Comments in Opposition to
Well Care Hospice of Cumberland, Inc.
CON Application for a New Hospice Home Care Agency in Cumberland County
Project ID #M-012594-25
Opposition on Behalf of VITAS Healthcare of North Carolina

Introduction:

Co-applicants VITAS Healthcare of North Carolina and VITAS Healthcare Corporation (collectively "VITAS") have filed Project #ID M-12592-25 to develop a new hospice home care office or agency in Cumberland County. VITAS is filing these comments in opposition to Well Care Hospice of Cumberland, Inc. ("Well Care"). Based on its application, Well Care is an existing, privately-owned, for-profit hospice provider based in Raleigh, N.C. While Well Care has a large regional home health presence in North and South Carolina, it only operates one hospice home care agency in Davie County, serving just five counties around the Winston Salem area. Throughout its application, it is difficult to discern when Well Care is discussing its overall operations and experience, including de novo projects, for its large home health agency and when it is focused on just its small hospice agency. It is also not clear in its application whether the required hospice services are proposed to be offered through the proposed hospice agency or through its existing home health agency. As will be discussed below, Well Care does not demonstrate a need for its project, nor does it meet the needs of the service area patients. Most notably:

- Well Care has not identified the needs of its projected service area population and has not identified underserved population groups in the service area with sufficient specificity to address their needs.
- Well Care has significant flaws in its utilization projections that lead to an overstatement of patient days, which raises concerns regarding the financial feasibility of its project.
- Well Care has not budgeted sufficiently for its capital costs, start-up costs, and working capital to demonstrate that it has the resources needed to establish a new hospice home care office.
- Well Care's projected payor mix and revenue by payor is flawed; it unreasonably assumes the same ALOS by payor and did not consider three of its four projected service area counties when projecting its payor mix.
- Well Care has understated its staffing needs, particularly its cost for contract services, which have not been reasonably budgeted. As a result, Well Care has not sufficiently demonstrated that it will provide all required ancillary and support services.
- Overall, Well Care has overstated its patient days and revenues, and understated its expense to open and operate a new hospice office by projecting an unreasonable level of net income for its project.

For these reasons, as detailed below, Well Care should be found non-conforming with Criteria (1), (3), (5), (6), (7), (8), (12), (13), and (18a).

Criterion (1): Well Care is Non-Conforming with Policy GEN-5

The 2025 SMFP contains a new general policy, GEN-5, which focuses on having applicants demonstrate how that provider will provide culturally competent healthcare. This Policy requires a certificate of need applicant to identify the underserved populations and communities it will serve, including any disparities or unmet needs , document its strategies to provide culturally competent programs and services, and articulate how these strategies will reduce existing disparities as well as increase health equity.

The SHCC identifies five specific items that each applicant is required to address. See pages 30-31, 2025 SMFP.As an existing provider, Well Care should have the ability to respond to each item in Policy GEN-5 with specificity and documentation of its historical track record. Well Care fails to do so as shown below.

Part (a) of the application asks the applicant to describe the demographics of the service area identifying medically underserved communities. In response, Well Care provides a simple table with data from the US Census Bureau for its four-county service area, which includes Cumberland, Harnett, Johnston, and Sampson Counties (page 27 of its application). No actual discussion is provided regarding these statistics that might identify medically underserved communities within the service area.

In Part (b) of the application, the applicant is asked to address strategies that it will implement to provide culturally competent care to the medically underserved communities described in Part (a) above. Because Well Care didn't identify any underserved communities, it could not address strategies specific to such populations. Well Care provides a generic summary list of strategies without linking any of these strategies to any community or underserved group within the service area. See pages 27-28 of the Well Care Application.

Part (c) of the application asks the applicant how the strategies in Part (b) reflect cultural competence. In response, Well Care again provides a generic list of core elements of cultural competence. Again, no specificity is provided to explain how these strategies may relate to underserved groups within the service area. Given that Well Care is an existing provider of hospice and home health in North Carolina, it has data on its existing operations to demonstrate how its strategies have impacted operations within its existing service areas. See pages 28-29 of the Well Care Application.

Well Care's 2024 LRA data for its existing hospice agency does not support any claim to high levels of cultural competence and access to underserved populations. Well Care reported serving just two non-white patients and two Hispanic patients in FY 2023. Further, Well Care did not serve any pediatric patients in FY 2023 with no patients under the age of 25 reported.

Part (d) of the application asks the applicant to provide support that the strategies in Part (b) and Part (c) are reasonable pathways for reducing health disparities, increasing heath equity, and improving health outcomes. In response, Well Care simply references it policy and one national study focused on outreach to Black/African American patients without linking this to any of the strategies described in Part (b) and Part (c) or to the service area. See page 29 of the Well Care Application.

Part (e) of the application asks the applicant to describe how it will measure and assess equitable access to healthcare services and reduce health disparities in underserved communities. Well Care does not identify any measures it will use to evaluate whether equitable access has been provided. Since Well Care does not identify any underserved communities, it is not possible for them to measure access to care for these communities.

Well Care has not reasonably responded to Policy GEN-5 and therefore should be found non-conforming with this policy and with Criterion (1).

Criterion (3): Well Care is Non-conforming with Criterion (3)

Scope of the Project

On page 30 of its application, Well Care provides a generic overview of services and a list of requirements that all hospice providers must meet. On page 31, Well Care describes its history, but the discussion of its large home health presence is co-mingled with discussion of hospice services, making its hospice experience unclear. Well Care has one licensed home hospice office located in Davie County.

On page 35, Well Care touts its experience with de novo branches or expansion, but these appear to only include home health agencies. It appears Well Care has not initiated a new hospice home care office in the areas it is discussing.

On page 36, Well Care lists its service capabilities and offerings. Notably, for hospice care, it does not include hospice aides, therapies, dietician services, or pharmacy services. Therapies are only listed under home health. It is unclear whether Well Care provides a full range of hospice services. See later discussion of lack of sufficient related expenses.

On page 39, Well Care describes continuous care as only being provided for brief periods of time during crisis. Notably, its 2024 LRA shows that Well Care did not report any continuous care days in 2023.

Starting on page 40 of its application, Well Care discusses its outreach efforts to minority populations, specifically noting African American populations. Well Care does not acknowledge other racial and ethnic groups, such as Hispanic/Latino populations, which represent a larger percentage in its proposed service area than the statewide average. As noted in Criterion (1), Well Care's LRA data indicates that it does not have a demonstrated track record of serving racial or ethnic minorities.

