Novant Health Asheville Medical Center, LLC
CON for a New Acute Care Hospital in Buncombe County
Project ID B-012230-22
Opposition on Behalf of MH Mission Hospital, LLLP

Introduction:

The 2022 SMFP identifies a need for 67 acute care beds in the acute care planning area that includes Buncombe, Graham, Madison, and Yancey Counties. The need was generated by the high occupancy of Mission Hospital, the only provider in the service area composed of Buncombe County and the three additional small, rural counties that alone cannot support a hospital. Mission is the regional tertiary medical center and, as a result, cares for the defined service area as well as the entirety of Western North Carolina. In response to the demand for its high-acuity and specialized ICU and medical/surgical services, MFoBission applied for the addition of 67 beds on its existing campus to address these specific needs.

Two other applicants have applied for new, 67-bed acute care community hospitals based upon the bed need determination in the SMFP. Both Novant Health Asheville Medical Center, LLC ("Novant" or "NH Asheville"), B-012233-022, and AdventHealth Asheville, Inc. ("Advent"), Project ID B-012233-22 have submitted applications to the Department in response to the published need.

Novant's application is based on redirecting low-acuity patients from Mission Hospital. However, it projects a significant percentage of its patient origin from Henderson County, a county that is not part of the defined service area and has two existing community hospitals, neither of which is generating a bed need. Henderson County patients already have abundant geographic access to acute care services and do not currently need to leave the county for the low-acuity services that Novant proposes to provide in its application.

In addition, Novant proposes to joint venture with Surgery Partners, Inc. to shift an existing outpatient operating room (OR) from a freestanding ASC to utilize in the proposed hospital. This is problematic from several perspectives. It diminishes the meaning of the SMFP Rules and Need Methodology for ASF ORs; it shifts surgeries from a more cost-efficient location to a more costly care environment; and it bypasses the SMFP determination that additional inpatient ORs are not needed in Buncombe County.

Most importantly, the application filed by Novant cannot be approved and is fatally flawed. It relies on a projection methodology that is overly complicated and based on erroneous assumptions, resulting in highly overstated utilization. It uses Novant Health – Mint Hill Hospital ("Mint Hill") located in Mecklenburg County as a basis for its entire application, though the size and market conditions for the Mint Hill hospital are vastly different than that of the Asheville hospital location. The flawed projections paired with other factors in the financial projections result in highly questionable financial feasibility for the project. For these reasons and others, the application must be denied.

Criterion (1) Novant's Application is Inconsistent with the SMFP and Policy GEN-3

Novant's proposal is inconsistent with need determinations in the State Medical Facilities Plan. First, Novant's proposal demonstrates that it does not intend to increase access to acute care services to the SMFP defined service area of Buncombe, Madison, Yancy, and Graham Counties. Novant projects to provide minimal services to residents of Madison, Yancey, and Graham Counties, and its location does not improve access to these counties. In addition to Buncombe County, Novant focuses on serving Henderson County, which is not part of the SMFP defined service area and does not have a bed need determination.

Novant's proposal is also inconsistent with Policy GEN-3 with respect to maximizing healthcare value for the resources expended. Novant proposes to relocate and replace a brand new OR that was just implemented in 2021 as a dedicated freestanding outpatient OR in an ambulatory surgery facility ("ASF"). The ASF will then use this newly constructed OR at the existing ASF as an unlicensed procedure room to do the very same surgical cases. The transfer of an operating room from the Outpatient Surgery Center of Asheville ("OSCA") to the proposed facility for use as a hospital-based inpatient/outpatient operating room diminishes, if not destroys, the intent and purpose of the SMFP OR Need Methodology with regard to differentiating between dedicated outpatient, inpatient, and shared operating rooms in the acute care setting and the use of unlicensed procedure rooms.

<u>NH Asheville Focuses on Serving Henderson County as Opposed to the Planning Area Counties</u>

The 2022 SMFP defines the service area for the project to be Buncombe, Madison, Yancey, and Graham Counties. However, NH Asheville defines its primary service area to be the SMFP counties previously listed plus Henderson County. (See application page 48.) Henderson County is designated as its own service area in the 2022 SMFP and has two community hospitals located within the defined service area, which offer a similar level of services to those proposed by NH Asheville. The 2022 SMFP does not show a need for additional acute care beds to serve Henderson County, indicating that the existing hospitals have sufficient capacity to serve both current and additional Henderson County patients in the future. In fact, the 2022 SMFP shows that Henderson County has a surplus of 104.5 beds between the two existing facilities.

NH Asheville's projected patient origin percentages demonstrate that its intent is to capture Henderson County patients rather than focus on expanding access to Madison, Yancey, and Graham Counties in the defined planning area. **Figure 1** shows the projected patients by county for the proposed project. In each of the first three years of operation, NH Asheville projects that 13.9% of total patients will originate from Henderson County. Combined Madison, Yancey, and Graham County patients total only 2.6% of total projected patients to be served by NH Asheville in the first three years. Novant's proposed hospital will clearly not increase access to the counties for which there is a defined acute care bed need but will serve a community that already has two existing acute care providers that are not generating a need for additional beds.

Figure 1 - Projected Patient Origin

Entire Facility or Campus	<NH Asheville> *					
	1st Full FY		2nd Full FY		3rd Full FY	
	01/01/2027 to 12/31/2027		01/01/2028 to 12/31/2028		01/01/2029 to 12/31/2029	
County or other geographic area such as ZIP code	Number of Patients **	% of Total	Number of Patients **	% of Total	Number of Patients **	% of Total
Buncombe	30,610	83.4%	48,727	83.4%	56,697	83.4%
Henderson	5,111	13.9%	8,136	13.9%	9,467	13.9%
Madison	511	1.4%	808	1.4%	933	1.4%
Yancey	372	1.0%	589	1.0%	681	1.0%
Graham	94	0.3%	148	0.3%	170	0.2%
Total	**36,698**	**100.0%**	**58,406**	**100.0%**	**67,948**	**100.0%**

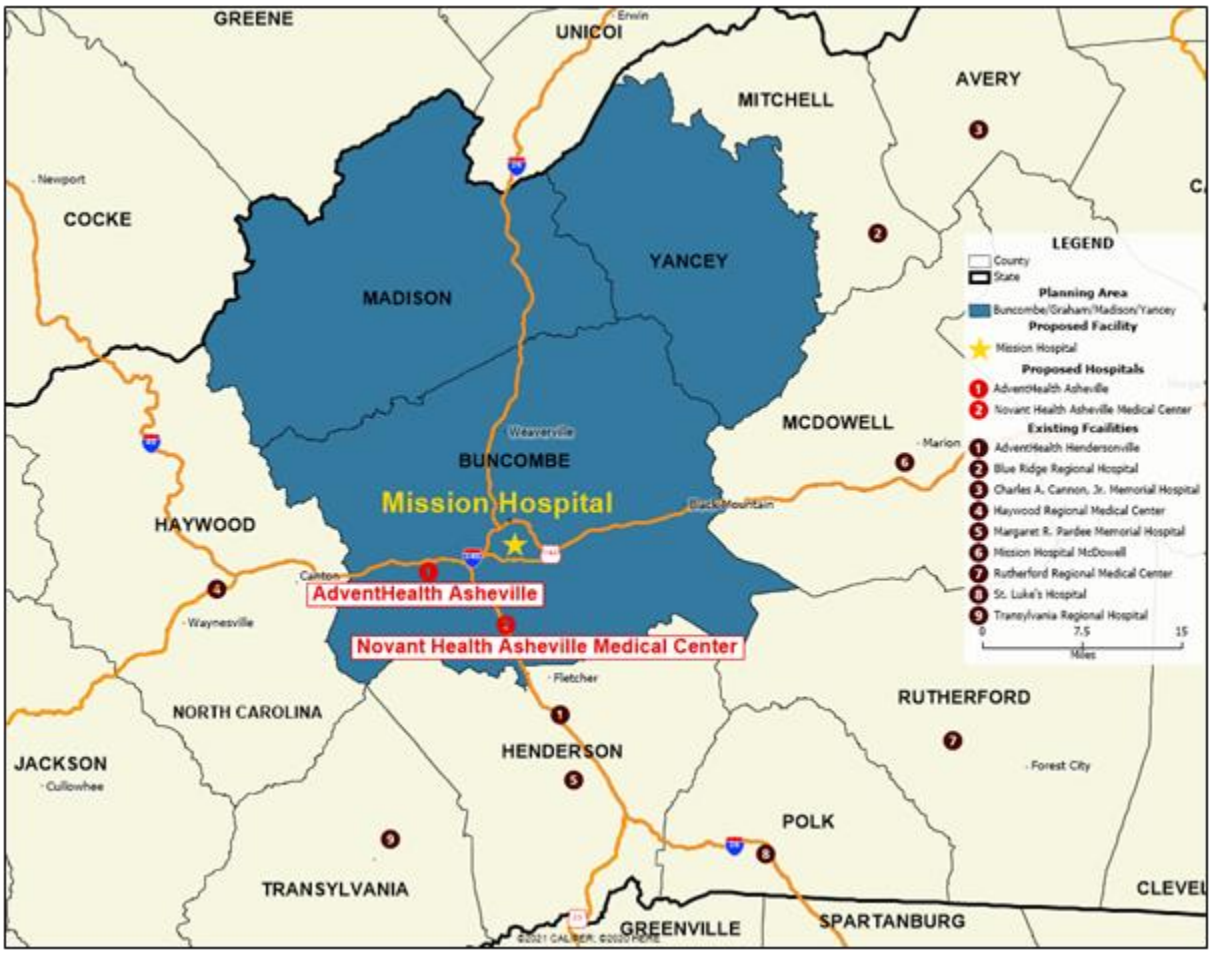
* This should match the name provided in Section A, Question 4.
** Home health agencies should report the number of unduplicated clients.

Source: Application for Novant Health Asheville Medical Center, ID B-012230-22, page 50
Includes inpatient admissions and all other ancillary and outpatient services.

NH Asheville's geographic location further confirms its priority to serve Henderson County residents over the more rural northern Buncombe, Madison, and Yancey Counties. **Figure 2** shows its location in relation to the other applicants and other existing providers. Novant has chosen a site that is the furthest south of all applicants and is just four miles from the Henderson County line. [1] It is the most removed from Yancey and Madison Counties and does not improve access to acute care services for those in the northern part of Buncombe County. As will be discussed in detail in Criterion (3) below, its location does not improve geographic access to the SMFP defined service area at all.

[1] Source: Google Maps

Figure 2



Novant's defined service area, patient origin projections, and geographic location are not consistent with the need projections outlined in the 2022 SMFP, and as a result, its application should not be approved. Further, Novant's proposal clearly demonstrates that increasing geographic and medical accessibility to the rural parts of the service area is not a priority of this project, and instead, Novant wants to serve Henderson County, which has a combined surplus of over 104 beds.

<u>The Operating Room Transfer from OSCA to NH-Asheville is Inconsistent with the Agency's Prior Approval and Intent as well as the SMFP OR Need Methodology</u>

In 2018, Orthopaedic Surgery Center of Asheville submitted a CON application pursuant to the 2018 SMFP to develop a new multispecialty ambulatory surgical facility, to be known as Asheville SurgCare with five operating rooms and two procedure rooms by relocating the three operating rooms at Orthopaedic Surgery Center of Asheville and developing the two operating rooms pursuant to the need identified in the 2018 SMFP. This facility is now known as Outpatient Surgery Center of Asheville ("OSCA") and currently houses the operating room that is proposed for transfer to NH Asheville in this application.

The timeline for the development of OSCA is critical in assessing the impact of the proposed transfer on the reliability and use of the SMFP in quantifying need for operating rooms. Though exact dates are not available, the 2022 SMFP implies that the two new ORs at Asheville SurgCare were not licensed or in use when the 2021 LRAs were submitted as the new, five-OR facility was not shown to have historical data at the time of publication. Based on our best information, Mission believes that OSCA moved to its new location with two ORs in September of 2021. Therefore, Mission believes that, although 5 ORs are reported on the 2022 LRA, two of the 5 ORs were not operational until September 2021.

The draft 2023 SMFP shows that OSCA is currently operating five ambulatory operating rooms and has a surplus of just 0.61 operating rooms. Based on this timeline, after being in operation for just one month with five operating rooms, OSCA has a surplus of less than one ambulatory OR. Once open for a full year, it is highly likely there will be no surplus.

The draft 2023 SMFP also shows that OSCA's case time was adjusted down because the case time is greater than 1 standard deviation above the group average. This is not surprising given the focus on complex orthopedic surgery cases, which are often long in duration.[2] This case time substitution may make sense when applying the need methodology, but in reality, the reported case times show that OSCA needs all 5 ORs with only a 0.39 surplus after operating all 5 ORs for one month. See **Figure 3**.

Figure 3

Outpatient Surgery Center of Asheville Need Calculation

Need Step:	**Draft SMFP**	**Draft SMFP with Actual FY 2021 Case Time**
ORs	5	5
Cases	3,880	3,880
Cases Time	85.5	90.0
Hours	5,529	5,820
Growth Rate	4.10	4.10
Projected Hours	5,756	6,059
Group 5 Standard Hours	1,312	1,314
Needed ORs	4.39	4.61
Licensed ORs	5	5
Needed or (Surplus) ORs	(0.61)	(0.39)

Source: 2022 LRA and Draft 2023 SMFP

This indicates that at best, this facility is currently right-sized and at worst, will have a need for additional capacity in the near future. It is short-sighted and financially inefficient to convert this needed outpatient OR that was just approved and constructed to a hospital-based OR. This OR was specifically approved by the CON Section based on the representations of OSCA that additional outpatient OR capacity was needed in Buncombe County. OSCA's plans to "lease," sell, or

[2] The OSCA website highlights robotic assisted knee replacement procedures as an example of complex, long duration cases performed.

contribute the OR to a new inpatient hospital represent a major failure to materially comply with the representations in that approved application and, we believe, eventual settlement arising from appeals of that matter.

What is even more concerning is the fact that OSCA as a co-applicant claims it will simply do the procedures it originally planned to do in a licensed OR in an unlicensed procedure room. While the room may be built to OR standards, this claim completely undermines the intent of the SMFP Operating Room Need Methodology. If any surgical case can simply be performed in a procedure room unregulated by CON or licensure standards, then there is no point in maintaining an inventory of ORs or regulating ORs through a need methodology. Ignoring such blatant misuse of a procedure room will render the SMFP OR need methodology meaningless. In effect, any facility, hospital, or ambulatory surgery center can build an unlimited number of unlicensed ORs and call them procedure rooms as they would become completely fungible. Once the difference between procedure rooms and ORs is gutted, any regulation of ORs may as well be thrown out. For these reasons, the Novant application should be found non-conforming with Criterion (1).

NH Asheville Does not Conform with the Basic Principles Outlined in Policy GEN-3

Policy GEN-3: Basic Principles states:

"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."

Equitable Access for Planning Area Residents

Novant's project fails to conform with multiple aspects of Policy Gen-3: Basic Principles. Among them, this project fails to promote equitable access, to maximize healthcare value for resources expended, to project volumes that incorporate GEN-3 concepts in meeting the need identified in the SMFP, and to address the needs of all residents in the acute care planning area.

