Comments on Competing Applications for Additional Acute Care Beds in Buncombe County

August 1, 2022

Written Comments on Competing Applications to Add 67 Acute Care Beds in the Buncombe/Graham/Madison/Yancey Service Area

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital ("Pardee UNC Health Care" or "Pardee") hereby submits the following comments related to three, competing applications to develop additional acute care beds in response to the need determination in the *2022 State Medical Facilities Plan (2022 SMFP)* for 67 additional acute care beds in the Buncombe/Graham/Madison/Yancey County service area. Pardee's comments include "*discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with the relevant review criteria, plans and standards*." *See* N.C. GEN. STAT. § 131E-185(a1)(1)(c). To facilitate the Agency's review of these comments, Pardee has organized its discussion by issue, noting the Certificate of Need statutory review criteria and regulatory standards creating the non-conformity on the application. Pardee's comments relate to the following applications:

- **Mission Hospital ("Mission"), Add 67 acute care beds, Project ID # B-012232-22**
- **Novant Health Asheville Medical Center ("Novant"), Develop a new 67 acute care bed hospital, Project ID # B-012230-22**
- **AdventHealth Asheville ("Advent"), Develop a new 67 acute care bed hospital, Project ID # B-012233-22**

Pardee's detailed comments include general comments regarding all three applications, as well as application-specific comments related to each competing application.

BACKGROUND COMMENTS APPLICABLE TO ALL THREE APPLICATIONS

Prior to the *2022 SMFP*, no bed need had been generated in the *SMFP*-defined service area of Buncombe/Graham/Madison/Yancey counties in over 10 years (since 2011). No need has existed even though Mission Health, the only acute care provider in the *SMFP*-defined service area, operates as the area's only tertiary facility drawing patients from surrounding counties and even other states. Not coincidentally, bed need has been generated only in the two years since COVID-19 began impacting patient days.

As the Agency is aware, the standard acute care bed methodology yielded no bed need in the Buncombe/Graham/Madison/Yancey service area in the *2022 SMFP*. The ultimate need determination for 67 beds was generated exclusively by the COVID-19 adjustments to the methodology. In other words, *actual patient days did not generate the need for additional beds in the Buncombe/Graham/ Madison/Yancey service area*. COVID-19 impacted the *2022 SMFP* adjusted bed need calculation in two ways:

(1) 2020 patient days, used as the baseline for 2024 projections, were adjusted to be higher than actual patient days. Specifically, Mission's actual patient days in 2020 were reported to be 200,068 on the 5/18/2021 version of Table 5A from the *2022*

SMFP planning process, which is generally consistent with reported days in the 2021 HLRA of 201,000. In contrast, the adjusted patient days included in the *2022 SMFP* are 207,208.

(2) Growth rates used to project 2024 patient days, which included the 2020 growth that was based on adjusted patient days, were also higher than actual. Using actual patient days of 200,068 on which to base the growth rate results in a growth rate multiplier of 1.0154 (1.54 percent growth), compared with the growth rate multiplier used in the *2022 SMFP* methodology, 1.0245 (2.45 percent growth).

Using the actual data from 2020 would have resulted no bed need in the *2022 SMFP*, compared with a bed need of 67, driven exclusively by the upward adjustments for COVID-19. (*See* Attachment 1.)

Pardee recognizes that the need determination in the *2022 SMFP* was finalized by the SHCC and approved by the Governor. Nonetheless, Pardee believes it is important for the Agency to consider these unique facts and circumstances in the context of this review, particularly with regard to each of the applicants' conformity with Criterion 3.

MISSION HOSPITAL, ADD NO MORE THAN 67 ACUTE CARE BEDS FOR A TOTAL OF NO MORE THAN 800 ACUTE CARE BEDS UPON PROJECTION COMPLETION, NORTH CAROLINA, PROJECT ID # B-012232-22

Issue-Specific Comments

1. The Mission application fails to adequately demonstrate the need for the proposed project, particularly its use of 2021 patient days as baseline volume results in overstated projections.

   Mission utilizes actual 2021 and annualized 2022 to calculate the baseline days of care and the future growth rates. According to its 2022 License Renewal Application (LRA), Mission had 224,049 days of care in FFY 2021, representing an 11.5 percent increase over its 201,000 days of care in FFY 2020. However, Mission's admissions only increased by 2.9 percent. Mission's historical volumes are as follows:

	FFY 2017	***FFY 2018***	***FFY 2019***	***FFY 2020***	***FFY 2021***
Patient Days of Care	190,158	193,739	204,907	201,000	224,049
Admissions	39,243	39,720	43,020	40,327	41,492
ALOS	4.85	4.88	4.76	4.98	5.40

Source: Mission LRAs

As shown in the table above, the days of care at Mission Hospital increased substantially in FFY 2021. However, the majority of its increase in patient days was the result of an increasing ALOS, not as a result of increasing patient admissions. This same trend was observed across North Carolina and was the reason for the proposed adjustments to the need methodology in the *2023 SMFP*. According to the Acute Care Services Committee,

> *"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."*[1]

Mission's average length of stay consistently remained well below 5.0 days from FFY 2017 to FFY 2019, averaging 4.83 during those years. During the COVID periods of FFY 2020 and FFY 2021, it increased to 4.98 and 5.40, respectively—an increase of 0.57 days per patient during the COVID-19 period (5.40 – 4.83 = 0.57). Not only does Mission not adjust for this spike in ALOS, Mission utilizes an ALOS even greater than its 2021 rate in every projected year. Page 170 of the

[1] Acute Care Services Committee Recommendations to the NC State Health Coordinating Council on June 1, 2022 found here: https://info.ncdhhs.gov/dhsr/mfp/pdf/2022/shcc/04-ACSCommitteeReport-6-1-22-Final.pdf

application shows that Mission assumes that its ALOS will be 5.6 days throughout the projection period. Mission includes little discussion on the impact of COVID-19 and includes no discussion as to why its projected ALOS is reasonable given its pre COVID-19 values.

In addition to its failure to address the impact of COVID-19 on average length of stay, Mission fails to consider the temporary nature of COVID related volumes in other assumptions. For example, on page 97 of the application, Mission calculates the FY 2018 – Annualized 2022 compound annual growth rate ("CAGR") by bed category. Of note, the Annualized 2022 volume is based on only one quarter of actual 2022 data, January through March of 2022, during which the nation and North Carolina hospitalizations from the Omicron variant spiked. (*See* Application, page 98.) Using this approach, for example, results in a CAGR for Adult ICU beds of 8.5 percent. Mission averaged this significantly high growth rate with the adult population growth as a basis for projecting future Adult ICU patient days. Thus, projected utilization was based on a growth rate essentially comparing pre-COVID volume (FY 2018) with one quarter of COVID-spiked volume (Annualized 2022).

Although not tied to its utilization assumptions, Mission similarly argues a need for more beds because of an increase in trauma admissions from 2020 to 2022. (*See* Application, page 88.) However, comparing emergency department volumes from the inaugural year of the COVID-19 pandemic when ED volumes plummeted everywhere to 2022 ED volumes on the rebound from the initial decline completely ignores the substantial cause of the increase between 2020 and 2022.

Furthermore, Mission's failure to address the impact of COVID-19 in this application is inconsistent with Mission's discussion relating to COVID-19 in other recent applications.

In Step 1 on page 62 of its Mission FSER application (Project ID # B-012191-22) filed on February 15, 2022, Mission stated, "*Mission established a historic trend in ED volume for the target service area as a whole regardless of which provider served patients from 2017 to 2019. This time frame was chosen as opposed to using 2020 data due to the COVID-19 pandemic, which has skewed volume for healthcare providers across the nation*." In addition, page 53 of the same application states, "*Mission has carefully reviewed its utilization trends prior to COVID and as the service area is recovering from the Pandemic. ED trends prior to the Pandemic have been used as an indicator of future trends in demand for ED services*." Also on February 15, 2022, Mission filed its Mission FSER West application (Project ID # B-012192-22). These same phrases were included on page 63 and page 54, respectively.

