Comments on the MH Mission Hospital, LLLP

Certificate of Need Application

Project ID # B-012057-21

May 28, 2021

In accordance with *N.C. Gen. Stat*. § 131E-185(a1)(1), Messino Cancer Centers, a division of American Oncology Partners, PA ("AOP"), submits these comments on the certificate of need application filed by HCA's MH Mission Hospital, LLLP ("MH"). Nothing in these Comments is intended to amend the AOP Application and nothing contained here should be considered an amendment to the AOP Application as submitted.

The 2021 State Medical Facilities Plan ("2021 SMFP") found there is a need for one additional fixed PET scanner in HSA I. Two applications to meet this need were filed by AOP[1] and by MH.[2] The Agency must decide which, if any, application to approve. An application can be approved only if it conforms to the CON review criteria and meets the performance standards. If both applications satisfy these requirements, the Agency must decide which application is the most effective alternative to meet the needs of HSA I residents.

In its application, AOP demonstrated it conforms to the CON review criteria and meets the performance standards. Having now reviewed the MH application, AOP will show the Agency:

- The MH application has not shown it conforms to the CON review criteria or meets the performance standards due to MH's inconsistencies and unreasonable and inadequately supported assumptions.

- The AOP application is the more effective alternative as compared to the MH application because, as shown in an analysis of the comparative factors typically relied upon by the Agency, AOP better maximizes healthcare value for the resources expended, better promotes equitable access to PET services, and better increases access for underserved groups.
- Specifically, the AOP application is the more effective alternative as compared to MH on ALL of the following comparative factors:
    - Conformity with applicable Statutory and Regulatory Review Criteria
    - Patient Access to Alternative Providers of fixed PET Scanner Services
    - Projected Access by Charity Care Recipients
    - Projected Access to Reduced-Cost Care Patients
    - Projected Access by Medicare Recipients
    - Projected Access by Medicaid Recipients

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[1] American Oncology Partners, CON Application to Acquire a Dedicated Fixed PET/CT Scanner Project ID #B-012059-21.
[2] MH Mission Hospital, LLLP, CON Application to Acquire a Dedicated Fixed PET/CT Scanner Project ID #B-012057-21.

- Projected Average Net Revenue per Procedure
- Projected Average Operating Expense per Procedure
- Geographic Accessibility

- The MH application does not compare favorably in terms of the scope of services offered, as it does not document it has the resources available to provide cardiac PET.

AOP first presents a comparative analysis of the AOP and MH proposals. The discussion that follows the comparative analysis demonstrates the reasons why the MH application fails to adequately demonstrate conformity with the applicable statutory and regulatory review criteria.

COMPARATIVE ANALYSIS

Conformity with the Review Criteria

For the reasons discussed below, only AOP adequately demonstrated its proposal is conforming to all applicable statutory and regulatory review criteria. The AOP application is the only effective alternative with regard to conformity with the review criteria.

Patient Access to a New Provider

Equitable access for patients includes expanding patient and physician choice of providers for PET scans in HSA I. There are only two providers of fixed PET services in HSA I—one in Buncombe County, and one in Catawba County.

Mission is now the only provider of fixed PET services in Buncombe County. If MH's application is approved, Mission would remain the only provider of fixed PET services in Buncombe County. Approval of AOP's application would create a second provider of fixed PET services in Buncombe County and a third provider of fixed PET services in HSA I.

As an example of how a new provider can increase access to services, AOP will offer weekend and evening hours of service on its proposed PET scanner. AOP staffing levels are sufficient for providing expanded access as proposed in the AOP CON application. The MH application does not indicate plans for weekend and evening hours of service on the proposed scanner. AOP's expanded hours will help working people who need PET scans or who must transport family members.

Introducing a new provider in the service area will encourage all providers in the service area to improve quality, access and value to compete for patients. With regard to providing HSA I residents with access to an alternative provider of fixed PET services, the proposal submitted by AOP is the most effective alternative.

Access by Underserved Groups

For promoting equitable access and increasing access by underserved groups, applications are generally measured for three underserved groups: charity care patients (i.e., medically indigent or low-income persons), Medicare patients, and Medicaid patients. Access by each group is treated as a separate factor.

The Agency may use one or more of these metrics to compare the applications:

- Total charity care, Medicare, or Medicaid patients
- Charity care, Medicare, or Medicaid patients as a percentage of total patients

- Charity care, Medicare, or Medicaid patients per scanner
- Total charity care, Medicare, or Medicaid dollars
- Charity care, Medicare, or Medicaid dollars as a percentage of total net revenues
- Charity care, Medicare, or Medicaid dollars per scanner

Whether the Agency uses all the metrics listed above is generally determined by whether each application included data that could be compared for each metric.

Projected Charity Care

The table below compares the number of charity care patients MH and AOP projected in each of the first three years of operations. MH stated it would serve 64 charity patients in its third year of operation; however, that is based on 1.4% of "the total" projected PET volumes for MH.[3] That is, those 64 patients will be served on the two PET machines at MH.[4] Assuming the payor mix is the same for both machines, the new proposed scanner would perform only half of the charity care scans and serve only 32 additional charity care patients.

AOP projects charity care patients will receive 3 percent of its total scans, or 66 scans in the third year. This is over twice the number of additional charity care scans MH proposes. Messino Cancer Center physicians agreed to provide this amount of charity care, as evidenced by their letters of support in Exhibit C-4.1. In the third project year, AOP proposes to do more charity care scans on one scanner than MH projects to perform on two scanners. AOP will better enhance access to PET services for charity care patients.

Projected Charity Care Patients, First Three Full Project Years

	1st Full FY	2nd Full FY	3rd Full FY
MH-Both Scanners	54	59	64
MH-Proposed Scanner*	27	29	32
AOP-Proposed Scanner	51	58	66

**Assumes half the charity care scans will be performed on the proposed scanner.*
Sources: AOP application, p. 103; MH application, p. 110.

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[3] MH CON Application, p. 109.
[4] 1.4% x 4,496 (scans on both PETs shown in Form C.2b) = 62.94. Note: MH states on page 32 of its application, "the proposed PET/CT will serve 54 Charity Care patients in the 1st Full FY, 59 in the 2nd Full FY, and 64 in the 3rd Full FY." This is inaccurate. Those numbers are the number of charity care scans that will be performed on both of the scanners. If MH intends to perform all charity scans on the proposed scanner, it is only because they are directing all of their charity care patients to one scanner and doing no charity care scans on the existing scanner.

As shown in the table above, AOP projects to serve the highest percentage and highest number of charity care patients in Project Year 3. The application submitted by AOP is the most effective alternative with regard to projected access by charity care recipients.[5]

Projected Reduced-Cost Patients

The newest CON application form has a question in Section L about the number of reduced-cost patients an applicant proposes to serve. Although this has not been a comparative factor in past reviews, it may be a useful comparison for the Agency now.

Section L, Question 4b requires applicants to project the number of patients estimated to be served "by the entire facility." However, both AOP and MH showed the number of reduced-cost PET patients to be served. In keeping with its methodology for projecting charity care patients, MH projected the number of reduced cost patients "by applying the 0.9% Self-Pay portion ... to the total projected PET volumes for Mission Hospital for Years 1–3 of the project."[6] This resulted in 42 reduced-cost patients in the third year of operations, across both scanners. Again, assuming half the scans are performed on each scanner, approval of the MH application means only 21 more reduced-cost patients receive scans.

AOP projects it will serve 54 reduced-cost patients in the third year, on one scanner. AOP will provide more access to care for medically indigent patients on one scanner than MH proposes on two scanners. AOP projected the number of reduced-cost patients by dividing the bad debt revenues by the average charge per scan to arrive at the total number of scans it would provide if no payment were received.[7] As discussed in the application, this underestimates the number of patients who will likely receive reduced care costs, as bad debt write-offs are often for a portion of the payment that a patient cannot afford (see AOP application, page 104).

Projected Reduced-Cost Patients, First Three Full Project Years

	1st Full FY	2nd Full FY	3rd Full FY
MH-Both Scanners	36	39	42
MH-Proposed Scanner*	18	19	21
AOP-Proposed Scanner	42	48	54

**Assumes half the reduced-cost patient volume will be performed on the proposed scanner.*
Sources: AOP application, p. 104; MH application, p. 110.

AOP's methodology for projecting reduced-cost patients is conservative, adequately supported, and shows AOP's proposal does the most to improve access for medically indigent patients. If

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[5] Please see discussion below of MH's non-conformity with Criterion (13).
[6] MH CON Application, p. 110.
[7] For example, on Form F.2b, AOP projected $228,542 in bad debt write-offs in the third year. Divided by the average charge of $4,180, this amounts to 54.7 full PET scan payment amounts.

AOP's methodology (dividing projected Y3 bad debt write-offs by Y3 average charge) is applied to MH, MH has fewer reduced-cost patients (29)[8] than AOP (54) in the third project year.

AOP believes its methodology for projecting reduced-cost patients captures the reality that reduced-cost care can be provided to patients across payor categories. However, to provide a comprehensive comparison of the two applications, the table below shows the number of patients AOP would serve using MH's methodology. The table below applies the self-pay percentage to total year three volumes at MH's proposed PET scanner, and the same at AOP's proposed scanner. As the table shows, even using MH's methodology, AOP offers better access to reduced-cost care than MH.

Projected Reduced-Cost Patients, Using MH's Methodology-Third Full Year

	Self-Pay Percent	Volume on Proposed Scanner	Calculated Reduced Cost Patients
MH-Proposed Scanner	0.9%	2,135	19
AOP-Proposed Scanner	1.0%	2,187	22

**Assumes half the reduced-cost patient volume will be performed on the proposed scanner.*
Sources: AOP application, pp. 114 and 129; MH application, pp. 108 and 124.

As shown in the tables above, the application submitted by AOP is the more effective alternative with regard to projected access by reduced-cost recipients. Using all potential metrics, AOP's proposal is the more effective alternative on this factor as AOP will serve more reduced-cost patients than MH's proposed second scanner.

Projected Access by Medicare Recipients

The table below compares Project Year 3 projections for the total number of procedures, the percentage of gross revenues attributable to Medicare patients, and the resulting number of Medicare PET procedures. Applying the percent of gross revenues is a reasonable proxy for patient volume percentage, as gross charges are uniform, regardless of payor. Generally, the application proposing either the higher percentage or number of Medicare procedures is the more effective alternative for this metric.

Projected Medicare PET Procedures, Third Full Project Year

	Total Procedures	Percent Medicare	Medicare Procedures
MH-Proposed Scanner	2,135	66.5%	1,420
AOP-Proposed Scanner	2,187	69%	1,509

Sources: AOP application, pp. 114 and 129; MH application, p. 131.

[8] Bad Debt at Vanderbilt Cardiac HOPD PET in Year 3 is $279,358, as shown on page 130 of its application. The average charge per patient is $9,568, as shown on page 131. $279,358 / $9,568 Y3 Average Charge = 29.2 patients.

As shown in the table above, AOP projects to serve the higher percentage and higher number of Medicare patients in Project Year 3. The application submitted by AOP is the most effective alternative with regard to projected access by Medicare recipients.

Projected Access by Medicaid Recipients

The table below compares Project Year 3 projections for the total number of procedures, the number of Medicaid procedures, and Medicaid procedures as a percentage of total patients. Generally, the application proposing either the higher percentage or the higher number of Medicare patients is the more effective alternative for this comparative factor.

Projected Medicaid PET Procedures, Third Full Project Year

	Total Procedures	Percent Medicaid	Medicaid Procedures
MH-Proposed Scanner	2,135	4.7%	100
AOP Proposed Scanner	2,187	6%	131

Sources: AOP application, pp. 114 and 129; MH application, p. 131.

As shown in the table above, AOP projects to serve the higher percentage and higher number of Medicare patients in Project Year 3. The application submitted by AOP is the more effective alternative with regard to projected access by Medicare recipients.

Projected Average Net Revenue per Procedure

The table below shows the projected net revenue per procedure in Project Year 3 for each applicant, based on the information provided in the applicants' pro forma financial statements (Form F.2b). Generally, the application proposing the lower average net revenue per procedure is the more effective alternative.

MH's net revenue per PET procedure is 150% higher than AOP's. AOP projects to provide services at a lower net revenue per procedure than MH.

Projected Average Net Revenue per PET Procedure, Third Full Project Year

	Total Procedures	Total Net Revenue	Average Net Revenue per Procedure
MH-Proposed Scanner	2,135	$4,871,580	$2,281.77
AOP-Proposed Scanner	2,187	$3,264,999	$1,492.91

Sources: AOP application, pp. 114 and 128; MH application, p. 130.

Both applications offer the same PET/CT services. The only potential difference is the cardiac scans, but the MH projections for cardiac PET scans are not based on reasonably and adequately

supported assumptions on the cost or revenue for these scans. *See* discussion of MH application's non-conformity with Criterion (5).

AOP projects the lower average net revenue per procedure in Project Year 3. AOP's projected average net revenue per procedure is based on reasonable and adequately supported assumptions. Therefore, the application submitted by AOP is the more effective alternative with regard to average net revenue per procedure in Project Year 3.

Projected Average Operating Expense per PET Procedure

The table below shows the projected average operating expense per procedure in Project Year 3 for each applicant, based on the information provided in the applicants' pro forma financial statements (Form F.4). Generally, the application proposing the lower average operating expense per procedure is the more effective alternative for this comparative factor.

AOP projects the lower average operating expense per procedure in Project Year 3. AOP's projected total procedures are based on reasonable and adequately supported assumptions. AOP's lower operating costs are not attributable to lower staffing or lower salaries. As shown in Form H, AOP will employ 2.75 PET/CT technologists at an average salary of $94,526.19.[9] In its third project year, MH will employ two additional technologists (it now employs two at its existing scanner) at an average salary of $94,553 per year.[10] The salaries are comparable, and AOP projects employing more technologists than MH. AOP also has a front desk representative and a business office person, while the MH staff is only technologists. Therefore, the application submitted by AOP delivers greater healthcare value for the resources expended than MH.

Projected Average Operating Expense per PET Procedure, Third Full Project Year

	Total Procedures	Operating Expenses	Average Operating Expense per Procedure
MH-Proposed Scanner	2,135	$2,109,789	$988.19
AOP-Proposed Scanner	2,187	$1,735,095	$793.37

Sources: AOP application, pp. 114 and 132; MH application, pp. 131 and 136.

The Agency has often found comparisons of this factor to be inconclusive because of differences in services and case mix. That is not a problem in this comparison. Both applications offer the same PET/CT services. The only potential difference is the cardiac scans, and MH's expenses do not include the additional expenses for cardiac PET scans. The Agency should find AOP delivers greater healthcare value for the resources expended than MH and is the more effective alternative on this factor.

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[9] AOP CON application, Form H, p. 136.
[10] MMC CON Application, Form H, p. 138.

AOP projects the lower average operating expense per procedure in Project Year 3. AOP's projected total procedures are based on reasonable and adequately supported assumptions. Therefore, the application submitted by AOP is the more effective alternative with regard to average operating expense per procedure in Project Year 3.

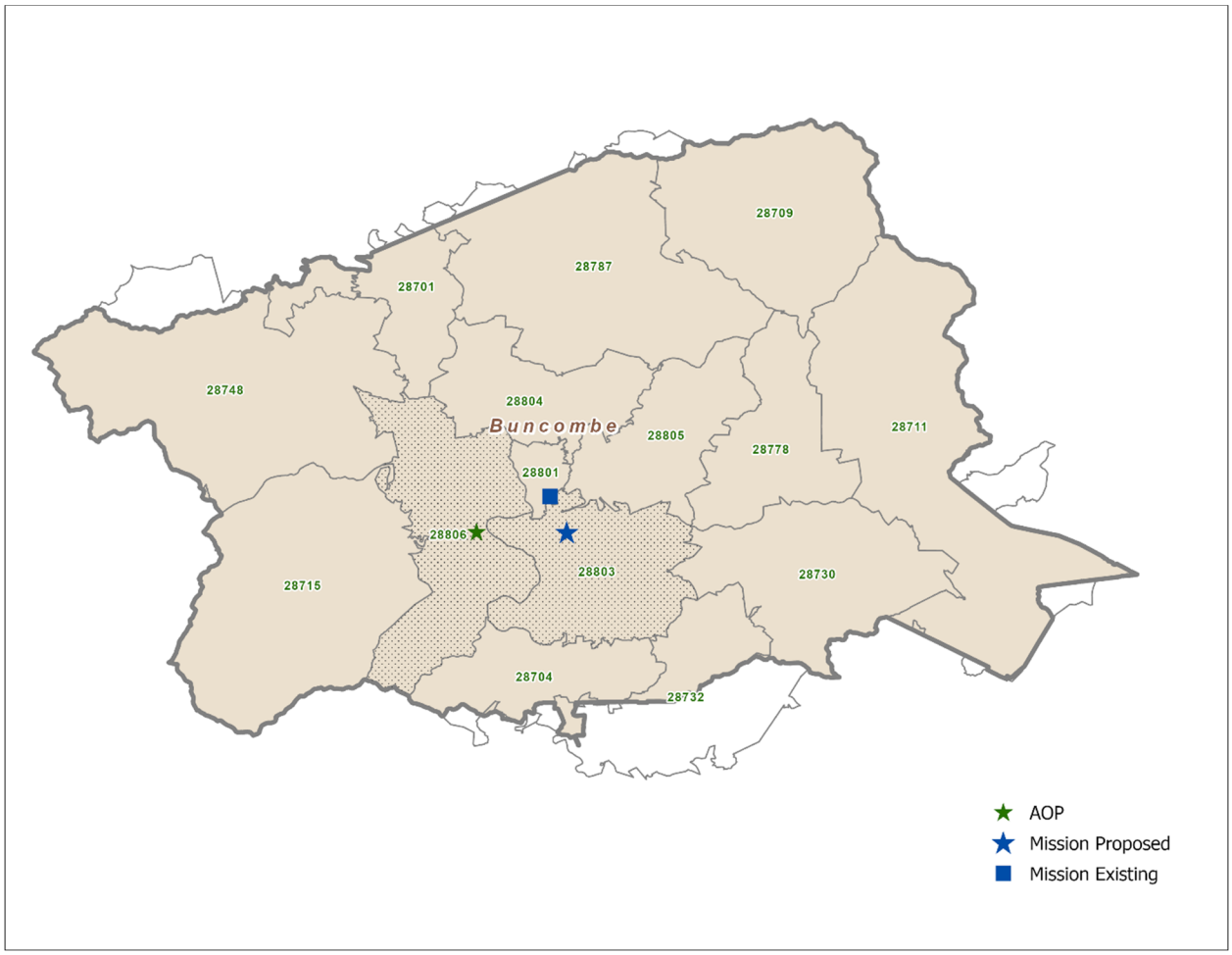
Geographic Accessibility

AOP proposes the Agency consider the better geographic accessibility AOP provides. The 2021 Need Determination is for HSA I, which includes Alexander, Alleghany, Ashe, Avery, Buncombe, Burke, Caldwell, Catawba, Cherokee, Clay, Cleveland, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes, and Yancey Counties.

It is likely that all or nearly all patients residing in the western counties of HSA I (Cherokee, Clay, Graham, Macon, Swain, Jackson, and Haywood) who choose to be served on a North Carolina PET scanner would be closer to the AOP PET scanner than to the proposed MH PET scanner at the Vanderbilt Cardiac HOPD.

Patients from the western Counties could more easily access the AOP PET scanner because accessing the scanner would not require travel into the more congested area near Mission Hospital. Although the applicants' proposed locations are both in Buncombe County, the AOP scanner would provide superior access for residents of the counties in the westernmost portion of HSA I. The map below shows the two applicants' proposed locations.

PET Applicants' Proposed Locations in Buncombe County



The AOP location is in zip code 28806:

- 28806 can be classified socioeconomically as a lower-middle-class zip code, compared to other zip codes in North Carolina.
- Nearly 70% (69.7%) of students in 28806 public schools receive or are eligible to participate in free or reduced lunch programs.
- The AOP site (551 Brevard Road) is near the 36-acre WNC Farmers Market (570 Brevard Road), which is open every day year-round as a regional center of agricultural activity. The market, located between two major interstate highways, has been a mainstay in Asheville for over 40 years.

