Comments in Opposition to
VIA Health Partners, Hospice & Palliative Care Charlotte Region
CON Application for a New Hospice Home Care Agency in Cumberland County
Project ID #M-12590-25
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 in Cumberland County. VITAS is filing these comments in opposition to VIA Health Partners, Hospice & Palliative Care Charlotte Region ("HPCCR"). Based on its application, HPCCR is an existing for-profit hospice provider based in Charlotte, N.C. Collectively with its affiliates, called VIA Health Partners, HPCCR serves 15 counties in North Carolina and 25 counties in South Carolina. As will be shown, HPCCR has not demonstrated a need for its project nor that it will meet the needs of the service area patients. Most notably:

- HPCCR has not demonstrated an understanding of the demographics and unique communities within its projected service area to ensure that access is increased through culturally competent care.
- HPCCR has not identified the needs of its projected service area population. In fact, HPCCR did little to no analysis of the needs for three of its four service area counties.
- HPCCR has significant flaws in its utilization projections that lead to an overstatement of patient days, which raises questions regarding the financial feasibility of its project.
- HPCCR 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 home care hospice office.
- HPCCR has understated its staffing needs and has relatedly understated its expenses for direct patient care staff, allocated staff, and administrative/management services. As a result, HPCCR has not sufficiently demonstrated that it will provide all required ancillary and support services.
- HPCCR's projected payor mix is flawed based on the use of outdated data and data that ignores three of four service area counties.

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

Criterion (1): HPCCR 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 and 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, HPCCR should be able to respond to each item in Policy GEN-5 with specificity and to document its historical track record. HPCCR fails to do so as will be shown below.

Part (a) of the application asks the applicant to describe specific demographic factors of the service area that are important in identifying medically underserved communities. First, HPCCR defines its service area as Cumberland, Robeson, Harnett, and Sampson Counties. According to HPCCR's patient origin (page 49) over 38% of its patients are projected to come from outside of Cumberland County. Yet, HPCCR only describes demographic characteristics of Cumberland County for many of the demographic characteristics identified in Part (a). HPCCR does not address underserved population needs of the other service area counties, which account for 38% of its projected patients.

HPCCR only provided analysis of age, median household income, and education for all service area counties. For Robeson, Harnett, and Sampson Counties, HPCCR did not provide any demographic analysis of gender, racial composition, disability, spoken languages, or payor type, all of which are specifically identified in the policy. For Cumberland County, HPCCR simply pasted statistics from other sources with regard to race/ethnicity, gender, and disability without providing any analysis, discussion, or comparison. See pages 28-29, and 31 of the HPCCR Application. This lack of analysis results in no acknowledgement of the underserved populations which would benefit from culturally competent care, including:

- A large Black/African American population (much higher percentage than NC as a whole), in HPCCR's proposed service area.
- A Hispanic population in HPCCR's proposed service area that also exceeds the percentage of NC as a whole.
- A large Native American population in Robeson County based on the presence of the Lumbee Tribe.
- Existing service area providers who are not serving the above populations to the degree these underserved communities are represented in the population.

HPCCR did not analyze any existing hospice providers to determine if they were serving these populations. HPCCR did not analyze payors at all for any county. Overall, HPCCR failed to identify any underserved population in the service area based on the terms specified in Policy GEN-5, Part (a).

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 HPCCR did not identify any underserved communities, it could not address strategies specific to such populations. Instead, HPCCR provided a generic description of strategies to provide culturally competent care in general rather than linking these strategies to any actual service area demographics or any underserved groups within its projected service area.

Many of the programs HPCCR describes (palliative care, direct ED to hospice, and heart failure) have no linkage to any specific underserved group in the service area. See page 33 of the HPCCR Application. HPCCR does not discuss or provide exhibits such as patient or staff education

materials to reflect that access is provided to non-English speaking patients or patients with religions other than Christianity. On page 34, HPCCR discusses its experience in Mecklenburg County but does not acknowledge that the service area is not a major metropolitan area like the greater Charlotte metropolitan area and does not recognize that the needs in its projected service area could be radically different.

Part (c) of the application asks the applicant how the strategies in Part (b) reflect cultural competence. In response, HPCCR provides data on its experience in urban Mecklenburg County. See page 37 of its application. No discussion links this experience to the service area population they are projecting to serve in this application or even explains how HPCCR's experience in Mecklenburg County relates in any way to the population demographics of Cumberland, Harnett, Robeson, and Sampson Counties. Further, HPCCR provides no evidence to demonstrate that it will increase access to underserved groups in Mecklenburg County or any other area it serves.

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, HPCCR simply references three national studies without linking them to any of the strategies described in Part (b) and Part (c) or to the service area it is proposing to serve in this application. See page 37 of its application. In fact, the studies cited are not even hospice specific.

Part (e) of the application ask the applicant to describe how it will measure and assess equitable access to healthcare services and reduction of health disparities in underserved communities. Again, HPCCR has not identified any specific underserved communities in the service area and thus, it cannot measure any increase in access. On page 38, HPCCR lists four measures unrelated to any specific underserved groups. This list is meaningless without context to underserved groups and is generic. HPCCR goes on to provide a general discussion of what health equity means in healthcare without even connecting it to hospice services.