As shown above, Mission discussed the impact of COVID-19 on other services and adjusted the respective applications for those impacts. In this instance, Mission failed to make similar adjustments; of note, unlike ED volumes, the COVID-driven volume trends are favorable for inpatient services. If Mission had adjusted its projections in this application as it did in the FSER applications by applying the experience of the FFY 2017 to FFY 2019 ALOS, 4.83, to the 43,568 projected admissions in PY 3, the result would yield 210,433 days of care. At those PY 3 patient days, the occupancy rate would be 72.1 percent, well below the 75.2 percent target occupancy

required by 10A NCAC 14C .3803 for hospitals with an average daily census greater than 200. As a result of using an unrealistic and unsupported ALOS, as well as other assumptions relied upon to project utilization, Mission's volume projections are not based on reasonably supported assumptions, and the application should be denied.

Based on the discussion above, Mission fails to demonstrate the need for the proposed project in accordance with Criterion 3, fails to meet performance standards in 10A NCAC 14C .3803, and fails to demonstrate that the proposed project will not unnecessarily duplicate existing services in accordance with Criterion 6. As such, the Mission application is non-conforming with Criteria 1, 3, 6 and 18a and 10A NCAC 14C .3803.

2. Mission fails to demonstrate need for the proposed project by failing to support its assertion that it needs additional beds to fulfill its role as the only tertiary provider in the region.

   On page 62 of the application, Mission states: "*Mission Hospital has an important function in the healthcare of western North Carolina; it treats the sickest and most fragile patients, trauma patients, and other high-acuity patients that cannot be treated elsewhere in the service area. As a result, it pulls patients from a broad and far-reaching service area. The availability of ICU beds is instrumental in Mission's ability to provide the level of care to this extensive service area and sets it apart from other smaller providers throughout western North Carolina*."

   Although Mission is a tertiary provider with a comprehensive range of services, 70 percent of inpatient days provided at Mission consistently are appropriate for admission to community-based hospitals. For Mission's self-defined 19-county service area in Western North Carolina (*See* Application, page 58), Pardee analyzed volume by MS-DRG codes to determine patient days that are appropriate for community facilities[2].

Mission's 19-County Patient Days*	***FFY 2019***	***FFY 2020***	***FFY 2021***
Community Hospital Appropriate	131,703	133,314	147,724
Specialty[3] or Not Community Appropriate	56,311	57,423	63,904
TOTAL	188,014	190,737	211,628
Community Appropriate % of Total	70%	70%	70%

Source: Hospital Industry Data Institute (HIDI)
*Excludes patient days originating from North Carolina but outside of the 19-county Mission-defined service area, as well as patient days from out of state. According to Pardee's analysis of HIDI data for FFY 2021, patients from these 19-counties account for approximately 94% of Mission's total volume from all geographies.

[2] Pardee, Advent Hendersonville, and Haywood Regional—the community hospitals closest to Mission—serve patients in virtually all of the community-appropriate MS-DRGs. The community-appropriate MS-DRGs that do not have any patient volume at those three facilities make up less than 4% of Mission's community-appropriate volume. In other words, 96% of Mission's community-appropriate volume is from MS-DRGs that could be served at Pardee, Advent Hendersonville and Haywood Regional.
[3] Includes Hematology/Oncology, High Risk OB, Neonatal, Thoracic Surgery, Trauma

For FFY 2021, these community-appropriate patient days equate to 538 beds at the target occupancy rate[4]. In other words, of Mission's existing 733 licensed acute care beds, at least 538 are utilized by patients who could be served in community hospitals and not by tertiary patients requiring services that only Mission can provide.

Moreover, there is some evidence that Mission itself has driven more community-appropriate volume to its facility and created the current circumstances under which it operates. Heightened since the acquisition of Mission Health by HCA are concerns that services in more rural parts of the service area have been diminished, forcing more patients to travel to Buncombe County for care.

> "Community members contend services have been reduced at Mission's rural hospitals....
>
> But while [Nancy Lindell, a spokesperson for HCA's North Carolina division] says the company is preparing TRH for 'explosive population growth,' [Brevard's mayor, Maureen] Copelof and others see a slow, quiet erosion of services."[5]
>
> "Once Mission took over, focus began to shift toward Asheville, and when HCA took over from Mission, Angel 'became even more of a teeny, tiny little cog in a huge machine,' she [Linda Tyler, a public health nurse in Macon County for 25 years who's now retired] said.... Franklin Mayor Bob Scott shares Tyler's concern. 'My concern is that the type of services that we once had at our community hospital, you're now shipped to Asheville to have the same,' Scott said. '(Franklin is a) minimum of an hour away from Asheville under the absolute best of circumstances.'"[6]

In addition to these news reports, Mission Health and HCA are now facing two anti-trust lawsuits, alleging in part that cuts to services in outlying communities are "compelling patients to travel to HCA's Asheville facilities to obtain care."[7]

An analysis of discharges from HCA-owned hospitals in Western North Carolina supports these anecdotal reports. According to HIDI data, four of the six HCA hospitals have experienced declines in inpatient volume; only two hospitals have experienced an increase, with Mission's the highest.

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[4] 147,724 / 365 = 404.7 average daily census / 0.752 target occupancy rate = 538 beds

[5] https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/

[6] https://www.citizen-times.com/story/news/2021/05/27/mission-health-breaks-ground-franklin-service-concerns-community-care/7429932002/

[7] https://www.citizen-times.com/story/news/2022/06/06/brevard-files-class-action-antitrust-lawsuit-against-mission-hca/7531321001/

HCA Hospital	*FFY 2017*	*FFY 2018*	*FFY 2019*	*FFY 2020*	*FFY 2021*	*CAGR*
Mission Hospital	38,680	39,038	40,250	39,108	40,112	0.9%
Mission Hospital McDowell	2,016	2,183	2,277	2,100	2,061	0.6%
Angel Medical Center	1,889	1,478	1,495	1,189	1,298	-9.0%
Transylvania Regional Hospital	1,512	1,462	1,509	1,227	1,377	-2.3%
Blue Ridge Regional Hospital	1,222	642	1,342	1,041	1,083	-3.0%
Highlands-Cashiers Hospital	301	169	344	206	273	-2.4%

Source: Hospital Industry Data Institute (HIDI), for patients originating from the 19-county Mission defined service area of Western North Carolina.

Other systems in North Carolina, including UNC Health and Atrium Health, have demonstrated through public statements and data that they are working to shift community-appropriate volume to facilities closer to patients' homes. In contrast, Mission appears to be pushing more community-appropriate volume to Asheville, which is in stark contrast to its statements regarding the need for more beds to support its tertiary services.

Currently, Mission is the only hospital provider in the Buncombe/Graham/Madison/Yancey service area and holds approximately 79.0 percent inpatient market share (of discharges) of the *SMFP*- defined service area. However, a notable portion—more than 40 percent—of Mission's community-appropriate patient days originate from the other 15 counties in its self-defined service area. Even though the *SMFP*-defined service area consists of four counties, the purported need generated by Mission is the result of volume throughout Mission's broader service area.