This project fails to promote equitable access and to address the needs of all residents in the identified acute care planning area that generated the bed need. As discussed briefly above, the 2022 SMFP identifies the Buncombe, Madison, Yancey, and Graham counties to be the service area with a need for additional acute care beds. However, NH Asheville heavily focuses on serving Henderson County. This is clear in its chosen location and projected patient origin. Some migration from outside the defined service area is always expected, but Novant's projections for Henderson County are unreasonable, particularly when Henderson County has two community hospitals that

provide a similar level of service to the proposed project, both of which have ample excess capacity.

More important than the inclusion of Henderson County, though, is the exclusion of Madison, Yancey, and Graham County patients in Novant's projections. **Figure 4** shows a comparison of Mission's actual acute care patient origin data for calendar year 2021 and NH Asheville's projected patient origin data for its proposed service area in Year 3 of operation. It is important to keep in mind that Mission is a tertiary care center and serves a broad service area of counties throughout Western North Carolina. In theory, Mission's service area and related percentages would be much more diluted than a community hospital, which primarily serves its designated service area. However, the comparison of the two facilities shows otherwise.

Figure 4

	Mission CY 2021 Acute Care Patient Origin	**NH Asheville Proposed Year 3 Acute Care Patient Origin**
Buncombe	46.9%	83.4%
Madison	4.5%	1.4%
Yancey	2.8%	1.0%
Graham	0.6%	0.2%
Henderson	*7.3%*	*13.9%*

Sources: Application for Mission Health, ID B-012232-22, p.44, Application for Novant Health Asheville Medical Center, ID B-012230-22, p. 48

NH Asheville projects that only 2.6% of its total patients will originate from Madison, Yancey, and Graham counties – **combined**. The comparison to Mission's percentages for these counties is striking. Mission's percentages of patients originating from these counties are two to three times higher than Novant's, though Novant only projects to serve a five-county service area compared to Mission's much larger Western North Carolina service area. NH Asheville has placed no importance on serving three of the four counties in the acute care planning area that has a quantified need for acute care beds according to the 2022 SMFP. As a result, the application is not conforming to Policy GEN-3 and cannot be approved.

Maximizing Healthcare Value

In addition, the proposed project does not maximize healthcare value for resources expended. Novant proposes to spend $328,729,395 to develop a small community hospital focused on serving Henderson County and south Buncombe County residents. The costly project is an unnecessary duplication of the two community hospitals already serving Henderson County and south Buncombe County – AdventHealth Hendersonville ("Advent Hendersonville") and Pardee Hospital ("Pardee"). If approved, the residents of south Buncombe County will have access to 3 hospitals within 10 miles and 4 hospitals within 15 miles. This certainly does not maximize healthcare value.

The proposed relocation of a newly constructed ASF OR and the expensive construction of a new hospital-based OR does not maximize healthcare value. The costly duplication of an OR that has

been in operation for just over year is not cost effective and simply wasteful. Moreover, the low-cost benefits of an ASF are undermined by shifting this OR to a more costly hospital-based environment. Please see additional discussion under Criterion (3a).

For the many reasons set forth above, NH Asheville's application does not meet the criteria set forth in the Policy GEN-3: Basic Principles and cannot be approved.

Criterion (3) Novant Fails to Adequately Document Need for the Project

Novant does not adequately document need for the proposed project and cannot be found conforming with Criterion (3). Among its deficiencies, Novant's utilization projections are fatally flawed across all services and cannot be reliably used in assessing the need for this project. In addition, it fails to improve access to care and fails to project a reliable or meaningful payor mix.

Novant's Projected Utilization is Entirely Inaccurate

The most compelling flaw in Novant's application relates to its projected utilization. Novant's methodologies result in volumes that are so overstated that they are not reliable. Novant calculates numerous projected service line volumes, using almost 30 cumbersome steps that build upon each other and compound flawed assumptions upon more flawed assumptions throughout the process.

Mint Hill as a Basis for Projections

Because Novant Health has no presence in acute care hospital services in western North Carolina or the planning area, Novant utilizes volumes and ratios from its Mint Hill hospital, located in eastern Mecklenburg County, as the starting point for many of its projections. This starting point is the first place where the utilization projections are based upon inaccuracies. Comparing the Mint Hill market to the Asheville market is apples to oranges for Novant. Mint Hill is a sub-market of Charlotte/Mecklenburg County where Novant already had a significant presence with four existing and 2 approved hospitals, an established patient base, and physician associations and relationships prior to the establishment of the hospital. In fact, Mint Hill was initially established as a campus of Novant Health Orthopedic Hospital (f.k.a. Presbyterian Orthopedic Hospital) through relocation of beds and operating rooms from this existing hospital.[3] Asheville will represent a new market for Novant and will require a more conservative ramp-up period to form relationships in the service area. It cannot expect to build upon its own existing utilization in the market for NH Asheville like it did for NH Mint Hill.

Inpatient Volumes

Novant is very clear that it bases its projections on low acuity admissions that it will divert from Mission Hospital. The foundation of its inpatient projections are patients who have historically received acute care in Buncombe County. Since Mission Hospital is the only provider in Buncombe County, Novant assumes that all its projected patients will be diverted from Mission.

[3] Earlier SMFPs present Mint Hill "utilization for reporting period shown with Presbyterian Orthopedic" as Mint Hill was a campus of Presbyterian Orthopedic Hospital. Mint Hill was established through Project ID #F-7648-06 through relocation of 50 existing beds and 5 existing operating rooms from Presbyterian Orthopedic Hospital.

In Steps 1-7, Novant's methodology essentially calculates the total projected acute care admissions for its five-county service area (the SMFP service area + Henderson County) for Years 2027-2029. Step 8 calculates the percentage and number of these patients that will seek care in Buncombe County at Mission Hospital. Then, in Step 9, Novant assumes a percentage, by county, of these patients. There is no actual basis or experience to suggest these percentages are reasonable. Moreover, Novant plainly states that residents of Madison and Yancey Counties will have to drive past Mission to reach NH Asheville. Clearly, it is NH Asheville's intent to serve Henderson County residents, who already have access to two acute care hospitals, and not to serve Madison and Yancey County residents, who have no local hospital. See **Figure 5**.[4]

Figure 5 – Novant Section Q Assumptions

Step 9. Projected % and # of County Resident Acute Care Admissions Treated in Buncombe County Served at NH Asheville

Novant Health projected the number of admissions treated in Buncombe County that would be served at NH Asheville. In order to project the percent admissions to be served at NH Asheville, Novant Health considered the low acuity DRGs, the physicians expected to provide services at NH Asheville, th projected lower patient costs, and the location of NH Asheville. The final variable considers that residents from Madison and Yancey counties must dri past Mission Hospital to reach NH Asheville and Henderson County residents must drive past NH Asheville to reach Mission Hospital. Taking these variables into consideration, Novant Health estimated the percentage of admissions treated in Buncombe County that would be served at NH Asheville

	2027	2028	2029
Buncombe	15.0%	20.0%	25.0%
Henderson	15.0%	20.0%	25.0%
Madison	3.0%	4.0%	5.0%
Yancey	3.0%	4.0%	5.0%
Graham	3.0%	4.0%	5.0%

Source: Novant Health Experience based on Facility Location

	2027		2028		2029	
	Patients	%	Patients	%	Patients	%
Buncombe	3,201	83.4%	4,314	83.4%	5,450	83.4%
Henderson	534	13.9%	720	13.9%	910	13.9%
Madison	53	1.4%	71	1.4%	90	1.4%
Yancey	39	1.0%	52	1.0%	65	1.0%
Graham	10	0.3%	13	0.3%	16	0.2%
Total	**3,837**	**100.0%**	**5,171**	**100.0%**	**6,531**	**100.0%**

Calculation: Projected County Resident Acute Care Admissions Treated in Buncombe County x Projected %

Source: Application for Novant Health Asheville Medical Center, ID B-012230-22, Section Q (no page number)

The percentages that Novant arbitrarily chooses in Step 9 are applied to the gross number of acute care admissions projected for Mission (patients served in Buncombe County). They are not applied to a filtered volume of "treatable" patients to account for low acuity DRGs that will be served in a small acute care hospital with only basic services. As referenced in the figure above, these percentages "considered the low acuity DRGs, the physicians expected to provide services at NH Asheville, the projected lower patient costs, and the location of NH Asheville." However, it is unclear how the percentage "considered" only low acuity DRGs. Moreover, it is unreasonable for a new market entrant to capture 25 percent market share almost as soon as its facility opens.

[4] Novant did not page number Section Q, which is very long. For ease of reference for the Agency staff, Mission has pulled excerpts from pages of Section Q into this opposition as relevant.

In the narrative for Step 12 of its inpatient methodology (Section Q, no page number), Novant states that "treatable admissions at Mission Health represented 34.9% of total admissions." Novant then also calculates 43.9% "treatable" admissions 7 pages later. It is unclear which percentage is accurate. It should also be noted that the 21,222 admissions identified as "treatable" includes normal newborns, which are not separate admissions from their mothers. Thus, the appropriate patient base is overstated by 1,734 admissions and 3.6% in the percent "treatable". Thus, there are three potential figures for the percentage of appropriate patients: 34.9%, 43.9% and 40.3% when normal newborns are removed as shown in **Figure 6**.

Figure 6
Novant's Unreasonable and Inconsistent Assumption of Appropriate or Treatable Patients

(Step 12)	Novant Calculation	Normal Newborns Removed
2019 "Treatable" DRG Admissions	21,222	21,222
Less DRG 795 - Normal Newborns		(1,734)
Corrected "Treatable" Admissions	21,222	19,488
Total 2019 Patients	48,341	48,341
Percent Treatable*	43.9%	40.3%

Step 12 Narrative: "Low acuity admissions at Mission Health represent 34.9 percent of 2019 total admissions."

Not only is the percentage appropriately treated at Novant unclear, the projections for acute care admissions from Buncombe and Henderson County are drastically overstated and completely unrealistic. If Novant had reduced the projected market size to just "treatable" patients and then applied market capture rates, the projections would become even more unreasonable as shown below in **Figure 7.** Novant projects to capture either 56.9%, 62.0% or 71.6% of the "treatable" patients from each county served by Mission. Any of these figures represents a completely unreasonable market share of Buncombe and Henderson Counties, where Novant has no existing acute care market presence.

Figure 7

Novant's Unreasonable and Inconsistent Market Capture Assumptions

County of Residence	2029 Projected Patients Served in Buncombe County (Step 9)	Appropriate Patients at % Treatable (Step 12)		
		43.9%	40.3%	35%
Buncombe	21,799	9,570	8,788	7,608
Henderson	3,640	1,598	1,467	1,270
Madison	1,793	787	723	626
Yancey	1,310	575	528	457
Graham	327	144	132	114
Total	28,869	12,674	11,638	10,075

County of Residence	Novant Projected Patients	Novant Market Capture Rate		
		Novant Capture (43.9% Treatable)	Novant Capture (40.3% Treatable)	Novant Capture (34.9% Treatable)
Buncombe	5,450	56.9%	62.0%	71.6%
Henderson	910	56.9%	62.0%	71.6%
Madison	90	11.4%	12.5%	14.4%
Yancey	65	11.3%	12.3%	14.2%
Graham	16	11.1%	12.1%	14.0%
Total	6,531	51.5%	56.1%	64.8%

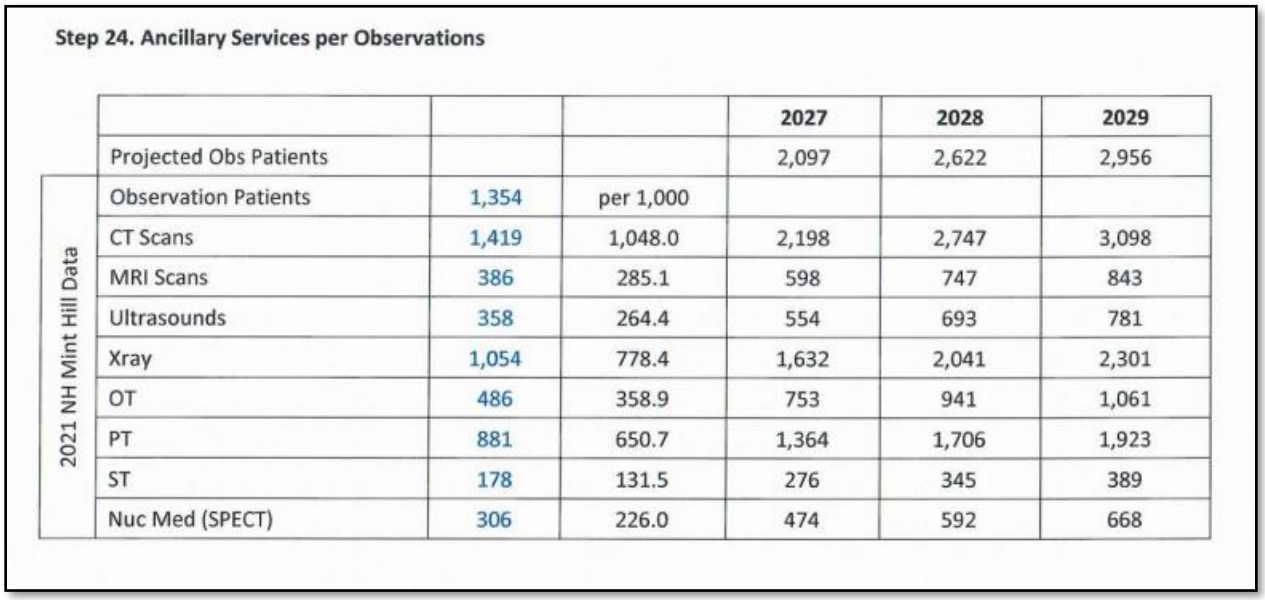
Conversely, Novant only projects to capture 5% of the inpatients from Madison, Graham, and Yancey counties who seek care at Mission in Year 3 of operation. These are the underserved counties in the service area, and Novant clearly places no importance on increasing accessibility to the residents of these counties. The inpatient volumes projected for Buncombe and Henderson counties are dramatically overestimated, and the inpatient volumes for the remaining three counties are negligible, accounting for only 171 of its 6,531, or 2.6%, of total inpatients projected for Year 3 of operation. As a result, the total inpatient volumes are severely overestimated, cannot be relied upon, and do not reflect increasing access to care.

Imaging and Ancillary Services Projections Are Dramatically and Unreasonably Overstated

Novant utilizes a methodology to project utilization for imaging and ancillary services that ends up double and triple counting patients. It applies a ratio based on historical utilization for NH Mint Hill by patient type – ED, inpatient, observation, and outpatient imaging – to each projected category to quantify imaging and ancillary services for each patient category and then sums these categories for an overall total projection for the facility. As an example, the imaging and ancillary projections for projected observation patients are shown below in **Figure 8**. This methodology fails to account for the fact that many patients individually end up in multiple patient categories, so one procedure would get counted in multiple categories. For example, a patient may present in the ED, be observed for a short period of time, and then get admitted as an inpatient. This patient would be triple counted in the methodology used by Novant.