HPCCR should be found non-conforming with Criterion (1) and Policy GEN-5 based on its failure to identify any specific groups of medically underserved patients within its projected service area and its lack of information specific to any underserved groups in terms of strategies, experience, success, or future plans to measure access in its proposed service area.

Criterion (3): HPCCR is Non-Conforming with Criterion (3)

Scope of the Project

On pages 41 to 47 of its application, HPCCR provides a general description of the services it intends to offer.

- On page 44, HPCCR describes the various levels of hospice care it proposes to provide, including continuous care. HPCCR does not acknowledge that it did not report providing any continuous care at its existing licensed hospice care offices, according to both its 2024 LRA

and its 2023 Medicare Cost Report. In fact, a review of HPCCR's MCRs going back to 2016, shows that no continuous care was provided over the past 8 years.

- On page 45, HPCCR describes its African American and minority outreach but does not identify outreach to languages spoken other than English or religions other than Christianity. Other than African American's, no other racial or ethnic minority group is discussed, ignoring the fact that there is a large Native America population, the Lumbee Tribe, in Robeson County.
- On page 46, HPCCR describes pediatric services with no link to the needs of the service area population and whether pediatric patients are being served. According to its 2024 LRA, only one of its 10 affiliated hospice agencies served any patients aged 0-14. Patients aged 0-14 comprised 0.6% of HPCCR's total patient volume for its affiliates. Patients aged 0-25 comprised just 1%.

Population to be Served

HPCCR identifies its service area as Cumberland, Harnett, Robeson, and Sampson Counties. No other rationale is provided as to why Harnett, Robeson, and Sampson are included in its service area other than that they have a need under the first part of the SMFP need calculation. HPCCR does not acknowledge that Sampson has 6.6 licensed offices per 100,000 population, well above the three or fewer per 100,000 population needed to generate a need in that county.

On pages 49-50, HPCCR projects 61.7% of its patients will come from Cumberland County, which means that over 38% come from the three other counties it projects to serve. HPCCR does not have any letters of support from these other counties and has not identified any underserved communities in these counties (see Criterion 1 discussion above). Therefore, it is unclear both why the additional counties were chosen and how HPCCR will get 38% of its patients from these counties.

Needs of the Service Area Population

On page 52, HPCCR identifies Johnston, Cumberland, and Robeson Counties as the top three counties with the largest patient deficit based on the 2025 SMFP. However, HPCCR fails to specify the patient deficit for Harnett County and Sampson Counties, which they propose to serve.

On pages 52-60, HPCCR provided a variety of analyses related to hospice utilization for Cumberland County. Almost 40% of patients are projected to come from outside Cumberland but no analysis of need provided for the other counties. Factors such as increasing death rates, low hospice penetration rates, and low hospice use rates are certainly factors that are considered in the SMFP need calculation. However, none of this analysis identifies why penetration rates are low or what groups of patients are underserved and need enhanced access to increase hospice utilization. In other words, HPCCR has not identified the specific hospice needs for Cumberland County in order to improve hospice access and utilization. Moreover, HPCCR did not even analyze the needs of its other service area counties.

On page 64, HPCCR highlights its historical experience in the greater Mecklenburg County area for serving patients by race. In total, White or non-minority patients comprise 78.4% of all patients. No comparison is made to the experience of hospices serving Cumberland County or any of the other service area counties. HPCCR's data on page 68 shows that only 53% of residents of Cumberland County are white.

Pages 65-67, HPCCR provides statistics related to heart disease, Alzheimer's disease, and respiratory disease but again only focus on Cumberland County and omits the three other proposed service area counties.

On pages 67-69, HPCCR repeats the same information provided regarding Cumberland County education and poverty from Section B. No information is provided for the other three proposed service area counties.

On pages 69-70, HPCCR again discusses its planned outreach to African American communities. No other racial or ethnic group is discussed, ignoring the large Native American community in Robeson County and the fact that there is a larger percentage of Hispanic residents in the service area than the state as a whole. The discussion of death rates by race (pages 71-72) again focuses on African American residents and fails to identify the extent to which the existing providers are reaching underserved populations in its proposed service area.

Overall, HPCCR fails to identify any actual underserved populations in its service area. In fact, it fails to even analyze any potential community needs in Robeson, Harnett, and Sampson Counties. HPCCR cannot meet the needs of the population it projects to serve if it has not identified what those needs are and what patient populations are not being served by existing providers. Data from current and past LRAs are available to analyze a variety of parameters for existing providers; however, HPCCR fails to use this or any other resource and does not identify any patient populations that are not currently served by existing providers.

Access to Care

On page 78, HPCCR projects the percentage of Medicare and Medicaid patients it will serve. HPCCR bases these projections on 2017 data for existing Cumberland County agencies. First, data on payor mix for existing providers is available through 2023 based on the 2024 LRAs. It is unclear why HPCCR used such outdated data. Second, HPCCR only considered Cumberland County hospice home care offices and failed to analyze Harnett, Robeson, and Sampson Counties, from which it expects to draw over 38% of its total patient volume. HPCCR has not demonstrated reasonable access to care.