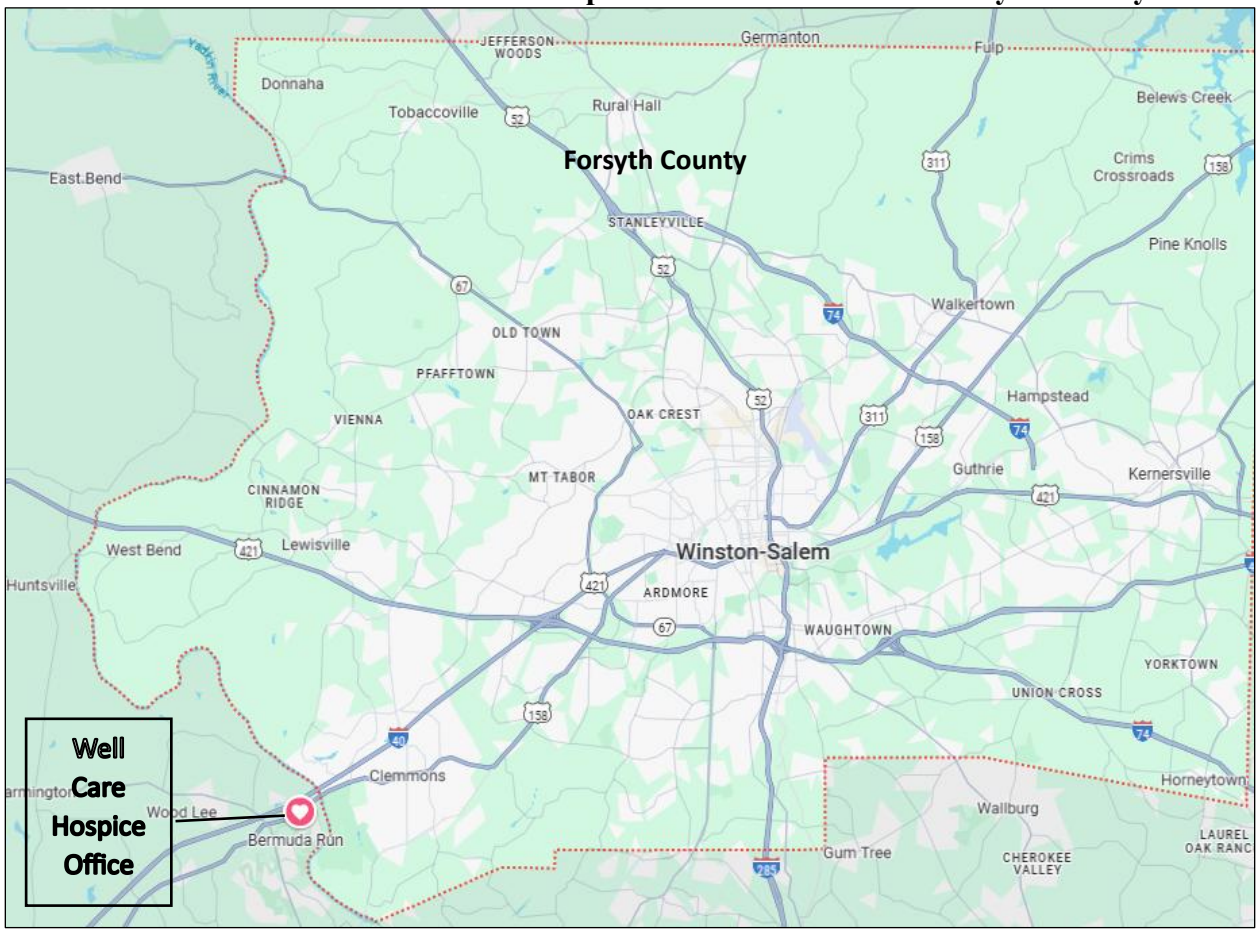
Population to be Served

On pages 43-44 of its application, Well Care presents its county patient origin to include Cumberland, Johnston, Harnett, and Sampson Counties. Notably, only 38.8% of patients will come from Cumberland County. That means that over 60% of patients projected come from other service area counties in Year 3. On page 46, Well Care identifies that the 2025 SMFP projects a patient deficit for Cumberland, Harnett, Johnston, and Sampson Counties. While Johnston County

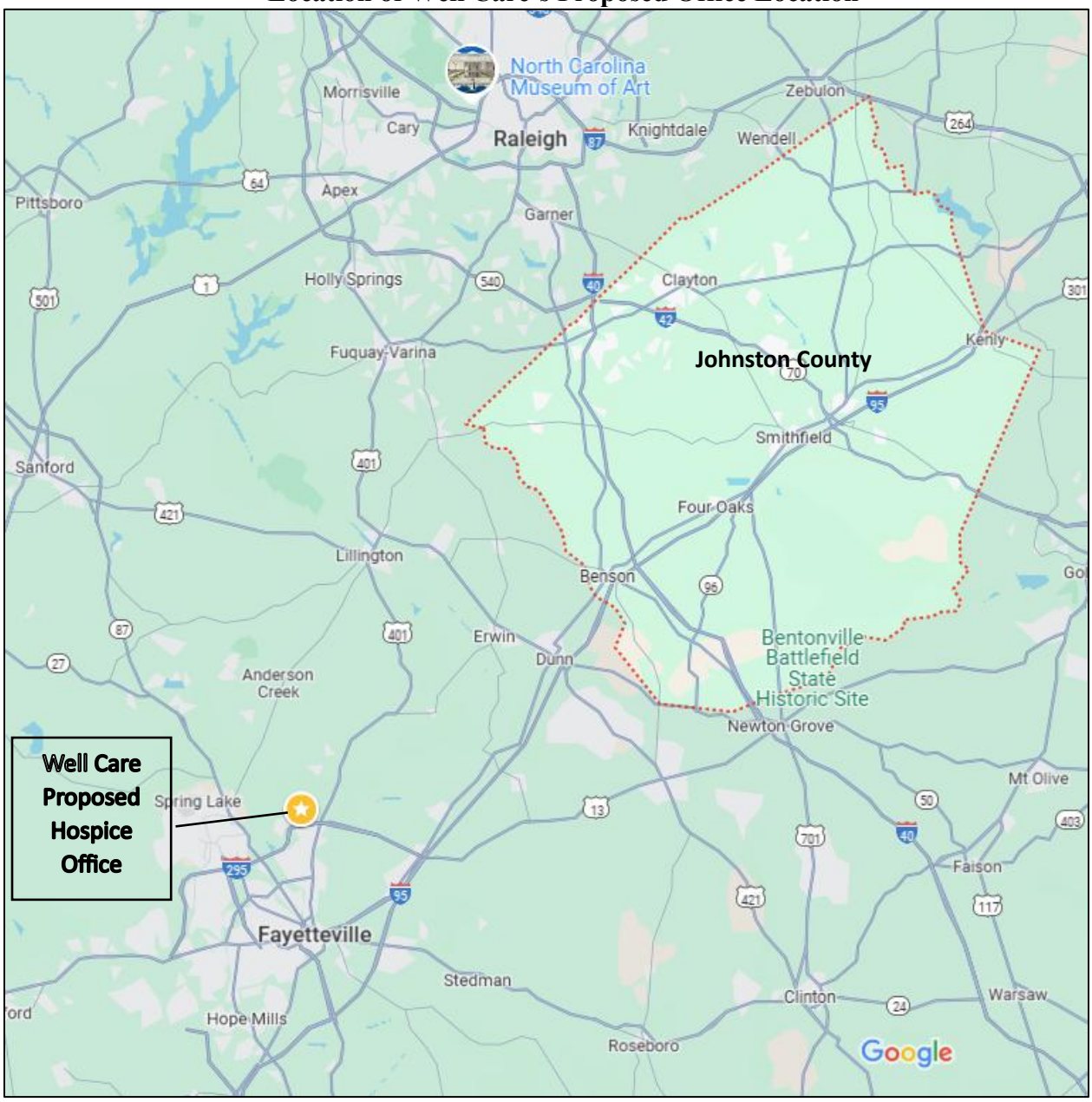
has a large patient deficit, it is not contiguous to Cumberland County. Well Care does not explain how it will reasonably serve Johnston County from Fayetteville nor how it will capture 22.4% of its patients in Year 3 from this distant county. It does not appear that Well Care has any letters of support from Harnett, Johnston, or Sampson Counties to support the reasonability of projecting such large patient volumes from each county. The vast majority of letters are form letters from duplicative organizations heavily focused on Cape Fear Valley Medical Center, which already has its own hospice organization.

Well Care claims it successfully serves Davidson, Forsyth, Stokes and Yadkin Counties from Davie County; however, there are several differences with this proposed service area. First, Well Care's main office is located in Davie County but right on the very edge of Forsyth County as shown below. Well Care's proposed Cumberland County office location is central to Fayetteville and quite distant from Johnston County. The following two maps reflect the respective locations of Well Care's existing and proposed office locations.

Location of Well Care's Hospice Office in Relation to Forsyth County



Location of Well Care's Proposed Office Location



Second, Well Care's existing hospice service area is anchored by the major tertiary health systems in Winston-Salem which provide the majority of referrals for hospice services. Residents of all four existing service area counties rely heavily on Winston Salem (Forsyth County) providers.[1] By contrast, Johnston County residents rely on Johnston County hospitals and Wake County tertiary health systems for their acute care services and not Fayetteville (Cumberland County) providers. In fact, the Agency's 2024 patient origin report did not show any Johnston County residents served at Cumberland County acute care hospitals. This is not a referral pattern that will

[1] Based on the Agency's 2024 patient origin report 76.2% of Davie,38.9% of Davidson, 87.4% of Stokes, and 76.8% of Yadkin County residents rely on Forsyth County providers for their acute care services.

result in any meaningful number of Johnston County patients using a hospice provider based in Fayetteville.