Proof of mis-capturing volumes in improper patient categories is best exemplified by a review of the imaging and ancillary projections for observation patients in Step 24, Section Q, shown below in **Figure 8.**

Figure 8 – Excerpt of Section Q Assumptions



Step 24. Ancillary Services per Observations

				2027	2028	2029
	Projected Obs Patients			2,097	2,622	2,956
2021 NH Mint Hill Data	Observation Patients	1,354	per 1,000			
	CT Scans	1,419	1,048.0	2,198	2,747	3,098
	MRI Scans	386	285.1	598	747	843
	Ultrasounds	358	264.4	554	693	781
	Xray	1,054	778.4	1,632	2,041	2,301
	OT	486	358.9	753	941	1,061
	PT	881	650.7	1,364	1,706	1,923
	ST	178	131.5	276	345	389
	Nuc Med (SPECT)	306	226.0	474	592	668

Source: Application for Novant Health Asheville Medical Center, ID B-012230-22, Section Q (no page number)

Figure 8 (Step 24), above, details the projected utilization of imaging and ancillary services for observation patients. If this table were correct, it would quantify the volumes of individual services that projected observation patients, during their time as observation patients, would receive. It is important to note that observation patients are generally being monitored after an ED visit for stability prior to release or inpatient admission and cannot remain in an observation bed for more than 24 hours. Therefore, these patients are not likely to receive a significant number of imaging procedures or ancillary services during this time. Such tests would typically be ordered in the ED or after admission.

For the 2,956 projected observation patients in Year 3, Novant projects that these will receive 3,098 CT scans, more than 1 CT scan per person during their time as an observation patient. Further, these 2,956 patients will receive a total of 1,923 physical therapy visits during their time as an observation patient. There are very few, if any, circumstances that necessitate a therapeutic (i.e., ST, PT, OT) visit for an observation patient. These therapies are typically provided on an outpatient basis or for inpatients but not for emergency patients or an observation patient before they are admitted. The volumes above would suggest that on average almost two-thirds of projected observation patients would be receiving a physical therapy visit, for example, during observation. These volumes are not remotely realistic. The above example represents the flaws in just one step of a four-step process to calculate the volumes for imaging and ancillary services. These same calculation issues are embedded in each of the four steps, resulting in dramatically overestimated imaging and ancillary volumes.

These overstated volumes are further exemplified by a comparison to the 2021 volumes at NH Mint Hill as Novant relied on Mint Hill and claimed to scale up Mint Hill's volume for the larger proposed facility. Using the hospital bed-size for a scale comparison, NH Asheville's volumes are significantly higher than the utilization of Mint Hill. See **Figure 9**. In 2021, NH Mint performed

on average 361.4 CT scans per bed in 2021. NH Asheville projects to perform 715.5 CT scans per bed in Year 3 of operation, almost double the volume of Mint Hill when scaled for hospital size. In 2021, NH Mint Hill performed 5,104 total mammography imaging procedures on two units for an average of 141.8 mammography scans per bed. NH Asheville projects to do more than three times as many total procedures, **18,056, on one unit**, for an average of 269.5 mammography scans per bed.

Figure 9

	NH Mint Hill				NH Asheville			
	Units	**Beds**	**2021 Scans**	**Scans per bed**	**Units**	**Beds**	**Year 3 Scans**	**Scans per bed**
CT Scanner	1	36	13,012	**361.4**	1	67	47,939	**715.5**
MRI	1	36	3,289	**91.4**	1	67	11,426	**170.5**
Fixed X-ray	2	36	15,875	**441.0**	5	67	38,039	**567.7**
Mammography	2	36	5,104	**141.8**	1	67	18,056	**269.5**
Ultrasound	2	36	6,054	**168.2**	2	67	16,897	**252.2**
SPECT	1	36	2,487	**69.1**	1	67	1,010	**15.1**

Sources: 2021 LRA, Application Form C.2b

Projected Ancillary Volumes Far Exceed Reasonable Capacity

A closer look at the MRI and CT projections shows that some of the projected volumes are not just overestimated, but completely unrealistic and not feasible to achieve based on the imaging equipment proposed in the application. Without even analyzing the calculations or the methodology, it is clear by comparing the total scans to the proposed number of scanners, that the volumes are not reasonable. According to Form C.2b of Novant's application, NH Asheville intends to operate one fixed CT scanner and one mobile MRI scanner in its first three years of operation.

According to the 2022 SMFP, the total capacity of a fixed MRI is 6,864 adjusted scans. Further, *"this definition of capacity represents 100% of the procedure volume the equipment can complete under ideal conditions"*. NH Asheville proposes to operate a mobile MRI, which would have a capacity that is lower than 6,864 scans. However, In Year 3 of operation, NH Asheville projects to perform **11,426 MRI scans on one mobile MRI unit (see Form C.2.b)**. This volume is almost three times higher than the stated capacity for a fixed MRI according to the 2022 SMFP. There is no viable way a mobile MRI unit could perform at this volume or anywhere near it.

While CT scanners are no longer subject to performance standards in the SMFP, previous versions have identified that existing providers in a service area must have performed an average of 5,100 HECTs annually before another provider could be approved in the service area. Applicants for CT scanners were required to show that they would perform 5,100 HECTs by the third year of operation. While this does not represent 100% capacity, it does give an idea of what the Agency has considered in the past to be a well-utilized CT scanner in order to demonstrate need for an additional unit. NH Asheville projects to perform **47,939 HECTs on one fixed scanner** in year 3 of operation (see form C.2.b). This is 9.4 times the previous capacity standard used by the Agency for CT scanners. Again, there is no way a single CT unit can perform anywhere close to the projected volume of scans presented by Novant in its application.

This same conundrum applies to other imaging modalities and ancillary services presented in the application. It has been well documented above that projected imaging and ancillary volumes are fatally flawed and cannot be relied upon. As documented below, these are not the only significant flaws in Novant's volume projections.

Various Other Flaws

- Novant includes 6 OB beds in its proposed hospital. However, OB projections are not separated from total inpatient admissions and patient days, so it is not clear that the proposed OB beds are needed, what utilization rate they will achieve, and if the inclusion of this service is reasonable, feasible, or appropriate.
    - All DRGs in MDC 14 (Pregnancy, Childbirth & the Puerperium) appear to be included in the "treatable" patient number. This would not consider the fact that Mission is the only Level IV NICU provider in the region and serves many high-risk mothers and babies from throughout the region.
    - This factor further undermines Novant's total inpatient admission projections and demonstrates that they have not adequately justified the inclusion of OB services in the project.
    - Moreover, Novant disregards declining birth rates, stagnant to declining utilization of OB beds in the region, and the fact that Mission has more than sufficient OB bed capacity. It is clear there is no need for this bed type/service line.
- Novant includes 8 ICU beds in its proposed hospital. However, ICU patient days are not projected or broken out to determine if these 8 beds are needed or will be well utilized.
    - If the ICU patient days at Mint Hill are used as a basis for projection, the proposed 8 bed ICU would operate at an occupancy rate of approximately 50%, which does not justify the inclusion of 8 beds in the project.
- Inpatient Surgery Projection (Step 13) – Inpatient surgeries are projected utilizing a ratio of low acuity inpatient ("IP") surgical cases per admission from Mint Hill to projected admissions at NH Asheville.
    - No definition of "low acuity surgical cases" is provided.
    - Regardless of whether the ratio is an accurate indicator of IP surgical cases, the fact that it is applied to already overestimated inpatient admissions (see above) results in overstated projected inpatient surgeries.
- Novant proposes 8 Observation Beds. In Step 14, Novant uses an ALOS of 1.2 days to project observation bed utilization. Observation stays are required to be less than 24 hours, and many are far less than a full 24 hours. As a result, NH Asheville has dramatically overstated its observation hours/days.
    - Mint Hill may be inappropriately using its observation beds for admitted patients staying longer than 24 hours. However, that does not make this practice appropriate for justifying observation beds at NH Asheville.
    - Moreover, Novant's projections result in more patient days than can be served in the proposed 8 beds as shown below in **Figure 10**. Based on Novant's assumptions, the observation beds would have to operate at almost 150% occupancy.

Figure 10
NH Asheville Observation Bed Occupancy

	Year 1	Year 2	Year 3
NH Asheville Admissions	3837	5171	6531
Observations per Admission	0.55	0.55	0.55
Projected Observation Patients	2,110	2,844	3,592
ALOS	1.2	1.2	1.2
NH Asheville Observation Days	2,532	3,413	4,310
ADC	6.94	9.35	11.81
Observation Beds	8	8	8
Percent Occupancy	86.7%	116.9%	147.6%

Source: Form C.4b

- ED Visits (Step 15) – ED Visits are calculated based on a ratio of NH Mint Hill ED Visits to Admissions. The number of inpatient admissions very well may be related to ED visits, but ED visits are not at all related to inpatient admissions. Using inpatient admissions as a basis to project ED visits is not logical and will not result in a reliable projection.
    - The results of this calculation suggest that this brand new, small community hospital will experience 52,085 ED visits in year 3, which is more than half of the 98,818 ED visits served in Buncombe County (provided by Mission as the regional tertiary, trauma center). This is completely unrealistic.
    - It is also important to note that Mission serves ED patients from throughout the region. Its patients from the Novant service area are just a subset of the total 98,818 ED visits reported, suggesting that Novant projects to provide well more than half of the service area ED visits being served in Buncombe County.
- Outpatient Visits (Step 16) – Outpatient visits are not defined in the application, so it is questionable what services are even being proposed in this projection. All outpatient surgical, imaging, ED, therapies, and other ancillary services are individually quantified in other steps, and they do not total or reconcile with the outpatient visit quantities. Because these other services are individually quantified, "outpatient visits" represents an undefined group of some other additional services.
    - Outpatient visit projections are again based upon a ratio of outpatient visits per admission at Mint Hill. Outpatient visits are not normally correlated with inpatient admissions, so these projections are meaningless.
    - These outpatient visits appear to be double counted with outpatient therapies (PT, OT, ST),lab tests, and perhaps even outpatient imaging because it is unclear what the outpatient visits could be if they are not outpatient imaging, therapies, and lab tests.
- Outpatient Surgeries (Step 17) – The methodology used to derive a ratio of outpatient surgery cases per outpatient visit is unclear. Novant uses a combined total of outpatient surgery cases and procedures and then only a percentage of OR surgical cases from Mint Hill as a basis for its ratio. There is no narrative to distinguish between these two figures, and they are not broken out. It then applies this ratio to NH Asheville OP visits (though the definition of outpatient visit is still undetermined). As a result, the projected outpatient surgical cases for Asheville are unreliable.

- In addition, the most alarming volume presented in this calculation is the percentage of surgeries that will be performed in unlicensed procedure rooms. According to the calculations presented in Step 17, **90 percent of the total outpatient surgical cases will not be performed in a licensed OR, rather they will be performed in one of the three procedure rooms proposed by NH Asheville**.
- By contrast, Mint Hill provided just 41.7% of cases in procedure rooms as shown in **Figure 11**. This raises serious concerns about Novant performing surgical cases appropriately in unlicensed procedure rooms as noted above.

Figure 11

	Mint Hill	NH Asheville
	FY 2021	Year 3
OP Surgical Cases in ORs	1,768	524
OP Procedures in Procedure Rooms	1,265	4,715
Total Outpatient Cases	3,033	5,239
Percent in Procedure Rooms	41.7%	90.0%

Sources: NH Ashville CON Step 17, Mint Hill 2022 LRA

- C-Sections (Step 18) – Novant uses the Step 9 assumptions discussed previously in relation to inpatient projections to capture 25% of **ALL** service area C-sections projected to be performed at Mission Hospital in its third year of operation. For the reasons previously discussed, this figure is drastically overstated.
  - There is no basis to assume that all C-Section cases performed in Buncombe County (at Mission Hospital) are appropriate for the proposed facility when these cases include a significant percentage of high-risk mothers and babies, including those that will need NICU support.
  - Novant makes no effort to determine the appropriate number of deliveries and C-Sections associated with low-risk mothers and babies appropriately served in the proposed hospital.
- GI Endoscopy Cases (Step 19) – Novant claims to project GI Endoscopy cases based on all patients served in Buncombe County. This ignores two critical factors:
  - Mission's patients should be acuity adjusted; and
  - In FY 2021, 71 percent of endoscopy procedures performed in Buncombe County were done at a freestanding endoscopy center, Asheville Endoscopy Center, which Novant does not acknowledge as existing.[5]
  - Novant plans to shift these patients to a higher cost, hospital endoscopy room.
  - Novant claims to use the same percentage market capture as it uses for inpatient beds, but the percentage in Step 19 does not in fact match the percentage admissions in Step 9.
  - For example, in year 3, Novant projects to capture 10% of GI Endoscopy cases but 23% of acute care admissions in Steps 8 and 9 (6,531 admissions / 28,869 service area residents treated in Buncombe County).
  - This results in a projection of 1,645 GI Endo procedures for NH Asheville, which compares to just 138 GI Endo procedures performed at Mint Hill or greater than

[5] Based on draft 2023 SMFP.

10 times more procedures projected for NH Asheville. If Mint Hill is a reasonable surrogate, as suggested by Novant, then the projected GI Endo procedures are severely overstated.

This does not represent an all-encompassing list. There are additional errors and misconceptions that are not listed here. This list above is simply to give an idea of the depth of erroneous assumptions and methodologies upon which the projections were based.

Based on these inaccuracies and faulty methodologies, it is likely that Novant will fail to meet the performance standards for acute care beds and gastrointestinal endoscopy procedures in a licensed health care facility as all volumes appear to be erroneously overestimated.

Novant Will Not Increase Access to Care

Figures 12 and 13 present a focused map of the areas surrounding the proposed NH Asheville hospital and a map of the broader western North Carolina region with the planning area counties of Buncombe, Graham, Madison, and Yancey. The location of NH Asheville does not increase access to Madison and Yancey to the north as Mission will remain the closest hospital. The Novant location also fails to improve access for Graham County. While it does not improve geographic access to Henderson County, given that Henderson already has two community hospitals inside its county lines, it does provide an additional proximal provider to Henderson County, a county that has no documented or quantified need for additional acute care beds.