Utilization Projections

<u>Service Area Definition and Projections</u>

As noted previously, only 61.7% of HPCCR's patients are projected to come from Cumberland County; however, little to no analysis has been done to support the projected patients from Harnett, Robeson, and Sampson Counties. It does not appear that HPCCR included any letter of support

from these other three counties. Attachment I.2.2 provides a list of people and organizations that HPCCR contacted for support. It appears that virtually all of these contacts were in Fayetteville (Cumberland County) or completely outside the service area such as Monroe (Union County) or Durham. On page 139, HPCCR projects its market share by county. There is nothing included to support its projections for Harnett, Robeson, or Sampson Counties based on the fact that no analysis was conducted related to the needs of the residents of these counties. HPCCR included nothing in its application to indicate it has any support in these other three counties.

Projection Methodology

Step 8 – Conversion to Fiscal Years

In Step 8, on page 140, HPCCR converts its service area projected deaths provided on a calendar year basis (Step 7) to the partial and fiscal year projections for its project. During this conversion, HPCCR makes two errors affecting its calculation. First, its stated partial year is April through September 2026, which represents a six-month period or 50% of the year. HPCCR uses 67% for its partial year allocation, thereby overstating its projection by 17%.

Next, HPCCR projects for fiscal year 2027, represented by three months of 2026 and nine months of 2027 incorrectly. The calculation should be 25% of 2026 and 75% of 2027. However, HPCCR uses 33% of 2026, which when added to 75% of 2027 equals 108%, overstating its FY 2027 projection.

	Beginning Date	**Ending Date**	**Months**	**% of 12 Months**	**% Used by HPCCR**	
FY 2026*	Apr-26	Sep-26	6	50%	**67.0%**	
FY2027*	Oct-26	Dec-26	3	25%	**33.0%**	**108%**
	Jan-27	Sep-27	9	75%	75.0%	
FY2028	Oct-27	Dec-27	3	25%	25.0%	
	Jan-28	Sep-28	9	75%	75.0%	
FY2028	Oct-27	Dec-27	3	25%	25.0%	
	Jan-28	Sep-28	9	75%	75.0%	

** HPCCR CON page 140.*

From this point forward, the projections for partial year FY 2026 and FY 2027 are overstated.

Step 13 – Patient Days Served (and ALOS)

In Step 13, page 142, HPCCR applies the North Carolina average length of stay ("ALOS') to its projected admissions to calculate projected days of care. This projection step is overly simplistic and fails to account for the fact that patient admissions and patients served will ramp up over time. For example, the calculated ALOS for partial FY 2026 is 78.9 days. This assumes that all patients admitted during this six-month period (April 1 to September 30, 2026) will achieve the projected total ALOS. In reality, the patient admissions and patients served will ramp up on a month-by-month basis over this period. Patients admitted toward the end of this period will not result in the full length of stay occurring within FY2026 and such days would not be counted (or billed for) in FY 2026. Please see additional discussion under Step 15.

Step 14 - Days of Care by Level of Care

On page 143, HPCCR projects days of care by level of care based on national data from CMS. This is flawed for multiple reasons. First, the CMS data only includes Medicare patients and not patients covered by other payors who often fall outside of Medicare age and ability limits and would have different care experiences. Second, the national data used does not consider the needs of local service area patients. Third, this data is inconsistent with HPCCR's actual experience as reported on its LRAs, despite its claims of consistency.

Step 15 – Projected Hospice Patients Served

In Step 15, HPCCR provides a long and detailed discussion of its assumptions related to carry over patients – which are patients admitted near the end of one year who continue to be served in the next year. This analysis is flawed on multiple levels.

First, HPCCR projects that all patients admitted in partial FY 2026 are also discharged in the same year in Form C.6. For example, in partial FY 2026, HPCCR projects 64 admissions and also 64 discharges; thus, there are no patients to carry over. However, HPCCR projects 18 carry-over patients from FY 2026 to FY 2027. If all admissions are discharged, then there are no carry-over patients, which would result in 176 patients in the first full FY rather than the 194 projected by the Applicant. This same error, which results in an overstatement of the number of patients served, applies to both the 2nd Full FY and the 3rd Full FY. Mathematically, since no patients are available to be carried over from the prior period, the number of admissions and the number of patients served during the period have to be the same. The applicant does not utilize its own discharge assumptions from the previous period to calculate the number of patients served in each following period. See the table below.

	Partial FY F: 4/1/2026 T: 9/30/2026	**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	64	176	214	242
# of Patients Served	64	194	251	287
Calculated Carry Over Patients from Prior Year		***18***	***37***	***45***
# of Deaths	58	159	193	219
# of Non-Death Discharges	6	17	21	23
Total Discharges	***64***	***176***	***214***	***242***
Patients Remaining for Carry-over (Admissions less Discharges)	***0***	***0***	***0***	***0***

Form C.6 states that there 287 admissions in Year 3. Assumptions page 144 shows 242 admissions in Year 3.