While Well Care might reasonably serve some patients from Johnston County, it is unreasonable to project that over 22%, almost a quarter of its patient volume, would be served in distant Johnston County.

Needs of the Service Area Population

Starting on page 50 of its application, Well Care presents information on death rates for each service area county and comparative death rates by race. Well Care also presents data on the percentage of population by minority groups. While this data highlights higher death rates for minority populations, it does not identify whether patients in various racial groups are getting hospice care from existing hospice providers. This data alone does not meaningfully identify any underserved group.

Similarly, Well Care presents hospice penetration rates and hospice days of care per 1,000 population on pages 52-55. Again, these rates and days of care do little more than reaffirm the SMFP need calculation, which already indicates that service area patients are not receiving hospice care at the expected rates. Well Care does not consider the trends among existing hospice providers or identify any specific patient groups that are not receiving hospice care.

Several of these data points call into question the inclusion of Sampson County in Well Care's proposed service area. First, Sampson County has historically had higher hospice days of care per 1,000 population than the state overall – 28% higher, as noted on page 55 of the Well Care application. Second, Sampson County has a very low population growth rate. See pages 56-57 of Well Care's application.

On page 57, Well Care presents a map of socioeconomic tiers. This map identifies Johnston County among Tier 3 - one of the 20 least distressed counties in the state. Well Care projects to capture 22.2% of its patients from this county. Similarly, Harnett County falls into Tier 2 of the less distressed counties. Well Care projects that 24.4% of its patients will come from Harnett County. See page 44 of its application.

Starting on page 58, Well Care tries to link Cumberland County's low hospice penetration rates to minority and ethnic populations. On page 60, Well Care presents data on the racial and ethnic composition of patients served by each licensed hospice office in Cumberland County. No analysis is performed for the other service area counties, and no consideration is made of the fact that other providers not licensed in Cumberland County serve Cumberland County patients. Nonetheless, Well Care suggests this data identifies underserved African American and Hispanic populations.

Well Care does not consider its own experience in serving these minority population groups. As reported on its 2024 LRA (FY 2023 data), two African American patients composed 3.4% of Well Care's 58 total admissions. Similarly, Well Care served just two Hispanic patients out of 58 total patients, again 3.4%. Well Care's actual track record of serving minority populations is far less

than the experience of the existing providers licensed in Cumberland County. It is unclear whether Well Care has relevant experience that would allow it to meet the diverse needs of the service area it proposes to serve.

To address access to minority populations, Well Care cites the National Hospice and Palliative Care Organization's strategies for outreach to African Americans. See pages 61-62. No specifics are provided about what Well Care specifically does now or will do to address this community in its proposed service area, likely because Well Care has little experience in serving African American patients.

Overall, while Well Care provided a variety of data and statistics, it did not meaningfully identify underserved populations within its proposed service area and how it would address these populations to increase hospice utilization and access in the service area. Well Care did not identify the needs of the population it proposes to serve.

Letters of Support

Well Care provides a number of letters of support, many of which are from the same organization. Volumes of letters from the same entity do not magnify the support for the project. It appears that all of the letters are from an organization within Cumberland County and/or Fayetteville, despite Well Care projecting that more than 60% of its patients will come from outside of Cumberland County. The inclusion of Johnston County in the service area is particularly questionable, given the lack of any support and the significant distance from Fayetteville to Johnston County.

Access

On page 71, Well Care projects that 50.8% of patients will be racial and ethnic minorities. This projection does not align with the demographic distribution of the full-service area including Harnett, Johnston, and Sampson County. For example, over 75% of Johnston County is White and over 70% of Harnett County is White. See the Well Care Application page 27. This projection also does not reflect Well Care's actual experience from its LRA data as noted above. Presuming that the two Hispanic patients Well Care served in 2023 are not also Black, at most, Well Care provided 7% of its care to minority populations in 2023.

Projection Methodology

<u>Overall Reasonability of Well Care's Projected Utilization</u>

Well Care's overall reasonability of its projected utilization is called into question by its existing operations. On page 31 of its application, Well Care describes its existing service area as Davie, Davidson, Forsyth, Stokes, and Yadkin Counties, an area with an estimated population of 675,996.[2] As reported on its 2024 LRA, Well Care admitted just 58 patients during FY 2023. For the proposed service area, roughly the same population base it currently serves from Davie County, Well Care projects 312 admissions in the third year of operation, for an estimated population of

[2] US Census Bureau, American Community Survey

780,923.[3] It is unreasonable that Well Care would admit five times more patients at the new proposed hospice office than it admitted last year at its existing agency.

Unserved Hospice Deaths

Well Care very simplistically projects unserved hospice deaths starting with the 2025 SMFP and grows the deficit of hospice death for 2026 from the plan to FY 2028 and FY 2029, based on increases in death rates. This overly simplistic methodology assumes all factors that result in hospice utilization will change at the exact same rate as the death rate, which is unreasonable.

This methodology also assumes that hospice deaths served by existing providers are also growing at the same rate as the death rate. However, Well Care's Table Q.2 refutes this assumption. In reality, hospice deaths in Cumberland and Harnett Counties are growing at a faster rate than the overall death rate, while hospice deaths in Johnston and Sampson Counties are declining. See pages 126-127.

Table Q.2 highlights the actual growth trends, which differ significantly from Well Care's projections. The impact of these trends on Well Care's methodology is as follows:

- Because hospice deaths are growing faster than the death rate for Cumberland and Harnett Counties, unserved hospice deaths will decline rather than grow.
- Because hospice deaths are declining in Johnston and Sampson Counties, unserved hospice deaths will increase faster than death rates.

Well Care's methodology assumes that death rates and hospice deaths are equal but provides historical data in Table Q.2 which refutes this assumption; this indicates that its projected unserved hospice deaths are not reasonably calculated.

Well Care's Capture of Unserved Hospice Deaths

In Step 2 (pages 127-128), Well Care projects the percentage of unserved hospice deaths it expects to serve. In Project Year 3, Well Care projects to serve 100% of all unserved hospice deaths in all service area counties except Johnston County, resulting in projected hospice deaths reaching 284. This level is unreasonable given Well Care's actual experience in its existing service area. In FY 2023, Well Care only reported 40 hospice deaths for its existing agency on its 2024 LRA. This patient total represents a five-county service area with a total population base similar to the proposed service area. Well Care's projected capture of unserved hospice deaths is not reasonable given this experience and is not supported by any other data or assumptions.

Hospice Admissions, Discharges, and Carry Over Patients

Well Care does not provide any assumptions for its calculation of the total number of patients served in Years 2 and 3; therefore, it is unclear how the patients served figures are derived. However, there is a clear disconnect between the patients served figures with the admissions and discharges included in Form C.6. Overall, the admissions, patients served, and discharges in Form C.6 are inconsistent and do not align, rendering this data problematic and unreliable.

[3] Well Care Application page 27

In Year 1, Well Care projected 129 admissions and 135 total discharges as shown below. This means Well Care projected six more discharges than patients it admitted (or served). It is not possible to have more discharges than admissions in the first year. Additionally, discharges should be less than admissions as some patients admitted toward the end of the first year will carry over to Year 2. Based on the number of patients discharged in each project year, the projected number of carryover patients cannot be accurate as shown in the table below.

	1st Full FY F: 10/1/2027 T: 9/30/2027	2nd Full FY F: 10/1/2028 T: 9/30/2028	3rd Full FY F: 10/1/2029 T: 9/30/2029
# of New (Unduplicated) Admissions	129	191	312
# of Patients Served	129	246	403
Calculated Carry Over Patients from Prior Year	-	***55***	***91***
# of Deaths	117	174	285
# of Non-Death Discharges	18	26	43
Total Discharges	***135***	***200***	***328***
Patients Remaining for Carry-over (Patients Served less Discharges)	***-6***	***46***	***75***
Understated Admissions (stated carryover - calculated carry over patients)	***61***	***45***	

Represents the flow of carryover patients from year to year.