Figure 12

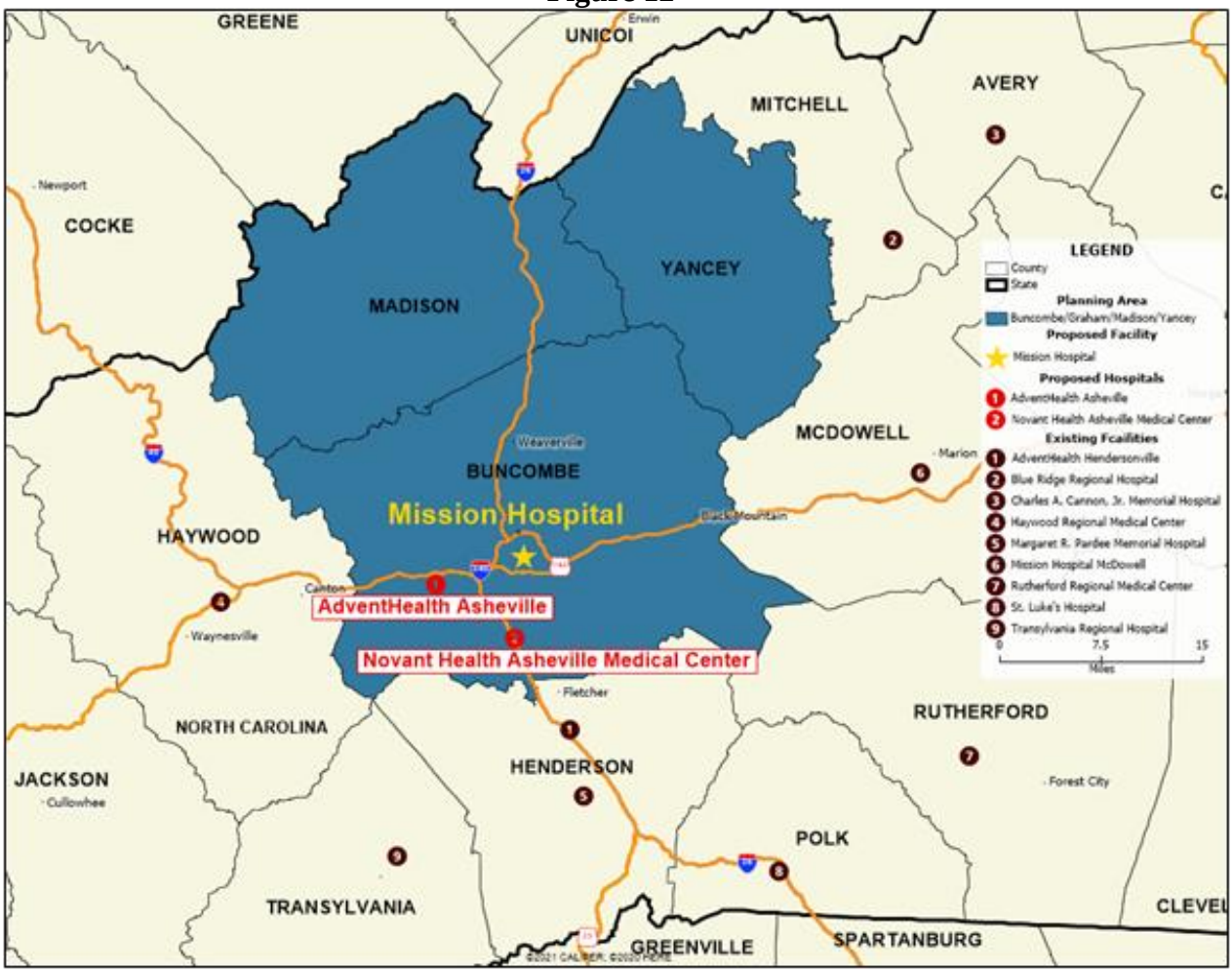

GREENE
UNICOI
Erwin
MITCHELL
AVERY
Newport
COCKE
MADISON
YANCEY
MCDOWELL
Marion
Weaverville
BUNCOMBE
Mission Hospital
HAYWOOD
Canton
AdventHealth Asheville
Novant Health Asheville Medical Center
Waynesville
Fletcher
NORTH CAROLINA
HENDERSON
RUTHERFORD
Forest City
JACKSON
Cullowhee
POLK
TRANSYLVANIA
GREENVILLE
SPARTANBURG
LEGEND
County
State
Planning Area
Buncombe/Graham/Madison/Yancey
Proposed Facility
Mission Hospital
Proposed Hospitals
1 AdventHealth Asheville
2 Novant Health Asheville Medical Center
Existing Fcailities
1 AdventHealth Hendersonville
2 Blue Ridge Regional Hospital
3 Charles A. Cannon, Jr. Memorial Hospital
4 Haywood Regional Medical Center
5 Margaret R. Pardee Memorial Hospital
6 Mission Hospital McDowell
7 Rutherford Regional Medical Center
8 St. Luke's Hospital
9 Transylvania Regional Hospital
0
7.5
15
Miles

Figure 13
Acute Care Planning Area with Existing and New Hospital Locations

A drive time analysis demonstrates that Novant will not increase access to hospital services for any of the four planning area counties (Buncombe, Graham, Madison, and Yancey) and in fact does not increase access to the adjoining counties of Haywood and Henderson to the west and south of Buncombe County as shown below. NH Asheville will not be the closest hospital to the major city/town in any of these counties as shown in **Figure 14**. Most importantly, Novant's project fails to increase access to care for residents of Graham, Madison, and Yancey County – the planning area counties that currently do not have a local acute care hospital.

Figure 14

Drive Time Analysis (Minutes)

Hospital:	Mission	Haywood	Advent Hendersonville	Margaret Pardee	Advent Asheville	Novant
County (City, State)						
Buncombe (Asheville, NC)	5-8	28-35	24-35	28-40	12-18	16-24
Graham (Robbinsville, NC)	90-120	70-85	100-130	110-140	85-110	90-120
Madison (Marshall, NC)	26-40	50	40-55	45-65	30-40	35-45
Yancey (Burnsville, NC)	40-55	60-75	55-60	60-80	45-55	45-65
Henderson (Hendersonville, NC)	30-45	40-55	12-20	4	26-40	18-26
Haywood (Waynesville, NC)	35-50	10-16	40-55	45-60	28-40	35-50

Drive Distance Analysis (Miles)

Hospital:	Mission	Haywood	Advent Hendersonville	Margaret Pardee	Advent Asheville	Novant
County (City, State)						
Buncombe (Asheville, NC)	1.4	26.5	20.1	24.8	7.3	12.7
Graham (Robbinsville, NC)	93.1	67.4	102.0	107.0	87.5	94.7
Madison (Marshall, NC)	21.9	32.7	37.2	41.9	24.5	29.9
Yancey (Burnsville, NC)	37.8	59.7	53.2	57.9	40.5	45.9
Henderson (Hendersonville, NC)	25.9	41.7	6.5	0.7	24.0	15.3
Haywood (Waynesville, NC)	31.4	4.7	39.6	44.3	25.0	32.2

Source: Goggle 2022

Note: Depart time 8:00am

NH Asheville's project fails to expand geographic access to acute care services. In fact, its patient origin projections demonstrate that it does not intend to significantly serve three of the four counties in the service area which have a demonstrated need for additional acute care beds.

Criterion (3a) Novant and OSCA Have Not Demonstrated that the Expensive Replacement and Relocation of an ASF OR to a Hospital-Based OR Meets the Needs of the Population.

For the reasons outlined in detail in Criterion (1) above, the proposed transfer of the freestanding outpatient operating room from OSCA to NH Asheville for hospital-based and inpatient use will not meet the needs of the population presently served by this dedicated freestanding outpatient OR. In fact, it will eliminate a lower cost, higher efficiency option for the service area and result in the need for additional ambulatory surgical facility operating rooms.

History of OSCA's OR

- OSCA obtained approval for two additional ORs to provide a service that was shown quantitatively to be needed in the community in a dedicated freestanding ASF setting.
- This CON was filed pursuant to a determination of need in the 2018 SMFP.
- OSCA constructed an entirely new ASF containing the OR to be transferred, which opened in approximately September 2021.
- Novant and OSCA now propose to again transfer the ambulatory OR to be used in a completely different capacity as a shared use, hospital-based OR.
- OSCA, a new facility with five ambulatory operating rooms, was not even in operation for a full year before attempting to make this change. CON applications require three years of projections for review. This transfer impacts all assumptions on which the approval of this application was based. This is also a significant change to a newly licensed project.

Inappropriate Use of ORs and Procedure Rooms

- Page 198 of the NH Asheville application (Form D assumptions) states that OSCA cases currently performed in the transferred OR will shift to a procedure room. As noted in the discussion of Criterion (1) above, such a claim and practice completely circumvents the SMFP OR Need Methodology.
- This also applies to NH Asheville's use of procedure rooms for 90 percent of the surgical cases it projects. If that has now become the standard of review for CON applications, then the entire OR Need Methodology is meaningless as are the Operating Room Performance Standards. Such standards and methodology might as well be eliminated if there is no distinction between an OR and a procedure room.

The Transferred OR Will Not Meet the Needs of Patients for Low Cost ASF Services

The ASF setting is generally accepted to differ from the hospital based surgical setting in the following ways:

- Higher efficiency in terms of cases and OR turnover
- Lower out of pocket costs for patients than outpatient surgery in an acute care hospital
- Easier access and convenience than a hospital setting

In fact, OSCA made these same assertions in its 2018 application to the Department to develop a new facility by adding two outpatient ORs to its existing three operating rooms for a total of five freestanding outpatient multi-specialty ORs. Specifically, its application contained the following comments:

Changes in Reimbursement, Cost Savings and Patient Choice

The list of surgical procedures provided at ambulatory surgical centers that are reimbursable under Medicare, Medicaid and commercial insurance has expanded in recent years. Freestanding ambulatory surgery centers provide advantages to patients and payors including:

- **Lower cost of care due to lower ASC reimbursement**
- **Convenient sites of care including superior convenience, access and efficiency**
- **Physician alignment through partnering with the ASC and medical staff**

Source: Application for Asheville SurgCare, ID No. B-11514-18, p34

As seen in the following table, a comparison of some of the most frequently performed outpatient orthopedic surgical procedures shows that ambulatory surgery centers have lower charges as compared to hospitals.

Comparison of BCBS Estimated Treatment Costs	Orthopaedic Surgery Center of Asheville	Park Ridge Hospital	Margaret R. Pardee Memorial Hospital
Counties	Buncombe	Henderson	Henderson
Carpal Tunnel	$2,207	$5,518	$5,457
Knee Arthroscopy with Cartilage Repair	$3,843	$9,846	$9,312

The relocation and replacement of the three existing operating rooms at OSCA to the proposed Asheville SurgCare will enable patients to continue to have access to cost effective orthopedic, spine and podiatry surgery. The proposed two additional operating rooms that originate from the 2018 SMFP need determination will be used in combination with the three relocated ORs to serve increased numbers of orthopedic, podiatric and pain management patients as well as other surgical specialties that include ophthalmology, plastic surgery, urology and pain management surgery.

Source: Application for Asheville SurgCare, ID No. B-11514-18, p36

There are only two ASFs in the Buncombe/Madison/Yancey service area, OSCA and an eye surgery center, with a combined total of 6 ORs. Thus, service area residents already have very limited access to outpatient services in an ASF environment. Converting this outpatient OR to hospital-based and shared inpatient/outpatient status will not meet the needs of service area residents and is not consistent with OSCA's representation to the Agency when this OR application was approved or with the CON issued to OSCA for this operation room.

The Transferred OR will Not Meet the Needs of Madison and Yancey County Residents

The OR proposed for transfer was determined to be needed for the Buncombe/Madison/Yancey OR service area. Moving this OR to southern Buncombe County will make it much more inaccessible for Madison and Yancey County residents. OSCA is located north of the proposed hospital, and patients from Madison and Yancey Counties will have to travel further south to the hospital-based OR.

Moreover, Novant does not project to serve as many or as high a percentage of Madison and Yancey patients as served by OSCA as shown in **Figure 15**.

Figure 15

	OSCA		NH Asheville	
	Patients	**Percent**	**OP Cases & Procedures***	**Percent**
Buncombe	1865	48.07%	4,372	83.4%
Madison	148	3.81%	72	1.4%
Yancey	109	2.81%	53	1.0%
Henderson	625	16.11%	730	13.9%
Other	1133	29.20%	13	0.2%
Total	3880	100.00%	5,240	100.00%

Source: CON page 46 and 49

**Novant includes both OR cases and procedure room cases in its projected patient origin.*

The proposed OR transfer will not meet the needs of the service area residents and the intended purpose for which it was approved and just recently constructed. Novant should be found non-conforming with Criterion (3a).

Novant should be found nonconforming to criterion (3a) for another reason. That criterion requires that an applicant who is proposing the reduction or elimination of a service, **including the relocation of a facility or service,** demonstrate that the needs of the population presently served by that reduction, elimination, or relocation of a facility or service, will be met by the proposed relocation or by alternative arrangements. Mission is intimately familiar with this criterion because in a recent freestanding ED CON application (Project I.D. No. # B-12093-21) Mission was found nonconforming to this criterion solely because it proposed to relocate an underutilized and unregulated (by the CON Statute) CT Scanner from a diagnostic center to a new FSED only a few miles away. According to the CON Section's decision, Mission did not specifically address how patients who previously used that CT Scanner would have access to CT services after the relocation, despite the Agency's admission that it knew when it made that determination that there were multiple available CT Scanners near the site from which the scanner would be relocated. The Agency must be consistent from review to review and from applicant to applicant. In this review, Novant has provided no explanation of how the patients currently served at the OSCA ASF OR will have ongoing access to outpatient surgeries that are currently being performed in the OR to be relocated to an inpatient setting. The OSCA ASF's operating rooms, as documented herein, are already operating at or near capacity, so this is a real issue. Further, Mission contends that the

relocation of this ASF OR to the proposed new hospital represents a major failure by co-applicant OSCA to materially comply with the representations in its CON application for that outpatient OR, which is occurring well within the 3-year period defined in OSCA's CON conditions of approval. Based on OSCA's own representations in its 2018 ASF OR CON application, replacing an outpatient OR with a hospital-based shared OR is not one in the same thing—they are vastly different, according to OSCA's own CON application representations.

Criterion (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.

Novant fails to demonstrate that its project is either the least costly or most effective alternative. From a cost standpoint, it is clear that adding beds to an existing facility is the more cost-effective option because it only requires building the actual beds/patient care units and the associated cost. Building an entirely new hospital not only requires constructing the beds (the only service identified as needed in the SMFP), but also incurs the costs to build all required ancillary and support services needed to operate a new hospital. The same is true for operating costs. Operating incremental beds in an existing hospital only requires the staff directly associated with the additional beds as opposed to the clinical, administrative, support staff, services, and overhead required to support an entirely new hospital operation. The CON Statute sets forth a clear mandate to control costs. Approving large capital cost and operating cost projects when a much less costly alternative is available is inconsistent with this directive. Additionally, of the three applicants, Novant's proposal is by far the costliest alternative. For these reasons and the associated discussions regarding Criteria (1), (3), (5), (12), and (20), Advent cannot be found conforming with Criterion (4).

Criterion (5) Financial Feasibility

Start-Up Costs

As with many other components of its application, Novant uses the Mint Hill actual start-up costs as a starting point and applies a year over year escalation percentage to each component to bring them to 2026 levels for NH Asheville. These costs fail to right-size the numbers to the size of the proposed facility. As a 67-bed hospital, NH Asheville will clearly have more staff than a 36-bed hospital. Other categories will be similarly affected. As a result, the start-up costs are notably underestimated. Therefore, not only will NH Asheville be not cost-effective because it is an entirely new facility, but also, the start-up costs alone for the facility will be higher than stated in the application, making the project even less cost effective.

Projected Utilization

As discussed in detail in Criterion (3), Novant's projected utilization is unreasonable, unsupported, and based on a flawed methodology that overstates almost all service components for the proposed facility. As a result, Novant's financial projections are wholly unreasonable and undocumented. There is no way to verify that the proposed project is financially feasible based on Novant's projected utilization as it is entirely incorrect and undoubtedly results in overstated revenues.