*Origin of Mission Community-Appropriate Days**	*FFY 2019*	*FFY 2020*	*FFY 2021*
Buncombe/Graham/Madison/Yancey	78,165	76,358	84,863
Remaining 15 Counties in Defined Service Area	53,538	56,956	62,861
Defined Service Area Total	131,703	133,314	147,724
15 Counties % of Total	41%	43%	43%

Source: Hospital Industry Data Institute (HIDI)

In FFY 2021, the community-appropriate patient days originating from these 15 counties equates to 229 beds at the target occupancy rate.[8] According to the *Proposed 2023 SMFP*, sufficient bed capacity exists at community hospitals within the region where these patients originate to accommodate the volume that is appropriately served closer to patients' homes. The bed surplus and utilization for the entire Mission self-defined service area is as follows:

[8] 62,861 / 365 = 172.2 average daily census / 0.752 target occupancy rate = 229 beds

Hospital	*County*	*Acute Care Beds*	*FY 2021 Patient Days*	*Bed Deficit (Surplus)*	*Utilization*
Mission Hospital	Buncombe	682	208,988	98	84.0%
*2022 Acute Care Bed Need Determination	Buncombe	67		(67)	
Margaret R. Pardee Memorial Hospital	Henderson	201	24,467	(92)	33.3%
Caldwell UNC Health Care	Caldwell	110	23,346	(3)	58.1%
UNC Blue Ridge	Burke	289	22,546	(196)	21.4%
Haywood Regional Medical Center	Haywood	121	19,840	(21)	44.9%
Harris Regional Hospital	Jackson	82	13,947	(22)	46.6%
AdventHealth Hendersonville	Henderson	62	11,341	(11)	50.1%
Rutherford Regional Medical	Rutherford	129	10,347	(87)	22.0%
Mission Hospital McDowell	McDowell	65	6,735	(35)	28.4%
Transylvania Regional Hospital	Transylvania	42	5,877	(18)	38.3%
Angel Medical Center	Macon	30	5,335	(1)	48.7%
Erlanger Murphy Medical Center	Cherokee	57	5,133	(36)	24.7%
Blue Ridge Regional Hospital	Mitchell	46	4,774	(12)	28.4%
St. Luke's Hospital	Polk	25	3,053	(11)	33.5%
Highlands-Cashiers Hospital	Macon	24	1,971	(13)	22.5%
Swain Community Hospital	Swain	48	2,971	(36)	17.0%
Charles A Cannon Jr Memorial Hospital	Avery	30	1,020	(26)	9.3%
Grand Total		**2,110**	**371,691**	**(589)**	**48.3%**

Source: Table 5A: Acute Care Bed Need Projections excluding NICU data and includes adjusted CGRM - Draft 6/01/2022

As shown above, the *2023 SMFP* Table 5A: Acute Care Bed Need Projections show a bed surplus at every Western North Carolina hospital except Mission. In fact, only two additional hospitals are operating at over 50 percent capacity. With a bed surplus of 589 acute care beds in Western North Carolina, there is adequate capacity for patients in the broader service area. Moreover, outside the Buncombe/Graham/Madison/Yancey service area, more of Mission's volume originates from (in rank order) Henderson, Haywood, McDowell, Macon, Transylvania and Jackson counties. (*See* Attachment 2.) The table above shows that these six counties alone have a surplus of over 200 acute care beds.

Mission also claims on pages 89-92 of the application that it has been forced to decline transfer requests because of the lack of bed capacity. Beyond the arguments above regarding the high percentage of Mission's patients who do not require tertiary care, Mission fails to document that the decline in transfers is the result of physical bed capacity. Pardee's direct experience attempting to transfer to Mission has been the lack of staff capacity at Mission, which is corroborated by numerous news stories documenting staffing issues at Mission. Second, there are other reasons—not related to bed capacity at Mission—that are behind the decline in

transfers from Pardee. According to Pardee's internal data, its transfers are down 6 percent overall since FFY 2019. Transfers declined from FFY 2019 to FFY 2020, likely the result of the drop in volume from the pandemic's first year, and then increased slightly in FFY 2021 before a significant drop in FFY 2022 YTD.

Mission remains the dominant transfer destination for Pardee's patients. Other transfers are spread across more than a dozen facilities. Pardee's transfers to Mission are down 10 percent since FFY 2019. However, there are reasons for the decline that are not attributable to Mission's bed capacity. For example, one of the ICD-10 groups with a significant decline in transfers to Mission was diseases of the circulatory system, which declined significantly in FFY 2022 as expected after Pardee was granted status as a PCI-capable facility in February 2022.

As such, Mission fails to demonstrate that physical bed capacity—particularly when the *SMFP* need determination was based on inflated, not actual, data—is the reason behind its inability to accept transfers.

Based on the discussion above, Mission fails to demonstrate the need for the proposed project in accordance with Criterion 3 and fails to demonstrate that the proposed project will not unnecessarily duplicate existing services in accordance with Criterion 6. As such, the Mission application is non-conforming with Criteria 1, 3, 6 and 18a.

3. The Mission application fails to demonstrate need for the proposed project by failing to address its own argument that demand for inpatient care is declining.

   On page 72 of the application, Mission states: "*The trends toward demand for high acuity hospitals in North Carolina, and increased bed need, mirrors the trend for higher acuity hospital care nationwide. Post-pandemic trends, both in care provision and Medicare reimbursement, are leaning toward an increased provision of outpatient and at home care for lower acuity patients. As a result, acute care hospital utilization overall is declining….The caveat to the decline in utilization of acute care services is in the provision of high-acuity care by tertiary and quaternary care providers, such as trauma and tertiary care centers. These facilities will continue to experience growth as their high level, specialized services cannot be accomplished in a different care environment.*" Citing a Moody's report, the application goes on to state "*that hospitals such as tertiary care centers with a strong focus on quaternary and tertiary care will be better able to sustain demand for inpatient services than hospitals offering primary less complex, or secondary, care in the future*." In addition, the application cites on page 73 more sources suggesting that inpatient volume in the future will decline as the result of hospital at home programs and the continued shift of surgical volume to the outpatient setting.

   Despite all the detailed documentation of its argument that inpatient volume, particularly lower acuity inpatient volume, is expected to decline, Mission fails to address this decline when projecting its own utilization. As noted previously, 70 percent of Mission's patient days are provided to patients with community-appropriate, not tertiary or quaternary, diagnoses. Thus, based on Mission's own arguments, it should have addressed the expected decline in 70 percent

of its own volume. On page 97 of the application, Mission notes that it used the adult population growth rate to project future adult medical/surgical patient days. While this is a lower rate of growth than Mission shows for historical adult medical/surgical patient days, it still represents growth in volume, rather than the significant expected decline in volume discussed on page 73 of the application.

Based on the discussion above, Mission fails to demonstrate the need for the proposed project in accordance with Criterion 3 and fails to meet performance standards in 10A NCAC 14C .3803. Moreover, Mission fails to demonstrate that its projected utilization and resulting financial feasibility is based on reasonable and supported assumptions. As such, the Mission application is non-conforming with Criteria 1, 3, 5, and 18a.

4. The Mission application fails to demonstrate need for the proposed project by failing to support its assertion that it needs more beds to reverse the outmigration of patients to other tertiary facilities that it purports to result from capacity issues.

On page 56 of the application and similarly elsewhere, Mission states: "*there was an increase in patients having to leave the area for tertiary providers such as Atrium Wake Forest Baptist and Duke University Hospital or providers in Tennessee, again due to Missions [sic] capacity constraints.*"

According to HIDI data for Mission's 19-county service area, outmigration of approximately 36,000 patient days to other tertiary facilities has remained relatively flat from FFY 2018 to FFY 2021, as shown in the table below.

Facility	*FFY 2018*	*FFY 2019*	*FFY 2020*	*FFY 2021*	*% of FFY 2021*
Atrium Health Carolinas Medical Center	14,658	13,938	13,645	15,032	41.1%
Atrium Health Wake Forest Baptist	11,425	10,895	10,164	11,167	30.5%
Duke University Hospital	5,756	5,348	4,541	4,749	13.0%
UNC Hospitals	3,014	3,515	3,184	3,035	8.3%
Novant Health Forsyth Medical Center	1,082	714	916	1,120	3.1%
Novant Health Presbyterian Medical Center	527	1,173	836	728	2.0%
The Moses H. Cone Memorial Hospital	132	200	127	343	0.9%
Novant Health New Hanover Regional Medical Center	143	79	98	183	0.5%
WakeMed Raleigh Campus	101	70	97	238	0.7%
Total	**36,838**	**35,932**	**33,608**	**36,595**	**100.0%**

Source: Hospital Industry Data Institute (HIDI)

As shown above, the majority of the outmigration is to the closest tertiary facilities—Atrium's CMC in Charlotte and Atrium Wake Forest Baptist in Winston-Salem.

Moreover, approximately half of the volume outmigrating to other tertiary facilities is for community-appropriate diagnoses, as shown in the table below, suggesting that those patients are not choosing other facilities because of lack of capacity at Western North Carolina's only tertiary facility, but for other reasons.