Well Care has understated its admissions in each year by not only projecting fewer admissions than discharges but also by failing to consider the admissions in each year that would carry over to the next year. For example, for a carryover of 55 patients in Year 2, Well Care would have had to admit 61 more patients for a total of 190 admissions (190 admissions less 135 discharges = 55 carryover patients). Likewise for Year 3, in order for Well Care to have 91 carryover patients, it would have to admit 45 more patients in Year 2 (291 patients served less 200 discharges = 91 carryover patients).

Average Length of Stay and Patient Days

Not only is Well Care's patient days projection flawed in its consideration of carryover patients, but it is also unreasonable based on its own experience. Well Care projects an ALOS of 93.5 days for all patients admitted in each year. By contrast, Well Care's own experience shows an ALOS of just 71.9 days as reported on its 2024 LRA. This further discredits Well Care's projected patient days and suggests that Well Care's patient day projection is overstated even more than identified above.

Moreover, Well Care's patient days are also overstated because the projected ALOS is applied to unduplicated admissions in each year, without consideration of the days that would carry over from patients admitted in the previous year or the days for each year's admissions that carry over

to the subsequent year. **Attachment A** provides a monthly calculation of admissions and patient days, assuming that admissions for each year are distributed evenly across the months and Well Care's 93.6-day ALOS is applied to patients served in each month.[4] Based on **Attachment A** and Well Care's stated patient days, the overstatement of days is summarized below:

Well Care Overstated Patient Days Served

	FY 2027	FY 2028	FY 2029
Well Care Projected Patient Days	12,027	17,961	29,384
Actual Patient Days with Carryover	10,539	17,140	27,763
Overstated Patient Days	1,488	821	1,621
% Overstatement	12.4%	4.6%	5.5%

Patient Days by Level of Care

Well Care is proposing a hospice program that is essentially limited to routine home care. The small amount of intensive care services (general inpatient and continuous care) restricts patient access to essential services that are required under Medicare's Conditions of Participation. This lack of comprehensive care could hinder patients from receiving the full range of hospice services necessary to meet their needs.

Percent of Days of Care by Level of Care

	1st Full FY	2nd Full FY	3rd Full FY
# Routine Home Care Days	99.74%	99.74%	99.75%
# Inpatient Care Days	0.17%	0.17%	0.17%
# Respite Care Days	0.06%	0.06%	0.06%
# CC Days	0.03%	0.02%	0.01%
Total Days	100.00%	100.00%	100.00%

Source: Form C.6

Summary of Need for the Project

Well Care fails to identify a reasonable service area, particularly by including Johnston County. Well Care also fails to justify how it will serve over 60% of its patients from outside of Cumberland County, including 22.4% from Johnston County. Well Care has not identified any specific underserved groups nor demonstrated that it has the experience to serve any such group based on its actual historical experience. Well Care's projected utilization has numerous flaws that lead to a significant overstatement of days of care, among other issues.

For all of these reasons, Well Care should be found non-conforming with Criterion (3).

[4] This analysis reflects the actual carry over of patients based on the ALOS and does not consider the discharges during each year presented in Form C.6. If Well Care's assumed discharges were considered there would be even fewer days of care.

Criterion (5) Financial Feasibility

Projected Utilization/Financial Feasibility

As discussed in Criterion (3), Well Care has a number of flaws in the assumptions and calculations of its utilization projections including overstated patient days. These errors result in overstated revenue which render Well Care's financial projections flawed and unreasonable.

Capital Cost

Well Care's projected capital costs are insufficient to develop a new hospice home care office. When the CON consulting fees of $50,000 are removed, Well Care projects $35,000 in total capital costs. It is unclear how $35,000 is sufficient to include office furnishings, IT and telecom needs, and potential minor renovations to the proposed office space. The assumptions for Form F.1a are minimal and solely rely on Well Care's experience. Thus, it is impossible to determine what Well Care has included in its minimal $35,000 project direct capital costs.

Working Capital

Startup Costs

Well Care projects its startup costs to be just $75,000, which represents two weeks of pre-opening staff training and other preparation. See pages 82-83. The assumption of two weeks to start a new hospice agency is unreasonable. Preparing and equipping the office, recruiting and training staff, advertising and marketing will certainly take more than two weeks. For example, Well Care would need to occupy the space before installing furniture and equipment. Thus, rent expense would need to start before installing equipment. This assumption is significantly understated and demonstrates Well Care's lack of experience in entering a new market and establishing a new hospice office.

Initial Operating Costs

According to page 83, Well Care's initial operating costs are based on 14 months of operation and round to an exact $1 million. This amount is understated for a number of reasons. First, as noted above, Well Care's patient days, on which hospice services are reimbursed, are significantly overstated. Correcting the number of days of care would reduce revenue and extend the initial operating period beyond 14 months. Second, Well Care has significantly understated its expenses, as discussed in detail below. With these two flaws, the initial operating period will be significantly extended, resulting in a higher initial operating cost.

Revenue and Payor Mix

Gross and net revenue are both overstated due to the overstatement of patient days as described above. Moreover, Well Care's revenue projections are unreasonable because it relies on the erroneous assumption that the ALOS and distribution of patient days by level of care are the same

for all payors. Hospice services are reimbursed on the basis of days of care, not patient admission. Also, Hospice patients covered by varying payors do not have the same ALOS. Therefore, the payor mix of patients served and days of care are different. This can be demonstrated by Well Care's actual experience reported on its 2024 LRA as shown below:

Well Care Existing License Payor Mix - FY 2023

	Patients Served	Days of Care	ALOS
Hospice Medicaid	1.5%	1.6%	76.67
Hospice Medicare	97.9%	96.3%	70.73
Other	0.5%	2.0%	282.00
Private Insurance	0.0%	0.0%	0.00
Self Pay	0.0%	0.0%	0.00
Total	0.0%	0.0%	0.00
Grand Total	**100.0%**	**100.0%**	71.91

Source: 2024 LRA database

Despite these variances, Well Care projects the same percentage payor mix for patients (Section L – page 107) and revenue based on admissions and not days of care (Form F.2b, page 133).

Moreover, Well Care significantly overstates its projected Medicaid and Self Pay percentages. Based on its 2024 LRA, Well Care provided just 1.5% Medicaid, and 0% Self Pay. Well Care's payor mix projection for the proposed project which estimates 7% Medicaid and 2% Self Pay in the proposed service area is unsupported by its historical payor mix as shown above.

Operating Costs

Well Care appears to understate its operating costs on Form F.3b. In its assumptions, Well Care states that the majority of its projected expenses are based on the cost per patient day (PPD) for its existing operations. In reality, the resultant expenses are far less on a PPD basis than Well Care's actual operations. Well Care's cost PPD identified in the 2023 Medicare Cost Report was $218.64, while its projected cost PPD in the CON application ranged from $139.43 to $130.44 over the first three project years, about an $80 to $90 dollar PPD difference in expenses that are supposed to be reflective of the existing hospice agency. See the tables below.

Well Care 2023 Cost Report Data	
Patient Days	15,151
Operating Costs	$3,312,666
Cost PPD	$218.64

Source: 2023 Medicare Cost Report Data

	Year 1	Year 2	Year 3
Total Expense	$ 1,677,712	$ 2,492,673	$ 3,809,155
Days of Care	12,074	17,877	29,203
Cost per Day of Care	$ 138.95	$ 139.43	$ 130.44

It is not reasonable for Well Care to breakeven in 14 months and generate a net income of $1.4 million in Year 3 based on a census of 80. Well Care operated at a 19.1% loss (net income/net revenue) and does not break even on its current hospice operations according to its 2023 cost report. In fact, according to Medicare Cost Reports, Well Care's existing hospice has not been profitable since it became operational.

Well Care provides two letters stating that the total annual rent for the proposed office space would be $55,550 for one space at 2,200 square feet and $66,950 for a larger space with 2,678 square feet. Well Care inexplicably includes a rent expense figure lower than both of these documented letters. See Exhibit K.4 and Form F.3b.