If the utilization projections were reasonable and supported, which they are not, the project is only projected to breakeven in the third year of operation with a net income of $16.1 million. Should the projected utilization be as overstated as it appears or should any unforeseen issues arise with the proposed site or proposed equipment, the project clearly will be operating in the negative.

Payor Mix

Novant's payor mix is based on inaccurate assumptions. According to page 76 of the NH Asheville CON application, "NH Asheville assumes its future payor mix will reflect the payor mix of patients in the NH Asheville service area who received care in an acute care hospital in Buncombe County in 2021." As Mission Hospital is the only acute care hospital in Buncombe County, it can reasonably be assumed that Novant bases its payor mix on Mission Hospital's historical payor mix. Novant further confirms this with its Form F.2b Revenue Assumptions. See **Figure 16.**

Figure 16– Section Q Payor Mix Assumptions

Payor Mix

The projected payor mix for inpatient services, outpatient surgery, and other outpatient services was calculated using the 2021 reported admissions, outpatient surgical cases, and outpatient visits reported by Mission Hospital in the 2022 Hospital License Renewal Application, Table E. The following table highlights the calculation:

	Inpatient		Outpatient Other		Outpatient Surgery	
Payor Mix w/o Charity Care Removed	**2021***	**2029****	**2021***	**2029****	**2021***	**2029****
Self-Pay	0.7%	0.7%	6.0%	6.0%	2.1%	2.1%
Medicare	51.6%	54.4%	45.7%	46.3%	43.1%	44.1%
Medicaid	20.0%	21.1%	15.1%	15.2%	10.3%	10.6%
Insurance	17.2%	18.1%	29.4%	29.8%	38.7%	39.7%
Other	5.3%	5.6%	2.6%	2.6%	3.4%	3.4%
Total	**94.8%**	**100.0%**	**98.8%**	**100.0%**	**97.6%**	**100.0%**
Charity Care %	5.2%		1.2%		2.4%	

Source: Application for Novant Health Asheville Medical Center, ID B-012230-22, Assumptions to F.2b, no page number

Mission Hospital is a tertiary care center that serves patients from all over Western North Carolina. NH Asheville proposes to bring a low-acuity community hospital to Buncombe County and to primarily serve Buncombe and Henderson Counties. In the scope of the Western North Carolina landscape, Buncombe and Henderson are among the least rural and the most affluent of the counties Mission Hospital serves. Of Mission Hospital's 2021 acute care patients, 46.9% originated from Buncombe County. Conversely, NH Asheville projects that 83.4% of its acute care patients will originate from Buncombe County. Only 7.3% of Mission's patients traveled from Henderson County for care in 2021, while NH Asheville projects that 13.9% of its patients will come from Henderson County. These two counties compose **97.3%** of NH Asheville's total projected acute care patient origin while they only composed 54.2% of Mission's acute care patients in 2021. See **Figure 4** above. Using Mission's historical patient mix will result in

overstated percentages related to Medicaid, reduced, and charity-based care for NH Asheville, which proposes to serve a more narrow and affluent area.

Expenses

There are several expense categories that are not clear in terms of inclusion in Form F.3b. For example, pharmacy expenses are not identified as an expense line item or within any other expense category noted in the assumptions. Insurance expenses are noted to include "direct malpractice, general, and property insurance based on Mint Hill;" however, this line item is $0 on Form F.3b. Rental expense is not noted in the assumptions to include the rent or lease of the property required at $45,000 per year.

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

Criterion (6) Unnecessary Duplication

NH Asheville represents the definition of unnecessary duplication. As previously discussed, Novant projects that 13.4% of its patients will originate from Henderson County. Henderson County has two existing community hospitals and no SMFP-identified need for additional acute care beds. NH Asheville has chosen a site located approximately four miles from the Henderson County line and projects Henderson County will represent the second highest county of origin for its proposed patient base. Novant uses its projection methodology to claim that all of its Henderson County patients are traveling to Mission and will be redirected to NH Asheville. It fails to consider what it shows on Step 5 of its utilization methodology: from 2016-2020, only 30.7% of Henderson County inpatients sought care at Mission Hospital. Many of these patients likely represent higher acuity patients that could not be treated closer to home in their community hospitals and therefore would not qualify for redirection to NH Asheville. In all likelihood, Novant will draw more patients from Advent Hendersonville and UNC Pardee as comparable community hospitals than it will draw from Mission.

As a result, NH Asheville represents an unnecessary duplication of the two existing community hospitals in Henderson County. It has made no attempt to disguise its intent to serve Henderson County in its application and will unnecessarily further dilute two hospitals which are not currently operating at capacity and are serving the Henderson County community with the same level of services Novant proposes to offer.

For these reasons and those referenced in the associated discussions of Criteria (1), (3), (4), and (18a), Novant should be found non-conforming with Criterion (6).

Criterion (7) Availability of Resources.

The healthcare industry is facing a considerable staffing shortage in the wake of COVID. The proposed project will place further demands on the availability of staff in the planning area and the region, including competing for staff with existing hospitals in Henderson and Buncombe Counties. The development of a new duplicative hospital will require over 450 FTEs by the third year of operation as proposed by Novant. This includes over 250 nursing staff and over 160

technical and therapy staff, all of whom are in high demand and experiencing shortages. See Section Q, Form H. Of the three applicants, Novant projects the highest volume of staffing – by far. Novant does not clearly document how it will obtain such high levels of staffing without impacting existing providers in the service area and region.

Criterion (12) Cost and Design

Site Conditions and Utilities

Novant's proposed site has a number of conditions that would limit its use for the construction of a hospital. With only 17 acres, the site is not suited for further expansion. Its current drawings will limit the amount of parking, and a parking structure is not included in the current proformas. While exempt from CON, the cost of a parking structure certainly can impact the feasibility of the project. It should be noted that a significant portion of the identified site has major grade issues, which has made development of this site for uses much less complex than a hospital cost prohibitive for many years. The GIS map in **Figure 17** below demonstrates the steep gradient of this site, which it is unclear if Novant has considered.

Figure 17 - Proposed Site Gradient

It is important to note that the proposed location is within a multi-use development with residential, retail, and commercial development, including an outdoor mall, known as Biltmore Park Town Square. To access the hospital, patients, and visitors as well as EMS providers and suppliers/vendors, will have to travel along Schenk Parkway, through the Biltmore Town Square

area, and around a traffic circle and multiple stop signs. This road was clearly not designed for through traffic as it includes multiple traffic calming features such as the traffic circle, a divided boulevard designed with one-lane/one-way roads each direction, on-street parking, and stop signs for pedestrian traffic. Moreover, the hospital entrance will be off of a two-lane road and will create a tough bottleneck, hindering other businesses in the area. This road was not practically designed for bringing EMS, patients, visitors, and employees to a large healthcare provider. Novant has not addressed whether a traffic impact study has been conducted or if it will need further analysis from Buncombe County for approval. Please see **Attachment A** for photos of the route to access Novant's proposed site.

Novant has disclosed that it will have to go through the zoning process for part of its parcel. The traffic issues outlined above may hinder this process. In addition, Novant's inexperience in Buncombe County may result in issues that have not yet been considered related to its proposed project site and related approvals that will be necessary through Buncombe County.

There is no documentation provided regarding the availability of any utilities as required. Novant identifies the companies which provide utility services in the area and other businesses in the area which currently have utility services but provides no documentation from local providers that there are utilities sufficient for a new hospital at the proposed site. Again, the cost of bringing utilities to this site with major grade issues has posed limitations to parties previously considering development in this location.

Criterion (13) Medically Underserved Population

Novant claims it will serve medically underserved populations in its application, but its patient origin and faulty payor mix projections indicate otherwise. As discussed previously, Novant claims that its payor mix will mirror that of Mission's 2021 payor mix. See Criterion (5). However, its projected patient origin is vastly different than Mission's. See **Figure 18** below. Buncombe and Henderson Counties are significantly more urban and affluent than Madison, Yancey, and Graham.

Figure 18

	Mission CY 2021 Acute Care Patient Origin	**NH Asheville Proposed Year 3 Acute Care Patient Origin**
Buncombe	46.9%	83.4%
Madison	4.5%	1.4%
Yancey	2.8%	1.0%
Graham	0.6%	0.2%
Henderson	7.3%	13.9%

Even though Mission serves the entire Western North Carolina area, Madison, Yancey, and Graham counties compose 8.9% of its total acute care patients. Because NH Asheville is a proposed community hospital that is supposed to be supporting its service area, it would be assumed that its patient composition from these three counties would be even higher than Mission's since it does not have the expanded service area of Mission. However, this is not the case. It only projects that 2.6% of its acute care patients will originate from these three counties.

Thus, elderly, low income, and other underserved populations in these rural planning area counties will not be meaningfully served by Novant's proposed project. Clearly, NH Asheville's proposal will not improve access to medically underserved populations. As a result, it cannot be found conforming with Criterion (13).

Criterion (18a) Novant's Project will Not be Cost Effective, Offer Quality Care, Increase Access, or Improve Competition

As discussed in detail above regarding Criteria (1), (3), (4), (5), (6), (7), (8), (12), (13), and below regarding Criterion (20), it is clear that Novant does not propose a cost-effective project. The proposed new hospital does not represent the most cost-effective option to develop the 67 beds needed from a capital or operating cost standpoint. Moreover, Novant has not justified the project costs for its project nor the associated operating costs as it has also failed to demonstrate need for the project. In fact, Novant has the potential to reduce the cost-effectiveness of existing providers as it attempts to recruit over 450 new staff positions in an already constrained and highly competitive labor market.

The quality of care proposed by Novant is highly questionable as it admits it will perform 90% of its outpatient surgical cases in unlicensed procedure rooms. This is inconsistent with licensure regulations, Facility Guideline Institute ("FGI") hospitals guidelines, and the intent of the SMFP in requiring a hospital to provide surgical services. As noted above, the project will not increase access either geographically or financially to the service area. The reduction of ambulatory surgical facility services related to the operating room transfer will also negatively affect access.

It is important to consider the exact language of G.S. 131E-183(a)(18a) in review of the Novant application:

> *(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.*

As discussed above, Novant's project will not create competition or increase access in three of the four service area counties: Graham, Madison, and Yancey Counties. Novant projects minimal service to these counties, which are critical as rural communities with the least access to care. Instead, Novant focuses on serving Henderson County where two community hospitals already exist.

While Novant has the potential to add competition in Buncombe County for a limited set of services, it clearly will not have a positive impact on cost effectiveness, quality, and access to services as discussed in detail above. The applicant did not claim or demonstrate that the application is for a service on which competition will not have a favorable impact and did not address this part of Criterion (18a).

The 2022 SMFP provides further guidance to the CON Section regarding the interpretation of the CON statute. Specifically, the SMFP discusses balancing the notion of competition with the following public health and public policy considerations:

- A competitive marketplace should favor providers that deliver the highest quality of care and best value, but only in circumstances where all competitors deliver like services to similar populations. SMFP p. 2.
- Small and rural communities that are distant from comprehensive urban medical facilities warrant special consideration. SMFP p. 3.
- The CON Section is directed to balance competition, collaboration, and innovation in health care. SMFP p. 3.
- The Agency should focus on "reducing duplicative and conflicting care." SMFP P. 3.
- "The SHCC also recognizes the importance of balanced competition and market advantage in order to encourage innovation, insofar as those innovations improve safety, quality, access and value in health care." SMFP p. 4

Based on this directive, the notion of simply approving a new provider to a market under the guise of competition is simply wrong. The Agency must carefully review the facts of each competing proposal and consider whether in this specific review, considering all the factors and the specific facts of each competing proposal, there is any reason to believe that a new competitor will improve safety, quality, cost, and access.

The CON Section must carefully weigh what competition means in this instance. It is short- sighted to simply approve another hospital in a county just to say there are "two choices." Such a decision would overlook the following facts:

- The need was generated by the utilization of beds at a major tertiary medical center and trauma center, and the approval of a basic, small community hospital will not meet that need.

- The proposed hospital will be located four miles from the immediately adjacent county which already has two community hospitals providing both competition and choice to the service area.

- The addition of Novant in its proposed location represents a costly duplication of the same services that are in the adjoining county with excess bed capacity.

- A second hospital represents a myriad of duplicative services and costs that simply are not needed. The SMFP identifies a need for beds alone and not additional "surgical" services or any other imaging, ancillary, or support services.

- The move of an ASF OR to a hospital-based OR reduces patient access to more affordable and convenient surgical options in Buncombe County.

- A second hospital will require duplicative staff and will add increasing demand for clinical staff, who are in short supply. This will harm existing hospitals in the service area and the region.

Approving a new facility does not represent positive competition in this review when there are so many harmful aspects to the introduction of a new facility in terms of unnecessary costs, duplicative services, lesser or even inadequate quality, and a further dilution of limited clinical staff.

Novant should be found non-conforming with Criterion (18a)

Criterion (20) Quality

As discussed in detail Criterion 1 above, Novant intends to obtain an OR for the proposed hospital through a joint venture with a service area ASF provider and a transfer of an ambulatory surgical facility OR for shared inpatient/outpatient use at NH Asheville. The impetus for this transaction is the lack of operating room need for the Buncombe County service area in the 2022 SMFP. This limits Novant's ability to apply for and receive an acute care operating room through an SMFP need determination.

Shown in **Figure 19**, Novant presents its projected outpatient surgical volumes in Step 17 of its assumptions to Section Q. This figure definitively shows that Novant intends to perform 90 percent of its outpatient surgeries in procedure rooms. This figure clearly exceeds the number of procedures that would be appropriate to perform in an unlicensed procedure room. However, it should be noted that Novant does not attempt to quantify the number of procedures that are appropriately performed in each type of room. It just arbitrarily assigns volumes to the rooms based on availability.

Figure 19

	2027	2028	2029	
NH Asheville OP Visits	30,394	49,165	56,178	
OP Surgical Procedure Cases per OP Visit	0.08	0.08	0.09	
NH Asheville OP Surgical Procedure Cases	2,467	4,071	5,239	
NH Asheville OP Surgical Procedure Cases in OR	247	407	524	10.0%
NH Asheville OP Surgical Procedure Cases in PR	2,220	3,664	4,715	90.0%

Calculations: (OP Visits x OP Procedure Cases per OP Visit)
(OP Surgical Procedure Cases x OR/PR percentage)

Source: Application for Novant Health Asheville Medical Center, ID B-012230-22, Assumptions to Section Q, Step 17, no page number

Likewise, co-applicant OSCA raises the exact same concerning issue by admitting that the surgical procedures previously performed in ORs will now be performed in an unlicensed procedure room. Even if a room is clearly built to OR licensure standards, at some point the CON Section and the Licensure Section must delineate what is the appropriate use for unlicensed rooms to ensure the safety of North Carolina patients and the integrity of health planning.

Novant presents significant narrative and data to highlight its historical commitment to quality. However, its application suggests something completely different. Its inflated utilization projections and its service area focus on Buncombe and Henderson Counties underscore the reality that its intent is to provide services to an affluent population without regard to appropriate equipment capabilities or licensed operating rooms.

Novant should be found non-conforming with Criterion (20).

