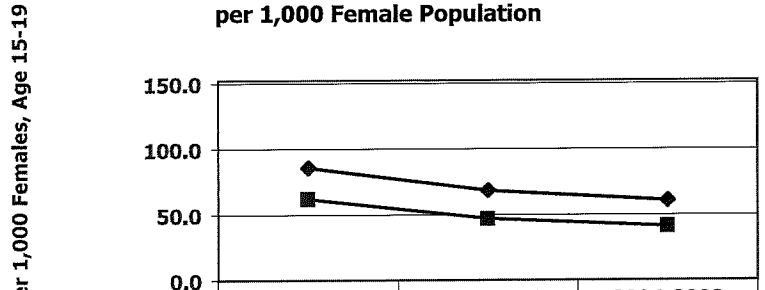
	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	8.8	8.9	9.1
WAKE	7.5	7.7	7.9

Percentage of Resident Live Births Where Mother Smoked During Pregnancy



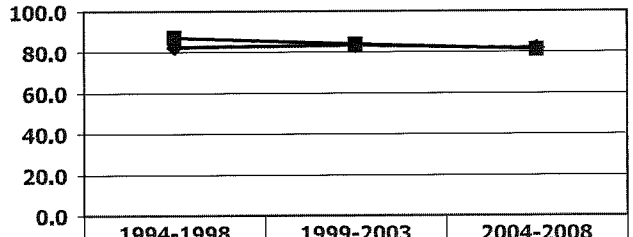
	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	15.7	13.6	11.5
WAKE	7.4	5.3	3.7

Resident Teen Pregnancies (Ages 15-19) per 1,000 Female Population



	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	86.7	69.3	61.7
WAKE	62.9	48.1	42.4

Percentage of Resident Live Births Where Mother Received Prenatal Care in the First Trimester



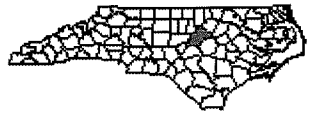
	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	83.1	84.0	82.1
WAKE	87.8	84.5	81.8

2008 Total Population: 864,429 **Percentage Population Ages 65+:** 8.5 **Percentage Population Minority:** 25.0

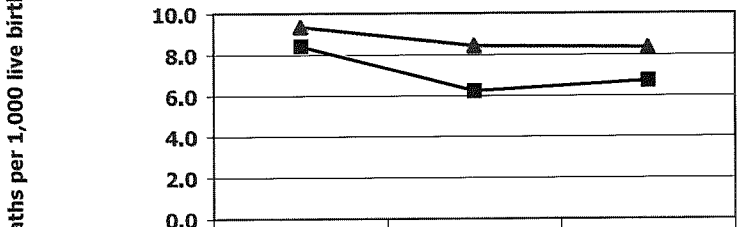
North Carolina County Trends Reports
North Carolina Department of Health and Human Services

Division of Public Health
State Center for Health Statistics

NORTH CAROLINA STATEWIDE AND COUNTY TRENDS IN KEY HEALTH INDICATORS: WAKE COUNTY

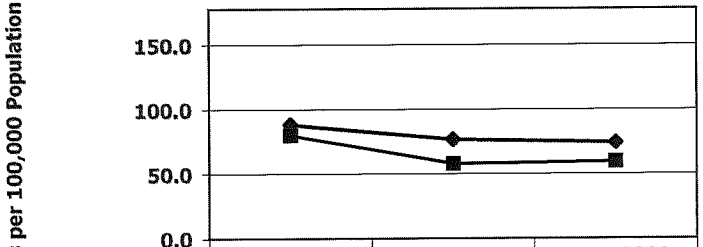


Infant Mortality Rates



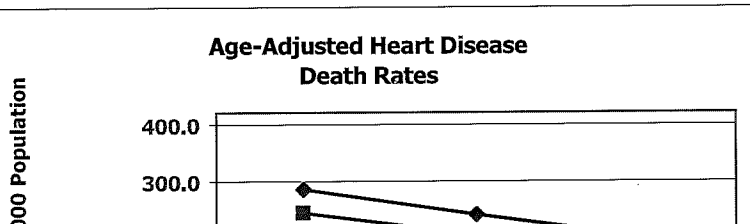
	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	9.4	8.5	8.4
WAKE	8.5	6.3	6.8