MH proposes to locate its scanner in zip code 28803:

- 28803 can be classified socioeconomically as a middle-class zip code compared to other zip codes in North Carolina.

- About 45.7% of students in 28803 public schools receive or are eligible to participate in free or reduced lunch programs.
- The Vanderbilt Cardiac HOPD location is considered part of the Biltmore South neighborhood.
- The adjacent area, Biltmore Forest, is the second wealthiest town in North Carolina by per capita income ($85,044).
- The average household income ($67,963) for 28806 is less than the average household income for 28803 ($81,802), Asheville ($70,949), and Buncombe County ($74,505).
- The per capita income for 28806 is $29,407, less than the per capita income for 28803 ($38,543), Asheville ($33,176), and Buncombe County ($32,426).
- The percent of high-income households (3.5%) for 28806 is less than the percent of high-income households for 28803 (5.8%), Asheville (5.2%), and Buncombe County (5.0%).[11]

Although both applicants propose to locate the fixed PET scanner in Buncombe County, the location proposed by AOP is over 5 miles from the existing MH PET scanner location, creating a different point of access for patients as compared to the proposed MH location, which is only about 2 miles from the existing MH PET scanner location.

MH chose to locate its proposed scanner in an area with higher average household income, higher per capita income, and higher percent of high-income households, as compared to Asheville, Buncombe County, and the area AOP chose. (*See* Review of Caldwell Surgery Center, Project ID #E-10261-14.) While the Agency may identify the applications as equally effective (as both propose a Buncombe County location), the considerations discussed above suggest the AOP location will be a more effective alternative for patient access.

Scope of Services

The Agency has not typically utilized a "Scope of Services" comparative factor in PET reviews. Here, AOP anticipates MH will advocate for use of such a comparative factor. If the Agency endeavors to so compare the applications, the following will be important considerations. (The considerations discussed here also relate to specific non-conformities in the MH application which are discussed below in relation to the applicable criteria.)

MH says it will perform cardiac PET scans in addition to oncology scans. MH does not have the equipment or staff required for cardiac scans, however. The broader scope of services described

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[11] See https://www.incomebyzipcode.com/northcarolina.

in the MH application does not show greater healthcare value that justifies the additional project cost, for several reasons:

A. The MH application does not include the equipment, staffing, and operating expenses needed to perform cardiac PET scans.

B. The higher MH project costs for a second scanner are not due to offering cardiac PET scans.

C. Agency approval of the AOP application will allow MH to add the equipment and staffing for cardiac PET scans at its existing scanner at a lower cost and without further CON review.

A. <u>The MH Application Does Not Include the Equipment, Staffing, and Operating Expenses Needed to Perform Cardiac PET Scans</u>

Radiopharmaceuticals Required for Cardiac PET Scans

All PET scans use radiopharmaceuticals which are injected into the patient. Radiopharmaceuticals are billed separately from the scan, and each has its own HCPCS code. Each radiopharmaceutical has its own half-life, supply chain, and cost. Most cardiac PET scans use different radiopharmaceuticals than oncology scans. The MH application does not include the equipment or operating costs for the radiopharmaceuticals for cardiac PET scans. Instead, MH assumed its operating costs for the new PET scanner will be the same as its existing scanner, which does not offer cardiac PET scans.

Oncology PET scans generally use FDG, which is produced in bulk by a cyclotron at a central pharmacy, drawn up in individual syringes (one syringe per patient), and transported to a PET facility based on daily patient volume. FDG has a half-life of approximately 2 hours, allowing for daily transportation before the doses decay away. The HCPCS code for FDG is A9552. Acquisition costs for FDG range from $100 to $300 per patient, depending on the contract price negotiated between the facility and the supplier.

One type of cardiac PET scan uses FDG rather than rubidium or ammonia. The procedure is myocardial imaging, PET, metabolic evaluation study, and its HCPCS code is 78459. This scan assesses the heart's metabolic activity and muscle viability to identify whether a patient is a good candidate for revascularization. Facilities with a PET scanner but without a rubidium generator or cyclotron can perform this scan. This is the only type of scan reported by hospitals in Mecklenburg and Forsyth Counties, and it accounts for only 8.2 percent of cardiac PET scans in North Carolina performed on Medicare beneficiaries. No North Carolina hospital performed over ten of these outpatient procedures on North Carolina Medicare beneficiaries in 2019.

The vast majority of cardiac PET scans require different radiopharmaceuticals with different half-lives, different supply chains, and different costs. Most cardiac PET scans use rubidium as the radiopharmaceutical. The HCPCS code for rubidium is A9555, and its half-life is 75 seconds. It is not produced in a cyclotron but occurs naturally from the radioactive decay process of strontium 82. A rubidium generator is essentially a shielded container for strontium 82. By running saline over strontium 82, it is possible to "generate" naturally occurring rubidium 82 from strontium's decay. The rubidium solution is immediately injected into a patient with a preexisting IV line to allow images to be captured before it decays. A rubidium generator is constantly producing rubidium until the strontium decays completely. Strontium 82 has a half-life of 25 days, so the useful shelf-life of a rubidium generator is typically between four and eight weeks before it must be replaced.

Another radiopharmaceutical that can be used for cardiac PET imaging is N–13 ammonia. This radiopharmaceutical is produced with a cyclotron and has a very short half-life. Therefore, the radiopharmaceuticals cannot be transported, and the PET machine must be located next to the cyclotron. Cyclotrons are expensive, costing over $2 million, and are usually found in university health systems that also use the cyclotron to produce other isotopes for research. The HCPCS code for N–13 ammonia is A9526. Duke University is the only hospital in North Carolina that billed this HCPCS code in the 2019 outpatient Medicare data.

The two North Carolina hospitals that performed many cardiac PET scans—University of North Carolina Hospital and Rex Hospital—use rubidium for the majority of their scans. In 2019, when the Agency approved UNC Rex Hospital for a second PET scanner under the 2019 Need Determination, it showed it had included all ancillary services for cardiac PET, including a rubidium generator. The Agency stated:

> *UNC REX has all necessary ancillary and support services in place including a Rubidium generator, which allow[s] it to produce the radiotracer required for cardiac PET imaging.*[12]

MH—unlike Rex—did not show it has an existing rubidium generator, or a specific plan and budget to ensure availability of one. Bracco Diagnostics Inc. is a national supplier of rubidium generators. Its 2021 term sheet is shown below.

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[12] Agency Findings, Rex Hospital PET Scanner Project I.D. # J-11659-19, p. 20.

BRACCO
LIFE FROM INSIDE

CARDIOGEN-82® (Rubidium Rb 82 Generator)
2021 TERM SHEET

Products:	CardioGen-82 (Rubidium Rb 82 generator) CardioGen-82 Infusion System
Term Terms of agreement:	2 years with 90-day termination at end of term, with one year evergreen
Quantity:	17 generators per year (1 every 21 days) 13 generators per year (1 every 28 days) 10 generators per year (1 every 35 days) 8 generators per year (1 every 42 days)
Price:	**21-day cycle:** $42,558.00 per generator SKU 1500 **28-day cycle:** $42,558.00 per generator SKU 1500 **35-day cycle:** $45,388.00 per generator SKU 1507 **42-day cycle:** $48,778.00 per generator SKU 1509 **NOTE:** There is an additional shipping charge of $175.00 per generator
Payment terms:	Net 30 days
Notification:	*90-day advance notice to term of contract
Infusion System:	$2,500.00 per month (plus one-time $5,000.00 shipping & set-up fee, and state sales tax where applicable)

* Bracco will work with you on an individual basis to expedite delivery.

This Term Sheet does not contain all matters on which agreement must be reached in order for a purchasing relationship to be commenced, and creates no binding rights in favor of either party. A purchasing relationship will commence only after execution and delivery of Bracco's form of Agreement, subject to the terms and conditions therein. The terms set forth in this Term Sheet are subject to change by Bracco at any time within Bracco's sole discretion.

The annual cost of rubidium, the radiopharmaceutical required for most cardiac PET scans, includes generators, shipping, and the infusion system. Using 2021 prices without inflation to 2025, the radiopharmaceutical cost to MH for rubidium is $882 to $1,224 per scan.

	28-Day Cycle	**42-Day Cycle**
Rubidium Generators	$553,254	$390,224
Shipping	$2,275	$1,400
Infusion System	$30,000	$30,000
Annual Cost	$585,529	$421,624
MH Year 3 Cardiac Scans	478	478
Radiopharmaceutical Cost Per Cardiac Scan	$1,224.96	$882.06
MH Pro Forma Cost Per Scan	$374.11	$374.11
MH Pro Forma Shortfall Per Scan	$850.85	$507.95
Total Pro Forma Shortfall	$406,704	$242,799

Sources: Bracco Term Sheet.

In its application, MH assumed its average cost per scan for radiopharmaceuticals in Year 3 would be $374.11, the same as in 2020, and MH did not offer cardiac PET in 2020.[13] MH understated its cost for cardiac PET scans by $508 to $851 per cardiac scan. The expenses in its pro forma for Year 3 are understated by $242,799 to $406,704. More importantly, MH failed to include essential equipment without which it cannot perform the projected number of cardiac scans.

Staff Required for Cardiac PET

The MH application lacks essential staff to provide cardiac PET scans. On page 80 of its application, MH says it needs a "cardiac nurse" to offer a cardiac PET service:

> *Myocardial PET scans are performed on patients in conjunction with stress testing, which is performed by a cardiac nurse.*

On Form H, MH did not list a cardiac nurse, had no FTE projection for a cardiac nurse, and had no salary or benefits package for a cardiac nurse.

MH cannot claim it will "borrow" a cardiac nurse from the PET scanner operation at the SECU Cancer Center, as MH does not offer cardiac PET scans. MH cannot rely on the services of nurses in its cardiac department for its proposed cardiac PET scanner without a Form H budgeted FTE allocation to assign costs for a cardiac nurse to its proposed cardiac PET project. A cardiac nurse is not "corporate overhead."

To the extent MH believes it can rely—with no budget or specific plans—on "existing" nursing and radiology techs, its assumptions are flawed. MH is seeking CON approval for a PET scanner

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[13] MH CON application, pp. 133, 135. 137.

to offer a PET service that includes both oncology and cardiac utilization. It must document its plans and the associated costs of hiring or utilizing the services of the staff necessary to offer that PET service, just as it must show the need for those PET services and the financial feasibility of the services based on reasonable assumptions about the costs of offering the service. It has not done so.

MH provides nothing to show plans or a budget for hiring the specially trained nurses who will put patients under pharmacological stress via IV-administered medications with their cardiac PET imaging. Such manpower is essential to offering a cardiac PET service, and it is not shown in the MH application. MH does not have the staff needed to perform cardiac PET scans.

The MH application also failed to include the administrative staff for patient scheduling and billing. Our complete analysis of this flaw is found in the discussion of Criterion (7).

To summarize, the MH application does not include essential equipment, supply costs, or staff to perform cardiac PET scans. The application only covers the same oncology scans AOP will perform with fewer resources and at a lower cost. MH cannot offer higher healthcare value for its higher costs.

B. The Higher MH Project Costs for a Second Scanner Are Not Due to Offering Cardiac PET Scans

The table below compares the AOP and MH project costs. The difference in project costs is $2,891,671. In its application, MH lists the cardiac-specific equipment and software as: a PET Cardiac Package, Low Dose 5-beat Cardiac with SnapShot Assist Package, Ivy 7800 Cardiac Monitoring Kit, and CardIQ Xpress Reveal Digital Kit.[14] The cost of these components as listed in Exhibit F-1.2 is $128,280. In addition to these items, AOP notes the SmartScore 4.0 Digital Kit and SnapShot Imaging package are described as being used for coronary artery calcium scoring, and has added the associated $33,080 to the cardiac cost category in the table below. All other project costs are required for oncology PET scans. Even if MH had included in the application the equipment and staff to perform cardiac scans, most of the difference in project cost does not increase healthcare value.

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[14] MH CON application, p. 38

Comparison of AOP and MH Project Costs

	AOP	MH
Renovation	$ 564,071	$ 1,893,000
Architect/Engineering Fees	$ 50,000	$ 176,000
Medical Equipment*	$ 1,229,960	$ 2,271,442
PET Cardiac Package		$ 7,540
Low Dose 5-Beat Cardiac Package		$ 69,745
Ivy 7800 Cardiac Monitoring Kit		$ 30,415
CardIQ Xpress Reveal Digital Kit		$ 20,580
SmartScore 4.0 Digital Kit		$ 8,575
SnapShot Imaging Package		$ 24,505
Cardiac Items Subtotal		*$ 161,360*
Non-Medical Equipment	$ 50,000	$ 61,100
Furniture	$ 12,000	$ 28,000
Consultant Fees	$ 100,000	$ 42,400
Contingency Costs**	$ 100,000	$ 364,400
Total	**$ 2,106,031**	**$ 4,997,702**

**Does not include Cardiac costs below*

***MH contingency costs include sales tax*

Sources: AOP application Form F.1a, MH application, Form F.1a and Exhibit F-1.2

Much of the difference in cost is cost to remodel interior space in an MH medical office for the PET equipment. There is no medical need to locate PET equipment in such expensive space. MH says the location will provide "convenient access for cardiac patients."[15] There is no claim cardiac patients cannot access the SECU location as conveniently. Convenience is not need and, in this case, does not increase healthcare value. AOP chose a location that can be built out for the PET equipment and support space economically. MH did not.

Besides the components related to cardiac PET, MH chose a PET scanner that costs $1 million more than the scanner AOP specified. There is no evidence the GE scanner will deliver more healthcare value than the Siemens scanner AOP specified. AOP now operates five PET scanners in three locations. As a physician-directed organization, it has the experience and technical expertise to select cost-effective scanners to support its oncologists.

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[15] MH application, p. 31.

C. Agency Approval of the AOP Application Will Reduce PET Volume at MH and Allow MH to Add the Equipment and Staffing for Cardiac PET Scans at its Existing Scanner at Lower Cost and without Further CON Review

MH states on page 31 of its application, "Currently, the lack of capacity on the existing PET/CT at SECU Cancer Center is prohibitive of allowing access to patients that need imaging to detect cardiovascular disease." Agency approval of the AOP application will add the same capacity to the Asheville area as approval of the MH application. Approval of the AOP scanner will establish additional PET capacity in the service area and allow MH to add components for cardiac PET scans on its existing scanner.

As shown in the table on the previous page, MH includes $161,360 in cardiac-specific costs for its PET scanner. Presumably, MH could add the same or similar software and equipment to its existing scanner. It is reasonable to assume MH could upfit its machine for cardiac PET for approximately $200,000, based on the costs included in its application. These modifications to an existing PET scanner can be done without CON review.

The combined cost of equipping the MH PET scanner for cardiac scans and the AOP project cost is $2,306,031. This is $2,691,671 less than the MH project cost. The Agency approval of AOP will maximize healthcare value for the resources expended by approving the more effective AOP application and denying the less effective MH application.

Additional Considerations

Project Cost

Although the Agency does not typically use "project cost" as a comparative factor, in this review, AOP suggests it may be appropriate to compare the applications in terms of the resources to be expended to meet the need for new PET scanning capacity for HSA I as both applications propose acquisition of a new PET scanner to be located in renovated medical office space.[16]

The project cost for AOP is $2,106,031, and the project cost for MH is $4,997,702. The MH project costs over twice the AOP project. AOP's cost is less for facility renovation and for equipment. Relative to meeting the need for additional PET capacity in HSA I, both applications add the same scanning capacity but AOP expends far fewer resources to add the capacity. The AOP application shows the capacity can be added with far fewer resources (*i.e.*, lower project cost and operating costs) than the MH application. This means (1) the AOP application is a more effective alternative

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[16] The medical office space MH proposes to renovate functions as Mission's cardiac hospital-based outpatient department.

and, as discussed below, (2) the MH application does not conform to Policy GEN-3 or to Criterion (1).

Possible Overutilization of Cardiac PET

Single-photon emission computerized tomography (SPECT) is an alternative imaging modality that can be used instead of cardiac PET. The cost to the patient and health plan for a cardiac PET scan is greater than for a SPECT scan. The table below shows the difference in the 2021 Medicare allowed amounts for the most common cardiac PET scan and a SPECT scan, if both were performed at MH in 2021. The cardiac PET scan costs Medicare and the patient $881.59 more than the SPECT scan. These amounts include payment for the radiopharmaceuticals.

Medicare Payment to MH for SPECT and Cardiac PET Procedures

	Medicare Payment	Patient Coinsurance	Total
SPECT (78452)	$975.11	$243.78	$1,218.89
PET (78431)	$1,680.38	$420.10	$2,100.48

Source: EncoderPlus.

The CON Law is intended to control costs and ensure "only appropriate and needed" services are made available. N.C. Gen. Stat. §131E-175. Patients appropriate for SPECT scans should not receive higher-cost cardiac PET scans just because it is in the interest of the hospital. Because the hospital pays a fixed price of $422,000 to $585,000 annually for the rubidium generator, the hospital has an increased incentive to perform cardiac PET scans on patients appropriate for SPECT scans to reduce the average cost per cardiac PET radiopharmaceutical. The incentive to use additional resources for a more expensive technology that does not increase healthcare value for the patient makes the MH application a less effective alternative.

COMPARATIVE ANALYSIS

In this competitive review, the Agency has two concrete and detailed options to meet the need for a new PET scanner in HSA I. The need is for more PET capacity in HSA I. The 2021 SMFP shows a need for a new fixed PET scanner because the existing PET scanner at MH performed over 2,080 scans in the year ending September 2019. Both applications propose new fixed PET scanners in remodeled locations.

The MH application is the less effective alternative because it has higher project cost, higher net revenue per scan, and higher operating expense per scan than the AOP application. The MH application offers a less effective alternative for access to care for charity care, Medicare and Medicaid recipients. Only AOP will offer a fully-conforming, new alternative proposal for PET services for HSA I.

While MH claims it will provide cardiac PET scans, the MH application does not include the equipment, staff, or operating expenses necessary for cardiac scans. Further, the higher project costs are unnecessary to provide cardiac PET scans in HSA I. Approval of the AOP application will allow MH to equip its existing scanner for cardiac PET scans. The sum of the AOP project cost and the cost to equip the existing MH scanner to perform cardiac PET scans is less than MH's project cost. Of the alternatives available to the Agency, the MH application is far less effective.

The following chart presents a summary of the comparative analysis described above, ranking the effectiveness of the proposals. Note that AOP has shown MH is not conforming with all required CON criteria and, therefore, not approvable.

Comparative Review of AOP and MMH

	AOP	**MMH**
Conformity with Review Criteria	Yes	No
Average Net Revenue Per Procedure	More Effective	Less Effective
Average Operating Expense Per PET Procedure	More Effective	Less Effective
Access to Alternative Providers	More Effective	Less Effective
Access to Charity Care	More Effective	Less Effective
Access to Reduced Care Cost	More Effective	Less Effective
Access for Medicare Recipients	More Effective	Less Effective
Access for Medicaid Recipients	More Effective	Less Effective
Geographic Accessibility	More Effective	Less Effective
Scope of Services	Equally Effective	Equally Effective*

** Although MH proposed cardiac PET services, it does not include the costs required to do so. Therefore, the two applicants are equal on this factor.*

NON-CONFORMITY OF THE MH APPLICATION WITH THE REVIEW CRITERIA

CRITERION (1)

> (1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

Although the MH application to acquire one fixed PET scanner is consistent with the 2021 SMFP Need Determination, it is not consistent with Policy GEN-3. Therefore, it does not conform to Criterion (1).

> Policy GEN-3: Basic Principles (2021 SMFP, p. 29)
>
> "A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area." (emphasis added)

The MH application does not adequately demonstrate how its projected volumes incorporate the concept of maximizing healthcare value for resources expended because MH does not adequately demonstrate the need to acquire a new PET scanner to offer cardiac PET scans at the Vanderbilt Cardiac HOPD.