Summary of Financial Feasibility

Well Care's capital cost and working capital are understated for the development and initial operation of a new hospice office. The numerous errors in Well Care's projected utilization are discussed in detail under Criterion (3), including overstated patient days, which will also impact the financial performance of the proposed hospice office. Well Care's payor mix assumptions are inappropriate for calculating hospice revenue and its expenses are significantly understated based on its existing operations.

For these reasons, Well Care should be found non-conforming with Criterion (5).

Criterion (6) Unnecessary Duplication

In its Criterion (6) discussion, Well Care only acknowledges the agencies licensed in Cumberland County and does not address all the providers serving Cumberland County. See page 89. In addition, Well Care fails to address, consider, or analyze the providers that are serving its other three proposed service area counties: Harnett, Johnston, and Sampson Counties.

Without considering and analyzing the other agencies serving the counties in its proposed service area and based on its failure to identify any unmet need not served by the existing providers, Well Care has not demonstrated that its new hospice home care office will not unnecessarily duplicate existing services or providers in any of its proposed service area counties. Well Care should be found non-conforming with Criterion (6).

Criterion (7) Staffing

Well Care's clinical staffing appears to be understated, particularly for nursing aides. Hospice agencies typically have more nursing aides than any other clinical staff position. Well Care projects the same number of nursing aides as RNs.

Well Care also claims it will recruit from its existing pool of home health staff within its existing home health agencies. See page 91. Well Care does not account for having to fill these positions for the home health agency if current staff are recruited to provide hospice care instead.

Well Care should be found non-conforming with Criterion (7).

Criterion (8) Support Services and Relationship with the Existing Healthcare System

Well Care claims it will use a variety of contract services including DME, medical supplies, physical, occupational, and speech therapy, dietary, and language interpretation services. See page 96. It does not appear that Well Care has correctly accounted for the cost of these contract services. As noted above, Well Care appears to have understated its operating costs.

Page 139 identifies that the costs of these contract services have been projected at $500 per month, inflated at 2.5% annually. This projection basis does not account for the significant increase in patient volume each year. Since these are direct patient care services, the cost should have been projected on a volume variable basis – increasing with patient volume rather than remaining fixed.

As shown below, Well Care projects that contract services covering a wide range of important patient care services will be just $0.50 per day in the first year of operation. This amount drops by half to just $0.22 per day by Year 3. This projected cost is insufficient to meet the clinical needs of the patients Well Care intends to serve.

Well Care Projected Cost of Contract Services

	Year 1	Year 2	Year 3
Days of Care	12,074	17,877	29,203
Contracted Services	$ 6,000	$ 6,150	$ 6,304
Cost PPD	**$ 0.50**	**$ 0.34**	**$ 0.22**

Source: Form C.6 and Form F.3b.

Well Care should be found non-conforming with Criterion (8) as it has not adequately accounted for important ancillary services needed for hospice patient care.

Criterion (12) Cost and Methods of Construction

As noted under Criterion (5), Well Care includes only $35,000 in capital costs for opening this hospice home office, excluding consulting fees. Well Care states that it will not renovate the space proposed for its office. No contingency is included. See page 100. However, Well Care fails to provide any drawings, making it impossible to determine the location of the office space within the building. Instead, Well Care only offers two letters from what appear to be a property manager that state the availability of the space, base rent rate, and rentable square footage of both offices. No information is available about the condition or suitability of the office without any renovation. See Exhibit K. Additionally, it is unreasonable to assume that there would be no need for any minor renovation or reconfiguration of the space.

Well Care should be found non-conforming with Criterion (12).

Criterion (13) Medically Underserved Population

As discussed previously, Well Care completely fails to consider or analyze agencies currently located in and serving Harnett, Johnston, and Sampson Counties, even though it projects that over 60% of its patient volume will come from these counties. Additionally, Well Care fails to consider the numerous additional agencies not located in its proposed four-county service area, which are currently serving residents in its four-county service area. Well Care fails to consider the current payor mix in its proposed four-county service area and the current services the residents in these counties are receiving, Well Care's projected payor mix is unreasonable.

Also, Well Care's projected Medicaid payor mix appears unreasonably high particularly in relation to its historical experience in serving Medicaid patients. Moreover, Well Care's payor mix projection in its financial projections is unreasonable as it assumes the same ALOS for all payor categories.

Since Well Care did not identify the medically underserved groups it was planning to serve, the extent to which the existing hospice services are utilized, or the specific hospice services currently being provided. As a result, it could not and did not demonstrate how it was going to provide services to or meet the needs of the underserved population, elderly, medically indigent or low-income persons. Well Care has not fully analyzed or considered information on hospice services provided to residents or medically underserved groups located in Cumberland, Harnett, Johnston, and Sampson Counties. Since Well Care did not look for medically underserved or indigent communities or groups or minority or low-income groups, it missed important communities and failed to recognize that its proposed service area has a higher percentage of Hispanic residents than the North Carolina average. Therefore, Well Care should be found non-conforming with Criterion (13).

Criterion (14) Clinical Education Programs

In its discussion of Criterion (14), Well Care stated that it has partnered with clinical programs at schools such as the University of North Carolina Wilmington (New Hanover County) and Coastal Carolina Community College (Onslow County), both of which are located outside its proposed service area. Well Care also briefly mentioned reaching out to other colleges and universities within the service area but provided no evidence of these efforts. See page 111. There is no indication of any current relationship or evidence of support from any facilities within its proposed service area.

Well Care should be found non-conforming with Criterion (14).

Criterion (18a) The Project did not Demonstrate Positive Effects on Competition

As discussed in Criteria (1), (3), and (13), Well Care has not identified any underserved populations for which it will try to increase access to care. Well Care has not fully analyzed or considered information regarding current hospice services provided to residents or medically underserved groups located in Cumberland, Harnett, Johnston, and Sampson Counties. Without knowing the level of accessibility to hospice for current service area residents , Well Care cannot

know or project what impact its project might have on cost-effectiveness, quality, and access to services in the proposed service area.

Well Care has not identified, analyzed, or considered other existing hospice providers that serve its proposed service area. Well Care did not identify, analyze, or consider the agencies currently serving, whether located inside or outside of Cumberland, Harnett, Johnston, and Sampson Counties. Without identifying what services are currently provided and omitted, Well Care cannot address how enhanced competition could improve access to service or quality care. Finally, based on its understated capital and operating costs, including a significant understatement of its contract services expenses discussed in Criteria (5), (7), (8), and (12), any arguments regarding their impact on cost-effectiveness services are unsupported in its application.

Therefore, Well Care should be found non-conforming with Criterion (18a).

Attachment A
Demonstration of Monthly Ramp Up Assumptions Accounting for Carry Over Patients

Well Care Projected Utilization

Initiation of service and Month	1	2	3	4	5	6	7	8	9	10	11	12
	Year 1 - FY2027											
	10/1/2026	11/1/2026	12/1/2026	1/1/2027	2/1/2027	3/1/2027	4/1/2027	5/1/2027	6/1/2027	7/1/2027	8/1/2027	9/1/2027
Admissions	11	11	11	11	11	11	11	11	11	11	11	11
Days per Month	31	28	31	30	31	30	31	31	30	31	30	31
Month - mid point	15.5	14	15.5	15	15.5	15	15.5	15.5	15	15.5	15	15.5
PDs - mid-point (actual)	167	151	167	161	167	161	167	167	161	167	161	167
PDs - maximum	1,006	1,006	1,006	1,006	1,006	1,006	1,006	1,006	1,006	1,006	1,006	1,006
ALOS - Assumed	**93.6**	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6
Calc/Dist of PDs by Month												
1	**167**	**151**	**167**	**161**	**167**	**161**	**167**	**167**	**161**	**167**	**161**	**167**
2	-	301	333	323	333	323	333	333	323	333	323	333
3	-	-	333	323	333	323	333	333	323	333	323	333
4	-	-	-	205	200	184	189	184	178	184	184	189
5					-	-	-	-	-	-	-	-
6						-	-	-	-	-	-	-
7							-	-	-	-	-	-
8								-	-	-	-	-
9									-	-	-	-
10										-	-	-
11											-	-
12												-
PDs - Current Period Admissions	167	151	167	161	167	161	167	167	161	167	161	167
PDs - Prior Period Admissions	-	-	-									
PDs - Total	167	452	833	1,012	1,033	990	1,022	1,017	985	1,017	990	1,022
Patients Served From Prior Period	-	-	-									

