

**PETITION**  
**Petition to Delete Policy AC-5 from the 2023 State Medical Facilities Plan**

**PETITIONER**

Blue Ridge HealthCare Hospitals, Inc.  
2201 South Sterling Street  
Morganton, North Carolina 28655

Thomas L Eure  
SVP, Corporate Services & Chief Legal Officer  
Blue Ridge HealthCare Hospitals, Inc.  
(828) 580-5553  
thomas.eure@blueridgehealth.org

**INTRODUCTION**

Blue Ridge HealthCare Hospitals, Inc. (Blue Ridge) respectfully petitions the State Health Coordinating Council (SHCC) to delete Policy AC-5, titled Replacement of Acute Care Bed Capacity, from the *2023 State Medical Facilities Plan (2023 SMFP)*. The proposed change is requested to address the inequitable treatment of some hospitals under the policy as well as the limited circumstances under which Policy AC-5 currently applies. Notably, as detailed below, the enactment of the “main campus exemption” under N.C. Gen. Stat. § 131E-184(g) has in large part rendered Policy AC-5 superfluous. As such, as applied today, Policy AC-5 places certain providers at a disadvantage—specifically those with multiple campuses under the same license seeking to replace acute care bed capacity not located on the “main campus.”

**BACKGROUND**

As the SHCC is aware, the *SMFP* is developed by the Department of Health and Human Services (DHHS) under the direction of the SHCC (see N.C. Gen. Stat. § 131E-177) to provide policies and projections of need for various types of healthcare facilities and services. Substantive policies applicable to Acute Care Hospitals are incorporated into the *SMFP*. The subject of this petition, Policy AC-5, titled Replacement of Acute Care Bed Capacity (excerpted below), is currently used by the Certificate of Need (CON) Section (the Agency) in its review of replacement acute care bed projects.

***Policy AC-5: Replacement of Acute Care Bed Capacity***

*Proposals for either partial or total replacement of acute care beds (i.e., construction of new space for existing acute care beds) shall be evaluated against the utilization of the total number of acute care beds in the applicant’s hospital in relation to utilization targets found below. For hospitals **not** designated by the Centers for Medicare & Medicaid Services as Critical Access Hospitals, in determining utilization of acute care beds, only acute care bed days of care shall be counted. For hospitals designated by the Centers for Medicare & Medicaid Services as Critical Access Hospitals, in determining utilization of acute care beds, only acute care bed days of care **and** swing bed days (i.e., nursing home facility days of care) shall be counted in determining utilization of acute care beds. Any hospital proposing replacement of acute care beds must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.*

*Additionally, if the hospital is a Critical Access Hospital and swing bed days are proposed to be counted in determining utilization of acute care beds, the hospital shall also propose to remain a Critical Access Hospital and must demonstrate the need for maintaining the swing bed capacity proposed within the application. If the Critical Access Hospital does not propose to remain a Critical Access Hospital, only acute care bed days of care shall be counted in determining utilization of acute care beds and the hospital must clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.*

<b>Facility Average Daily Census</b>	<b>Target Occupancy of Licensed Acute Care Beds</b>
1 – 99	66.7%
100 – 200	71.4%
Greater than 200	75.2%

Historically, Policy AC-5 applied if an applicant proposed to construct new space to replace existing beds on any campus on the hospital license. However, and as noted previously, the enactment of the “main campus exemption” under N.C. Gen. Stat. § 131E-184(g) (excerpted below)<sup>1</sup>, has in large part rendered Policy AC-5 superfluous.

*(g) The Department shall exempt from certificate of need review any capital expenditure that exceeds the two million dollar (\$2,000,000) threshold set forth in G.S. 131E-176(16)b.<sup>2</sup> if all of the following conditions are met:*

- (1) The sole purpose of the capital expenditure is to renovate, replace on the same site, or expand the entirety or a portion of an existing health service facility **that is located on the main campus.***
- (2) The capital expenditure does not result in (i) a change in bed capacity as defined in G.S. 131E-176(5) or (ii) the addition of a health service facility or any other new institutional health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.*
- (3) The licensed health service facility proposing to incur the capital expenditure shall provide prior written notice to the Department along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection.*

**[emphasis added]**

<sup>1</sup> Please note that the “main campus” exemption, N.C. Gen. Stat. § 131E-184(g), appeared for the first time in the 2014 SMFP following its enactment the previous year.