	FFY 2018	*FFY 2019*	*FFY 2020*	*FFY 2021*
Community Hospital Appropriate	19,340	19,807	17,208	18,315
Specialty[9] or Not Community Appropriate	17,498	16,125	16,400	18,280
Total	**36,838**	**35,932**	**33,608**	**36,595**
Community Appropriate % of Total	53%	55%	51%	50%

Source: Hospital Industry Data Institute (HIDI)

Of the outmigrating patients that are not community-appropriate, many are for specialties for which the academic and quaternary facilities in North Carolina have national reputations, such as cardiology, oncology, and neurosurgery.

Specialty	*FFY 2018*	*FFY 2019*	*FFY 2020*	*FFY 2021*
Cardiac Services	3,293	3,630	2,855	3,519
Oncology / Hematology	3,305	3,019	3,149	3,260
Neurosurgery	1,479	1,604	1,670	1,949
Other Specialties	9,421	7,872	8,726	9,552
Total	**17,498**	**16,125**	**16,400**	**18,280**

Source: Hospital Industry Data Institute (HIDI)

Based on the discussion above, Mission fails to demonstrate the need for the proposed project in accordance with Criterion 3 and fails to demonstrate that the proposed project will not unnecessarily duplicate existing services in accordance with Criterion 6. As such, the Mission application is non-conforming with Criteria 1, 3, 6 and 18a.

5. The Mission application fails to demonstrate that its projections of costs and charges are based on reasonable assumptions.

On page 177 of the application, Mission states that it assumes an average charge increase of 8 percent per year "to account for charge master increases." An examination of this gross charge increase coupled with the contractual adjustments yields net patient revenue that increases approximately 4 percent per year on average, excluding the impact of volume increases. In other words, Mission's financial projections assume that it will receive rate increases of about 4 percent each year. (*See* Attachment 3 for calculations.)

[9] Includes Hematology/Oncology, High Risk OB, Neonatal, Thoracic Surgery, Trauma

Mission's assumptions regarding its future revenue increases would be in addition to existing concerns about pricing by Mission Health. The North Carolina Attorney General[10] has raised concerns about the high price of healthcare in Western North Carolina, specifically citing in his March 16, 2022 letter to the HCA North Carolina Division President that "Mission Health charges insurers prices far higher than the state-wide average price for the same service….insurance premiums within Mission Health's service area are 30% higher than premiums in nearby counties, and over 50% higher than premiums in the State's other large metropolitan areas."[11]

Beyond the concerns of the Attorney General, the two anti-trust lawsuits brought against Mission and HCA allege in part that Mission charges "supracompetitive prices—prices above their competitive level."[12] As recently as July 27, 2022, a third lawsuit has been brought against Mission and HCA by Buncombe County and the City of Asheville, alleging similar issues regarding Mission's pricing practices.[13] The ability of Mission to achieve the projected increases in net revenue from government payors such as Medicare and Medicaid is highly questionable, and the scrutiny of the Attorney General's office and these lawsuits cast doubt on Mission's ability to continue raising prices over the remainder of this decade at the levels assumed in this application.

Based on the discussion above, Mission fails to demonstrate that the financial feasibility of the proposed project is based on reasonable projections of charges and costs as required by Criterion 5. As such, the Mission application is non-conforming with Criteria 5 and 18a.

In summary, based on the issues detailed above, Mission has failed to demonstrate that the project is consistent with the review criteria implemented under N.C. GEN. STAT. § 131E-183, including the need for the proposed project and that it will not unnecessarily duplicate existing services. As such, the Mission application should be found non-conforming with Criteria 1, 3, 5, 6, and 18a, as well as the performance standards in 10A NCAC 14C .3803. The Mission application should not be approved.

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[10] As the Agency is aware, the Attorney General's office has submitted a letter indicating that the Agency should find Mission non-conforming with Criterion 18a and deny the application because of alleged pricing issues and lack of competition.
[11] https://www.scribd.com/document/567469487/NC-DOJ-Letter-to-HCA-16-March-2022
[12]https://www.citizen-times.com/story/news/2022/06/06/brevard-files-class-action-antitrust-lawsuit-against-mission-hca/7531321001/
[13]https://www.citizen-times.com/story/news/2022/07/28/buncombe-asheville-filed-class-action-lawsuit-against-hca-healthcare-mission-health/10171852002/

NOVANT HEALTH ASHEVILLE MEDICAL CENTER, DEVELOP A NEW 67 ACUTE CARE BED HOSPITAL AND RELOCATE ONE OR FROM OUTPATIENT SURGERY CENTER OF ASHEVILLE, AND DEVELOP ONE DEDICATED C-SECTION OR AND THREE PROCEDURE ROOMS, NORTH CAROLINA, PROJECT ID # B-012230-22

Issue-Specific Comments

1. The Novant application fails to demonstrate need for the proposed project by failing to demonstrate that its projected market share is based on reasonably supported assumptions.

   In Form C, Step 9 of the application, Novant notes its assumptions for the share of admissions treated in Buncombe County that are expected to be served at its proposed facility. Although the first paragraph in Step 9 describes the factors Novant considered, it provides no basis for the 25 percent share of Buncombe and Henderson patients it projects to serve, nor the 5 percent of Madison, Yancey and Graham patients. Of note, the 25 percent of patients served in Buncombe County equates to 22.85 percent of total acute care patients who reside in Buncombe County.

   An analysis of existing market share patterns casts significant doubt on Novant's ability to achieve such market share. Novant's proposed location is halfway between and approximately nine miles from both Mission and AdventHealth Hendersonville, which is located within five miles of the Buncombe County line in Henderson County. AdventHealth has operated in the region for decades. AdventHealth's mission is "extending the healing ministry of Christ," and it is affiliated with the Seventh-day Adventist Church, which has a large community in and around Fletcher, North Carolina. Novant does not operate acute care services in the area. AdventHealth Hendersonville is licensed for 62 acute care beds; Novant proposes to develop and license 67 acute care beds. AdventHealth Hendersonville is licensed for six operating rooms; Novant proposes to relocate one existing operating room. In FFY 2021, AdventHealth Hendersonville had 4.3 percent market share[14] of Buncombe County residents, despite being located within five miles of Buncombe County. Pardee, located farther south in the center of Henderson County, is the second largest hospital in the region and offers a broader scope of advanced services than the smaller community hospitals like AdventHealth or the proposed Novant hospital. Pardee had 1.6 percent share of Buncombe County inpatients in FFY 2021.

   Furthermore, if approved, Novant would have 8.4 percent of the acute care beds in the Buncombe/Graham/Madison/Yancey County service area. (733 currently licensed by Mission + 67 at issue in this review = 800; 67 / 800 = 8.4 percent.) However, Novant projects that it will have 16.1 percent market share of the admissions in the service area—double its share of beds.

[14] Source: HIDI, excluding normal newborns, psychiatric and substance abuse discharges.

County	*2029 Admissions**	*Novant Admissions***	*IP Market Share*
Buncombe	23,849	5,450	22.9%
Graham	11,863	910	7.7%
Henderson	1,936	90	4.6%
Madison	1,915	65	3.4%
Yancey	871	16	1.8%
Grand Total	**40,434**	**6,531**	**16.1%**

*Novant Application, Form C, Methodology Step 7
**Novant Application, Form C, Methodology Step 9

Novant's assumptions that it will develop a small community hospital and enter the region as an unfamiliar provider with only 8 percent of the acute care bed capacity yet gain over 20 percent share of all Buncombe County patients is not based upon any reasonable assumption.

Also stated in Form C, Step 9 of the application is Novant's projected market share of 5 percent in each of Madison and Yancey counties because it considered that "residents from Madison and Yancey counties must drive past Mission Hospital to reach NH Asheville." While true that residents of these counties would likely be closer to Mission Hospital than Novant's proposed location, Novant failed to consider that given its proposed location in southern Buncombe County less than five miles from the Henderson County border a significant portion of Buncombe County residents would also have to "drive past Mission Hospital to reach NH Asheville."