Next, on page 144, HPCCR notes its detailed calculation of carry-over patients, but provides no explanation for omitting the necessary related adjustments for carry-over patient days. HPCCR

assumes that all patients admitted in each FY have an ALOS of 78.6, which implies that all admitted patients complete the entire length of stay and are discharged within the same FY of admission. In reality, patients admitted near the end of the year will often have some days of care carry-over into the next year. By calculating patient days in Step 13 prior to calculating the carry-over patients in Step 14, HPCCR has ignored patient days associated with the carry-over patients that would be provided in the following year.

	Partial FY	**1st Full FY**	**2nd Full FY**	**3rd Full FY**
	F: 4/1/2026 T: 9/30/2026	F: 10/1/2027 T: 9/30/2027	F: 10/1/2028 T: 9/30/2028	F: 10/1/2029 T: 9/30/2029
# of New (Unduplicated) Admissions	64	176	214	242
# of Patients Served	64	194	251	287
Days of Care	5,049	13,834	16,811	19,059
ALOS Calculated Based on Admissions and Days from Form C.6	**78.9**	**78.6**	**78.6**	**78.8**

Source: Form C.6, page 136

The impact of this flaw is an overstatement of patient days for each time period projected. **Attachment A** replicates HPCCR's assumptions regarding carry-over patient projections described on page 144. It then applies the same methodology to patient days associated with the carry-over patients to calculate days of care associated with the carry-over patients that HPCCR failed to consider. In each project year, HPCCR's patient days are overstated due to its failure to account for the patients admitted in the last 2.5 months of each reporting year that would have patient days occurring in the subsequent year. The same is true for each subsequent year. The adjustment results in fewer patient days in each year and a lower length of stay as the patient census builds. Thus, HPCCR's patient day projections are overstated by the following number each year:

	Form C.6 Days	**Days Adjusted for Carry Over**	**Overstated Patient Days**
Partial Year	5,038	4,346	692
FY 2027	13,807	13,085	722
FY 2028	16,777	16,513	264
FY 2029	19,020	18,795	225

This calculation only shows the overstated patient days based on the carry-over errors described previously. Two other flaws also overstate patient days:

- First, it is unreasonable to assume that there would be the same number of admissions in each month (total annual admissions ÷ 12 months). In reality, admissions for a new hospice office would ramp up over time with continually increasing admissions month over month. This can be seen in the unreasonable jump in admissions from seven in September 2026 to 15 in October 2027 (more than doubling admissions in one month). The same flaw occurs each year. If admissions were gradually and reasonably ramped up month after month, this

would result in more admissions at the end of the year and more carry-over patients and days.[1]

- Second, HPCCR's projections assume that all patients admitted in any given month are admitted on the first day of the month, which results in HPCCR counting patient days for the entire month for every patient admitted, affecting carry-over from month to month. Since patients are admitted on various dates throughout the month, this methodology effectively reduces the days of care in subsequent months for patients admitted at the end of the month.

On page 151, HPCCR identifies that it will only serve three to five Medicare patients prior to certification, which is assumed to be the first three months of operation. Given that HPCCR projects almost 90% of its patients to be Medicare patients, this would result in approximately seven total projected admissions per month for the first several months of partial FY 2026. This is not reasonable based on its projected utilization and these representations are in direct conflict with each other.

HPCCR has numerous errors and omissions related to identifying need for the project and projecting its utilization. For these reasons, its application should be found non-conforming with Criterion (3).

Criterion (5) Financial Feasibility

Projected Utilization/Financial Feasibility

As discussed in Criterion (3), HPCCR 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 HPCCR's financial projections likewise flawed.

Capital Cost

HPCCR's projected capital costs associated with the project are insufficient to develop a new hospice home care office. When the CON consulting fees of $60,000 are removed, HPCCR projects just $25,000 in total capital costs. It is unclear how $25,000 will sufficiently cover office furnishings, IT and telecom needs, and potential minor renovations to the proposed office space. No assumptions to Form F.1a are included. Thus, it is impossible to determine what HPCCR has included in its minimal $25,000 direct project capital costs.

Working Capital

Start-up Costs

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[1] Note that HPCCR states that it assumed 7 patient admissions in each of the last three months to calculate carryover patients of 4 (4 = 7 x 50 percent) and 14 (7 x 2) as noted on page 144. If there are 7 patients admitted in July, August, and September of the first 6-month partial year, then there would have to be 14+ patients admitted in the first three months (April, May, June) to reach 64 total admission (14 x 3 + 7 x 3 = 63). It is unreasonable to assume 14 patient admissions for the first three months of operation, when Medicare certification has not occurred, and then a drop to only 7 patient admissions. If admissions by month were reasonably spread, the shortfall in carryover patient days would be even larger.

As shown on page 92, HPCCR includes just $62,000 in start-up costs, which represent four weeks of start-up. Assuming that staff will be hired and trained during this period, one month of salaries and benefits alone would exceed this amount, as shown below. In addition to these operating costs, HPCCR claims that its start-up costs also include equipment and IT setup, marketing/advertising, purchasing supplies, and other fees.