<sup>2</sup> While the cost threshold for “new institutional health services” established under N.C. Gen. Stat. § 131E-176(16)b doubled from \$2,000,000 to \$4,000,000 effective January 1, 2022, the reference to N.C. Gen. Stat. § 131E-176(16)b in N.C. Gen. Stat. § 131E-184(g) was not similarly amended and remains at \$2,000,000.

Following the enactment of the “main campus exemption” under N.C. Gen. Stat. § 131E-184(g), providers seeking to replace a portion of or all of their existing acute care beds on the main campus now may seek to do so through the exemption process rather than the CON process. In 2021 alone, 20 providers submitted exemption requests under the main campus exemption, at least two of which involved replacement acute care beds, including Blue Ridge’s exemption request to develop a replacement hospital tower at a cost of \$88 million as well as Novant Health Matthews Medical Center’s exemption request to develop a bed and surgical services tower at a cost of \$148,459,164. Given that providers seeking to replace existing acute care beds on the main campus no longer must do so via the CON process, they likewise no longer have to demonstrate conformity with Policy AC-5. As such, as a practical matter, Policy AC-5 applies only to those providers seeking to replace a portion of or all of their existing acute care beds that are not located on the main campus, and those providers must submit a CON application and demonstrate conformity with Policy AC-5 therein. Since the General Assembly has already determined that the vast majority of hospitals seeking to replace beds on their main campuses may do so without needing to “demonstrate the need for maintaining the acute care bed capacity” as contemplated in Policy AC-5, requiring the remaining hospitals seeking to replace beds to be evaluated against a specific target occupancy rate is inconsistent with that approach.

Further, as written, the policy actually places a burden on the “main campus” beds of a hospital when a portion of the hospital’s licensed beds are located off the main campus. For instance, if one of the hospitals listed below that are licensed as part of another hospital seek to replace beds on a non-main campus, the policy states that the evaluation of the need to replace those beds will be evaluated against the licensed beds of the hospital, which includes those beds located on the main campus. As such, the policy establishes a requirement to “demonstrate the need for maintaining the acute care bed capacity,” including those licensed beds on a main campus, because those beds are part of the same licensed hospital. This requirement is clearly incongruent with the intent of the exemption statute for main campuses.

Given the foregoing, Policy AC-5 is currently applicable to providers seeking to replace a portion of or all of their existing acute care beds at a new site that is not located on the main campus and facilities that are licensed as a campus of another acute care hospital facility and are not located on the “main campus” as designated on the hospital license. A review of the 2022 *SMFP* and applicable license renewal applications reveals that of the 108 licensed acute care hospitals in the state, there are 16 acute care hospital facilities (identified below) which are licensed as (or will be licensed as once developed) a campus of another acute care hospital facility and are not located on the “main campus” as defined in N.C. Gen. Stat. § 131E-176(14n).

- Atrium Health Kings Mountain, a facility of Atrium Health Cleveland
- Atrium Health Mercy, a facility of Carolinas Medical Center
- Atrium Health Steele Creek, a facility of Atrium Health Pineville
- Atrium Health Union West, a facility of Atrium Health Union (under development)
- Blue Ridge HealthCare Hospitals Valdese Campus, a facility of Blue Ridge HealthCare Hospitals Morganton Campus
- Central Harnett Hospital, a facility of Betsy Johnson Hospital
- Johnston Health Clayton, a facility of Johnston Health
- Maria Parham Franklin, a facility of Maria Parham Health
- New Hanover Regional Medical Center Orthopedic Hospital, a facility of New Hanover Regional Medical Center