Because MH's projected utilization is questionable, the financial feasibility of the MH proposal, which is based on that projected utilization, is also questionable. *See* discussion of Criteria (3) and (5) below. Consequently, MH does not adequately demonstrate how its projected volumes incorporate the concept of maximum value for resources expended in meeting the need for a new PET scanner for HSA I.

As discussed in detail in the "Scope of Services" comparative factor above, MH's proposed project does not maximize healthcare value for resources expended. Those comments are incorporated here by reference. MH's proposal is not the most cost-effective alternative to add cardiac PET scans. It would be more cost effective for MH to add the equipment and software for cardiac scans to its existing PET scanner.

CRITERION (3)

> (3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, … persons [with disabilities], the elderly, and other underserved groups are likely to have access to the services proposed.

Reasonable and adequately supported utilization projections are required to show need for a proposed project. If projected utilization is not reasonable and adequately supported, that calls into question the need to develop the proposed project.

MH Reliance on Cardiac PET Scans Without Capability to Perform

MH's projected volume of cardiac PET scans is not reasonable and adequately supported. This component of the projection is critical because without the cardiac PET scans, MH does not project it will meet the performance standard and, thus, cannot demonstrate conformity with Criterion (3).

MH must project at least 2,080 scans on each scanner in Year 3. MH projects the existing scanner will perform 2,080 scans based on its current volume and projected growth in scans. MH projects shifting oncology scans to the proposed scanner and adding cardiac PET scans to reach 2,080 scans on the new scanner. The table below shows MH depends on cardiac PET scans to meet the performance standard.

MH Vanderbilt's Year Three PET Volume Projections and Performance Standard

PET Scans Transferred from SECU	1,657
Performance Standard	2,080
Additional Scans Required to Meet Performance Standard	423
Cardiac Scans Projected in Application	478

Source: MH application, page 64.

As discussed above, MH failed to include in its application the equipment, staff, and operating expenses required to perform cardiac PET scans. Without amending the application, MH lacks the

capability to perform the 423 scans required to meet the performance standard and only projects 1,657 scans in year three.

Unreasonable Cardiac Utilization Projections

Even if MH were equipped and staffed to perform cardiac PET scans, its projected utilization is not based on reasonable and adequately supported assumptions.

Despite the critical importance of the cardiac PET scans to meeting the performance standard, MH devoted only a little over two pages in its application to its projection of cardiac PET scans. MH's sole "need methodology" for projecting cardiac PET scans was to apply two age-defined use rates from two North Carolina counties (Orange and Wake) to the population of the counties in HSA I.

This "need methodology" is remarkable in terms of what it does not provide. MH presents nothing on:

- Mission's existing cardiac imaging procedures;
- Historical experience with cardiac procedures;
- Growth or decline in cardiac imaging, such as cardiac SPECT or cardiac stress echo procedures;
- The types of cardiac PET studies (CPT codes) MH intends to perform;
- Data on the prevalence of conditions relating to use of cardiac PET; or
- How many physicians are expected to refer patients for cardiac PET scans.

To project utilization meeting the PET Performance Standard and to support its financial projections, MH assumed it will perform between 418 and 468 cardiac PET scans in each of the initial years of operation of its proposed PET scanner, or roughly 2 cardiac PET scans per operating day. Nationwide, cardiac PET scans represent only about 5% of all PET scans performed.[17] Remarkably, MH projects that nearly 22% of the scans at the Vanderbilt HOPD will be cardiac PET scans in its third year.

Estimates suggest only about 200 cardiac PET programs existed nationwide as of 2019. The cost of providing cardiac PET scans is said to be a major factor behind the relatively few locations offering the service in the United States. The fixed cost for radiopharmaceuticals is a significant consideration in the decision to offer cardiac PET scans.[18] We note no hospitals in Mecklenburg County or Forsyth County had any 2019 Medicare outpatient claims that billed for rubidium (CPT

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[17] See IMV Benchmark Report©, PET Imaging 2021. Attachment 1.

[18] See https://www.cardiovascularbusiness.com/topics/cardiovascular-imaging/making-case-cardiac-pet-buying-evaluate-clinical-business.

code A9555), or ammonia (CPT code A9526). Apparently, the Atrium, Baptist, and Novant flagship hospitals do not find it necessary or economical to offer most types of cardiac PET scans in addition to other forms of cardiac imaging.

Lack of Physician Support

MH did not adequately document physician support for its proposed scanner or for a new cardiac PET service. While the MH Application is replete with accolades regarding Mission, it ignores the wide range of media accounts describing the tensions that have arisen, particularly with doctors and nurses and those in rural areas, since HCA gained control of the hospital system. Attached as Attachment 2 are a series of articles from local and trade press outlets. Considering the very visible issues with Mission, as a CON applicant, MH carried the burden to describe why it is reasonable to project physician support and positive coordination with the health care community. MH left these topics largely unaddressed in its application as submitted.

MH's utilization projections are not adequately supported by evidence of physician support/referrals.

The support letter from Dr. Rosal (Ex. C-4.1) makes no mention of using the proposed MH PET scanner for cardiac PET. Dr. Rosal is a radiologist/nuclear medicine doctor; however, it is typically an oncologist who refers the patient for a PET scan and coordinates with a radiologist to "read" or interpret the scan. Physicians in Dr. Rosal's specialty do not refer patients for PET scans.

Dr. Kuehn's letter (Ex. C-4.2) makes only a limited comment about the siting of the MH proposed PET scanner in the cardiovascular diagnostics department. Dr. Kuehn is an oncologist with a specialty in radiation oncology, not a cardiologist who would refer a patient for a cardiac PET scan.

Dr. Bajaj is a cardiologist new to the Asheville community as of fall 2020. His letter, like those of the other physicians, did not estimate how many patients he expected to refer for cardiac PET scans. While his discussion of cardiac PET provides general background, the letter is of limited usefulness as support for the MH cardiac PET volume projections.[19]

All three physicians noted cardiac PET is only appropriate for the relatively small percent of patients who have received a poor-quality or otherwise inadequate SPECT imaging test, or who have unusual body characteristics or certain high-risk characteristics. Just as Dr. Bajaj called cardiac PET a "strategic goal," Drs. Kuehl and Davidson termed it an effort "to launch" a cardiac PET service.

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[19] Of the cardiologists on staff at Mission, only Dr. Kuehl, a member of Mission's administrative staff wrote a letter. No information was provided by Mission on the status of the negotiation of contracts with the cardiologists who have historically practiced at Mission.

Oncologists Dr. Quiery and Dr. McGovern generally discussed the uses of PET technology for oncology patients but provided no estimates of the number of PET scans they intend to refer. These doctors use the MH PET scanner, and approval of either application will allay their concerns about scheduling delays. These oncologists will not refer patients for cardiac PET scans.

Dr. Buell's letter could easily be read as support for any proposal to add an additional PET scanner to HSA I. Nothing indicates Dr. Buell even knew of the MH plan to locate a second scanner in the cardiac HOPD instead of in the "regional cancer center."

Despite the volume of oncology scans projected by MH, its application includes only 1 radiation oncologist, 1 medical oncologist, 1 hematologist and 1 surgeon letter. The six letters described above are MH's only physician support letters; none contains estimates of scan referrals. No letters by area cardiologists state the number of patients they see annually whom they expect to refer for cardiac PET scans.

All PET scans must be physician ordered. A lack of physician support makes MH's PET utilization projections speculative.

Unsupported Use of Orange and Wake County Use Rates

Although MH purports to rely on use rate data for Orange and Wake counties, it is unclear whether Figure 15 on page 62 of the MH application shows "cardiac PET use rates" or just overall PET use rates (and no year is identified).

Not surprisingly, Orange and Wake counties have higher PET use rates, as they are home to two PET scanners at Rex, a CON-approved PET scanner at Duke Raleigh, and two PET scanners at UNC Hospitals in Orange County (not to mention two scanners at nearby Duke University Hospital). Because the rates (for an unstated year) are labeled and called either "cardiac PET use rates" or just "use rates," it is difficult to surmise what is depicted. Historically, PET data for Orange County have been plagued by issues of inconsistent and incorrect reporting of UNC Hospitals' fixed PET scanner utilization in the SMFP.

The MH application offered no support for the appropriateness of using the cardiac PET use rates from Orange and Wake Counties. It has not controlled for any differences in population characteristics or cardiac disease incidence rates between the geographic areas. It included no letters of support from cardiologists in Wake or Orange Counties justifying the use of more expensive imaging studies.

Instead, MH appears to have "cherry picked" Orange and Wake Counties, where cardiac care dynamics are likely among the most robust of anywhere in North Carolina. UNC Hospitals performed 17 heart transplants and 6 heart/kidney transplants, according to the 2021 SMFP (p. 105). None are performed at Mission.

Historically, Wake County facilities in total have the highest utilization of fixed cardiac catheterization equipment in HSA IV, with more than twice as many weighted procedures as Durham, the county with the second highest utilization. The Triangle hospitals are well-known destinations in North Carolina for patients seeking cardiac catheterization to address cardiac and coronary artery disease or defects. Within Wake County, UNC Rex was the highest volume provider in FFY 2017 and has shown continued growth in utilization. In FFY 2017, UNC Rex was the highest-volume provider in the state and performed more interventional procedures than any other facility. UNC Rex has since developed two additional fixed cardiac catheterization units, for a total of six.

More recent data show Rex Hospital performed 8,754 catheterization procedures (weighted) in 2019. (*See* 2021 SMFP, p. 321.) Rex's cardiac catheterization utilization suggests Rex could support an additional seventh unit of cardiac catheterization equipment, based on its high utilization.

MH has the only cardiac catheterization laboratory in Buncombe County and its volume does not show a need for additional catheterization equipment. MH performed far fewer diagnostic and interventional catheterization procedures than Wake County hospitals. (*See* 2021 SMFP, pp. 316–317.)

MH's scanner will not be in its hospital. Mission does not currently offer nor does it propose to offerPET scans in the inpatient setting Unlike MH's proposed site, Rex's PET scanner is sited at the hospital and is available to acutely ill or high-risk patients, such as those presenting in the emergency department or with acute chest pain. Being located within the hospital, Rex's PET scanner is available to inpatients.

Yet, in Figure 16, MH dropped in what are presumably the Orange/Wake cardiac PET use rates (for an unstated year) and then inflated those use rates by a full 5% per year for Project Years 2 and 3. MH stated with no explanation or support that an annual increase of 5% in the assumed use rate is "very conservative." The cardiac PET use rate is not adequately supported.

MH referred to the "projected use rate for Mission's 18-county service area" and stated this is "according to the Advisory Board." Using the search feature in Word, we found no references to "Advisory Board" in the MH Application or Exhibits, except on pages 62–63. It is unclear what information from the Advisory Board is the basis for Figure 17. MH included no report identified as from the Advisory Board in the exhibits to its application. Simply referencing the Advisory Board does not make an assumption reasonable or adequately supported.

Figure 17 possibly purports to represent that, in 2019, 73 patients per 100,000 residents of Wake and Orange counties had cardiac PET scans. However, this is unclear from the limited information MH provided.

Figure 17 seems to project that 129 patients per 100,000 population in MH's 18 county service area are expected to have cardiac PET scans in 2024. These numbers are nearly impossible to reconcile with the numbers in Figures 15 and 16. The use rates for Orange and Wake counties (with a multitude of PET scanners) for the under-65 age group are only about 15 or 16 per 100,000 population. Yet, MH's projected use rates are markedly higher (26 to 28) for that same age group for the "contiguous counties," which suggests a much higher use rate for residents of the more rural counties around Orange and Wake. MH assumed the overall use rate for the 18 counties surrounding MH would be 129, which is over 20 points higher than even the highest contiguous county use rate for the elderly population segment in 2025.

MH did not adequately explain the basis for the numbers in Figure 18. Presumably, Figure 18 is the result of multiplying county-level population by the MH-calculated Orange/Wake use rates for the two age cohorts (over and under 65), using home county rates for Buncombe and contiguous county rates for all other counties. However, this is not explicit, and the calculation is not shown.

The MH utilization projections for cardiac PET scans are not reasonably and adequately supported by transparent calculations using a publicly available, reliable data source.

As a final flaw, MH simply added 9 or 10 scans to its total and referenced these scans as "in-migration." Arbitrarily adding 10 scans labeled as "in-migration" as a final step in the MH methodology is not reasonable or adequately supported.

For these reasons and such others as the Agency may discern, the MH application is not conforming with CON Review Criterion (3) nor the performance standards.

Unsupported Shift of Oncology/Neurology Scans from the Mission SECU Scanner

Mission's existing PET scanner operates at the SECU Cancer Center; Mission projects approximately half of its PET volumes will "shift" out of the Cancer Center to the proposed PET scanner in its Cardiac HOPD.[20]

MH's proposed PET scanner must be utilized at an annual rate of at least 2,080 PET procedures by the end of the third year following project completion to satisfy the first prong of the Performance Standards. The new scanner at Vanderbilt must ***itself*** perform at least 2,080 procedures by the third year. *See* 10A NCAC 14C.3703(a)(1). To satisfy the third prong of the Performance Standard, MH's existing PET scanner at the SECU Cancer Center must ***itself*** perform at least 2,080 PET procedures during the third year following project completion. *See* 10A NCAC 14C.3793(a)(3).

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[20] In the Fall of 2019, Mission's SECU Cancer Center received a CON exemption for a multi-million dollar renovation. By way of background, although Mission has partnered with Sarah Cannon, the Cancer Institute of HCA Healthcare, Messino Cancer Centers through AON has exclusive access to medical oncology trials with Sarah Cannon.

Because a failure to reasonably project at least 2,080 procedures on each proposed and existing scanners is a failure to satisfy the Performance Standard, it was critically important for MH to explain how it expected to "split" scans between the two scanners for each to perform 2,080 or more scans. MH did not do so.

To try to satisfy the Performance Standard, beginning on page 61, MH describes a method to project the patients on each scanner in the first year. MH claims it will balance scans between the scanners by scheduling "newly diagnosed cancer patients" at Vanderbilt using specific ramp-up assumptions. Using 2020 data, MH calculated that it serves 148 new patients each month and each patient receives 1.21 scans. MH described its plan to ramp-up utilization at the proposed scanner each month "until half of new patients are scanned on each scanner. [21]

Figure 12 in the MH application shows numbers of new monthly patients and scans per patient. MH projected 20% of new patients at Vanderbilt in Month 1, increasing by five percentage points per month until half the new patients each month used each scanner. Using MH's stated assumptions, the table below shows oncology/neurology scan volume for the first six months at Vanderbilt.

New Patient Split Between MH Scanners, Using Stated Assumptions

Year One Month:	1	2	3	4	5	6
MH New Patients	148	148	148	148	148	148
Vanderbilt Percent New Patients	20%	25%	30%	35%	40%	45%
Vanderbilt New Patients	30	37	44	52	59	67
Scans (at 1.21 per patient)	36	45	54	63	72	81
Cumulative Total Scans	36	81	135	198	270	351

Note, scan calculations are rounded to the nearest whole number
Source: MH CON Application, page 61

The table shows only 351 scans at Vanderbilt in the first six months. With 74 new patients and 90 scans monthly, MH would perform another 540 scans in the second six months, for a total of 891 oncology/neurology scans in the first year.

Applying MH's assumed CAGR of 9%,[22] the projected number of oncology/neurology scans in year 3 is 1,059.[23] Even adding the projected 478 cardiac scans, this is not enough volume to satisfy the Performance Standard (1,059 + 478 =1,537).

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[21] MH CON Application, page 61.
[22] MH CON Application, page 61.
[23] MH includes no language discussing how the split of new patients would change after year 1, suggesting the split will remain at 50% going forward.

The sum of the "projected patients" in Figure 13 of the MH application is 3,382.[24] This is the same as the number of projected PET scans in Figure 11.[25] On Figure 13, MH appears to split the total number of scans - not the number of new patients - by the ramp-up percentages. Such a split is contrary to MH's stated assumptions about the number of new patients each month and its stated plan to ramp-up utilization at Vanderbilt until the "balance of new patients between both sites reaches 50%." No stated assumptions support the numbers shown on Figure 13. Projections that are contrary to and not supported by the stated assumptions are not reliable. Similarly, numbers not based on stated assumptions are not reliable.

MH is not the first CON Applicant found non-conforming due to erroneously labeled projections. In the 2020 Rowan County Hospice Review, one applicant switched from a correct label (Incremental Hospice Deaths) to an incorrect label (Incremental Hospice Patients). The Agency concluded "the applicant's projected utilization is incorrect, not reasonable, and not adequately supported." Rowan Hospice Agency Findings, p. 18.

Because MH does not provide projections consistent with supporting assumptions for allocating patients and PET scans between the two scanners, its utilization projections for the scanners are not reasonable or adequately supported and do not satisfy the Performance Standards.

CRITERION (4)

> **(4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.**

MH did not adequately demonstrate that the alternative proposed in its application is the most effective alternative to meet the need, because its application is not conforming to all statutory and regulatory review criteria. An application that cannot be approved cannot be an effective alternative to meet the need.

The 2021 SMFP shows a need for one new PET scanner in HSA I. The AOP application conclusively shows there is a less costly alternative for adding a PET scanner to HSA I. AOP's project cost ($2,106,031) is less than half MH's project cost ($4,997,702.49). While Criterion (4) is not applied comparatively to the MH application to determine conformity, MH bears the burden

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[24] MH CON Application, page 61.
[25] MH CON Application, page 60.

of showing that a $4.9 million project cost was the most effective alternative for meeting the need. It did not carry that burden.[26]

For these reasons and such others as the Agency may discern, the MH application is not conforming with Criterion (4).

CRITERION (5)

> **(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.**

MH's projected utilization is not reasonable and adequately supported for all the reasons discussed above as to Criterion (3). As projected revenues and expenses are based at least in part on projected utilization, MH's projected revenues and expenses are also questionable, rendering the MH application non-conforming to Criterion (5). *See* Criterion (3) discussion above.

Further, the MH application is non-conforming with Criterion (5) because:

- It fails to properly demonstrate the availability of funds.
- It fails to demonstrate the financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

Failure to Properly Demonstrate Availability of Funds

MH's application does not "demonstrate the availability of funds," and thus does not demonstrate conformity with Criterion (5).

MH's application is filed by "MH Mission Hospital, LLLP." This entity appears to have been formed in Delaware in 2018, and no information in the MH application indicates the applicant itself has any funds. Nor does the applicant commit to make any of its own funds available for the PET proposal.

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[26] As a practical matter, if AOP is approved, MH has the alternative of upgrading its existing PET unit to allow cardiac PET scans to be performed on the existing scanner. If the Agency finds it adds healthcare value to offer cardiac PET scans using a rubidium generator in HSA I, the discussion on page 18 of these comments shows that the sum of the project cost for the AOP application and the cost to add cardiac PET capability to the existing MH PET scanner are less than MH's project cost. *See* discussion of Additional Considerations in the Comparative Analysis section, above.

While it is permissible for a project to be funded by a non-applicant, our courts have held that "where the project is to be funded other than by the applicants, the application must contain evidence of ***a commitment to provide the funds by the funding entity***."[27] In North Carolina, "without such a commitment, an applicant cannot adequately demonstrate availability of funds or the requisite financial feasibility."[28]

Here, MH states its source of funding is "Other (Funding from Parent Company. See funding letter at Exhibit F-2.1, Tab 4)."[29] At page 81, the MH application does not identify the "Parent Company" by name.

Elsewhere, the MH application refers to "Mission affiliate HCA Healthcare Inc." On another page, the applicant indicates HCA Healthcare Inc. is the "ultimate upstream parent" of MH Mission Hospital, LLLP, but explains there are several intervening HCA subsidiaries between the applicant and its ultimate upstream parent, HCA Healthcare Inc.

Assuming HCA Healthcare Inc., the applicant's "affiliate" or "ultimate upstream parent," is the "Parent Company" referenced as the funding source on page 81, under the court's holding in *Retirement Villages*, the application must contain a funding commitment "by the funding entity" or, in this case, by HCA Healthcare Inc.

The only letter furnished in the MH application is a letter from Terence van Arkel, identified as "Chief Financial Officer, North Carolina Division" which is written on stationery of HCA Healthcare North Carolina Division, with an address of 50 Schenck Parkway, Asheville, NC 28803.