Partial FY 2026		
Salaries	$	508,875
Benefits	$	101,225
Utilities	$	900
Rent Expense	$	27,500
Total for 6 months:	$	638,500
1 month of expenses	**$**	**106,417**

Source: Form F.3b

Initial Operating Cost

HPCCR assumes a three-month initial operating period until it begins to generate a profit. This assumes that HPCCR will be Medicare and Medicaid certified in this minimal period and that operating revenue will exceed operating costs. On page 92, HPCCR assumes it will breakeven as soon as it is Medicare certified. This is simply unreasonable. HPCCR's own performance shows that it will not break even at three months with a minimal census.[2] In Exhibit F.2, HPCCR provides its audited financial statements including income statements for two of its smaller hospice organizations: Hospice of Laurens County and Hospice of Cleveland County, both of which lost money in FY 2023 as shown below with a negative change of assets (expenses exceeded revenue):

[2] On page 151, HPCCR states it will only admit three to five Medicare patients prior to certification. If Medicare is 90% of its patient volume by payor mix, then the total admissions during this three-month assumed certification period would be no more than five to six patients.

YEAR ENDED DECEMBER 31, 2023

	Hospice and Palliative Care Charlotte Region	Hospice of Laurens County	Hospice of Cleveland County	Elimination Entries	Consolidated
Revenue and Support:					
Patient service revenue, net	$ 85,723,006	$ 9,508,235	$ 16,610,629	$ -	$ 111,841,870
Contributions and grants	1,537,086	75,210	756,069	-	2,368,365
Special events	250,973	40,337	39,735	-	331,045
Donated assets and services	227,018	28,863	70,541	-	326,422
Investment return, net	53,647	-	-	-	53,647
Thrift store income	-	351,216	371,109	-	722,325
Other income	(48,510)	19	173,566	-	125,075
Total Revenue and Support	87,743,220	10,003,880	18,021,649	-	115,768,749
Expenses:					
Patient services	74,628,949	9,171,782	17,110,810	-	100,911,541
Management and general	8,262,425	713,457	1,206,863	-	10,182,745
Fundraising	890,909	353,884	449,009	-	1,693,802
Total Expenses	83,782,283	10,239,123	18,766,682	-	112,788,088
Change in Net Assets from Operations	3,960,937	(235,243)	(745,033)	-	2,980,661
Other Changes:					
Gain from insurance claims	-	11,199	-	-	11,199
Investment return, net, not credited to operations	2,804,618	-	1,935	-	2,806,553
Change in net assets	6,765,555	(224,044)	(743,098)	-	5,798,413
Net assets, beginning of year	67,866,652	(1,821,621)	10,395,592	-	76,440,623
Net assets, end of year	$ 74,632,207	$ (2,045,665)	$ 9,652,494	$ -	$ 82,239,036

According to its 2024 LRA (2023 data), Hospice of Cleveland County reported 897 admissions and was showing a loss in net assets. Here, HPCCR projects 21 admissions for the first three months of operation and projects to break even. There is no data in the application, based on the overstated revenue and the understated expenses that explain how this hospice home care office will break even in three months, given their operating experience in other North Carolina counties.

Revenue and Payor Mix

Gross and net revenue are both overstated due to the overstated patient day projection described above. Moreover, HPCCR'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 admissions.

Also, Hospice patients with varying payor sources will not have the same ALOS. Therefore, the payor mix of patients served and days of care are different. This can be demonstrated by HPCCR's actual experience reported on its 2024 LRA as shown below:

HPCCR Affiliates Payor Mix - FY 2023

Payor	ALOS	Days of Care	Patients Served
Hospice Medicaid	59.4	3.2%	3.7%
Hospice Medicare	71.7	93.6%	89.5%
Other **	-	0.0%	0.0%
Private Insurance	37.0	2.7%	5.0%
Self Pay *	20.1	0.5%	1.7%
Grand Total	68.6	**100.0%**	**100.0%**

Source: 2024 LRA database

Despite these variances, HPCCR projected the same percentage payor mix for patients (Section L – pages 120-121) and revenue based on admissions and not days of care (Form F.2b and assumptions – pages 147 and 151).

Operating Expenses

It appears that HPCCR has significantly understated its expenses including direct patient care costs, overhead/administrative and support costs. The following table summarizes HPCCR's third year expenses and expense per projected patient day.

HPCCR Projected Expense and Expense PPD (Year 3)

	Expense	PPD
Staffing	$1,615,324	$84.93
Benefits	$321,413	$16.90
Medical Supplies	$72,588	$3.82
Other Supplies	$180,130	$9.47
Pharmacy	$137,320	$7.22
Other Direct Care	$88,114	$4.63
Total Direct Care Expense	**$2,414,889**	**$126.97**
All Other Indirect Expense	$168,183	**$8.84**
Total Expenses	**$2,583,072**	**$135.81**

Source: Form C.6 and F.3b

Projected expense can also be compared to the actual expenses incurred historically by HPCCR as reflected in its audited financial statements for FY 2023 (Exhibit F.2). Expenses for two divisions: HPCCR (Mecklenburg) and Hospice of Cleveland were used to calculate a cost per patient day ("PPD") using FY 2023 data from the LRAs for the affiliated hospice agencies.