- New Hanover Regional Medical Center – Scotts Hill, a facility of New Hanover Regional Medical Center
- Novant Health Charlotte Orthopedic Hospital, a facility of Novant Health Presbyterian Medical Center
- Novant Health Clemmons Medical Center, a facility of Novant Health Forsyth Medical Center
- Novant Health Kernersville Medical Center, a facility of Novant Health Forsyth Medical Center
- UNC Hospitals Hillsborough, a facility of UNC Hospitals
- UNC REX Holly Springs Hospital, a facility of UNC REX Hospital
- WakeMed North Hospital, a facility of WakeMed

Under the current application of Policy AC-5, if any of the facilities identified above were to seek to replace a portion of or all of its existing acute care bed capacity, not only would a CON be required, but such provider must also demonstrate conformity with Policy AC-5, which, in the context of the majority of replacement acute care beds (i.e., those located on a hospital’s main campus) being exempt from any review, is unneeded.

Blue Ridge believes Policy AC-5 is also problematic for other reasons that suggest it is outdated and needs to be deleted. Most notably, the recent pandemic and public health emergency has created the need for excess acute care bed capacity beyond that allowed by the policy. Many hospitals across the state were granted emergency approval for additional licensed bed capacity at the height of the pandemic, and all hospitals were impacted by high census and lack of sufficient beds at times. While the temporary use of space not designed for acute care beds may be necessary during a public health emergency, Blue Ridge believes that prudent planning should allow the development of sufficient space that is appropriate for acute care beds, even beyond what may be utilized during “normal” times. Another change in healthcare delivery that is not addressed in the policy is the increasing “admission” of patients to observation status, rather than as inpatients. As the SHCC is no doubt aware, patients admitted to observation status are often in a bed for up to two midnights but are not considered “inpatients” for calculating the utilization of acute care beds. Nonetheless, these patients require the same – or often more intensive – resources as inpatients, given the need to discharge them within such a short timeframe. While some facilities may operate dedicated observation bed units, given the current nursing shortage crisis, observation patients at Blue Ridge are typically housed in an acute care bed, where nursing and other staff can care for them most efficiently. Although the percentage of patients in a bed that are observation patients varies, a significant portion of the beds at any given time – often 10 to 20 percent or more – can be occupied by observation patients, yet the capacity needed to serve this growing cohort of patients is not considered by Policy AC-5.

**STATEMENT OF THE PROPOSED CHANGE**

Given the limited circumstances under which Policy AC-5 applies, as well as its limitations and failure to address the current needs of acute care hospitals as explained above, Blue Ridge requests that the policy be removed from the *2023 SMFP*. It is important to note that Blue Ridge is not suggesting that providers seeking to replace a portion of or all of their existing acute care beds that are not located on the main campus or facilities that are licensed as a campus of another acute care hospital facility and are not located on the “main campus” should be exempt from the CON process; indeed, it recognizes that such a change is beyond the scope of the SHCC’s authority. Rather, in such instances, Blue Ridge maintains that the need for such replacement can be determined in the context of the CON review process without the need for demonstrating conformity with Policy AC-5. In particular, the CON review would include an analysis of

the need for the replacement beds (under N.C. Gen. Stat. § 131E-183(a)(3)) and whether the project would result in unnecessary duplication (under N.C. Gen. Stat. § 131E-183(a)(6)). These criteria are applied in every CON review; thus, the deletion of Policy AC-5 would not result in an unneeded or unnecessarily duplicative project being developed. Rather, it would allow the CON Section to review the application for a non-main campus project without the specific capacity thresholds, which is still a higher level of review than that to which main campus projects are subjected.

While Blue Ridge believes that deleting the policy is the most effective approach, in the alternative, and at a minimum, Blue Ridge requests that the policy be amended to be consistent with the exemption statute. In particular, Blue Ridge believes that, minimally, the first sentence of Policy AC-5 should be amended as follows:

*Proposed*

Proposals to construct new space for either partial or total replacement of acute care beds under the same hospital license on either a new campus location or an existing campus location that does not have any acute care beds, regardless of the current location of the acute care beds to be replaced, shall be evaluated against the utilization of the total number of acute care beds under the applicant's hospital license in relation to utilization targets found below.