Criteria and Standards – Advent's Project Does Not Conform to the Performance Standards for Acute Care Beds and Operating Rooms

Acute Care Bed Performance Standards

SECTION .3800 - CRITERIA AND STANDARDS FOR ACUTE CARE BEDS

10A NCAC 14C .3803 PERFORMANCE STANDARDS

(a) An applicant proposing to develop new acute care beds shall demonstrate that the projected average daily census (ADC) of the total number of licensed acute care beds proposed to be licensed within the service area, under common ownership with the applicant, divided by the total number of those licensed acute care beds is reasonably projected to be **at least 66.7 percent when the projected ADC is less than 100 patients**, 71.4 percent when the projected ADC is 100 to 200 patients, and 75.2 percent when the projected ADC is greater than 200 patients, in the third operating year following completion of the proposed project or in the year for which the need determination is identified in the State Medical Facilities Plan, whichever is later.

Novant's assumptions and basis for its inpatient utilization projections are fundamentally flawed in numerous ways as discussed in detail under Criterion (3). Incorporating these flaws, Novant does not meet the required Acute Care Bed Performance Standards.

Comparative Review of Buncombe County
Acute Care Bed CON Applications

Pursuant to G.S. 131E-183(a)(1) and the 2022 State Medical Facilities Plan (SMFP), no more than 67 acute care beds may be approved for the Buncombe/Graham/Madison/Yancey County service area in this review. Because the applications in the review collectively propose to develop 201 additional acute care beds in Buncombe County, all applicants cannot be approved for the total number of beds proposed. Therefore, after considering all review criteria, Mission conducted a comparative analysis of each proposal to demonstrate why Mission is the best applicant and should be approved.

Below is a brief description of each project included in the Acute Care Bed Comparative Analysis.

- Project ID B-012233-22/**AdventHealth Asheville, Inc. ("Advent")**/ Develop a new hospital with 67 acute care beds pursuant to the 2022 SMFP Need Determination.
- Project ID B-012230-22/ **Novant Health Asheville Medical Center, LLC ("Novant")**/ Develop a new hospital with 67 acute care beds pursuant to the 2022 SMFP Need Determination.
- Project ID B-012230-22/ MH **Mission Hospital, LLLP ("Mission")**/ Develop 67 additional acute care beds at Mission's existing hospital in Asheville pursuant to the 2022 SMFP Need Determination.

As the above description of each proposed project indicates, two applicants are seeking to develop a new hospital with 67 acute care beds, while one applicant is proposing to add 67 acute care beds to its existing tertiary care hospital. Advent proposes a new small acute care hospital with 67 beds, no ORs, and 6 procedure rooms. Advent also plans to develop a C-section room, which plainly does not qualify as an OR for the purposes of a new acute care hospital. Advent's proposed small hospital plans to treat patients with low acuity levels and projects 18,287 acute care patient days and 4,889 discharges in its third full fiscal year (FY2027). Novant also proposes a new small acute care hospital with 67 beds, one dedicated C-section OR, and one OR to be relocated from the Outpatient Surgery Center of Ashville and used as a shared OR within the hospital. Novant projects18,680 acute care days and 6,531 admissions in its third full fiscal year (FY2029). Mission proposes to add 67 acute care beds to better serve its Level II trauma and tertiary care patients, resulting in a total of 800 acute care beds with 241,663 acute care patient days and 43,568 discharges in its third full fiscal year (FY2029) for the hospital as a whole, with the addition of 67 acute care beds.

In the following analysis, Mission describes the relative comparability of each competing applicant regarding those comparative criteria typically used by the CON Section and further indicates which such factors cannot be effectively compared in this review because of differences among the competing applicants.

Conformity with Review Criteria

Among the competing applicants, only the **Mission** application conforms with all applicable statutory and regulatory review criteria. **Advent** and **Novant** do not conform to several statutory and regulatory review criteria. Please see detailed discussion under each criterion that confirms:

- Advent and Novant are not conforming with the SMFP - Criterion (1).
- Neither Advent nor Novant demonstrates a need for its project or that its project will enhance geographic access – Criterion (3).
- The utilization projections for Novant and Advent are both riddled with inappropriate and unreasonable assumptions rendering them highly flawed – Criterion (3) and Acute Care Bed Performance Standards.
- Advent and Novant's projects are not the least costly or most effective alternative, as both would result in poorly utilized, limited, and small acute care hospitals and leave Mission with continuingly high occupancy rates – Criterion (4).
- Due to the flawed utilization projections and many other critical financial assumptions, neither Advent nor Novant are financially feasible as presented – Criterion (5).
- Both Novant and Advent represent unnecessary duplication of other small community hospitals already serving the service area and in particular duplicate OB services that are not well utilized at these existing, similar small hospitals – Criterion (6).
- Advent and Novant each project to hire over 400 new FTEs of clinical, support, and administrative staff, which are required to support an entirely new hospital but are not required to simply add 67 new beds to Mission's existing hospital. By creating a new hospital with redundant and unneeded ancillary, support, and administrative services, each new hospital will place extraordinary demands on already constrained staffing resources in the service area and region – Criterion (7).
- Likewise, Novant and Advent propose duplicative and redundant ancillary and support services that are not needed as only beds are identified as needed in the SMFP and neither has appropriately demonstrated the need for other proposed services. Moreover, Advent and Novant proposes OB beds that are clearly not needed based on flat to declining population and growth trends relevant to this service line – Criterion (8).
- The presented cost of the new hospitals proposed by Advent and Novant are exceedingly high, and not well documented. Advent's site is not usable as proposed and Novant's site is not appropriate for a hospital location – Criterion (12).
- Both Advent and Novant project a payor mix that is not reflective of the demand of the service area. Advent projects far less Medicaid and charity care, in particular, than the historical experience of service area hospitals, while Novant's payor mix is flawed as it claims to rely on existing providers, but its projections do not in fact equal or otherwise comport with existing providers. – Criterion (13).
- Any supposed competition that might be interjected by the hospitals proposed by Novant and Advent is offset by the fact that the proposed new hospitals will not offer the range of services that actually created the bed need in the SMFP. They will duplicate costly services,

place additional demands on already constrained staffing resources, and add costs to the system – Criterion (18a).

- Advent cannot meet the quality of care criterion or the requirements of the State's acute care licensure standards since it will not have an OR, and Advent wrongly suggests that it is appropriate to offer "major surgical cases" in procedure rooms as opposed to ORs. Likewise, Novant projects that 90 percent of its outpatient surgery cases will be performed in unlicensed procedure rooms and not in ORs as required. This similarly results in significant quality of care concerns – Criterion (20).

Therefore, **Mission** is the most effective alternative with regards to conformity with review criteria, and neither Advent nor Novant are approvable.

Scope of Services

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

Mission is an existing tertiary care provider that offers a broad range of medical and surgical services. **Mission** provides a comprehensive range of inpatient and outpatient services, including cardiology and cardiovascular surgery, general and urologic surgery, pediatrics, orthopedics, oncology, women's services, neurology, and trauma. Among the specialized programs and referral services offered at **Mission** are a state-designated high-risk pregnancy center, interventional cardiology (including cardiac catheterization, electrophysiology, and stents), cardiac surgery (including transcatheter aortic valve replacement, left ventricular assist device placement, structural heart, and bypass surgeries), inpatient dialysis, advanced imaging, and many others.

Both **Advent** and **Novant** propose a new community hospital. However, as a smaller community hospital, neither will provide as many types of medical services as **Mission**, a Level II Adult trauma center, and a tertiary care provider. **Novant and Advent** will not offer the range of services offered by **Mission**.

Proposed Acute Care Beds (Not Including NICU)

	ICU	Step Down	Med/Surg	OB	Pediatric	Total Beds	ORs***
Mission (Incremental)	22	-	45	-	-	67	0
Mission Total*	113	160	404	44	28	749	44
Novant	8		53	6	-	67	1
Advent**	12		42	13	0	67	0

**Mission's ICU beds include Cardiac/Cardiovascular, Truama, Neuro and Med/Surg. Mission's Med/Surg beds include specialized orthpedic and oncology units. With NICU, Mission will have 800 acute care beds at the end of the project.*

***Advent proposes only a C-Section room and procedure rooms, niether of which meets the definition of an OR.*

**** Does not include C-Section Rooms*

As shown in the table above, the distributions of the proposed beds for **Novant** and **Advent** include OB beds though there is no need for OB-specific services. In fact, births across the service area

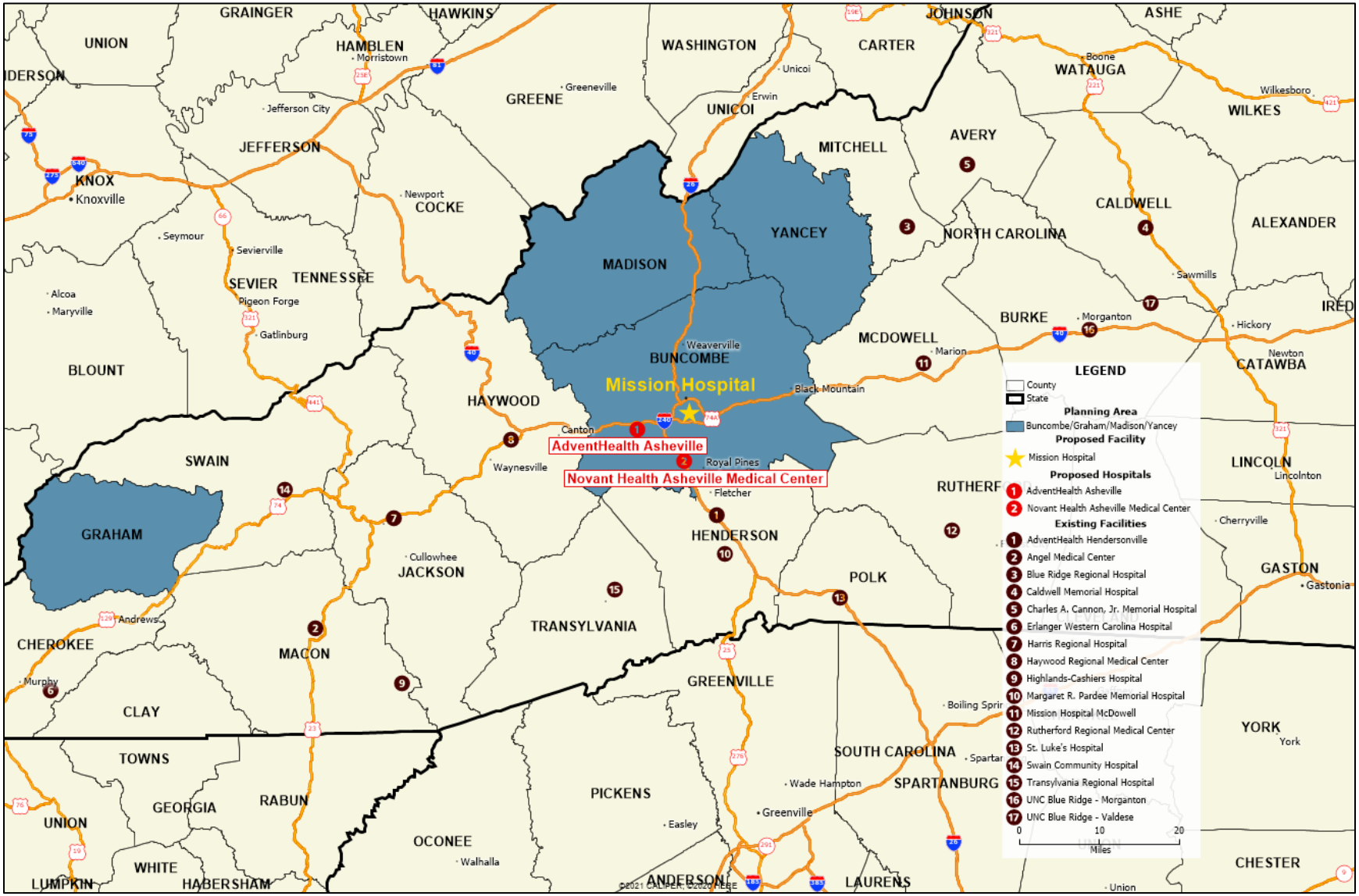
have declined over recent years. All nearby facilities except Mission Hospital McDowell and Harris Regional Hospital have experienced a decline in deliveries over the past 5 years. Three hospitals closed their OB services during this time, which largely contributed to the increase of births at Mission Hospital McDowell and Harris Regional Hospital. This is important because as birth rates decline, the need for OB and NICU services will also decline, which further supports the conclusion that Med/Surg and ICU beds are driving the need for additional beds in the service area, not any OB-specific beds

Therefore, **Mission** projects the broadest range of services, specifically including those that drove the SMFP need for acute care beds in the service area, making it the most effective alternative with respect to this comparative factor. **Advent** and **Novant** are the least effective alternatives.

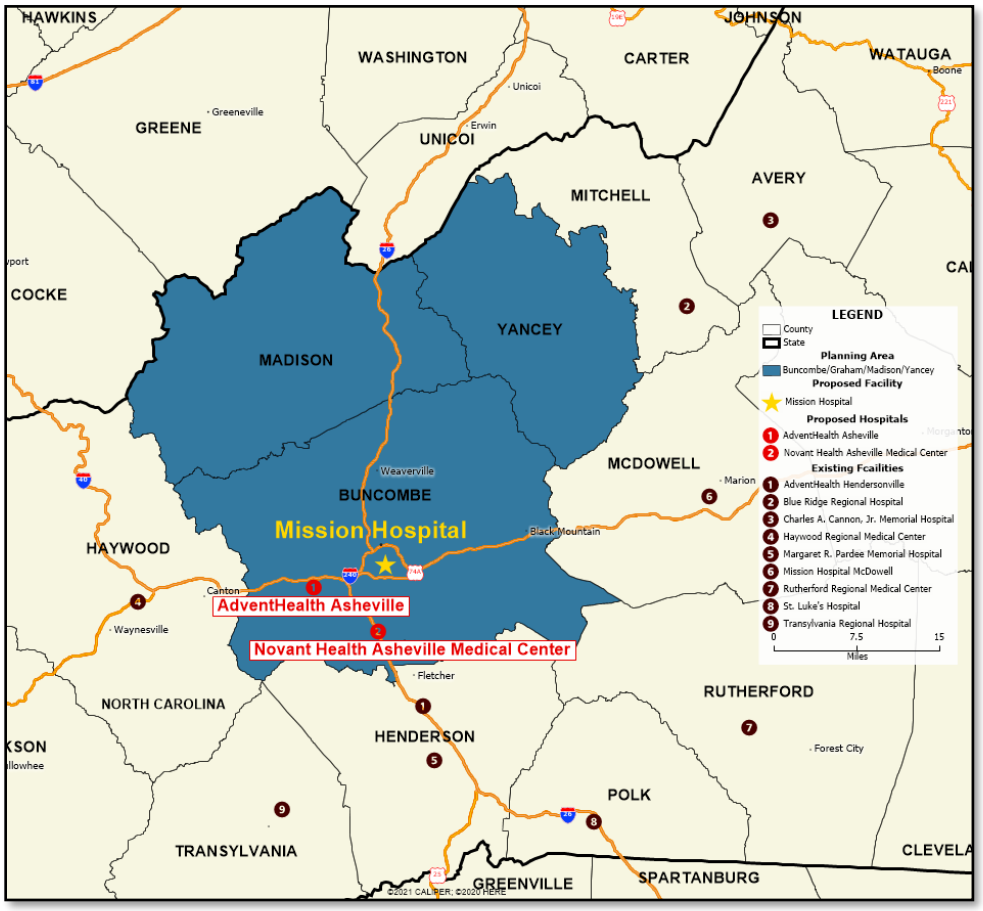
Geographic Access

There are 682 existing and approved acute care beds (not including NICU) in Buncombe County and none in Graham, Madison, and Yancey Counties, all part of the acute care planning area that generated the need. As shown in the map below, there is only one existing hospital located in Buncombe County—Mission Hospital. **Mission** proposes to add 67 acute care beds to its existing facility in Buncombe County. **Advent** and **Novant** both propose a new community hospital in Buncombe County. The following maps show the locations of **Mission** and the proposed locations of **Advent** and **Novant** as well as the other hospitals in the highlighted 4-county, SMFP defined planning area and the surrounding areas of western North Carolina region.