A letter from a child stating he will receive an allowance from his parent does not suffice to show the parent's willingness to provide that allowance. To be worthwhile, such a letter must come from the parent, not from the one who hopes to receive the allowance.

Mr. van Arkel is not shown to be an officer of HCA Healthcare Inc. (One Park Plaza, Nashville, TN 37203). The MH application never states Mr. van Arkel is an officer of HCA Healthcare Inc., nor does it attach any documentation to show he is an officer of HCA Healthcare Inc. Nowhere in his letter does Mr. van Arkel say he is an officer nor does he state he may commit the funds of HCA Healthcare Inc.

Without documentation, the analyst cannot presume Mr. van Arkel is an officer of HCA Healthcare Inc. The analyst cannot assume Mr. van Arkel has the authority to commit nearly $5 million of

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[27] *Ret. Villages Inc. v. N. Carolina Dep't of Hum. Res.*, 124 *N.C. App*. 495, 499, 477 *S.E.*2d 697, 699 (1996). Emphasis added.
[28] *Ibid.*
[29] MH Application, p. 81.

funds from a company in which he is not an officer, especially when his letter does not indicate he has any such authority.

The MH application provides the names of the officers of HCA Healthcare Inc., and Mr. van Arkel is not one of them:

Information about our Executive Officers

As of February 1, 2021, our executive officers were:

Name Age Position(s)

Samuel N. Hazen . . . . . 60 Chief Executive Officer and Director

Jennifer L. Berres . . . . . 50 Senior Vice President and Chief Human Resource Officer

Phillip G. Billington . . . . . 53 Senior Vice President — Internal Audit Services

Jeff E. Cohen . . . . . 49 Senior Vice President — Government Relations

Michael S. Cuffe, M.D. . . . . 55 President — Physician Services Group

Jane D. Englebright . . . . . 63 Senior Vice President and Chief Nursing Officer

Jon M. Foster . . . . . 59 President — American Group

Charles J. Hall . . . . . 67 President — National Group

A. Bruce Moore, Jr. . . . . 60 President — Service Line and Operations Integration

Sandra L. Morgan . . . . . 58 Senior Vice President — Provider Relations

J. William B. Morrow . . . . . 50 Senior Vice President — Finance and Treasurer

P. Martin Paslick . . . . . 61 Senior Vice President and Chief Information Officer

Jonathan B. Perlin, M.D. . . . . 59 President — Clinical Operations Group and Chief Medical Officer

Deborah M. Reiner . . . . . 59 Senior Vice President — Marketing and Communications

William B. Rutherford . . . . . 57 Executive Vice President and Chief Financial Officer

Joseph A. Sowell, III . . . . . 64 Senior Vice President and Chief Development Officer

Kathryn A. Torres . . . . . 57 Senior Vice President — Payer Contracting and Alignment

Robert A. Waterman . . . . . 67 Senior Vice President and General Counsel

Kathleen M. Whalen . . . . . 57 Senior Vice President and Chief Ethics and Compliance Officer

Christopher F. Wyatt . . . . . 43 Senior Vice President and Controller

As shown above, Mr. Rutherford—not Mr. van Arkel—is the CFO of HCA Healthcare Inc. The Form 10-K (p. 34, Ex. p. 60) states Mr. Rutherford has been the CFO since January 2014.

Not only did the MH application include nothing showing Mr. van Arkel is an officer authorized to commit HCA Healthcare Inc. to "provide financing" to the applicant, the application confirms someone other than Mr. van Arkel is the CFO of HCA Healthcare Inc.

Mr. van Arkel states his "letter is to confirm that ***HCA*** will provide financing" (emphasis added). A quick search on the North Carolina Secretary of State website indicates 62 different companies in North Carolina alone use some variation on the company name "HCA." For instance, HCA Inc. was suspended in 2005. When Mr. van Arkel writes "HCA" will provide financing, his reference to a specific corporate entity is not clear. His letterhead does not state "HCA Healthcare Inc.," and there is no company in North Carolina named "HCA Healthcare North Carolina Division." A funding commitment letter in a CON application is a document with legal significance. The documentation is deficient when entity names are not provided in full.

Next, Mr. van Arkel states HCA "will provide financing" to purchase a PET/CT scanner for MH Mission Hospital, LLLP. The phrase "will provide financing" is commonly used to mean make a loan of funds to a borrower, with an expectation of repayment. For example, an internet primer on real estate says:

> *You may have heard of mortgages, or third-party financing, where a bank or other lending institution provides a loan to the buyer that the buyer pays back over time. But when a buyer cannot get financing through a lender (or just decides not to), sometimes the seller* ***will provide financing*** *to the buyer.*[30]

In the above passage, the phrase "will provide financing" does not mean the seller will commit to provide cash to the buyer without expectation of repayment.

The phrase "will provide financing" should be read per common usage as "will provide a loan." For a loan—any loan, even between related or affiliated companies—the expectation is that the CON application must include:

- Proposed borrower (if not the applicant, documentation of commitment of the borrower to commit the loan proceeds for the project's capital cost);
- Purpose of the loan;
- Proposed interest rate;
- Proposed term (period of the loan);

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[30] https://www.lawdepot.com/blog/what-is-owner-financing-in-real-estate/.

- Proposed amount of the loan; and
- Amortization schedule.

In a prior-filed CON application for an MRI scanner for Buncombe/Graham/Madison/Yancey counties, an MH applicant stated its project would be "funded via an inter-company loan from HCA Healthcare Inc." and stated no interest would be assessed.

Here, "HCA" says it will "provide financing" but does not state that no interest will be assessed. Considering HCA is familiar with saying "no-interest" when that is its intent, one can only assume HCA will charge (or at least reserve the right to charge) interest when it provides "financing" or a loan to the applicant.

Here, Mr. van Arkel states "HCA" will "provide financing" for purchase of the PET scanner "for MH Mission Hospital, LLLP," but does not identify the borrower, the interest rate, the amount of the loan, or the amortization schedule. Nor does he say, as HCA did in the Buncombe MRI Review, no interest would be assessed.The phrase "for MH Mission Hospital, LLLP," is similarly off the mark. In North Carolina, a CON is only valid for the person named in the certificate. Thus, HCA cannot provide financing for HCA to buy a PET/CT scanner "for [the use of] MH Mission Hospital, LLLP." Under North Carolina CON law, a non-applicant can commit to provide funds for the applicant to undertake the capital expenditure authorized by the CON issued to the applicant. But, to be sure, HCA cannot provide financing to purchase a PET scanner for the use of the applicant entity MH Mission Hospital, LLLP.

Later in his letter, Mr. van Arkel refers to a commitment "to provide financing." The letter again mentions HCA's expecting "to finance" the project. At best, Mr. van Arkel is describing a plan for an entity called HCA to provide a financing or lending mechanism to allow for the purchase of a PET/CT scanner for MH Mission Hospital, LLLP.

Mr. van Arkel's letter, at one point, states HCA "will provide any necessary working capital and additional funding to cover any operating losses." Of course, MH does not project any operating losses.

At no point in the letter does Mr. van Arkel state HCA Healthcare Inc. hereby commits to provide MH Mission Hospital, LLLP, with funds to acquire the proposed PET scanner and will do so without expectation of repayment.

The money to come from "HCA" would have to be either a loan or cash/reserves. Yet, in its application, MH side-steps this issue by answering only subpart (a), not subparts (b) or (c) under Section F, Question 2. If one reads "provide financing" under common usage to mean "provide a loan" of funds, MH failed to answer applicable questions in subpart (b) about the term of the loan and the specific plans for repayment.

If one stretches the terms "provide financing" into "provide cash," MH likewise failed to answer applicable questions in subpart (c) about the legal entity name, its willingness to commit, and its cash position. In his letter, Mr. van Arkel does not even specify where "HCA" will get the funds, assuming it would provide them in some fashion to the applicant. The letter suggests HCA will make a future choice about whether it will use "internally generated and/or borrowed" funds, rely on a revolving credit line, or possibly take a bank loan or rely on "publicly issued securities."

The CON application form calls on the applicant to identify whether a funding source will provide funds from cash, cash equivalents, accumulated reserves, or owner's equity. Putting aside the concerns raised above, the letter does not even specify which category of funds will be relied upon.

A funding source other than an applicant must document that funds will be available when needed. "HCA" does not do even that much; it says it might use the funds it has, but it might not. It might borrow the funds from a bank or via a credit line, but perhaps it will "issue securities" to obtain the money. By naming numerous options, HCA fails to provide an answer to the question posed by the CON application form.

Ultimately, the problems discussed here are not resolved because the applicant has a corporate relationship with the entity that, at least arguably, is the intended source of project funds. This issue was put to rest years ago in the *Retirement Villages* case cited above (*Ret. Villages, Inc. v. N. Carolina Dep't of Hum. Res.*, 124 N.C. App. 495, 499, 477 S.E.2d 697, 699 [1996]). The mere fact of a corporate relationship does not absolve an applicant from its legal obligations under Criterion (5).

This final prong of Question 2(c) in Section F points to yet another deficiency in Mr. van Arkel's letter. He mentions "HCA's ability" to provide the necessary capital, the extent of HCA's healthcare operations, its 2019 multi-billion cash from operations, and its revolving credit facilities. With all that, at no point does Mr. van Arkel make the simple statement that cash will be available when needed for the proposed project.

Even if the CON section overlooked the absence of such a statement considering the extent of the resources of HCA Healthcare Inc., the range of problems noted above cannot be swept aside merely out of deference to the size of HCA Healthcare Inc.

Finally, and perhaps most obviously, Mr. van Arkel does not state that the applicant, MH Mission Hospital, LLLP, will use the funds for the project. *See* 2016 New Hanover County OR Review ("there is no letter from an officer of the applicant confirming how the money would be used. Therefore, the applicant does not adequately demonstrate the availability of sufficient funds").

Based on these deficiencies, MH has not properly documented the availability of funds, and its application as submitted does not demonstrate conformity with Criterion (5).

Failure to Demonstrate Long-Term Financial Feasibility Based on Reasonable Cost Assumptions

Failure to Account for Costs of a Cardiac PET Service

MH bases its long-term financial feasibility on providing over 400 cardiac PET scans in each project year. However, MH mistakenly assumed there was no difference between the cost of its current PET scans and cardiac PET scans. It failed to include the greater cost of a rubidium generator required to perform most cardiac PET scans. It also failed to include the additional staff costs for a cardiac nurse. The additional costs are explained above. Because MH's financial feasibility projections are not based on reasonable assumptions about the cost of cardiac PET scans, MH fails to show conformity with Criterion (5).

In 2019, when the Agency approved UNC Rex Hospital for a second PET scanner under the 2019 Need Determination, it accepted as reasonable statements by the applicant indicating:

> *UNC REX has all necessary ancillary and support services in place including a Rubidium generator, which allow[s] it to produce the radiotracer required for cardiac PET imaging.*[31]

In the prior HSA IV competitive Fixed PET scanner Review involving Project ID #'s J-11384-17 and J-11386-17, Rex Hospital was also an applicant:

- Rex Hospital explained that its drug expense included rubidium tracer for cardiac PET procedures and thus was "not comparable" to providers who do not perform PET procedures with these tracers; and
- In its application, Rex Hospital included expenses for the rubidium generator used for cardiac PET procedures, inflated 3.0% annually.

On Form F.3a on page 132 of its application, MH shows the operating costs for its non-cardiac PET service at SECU. (The only other operating costs shown on Form F.3a are for salaries, taxes/benefits, central office overhead, and depreciation.)

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[31] See Agency Findings, Rex Hospital PET Scanner Project I.D. # J-11659-19, p. 20.

MH PET/CT Volume and Expenses at SECU

	Last Full FY (2020)	Interim Full FY (2021)	Interim Full FY (2022)
PET Scan Volume	2,611	2,846	3,102
Pharmacy Expense*	$976,809	$1,064,717	$1,160,489
Equipment Maintenance^	$175,075	$175,075	$175,075

**Assumption (p. 133): $374.11/scan in CY 2020 multiplied by scan volume.*
^Assumption (p. 133): Actual expenses in last FFY held flat.

MH simply based its operating cost projections for its new cardiac PET scans on the past operating costs for its non-cardiac PET scans.

MH PET/CT Volume and Expenses at Vanderbilt HOPD

	1st Full FY (2023)	2nd Full FY (2024)	3rd Full FY (2025)
PET Scan Volume	1,822	1,975	2,135
Pharmacy Expense*	$681,628	$738,867	$798,725
Equipment Maintenance^	$0	$175,075	$175,075

**Assumption (p. 137): $374.11/scan in CY 2020 multiplied by scan volume.*
^Assumption (p. 137): One year of Warranty & Actual expenses held flat.

Again, the only other operating costs shown on Form F.3a are for salaries, taxes/benefits, central office overhead, and depreciation. So, there are no new operating costs reflected on other line items on Form F.3a. The cost assumptions for pharmacy and equipment-related expenses for the cardiac PET are based on the same assumptions as for the non-cardiac PET at SECU.

Mission operates its oncology PET service at the SECU Cancer Center with two technologists; its only proposal for added staff at the Vanderbilt Cardiac HOPD is for two technologists. MH made no allowance on Form H for the nursing staff which must be part of rendering cardiac PET services.

MH did not factor in any new operating costs associated with offering a new cardiac PET service, even though a new cardiac PET service requires costly radiopharmaceuticals and nursing staff that are not a part of a non-cardiac PET service. Instead, MH used the **exact same** cost-per-scan assumption for pharmacy expenses as it historically experienced at SECU. By doing so, MH failed to account for necessary labor costs and for the expense of radiopharmaceuticals —a variable and significant operating cost item, without which it could not offer 400+ cardiac PET scans.

As is made obvious by an understanding of the differences in oncology and cardiac PET scans, an assumption the pharmacy expense and staffing requirements for the two services (oncology PET

and cardiac PET) will be the same is a significant mistake. It is not reasonable to assume cardiac PET scans can be performed without the additional costs associated with offering a service that differs from oncology PET.

Without the requisite radiopharmaceuticals and nursing staff, MH cannot do cardiac PET scans. Without the cardiac PET scans, the proposed PET scanner would perform only 1,667 scans.

Removing cardiac scans would affect the MH revenue projections. MH would still purchase the PET scanner and still need to employ two technologists, but it would not have revenue associated with the cardiac PET service.

Because the extent of the radiopharmaceutical and added labor expense is not a number the project analyst can be expected to derive independently, the analyst can only conclude the MH numbers have omitted operating costs associated with the service proposed; thus, the numbers are inherently unreliable.

Without reliable cost projections, the analyst cannot reasonably conclude the MH project proposal demonstrates financial feasibility or documents the availability of sufficient funds for the project. In response to comments, MH cannot supply a cost assumption that does not appear in its application as filed. MH cannot amend its operating cost projections or assumptions to supply new information or projections intended to show accurately the cost of initiating cardiac PET scans.

Failure to Provide Reasonable Assumptions for Start-Up and Related Costs

MH erroneously assumed its project will require no start-up costs. MH intends to hire two new technologists to work at a new location on a new piece of equipment with new cardiac capabilities. Yet, MH budgeted nothing to bring these technologists in for orientation and training before commencing operation of the new proposed scanner. MH's assumption of zero start-up expenses is unreasonable and completely unsupported.

MH said that it "currently provides PET/CT services and has trained staff available for start-up."[32] This is a flawed assumption because MH does not offer cardiac PET.

Patients undergoing a cardiac PET study are typically placed under pharmacological stress using IV-administered medications. This is not the protocol for oncology patients; thus, Mission's current staff is not trained to perform the functions of a nurse for a cardiac PET service. A cardiac PET service must have nurses trained to perform the clinical aspects of the pharmacological stress process. MH provides no budget on Form H for the nurses needed for a cardiac PET service;

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[32] MH CON application, page 83.

likewise, it provides no budget in a start-up expense line item for orientation and training of the nurses who will provide this all-new cardiac PET service. These are not reasonable assumptions.

MH unreasonably assumed it need not define a time period before it reaches break-even on a cash or pro forma basis. MH asserted it will not have start-up costs under the Agency's definition because it will place the proposed PET scanner in an existing hospital-based outpatient department. MH stated it will not incur initial operating expense because the proposed project involves placing the new PET/CT scanner "at a fully functioning, existing hospital-based outpatient department at which revenues will exceed expenses from day one of the new project because of ongoing, existing operations there." MH failed to consider incremental revenues and expenses when adding equipment.

This is a flawed approach, because the MH application does not document the revenues and expenses of the Vanderbilt HOPD. No forms, assumptions, or exhibits to the MH application show the historical revenues and expenses of the Vanderbilt HOPD. There is nothing to show the analyst whether this "service line" or department of MH is a loss-leader or a profitable service—the Agency cannot assume its financial condition with no financial data.

MH only shows financial data for the existing PET scanner at the SECU Cancer Center, for both PET scanners, and for the proposed PET scanner separately. There is no financial data for the so-called "fully functioning, existing hospital-based [cardiac] outpatient department." No publicly available data shows adding a PET scanner to the cardiac HOPD will cause revenues to exceed all expenses—including those of the new PET unit—from the day the new PET scanner is operational.

For these and such other reasons the Agency may discern, the MH application is not conforming with Criterion (5).

CRITERION (6)

> **(6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.**

For the reasons explained throughout these Comments, MH did not adequately demonstrate projected utilization based on reasonable and adequately supported assumptions. Because the MH cardiac PET utilization is questionable, the applicant does not adequately demonstrate that its PET/CT scanner as proposed is needed. Therefore, MH does not demonstrate its conformity with Criterion (6).

CRITERION (7)

> **(7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.**

MH failed to provide evidence of the availability of resources for all the health manpower and management personnel needed for its proposed PET scanner at the Vanderbilt HOPD. The CON application form at Section F (Criterion 5), Question 4 explains that applicants must "describe the assumptions and methodology used to complete each form in 4.b," and the form plainly states:

> *The description of the assumption and methodology used for each form should be done in Microsoft Word or similar software and should address each line item on that form. Include the description in Section Q, immediately following the completed form to which it relates.*

Specifically, on Form H, MH only identified resources associated with hiring two new radiology technologists. MH included no documents on its methodology or assumptions following Form H. Instead, MH has a short legend below Form H that says:

> ***Form H: Staffing Assumptions***
>
> *Current Staff includes full year 2020 salary of 2 technologists that currently work at SECU.*
>
> *1st Full Year includes salary of 2 techs at SECU plus 2 additional technologists at SVP for total of 4.*
>
> *Years 2–3 FY includes 2% salary increase for all technologists.*

MH identified no other health manpower or management personnel for the proposed PET scanner. There is no mention of the cardiac nurse needed for cardiac PET scans.

MH Application Has No Cardiac Nurse

On page 80 of its application, MH acknowledges it needs a "cardiac nurse" to offer a cardiac PET service: "Myocardial PET scans are performed on patients in conjunction with stress testing, which is performed by a cardiac nurse." However, on Form H, MH included no FTE projection for a cardiac nurse and no budget for the salary and benefits package for a cardiac nurse.

MH cannot claim it will "borrow" a cardiac nurse from the PET scanner operation at the SECU Cancer Center, as MH does not offer cardiac PET scans. MH cannot rely on the services of nurses in its cardiac department for its proposed cardiac PET scanner without a Form H budgeted FTE

allocation to assign those nurses to its proposed cardiac PET project. Moreover, a cardiac nurse is not "corporate overhead."

To the extent MH believes it can rely—with no budget or specific plans—on "existing" nursing and radiology techs, its assumptions are unreasonable. MH is seeking CON approval for a PET scanner to offer a PET service including both oncology and cardiac utilization. It must document its plans and the associated costs of hiring or utilizing the services of the staff necessary to offer that PET service, just as it must show the need for those PET services and the financial feasibility of the services based on reasonable assumptions about the costs of offering the service.