Based on the discussion above, Novant fails to demonstrate the need for the proposed project in accordance with Criterion 3 and fails to meet performance standards in 10A NCAC 14C .3803. As such, the Novant application is non-conforming with Criteria 1, 3, and 18a.

2. The Novant application fails to demonstrate need of the population in Henderson County has for the proposed project.

On pages 48-50 of the application, Novant identifies the service area it proposes to serve with the proposed project. As shown in the patient origin tables, Novant proposes to serve more residents from Henderson County than the other three counties outside of Buncombe, *combined*. The *2022 SMFP* shows a surplus of acute care beds in Henderson County, and Novant fails to demonstrate why it needs to serve 910 inpatients and the many other emergency, outpatient, and surgical patients who reside there.

Novant's inclusion of Henderson County in its service area is not "incidental" to the proposed project. The *SMFP*-defined service area for the 67 beds is Buncombe, Madison, Yancey and Graham counties. Rather than propose to develop a facility that would focus on serving those populations, Novant chose to locate its facility less than five miles from the Henderson County border in order to serve more Henderson County patients than those from the *SMFP*-defined service area. Novant's proposed location is less than 16 miles from Pardee and less than 10 miles from AdventHealth Hendersonville, where sufficient capacity already exists to serve Henderson

County residents. In contrast, Novant's proposed location is more than 45 miles to Burnsville, the seat of Yancey County, almost 30 miles from Marshall (Madison County), and over 100 miles to Tapoco, the most populated area in Graham County. Novant failed to propose a location that would improve access to the residents of the counties in the *SMFP*-defined service area and instead proposed a location closer to Henderson County residents for which there is no need for more acute care beds or another acute care hospital. Without the patient days from Henderson County, Novant fails to meet the performance standard in 10A NCAC 14C .3803[15].

Based on the discussion above, Novant fails to demonstrate the need for the proposed project in accordance with Criterion 3, fails to demonstrate that the proposed project will not unnecessarily duplicate existing services in accordance with Criterion 6, and fails to meet performance standards in 10A NCAC 14C .3803. As such, the Novant application is non-conforming with Criteria 1, 3, 6 and 18a.

3. The Novant application fails to demonstrate need for the proposed project by failing to demonstrate that its projected ED and ancillary utilization is based on reasonably supported assumptions.

   Novant's ED visits are completely unrealistic and not based on any reasonable assumptions. As stated on Form C, Step 15, Novant based its Asheville utilization on the ratio of ED visits to admissions from Novant Mint Hill. While Novant Mint Hill is the newest of Novant's community hospitals, there are significant reasons why Novant Mint Hill is not a reasonable proxy for expected experience in Asheville. First, Novant Mint Hill is part of a long-established provider in Mecklenburg County, with established physician practices, multiple hospitals and other services throughout the county. Volumes at Novant Mint Hill were, in part, shifted from existing Novant facilities[16]. None of that will be true of Novant Health Asheville. Second, the population in Buncombe County and Western North Carolina is notably different from that of the Charlotte region. Western North Carolina is known as a retirement destination and the median age reflects that population. Specifically, the median age of the Novant's five county service area is 44.9 years, compared with the considerably younger average age of Mecklenburg County at 35.9 years[17]. As a result of the population differences, the payor mix and service needs are different in the two markets. A review of the 2022 HLRAs for Mission and Novant Mint Hill show the differences in payor mix for ED services. As shown on the table below, Mission experiences a significantly higher percentage of ED visits from Medicare in particular, as well as Self Pay/Charity and Medicaid, compared with Novant Mint Hill.

[15] From Novant Application, Form C, Step 10: 2029 total patient days of 18,680 – 2603 Henderson County days = 16,077 / 365 = 44 ADC / 67 beds = 65.7% occupancy compared to requirement of at least 66.7%

[16] See page 45 of Novant's Steele Creek Hospital Application, Project ID #F-11993-20, which shows that in Region C, Novant Mint Hill gained 11.8% points of share, while the entire Novant system gained 5.5% points of share in that region, indicating that more than half of Mint Hill's share was shifted from existing Novant facilities.

[17] ESRI.

ED Visits by Payor	Mission	Novant Mint Hill
Self Pay/Charity	18.9%	14.9%
Medicare	32.5%	24.1%
Medicaid	20.7%	18.2%
Insurance	22.6%	37.4%
Other	5.3%	5.5%
Total	100.0%	100.0%

Source: 2022 HLRAs

Without taking any of these factors into consideration, Novant simply applied the Mint Hill ratio of ED visits per admission to its projected admissions. The results are simply not believable. First, Mission provided 98,818 ED visits in FFY 2021 according to its LRA. Novant projects to provide 52,085 ED visits in PY 3, which would be more than a 50 percent increase in ED visits from FFY 2021. A greater than 50 percent increase in ED visits compared with a 9 percent increase in acute care bed capacity is not based on reasonable assumptions.

Second, the table below compares Novant's projections with the experience of the existing three hospitals in Novant's proposed service area. Novant's acute care bed capacity will be similar to Advent's. Novant's total patient days are projected to be higher than Advent, but lower than Pardee's and Mission's. Nevertheless, Novant projects its ED visits will be more than twice that of Pardee's and Advent's and equate to more than 50 percent of Mission's current volume.

	NH Asheville CON PY 3	AdventHealth Hendersonville	Pardee	Mission Hospital
Licensed Beds	67	62	201	733
Patient Days of Care	18,680	11,096	25,130	224,049
ED Exam Rooms	35	16	21	94
ED Visits	52,085	22,988	24,867	98,818

Source: Novant Application; 2022 HLRAs

Novant did not provide any information as to why ED visits would increase so dramatically in the service area, nor did it provide any documentation as to residents' current inability to access emergency care.

Third, Mission currently has 94 exam rooms in operation, Advent has 16, and Pardee has 21. In addition, Mission was approved to develop two FSERs in Buncombe County, each with 12 exams rooms and neither of which Novant considered in its ED projections. Novant proposes to develop 35 ED exam rooms, which would increase ED capacity by 22.5 percent and result in a total of 190 exam rooms in its proposed service area. Under this scenario, Novant's share of ED exam rooms in its proposed service area would be 18.4 percent. Novant did not demonstrate the population's demand for a 50 percent increase in ED visits, nor the population's need to increase ED exams rooms by more than 20 percent.

Fourth, the ED market share that results from Novant's projected utilization is not reasonable. Using actual 2021 ED visits by county of patient origin[18] as the baseline volume, Pardee applied the population's compound annual growth rate in each county as calculated from the Novant application,[19] to project total ED visits in 2029, Novant's third project year.[20] Novant's projected ED visit market share by county is based on its projected ED visits by county, compared with the 2029 total ED visits as calculated. Most sensational is its nearly 60 percent market share of Buncombe County ED visits, despite its proposal to have one ED located within five miles of the Henderson County border, compared with Mission's large tertiary-based ED located in the geographic center of the county along with its two approved FSERs. Overall, Novant's projections equate to nearly 40 percent of all projected ED visits in the five-county service area, which is not reasonable considering it would be the third smallest of four hospitals in the service area and the least-established provider as well.

County	***2021 ED Visits***	***Population CAGR***	***2029 ED Visits***	***PY 3 Novant Asheville***	***ED Market Share***
Buncombe	75,059	1.1%	81,854	46,876	57.3%
Graham	3,306	-0.2%	3,251	140	4.3%
Henderson	39,308	1.0%	42,724	7,827	18.3%
Madison	5,847	0.3%	5,989	771	12.9%
Yancey	7,996	0.5%	8,323	563	6.8%
Grand Total	**131,516**		**142,140**	**56,177**	**39.5%**

Source: NCDHHS 2022 (2021 Data) Emergency Department Patients: Patient's County of Residence table, Population calculated using Novant Application, Form C, Steps 1 and 6.

Because Novant's ancillary projections as outlined in Steps 22 through 26 of Form C are all based on Mint Hill ratios, the results are not based on reasonably supported assumptions as discussed previously. Furthermore, the outcome of Novant's assumptions clearly show why the assumptions are not reliable. The table below compares key statistics from Novant's application with actual utilization of AdventHealth Hendersonville, Pardee, and Mission—the three existing hospitals in Novant's proposed service area.