Youth Death Rates (Ages 0-17)



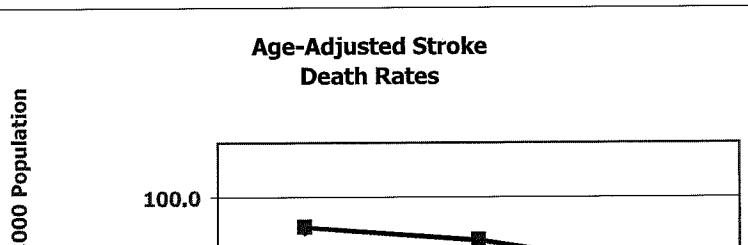
	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	88.9	77.3	74.7
WAKE	81.0	58.7	60.3

Age-Adjusted Heart Disease Death Rates



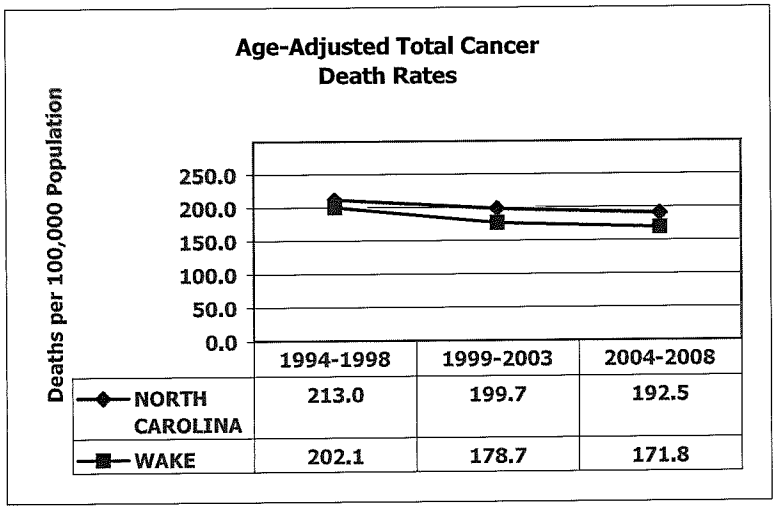
	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	288.2	243.2	202.2
WAKE	246.7	207.8	163.2