MH Application Has No Support Staff

Operating a PET service is not feasible with no manpower other than the technologists who provide the clinical scanning services. Besides clinical personnel, MH cannot reasonably assume it can operate a new PET scanner at the Vanderbilt HOPD without an additional front desk representative and a business office staff-person. MH must have the personnel to allow patients to schedule (and reschedule) appointments for PET scans, to get directions to the PET scanner, etc. MH must have personnel to bill patients and health plans, to answer billing-related questions, to arrange for free or discounted services, etc.

At Exhibit H-1.1, MH provides a job description for a "Nuclear Medicine Technologist," which is evidently the position it identifies on Form H as "Radiology Technologists." Clearly, this person does not perform scheduling and billing functions.

If MH intended to use existing personnel as health staffing for the new PET service, the Agency requires MH to identify the number of FTEs or partial FTEs it would need for the new PET service and assign an associated cost for those positions as a project cost on Form H of the CON application for the new PET service. (Then, under Criterion (5), MH must show the availability of funds for the resources it identified as needed).

If MH intended to use personnel with responsibilities for patient scheduling and billing for non-PET services to work expanded hours to provide scheduling and billing support for the new PET service, the Agency required MH to identify the number of FTEs of staff by position it would need, and then to identify the availability of resources for the salaries and benefits for the health manpower and management personnel to offer the proposed service.

No doubt, MH will point to the "Central Office Overhead" line item on Form F.3b in the projection of operating costs and the assumption that a PET percentage would be assigned based on hospital net revenue to allocate "corporate overhead." However, MH does not define what functions "corporate overhead" covers.

MH states on pages 133 and 135, "PET % of hospital net revenue (0.52%) to allocate corporate overhead." Based on the numbers, MH allocated corporate overhead based on total hospital net revenue. However, the MH application did not include a projection of Mission's net revenue for the 1st Full FY (calendar year 2023). The analyst has no way to determine whether MH included an appropriate corporate overhead allocation, because the assumption only tells the reader the amount is 0.52% of a hospital net revenue number, but that hospital net revenue number appears nowhere in the MH application.

For these reasons and any others the Agency may discern, the MH application is not conforming with Criterion (7).

CRITERION (8)

> **(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.**

The MH application does not include the necessary ancillary and support services to operate a second PET scanner and to perform cardiac PET scans. The omissions have been discussed earlier in these comments and those discussions are referenced here:

- The MH application does not include mention or budget for a rubidium generator or other radiopharmaceuticals required for most cardiac PET scans. This is discussed under Criterion (1).
- The MH application does not include staffing or budget for a cardiac nurse required for cardiac PET scans. This is discussed under Criteria (1), (5), and (7).
- The MH application does not include mention or budget of administrative staff for scheduling and billing the services of the proposed scanner. This is discussed under Criterion (7).

For these and any other reasons the Agency may discern, the MH application is not conforming with Criterion (8).

CRITERION (12)

> (12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

MH proposes a multi-phased interior renovation that will require it to relocate its existing hot lab, injection rooms, and nuclear medicine camera, and will require construction of a new, shared control room, a new PET/CT room, an associated equipment room, and a new third injection room to accommodate patients on stretchers. The remodeling cost alone is **$1,893,000**.

There is no medical necessity for the PET scanner to be in this medical office building. MH did not demonstrate there were not suitable locations that could be remodeled or built out at a much lower cost. To demonstrate conformity with Criterion (12), the burden rests with the applicant to demonstrate that the cost and design of its proposed project represent "the most reasonable" alternative and will not unduly increase the costs of providing the service. MH failed to carry its burden.

MH is not conforming to Criterion (12) because MH did not adequately demonstrate the need the population proposed to be served has for the new construction to support a PET scanner providing 400+ cardiac PET scans in Project Year 3. (*See* 2019 Mecklenburg Acute Care Bed and OR Review, finding Atrium Lake Norman non-conforming to Criterion (12).)

For these and others reasons the Agency may discern, the MH application is not conforming with Criterion (12).

CRITERION (13)

> (13) The applicant shall demonstrate the contribution of the proposed service in meeting the health related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and … persons [with disabilities], 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. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:
>
> (a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved.

Curiously, MH did not provide the payor mix for the "facility or campus where the proposal will be developed or offered." Clearly, the MH PET scanner is proposed to be developed in the Vanderbilt HOPD, the site identified in Question 4.a. of Section A of the MH application.

In Section L, Question 1.a must be answered for the facility or campus identified in Section A, Question 4, where MH identified the Vanderbilt HOPD. MH failed to provide a description or data on the extent to which medically underserved populations use the Vanderbilt HOPD as compared to the percentage of medically underserved in its service area. No publicly available data report the payor mix of the Vanderbilt HOPD. MH provided only the historical payor mix of the PET scanner at the SECU Cancer Center. That is not where MH says the proposed scanner will be located.

This is one example of a problem throughout the MH application: where convenient, MH speaks of locating the proposed PET scanner at the Vanderbilt HOPD. For instance, it says it did not need to project an initial operating period based on the finances of the Vanderbilt HOPD and expects it can just "use" existing personnel from that facility.

Elsewhere, MH speaks of expanding its PET service with a second scanner, and shows the PET scanner information for the unit at the SECU Cancer Center. Under Criterion (13)a, it shows the payor mix for the PET unit at the Cancer Center but provides no data for the Vanderbilt HOPD. And, as shown below, in some responses, MH references its experience with "cardiac diagnostics."

MH projects payor mix for the proposed PET scanner at the Vanderbilt HOPD and for its existing PET scanner at the SECU Cancer Center. Acknowledging that the SECU Cancer Center performs no cardiac PET scans, MH shows payor mix for something it calls "cardiac diagnostics." This is a third option MH uses. (MH answered some questions with information on its one existing PET scanner; it answers other questions with information on its cardiac HOPD; it answers other questions with information on its "cardiac diagnostic" service).

MH did not define "cardiac diagnostics." Therefore, the payor mix percentages cannot be adequately supported. MH did not represent the payor mix to be that of the cardiac outpatient department. Nowhere does the MH application show the payor mix for cardiac diagnostics. MH gave the analyst no data to analyze the sufficiency of its projected payor mix for its proposed PET scanner at the Vanderbilt HOPD.

MH cannot flip-flop among various approaches. The analyst has no information on the extent to which medically underserved populations use the applicant's existing services at the Vanderbilt HOPD in comparison to the percentage of the medically underserved population in the applicant's service area. Therefore, MH has failed to demonstrate conformity with Criterion (13)(a).

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services;

MH fails to demonstrate conformity with Criterion (13)(c) because its projections lack support. The MH "cardiac diagnostics" payor mix shows only slightly over 60% Medicare utilization, which casts doubt on the projection to serve 66.5% Medicare with its PET scanner in the Vanderbilt Cardiac HOPD. MH terms it "conservative" to use a higher Medicare projection but does not explain why this assumption is reasonable or supported, considering its plans to offer cardiac PET services.

The MH projections are not based on reasonable and supported assumptions, as MH has selectively provided historical data or omitted the presentation of historical data necessary to evaluate the reasonableness of its proposed payor mix. Based on the application as submitted, MH did not demonstrate conformity with Criterion (13)(c).

For these and other reasons the Agency may discern, the MH application is not conforming with Criteria (13)(a) and (13)(c).

CRITERION (18a)

> (18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

MH did not adequately demonstrate how its proposal will promote the cost effectiveness of the proposed services because MH's projected utilization is not based on reasonable and adequately supported assumptions. The discussions regarding analysis of need and projected utilization found in Criterion (3) are incorporated herein by reference.

MH did not adequately demonstrate how its proposal will promote the cost effectiveness of the proposed services because MH did not adequately demonstrate how it would be able to repay the loan from HCA (regardless of whether it included interest). MH does not adequately demonstrate that the financial feasibility of the proposal is based on reasonable projections of costs and charges. MH does not adequately demonstrate that its proposal is cost-effective. The discussion regarding availability of funds and financial feasibility found in Criterion (5) is incorporated herein by reference. Consequently, MH does not adequately demonstrate that any enhanced competition would have a positive impact on the cost effectiveness of the proposed PET service and has failed to demonstrate conformity with Criterion (18).

For these and other reasons the Agency may discern, the MH application is non-conforming with CON Review Criterion (18a).

SECTION .3700 - CRITERIA AND STANDARDS FOR POSITRON EMISSION TOMOGRAPHY SCANNER 10A NCAC 14C .3703 PERFORMANCE STANDARDS

To meet both prongs (1) and (3) of the performance standard, MH must project to perform at least 2,080 procedures on each one of its scanners. To satisfy the rule, MH must perform 400+ cardiac PET scans on its proposed scanner in Year 3. In the comments under Criteria (1), (3), (5), and (7), AOP showed the MH application does not include the radiopharmaceuticals or the staffing required to perform cardiac PET scans. Therefore, without amending its application, MH cannot perform the cardiac PET scans it projects and cannot meet the performance standard.

CONCLUSION

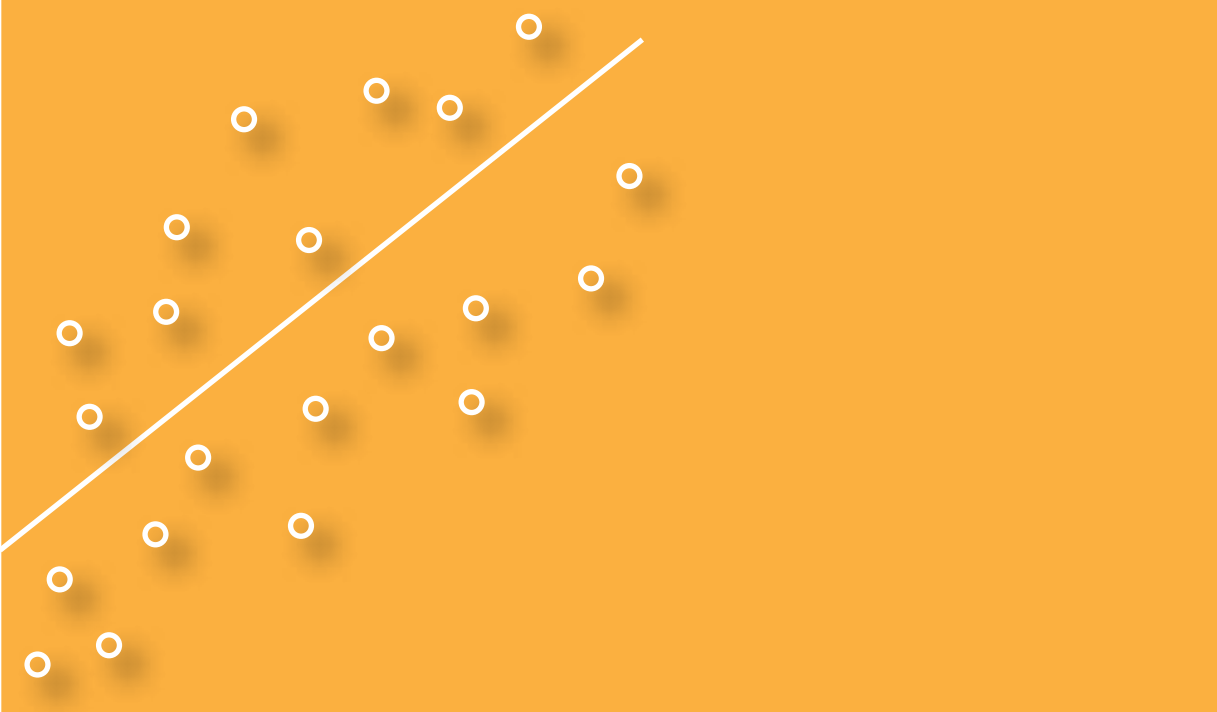
Pursuant to N.C. Gen. Stat. § 131E-183(a)(1) and the 2021 SMFP, no more than one fixed positron emission tomography (PET) scanner can be approved for HSA I in this review. Because each of the two applicants proposes to acquire one fixed PET scanner, both applicants cannot be approved.

Only the AOP application is individually conforming to all applicable statutory and regulatory review criteria. The Agency should determine AOP's application is the most effective alternative proposed in this review for developing one additional fixed PET scanner in HSA I. For the reasons set forth in these comments, the application submitted by AOP should be approved and the MH application should be denied.

imv
information for the decisions ahead

Benchmark Report

PET Imaging 2021



Benchmark Report

PET IMAGING

2021

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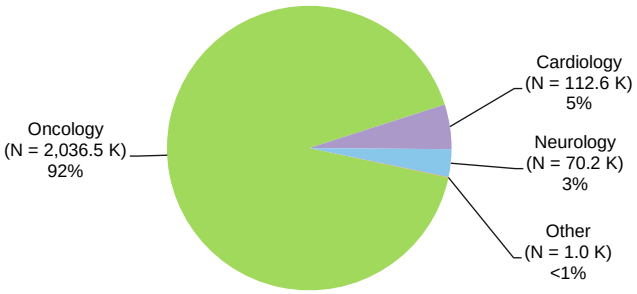
PET Clinical Patient Scan Mix

Clinical PET Scan Volume, by Application Type

Of the estimated 2,220,300 clinical PET scans performed in 2020, 86% were for oncology studies, 5% were for cardiology studies, and 3% were for neurology studies. A negligible <1% scans were other types of PET studies.

Mix of Oncology, Cardiology, and Neurology Applications for Clinical PET Scans, 2020

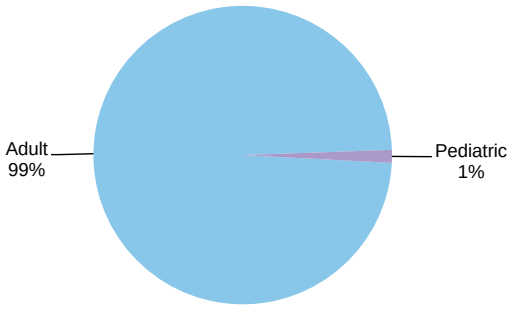


N = 2,220.3K Clinical PET Scans

Pediatric vs. Adult Mix

Of the PET scans performed in 2020, 99% were performed on adults and 1% were performed on pediatric patients.

Mix of Pediatric vs. Adult PET Scans, 2020



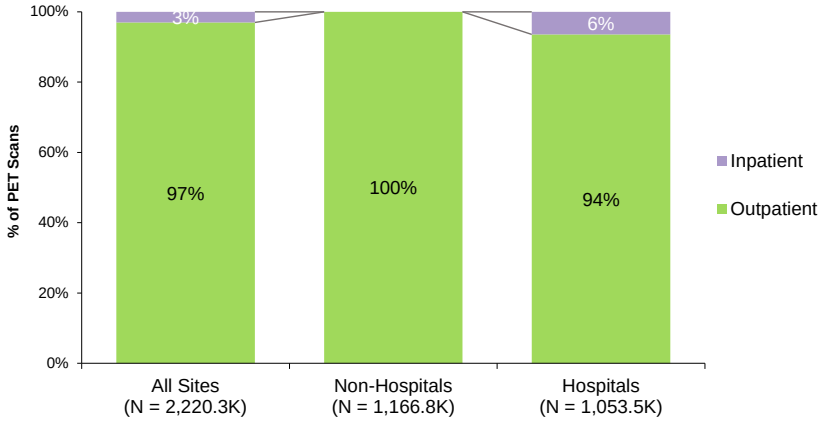
N = 2,220.3K PET Scans

Inpatient vs. Outpatient Mix

In 2020, 97% of all PET scans were performed on an outpatient basis and 3% were for inpatients.

In hospitals, 94% of their PET scans were conducted on an outpatient basis and 6% were for inpatients.

PET Inpatient vs. Outpatient Mix, by Non-Hospitals vs. Hospitals, 2020



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Attachment 2

Citizen Times

LOCAL

Mission Health: What has changed under HCA Healthcare and why?

Mackenzie Wicker Asheville Citizen Times

Published 7:50 a.m. ET Sep. 27, 2020

Dr. Josh Short calls it a “double whammy.”

Now an emergency room physician at Haywood Regional Medical Center, Short left a job within the Mission Health system about two years ago. He has watched from nearby as the six-hospital system experiences growing pains after being purchased by for-profit hospital giant HCA Healthcare in February 2019.

As a health care professional, Short said the changes made in Mission Health — which also operates numerous outpatient clinics — have started to impact his work and that he's concerned about the challenges his former colleagues face.

But it’s recently become a personal issue, too.

“My son, my wife, myself, my aunt, ages 6 to 83, all go to one of the clinics that was closed,” he said. “Even as a physician, I haven’t been able to find doctors' appointments for (all) of us.

“My son was the first pediatric patient at the Candler clinic that’s closing. Flu season’s starting in the middle of a pandemic. He doesn’t have a doctor now."

Short said this is par for the course for HCA's treatment of the Western North Carolina health system. Since the national health care conglomerate acquired Mission Health, patients and employees alike have criticized a plethora of changes. These range from frustrations over rural services being moved to the flagship in Asheville to complaints from registered nurses who call low staffing levels dangerous.

Tim Gary, CEO of Crux Strategies in Nashville and a member of the firm’s health care and government relations practices, said consolidating rural services is a typical move for HCA and that these types of changes are generally determined by market need.

“HCA is a good provider … but they’re also obviously professionally managed,” Gary said. “They have a lot of data at their fingertips and they will make pretty tough business decisions based upon the information that’s available to them."

Mission spokeswoman Nancy Lindell did not answer a question from the Citizen Times about what additional consolidations or cuts might be made in the future.

But she provided information about additions made under HCA's management, which include more than $200 million in capital investments and funding toward higher wages and student loan relief for employees. She also said more new technologies and services will be announced in the coming year.

Consolidations and complaints

Nashville-based conglomerate HCA purchased Mission Health for $1.5 billion in a deal approved by state attorney general Josh Stein. Prior to its execution, Stein negotiated 15 commitments to hold HCA to terms of the deal, which included a requirement that certain services continue to be offered at Mission's rural hospitals for at least 10 years.

That hasn't stopped the system from making changes to rural and suburban services, though. Most recently, Mission announced offices in Biltmore Park and Candler will stop offering primary care services. Lindell said these services will be "consolidated to our other primary care locations."

More: Mission Health to stop primary care services in Biltmore Park, Candler

When his family got their notifications that the Candler clinic would be closing in six weeks, Short said Mission included a list of other doctors "which was largely not helpful because none of them are around here.”

He said there are about 4,000 patients at each of these primary care offices who have effectively been let loose.

“There’s almost 8,000 patients that have six weeks to find a new physician,” said Short. “Many of them are (insured through) Medicare and Medicaid, which local physicians aren’t accepting. On average, it takes several months to get an appointment with a new doctor. These patients also will not be able to get a flu shot from their primary care physician in the middle of a pandemic which disproportionately affects the elderly, who are most at risk because they have the most difficulty getting transportation to other places to get flu shots and the care they need.”

Mission also recently centralized chemotherapy services from Mission Medical Oncology locations in Franklin, Brevard, Marion and Spruce Pine to the Asheville clinic. Though an independent provider offers coverage in these areas, the move drew complaints from officials.

In January, Cashiers-area residents complained that the local clinic did not have a full-time doctor — Mission has since hired a new one — and said they sensed lower staffing levels negatively impacting quality of care.

Employees at Mission Hospital in Asheville also have complained of low staffing. This came as registered nurses unionized at Mission Hospital, in an effort ending with a landslide vote Sept. 17.

In response to staffing complaints, Mission spokespersons accused the union, National Nurses United, of stoking anxieties as part of a campaign "aimed at undermining the hospital's reputation in the community."

HCA also closed the CarePartners Wheelchair and Seating Clinic last December. Lindell said the clinic had been grant funded and, because HCA cannot accept grants, it was transitioned from CarePartners to MountainCare "without any disruption in service to patients."

In addition to complaints about service changes, some patients have criticized Mission's new charity care system, though chief medical officer Dr. William Hathaway said previously HCA's charity care setup is more standard for both for-profit and not-for-profit hospital systems across the country.

Lindell said Mission Health provided about $100 million more in their first full year under HCA's policy in charity care, uninsured discounts and other financial assistance, a total of about $252 million in the first full year of HCA operation.

Mission Health additions under HCA

Mission also has boasted additions to its system since the acquisition as well as plans for more.