[18] Source: NCDHHS 2022 (2021 data) Emergency Department Patients: Patient's County of Residence table as provided by the Planning Section.

[19] Pardee calculated the population CAGR using Novant's 2020 population from Application, Form C, Step 1 and the 2029 population from Step 6.

[20] Novant calculated its ED visits using a ratio to inpatient admissions; Novant's projected total acute care admissions by county were based on population growth, with no projected increase in use rates. Thus, Pardee applied the same methodology here to project 2029 ED visits.

	NH Asheville CON PY 3	*AdventHealth Hendersonville*	*Pardee*	*Mission Hospital**
Licensed Beds	67	62	201	733
Patient Days of Care	18,680	11,096	25,130	224,049
ED Visits	52,085	22,988	24,867	98,818
Inpatient Surgical Cases	574	1,048	2,073	13,495
Outpatient Surgical Cases	524	4,962	6,248	10,800
GI Endoscopy Cases	1,645	413	1,774	5,579
MRI Total Procedures	8,966	2,544	6,430	8,245
CT	32,396	13,195	13,810	56,549
Ultrasound	16,897	6,383	7,201	23,147
Fixed X-Ray	38,039	18,926	33,795	42,247
SPECT	2,487	467	528	1,261

Source: Novant Application, 2022 North Carolina LRAs. *Hospital location only.

Despite having fewer days of care than Pardee and Mission and far fewer surgical cases than any of the three existing hospitals, Novant projects to perform:

- More MRI procedures than all three existing hospitals, including Mission—the region's tertiary facility and Pardee—a much larger hospital with an extensive scope of services such as interventional cardiac catheterization;
- More than double the CT scans of Advent and Pardee and almost 60 percent of Mission's CT volume;
- More than double the ultrasound volume of Advent and Pardee and over 70 percent of Mission's ultrasound volume;
- More than double the X-ray volume of Advent—a similarly sized hospital, more volume than Pardee, and 90 percent of the X-ray volume at Mission; and,
- Approximately five times the number of SPECT scans that Advent and Pardee provide and double the volume of Mission.

Novant does not document any unmet need that would support these excessive ancillary projections. In addition, because projected ED visits are not based on reasonable assumptions, the corresponding ancillary volumes for ED visits as calculated in Step 23 are not reasonable.

In Steps 18 through 20 of Form C, Novant fails to support the assumptions used to project C-Sections, GI endoscopy cases and lab volume. To project its C-Section cases, Novant takes all the C-Section cases *performed in Buncombe County* (at Mission)—regardless of patient origin—and applies its projected market share of inpatients *residing in Buncombe County* from Step 9 to determine projected volume. This grossly overstates its C-Section cases, as Novant assumed in Step 9 that in 2029 it would gain only five percent market share of inpatients from Madison, Yancey and Graham counties. Rather than apply the lower market share of inpatients from those

counties, it assumed that its market share of C-Sections from all counties would equate to the market share from Buncombe.

To project its GI endoscopy cases, Novant applies a market share assumption to all GI endoscopy cases performed in Buncombe County, which includes not only cases performed at hospitals but also freestanding centers. Novant's stated assumption in Step 19 is that it applied "the same percentages discussed in Step 9." That is not accurate, as shown on the table below.

	2027	*2028*	*2029*
Step 19 Percentages	5.0%	7.5%	10.0%
Step 9 Percentages:			
Buncombe	15.0%	20.0%	25.0%
Henderson	15.0%	20.0%	25.0%
Madison	3.0%	4.0%	5.0%
Yancey	3.0%	4.0%	5.0%
Graham	3.0%	4.0%	5.0%

Source: Novant Application

In addition, Pardee has not been able to replicate the "Service Area in Buncombe County" cases for 2018-2020, as included in the table in Step 19. Novant's introductory statements in Step 19 indicate a "four-county service area," but its proposed service area includes five counties: Buncombe, Henderson, Madison, Yancey and Graham. According to the 2021 patient origin report by county served,[21] the five counties in Novant's service area had 15,850 GI cases performed in Buncombe County in 2020 and the four county *SMFP*-defined service area for acute care beds had 14,282.

To project Lab test volume in Step 20, Novant cites assumptions of 3 tests per inpatient day of care and 2 tests per outpatient visit. However, it provides no basis whatsoever for these assumptions.

Based on the discussion above, Novant fails to demonstrate the need for the proposed project in accordance with Criterion 3 and fails to demonstrate that the proposed project will not unnecessarily duplicate existing services in accordance with Criterion 6. As such, the Novant application is non-conforming with Criteria 1, 3, 6 and 18a.

4. The Novant application fails to demonstrate that its financial feasibility is based on reasonable projections of costs as its start-up costs are grossly understated and it provides no basis for its initial operating expenses.

On page 97 of the application, Novant states that it calculated start-up costs for the proposed Asheville hospital by inflating the actual start-up costs for its Mint Hill hospital in the Charlotte

[21] https://info.ncdhhs.gov/dhsr/mfp/pdf/por/2021/10-Destination_GI-2021.pdf

metro region. However, Novant failed to consider in these calculations the differences in size and scale of the two hospitals. Mint Hill is a 36-bed hospital and Novant is proposing a 67-bed hospital in Asheville. Projected year one volume for Asheville is significantly higher than actual volume Mint Hill experienced in first full year it was open[22], 2019, as illustrated in the table below.

	Volume
Novant Asheville Year 1 Discharges (2027)	3,987
Novant Asheville Year 1 Days (2027)	10,974
Novant Mint Hill Discharges (2019)	2,011
Novant Mint Hill Days (2019)	6,618

Source: Novant application, Novant Mint Hill 2020 HLRA

This error impacts all the line items listed on page 97 of the application. For example, medical/surgical supply start-up costs represent less than two weeks of total medical/surgical supply costs in the first full fiscal year.

Novant did not provide any assumptions for its initial operating expense projections on page 97 of the application, but its projections for cash out-flow appear to be understated. Year 2027 expenses, excluding depreciation, total $97,464,527, or approximately $8,122,044 per month. At nine months, these expenses would total over $73 million, not the approximately $60 million Novant shows in its table on page 97.

Based on the discussion above, Novant fails to demonstrate that the financial feasibility of the proposed project is based on reasonable projections of charges and costs as required by Criterion 5. As such, the Novant application is non-conforming with Criteria 5 and 18a.

5. <u>The Novant application fails to demonstrate that its financial feasibility is based on reasonable projections of costs and charges as it understated its expenses and its utilization projections upon which its costs and charges are based on unreasonable.</u>

   In its Form F.3b Expense Assumptions, Novant states that building depreciation is depreciated annually using the straight-line method over 30 years. However, expenses for 2027 fail to include the full depreciation costs, as building depreciation is a fraction of the depreciation costs in years 2028 and 2029.

   Furthermore, given the issues with Novant's projected utilization as discussed previously, Novant's financial projections are not based upon reasonable assumptions of the costs and charges.

[22] According to Novant's Steele Creek Hospital Application, Novant Mint Hill opened on October 1, 2018.

Based on the discussion above, Novant fails to demonstrate that the financial feasibility of the proposed project is based on reasonable projections of charges and costs as required by Criterion 5. As such, the Novant application is non-conforming with Criteria 5 and 18a.

In summary, based on the issues detailed above, Novant has failed to demonstrate that the project is consistent with the review criteria implemented under N.C. GEN. STAT. § 131E-183, including the need for the proposed project and that it will not unnecessarily duplicate existing services. As such, the Novant application should be found non-conforming with Criteria 1, 3, 5, 6, and 18a, as well as the performance standards in 10A NCAC 14C .3803. The Novant application should not be approved.

ADVENTHEALTH ASHEVILLE, DEVELOP A NEW 67 ACUTE CARE BED HOSPITAL WITH ONE DEDICATED C-SECTION OR AND FIVE PROCEDURE ROOMS, NORTH CAROLINA, PROJECT ID # B-012233-22

Issue-Specific Comments

1. The Advent application fails to demonstrate need for the proposed project by failing to demonstrate that its projected market share is based on reasonably supported assumptions.