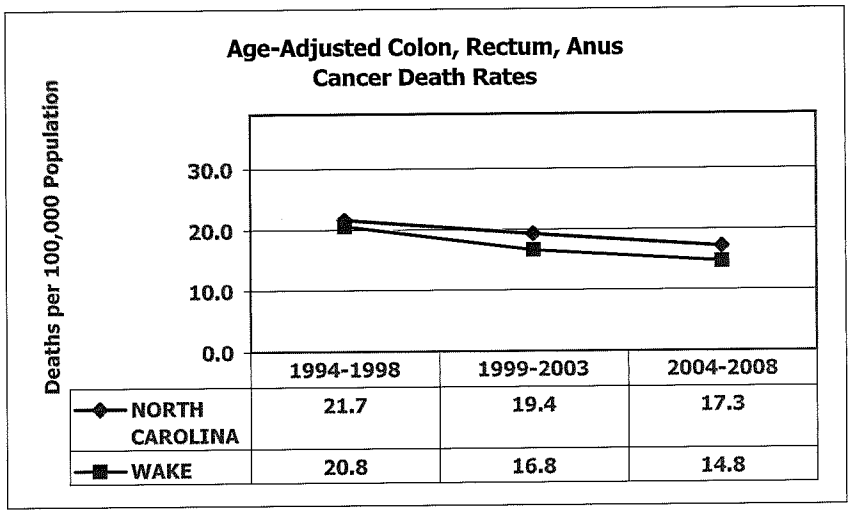
Age-Adjusted Stroke Death Rates

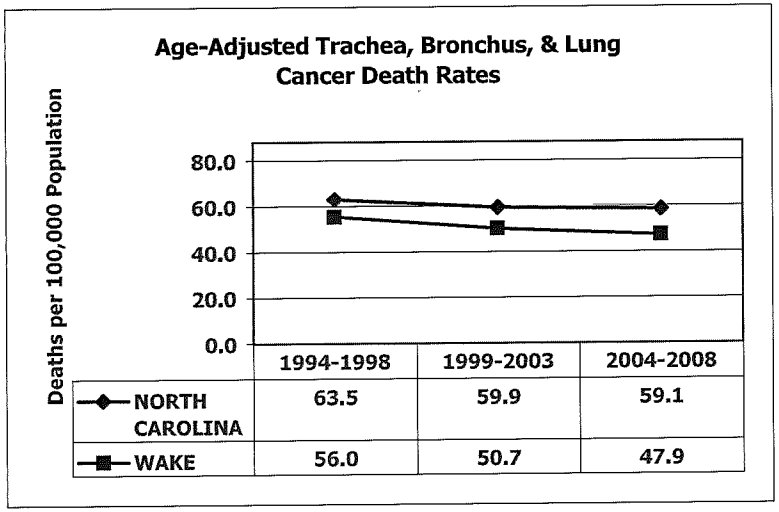


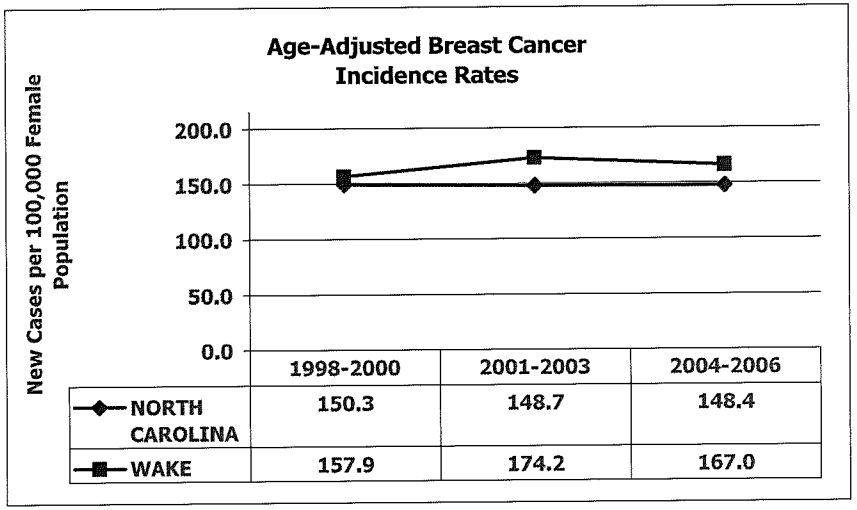
	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	80.0	70.7	54.4
WAKE	80.7	72.0	53.7

NORTH CAROLINA STATEWIDE AND COUNTY TRENDS IN KEY HEALTH INDICATORS: WAKE COUNTY



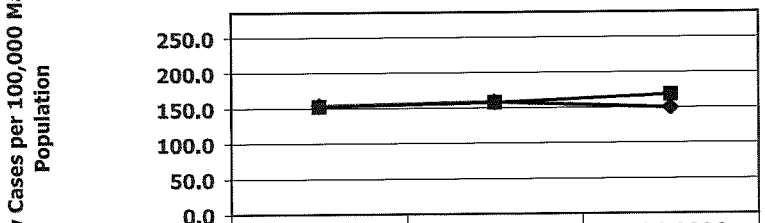






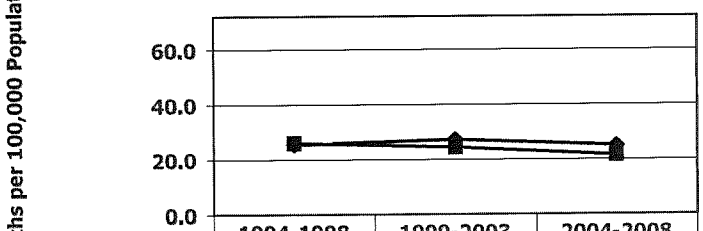
NORTH CAROLINA STATEWIDE AND COUNTY TRENDS IN KEY HEALTH INDICATORS: WAKE COUNTY