Under terms of the sale agreement, HCA agreed to build a 120-bed inpatient behavioral health hospital in Asheville, complete the Mission Hospital North Tower, build a replacement hospital for Angel Medical Center in Franklin and invest $232 million into Mission's existing facilities.

So far, HCA has dedicated more than $200 million in capital investments and completed the North Tower and its expanded emergency department, according to Lindell.

The capital investments also supported:

- Land for building a new Angel Medical Center facility in Franklin.
- Land for a new 120-bed behavioral health facility in Asheville.
- State-of-the-art technology, including two da Vinci Xi robots, an upgraded Mako Robot, an O-arm surgical imaging system and six StealthStations.
- Upgrades in imaging equipment, including new MRI and CT machines, and several new Mammography Units.
- Investments in sister facilities to expand surgical and imaging capabilities throughout Western North Carolina.

Lindell said the health system also has "invested in (its) team" through a student loan repayment program, increasing minimum wage across Mission Health from $11 to $12.50 per hour and implementing "a new career ladder for hospital-based patient care technicians" with the minimum hourly rate increased to $13 per hour.

Mission Health employed about 12,000 people across Western North Carolina at the time it was acquired by HCA and Lindell said the same is true today, though there are almost 600 open positions in the system.

"We continually evaluate our services and operations to effectively meet the needs of our organization and community," she said. "During these evaluations, we have identified areas where we have needed to hire additional staff and where consolidations have also been necessary."

‘Medicine as a business’

Joe Lupica, of Newpoint Healthcare Advisors, questioned some of the complaints angled at HCA. He said it's common to hear gripes about low staffing during a unionizing campaign, but that it's not typical for medical staff cuts to come as part of an acquisition.

More: Answer Man: HCA changing Mission Hospital culture? Cutting hours?

Based in Phoenix, Arizona, Lupica is a consultant to independent hospitals and health systems, advising on mergers, acquisitions, affiliations and other structures designed to enhance finances and operations.

He said cuts following a health system acquisition stem from changes in the market — such as the appearance of a competing provider — and tend to occur when a service is unneeded.

“The question is whether services like this are still being provided in the community, because community need and demand is always the first question that a ... hospital system has to ask,” he said. “It’s not just a matter of doing the right thing, it’s also a business question.”

Gary, on the other hand, said HCA is prone to making cuts to rural services.

Without being familiar with the Mission Health system sale, Gary wagered a guess that HCA was “consolidating services in Asheville and using the other facilities as really feeders to feed patient flow to that big facility.”

“That’s straight out of their playbook,” he said. ... “I’m not saying that’s a bad thing, but part of the play to improve profitability is often to scale down services in local communities, use those facilities as, essentially, intake points through the ER and other clinics and then feed the higher acuity patients to a centralized facility that then they can staff up and deal with the more specialized cases.”

Gary advises clients on restructuring financial systems, mergers, acquisitions and financial revitalization. He has worked with rural hospitals on the other side of HCA deals.

He said it's less profitable to offer services in rural areas that are available at a centralized hub because that requires a system to double up on expensive equipment and staff. Instead, he said, a system might offer basic services at the smaller hospitals and refer patients who need higher levels of care to the larger flagship.

“You’ll often see, for example, a rural hospital that has been the facility in a small county essentially convert over to an emergency department and health clinics, primary care physicians clinics, that sort of thing so that folks can ... go see the doctor," Gary said. "They can get their routine services, their flu shots, all of that. If they have an emergency, there’s an ER to go to. And then everything else, as far as the longer stay hospital beds, that sort of thing, gets moved to a centralized facility.”

Gary said HCA tends to look at several factors when it acquires a hospital or health system including:

- Reducing the cost of management at a facility.
- Reducing supply and inventory costs through purchasing power.
- How a facility fits in with others in the area.

"You'll see a different approach, more of a 'medicine as a business' approach than you will often see in locally-owned, standalone or small systems because it's viewed as a business versus just purely a community service," he said.

The impacts of Mission changes

Franklin Mayor Bob Scott has regularly voiced concerns about cuts to rural health care services. He took issue with Mission's decision-making prior to the HCA deal, in particular when the system discontinued labor and delivery services at Angel Medical Center in 2017.

"After that everything just sort of went downhill and it's been going downhill ever since," he said.

Scott said things "absolutely" have gotten worse since HCA acquired the system and, while the care offered at Angel Medical is great, Franklin has access to fewer and fewer services as they slowly get moved to Asheville. He also said he's received complaints about the way HCA does billing.

"I feel very, very strongly that a community is only as strong and viable as its health care," he said. ... "You have got to have health care. And I don't think that this is necessarily just here in Western North Carolina. I think that there's a problem nationwide about rural health care."

Short, who has friends still working in the Mission system, said some changes have been "devastating" for staff. As offices close, employees who have been with Mission for years are required to go through an application process for a new placement in the system. And Short said new positions don't really exist.

"It's not like they're consolidating, they just let people go and they don't have other jobs for them to fill," he said.

An employee at one of Mission's Buncombe County offices that recently stopped primary care services spoke to the Citizen Times on the condition of anonymity. They, too, said cuts have increased under HCA and that this re-application process even applies to veteran staff members.

"Everybody has to reapply for any positions that are open within Mission," the employee said. "You have to reapply and go through the hiring process to get those positions. ... And we don't know if that potentially means that you're up for pay cuts."

With primary care offices closing, Short said he's expecting Haywood Regional's emergency room to see a dramatic influx of patients who don't have a doctor with whom his staff can coordinate long term treatment.

Absent an emergency, he said it will take time for patients to get new basic care, noting that this comes amid a pandemic with flu season on the horizon.

Some patients have immediate care needs unrelated to the pandemic. Another patient at the Candler primary care office, Geoff Noblitt, said the news of primary care services ending came without warning a couple of days after he'd had neck fusion surgery.

"I saw it on Facebook and had to confirm it with my doctor," he said.

Now, Noblitt said he'll have to find a new doctor to aid him in pain management and other recovery issues following his surgery. He said he's disappointed to lose a provider he's gotten to know through several years.

Noblitt hopes he'll be able to obtain care through a family member's physician, but he said some patients won't be so lucky.

"The closing of this office with no notice to the community, the staff that works there or the patients they serve show that HCA cares nothing about their patients or the community," said Noblitt. "The little people get crushed under big corporate greed again. It's messed up."

He said he thought selling the "this gigantic private company" would offer Mission more resources and enable them to better serve the community.

"And all they've done since is under serve the community and take away resources," he said. ... "It looks like it's an increasingly bad deal for our area."

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MEDPAGE TODAY®

Mission Health Monitor Promises Look at Physician Departures

— Some 200 people registered for webinar to air their concerns

by Jennifer Henderson, Enterprise & Investigative Writer, MedPage Today
April 9, 2021

As physicians quit Mission Health facilities in western North Carolina following the system's purchase by HCA Healthcare, an independent monitoring team said they were paying attention to the issue.

The outside monitor -- Nashville-based consulting firm Gibbins Advisors -- was put in place as a result of stipulations the North Carolina attorney general made in greenlighting Mission Health's $1.5-billion sale to HCA in 2019. Team leaders held a 2-hour virtual meeting on Wednesday to address the issue for members of the public.

Recently, many of the questions submitted to the independent monitor by members of the communities that Mission Health serves relate to physicians leaving local facilities, leaders at Gibbins said during the online webinar.

Though the team from the consulting firm said it's likely many of the physician departures don't fall within the independent monitor's purview, they assured meeting attendees that they are still taking a look and raising the issue to HCA.

Ronald Winters, principal at Gibbins Advisors, said during the webinar that he would break questions about physician departures into two groups -- those regarding primary care physicians, and those regarding surgeons.

Generally, a set of 15 commitments from HCA that the independent monitor is tasked with examining do not include physician employment or primary care, Winters noted. However, one of the commitments states that Mission Health's local hospitals -- which serve 18 largely rural counties -- must provide emergency, acute medicine, and surgical services.

"To the extent those departures impact services at hospitals, that's certainly something we're going to look at and inquire about," Winters said. Surgeons leaving facilities is going to have an impact on the ability to provide services, he added.

Also during Wednesday's webinar, Thomas Urban, managing director at Gibbins Advisors, said that the team would take a look at service levels relative to emergency, acute medicine, and surgical areas in particular, and see if there are any trends or patterns that relate back to physician retention.

Many of the physicians departing Mission Health facilities have landed at other health systems in the region, *MedPage Today* previously reported.

Other concerns fielded by the monitoring team involved confusion around charity care, as well as long emergency department wait times, inadequate nurse and housekeeping staff levels, and diminished cleanliness of facilities.

One concern raised with the independent monitor was that HCA's charity care policy was confusing for patients. In some cases, patients may have been required to pay for care up front before the policy kicked in, the Gibbins team noted at the meeting.

However, the monitoring team's role is only to check compliance with policies, not evaluate them -- and the team's review found HCA had followed the charity care policy, Winters said.

Winters noted that some of the other concerns fall under regulatory requirements monitored by government agencies. Having said that, there may be issues that indirectly affect compliance, or give rise to not providing services as specified in HCA's commitments, he added.

Each year, the independent monitor's role is to advise a foundation called Dogwood Health Trust on HCA's compliance with a list of agreed-upon commitments, as well as the attorney general's office. The foundation was formed with proceeds from Mission Health's sale for the purpose of ensuring that HCA meets its obligations and serves local communities properly.

Dogwood Health Trust hasn't notified HCA of any issues of noncompliance to date. But the recent or impending losses of handfuls of physicians has caught the attention of the North Carolina attorney general's office, as well as Gibbins Advisors, *MedPage Today* previously noted.

J.C. Luckey Sadler, a spokesperson for HCA Healthcare's North Carolina division, said in a statement provided to *MedPage Today* that the team joined the independent monitor's webinar: "Our commitment to our patients across Western North Carolina remains steadfast and at the forefront of all we do. The Mission Health team understands the enormous trust placed in us to serve this community."

Leaders from Gibbins Advisors said that some 200 people registered for the webinar.

Gibbins expects to receive an annual report and capital expenditure report from HCA later this month or early next month, its team said during the meeting. It plans to complete its annual evaluation and submit its own report to Dogwood Health Trust over the summer.

Jennifer Henderson joined MedPage Today as an enterprise and investigative writer in Jan. 2021. She has covered the healthcare industry in NYC, life sciences and the business of law, among other areas.

Citizen Times

LOCAL

Mission to move rural cancer services to Asheville, leave areas to independent provider

Mackenzie Wicker Asheville Citizen Times

Published 7:00 a.m. ET Aug. 12, 2020 | **Updated 11:21 a.m. ET Aug. 12, 2020**

Mission Health has decided to relocate several rural cancer services to Asheville, effective Sept. 3, leaving the areas they serve to an independent group of cancer centers that opened earlier this year, system spokeswoman J.C. Sadler said Aug. 10.

Messino Cancer Centers, which was founded by a group of physicians who previously were part of Mission Health, offer the majority of the treatments the system was providing to the areas.

However, two mayors of rural towns in Western North Carolina say this move does not bode well for the future of health care in their communities.

Franklin Mayor Bob Scott said he would prefer to see HCA Healthcare, a for-profit conglomerate that acquired Mission Health in February 2019, put more money into "local areas rather than increasing the services in Asheville."

"I really would rather to see some of these bailout funds and profits and all coming back into our hospital in our town, because that's where people get sick," he said.

Mission Health — which operates six hospitals and numerous clinics in Western North Carolina — will "centralize" chemotherapy services from Mission Medical Oncology locations in Franklin, Brevard, Marion and Spruce Pine to the Asheville clinic, Sadler said.

More: Buncombe sees fewer new COVID-19 cases, Mission hospitalizations decline this week

More: HCA receives $1 billion in pandemic bailout funds. Where is the money going?

It will also move non-chemotherapy infusion services onto the hospital campuses at Blue Ridge Regional Hospital, Mission Hospital McDowell and Transylvania Regional Hospital. Non-chemotherapy infusion services in Franklin will continue in the same building at 834 Depot Street, as a service of Angel Medical Center.

Patients opt for independent centers

Sadler said Mission Health did not make the decision to relocate services lightly.

She said many patients have chosen to stay with Messino Cancer Centers since a group of physicians separated from Mission earlier this year to open it.

Tena Messer, vice president of operations for Messino Cancer Centers, said the physicians split from HCA in January 2020 because they "wanted to continue to be able to provide the quality of service that (they) had done for years in the community and felt that being able to establish (their) practices independently would be the best way to do that."

“Plus with the support behind us from the American Oncology Network, we knew we would have additional support with oral pharmacy services, care management services and so it was just a better option for providing quality care for our patients,” she added.

More: 'These conditions have got to change': Mission Hospital nurses double down in call for more staff amid pandemic

More: After long wait, Mission nurses' union election day and details set

Sadler said Mission respects patients' decision to stay with the Messino physicians but that the "additional care options have created less of a need for similar services at some of (Mission Health's) facilities."

Mission Health will be contacting each patient impacted by this change by phone and mail and will assist them with "transitioning their care and records within Mission Health or to any local provider of their choice," according to Sadler.

According to Messer, Messino — which has locations in Brevard, Franklin, Marion, Spruce Pine and Sylva — provides all of the infusion services Mission will be relocating to Asheville, but does not provide transfusions. For those, residents will still need to go to the nearest hospital.

“Our facilities take care of all the chemotherapy and immunotherapy services in the region and are available to do that,” she said.

'Chipping away' of services

Asked if she thinks Mission's move is a loss for these rural towns, Messer said that's always a question when there is a transition of medical services.

"But I feel confident that our facilities are able to provide those services and we are available to do that in those communities,” she said. ... “Our physicians have been dedicated to those regions for many years. ... We look forward to continue working in the community.”

Scott isn't sure yet how this change will affect Franklin residents, but he said that, even with the Messino centers, he has some concerns.

"It appears that it's a little bit of a chipping away of all the services that we've always enjoyed out here with Angel Community Hospital and then it became Angel Medical Center and now ... it’s becoming sort of a triage area to send folks on over to Asheville,” he said. “And that’s a 60-mile drive.”

Highlands Mayor Pat Taylor shares his worries.

"We’re still seeing that we’re losing access and it seems like we’re moving toward more and more of a centralized system where all hospital and health care roads lead to Asheville,” he said.

Scott and Taylor aren't the first to bemoan changes to rural health care under HCA. In January, Cashiers-area residents said their clinic lacked a full-time doctor and that they sensed lower staffing levels negatively impacting quality of care.

More: HCA-Mission's independent monitor got an earful. What happens now?

Though Messino will provide much of the care Mission is relocating, Taylor said he hates to see "any cutback in services" in these communities.

Scott said he wants to see more health care options, not fewer.

"Rural health care is in a crisis," he said. “And I feel it every day as I get older. And I feel for our people. I feel for our young couples. ... Our local physicians, I know that they’re feeling the change from a community service-type hospital to a for-profit hospital. This is not boding well for any area, not just rural areas.”

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Mackenzie Wicker covers growth, development and healthcare for the Asheville Citizen Times. You can reach her at mwicker@citizentimes.com or follow her on Twitter @MackWick.

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Citizen Times

LOCAL

Mission Health to stop primary care services in Biltmore Park, Candler

Mackenzie Wicker Asheville Citizen Times

Published 1:45 p.m. ET Sep. 16, 2020 | **Updated 12:19 p.m. ET Sep. 17, 2020**

ASHEVILLE - Mission Health will no longer offer primary care services at offices in Biltmore Park and Candler, effective Oct. 30.

Spokeswoman Nancy Lindell confirmed the news in a Sept. 16 email. She said services at those offices — located at 310 Long Shoals Road in Asheville and 1388 Sand Hill Road in Candler — will be "consolidated to our other primary care locations."

The Mission My Care Now and other specialty services available at the Long Shoals Road location will remain open for the community, Lindell said.

She said that patients of the practices are being individually contacted about transitioning their care to another primary care or internal medicine provider near these locations.

Asked what will happen to employees at these offices, Lindell said Mission Health is "working closely with the teams at these locations to find other openings" within the system.

Cuts under HCA

Mission Health operates six hospitals and numerous clinics in Western North Carolina. Since the system was purchased by HCA Healthcare, a for-profit conglomerate, in February 2019, a plethora of changes have been made.

Most recently, Mission announced it would "centralize" chemotherapy services this month from Mission Medical Oncology locations in Franklin, Brevard, Marion and Spruce Pine to the Asheville clinic.

The move drew complaints from officials in those areas, who said HCA has been "chipping away" at rural health care services.

More: Mission to move rural cancer services to Asheville, leave areas to independent provider

In January, Cashiers-area residents complained that the area clinic did not have a full-time doctor. They also said they sensed lower staffing levels negatively impacting quality of care.

Mission Health has hired a new physician at the Family Medicine Practice in Cashiers in May.

RNs' unionizing vote

Some employees at Mission Hospital in Asheville also have complained of low staffing this summer — something they say poses a threat both to patients and to employees.

This comes as registered nurses voted to unionize at Mission Hospital. The National Labor Relations Board announced Sept. 17 that the vote was 965-411 in favor of unionization, with 100 challenged ballots.

For subscribers: Mission exposes staff to COVID-19, doesn't test all elective surgery patients: nurse

More: With final vote tally near, Asheville's nurses union campaign captures national attention

Mission Hospital RNs will be represented by National Nurses United, the nation's largest nurses' union.

In response to complaints about low staffing, Mission spokespersons have accused NNU of stoking anxieties and creating conflict as part of a union campaign "aimed at undermining the hospital's reputation in the community."

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Mackenzie Wicker covers growth, development and healthcare for the Asheville Citizen Times. You can reach her at mwicker@citizentimes.com or follow her on Twitter @MackWick.

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Citizen Times

NEWS

How Mission Health wooed HCA: More than 2 years later, secrets and silence continue

By Peter H. Lewis AVL Watchdog

Published 6:00 a.m. ET Oct. 21, 2020 | **Updated 9:57 a.m. ET Oct. 21, 2020**

The news stunned Asheville and Western North Carolina, where Mission Health System Inc. was the area's largest employer, its main healthcare provider, and a long-time source of civic pride. Seemingly out of the blue, Mission's directors publicly announced on March 21, 2018, that they had voted to sell the 133-year-old nonprofit to HCA Healthcare, the nation's largest for-profit hospital chain, for an estimated $1.5 billion.

"To say that [Mission's] announcement ... was a surprise would be an understatement," the Asheville Citizen Times observed in an editorial. "There has not been the slightest hint anything was afoot until Mission announced that its board had approved the deal unanimously."

Coming Thursday: A smaller, less-profitable nonprofit hospital system in North Carolina sells for $2 billion, plus $3.1 billion in additional commitments — more than double what Mission negotiated with HCA.

More: Mission Health: What has changed under HCA Healthcare and why?

"The first I learned about the Mission sale was when it was publicly announced that it was under contract with HCA," Esther Manheimer, Asheville's mayor, told AVL Watchdog. "It was explained to me later that the negotiations were confidential."

Confidential indeed. Nearly everyone, including doctors, nurses, and local and regional officials, had been shut out of the secret discussions that would lead to one of the biggest business deals in Western North Carolina history, one that Mission's directors said would transform healthcare in the region for generations to come.

Today, two and a half years later, the story of how and why Mission's leaders chose HCA remains opaque, cloaked in claims of confidentiality and bound by non-disclosure

agreements that, they say, still restrict anyone involved in the sale from publicly discussing or criticizing the deal.

More: Union prevails in Mission nurses' election. National Nurses United to represent workforce

A head start for HCA

But four things are becoming clear, based on documents obtained by AVL Watchdog under public records requests:

One, a core group of Mission directors and executives, including board Chairman John Ball, President and CEO Ronald Paulus, and long-time external strategic advisor Philip D. Green received offers from HCA at least three months before the board formally authorized Paulus to start looking for potential partners. They gave HCA a head start, conferred with HCA executives before setting terms and conditions for other potential bidders, and planned all along to use HCA's early offers as leverage against other candidates.

Two, although Mission's board considered other partners — at one point even speculating about alliances with Google or Amazon — it invited only a select few companies to make proposals, quickly dismissed other suitors besides HCA, and invited only one other bidder to make a formal presentation, according to an investment advisor's report to the Attorney General. The other bid was rejected quickly.