Summary - 1st Full FY	
Admissions	129
Patient Days	10,539
Assumed LOS	93.6
Actual LOS	81.7
Carry Over Patients	-
Patients Served	129

Well Care Projected Utilization

Initiation of service and Month	13	14	15	16	17	18	19	20	21	22	23	24
	Year 2 - FY2028											
	10/1/2027	**11/1/2027**	**12/1/2027**	**1/1/2028**	**2/1/2028**	**3/1/2028**	**4/1/2028**	**5/1/2028**	**6/1/2028**	**7/1/2028**	**8/1/2028**	**9/1/2028**
Admissions	16	16	16	16	16	16	16	16	16	16	16	16
Days per Month	31	29	31	30	31	30	31	31	30	31	30	31
Month - mid point	15.5	14.5	15.5	15	15.5	15	15.5	15.5	15	15.5	15	15.5
PDs - mid-point (actual)	247	231	247	239	247	239	247	247	239	247	239	247
PDs - maximum	1,490	1,490	1,490	1,490	1,490	1,490	1,490	1,490	1,490	1,490	1,490	1,490
ALOS - Assumed	**93.6**	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6
Calc/Dist of PDs by Month												
1	**247**	**231**	**247**	**239**	**247**	**239**	**247**	**247**	**239**	**247**	**239**	**247**
2	333	462	493	478	493	478	493	493	478	493	478	493
3	333	312	493	478	493	478	493	493	478	493	478	493
4	184	178	195	288	288	272	280	272	264	272	272	280
5					-	-	-	-	-	-	-	-
6						-	-	-	-	-	-	-
7							-	-	-	-	-	-
8								-	-	-	-	-
9									-	-	-	-
10										-	-	-
11											-	-
12												-
PDs - Current Period Admissions	247	231	247	239	247	239	247	247	239	247	239	247
PDs - Prior Period Admissions	850	490	195									
PDs - Total	1,097	1,183	1,428	1,482	1,522	1,466	1,514	1,506	1,458	1,506	1,466	1,514
Patients Served From Prior Period	11	11	11									

Summary - 2nd Full FY	
Admissions	191
Patient Days	17,140
Assumed LOS	93.6
Actual LOS	89.7
Carry Over Patients	32
Patients Served	223

Well Care Projected Utilization

Initiation of service and Month	25	26	27	28	29	30	31	32	33	34	35	36
	Year 3 - FY2029											
	10/1/2028	11/1/2028	12/1/2028	1/1/2029	2/1/2029	3/1/2029	4/1/2029	5/1/2029	6/1/2029	7/1/2029	8/1/2029	9/1/2029
Admissions	26	26	26	26	26	26	26	26	26	26	26	26
Days per Month	31	28	31	30	31	30	31	31	30	31	30	31
Month - mid point	15.5	14	15.5	15	15.5	15	15.5	15.5	15	15.5	15	15.5
PDs - mid-point (actual)	403	364	403	390	403	390	403	403	390	403	390	403
PDs - maximum	2,434	2,434	2,434	2,434	2,434	2,434	2,434	2,434	2,434	2,434	2,434	2,434
ALOS - Assumed	**93.6**	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6	93.6
Calc/Dist of PDs by Month												
1	**403**	**364**	**403**	**390**	**403**	**390**	**403**	**403**	**390**	**403**	**390**	**403**
2	493	728	806	780	806	780	806	806	780	806	780	806
3	493	446	806	780	806	780	806	806	780	806	780	806
4	272	264	304	497	484	445	458	445	432	445	445	458
5					-	-	-	-	-	-	-	-
6						-	-	-	-	-	-	-
7							-	-	-	-	-	-
8								-	-	-	-	-
9									-	-	-	-
10										-	-	-
11											-	-
12												-
PDs - Current Period Admissions	403	364	403	390	403	390	403	403	390	403	390	403
PDs - Prior Period Admissions	1,259	710	304									
PDs - Total	1,662	1,802	2,319	2,447	2,499	2,395	2,473	2,460	2,382	2,460	2,395	2,473
Patients Served From Prior Period	16	16	16									

Summary - 3rd Full FY	
Admissions	312
Patient Days	27,763
Assumed LOS	93.6
Actual LOS	89.0
Carry Over Patients	48
Patients Served	360

Comparative Analysis for Cumberland County
Hospice Home Care Office CON Application

Pursuant to G.S. 131E-183(a)(1) and the 2025 State Medical Facility Plan ("SMFP"), no more than one Hospice Home Care Office may be approved for the Cumberland County service area in this review. Because the applications in this review collectively propose to develop three hospice home care offices in Cumberland County, all applicants cannot be approved for the total number of hospice home care offices proposed. Therefore, after considering all review criteria, **VITAS** conducted a comparative analysis of each proposal to demonstrate why **VITAS** is the best applicant and should be approved.

Below is a brief Description of each project included in the Hospice Home Care Office Comparative Analysis.

- Project I.D.# M-12592-25/**VITAS Healthcare Corporation of North Carolina (VITAS")**/ Develop a hospice home care office in Cumberland County pursuant to the 2025 SMFP Need Determination
- Project I.D.# M-12590-25/**VIA Health Partners, Hospice & Palliative Care Charlotte Region ("HPCCR")**/ Develop a hospice home care office in Cumberland County pursuant to the 2025 SMFP Need Determination
- Project I.D.# M-12594-25/**Well Care Hospice of Cumberland ("Well Care")**/ Develop a hospice home care office in Cumberland County pursuant to the 2025 SMFP Need Determination

In the following analysis, **VITAS** describes the relative comparability for each competing applicant regarding the comparative criteria typically used by the CON section and further indicates which factors cannot be effectively compared in this review because of the differences between the three competing applicants.

Conformity with Review Criteria

The **HPCCR** and **Well Care** applications do not conform with all applicable statutory and regulatory review criteria for the reasons discussed throughout **VITAS'** Comments in Opposition submitted for each of these applicants. Therefore, the **HPCCR** and **Well Care** applications are not approvable and are comparatively inferior to the **VITAS** application. **VITAS** has prepared the following comparative analysis to demonstrate that the **VITAS** application is comparatively superior.

VITAS conforms with all applicable statutory and regulatory review criteria. Therefore, the application submitted by **VITAS** is approvable with respect to conformity with statutory and regulatory review criteria.

Scope of Services

Generally, the application proposing to provide the broadest scope of service is the most effective alternative regarding this comparative factor.

Hospice Home Care Utilization - 3rd Full Fiscal Year (%)

Applicant	Routine Home Care	Inpatient Care	Respite Care	Total	Rank
VITAS	97.2%	1.7%	1.1%	**100.0%**	**Most Effective**
HPCCR	99.0%	0.8%	0.2%	**100.0%**	Least Effective
Well Care	99.8%	0.2%	0.1%	**100.0%**	Least Effective

Source: Form C.6 Hospice Home Care Utilization of the respective application

Hospice Home Care Utilization - 3rd Full Fiscal Year (Value)

Applicant	Continuous Care Hours	Rank
VITAS	8,880	**Most Effective**
HPCCR	305	Least Effective
Well Care	32	Least Effective

Source: Form C.6 Hospice Home Care Utilization of the respective application

All three applicants propose to develop a hospice home care office in Cumberland County, offering routine home care, inpatient care, and respite care, and continuous care. However, as shown in the tables above, VITAS projects significantly higher levels of continuous care and inpatient care – representing higher levels of services. VITAS also projects a higher level of respite care, an important component of a full continuum of hospice care. As noted in the comments on each specific application, neither HPCCR nor Well Care have a history of providing continuous care, despite the fact that this is a CMS-required service offering. It is questionable whether these providers will offer any continuous care through a new Cumberland County office.