Age-adjusted Prostate Cancer Incidence Rates



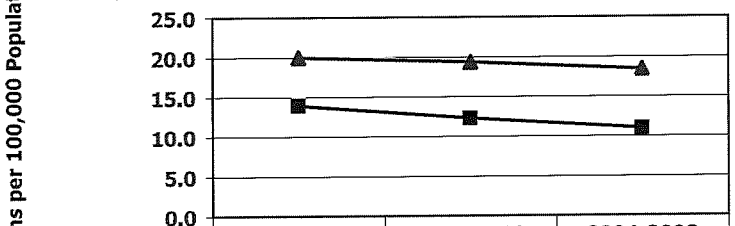
	1998-2000	2001-2003	2004-2006
NORTH CAROLINA	155.3	160.2	151.9
WAKE	154.6	160.0	170.3

Age-Adjusted Diabetes Death Rates



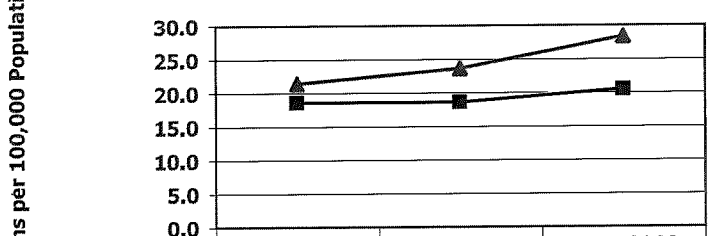
	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	25.7	27.5	25.2
WAKE	26.4	24.7	21.8

Age-Adjusted Unintentional Motor Vehicle Injury Death Rates



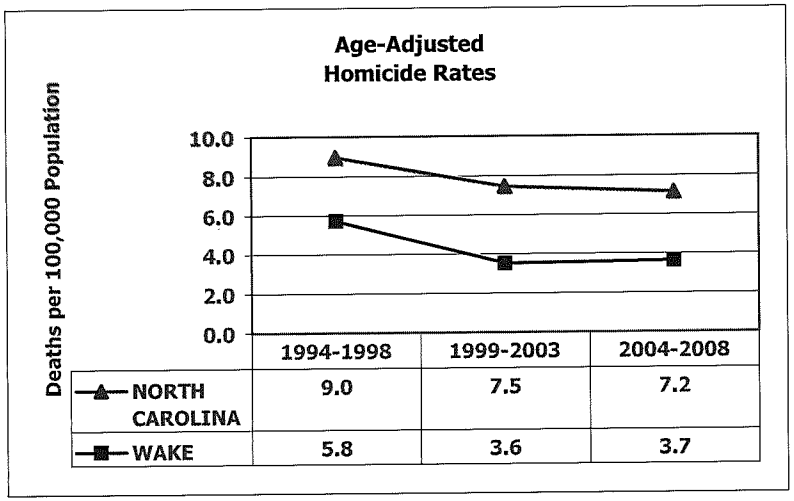
	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	20.1	19.5	18.6
WAKE	14.1	12.5	11.2

Age-Adjusted All Other Unintentional Injury Death Rates (excluding Motor Vehicle Deaths)

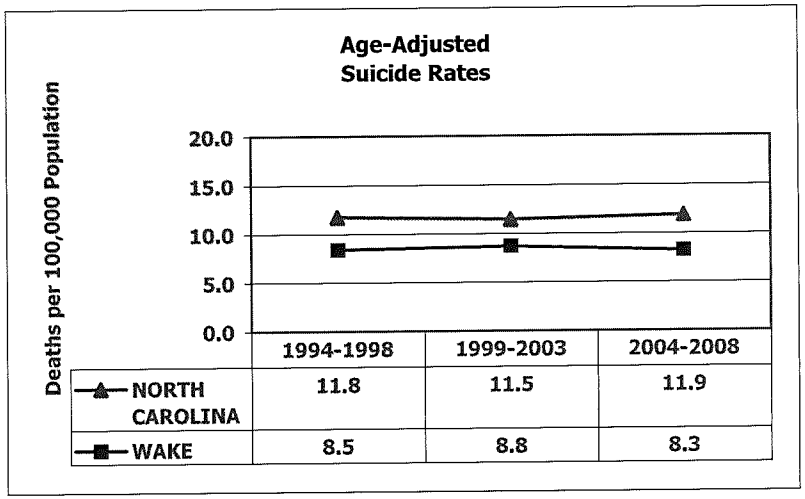


	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	21.5	23.7	28.4
WAKE	18.8	18.8	20.7