Three, based on "issues and concerns" that surfaced during pre-approval investigations by Attorney General Josh Stein, the Mission board held a special meeting Jan. 8, 2019, to discuss issues involving Green, Mission's chief negotiator and a long-time friend and advisor to Paulus. Stein approved the sale just days after receiving legally binding assurances from Mission's general counsel, the board, and Ball that they found no evidence Green "profited or benefitted directly or indirectly" in the negotiations or sale.

More: Mission Health named among 'Most Wired' health systems

And four: Even today, former Mission directors and executives, HCA officials, and board members of the Dogwood Health Trust that was created with proceeds from the deal cite confidentiality and non-disclosure restrictions in refusing to discuss the negotiations except in broadly general terms. AVL Watchdog reached out to Paulus, Green, Ball, and others involved in the negotiations, all of whom either declined to answer questions or did not respond.

By continuing to prevent even superficial scrutiny of the documents and reports related to the agreement, or even answer basic questions, they make it hard for the public to trust that Mission, and the community it was created to serve, got the best possible deal.

Board explores partnering options

Leading up to the sale, board members later acknowledged, the Mission system was as strong financially as it had ever been, consistently profitable, dominant in the region, deeply respected, and recognized as one of the highest-quality healthcare systems in America.

Even so, the national trend to hospital consolidations was accelerating. Competition was growing. Reimbursements from Medicare and Medicaid were falling, and the North Carolina legislature was steadfast in refusing to expand Medicaid, leading to a rising number of uninsured patients.

Without a financially and operationally strong partner or buyer, board members and consultants said, Mission was doomed to a future of relentless cost-cutting that ultimately would degrade the quality, access, and affordability of care, and possibly even lead to the closure of hospitals.

According to a confidential analysis provided to the Attorney General's office by Stout Risius Ross, an investment bank hired by the state — a redacted copy was provided to AVL Watchdog under a public records request — Mission's active search for a partner or buyer intensified in July 2017. Ball created a seven-person working group to consider Mission's partnering options that included himself, Paulus, Green, Mission's General Counsel Ann Yaeger Young, and three board members: Dr. John Garrett, attorney Wyatt Stevens, and banker Robert Roberts.

More: Letter: An open letter to Dr. Ron Paulus

More: HCA receives $1 billion in pandemic bailout funds. Where is the money going?

HCA, the biggest for-profit hospital operator in America, with annual revenues of $50 billion, was at the top of their list. HCA had unmatched scale and a reputation for cost-cutting and back-office efficiency, strengths that Mission needed. HCA also had no existing presence in North Carolina, and thus could acquire Mission, effectively a regional monopoly, without being subject to antitrust concerns, an attractive option for the company.

Three months before the full board authorized Paulus to contact potential partners, "The working group directed Mr. Green to negotiate proposed term sheets with HCA for both a

50/50 joint venture model and a full asset acquisition model," the Stout report said.

Visit to HCA headquarters

On Aug. 12, 2017, Green delivered HCA's offers to buy or partner with Mission to Paulus, who passed them to Ball. Members of the working group later confirmed to Stout's interviewers that their strategy all along was to use HCA's offers as negotiating leverage against other possible bidders, the report said.

The following month, Sept. 17 and 18, "most of" the working group traveled to HCA's headquarters in Nashville for meetings, the report said.

HCA Healthcare, formerly known as Hospital Corporation of America, had a history that included settling lawsuits ranging from Medicare and Medicaid fraud to breaking contractual promises. But Mission directors said after their Nashville visit that they were convinced HCA's new management was scrupulously ethical.

Just six months earlier, in 2017, HCA paid more than $200 million to settle lawsuits related to its purchase of a nonprofit hospital system in Kansas City, a deal very similar to the one HCA was proposing with Mission.

And in 2003, in what was the largest health care fraud investigation in history, HCA paid the government more than $1.7 billion in restitution, fines and penalties to settle cases. In all cases, HCA denied wrongdoing.

There is no indication that HCA did anything wrong in pursuing or negotiating the deal with Mission.

Nancy Lindell, a spokesperson for Mission Health/North Carolina Division of HCA, did not respond to AVL Watchdog's questions about HCA providing term sheets to Green in August 2017 or the meetings at HCA headquarters the next month.

Ball, Mission's chairman, did not include the early offers from HCA or the meetings in Nashville in a timeline of the deal he provided to the Attorney General, according to records obtained by AVL Watchdog.

No RFPs: Board restricts bidders

Not until a board meeting on Oct. 26, 2017, more than five weeks after the meetings at HCA, did the full 20-member Mission board create a Strategic Planning Committee to officially

begin exploring potential partnerships and authorize Paulus to begin sending formal letters of inquiry to potential bidders, records show. Green, a lawyer, was also tasked with being Mission's lead negotiator.

Paulus told NC Health News after the deal with HCA was announced that he focused the bidding invitations on potential buyers who would have "enough value to bring that they should be considered." Paulus said he identified "a good handful" of potential bidders and wrote formal letters to them to solicit their interest. Based on those responses, he said, the field was narrowed to two candidates besides HCA, then one.

The board's decision to limit competitive bids also makes it difficult to determine if Mission got the best possible deal.

Other Potential Partners Dismissed Quickly

In the end, only one potential suitor besides HCA was invited to make a formal presentation to the board. Even today, neither HCA nor Mission will say who the other bidder was, except that it was a nonprofit, or how that company's offer compared to the one from HCA that Mission already had.

Both HCA and the other company made their presentations on Feb. 12, 2018, and the Mission board — in the same meeting — voted unanimously to pursue a deal with HCA. The only question was whether to partner with HCA, thereby retaining some local control, or sell to HCA completely.

HCA has entered into joint partnerships with other not-for-profit hospital systems, including Austin and San Antonio.

At the next board meeting, March 8, 2018 — 19 weeks after the board formally authorized Paulus to initiate a search for potential partners — the board voted unanimously to sell Western North Carolina's legacy healthcare system to HCA.

On March 21, 2018, Mission publicly announced that it had signed a letter of intent to be acquired by HCA. The letter allowed formal negotiations and due diligence to begin.

'Issues and concerns'

By state law, the sale of a nonprofit company to a for-profit company must be reviewed by the Attorney General. The investigation led to a number of stipulations added to the

proposed Asset Purchase Agreement, but also raised questions about how Mission's leadership and outside advisors conducted the negotiations.

Green and Paulus were long-time friends from Pennsylvania. After Paulus joined Mission as CEO in 2010, Green and his consulting company, PDG Consulting of Arlington, Va., became a long-standing strategic advisor to Mission.

According to his biography on the business database Crunchbase, "Since 1976, Mr. Green has represented clients in a variety of fields, including health industry mergers and acquisitions, corporate planning and transactions, and litigation."

Green did not respond to questions about whether he had other business dealings with HCA either before or during the Mission negotiations.

Records obtained by AVL Watchdog from the Attorney General indicate that the Mission board held a special meeting on Jan. 8, 2019 for "extensive deliberations regarding specific factual circumstances of interest to both the Board and the OAG (Office of the Attorney General)." Both Paulus and Green were excluded for at least a portion of the meeting.

The board heard a report from "outside legal counsel" about "various issues involving or related to officers of and/or advisors to Mission and the negotiation of the transaction."

After the Jan. 8 meeting, Donald Esposito Jr., then Mission's General Counsel, wrote to the Attorney General's office to confirm that "neither Mission's strategic advisor (PDG Consulting), its principals, nor any company with which they are affiliated will benefit directly or indirectly as a result of the transaction between HCA and Mission."

The letter was requested by the Attorney General's office, and Mission's assurances were considered "legally binding," Laura Brewer, communications director for Stein, told AVL Watchdog.

Ball also wrote to Stein, saying that the board had discussed "historical communications between Mission representatives and HCA," communications with other potential partners, and "various issues involving or related to officers of and/or advisors to Mission and the negotiation of the transaction."

"The Board has concluded," Ball wrote to the Attorney General, "… that no member of Mission's management or its outside advisors took any action, or failed to take any action, that was detrimental to Mission's interest."

"The Mission Health Board of Directors held the legal authority to govern that nonprofit corporation," Brewer said. It had heard and discussed the Attorney General's "issues and concerns" and decided, unanimously, to go ahead with the sale to HCA.

"The Attorney General's Office determined that the Mission Board of Directors was fully informed as required by North Carolina law," Brewer said. Stein traveled to Asheville January 16 to announce that he would not oppose the sale.

'A fair deal'

Multiple experts in healthcare finance and mergers, including Mission's investment banker, Cain Brothers, agreed that from a strictly financial perspective, HCA's $1.468 billion offer to buy Mission was a fair deal.

They also noted that a fair deal is not necessarily the same as the best deal.

Today, after 20 months of HCA's contentious management of the Mission system, and after a recent, eye-popping deal for a smaller, less profitable nonprofit hospital system on the other side of the state, it's unclear if Mission even got the best possible deal.

Paulus joins HCA

The sale of Mission Health Care to HCA became official on Feb. 1, 2019. Just two weeks later, Paulus, who along with Green had championed the sale of Mission to HCA from the start, announced that he was resigning to take a new job, as strategic advisor to HCA.

Paulus is still on HCA's payroll, the company confirmed.

Green declined to answer specific questions from AVL Watchdog, but wrote: "I hope you will take the opportunity in your article to give Mission's Board of Trustees, as well as the Mission executive team, credit for the unbelievably successful transaction consummated with HCA; a transaction which was of enormous benefit to Mission and its employees, its patients and to the larger Western North Carolina community. While Mission's outside advisors provided guidance, the Mission Board of Trustees made a fully informed and independent decision."

Today, Green and Paulus remain close. PDG Consulting LLC and RAPMD Strategic Advisors LLC, their respective consulting firms, share the same executive assistant.

AVL Watchdog is a nonprofit news team producing stories that matter to Asheville and Buncombe County. Peter H. Lewis is a former senior writer and editor at The New York

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Citizen Times

NEWS

Mission sale: Good for WNC, or just HCA? Smaller, less-profitable hospital nets twice the price

By Peter H. Lewis AVL Watchdog

Published 5:00 a.m. ET Oct. 23, 2020

Years from now, the decision in 2018 by the directors of Mission Health to sell to HCA Healthcare might be seen as a brilliant strategic maneuver, one that guaranteed affordable, high-quality healthcare for future generations of western North Carolinians. This was, and still is, the position of the directors and executives who pushed the deal.

In return for giving up its independence, local control, and century-long legacy as a nonprofit providing quality care for the benefit of local residents, Mission accepted a $1.5 billion offer from HCA, the biggest hospital chain in the country. As a public company, HCA is required by law to prioritize profit-making for its shareholders.

The money from the sale was designated to fund a new nonprofit, the Asheville-based Dogwood Health Trust. Based on the relatively small population of the 18-county mountain region it serves, Dogwood overnight became not just the richest per capita health-related endowment in North Carolina, but in all of America.

More: Part 1:How Mission Health wooed HCA: More than 2 years later, secrets and silence continue

But did the Mission directors — so eager to strike a deal with HCA that they gave it a head start, conferred with HCA executives before setting terms for other potential bidders, and invited only one still unnamed company besides HCA to make a formal proposal to the board — get the best possible deal for the communities Mission was formed to serve?

$5.1 Billion for Smaller Hospital System

Much is still unknown about the Mission-HCA deal because the negotiations were conducted in secret, and Mission's directors agreed to confidentiality restrictions that they say prevent

them from discussing the sale even now, more than two years later.

In stark contrast, the recent courtship of not-for-profit New Hanover Regional Medical Center in Wilmington, N.C., was conducted in public with full transparency.

After a rigorous, nine-month process that included public meetings, escalating bids from six wealthy suitors, and all documents posted online for the public to examine, the New Hanover County Commissioners voted this summer to pursue a $2 billion cash offer from Novant Health of Winston-Salem, a nonprofit. The Novant deal also includes an additional $3.1 billion in spending commitments, for a total package of $5.1 billion.

That's more than $3 billion higher than the total $1.923 billion package the Mission board accepted from HCA, which included $1.468 billion cash, $430 million in capital spending, and a $25 million donation to a healthcare innovation fund.

More: Mission Health: What has changed under HCA Healthcare and why?

New Hanover received at least three bids that exceeded the price paid by HCA for Mission. Charlotte-based Atrium Health bid $2 billion cash up front for New Hanover Regional, with an additional $1.1 billion in spending commitments. Durham-based Duke Health offered at least $1.35 billion cash plus $1.9 billion in capital commitments, for a total package of $3.25 billion.

HCA Healthcare also submitted an offer that valued New Hanover Regional at $1.25 billion, but it was not selected as a finalist.

Novant, Atrium, and Duke Health did not respond to AVL Watchdog questions about whether they had been invited to make offers for Mission.

Mission 'An Attractive Target'

By conventional metrics often used to evaluate healthcare deals, Mission appeared to be a more valuable prize than New Hanover.

At the time of the sale, Mission had six hospitals, 1,057 beds, 12,000 employees, $1.8 billion in total revenue in its latest fiscal year, and $180 million in earnings before interest, taxes, depreciation and amortization (EBITDA, a measure of a company's overall financial profitability and performance). Mission commanded a near monopoly market share in Buncombe and the 17 other counties of Western North Carolina it serves.

New Hanover Regional, in comparison, has three hospitals, 855 beds, 7,400 employees, $1.2 billion in revenue for the latest fiscal year, and $111 million earnings, in a highly competitive market.

Experts in healthcare merger valuations contacted by AVL Watchdog stressed that it is difficult to compare the relative values of two different hospital groups in different markets and different years. Also, they noted, New Hanover Regional is in a faster-growing market and has a higher percentage of patients covered by private insurance, the most lucrative source of revenue for hospitals.

The so-called payer mix for Mission was, and still is, less favorable. People in Western North Carolina are older, poorer, and sicker than state and national averages. A majority of Mission's patients are either uninsured or covered by Medicare and Medicaid, neither of which reimburse the hospital the full cost of care.

More: Mission Hospital RNs have voted to unionize. What happens now?

Even so, Mission was a very attractive target, Alan Levine, chief executive of Ballad Health, a $2 billion healthcare system based in Johnson, Tenn., told Business North Carolina at the time of the deal.

"This is a home run for HCA," said Levine, a former HCA executive. "First, it is a high-growth market where they have no competition and their margins are already strong. Then when you are HCA deploying your staffing models and eliminating corporate overhead, that leads to pure synergies. HCA shareholders will benefit tremendously."

Levine told AVL Watchdog through a spokesperson that his views of the Mission-HCA sale have not changed.

He said Mission never approached Ballad about a potential partnership.

Profits and quality of care

HCA shareholders have benefited since the Mission acquisition. Despite the pandemic, HCA reported record earnings for the second quarter of 2020 and is expected to report its third-quarter earnings next week. In a preview, the company said quarterly revenue would be approximately $13.3 billion, up sharply from a year ago. HCA also reported that it will return, or repay early, approximately $6 billion of government assistance funds received as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

"When Mission Hospital was being proposed for sale to HCA, the community was told that it would be more financially successful due to better economies of scale and a more efficient business structure," Brownie Newman, chairman of the Buncombe County Board of Commissioners, told AVL Watchdog. "Unfortunately, the community's experience has been that HCA has increased their profits at the expense of patient care through inadequate staffing of the hospital."

Invited to respond to Newman's comment, Nancy Lindell, spokesperson for HCA Healthcare/North Carolina Division, wrote that Mission Health "continues to raise the bar for excellent patient care exemplified by our 5 Star rating from CMS," the Centers for Medicare & Medicaid Services, "something only achieved by about 10% of hospitals in North Carolina and we have been nationally recognized as a Top 50 hospital for our cardiac care."

"Year to date," Lindell continued, "Mission Health has hired almost 400 full-time RNs and nearly 300 CNA and PCT positions," referring to registered nurses, certified nursing assistants, and patient care technicians. "We continue to actively recruit nurses," she said. Additionally, we have hired more than 100 new providers and advanced practitioners."

"Mission Hospital has almost 80 more RN positions today than in February of 2019," she wrote. Comparisons for doctors and other positions were not immediately available, she said.

More: Mission Health to stop primary care services in Biltmore Park, Candler

'Good Common Sense'

The public accessibility to the negotiations for New Hanover Regional system arose partly because the hospital system is owned by New Hanover County. It received government funds, which come with more stringent reporting and open meetings requirements.

But the county commissioners and the citizen advisory group the commission established to oversee the process also told AVL Watchdog that, as stewards of a nonprofit community resource established to serve the community, they felt they had an obligation to involve the public in all aspects of the deliberations.

"The more input [from the public] we could get, the better off we'd be," said Spence Broadhurst, a co-chair of the 21-member Partnership Advisory Group, adding that going "above and beyond" the legal requirements for transparency "just made good common sense."

Barbara Biehner, also a co-chair of the New Hanover group, said another priority was “trying to communicate with anyone who wanted to listen.” The group held weekly forums with hospital staff to discuss the process, made regular public updates on Facebook and other social media, and established a website where all bids were posted in detail for public scrutiny.

The result, they said, was greater public trust in the process.

Local Control, No Staff Cuts, Board Seats

Members of the citizen council evaluating the bids for New Hanover Regional wrote on the public website that they were initially opposed to an outright sale. They changed their minds, they said, after learning that a deal would not require giving up significant local control.

If the proposed deal with Novant gets regulatory approval, as seems likely, New Hanover Regional will remain a nonprofit hospital system with local governance and local decision-making; Novant will not be able to change staffing levels without local New Hanover hospital board approval; and Novant will offer no-cost charity care to anyone who earns less than 300 percent of the federal poverty level, up from the current 200 percent. New Hanover Regional also gets up to two seats on the Novant Health parent company board.

In its deal with HCA, the Mission board considered but rejected an offer by HCA for a 50/50 joint venture, AVL Watchdog learned. Instead, the board struck a deal that ceded control to an out-of-state company, surrendered its not-for-profit status, lost control of local staffing levels, and got no HCA board seats.

HCA promised to continue Mission’s existing charity and uninsured care policies, but soon after the sale drew complaints from elected officials and healthcare advocates, along with rebukes from the Attorney General, for its lack of transparency in implementing those promises.

Mission’s board chairman at the time, Dr. John Ball, and Vice Chairman Dr. John Garrett explained their rationale in an opinion piece published in the Asheville Citizen Times: “Ultimately, the Board decided that it could no longer remain both independent and true to its mission: to improve the health of the people of western North Carolina.”

“And,” they wrote, “it is the Board’s ultimate responsibility to decide how best to meet that mission.”

AVL Watchdog reached out to Ball, now a board member at Dogwood Health Trust, and Janice Brumit, chair of Dogwood. Through a Dogwood spokeswoman, both declined to comment.

Mission: 'No requirement' to inform public

In a letter to Mission's employees and volunteers on the day the sale to HCA was announced, Paulus, Mission's CEO, pledged transparency in the transaction. Shortly thereafter, Rowena Buffett Timms, Mission's senior vice president, clarified, "We pledge to be as transparent as possible."

More: Would a for-profit Mission Hospital be better for Western North Carolina, officials ask

Two months after that, Timms said the public had no right to be involved in the decision process.

"There was no requirement to even announce that a letter of intent had been reached," Timms told the Citizen Times in June that year.

"While it's easy to understand why those who don't appreciate the challenges and complexity of operating a rural hospital in today's environment may reflexively and emotionally want 'their' hospital back, it is unlikely that any knowledgeable observer would believe that is a realistic possibility," Timms told the Citizen Times the following month.

By November 2018, as public concerns and criticism of the deal continued to increase, Timms said: "No outcome would or could ever fully satisfy everyone, particularly those with only a limited understanding of the transaction."

In seeking a fuller understanding of the transaction, AVL Watchdog was told that all such information was confidential.

AVL Watchdog is a nonprofit news team producing stories that matter to Asheville and Buncombe County. Peter H. Lewis is a former senior writer and editor at The New York Times. Contact us at avlwatchdog@gmail.com.