Buncombe, Graham, Madison and Yancey Planning Area with Existing and Approved Hospitals



Buncombe, Madison, and Yancey Counties with Existing and Proposed Hospitals



All 3 applicants proposed to develop the acute beds in Buncombe County, within 10 miles of one other. In addition, the following table shows the Drive Time Analysis in minutes and miles and demonstrates how long it will take residents from the major city in each of the acute care planning area counties and other adjacent counties to get to each of the three applicants' proposed location and other nearby facilities. The Drive Time Analysis shows that of all the hospitals, **Mission** is the most accessible to the residents of 3 of the 4 counties in the planning area (Buncombe, Madison, and Yancey). In comparison, neither **Advent** nor **Novant** improve access for any of the counties in the planning area.

Drive Time Analysis (Minutes)

Hospital:	Mission	Haywood	Advent Hendersonville	Margaret Pardee	Advent Asheville	Novant
County (City, State)						
Buncombe (Asheville, NC)	5-8	28-35	24-35	28-40	12-18	16-24
Graham (Robbinsville, NC)	90-120	70-85	100-130	110-140	85-110	90-120
Madison (Marshall, NC)	26-40	50	40-55	45-65	30-40	35-45
Yancey (Burnsville, NC)	40-55	60-75	55-60	60-80	45-55	45-65
Henderson (Hendersonville, NC)	30-45	40-55	12-20	4	26-40	18-26
Haywood (Waynesville, NC)	35-50	10-16	40-55	45-60	28-40	35-50

Drive Distance Analysis (Miles)

Hospital:	Mission	Haywood	Advent Hendersonville	Margaret Pardee	Advent Asheville	Novant
County (City, State)						
Buncombe (Asheville, NC)	1.4	26.5	20.1	24.8	7.3	12.7
Graham (Robbinsville, NC)	93.1	67.4	102.0	107.0	87.5	94.7
Madison (Marshall, NC)	21.9	32.7	37.2	41.9	24.5	29.9
Yancey (Burnsville, NC)	37.8	59.7	53.2	57.9	40.5	45.9
Henderson (Hendersonville, NC)	25.9	41.7	6.5	0.7	24.0	15.3
Haywood (Waynesville, NC)	31.4	4.7	39.6	44.3	25.0	32.2

Source: Goggle 2022

Note: Depart time 8:00am

Therefore, none of the applicants meaningfully change geographic access to the Buncombe/Graham/ Madison/Yancey County service area. **Mission** will continue to be the most proximate provider to Madison and Yancey County. Geographic access should be found to be inconclusive or that **Mission** is the most effective applicant.

Historical Utilization

The table below shows acute care bed utilization for existing facilities based on acute care beds and days reported on the 2022 LRAs, excluding NICU services days and beds. Generally, the applicant with the higher historical utilization is the more effective alternative with regards to this comparative analysis factor.

Historical Acute Care Bed Utilization Comparison*

Hospital/Applicant in Market	Beds	Patient Days	ADC	% Occupancy
Mission	682	210,716	577	84.6%
Advent Hendersonville	62	11,096	30	49.0%
Novant	NA	NA	NA	NA

Source: 2022 LRAs

**Acute care beds not including NICU services*

As shown in the Table above, **Mission's** historical utilization **is** higher than **Advent's** existing facility, Advent Hendersonville, near Buncombe County. **Novant** does not have an existing facility near nor in the Buncombe County service area and thus has no historical utilization.

Therefore, a comparison of historical utilization cannot be effectively conducted between all three applicants. However, **Mission** is the most effective alternative among the two comparable applicants.

Projected Utilization and Bed Capacity

The following table shows each facility's projected acute care bed utilization, excluding NICU services days and beds. Generally, the applicant with the higher projected utilization is the more effective alternative regarding this comparative analysis factor in terms of the effectiveness of use of the proposed beds.

Projected Acute Care Bed Utilization Comparison*

Hospital/Applicant in Market	Beds	Admissions	Patient Days	ADC	% Occupancy
Mission	800	43,568	243,078	665.97	83.2%
Advent Hendersonville**	67	4,899	18,287	50.10	74.8%
Novant	67	6,531	18,680	51.18	76.4%

Source: 2022 LRAs

**Acute care beds not including NICU services*

***Advent's projections are not reasonable as they include surgical inpatients with surgical cases that cannot be appropriately performed without an OR.*

As shown in the table above, **Mission's** projected utilization is higher than **Advent's** and **Novant's.** As discussed above, there are also numerous flaws in the utilization assumptions of both **Advent** and **Novant**, which result in inaccurate projected utilization. Therefore, with regard to projected utilization, **Mission** is the most effective alternative; **Advent** and **Novant** are the least effective alternatives.

Service to the Planning Area Counties (Access by Service Area Residents)

On page 33, the 2022 SMFP defines the service area for acute care beds as *"... the single or multicounty grouping shown in Figure 5.1."* Figure 5.1, on page 38, shows the multicounty grouping of Buncombe/Graham/Madison/Yancey Counties as the acute bed service area. Thus, the service area for this review of acute care beds is Buncombe/Graham/Madison/Yancey Counties. Facilities may also serve residents of counties not included in the service area. Generally, the application projecting to be the most accessible to Buncombe/Graham/Madison/Yancey County residents is the most effective alternative with regards to this comparative factor.

Inpatient Admissions of Patients from the Acute Care Planning Area

	Advent*		Novant		Mission	
	3rd Full FY		3rd Full FY		3rd Full FY	
Buncombe	3,782	85.8%	5,450	97.0%	20,412	86%
Madison	267	6.1%	90	1.6%	1,961	8%
Yancey	265	6.0%	65	1.2%	1,213	5%
Graham	95	2.2%	16	0.3%	276	1%
Total Planning Area	4,409	100.0%	5,621	100.0%	23,862	100%
Henderson	?	?	910		3,196	

Sources: Applications, Section C, Question 3.
**Advent's projections are flawed by the inclusion of surgical cases that cannot be performed without and OR. Advent unreasonably does not identify any projected patients from either Henderson County or immediately adjacent Haywood County.*

The table above shows the patient origin for admissions from the acute care planning area for each proposed facility. It is important that the agency look beyond a simple percentage when evaluating this factor and not ignore the services actually needed by the projected patients and the various roles that hospitals play, especially a regional tertiary provider and trauma center like Mission. This is because such a simplistic analysis ignores this significant role and can in fact penalize the applicant serving in this role as it serves a significant percentage of patients from outside the planning area. The table shows that **Mission** is projected to serve the most patients in the planning area counties, including the most patients from Madison, Yancey, and Graham Counties. In comparison, both **Advent** and **Novant** serve only a small fraction of the patients projected by **Mission,** particularly for Madison, Yancey, and Graham Counties.

Therefore, with regard to service to the planning area, **Mission** is the most effective alternative, and **Novant** and **Advent** are the least effective alternatives.

Historical Financial Access

Two of the applicants, **Mission** and **Advent**, are already serving the planning area directly or through an affiliated hospital (e.g., Advent Hendersonville). A review of the historical level of financial accessibility for these two providers gives an indication of the likely projected financial accessibility of each applicant. The following table provides a comparison of the historical payor mix for all services reported on the 2022 LRAs for Mission and Advent Hendersonville.

Facility Total Historical Payor Mix			
Historical	**Mission**	**Advent**	**Novant**
Self Pay	4.3%	3.9%	NA
Charity Care	2.4%	0.2%	NA
Medicare	47.3%	50.8%	NA
Medicaid	16.5%	9.0%	NA
Insurance	26.1%	31.4%	NA
Other	3.4%	4.7%	NA
Total	100.0%	100.0%	NA
Total Low Income*	**23.2%**	**13.1%**	NA

Source: 2022 LRAs

Mission serves a significantly larger percentage of self-pay, charity care, and Medicaid patients, collectively low-income patients, than Advent Hendersonville. Thus, **Mission** is most effective in this comparative factor.

Projected Financial Access (Access by Underserved Groups)

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

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

For access by underserved groups, the applications in this review are compared with respect to 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.

Projected Charity Care

The following table shows projected charity care during the third full fiscal year following the completion of the project for each applicant. Generally, the application projecting to provide the most charity care is the more effective alternative with regard to this comparative factor.

Projected Charity Care - 3rd Full Fiscal Year				
Applicant	**Total Facility Charity Care**	**Admissions**	**Estimated Charity Admissions**	**% of Total Gross Patient Revenue**
Mission	$ 347,713,911	43,568	1,676	3.85%
Advent*	$ 8,718,032	4,899	138	2.83%
Novant**	$ 40,356,776	6,531	347	5.32%

**Advent projects 1,405 charity care patients in Section L but the equivalent of only 138 patients in Section Q. Form F.2B*

***Novant's charity care projections are suspect as they are equal to more than double the self pay payor mix.*

Based on the pro forma financial statements, **Mission**'s percentage of charity care to gross patient revenue is estimated to be 3.85 percent. **Advent**'s projected charity care is 2.83 percent, meaning they are proposing to provide less charity care than **Mission**. **Novant** is projecting to provide more charity care than **Mission** and **Advent**, with 5.32 percent of charity care to gross patient revenue. However, **Novant**'s charity care projections appear unrealistic since its charity care projection is more than double its self-pay percentage projection. It should be noted that **Novant** claims in its application that it based its projected charity care on Mission's experience, with no other basis, but then substantially exceeds **Mission**'s actual and projected charity care without any explanation as to why or any supporting assumptions. **Novant**'s projections are rendered unreliable as a result.

Therefore, regarding charity care, **Mission** is the most effective applicant. **Novant** and **Advent** are the least effective alternatives.

Projected Medicare

The following table shows projected Medicare revenue during the third full fiscal year following project completion for each applicant. Generally, the applicant projecting the highest Medicare revenue is the more effective alternative with regard to this comparative factor.

Projected Medicare Revenue - 3rd Full Fiscal Year				
Applicant	**Total Facility Medicare Revenue**	**Admissions**	**Estimated Medicare Admissions**	**% of Total Gross Patient Revenue**
Mission	$ 4,481,645,969	43,568	21,605	49.59%
Advent	$ 145,422,843	4,899	2,309	47.13%
Novant	$ 365,749,147	6,531	3,149	48.21%

Based on its proforma, **Mission's** percentage of Medicare revenue to gross patient revenue is estimated to be 49.59 percent. **Advent's** percentage of projected Medicare revenue to gross revenue is 47.13 percent, and **Novant's** percentage of projected Medicare revenue to gross revenue is 48.21 percent. Both Advent and Novant project less Medicare revenue than **Mission.**

Therefore, regarding Medicare Revenue, **Mission** is the most effective applicant. **Novant** and **Advent** are the least effective alternatives.

Projected Medicaid

The following table shows projected Medicaid revenue during the third full fiscal year following project completion for each applicant. Generally, the applicant projecting the highest Medicaid revenue is the more effective alternative with regards to this comparative factor.

Projected Medicid Revenue - 3rd Full Fiscal Year				
Applicant	**Total Facility Medicaid Revenue**	**Admissions**	**Medicaid Revenue per Admission**	**% of Total Gross Patient Revenue**
Mission	$ 1,577,929,797	43,568	7,607	17.46%
Advent	$ 40,334,818	4,899	640	13.07%
Novant	$ 118,220,399	6,531	1,018	15.58%

Based on its pro forma, **Mission's** percentage of Medicaid revenue to gross patient revenue is estimated to be 17.46 percent. **Advent's** projected percentage of Medicaid revenue to gross patient revenue is estimated to be 13.07 percent. **Novant's** percentage of Medicaid revenue to gross patient revenue is estimated to be 15.58 percent. Both Novant and Advent project less Medicaid revenue than **Mission.** This is particularly notable given that both **Advent** and **Novant** propose to offer OB services, which is typically a high Medicaid service line.

Therefore, in regard to Medicaid Revenue, **Mission** is the most effective applicant. **Novant** and **Advent** are the least effective alternatives.

Projected Average Net Revenue per Admission

The following table shows the projected average net revenue per patient in the third full fiscal year following project completion for each applicant. Generally, the application projecting the lowest average net revenue per patient is the more effective alternative with regard to this comparative factor. However, differences in the acuity level of patients at each facility, the level of care (community hospital, tertiary care hospital, etc.) at each facility, and the number and types of surgical services proposed by each facility significantly impacts the simple averages shown in the table below.

Projected Case Mix Adjusted Net Revenue per Admission

Applicant	Total Admissions	Gross Revenue	Average Net Rev per Admission
Mission	43,568	1,627,733,826	$ 37,361
Advent	4,899	106,965,286	$ 21,834
Novant	6,531	174,997,647	$ 26,795

Such a comparison can be performed using publicly available Case Mix Index (CMI) data for existing and comparable hospitals. Mission's projections can be evaluated based on its historical CMI. Novant's projections can be evaluated based on the CMI for Novant Health Mint Hill Hospital, which was used as a basis for many of Novant's projections. Advent Hendersonville could be considered as a CMI surrogate for Advent; however, Advent Hendersonville has 6 ORs and provides a range of surgical cases that Advent's proposed facility will not be able to offer, thus resulting in a CMI that would be too high for the proposed Advent Hospital. Noting that Advent cannot function as a licensed hospital without an OR, the SMFP listing of licensed hospitals

includes several small hospitals operating with just 1 or 2 ORs. The vast majority of these are Critical Access Hospitals ("CAH"). There are no non-CAH facilities in North Carolina that are operating without an OR. There is one non-CAH facility in North Carolina that operates 1 OR.[6] This hospital, Atrium Health Anson, was used as a surrogate for Advent.

Hospital	**CMI**
Mission Hospital	2.0133
Advent Hendersonville	1.7405
Novant Health Mint Hill	1.2227
Atrium Health Anson	1.1304

Source: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page
2022 LRAs and SMFP

When the average net revenue per admission is case mix adjusted, **Mission's** CMI average adjusted net revenue per admission is lower than both **Advent** and **Novant.**

Projected Case Mix Adjusted Net Revenue per Admission

Applicant	**Total Admissions**	**Gross Revenue**	**Average Net Rev per Admission**	**CMI**	**CMI Adjusted Net per Admission**
Mission	43,568	1,627,733,826	$ 37,361	2.0133	$ 18,556.98
Advent*	4,899	106,965,286	$ 21,834	1.1300	$ 19,322.22
Novant**	6,531	174,997,647	$ 26,795	1.2227	$ 21,914.55

Source: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page
**Advent Health - Atrium Health Anson used as a surrogate based on the operation of just 1 OR.*
***Novant Health - Mint Hill used for surrogate*

Therefore, with regard to projected average net revenue per admission, given the extreme variation in service offerings and acuity levels between the applicants, this comparative factor is inconclusive. If acuity is considered and the projections are case mix adjusted, **Mission** is the most effective proposal.