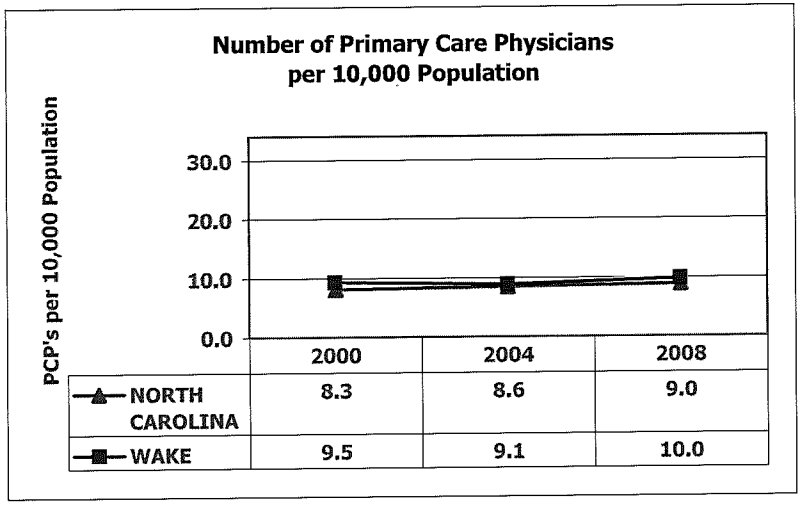
NORTH CAROLINA STATEWIDE AND COUNTY TRENDS IN KEY HEALTH INDICATORS: WAKE COUNTY



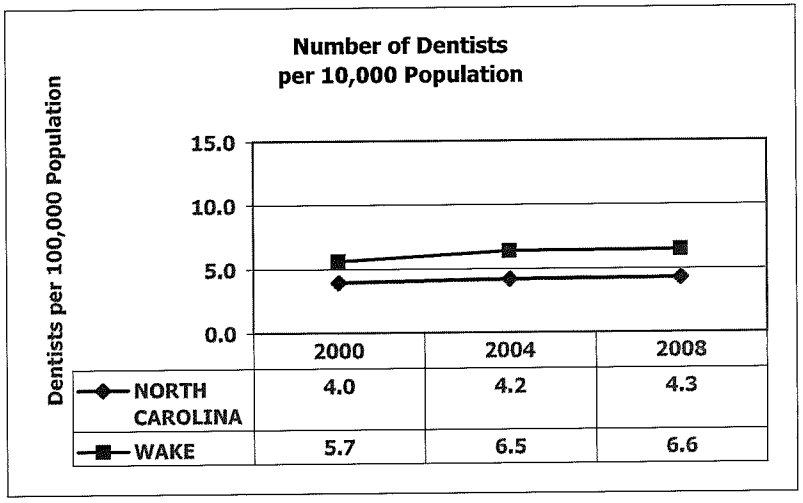
	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	9.0	7.5	7.2
WAKE	5.8	3.6	3.7



	1994-1998	1999-2003	2004-2008
NORTH CAROLINA	11.8	11.5	11.9
WAKE	8.5	8.8	8.3



	2000	2004	2008
NORTH CAROLINA	8.3	8.6	9.0
WAKE	9.5	9.1	10.0



	2000	2004	2008
NORTH CAROLINA	4.0	4.2	4.3
WAKE	5.7	6.5	6.6

NORTH CAROLINA STATEWIDE AND COUNTY TRENDS IN KEY HEALTH INDICATORS: WAKE COUNTY