Calculation of Expenses per Day – FY 2023 Audit and 2024 LRA

	Hospice of Cleveland		HPCCR (Mecklenburg)	
	Expense	**PPD**	**Expense**	**PPD**
Patient Days		***65,622***		***331,104***
Patient Services	$17,110,810	$260.75	$74,628,949	$225.39
Management & General	$1,206,863	$18.39	$8,252,425	$24.92
Fundraising	$449,009	$6.84	$890,909	$2.69
Total	**$18,766,682**	**$285.98**	**$83,772,283**	**$253.01**

Source: Exhibit F.2 HPCCR Audit page 27

HPCCR's projected expenses can also be compared to its existing agencies' 2023 Medicare Cost Report.

Calculation of Expenses per Day – FY 2023 Medicare Cost Report

	Hospice of Cleveland	**HPCCR (Mecklenburg)**
Patient Days	67,447	340,635
Operating Costs	$ 18,704,838	$ 76,103,933
Cost PPD	$ 277.33	$ 223.42

Source: 2023 Medicare Cost Report Data

When compared to the projected expenses per patient day for the new Cumberland hospice office, it is clear that HPCCR's projected expenses are significantly understated, based on its historical costs for providing care in North Carolina. Even if you set aside the insufficient administrative and support costs which have been allocated, the projected direct patient services expense per patient day for Cumberland County is less than the patient services cost per patient day for HPCCR's existing operations.

The total cost per patient day for the proposed Cumberland hospice office is far less than the experience of HPCCR's existing North Carolina operations whether compared to audit or cost report data. HPCCR's methodology of calculating costs on a per patient day basis ignores the fact that there are fixed or relatively fixed costs of operation regardless of the size of the operation.

Staffing

HPCCR has understated its staffing expenses in a number of areas as identified below:

- HPCCR projects just 0.25 FTE for the Medical Director, which does not increase as census increases.
- HPCCR does not appear to have any administrative manager that would oversee the operations of the new hospice home care office. Administrative positions include 1.0 FTE for a Business Office staff member and 1.0 FTE for Marketing staff.
- Therapy is listed as a provided service; however, therapy staff are not identified on Form H and the cost of therapy staff is not specifically identified under any allocated expense category.

Net Income

HPCCR's overall projections are called into question by the fact that its projected net income declines from FY 2027 through FY 2029 despite the fact that utilization is increasing. That pattern is inconsistent with typical operations wherein profitability increases as volume increases. Instead, HPCCR's net income per patient day declines over time.

Form F.2b Projected Revenues and Net Income upon Project Completion	Partial FY	1st Full FY	2nd Full FY	3rd Full FY
	F: 4/1/2026	F: 10/1/2026	F: 10/1/2027	F: 10/1/2028
	T: 9/30/2026	T: 9/30/2027	T: 9/30/2028	T: 9/30/2029
Total Rev Adjustments as a % of Total Gross Rev	23%	30%	30%	31%
Net Income as a % of Total Net Revenues	-17%	9%	6%	3%
Total PDs (Form C.6)	5,048	13,835	16,811	19,058
Net Income PPD	-$22.27	$12.05	$8.58	$4.82

Based on the issues previously identified regarding costs and revenues projections, HPCCR should be found non-conforming with Criterion (5).

Criterion (6) HPCCR Represents Unnecessary Duplication

In its discussion of Criterion (6), HPCCR only acknowledges the agencies licensed in Cumberland County and does not address all the providers that are actually serving Cumberland County. See page 99. In addition, HPCCR fails to address, consider, or analyze the providers that are serving its other three proposed service area counties: Harnett, Robeson, and Sampson Counties.

Without considering and analyzing the other agencies serving the counties HPCCR is proposing to serve and based on its failure to identify any unmet community needs in the service area, HPCCR fails to demonstrate that its proposed hospice home care office will not unnecessarily duplicate the existing hospice providers that serve its proposed service area counties. HPCCR should be found non-conforming with Criterion (6).

Criterion (7) Staffing – HPCCR Does Not Project Sufficient Staff

As described above in Criterion (5), HPCCR has not projected sufficient staff for the services it proposes in its application, particularly as it relates to the projection of administrative and support staff.

- There is no projection for an overall administrative manager of the new office.
- The medical director's staffing is minimal and does not increase with increased patient load.

- On page 43, HPCCR discusses its therapy services; however, no therapy staff are listed on Form H and there are no contract expenses for such position(s) identified on Form F.3b.

Since HPCCR has not projected sufficient staff for its proposed services and related volumes, it did not provide sufficient evidence to demonstrate the availability of resources. Therefore, HPCCR should be found non-conforming with Criterion (7).

Criterion (8) Support Services – HPCCR Does Not Demonstrate Support Services

On pages 104-105, HPCCR claims most support services will be provided by existing HPCCR staff. However, allocated expenses for such services are minimal at best. Please see the discussion of understated allocated and support costs under Criterion (5).