Therefore, **VITAS** projects the most extensive range of higher levels of care and greater access to all hospice services, making it the most effective alternative with respect to this comparative factor.

Historical Utilization

None of the applicants currently operate a hospice home care office in Cumberland County. Therefore, this comparative factor is not applicable to this review.

Geographic Accessibility (Location within Service Area)

The 2025 SMFP identifies the need for one hospice home care office in Cumberland County. There are currently seven (7) hospice home care offices in Cumberland County, all of which are located in Fayetteville, Cumberland County. All three applicants (**VITAS**, **HPCCR**, and **Well Care**) propose to develop a hospice home care office in Fayetteville.

Since a hospice home care office serves patients in their homes or in an inpatient setting and patients and staff are not required to access an office for the provision of care, the geographic location of the hospice home care office is not a determinative factor. Therefore, the applications are equally effective alternatives with respect to this comparative factor.

Access by Service Area Residents

On page 259, the 2025 SMFP defines the service area for hospice office as *"…the county which the hospice office is located. Each of the 100 counties in the state is a separate hospice office service area."* The need determination is for a hospice home care office in Cumberland County; thus, the SMFP defined service area is Cumberland County. Generally, the applicant projecting to serve the highest number of new service area residents is a more effective alternative with regard to this comparative factor.

The following table illustrates access by service area residents during the third full fiscal year following project completion.

Projected Patient Origin - 3rd Full Fiscal Year

Applicant	# of Cumberland County Residents Served	Total # of Patients Served (Unduplicated)	% Cumberland County Residents	Rank
VITAS	307	371	**82.7%**	**Most Effective**
HPCCR	150	242	62.0%	Least Effective
Well Care	121	312	38.8%	Least Effective

Source: Section C, Question 3 - Projected Patient Origin of the respective application

As shown in the table above, **VITAS** projects to serve the highest total number and percentage of Cumberland County residents. Therefore, **VITAS** most effectively meets the need identified in the service area, and the remaining applications are less effective with respect to this comparative factor.

Access by Underserved Groups

"Underserved groups" are defined in G.S. 131E-183(a)(13) as follows:

> *"Medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority."*

Projected Charity Care

The following table shows each applicant's projected charity care for the third full operating year. Generally, the application proposing the most charity care is the most effective alternative with regard to this comparative factor.

Projected Charity Care - 3rd Full Fiscal Year

Applicant	Charity Care	Gross Revenue	% of Gross Revenue	Self Pay/Charity Care % of Patients
VITAS	$60,498	$7,414,944	0.8%	0.9%
HPCCR	$52,224	$3,876,537	1.3%	0.7%
Well Care	$134,069	$5,629,532	2.4%	2.0%

Source: Form F.2b and Section L, Question, Question 3b

As shown in the table above, **Well Care** projects the highest total charity care in dollars, highest charity care as a percentage of gross revenue, and the highest charity care/self-pay percent of patients. However, in recent reviews, the Agency has determined that comparing charity care is inconclusive based on the fact that various applicants define charity care differently. This comparative factor is inconclusive.

Projected Medicare

The following table shows each applicant's projected Medicare for the third full operating year. Generally, the application proposing to provide the most Medicare is the more effective alternative with regard to this comparative factor.

Projected Medicare - 3rd Full Fiscal Year

Applicant	Medicare	Gross Revenue	% of Gross Revenue	Medicare % of Patients	Rank
VITAS	**$6,972,001**	$7,414,944	**94.0%**	**94.3%**	**Most Effective**
HPCCR	$3,424,436	$3,876,537	88.3%	88.5%	Least Effective
Well Care	$5,035,125	$5,629,532	89.4%	90.0%	Least Effective

Source: Form F.2b and Section L, Question, Question 3b

As shown in the table above, **VITAS** projects the most Medicare in dollars, highest percentage of gross revenues, and highest percentage of patients. Further, both **Well Care** and **HPCCR** had errors related to the projection of payor mix, as they assumed the same ALOS across all payors. See Comments in Opposition to Well Care and Comments in Opposition to HPCCR. Therefore, **VITAS** provides the most access to Medicare patients and is the most effective alternative. The remaining applications are less effective with respect to this comparative factor.

Projected Medicaid

The following table shows each applicant's projected Medicaid for the third full operating year. Generally, the application proposing to provide the most Medicaid is the more effective alternative with regard to this comparative factor.

Projected Medicaid - 3rd Full Fiscal Year

Applicant	Medicaid	Gross Revenue	% of Gross Revenue	Medicaid % of Patients	Rank
VITAS	$166,449	$7,414,944	2.2%	2.4%	Least Effective
HPCCR	$276,723	$3,876,537	7.1%	3.4%	Least Effective
Well Care	**$392,772**	$5,629,532	**7.0%**	**7.0%**	**Most Effective**

Source: Form F.2b and Section L, Question, Question 3b

As shown in the table above, **Well Care** projects the most Medicaid in dollars, highest percentage of gross revenues, and the highest percentage of Medicaid patients. Therefore, **Well Care** provides the most access to Medicaid patients and is the most effective alternative. The remaining applications are less effective with respect to this comparative factor. However, Well Care's Medicaid projections are questionable given its historical track record of care to Medicaid patients and its omission of methods it would use to enhance access to underserved groups. See Comments in Opposition to Well Care.

Access to Underserved Communities

Expanding hospice services in Cumberland County and surrounding communities depends on addressing the needs of the underserved groups that have traditionally faced barriers to access. Hospice care is one service for which it is especially important to evaluate the needs of these populations.

For example, Cumberland County and its surrounding communities have a higher percentage of Hispanic residents compared to the state average, highlighting the need for culturally competent outreach and education. Additionally, the large African American population in the region underscores the importance of reducing disparities in end-of-life care. Ensuring equitable access to hospice services for these groups aligns with the priorities outlined in the SMFP and supports the goal of meeting the needs of the medically underserved population. In Robeson County, the Lumbee Tribe represents a significant group that has historically underutilized hospice care.

Section C of the application requests information on projected percentages of patients to be served in various underserved populations. The following table shows each applicant's percentage of projected underserved groups to be served in the third full operating year. Generally, the application proposing to serve the most underserved communities is the more effective alternative with regards to this comparative factor.

Projected Underserved Communties - 3rd Full Fiscal Year

Underserved Groups	VITAS	HPCCR	Well Care
Low Income Persons	28.0%	15.3%	15.3%
Racial and Ethnic Minorities	50.0%	50.8%	50.8%
Women	57.0%	50.5%	55.0%
Persons with Disabilities	16.9%	12.8%	N/A
Persons 65 and older	91.5%	88.9%	90.0%
Medicare Beneficiaries	94.3%	88.9%	90.0%
Medicaid Recipients	2.4%	6.6%	7.0%
Rank	**Most Effective**	Least Effective	Least Effective

Source: Section C, Question 6b

As shown in the table, **VITAS** projects the largest percentage of low-income persons, women, persons with disabilities, persons 65 and older, and Medicare beneficiaries. All applicants (**VITAS**, **HPCCR**, and **Well Care**) projected to serve a similar percentage of racial and ethnic minorities. Additionally, **HPCCR** and **Well Care** project a similar percentage of Medicaid recipients. Therefore, regarding overall access to underserved communities, **VITAS** is the most effective alternative, and the remaining applications are less effective with respect to this comparative factors.

Projected Average Net Revenue per Days of Care

The following table shows the projected average net revenue per patient day in the third full fiscal year following each applicant's project completion. Average net revenue is calculated by dividing the projected net revenue by the total number of days of care. Generally, the applicant proposing the lowest net revenue per day of care is the most effective alternative. However, differences in levels of care proposed by each applicant significantly impact the simple average shown in the table below.