   On page 137 of the application, Advent provides assumptions regarding its projected share of the medical/surgical patients from each of the four service area counties: 20 percent by PY 3 from most of the Buncombe County ZIPs, 12 percent from Graham County, and 15 percent from both Madison and Yancey counties. Advent offers similar assumptions for obstetric services on page 146. (Note: on page 137 Advent shows different assumptions for five ZIPs in Buncombe County without explanation; for OB services, the assumptions are the same across all Buncombe County ZIPs.) Although on page 139 Advent describes the factors it considered in developing these assumptions, these assumptions are not supported by analysis of relevant data.

   AdventHealth Hendersonville has been in operation in northern Henderson County for decades and is an established provider in the region. AdventHealth's mission is "extending the healing ministry of Christ," and it is affiliated with the Seventh-day Adventist Church, which has a large community in and around Fletcher, North Carolina. AdventHealth Hendersonville is located within five miles of the Buncombe County line. AdventHealth Hendersonville serves more patients from Buncombe County than any other county outside of Henderson; almost one-third of its inpatients originate from Buncombe County.[23] Despite being a long-standing provider, located immediately adjacent to Buncombe County, and already serving Buncombe County residents, AdventHealth's share of Buncombe County inpatient discharges is currently less than 5 percent, as shown in the table below. Furthermore, its inpatient share of its home county of Henderson is less than 20 percent.

County	*AdventHealth Hendersonville FFY 2021 Market Share*
Henderson	17.4%
Buncombe	4.3%
Rutherford	1.0%
Polk	9.6%
Transylvania	4.3%

Source: HIDI

   Advent's actual experience in the region contradicts its market share assumptions. Advent proposes to develop a similarly-sized hospital with a similar scope of services, yet assumes that it will achieve 20 percent share of appropriate Buncombe County inpatients and 12 to 15 percent

[23] *See* page 25, 2022 HLRA.

share of the remaining three counties. Advent states on page 139 that these assumptions would result in it achieving 14.7 share of all inpatient discharges from these four counties.

None of those assumptions are supported by the analysis of its existing share. Advent's current share of its home county is considerably less than the 20 percent it projects the new hospital would gain from Buncombe County. Today, Advent's primary, in-county competitor is Pardee, which is larger and provides an expanded scope of services but is not the tertiary competitor Advent faces in Buncombe County. Advent's current share of other nearby counties is less than 10 percent; none are close to the 15 percent it projects for Madison and Yancey counties. The assumption for Yancey County is particularly questionable since Advent's proposed location is on the opposite side of Buncombe County from Yancey County.

Furthermore, if approved, Advent would have 8.4 percent of the acute care beds in the Buncombe/Graham/Madison/Yancey County service area. (733 currently licensed by Mission + 67 at issue in this review = 800; 67 / 800 = 8.4 percent.) However, Advent projects that it will have 14.7 percent market share of all discharges from the service area, almost double its share of beds.

Despite a similarly-sized hospital offering a similar scope of services, Advent projects that by 2027 (year 3 of the new hospital) it will serve more patients than it does at its well-established hospital in Henderson County. According to Advent's 2022 HLRA, it served 3,008 inpatients and provided 11,096 acute days of care in FFY 2021.[24] In contrast, Advent projects to serve 4,899 patients at the new hospital in 2027, with a corresponding 18,287 days of care. While the population of Buncombe County as a whole is larger than Henderson County, it is interesting to note that the 2022 population of the ZIP code in which Advent currently operates in Henderson County (28792) is larger than the ZIP code in which the new hospital is proposed to be developed (28715)—37,204 versus 28,136,[25] respectively.

In addition, on page 53 of the application, Advent states that ZIP codes 28806, 28715, and 28803 represent the areas with the highest volume of discharges in the service area. As shown in the table below, the distance between these three ZIP codes and the existing AdventHealth Hendersonville hospital is roughly 20 miles or less. As noted, Advent's current share of these ZIPs is less than 5 percent, despite the availability of more than half of its licensed acute care beds on any given day.[26] While the closer proximity of the proposed hospital might encourage some additional market share within these ZIPs, Advent's experience in its home county suggests that 20 percent is not reasonable, as discussed previously. Moreover, the distance of the other three service area counties to the new hospital is significantly longer than the distance of the three Buncombe ZIPs to the existing Advent facility. For example, Burnsville is 42 miles from the proposed hospital, roughly double or more the distance of the three Buncombe ZIPs today from AdventHealth Hendersonville. Nonetheless, Advent has assumed that projected market share for

[24] Pardee also reviewed pre-COVID volumes for AdventHealth Hendersonville. According to its 2020 HLRA, Advent provided 11,398 acute days of care to 3,290 discharges.

[25] ESRI.

[26] Advent's 2022 HLRA lists 11,096 acute days of care / 365 = 30.4 ADC, compared with 62 licensed acute care beds.

the new hospital from Yancey County ZIP codes will more than triple its existing facility's share of ZIP codes that are far closer than the Yancey County ZIP codes will be.

ZIP Code	*AdventHealth Hendersonville FFY 21 Share of Discharges*	*Distance to AdventHealth Hendersonville*	*Distance to Proposed Hospital in Candler*	*Proposed Medical/Surgical Share in 2027*
28806* South (NC Arboretum) North (Clyde Erwin HS)	3.0%	13 miles 22 miles	6 miles 9 miles	20%
28715 (Candler)	4.1%	20 miles	3 miles	20%
28803 (Biltmore Forest)	4.2%	12 miles	10 miles	20%
28714 (Burnsville, Yancey)	1.7%	53 miles	42 miles	15%
28753 (Marshall Madison)	2.3%	38 miles	26 miles	15%
28771 (Tapoco, Graham)	0.6%	108 miles	91 miles	12%

*ZIP 28806 is elongated north and south, thus a measurement was taken from both northern and southern areas of the ZIP code.

Based on the discussion above, Advent fails to demonstrate the need for the proposed project in accordance with Criterion 3, fails to meet performance standards in 10A NCAC 14C .3803, and fails to demonstrate that the proposed project will not unnecessarily duplicate existing services in accordance with Criterion 6. As such, the Advent application is non-conforming with Criteria 1, 3, and 18a.

2. The Advent application fails to demonstrate need for the proposed project as some ancillary utilization is overstated.

   On page 155 of the application, Advent calculates the ratio of various ancillary services to discharges at AdventHealth Hendersonville and then applies those ratios to projected medical/surgical discharges at the proposed new hospital. The projected volume for at least three services was miscalculated and is overstated: PT, OT and interventional radiology. For example, in 2027, the correct volume should be as follows: 532 interventional radiology procedures (0.124 x 4,282); 12,877 physical therapy units (3.007 x 4,282); and, 7,894 occupational therapy units (1.843 x 4,282).

   Based on the discussion above, Advent fails to demonstrate the need for the proposed project in accordance with Criterion 3. As such, the Advent application is non-conforming with Criteria 1, 3, and 18a.

3. The Advent application fails to demonstrate that its financial feasibility is based on reasonable projections of costs and charges.

   On page 172 of the application, Advent indicates that gross revenue is based on an inflation factor of 1 percent per year, applied to per patient volume gross revenue. That assumption appears

correct for all service components except for inpatient services. Using patient days as the inpatient volume statistic, the increase in gross revenue per patient day is 1.53 percent, not 1 percent. While seemingly inconsequential, if the assumption of 1 percent inflation was applied correctly, net revenue would be reduced by about $700,000 in 2027[27]. On a per discharge basis, the actual gross revenue inflation is 2 percent, not the 1 percent stated in the assumptions.

Salary expense in Form H is unreasonable. Annual salary inflation factors vary by position, ranging from -8.9 percent to as high as 17.4 percent. The "negative" inflation factors are particularly troubling as that suggests that salaries for certain positions are expected to decline in future years. For example, Lab Tech salaries are expected to decline from $61,760 in 2025 to $61,654 in 2026 and again to $61,570 in 2027. Similarly, Maintenance/Engineering salaries are expected to decline from $74,924 in 2025 to $68,395 in 2026 and then to $65,798 in 2027. Overall salaries increase by an average of 1.75 percent per year, considerably less than the inflation factor assumed for most other expenses. If salaries were uniformly inflated at 2.5 percent, expenses in 2027 would increase by more than $500,000.