It is not clear that HPCCR has allocated sufficient dollar amounts in the application to cover the expenses for certain identified services, such as therapies, dietary, and other allocated indirect clinical support. For example, in FY 2029, HPCCR allocates $8,447 for indirect clinical support. See Form F.3b. This is apparently assumed to cover contract labor, clinical mileage (to cover a four-county service area) and cell phone charges. It is unreasonable to assume this amount would be sufficient to include the therapy and dietary staff, who are not enumerated anywhere in HPCCR financial assumptions. See page 151.

Since HPCCR did not demonstrate that it would provide or allocate sufficient funds to provide the necessary ancillary and support services needed, it should be found non-conforming with Criterion (8).

Criterion (12) – Cost and Methods of Construction

As noted under Criterion (5), HPCCR includes only $25,000 in capital costs for opening this hospice home care office, excluding consulting fees. HPCCR also states that it will not renovate the space proposed for its office. No contingency is included. See page 109. From the poorly copied images in the application, it is impossible to determine the office space location within the building, how many square feet it will occupy or any basis for determining the rent, to determine what this cost is based on. It is unreasonable to assume that minor renovations or reconfiguration of space would not be needed.

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

Criterion (13) Medically Underserved Population

HPCCR does not use a reasonable basis to project payor mix. On pages 119-120, HPCCR uses 2017 data from the existing Cumberland County agencies, as a basis for its projected payor mix, claiming this is the most recent data available. However, 2024 LRAs (showing FY 2023 data) are available and should be considered as the most recent available information for analyzing payor mix. Moreover, HPCCR fails to consider or analyze agencies currently located in and serving Harnett, Robeson, and Sampson Counties even though it projects that over 38% of its patient volume will come from these counties. Additionally, HPCCR omits from its analysis the

numerous additional agencies not located in its four-county service area, which are currently serving residents in its four-county service area. Without considering the current payor mix in its four-county service area and the current services the residents in these counties are receiving, HPCCR's projected payor mix is unreasonable and outdated.

As discussed in Criterion (5), HPCCR also fails to recognize the difference between payor mix based on patients and days of care. Hospice patients in different categories have varying lengths of stays. Revenue is based on days of care and not patients served. Yet, HPCCR projects its gross revenue by payor on the basis of patients, not days of care. See pages 121-122 for payor mix of patients and page 151 for HPCCR's projected payor mix used in its revenue projections, which are the same.

Since HPCCR 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 underserved populations, elderly, medically indigent or low-income persons. HPCCR has not fully analyzed or considered information on hospice services provided to residents or medically underserved groups located in Cumberland, Harnett, Robeson, and Sampson Counties. Since HPCCR did not look for medically underserved or indigent communities or groups or minority or low-income groups, it missed important communities such as the Lumbee Tribe in Robeson County and failed to recognize that its proposed service area has a higher percentage of Hispanic residents than the North Carolina average. Therefore, HPCCR should be found non-conforming with Criterion (13).

Criterion (18a) HPCCR did not demonstrate the expected effects on competition

As discussed in Criteria (1), (3), and (13), HPCCR has not identified any underserved populations for which it can increase access to care. HPCCR has not fully analyzed or considered information regarding current hospice services provided to residents or medically underserved groups located in Cumberland, Harnett, Robeson, and Sampson Counties. Without knowing the level of accessibility to hospice for current service area residents, HPCCR cannot know or project what impact its project might have on cost-effectiveness, quality, and access to services in the proposed service area.

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

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

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

VIA Projected Utilization

Initiation of service and Month	4/1/26						1	2	3	4	5	6
	Partial Year (First 6 Months: April - September 2026)											
	10/1/2025	**11/1/2025**	**12/1/2025**	**1/1/2026**	**1/31/2026**	**3/1/2026**	**4/1/2026**	**5/1/2026**	**6/1/2026**	**7/1/2026**	**8/1/2026**	**9/1/2026**
Admissions	-	-	-	-	-	-	14	14	14	7	7	7
Days per Month	0	0	0	0	0	0	31	31	30	31	30	31
Month - mid point	0	0	0	0	0	0	15.5	15.5	15	15.5	15	15.5
PDs - mid-point (actual)	-	-	-	-	-	-	222	222	215	109	105	109
PDs - maximum	-	-	-	-	-	-	1,127	1,127	1,127	550	550	550
ALOS - Assumed	**78.6**	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6
Calc/Dist of PDs by Month												
1	-	-	-	-	-	-	**222**	**222**	**215**	**109**	**105**	**109**
2		-	-	-	-	-	-	444	430	444	210	217
3			-	-	-	-	-	-	430	444	430	217
4				-	-	-	-	-	-	30	30	37
5					-	-	-	-	-	-	-	-
6						-	-	-	-	-	-	-
7							-	-	-	-	-	-
8								-	-	-	-	-
9									-	-	-	-
10										-	-	-
11											-	-
12												-
PDs - Current Period Admissions	-	-	-	-	-	-	222	222	215	109	105	109
PDs - Prior Period Admissions												
PDs - Total	-	-	-	-	-	-	222	667	1,075	1,027	775	580
Patients Served From Prior Period												