Net Revenue per Days of Care - 3rd Full Fiscal Year

Applicant	Total Days of Care	Net Reveneue	Net Revenue per Days of Care
VITAS	31,200	$7,146,166	$229.04
HPCCR	19,059	$2,674,887	$140.35
Well Care	29,203	$5,240,509	$179.45

Source: Form F.2b and Form C.6 of the respective application

Revenue for hospice agencies is based on days of care by level of care. More intensive services such as continuous care, respite care, and inpatient care are charged and reimbursed at higher levels. Thus, a provider offering higher acuity and more intensive levels of care would be unfairly penalized if the lowest net revenue per day is an evaluated factor. As noted in the scope of services comparison, VITAS projects significantly higher levels of continuous care, inpatient care, and respite care – services that receive higher reimbursement rates. Consequently, net revenue per patient day is not a meaningful comparison and is found to be inconclusive.

While **HPCCR** projects the lowest net revenue per patient days of care in the third operating year, the variations in hospice care levels among applicants affects the averages reflected in the table. Therefore, this analysis is **inconclusive**.

Revenue and Cost per Patient

In some comparative reviews, the Agency has compared revenue and cost per patient. This comparative factor is not meaningful for hospice due to the variability in ALOS and acuity of care. Hospice services are reimbursed by patient day and thus a significant variance in length of stay would result in significant variances in both revenue and cost per patient. As discussed below, the acuity of patients by level of care also impacts both revenue and cost. As each applicant projects a different ALOS and a mix of days of care by level of care, performing any analysis at the patient level is not meaningful and would penalize the provider with the longest ALOS and higher acuity care. Moreover, Medicare and Medicaid have established rates by level of care that will be the same for all providers in the same geographic area. Thus, variation in projected net revenue is a function of the level of care and ALOS and not a measure of cost effectiveness.

Projected Average Cost per Day of Care

The following table shows the projected average cost per patient day in the third full fiscal year following each applicant's project completion. Average cost per day of care is calculated by dividing the projected total costs by the total number of days of care. Generally, the applicant proposing the lowest cost per day of care is the more effective alternative. However, the differences in levels of care proposed by each applicant significantly impact the same average shown in the table below.

Total Expense per Patient - 3rd Full Fiscal Year

Applicant	Days of Care	Total Expense	Expense per Patient
VITAS	31,200	$7,114,770	$228.04
HPCCR	19,059	$2,583,072	$135.53
Well Care	29,203	$2,809,406	$96.20

Source: Form F.2b and Form C.6 of the respective application

The cost of care is more expensive with higher acuity/more intensive levels of care such as continuous care, respite care, and inpatient care as they require higher levels of staffing and potentially more medication and supplies. Thus, applicants offering higher levels of care would be unfairly penalized by this comparative factor if the evaluation is seeking the lowest expense per day. As noted in the scope of services comparison, **VITAS** projects significantly higher levels of continuous care, inpatient care, and respite care – complex services that are more expensive to provide. Consequently, the cost per day of care is not a meaningful comparison.

While **Well Care** projects the lowest cost per patient day of care in the third operating year, the variations in hospice care levels among applicants affect the averages reflected in the table. Therefore, this analysis is **inconclusive**.

Salaries for Key Direct Care Staff: RN, CNA/Aides, Social Worker

In recruitment and retention of personnel, salaries are a significant factor. The applicants provide the following information in Section Q, Form H. The proposed salaries of these key direct-care staff are compared in the table below. Generally, the application proposing the highest annual salary is the more effective alternative regarding this comparative factor.

Summary of Direct Staff Salaries - 3rd Full Fiscal Year

Applicant	Registered Nurse	CNA/Aides	Social Worker	Rank
VITAS*	$93,154	$37,886	**$87,215**	Second Most Effective
HPCCR	$90,696	$40,977	$65,564	Least Effective
Well Care	**$97,277**	**$46,362**	$80,111	**Most Effective**

Source: Form H of the respective application

** VITAS has differing salaries depending on the focus of the CNA/Aides (CNA/Aides for Homecare salary is $37,477 and CNA/Aides for Continuous Care $40,670). Thus, the weighted average based on FTEs was used.*

As shown in the table above, **VITAS** projects the highest annual salaries in the third full fiscal year for social workers, while **Well Care** projects the highest salaries for registered nurses and certified nursing assistants/aides. Therefore, with regards to salaries of key direct care staff, **Well Care** is the most effective alternative followed by **VITAS**, as the second most effective alternative.

Staffing/FTEs for Key Direct Care Staff: Nurses, Social Worker, Physician and Chaplin/Clergy/Bereavement

In prior reviews, the Agency compared average caseloads for various clinical positions. This data is no longer requested on the application form. This same type of evaluation can be performed using FTEs for clinical positions and the calculated average daily census ("ADC") projected for each provider.

The following table shows clinical hours per ADC in the third full fiscal year following each applicant's project completion. This comparison measures the availability of the direct care workforce to cover the needs of the patient. Generally, the application proposing the highest clinical hours per ADC is the most effective.

Each standard FTE is the equivalent of 2,080 hours. The combined clinical FTEs including all nursing positions, social worker, physician, and Chaplin/Clergy/Bereavement were considered. Therapy personnel were not included as some applicants project to use contract staff and thus FTEs are not identified.

Clinical Hours of Care per Patient Census

Applicant	Direct Care Staff FTEs*	Patient Days	ADC	Clinical Hours per ADC**	Rank
VITAS^	**33.74**	**31,200**	**85.48**	**821.05**	**Most Effective**
HPCCR	17.00	19,059	52.22	677.18	Least Effective
Well Care	20.80	29,203	80.01	540.74	Least Effective

Source: Form H and Form C.6 of the respective application

**Includes FTEs for Nurses, Social Worker, Physician, and Chaplin/Clergy/Bereavement.*

***Clinical hours based on 2,080 hours per FTE. FTEs x 2,080 hours / ADC*

^Continuous Care nurses were converted to a fraction of an FTE and included in the total VITAS RN FTEs.

As shown in the table above, **VITAS** offers the highest clinical hours per ADC for the key direct care staff. Therefore, **VITAS** is the most effective alternative, and the remaining applications are less effective with respect to this comparative factor.

Competition

None of the applications and/or related entities have a hospice home care office, or inpatient hospice facility, located in the services area of Cumberland County; therefore, all applicants would qualify as a new or alternative provider located in the service area. Therefore, regarding this comparative factor, all applications are equally effective alternatives. It should be noted however, that VITAS represents a new provider to North Carolina with vast national experience that can bring unique and innovative programs and services to the service area and the state.

Conclusion

G.S. 131E-183(a)(1) states that the need determination in the SMFP is the determinative limit on the number of Hospice Home Care Offices that can be approved by the Health Planning and Certificate of Need Section. Approval of all applications submitted during the review would result in hospice home care offices exceeding the need determination in the 2025 SMFP for the Cumberland County service area. Only **VITAS'** project can be approved as it is the only applicant that conforms to all project review criteria. However, if all applicants were approvable based on these criteria, **VITAS'** project is still the most effective alternative to meet the need, based on the summary chart below. As such, **VITAS'** project should be approved.

Summary of Comparative Factors

Comparative Factor	VITAS	HPCCR	Well Care
Conformity with Statutory and Regulatory Review Criteria	Yes	No	No
Scope of Services	**Most Effective**	Least Effective	Least Effective
Historical Utilization	Not Applicable	Not applicable	Not Applicable
Geographic Accessibility (Location in the Service Area)	Equally Effective	Equally Effective	Equally Effective
Access by Service Area Residents	**Most Effective**	Least Effective	Least Effective
Access by Underserved Groups			
Charity Care	Inconclusive	Inconclusive	Inconclusive
Medicare	**Most Effective**	Least Effective	Least Effective
Medicaid	Least Effective	Least Effective	**Most Effective**
Access to Underserved Communities	**Most Effective**	Least Effective	Least Effective
Projected Average Net Revenue per Day	Inconclusive	Inconclusive	Inconclusive
Projected Average Cost per Day of Care	Inconclusive	Inconclusive	Inconclusive
Direct Care Salaries	**2nd Most Effective**	Least Effective	**Most Effective**
Direct Care Staffing / FTEs	**Most Effective**	Least Effective	Least Effective
Competition (Access to New or Alternative Provider)	**Equally Effective**	**Equally Effective**	**Equally Effective**