Expense assumptions are inconsistent with the expense line items included in Form F.3b. For example, Advent fails to provide any assumptions for the following line items: independent contractors, travel reimbursement, dietary, housekeeping/laundry, transportation, equipment maintenance, building and grounds maintenance, marketing / PR, Medicaid assessment fee, and central office overhead, or depreciation. Advent also has assumptions for line items that are not included in Form F.3b. A notable example is the assumption for Purchased Services, which is stated to include outsourced physical therapy, outsourced lab testing, and outsourced billing services. Particularly concerning is that no other line item is noted as having included these services, including those that are critical to patient care such as outsourced therapy and lab testing. A third form of inconsistency is the same item listed in a particular assumption and also as its own expense for a different line item. An example is the two specific line items for Equipment Maintenance and Building & Grounds Maintenance. While there is no assumption provided for those line items, the "Purchased Services" assumption indicates that line item—which does not exist on Form F.3b—include these expenses. Similarly, Marketing/Public Relations is included as a separate line item on Form F.3b but is also listed as part of the "Other Professional Fees" assumption.

In addition, inflation factors as stated in the assumptions did not align for many other expense line items beyond salaries. Pardee analyzed multiple methods for calculating costs, such as per volume, as a percent of gross revenue, as a percent of net revenue, as a fixed cost, or as a percent of salary. None of these methods explains the variation in line item expenses from year to year. Just one example is Professional Fees from the Form F.3b for OP Emergency Department (page 165 of the application). As shown in the table below, the variation in Professional Fees expense does not appear to have any reasonable explanation.

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[27] Gross charge per patient day in 2025 is calculated at $9,187, at $9,328 in 2026, and at $9,470 in 2027, an increase of 1.53% each year. At only 1% inflation, the gross charge per patient day would be $9,279 in 2026 and $9,372 in 2027. At 18,287 patient days, the difference in gross revenue in 2027 is $1,792,126. Applying Advent's % of net revenue to gross charges, 38.78%, results in a net income difference of $694,986.

	2025	2026	2027
Professional Fees (Form F.3b)	$1,225,124	$1,086,947	$1,167,634
ED Visits (Form C.4b)	4,808	8,287	12,706
Fixed Cost (Annual Change)	N/A	-11.28%	7.42%
Per ED Visit	$254.81	$131.16	$91.90
As a Percent of Total Gross Revenue	7.59%	3.87%	2.68%
As a Percent of Total Net Revenue	28.72%	14.64%	10.16%
As a Percent of Salary Expense	54.94%	36.39%	30.40%

Source: Advent Application

If Professional Fees were calculated as a fixed cost, the expense goes down dramatically in 2026 and then back up in 2027 but still below the expense total in 2025. On per volume (ED visit) basis, the expense declines year over year. Similarly, on a percent of gross charges, net revenue or salaries basis, the factor declines each year. In contrast, the assumption for professional fees on page 173 of the application indicates that the expense is inflated by 2.5 percent per year. The information shown in the table above clearly contradicts that assumption. The ED Professional Fees is just one example of many in Advent's Forms F.3b. These significant inconsistencies that do not appear to have any rational basis indicate the unreasonable basis of Advent's projected costs.

Based on the discussion above, Advent fails to demonstrate that the financial feasibility of the proposed project is based on reasonable projections of charges and costs as required by Criterion 5. As such, the Advent application is non-conforming with Criteria 5 and 18a.

In summary, based on the issues detailed above, Advent has failed to demonstrate that the project is consistent with the review criteria implemented under N.C. GEN. STAT. § 131E-183, including the need for the proposed project and that its financial feasibility is based on reasonable projections of costs and charges. As such, the Advent application should be found non-conforming with Criteria 1, 3, 5, 6, and 18a, as well as the performance standards in 10A NCAC 14C .3803. The Advent application should not be approved.

ATTACHMENT 1

Calculation of SMFP Methodology Without COVID Adjustment

	Per 2022 SMFP	Growth Rate Multiplier	Excluding COVID Adjustments	Growth Rate Multiplier
2018 SMFP	188,214		188,214	
2019 SMFP	189,146	1.0050	189,146	1.0050
2020 SMFP	193,482	1.0229	193,482	1.0229
2021 SMFP	195,732	1.0116	195,732	1.0116
2022 SMFP	207,208	1.0586	200,068	1.0222
Multiplier for 2022 SMFP	1.0245		1.0154	
2024 Projected Days	228,303		212,692	
2024 Projected ADC	625		582	
Adjusted Target (78%)	800		745	
Licensed Beds	733		733	
Need	67		12	*Rounds to 0*

ATTACHMENT 2

COUNTY	FFY 2021	
	DISCHARGES	PATIENT DAYS
BUNCOMBE	19,854	98,524
MADISON	1,840	8,913
YANCEY	1,201	6,326
GRAHAM	299	1,955
ACUTE CARE BED SERVICE AREA TOTAL	**23,194**	**115,718**
HENDERSON	3,129	17,156
HAYWOOD	2,951	15,463
MCDOWELL	2,216	12,821
MACON	1,683	9,712
TRANSYLVANIA	1,383	7,267
JACKSON	1,282	7,746
SWAIN	863	5,410
RUTHERFORD	839	5,004
MITCHELL	718	4,295
BURKE	502	3,278
CHEROKEE	422	2,524
POLK	352	1,868
CALDWELL	223	1,440
AVERY	238	1,217
CLAY	117	709
GRAND TOTAL MISSION SELF-DEFINED 19-COUNTY SERVICE AREA	**40,112**	**211,628**

Sources: Service area as defined by Mission in its application, page 58. Data from Hospital Industry Data Institute (HIDI).

ATTACHMENT 3

Calculation of Mission's Increase in Net Revenue, Excluding Volume Increase

	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026
Charge per Adjusted Patient Day	$ 12,156.74	$ 13,129.28	$ 14,179.62	$ 15,313.99	$ 16,539.11	$ 17,862.24
Total Patient Services Gross Revenue	$ 4,516,354,266	$ 4,921,347,401	$ 5,366,164,558	$ 5,851,741,302	$ 6,381,876,656	$ 6,960,731,064
Calculated Adjusted Patient Days	371,510	374,838	378,442	382,117	385,866	389,690
Total Net Revenue	$ 1,108,399,283	$ 1,167,439,102	$ 1,229,010,967	$ 1,292,363,342	$ 1,357,316,247	$ 1,423,641,166
Total Net Revenue per Adjusted Patient Day	$ 2,983.50	$ 3,114.52	$ 3,247.55	$ 3,382.11	$ 3,517.59	$ 3,653.27
Projected Increase in Net Revenue, Excluding Volume Increases		4.4%	4.3%	4.1%	4.0%	3.9%

	CY 2027	CY 2028	CY 2029	
Charge per Adjusted Patient Day	$ 19,291.22	$ 20,834.52	$ 22,501.28	*Source: Application, p 177 and 179*
Total Patient Services Gross Revenue	$ 7,592,861,587	$ 8,283,260,641	$ 9,037,398,606	*Source: Application, p 176 and 178*
Calculated Adjusted Patient Days	393,592	397,574	401,639	*Calculated: Gross Revenue/Charge per Adjusted Patient Day*
Total Net Revenue	$ 1,491,053,419	$ 1,559,203,507	$ 1,627,667,289	*Source: Application, p 176 and 178*
Total Net Revenue per Adjusted Patient Day	$ 3,788.33	$ 3,921.80	$ 4,052.56	*Calculated: Total Net Revenue/Adjusted Patient Days*
Projected Increase in Net Revenue, Excluding Volume Increases	3.7%	3.5%	3.3%	*Calculated: Year over Year Increase in Total Net Revenue per Adjusted Patient Day*
			3.9%	*Calculated: Average of Year over Year Increase*