Projected Average Expenses per Admission

Total Expense
The following table shows the projected average expense per admission in the third full fiscal year following project completion for each applicant. Generally, the application projecting the lowest average total expense per surgical case is the more effective alternative with regard to this comparative. However, in this instance the service offerings cannot be compared between a regional tertiary trauma provider and two small community hospitals, which renders a simple comparison inconclusive. As noted above, when the projections for the three applicants are case

[6] This does not include specialty or LTACH facilities.

mix adjusted for acuity, then an appropriate comparison can be rendered. As shown below, **Mission** is the most effective provider based on CMI adjusted projected average expense per admission.

Projected Average Expense per Admission - 3rd Full FY

Applicant	Total Admissions	Total Expense	Average Expense per Admission	CMI	CMI Adjusted Expense per Admission
Mission	43,568	1,281,326,998	$ 29,410	2.0133	$ 14,608
Advent*	4,899	104,301,203	$ 21,290	1.1304	$ 18,834
Novant**	6,531	158,897,293	$ 24,330	1.2227	$ 19,898

Source: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page

**Advent Health - Atrium Health Anson used as a surrogate based on the operation of just 1 OR.*

***Novant Health - Mint Hill used for surrogate*

Project Costs

The table below shows the projected cost for each project. Generally, the applicant who projects the lowest project cost should be found to be the most effective alternative regarding this comparative analysis factor based on the clear directive of the CON Statute to contain costs. The Agency does not always consider project cost in the comparatives analysis, but cost containment is a basic premise of CON statue. In this instance there are three proposals to bring 67 beds to the community and 3 vastly different costs. Thus, the cost effectiveness of the project should be considered in this comparative analysis.

Applicant	Project Cost	Variance from Low Cost Option
Mission	$ 125,045,000	
Advent	$ 254,125,000	$ 129,080,000
Novant	$ 328,729,394	$ 203,684,394

As displayed in the table above, **Mission** has the lowest project cost. **Advent** has the second lowest cost, which is a little over double the project cost of **Mission**. **Novant** has the largest project cost, which is almost triple that of **Mission**'s project cost.

Therefore, in regard to cost, **Mission** has the lowest project cost making it the most effective applicant. **Novant** and **Advent** are the least effective alternatives.

Project Timing

The table below shows the date when the acute care beds will come online (when beds will be available for use) as reported in each applicant's proposal. Generally, the applicant who can have beds available the soonest is the most effective alternative regarding this comparative analysis factor.

Beds Online and Available

Mission	12 beds January 2023	45 beds 6/1/2026
Advent*		1/1/2025
Novant		1/1/2027

**Advent's projected timeline is unreasonable given the planning involved in a new hospital, the global supply chain issues, and the site work required for an inappropriate and undesirable site.*

As shown in the table above, **Mission** will be the first to get beds online. Upon approval of its application, Mission will be able to bring 12 beds online in January 2023. As mentioned in **Mission's** application, **Mission** is experiencing incredibly high occupancy rates and a growing demand for its high acuity services, factors that actually generated the bed need in the 2022 SMFP. **Mission** projects to have all 67 beds online on 6/1/2026, which is sooner than **Novant's** projection date of 1/1/2027, but later than **Advent's** date of 1/1/2025. However, **Advent's** timing is unrealistic for multiple reasons including the fact that there is no confirmed entitlement to any site and the site identified has serious issues relating to potential mitigation of hazardous material. As a result, **Advent** has included insufficient time to complete due diligence on the site between approval and prior to its proposed 1/15/2023 acquisition, no time allotted for site mitigation and site prep, and insufficient time for full architectural and engineering drawings.

Therefore, with regard to timing, **Mission** will have beds online more quickly than the other applicants, making it the most effective applicant. Although **Advent's** projection indicates that its total number of beds will be available sooner, Advent's proposed project schedule does not appear realistic for the reasons regarding its site detailed in Mission's comments on the Advent application. Mission is the most effective alternative regarding this comparative factor.

Staffing Resources and Needs

Often, the Agency compares projected FTE per admissions, case, or other measure of utilization. In this instance, such a comparison is not conclusive because two applicants proposed new facilities and all new FTEs, and one applicant is an existing provider adding incremental FTEs. Given the severe staffing shortages, particularly clinical staff, which are impacting the healthcare industry in the wake of COVID-19, it is critical to evaluate in this review the impact of staff recruitment on already short supplies and the potential for resultant increases in staffing costs that may impact existing providers in the entire region. In this instance, a more relevant measure for this review is the total new FTEs to be recruited to support the need, which is simply for 67 acute care beds.

The table below shows the sum of the total FTEs proposed by each applicant for the third fiscal year. For **Mission**, this reflects the incremental FTEs only associated with the opening of the 67 new beds. This comparative measure demonstrates the impact of the project in terms of total FTEs and types of positions that will need to be recruited in today's highly competitive job market. Generally, the applicant who has the lowest number of new FTEs will have the least impact on the competitive job market, while the applicant with a greater FTE need will have the greatest potential

to impact existing providers by recruiting away staff through competition for these limited resources and driving up costs for all existing providers.

Incremental Staffing Requirements

	Advent	Novant	Mission Incremental
Nursing, CRNA, and Nursing Supervision	188	260	75.5
Technical Staff (Surgical, Imaging, Therapy, Pharmacy, Other)*	89	159	
Support Staff	80	43	
Administrative and Clerical Staff**	44.9	2.0	
Total	401.7	464.4	75.5

**Note: Advent's staffing plan does not show any therapists except for respiratory.*

*** Note: Novant's staffing plan only shows 1.0 FTE President, an executive assistant, and no other senior administrative leadership.*

As shown in the table above, **Mission** will require the smallest number of newly recruited positions/FTEs and can therefore staff its project most efficiently with the lease potential impact on existing providers**.** Therefore, in regard to staffing resources, **Mission** is the most effective applicant. **Novant** and **Advent** are the least effective alternatives.

Competition (Impact on Quality, Safety, Access, Cost Effectiveness, and Value)

There are 733 existing and approved acute care beds located in Buncombe County and no acute care hospital beds in Graham, Madison, and Yancey Counties. Graham, Madison, and Yancey Counties are included in the planning area for the calculation of the bed need methodology due to their reliance on Mission as the regional tertiary care and trauma provider. However, planning area residents utilize numerous other community and rural hospitals in the region including UNC Pardee Hospital, Advent Hendersonville, Haywood Regional Medical Center, Blue Ridge Regional Hospital, Swain County Community Hospital, and Harris Regional Hospital, to name a few.

In terms of regional tertiary and trauma services, **Mission** is the only existing provider and the only applicant offering this range of services that are critical to the region. In terms of small community hospitals with a limited range of services, there are multiple competing hospitals already offering the same services as those proposed by **Advent** and **Novant**. **Advent**'s project simply duplicates its similarly sized existing hospital, Advent Hendersonville, located approximately 4 miles from the Buncombe County line, and does not enhance competition. **Novant**'s project proposes the development of a new provider in the planning area, but it simply duplicates the existing community hospitals already serving the planning area. Novant's project does not increase geographic access given that it is less than 10 miles from Advent Hendersonville.

In the past, the Agency has taken a rather one-dimensional approach to competition, often concluding that any new provider represents beneficial competition and ignoring the fact that the high and often specialized utilization of existing providers generated the need in the SMFP for a given review. This approach ignores the fact that quite often the provider generating the need offers

more complex and diverse services than those which can be offered by a new provider. Moreover, the cost to establish a new provider or facility is often far more than simply adding the needed service to existing facilities that created the SMFP need, as is the case in this review. In such cases, approving a new provider simply because they represent new "competition" represents a costly duplication of services. Mission encourages the Agency to consider the competition factor in combination with other equally important CON Statutory criteria, such as unnecessary duplication of services, limiting costs, and serving the needs of the service area population based on the scope of services provided, not just additional beds proposing to serve types of patients for which adequate services already exist. This balancing of criteria is specifically directed by the SHCC on page 3 of the 2022 SMFP.

It is important to note that competition can only be evenly measured when the competitors are delivering like services to a similar population. In this instance, the proposed two new community hospitals will not be offering like services to those already offered by Mission, which Mission proposes to expand. However, there are aspects of each proposal that can be compared for the various competitive factors including quality, safety, access, cost effectiveness and value. The table below provides such a comparison.

In this review, it is clear that the two applicants proposing new hospitals, **Advent** and **Novant,** do not represent beneficial competition and will actually have a negative impact on competition. **Mission**'s project is the least costly and offers the highest acuity and broadest range of services. **Mission** also provides the most positive impact on competition without the negative impacts associated with the costly and duplicative services proposed by the other two applicants. For these reasons, the Agency should find that competition is either inconclusive, due to fact that "like services" are not proposed or find that **Mission** will have the most positive (or least negative) impact on competition.

Summary of Impact of Competition			
Factor:	**Mision**	**Advent**	**Novant**
Impact of Competition on Quality:	Expands existing high quality services including access to tertiary and trauma care.	- Proposes only basic community hospital service that already exist. - Proposes to inappropriately offer "major surgical cases" in unlicensed procedure rooms.	- Proposes only basic community hospital service that already exist. - Proposes to inappropriately to provide 90% of outpatient surgery cases in unlicensed procedure rooms.
Impact of Competition on Safety:	- Mission is known for its safety score ratings. - The project will expand care to such services.	- Proposal to inappropriately offer "major surgical cases" in unlicensed procedure rooms is a significant safety concern.	- Proposal to inappropriately to provide 90% of outpatient surgery cases in unlicensed procedure rooms is a significant patient safety concern.
Impact of Competition on Access to Care:	- Serves the most patients within the four-county service area. - Provides the broadest range of services. - Provides the most favorable access to low income and underserved patients.	- Serves minimal patients from Graham, Madison, and Yancey Counties. - Provides only basic community hospital services that duplicate existing hospitals. - Does not provide favorable access to low income and underserved patients.	- Serves minimal patients from Graham, Madison, and Yancey Counties focusing instead on Henderson County. - Provides only basic community hospital services that duplicate existing hospitals. - Does not provide reasonable projections of access to low income and underserved patients.
Impact of Competition on Cost Effectiveness:	- Proposes the lowest capital cost project. - Does not add costly ancillary and support services that are not needed. - Does not duplicate existing and costly administrative and support services.	- Proposes the second highest capital cost project. - Proposes to add numerous ancillary and support services that are not needed. - Proposes costly and duplicative administrative and support services.	- Proposes the highest capital cost project. - Proposes to add numerous ancillary and support services that are not needed. - Proposes to shift a cost effective freestanding OR to more costly hospital-based use. - Proposes costly and duplicative administrative and support services.
Impact of Competition on Staffing:	- Proposes to recruit only 75 incremental direct patient care staff to support the proposed beds. - No duplication of ancillary and support staff will occur. - Least impact of cost of recruiting and retaining limited clinical staff in an already limited labor market. - Provides the greatest contribution to training future care givers in western NC.	- Proposes to recruit over 400 incremental staff including direct care clinical personnel, ancillary staff, support staff and administrative staff. - Staff will directly duplicate the existing ancillary and support services provided by other community hospitals. - Has the potential to impact the cost of staff and staffing shortages at existing area hospitals.	- Proposes to recruit over 460 incremental staff including direct care clinical personnel, ancillary staff, support staff and administrative staff. - Staff will directly duplicate the existing ancillary and support services provided by other community hospitals. - Has the potential to impact the cost of staff and staffing shortages at existing area hospitals.
Impact of Competition on Duplication:	- Expands only the existing service that generated the need. - Does not unnecessarily duplicate existing ancillary and support services.	- Directly duplicates the services of existing community hospitals including Haywood Regional and Advent's affiliate Advent Hendersonville. - Proposes to duplicate numerous ancillary and support services that it has not demonstrated are needed.	- Directly duplicates the services of existing community hospitals including the two hospitals in Henderson County, which have surplus bed capacity. - Proposes to duplicate numerous ancillary and support services that it has not demonstrated are needed.
Impact of Competition on Value:	- Value is created by cost effectively adding the specific service only that generated the need determination. - Value is created through the most cost effective project from a capital and operating cost perspective.	- Value is not created due to high capital and operating cost expenditure to add unnecessary and duplicative services	- Value is not created due to high capital and operating cost expenditure to add unnecessary and duplicative services

Conclusion

G.S. 131E-183(a)(1) states that the need determination in the SMFP is the determinative limit on the number of acute care beds that can be approved by the Healthcare Planning and Certificate of Need Section. Approval of all applications submitted during the review would result in acute care beds in excess of the need determination in Buncombe/Graham/Madison/Yancey County service area. Only **Mission's** project can be approved as it is the only applicant that conforms to all project review criteria and applicable performance standards. However, if all applicants were approvable, **Mission's** project is still the most effective alternative to meet the need based on the summary below. As such, **Mission's** project should be approved.

Summary of Comparative Factors

Meaure/Analysis	**Mission**	**Advent**	**Novant**
Conformity with Review Criteria	Yes	No	No
Scope of Services	Most Effective	Least Effective	Least Effective
Geographic Access	No difference or Most Effective	Least Effective	Least Effective
Historical Utilization	Most Effective	Least Effective	NA
Projected Utilization / Use of Beds	Most Effective	Least Effective	Least Effective
Competition/Access to New Provider	Inconclusive	Inconclusive	Inconclusive
Service to the Planning Area Counties (a)	Most Effective	Least Effective	Least Effective
Historical Financial Access	Most Effective	Least Effective	NA
Projected Financial Access	Most Effective	Least Effective	Least Effective
Projected Charity Care	Most Effective	Least Effective	Least Effective
Projected Medicare	Most Effective	Least Effective	Least Effective
Projected Medicaid	Most Effective	Least Effective	Least Effective
Projected Average Net Revenue per Admission	Inconclusive	Inconclusive	Inconclusive
CMI Adjusted Net Revenue per Admission	Most Effective	Least Effective	Least Effective
Projected Average Expense per Admission	Inconclusive	Inconclusive	Inconclusive
CMI Adjusted Expense per Admission	Most Effective	Least Effective	Least Effective
Effective Staffing Resources	Most Effective	Least Effective	Least Effective
Project Cost	Most Effective	Least Effective	Least Effective
Project Timing	Most Effective	Least Effective (b)	Least Effective

(a) Given the variation in types of projects (small community hospitals v. regional tertiary medical center), the most reasonable method to compare service to the planning area counties is the number of patients served.

(b) Advent's project timing would be the second most effective but the timing appears to be highly unlikely to be achievable.

Attachment A

Views of Access to Novant Site

NH Asheville Hospital Site Access Photos

Route through Biltmore Village to Access Hospital Site


Schenck Pkwy
YIELD


Google


Google


STOP