NewsRoom

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September 18, 2020

Section: News

Union wins Mission nurses' election

Brian Gordon

September 18, 2020

Mission Hospital nurses will unionize and gain the power to collective bargaining over their benefits and working conditions following an early morning ballot count Sept. 17 that saw "Yes" union ballots more than double "No" union ballots.

The counting process began midday yesterday Sept. 16 and stretched well into Thursday. Through Zoom, hospital and union representatives watched as a National Labor Relations Board agent, Ingrid Jenkins, displayed ballots one-by-one from the NLRB offices in Winston-Salem. After all the yellow paper ballots were tallied, Jenkins announced 965 ballots were marked "Yes," 411 ballots were marked "No," and 100 were challenged ballots.

The final vote concluded a year-long effort by nurses and union representatives to organize Mission nurses. The union victory arrived less than two years after HCA Healthcare purchased the hospital as part of a $1.5 billion sale.

The benefits and workplace conditions of around 1,600 registered nurses who work at Mission Hospital and the St. Joseph campus will be bargained over by National Nurses United, the nation's largest nurses' union. North Carolina is a right-to-work state, so nurses won't be compelled to pay dues. However, they will still be directly affected by the contracts NNU and HCA leaders negotiate.

In an NNU press release Sept. 17, Mission nurse Lesley Bruce said: "We're all thrilled that we've finally won. This victory means we can use our collective voice to advocate for patient safety and safer staffing. I can't wait to see what improvement we'll win together."

In the press release, NNU called the Mission nurses' election the biggest union victory at a hospital in the American South since 1975.

Mission Health operates six hospitals and numerous out-patient clinics across Western North Carolina. Mission Hospital, in Asheville, is its flagship facility. Mission will be NNU's first union in North Carolina and its largest at any HCA-affiliated hospital.

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Mission opposed the union effort, saying it would would interfere with supervisor and staff communications and ultimately hurt the hospital's quality of care. In its annual public financial statement, HCA stated more unionization could cause its labor costs to "increase materially."

In an email, Mission Health spokeswoman Nancy Lindell said: "We are grateful for our nursing team and their dedication to quality patient care throughout this challenging time for our nation and world. As divisive as this election has been over the last few months, we respect the right of nurses to decide for themselves whether or not they supported NNU."

What comes next

Last winter, staff and community members across Western North Carolina voiced concerns over the hospital's staff-to-patient ratios and patient care under HCA ownership.

In early March, a group of Mission nurses petitioned the NLRB to unionize. This sparked a contentious, six-month formal campaign that culminated in Wednesday's vote count.

Once the NLRB certifies the election, hospital management has an obligation to bargain in good faith with the union. HCA representatives can ask the NLRB to review any alleged unfair labor practices before the election is certified.

Lindell suggested the hospital might ask for the election to be revie

"In the coming days, the hospital will thoroughly examine the election process and the manner in which the election was conducted," she said, and added "the hospital may utilize that process to ensure that all of our nurses had the fair election that they deserve."

While the organizing campaign is over, a fight for a first contract between union and Mission management will now unfold.

Around three years is the average time between a union election and a first contract that spells out benefits and conditions, said Kate Bronfenbrenner, director of Labor Education Research at Cornell University's School of Industrial and Labor Relations. However, Bronfenbrenner added that some unions, like NNU, typically secure first contracts in closer to a year.

"If an employer really wants to refuse (to bargain), it can take forever unless the union uses its power to organize the workers and exert community, allies, and economic pressure," she said.

---- Index References ----

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NewsRoom

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SHARE

Concerns mount as doctors leave HCA

Physicians citing more work, less pay

Derek Lacey Asheville Citizen Times USA TODAY NETWORK

Dr. Tom Large planned to retire in Asheville, to finish out his career with Mission Hospital as an orthopedic surgeon.

Then the nonprofit Mission sold to for-profit HCA Healthcare in 2019, and that changed. He let his contract expire at the end of March and is now packing up to move his wife and three children to Atlanta and take a position with Emory University.

"We love it here," he said. "My family is happy here, we like the schools here. My wife's family is an hour from here, and I planned on spending the rest of my life here. It's a huge deal. ... It's awful."

See DOCTORS, Page 4A

Bill O'Connell, founder of Communities for Older Adult Health, talks about Mission Hospital during a public meeting with the independent monitor of HCA, Gibbins Advisors, at MAHEC on Feb. 10, 2020. ANGELI WRIGHT/ASHEVILLE CITIZEN TIMES

Mission Hospital April 8, 2020. ANGELA WILHELM/AWILHELM@CITIZENTIMES.COM

Continued from Page 1A

Large is one of an unclear number of doctors parting ways with Mission after the sale, citing not only more work and less pay but what he says is a culture that settles for mediocrity and removes physicians from leadership positions.

At Transylvania Regional Hospital, more than a dozen providers leaving has spurred Brevard City Council into action.

In a statement, Large says in his opinion, which he says echoes conversations with many other physicians at Mission Hospital, HCA "consistently demonstrated that all decisions are seemingly strongly driven by profit."

The company, based in Nashville, Tennessee, has systematically removed physicians from positions of leadership and disbanded a committee that advised non-physician administrators on patient care issues, he says.

"Part of the attraction of working at Mission was to be surrounded by high quality, very well-trained physician colleagues," Large said. "Many of these people are leaving as they aren't wiling to compromise patient care in Asheville."

To his knowledge, Large said about 25 physicians from one group of doctors have left the hospital, which now contracts much of its staffing through Team Health, a contracted physician supplier. He says staffing is critically low throughout many areas of the hospital, including

housekeeping and patient transporters, and nursing is relying on a huge number of traveling nurses.

"Consistently excellent patient care flows from people working together over time versus this revolving door model," Large said. "I believe they are simply overworking and underpaying most of these positions so they cannot recruit or retain people into permanent position." He says his patients were routinely waiting 18-24 hours in the emergency department to get admitted to a regular room, not because there weren't beds, but because there weren't nurses to staff the rooms.

Mission Hospital takes care of the most medically unwell and most severely injured patients in the region, Large said, but it's his belief that HCA is using its staffing models from smaller hospitals that take care of less complex patients.

That, he said, is contributing to physician and staff burnout, frustration and unhappiness, and ultimately compromised patient care.

"Unfortunately, this seems to be the HCA culture.This is their way, to staff their facilities razor thin, overworking those that are willing to stay, all in the name of increased profit," Large said. "I was proud to be part of Mission Health for nearly nine years but could not bear the thought of working under HCA for the remainder of my career."

He said physicians at Mission were blindsided by an Asheville Watchdog report showing that Mission didn't even consider joining Duke University Health, UNC Health, Wake Forest Baptist Health, Atrium Health or any other nearby major nonprofit health systems. And Large, who served two tours in Afghanistan as a deployed orthopedic surgeon, said the work and pay issues are just a small part of his decision.

"For me, it's the cultural issues," he said. "the way they're running the hospital and disempowering physicians and taking our once-great hospital and filling it with mediocrity."

HCA: Doctors still in hospitals; RN

shortage

HCA maintains that while doctors may no longer be on their payroll, for the most part they're still on medical staff at its hospitals.

"The majority of physicians who may have chosen not to renew their contracts with Mission - whether it be the cancer center or (Transylvania Regional Hospital) - are still on medical staff at both hospitals," Media Relations Director Nancy Lindell said in an email.

HCA has retained most on medical staff unless they chose to leave the area or retire, she said, and keeps many physicians in leadership roles across many service line committees in the hospital.

She noted the North Carolina Division chief medical officer and Mission Hospital chief Mmedical officer, as well as physicians on the hospital board.

The hospital's 2020 annual report, dated April 30, shows Mission Health has 1,600-plus active and affiliated providers and more than 800 employed providers.

The departures come as Asheville Watchdog reports HCA doubled its earnings in the first three months of the year while ratings drop from the Centers for Medicare and Medicaid Services and the independent Leapfrog Group.

"The team at Mission Hospital is committed to delivering quality care to every patient who comes to us," Lindell said. "We were disappointed in the report from Leapfrog and CMS and are working diligently to improve."

She said between the Fall 2020 and Spring 2021 Leapfrog score, there was a one- or two-point drop in some metrics regarding communication between staff and patients that caused the downgrade to a "B" grade from the group, and CMS changed its methodology from seven measure groups to five, also changing the weighting of those groups.

"We are using the feedback from both of these scores to implement improvements in these areas at Mission Hospital, and we continue to be very proud of our outstanding clinical outcomes as a regional destination for care," Lindell said.

Brevard City Council has reached out to the North Carolina Attorney General's Office about concerns at Transylvania Regional Hospital. Lindell said there are 425 active and affiliated physicians on medical staff there.

"While some physicians may have changed who formally employs them, the physicians involved in Mission's Cancer program remain involved and active on our medical staff," she said in a statement. "Mission Cancer Center has all of the same physician services that it has always had and has added a rapid anemia and a urology clinic."

Addressing emergency department wait times and staffing, Lindell said contracting with ER provider groups is a practice across most hospitals in the country. Mission Health previously contracted with Carolina Mountain Emergency Medicine and now uses Team Health to staff the ER.

In the ER, patients are evaluated and treated, she said, and if they need to be admitted, are cared for in the ER until an inpatient bed is available.

"Recent staffing constraints, along with a high volume of patients, has the length of time a patient is in an ER bed abnormally high with a year-to-date average of 7.5 hours," Lindell said. "We are working diligently to meet or exceed our goal of 3.5 hours or less. Our ER remains available to serve our community."

She also said the nationwide shortage of RNs across the country is well known, as Mission Health continues to recruit

See DOCTORS, Page 10A

Mission Hospital April 8, 2020. Concerns are mounting in the community as doctors leave HCA Healthcare both at Mission and at Transylvania Regional Hospital. ANGELA WILHELM/AWILHELM@CITIZENTIMES.COM

Continued from Page 4A

both RNs and RN support positions like health unit coordinators and certified nursing assistants.

An RN recruitment event is planned for May 20 with up to $15,000 signing bonuses for certain roles, and Lindell pointed to robust benefits packages, tuition reimbursement and more.

Mission's state-certified CNA Training programs at Mission Hospital and Highlands-Cashiers Hospital began classes last fall at full capacity, she added, hoping the programs can help fill RN support positions more quickly.

But staffing levels were also an impetus for nurses at Mission to unionize last year.

Bradley Van Waus, southern regional director for National Nurses United, said contract negotiations continue between HCA and the nurses union at Mission Hospital.

"We are hopeful that we can reach an agreement that will keep patients safe by ensuring that nurses have a voice in ensuring safe and appropriate staffing and ensures the recruitment and retention of experienced nurses," Van Waus said in a statement.

Throughout the bargaining process, he said, nurses have advocated for the community, and they're eager to reach an agreement that addresses both their needs and the community's.

Brevard 'extremely concerned'

"We want our hospital to remain viable," said Brevard City Council member Maureen Copelof. "The community here loves that hospital. They built the hospital."

Copelof, who was appointed liaison for the city with Gibbins Advisors, the independent monitors for the Mission sale, said the end goal is quality health care, which is critical to the community.

She meets with Gibbins and the compliance division from Dogwood Health Trust to talk about any compliance issues.

Copelof said it's hard to get confirmation from HCA on the exact number, but apparently 14 health care providers have parted ways with Transylvania Regional Hospital since the sale.

That doesn't sit well with Brevard City Council, which voted March 15 to send a second letter to North Carolina Attorney General Josh Stein expressing their concerns.

According to the minutes from the council's March 15 meeting, Copelof updated the council about her last meeting with Gibbins, saying she had several questions about why so many physicians, doctors and health care providers are leaving HCA and not renewing their contacts.

The council voted unanimously to approve and mail the letter she wrote asking Stein to initiate a study looking at the "impact to rural health care in North Carolina due to the change in the business model of going from non-profit to profit."

The letter is a follow-up to one sent the month before expressing concerns about "the state of medical care in Transylvania County resulting" from the HCA sale.

"We were assured when this sale was pending that our community would continue to receive the same local access to medical services that we had received before the sale," the letter says. "Recent events, however have us extremely concerned about what it happening regarding health care in our rural community."

The first item listed notes the "majority of physicians/health care providers associated with Transylvania Regional Hospital have opted not to continue under contract with HCA."

It verifies 15 providers who recently left HCA, which Copelof clarified is actually 14 after one decided to sign with HCA. The letter lists eight primary care physicians, one of two orthopedic surgeons in the county and "all the general surgeons will have departed when the last one leaves HCA on March 30th."

The primary reason for that, according to Brevard's letter, is a change in compensation from Revenue Value Units to Fair Market Value, "a major change in how rural health care is provided/ compensated."

But in a statement, Lindell said, "Our primary care physicians were offered contracts aligned with Fair Market Value as the next step in transitioning them to HCA Healthcare contracts."

Mission Health's previous contracts included non-compete clauses that were waived on a one-time basis so physicians could either accept the new contracts with HCA or choose other local practices, she said, so they could consider their options and remain in the same communities where the hospitals are located.

"While some have chosen to pursue other local options, we are confident that most will continue to care for our community here in Western North Carolina as members of our Mission Health medical staff," Lindell said. "We are actively recruiting to fill any vacancies that we anticipate, and recently signed contracts with several new providers."

For Brevard City Council, doctors leaving raises the question of whether HCA actually is in compliance with its purchase agreement that says it must maintain certain services at TRH, including emergency, surgical and acute medicine services, as well as its transitional care unit.

The letter asks if the company is in compliance when a 24/7 service is cut in half, and whether it actually has to go all the way to zero before it triggers a noncompliance.

HCA's primary care locations continue to be available to the community, Lindell said, and that while the employment relationship with some physicians has changed, they continue to be a part of the medical staff and hospital team.

"It's not so much quality of care, but wanting to make sure we have access to all the care locally and that care does not get centralized in Asheville," Copelof said, and gauging the presence of that care in Transylvania is going to require some numbers.

On May 12, Copelof had a follow-up call with Assistant District Attorney Llogan Walters, sharing concerns and talking about how these departures may impact rural health care in Transylvania County and regionally.

Walters said she would get back in touch, Copelof said, after discussions of concerns expressed in the letter and that "we really believe at a state level ... it's important to look at what's happening to rural health care across Western North Carolina."

But they'll only know the impact on the departure of doctors who can still refer patients to TRH, and whether that presents a threat to services by looking at metrics that they currently don't have access to, she said.

Monitors: No commitment on staffing

Noting that the HCA-Mission purchase agreement doesn't specify keeping physician staff numbers at a certain level or specifically mention primary care, Copelof said, "There's the overall indirect impact to health care when these types of shifts and disruptions occur."

Since population locally has remained relatively stable over the past two years, she'd like to compare things like the number of surgeries being performed before and after the sale, the number of acute care cases being referred to Mission and the occupancy of the transitional care unit before and after the sale.

She said she hasn't seen those numbers yet, but will keep asking for them.

Ronald Winters, with independent monitor Gibbins Advisors, said in a May 12 statement "There is no specific commitment under our province that relates to physician retention. We do note that while physician departures viewed alone would not be a violation of HCA's 15 commitments, it is important information that informs our compliance evaluation."

HCA/Mission Health is required to provide services as part of the asset purchase agreement, he said, but regulators like the state Department of Health and Human Services assure compliance with clinical and safety standards, including staffing. "We review information on various topics not specifically covered by the APA all the time, and we consider how those factors may impact the 15 commitments," Winters said. Copelof said Brevard will continue to work closely with Gibbins, HCA and Dogwood to make sure Transylvania has a high quality hospital with a full range of services.

In February 2020, Stein's office sent a letter to HCA North Carolina Division President Greg Lowe about a number of issues, including "a surge in complaints about quality of care," which "frequently raise

concerns about the impact of staffing cuts, especially for nurses," that are "harrowing to read."

The letter then cites the asset purchase agreement when HCA purchased Mission. In it, HCA agreed to those 15 commitments, including one to maintain certain services like "general medicine services" at the Asheville facility.

"Widespread quality of care issues at Mission facilities would raise real questions about whether HCA is providing the services that it guaranteed," the letter says.

Two years since the sale, Gibbons Advisors continues to monitor the company's compliance with those commitments.

In its second annual report to monitors dated April 30, HCA says it has not discontinued any services it's required to continue under the asset purchase agreement, including general medicine, emergency and trauma, and oncology services, as well as specific services at five other hospitals.

At Transylvania Regional, that includes emergency, surgical, acute medicine services and the transitional care unit, its skilled nursing facility.

Copelof said one concern was the closure of the transitional care unit, which has been reopened.

In an April 7 public meeting hosted by Gibbins, questions included concerns about staffing at the hospital system, according to the transcript: "Way too many physicians or staff are leaving HCA hospitals. This is not a coincidence. If this is not a breach of contract by eliminating services then I'm not sure what is?"

Winters answers that the asset purchase agreement doesn't deal with nor do commitments include anything about employing physicians.

But, he says, "To the extent that those departures impact services at the hospital, that's certainly something we're going to look at and inquire about."

Later in the transcript, Winters clarifies that HCA is only not in compliance when the services stop and in each case monitors determined that HCA was providing the services, and that there have been no official disputes as of yet, but the two issues he gives as examples are the transitional care unit at Transylvania Regional and physicians leaving the system.

He says HCA hoped to provide the transitional care at a different location within the structure, and felt it was a service still being provided.

"At the end of the day, as a result of what the community said as a result of us bringing it to them, they decided to reopen that space again, and it's operational," Winters said in the transcript.

The monitors have had several conversations over the past six months about physicians leaving, and he says HCA has "spent a lot of time making sure that the surgeons that were leaving are being replaced and we've kept track with that."

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Mission nurses and supporters rallied to form a union at Pack Square Park in downtown Asheville Sunday, March 8, 2020.

ANGELA WILHELM/AWILHELM@CITIZENTIMES.COM

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HCA CEO made $30.4M in 2nd year at helm

Ayla Ellison (Twitter) - Monday, March 22nd, 2021 Print | Email

Though top executives at Nashville, Tenn.-based HCA Healthcare accepted reductions in their base salaries last year, four of the company's top executives ended 2020 with higher total compensation, according to HCA's shareholder proxy statement.

In response to the COVID-19 pandemic, HCA executives saw their base salaries reduced by 30 percent from April 1, 2020, through June 30, 2020.

Samuel Hazen, who took over as CEO in January 2019, received a base salary of $1.3 million last year, compared to $1.4 million a year earlier. After factoring in incentive compensation, stock awards and pension benefits, Mr. Hazen's compensation totaled $30.4 million in 2020, according to the proxy statement.

HCA American Group President Jon Foster received total compensation of $8.6 million last year, up from $7.8 million in 2019. National Group President Charles Hall saw his compensation rise from $6.5 million in 2019 to nearly $7 million last year.

The company's CMO and clinical operations group president Jonathan Perlin, MD, saw his compensation rise from $6 million in 2019 to $6.5 million last year.

HCA Executive Vice President and CFO William Rutherford's total compensation dipped to $6.1 million in 2020 from $6.3 million in 2019. He saw incentive plan compensation decline year over year.

HCA's compensation committee reviews and approves executive compensation. In 2020, the committee retained the services of independent outside consultants to assist with the assessment of executive compensation, according to the proxy statement.

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HCA profit more than doubles to $1.4B in Q1

Ayla Ellison (Twitter) - Thursday, April 22nd, 2021 Print | Email

HCA Healthcare, a 186-hospital system based in Nashville, Tenn., said April 22 that its revenue and profit increased in the first quarter this year.

The for-profit hospital operator posted revenue of $13.98 billion in the first quarter of this year, up 8.7 percent from the same period a year earlier, when revenue totaled $12.86 billion.

HCA said same-hospital admissions declined 4.2 percent year over year. Same-facility emergency room visits were down 18.4 percent while inpatient surgeries declined 5.4 percent. Outpatient surgeries increased 2.3 percent year over year.

"Same facility revenue per equivalent admission increased 16.6 percent in the first quarter of 2021, compared to the first quarter of 2020, due to increases in acuity of patients treated and favorable payer mix," HCA said in an earnings release.

After factoring in operating expenses and nonoperating items, the company ended the first quarter of this year with net income of $1.4 billion. That's up from net income of $581 million in the same period a year earlier.

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