Summary - Partial FY	
Admissions	64
Patient Days	4,346
Assumed LOS	78.6
Actual LOS	67.9
Carry Over Patients	-
Patients Served	64

VIA Projected Utilization

Initiation of service and Month	7	8	9	10	11	12	13	14	15	16	17	18
	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	15	15	15	15	15	15	15	15	15	15	15	15
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)	227	205	227	220	227	220	227	227	220	227	220	227
PDs - maximum	1,153	1,153	1,153	1,153	1,153	1,153	1,153	1,153	1,153	1,153	1,153	1,153
ALOS - Assumed	**78.6**	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6
Calc/Dist of PDs by Month												
1	**227**	**205**	**227**	**220**	**227**	**220**	**227**	**227**	**220**	**227**	**220**	**227**
2	217	411	455	440	455	440	455	455	440	455	440	455
3	217	196	455	440	455	440	455	455	440	455	440	455
4	15	11	29	60	53	31	38	31	24	31	31	38
5					-	-	-	-	-	-	-	-
6						-	-	-	-	-	-	-
7							-	-	-	-	-	-
8								-	-	-	-	-
9									-	-	-	-
10										-	-	-
11											-	-
12												-
PDs - Current Period Admissions	227	205	227	220	227	220	227	227	220	227	220	227
PDs - Prior Period Admissions	449	207	29									
PDs - Total	676	823	1,165	1,160	1,190	1,131	1,175	1,168	1,124	1,168	1,131	1,175
Patients Served From Prior Period	4	7	7									

Summary - 1st Full FY	
Admissions	176
Patient Days	13,085
Assumed LOS	78.6
Actual LOS	74.3
Carry Over Patients	18
Patients Served	194

VIA Projected Utilization

Initiation of service and Month	19	20	21	22	23	24	25	26	27	28	29	30
	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	18	18	18	18	18	18	18	18	18	18	18	18
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)	276	259	276	268	276	268	276	276	268	276	268	276
PDs - maximum	1,402	1,402	1,402	1,402	1,402	1,402	1,402	1,402	1,402	1,402	1,402	1,402
ALOS - Assumed	**78.6**	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6
Calc/Dist of PDs by Month												
1	**276**	**259**	**276**	**268**	**276**	**268**	**276**	**276**	**268**	**276**	**268**	**276**
2	455	517	553	535	553	535	553	553	535	553	535	553
3	455	425	553	535	553	535	553	553	535	553	535	553
4	31	24	46	55	55	38	47	38	29	38	38	47
5					-	-	-	-	-	-	-	-
6						-	-	-	-	-	-	-
7							-	-	-	-	-	-
8								-	-	-	-	-
9									-	-	-	-
10										-	-	-
11											-	-
12												-
PDs - Current Period Admissions	276	259	276	268	276	268	276	276	268	276	268	276
PDs - Prior Period Admissions	940	449	46									
PDs - Total	1,217	1,225	1,428	1,393	1,438	1,375	1,429	1,420	1,366	1,420	1,375	1,429
Patients Served From Prior Period	7	15	15									

Summary - 2nd Full FY	
Admissions	214
Patient Days	16,513
Assumed LOS	78.6
Actual LOS	77.2
Carry Over Patients	37
Patients Served	251

VIA Projected Utilization

Initiation of service and Month	31	32	33	34	35	36	37	38	39	40	41	42
	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	20	20	20	20	20	20	20	20	20	20	20	20
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)	313	282	313	303	313	303	313	313	303	313	303	313
PDs - maximum	1,585	1,585	1,585	1,585	1,585	1,585	1,585	1,585	1,585	1,585	1,585	1,585
ALOS - Assumed	**78.6**	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6	78.6
Calc/Dist of PDs by Month												
1	**313**	**282**	**313**	**303**	**313**	**303**	**313**	**313**	**303**	**313**	**303**	**313**
2	553	565	625	605	625	605	625	625	605	625	605	625
3	553	499	625	605	625	605	625	625	605	625	605	625
4	38	29	73	83	73	43	53	43	32	43	43	53
5					-	-	-	-	-	-	-	-
6						-	-	-	-	-	-	-
7							-	-	-	-	-	-
8								-	-	-	-	-
9									-	-	-	-
10										-	-	-
11											-	-
12												-
PDs - Current Period Admissions	313	282	313	303	313	303	313	313	303	313	303	313
PDs - Prior Period Admissions	1,143	528	73									
PDs - Total	1,456	1,375	1,636	1,595	1,636	1,555	1,616	1,605	1,545	1,605	1,555	1,616
Patients Served From Prior Period	9	18	18									

Summary - 3rd Full FY	
Admissions	242
Patient Days	18,795
Assumed LOS	78.6
Actual LOS	77.7
Carry Over Patients	45
Patients Served	287

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.

<u>Projected Average Net Revenue per Days of Care</u>

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**