As an alternative, Blue Ridge offers the following amendment for consideration:

*Alternative*

Proposals to construct new space for either partial or total replacement of acute care beds on a campus other than the "main campus" (as that term is defined in N.C. Gen. Stat. § 131E-176(14n)), regardless of the current location of the acute care beds to be replaced, shall be evaluated against the utilization of the total number of acute care beds under the applicant's hospital license in relation to utilization targets found below.

**IMPACT OF THE PROPOSED CHANGE**

As previously shown, the current application of Policy AC-5 is limited and results in inequitable treatment of providers seeking to replace existing acute care bed capacity if such replacement does not occur on the main campus. This creates an unfair and unnecessary competitive advantage for providers who are able to replace existing acute care bed capacity on the main campus without falling under the restrictions of Policy AC-5. The proposed removal of the policy will eliminate this issue of concern.

In the alternative, the proposed revision to Policy AC-5 will serve to alleviate some confusion relative to the current application of the policy as it will clearly specify that Policy AC-5 will not apply in situations where existing acute care beds are being replaced in space that is otherwise exempt from CON review. That is, if a provider receives approval via an exemption request to build space to house replacement (existing) acute care beds on its main campus, Policy AC-5 would not apply – even if, by way of example, the replacement (existing) acute care beds were to be relocated from another acute care hospital campus on the same license (e.g., UNC Hospitals could apply for a CON to relocate existing acute care beds from UNC Hospitals Hillsborough Campus to a CON-exempt replacement tower at UNC Medical Center, which

is on UNC Hospital's main campus, without having to demonstrate conformity with Policy AC-5, but would still need to show conformity with the applicable Statutory Review Criteria).

Based on Blue Ridge's review of the 2022 SMFP and applicable license renewal applications, the proposed changes will alleviate or eliminate the issues of concern regarding the current application of Policy AC-5.

#### **REASONS FOR THE PROPOSED CHANGE**

The need for the proposed change is to promote an equitable approach to the replacement of existing acute care bed capacity. As noted previously, historically, Policy AC-5 applied if an applicant proposed to construct new space to replace existing beds on any campus on the hospital license. When originally established, Policy AC-5, which first appeared in the 1997 SMFP and required applicants proposing to replace existing acute care beds to meet certain occupancy thresholds, was intended to prevent the warehousing of acute care beds. Moreover, at the time, the planning assumptions under the acute care bed need methodology first identified any "high use hospital service systems" and then examined whether and to what extent such high use hospital systems required additional capacity. See page 33 of the 1997 SMFP. Resulting bed need for high use hospital service systems was determined based on increased occupancy rates. Now, the acute care bed need methodology assumptions no longer identify "high use hospital systems." Instead, the current assumptions specifically recognize that target occupancies of hospitals vary with average daily census. In order to project bed need, the current acute care bed need methodology analyzes the growth in acute care bed days in the service area over the last five reporting years by calculating the difference in the number of inpatient days of care provided from year to year. Ultimately, while Policy AC-5 may have been appropriate under the acute care bed need methodology as it appeared in the 1997 SMFP, given changes to the acute care bed need methodology since that time, as well as the evolution in the delivery of care described previously, Policy AC-5 is now outdated.

Second, the CON statute already offers a pathway for providers seeking to replace acute care bed capacity not on the main campus a way to do so under the CON review process. As noted previously, Blue Ridge maintains that the need for such replacement can be determined in the context of the CON review process without the need for demonstrating conformity with Policy AC-5.

Third, state policy should encourage replacement of aging hospital infrastructure and new types of room configurations (e.g. to accomplish better infection control, enhance technology support and allow more efficient staffing). The health care regulatory and reimbursement systems already include other controls on inpatient utilization, such as government reimbursement based on Diagnostic Related Group ("DRG") rather than length of stay, such that limiting replacement of existing bed capacity is not needed for this purpose. The critical need to assure accessible health care in congested urban areas and meaningful rural health care, increased use of telemedicine and remote treatment and surgical techniques, such as robotic surgery, also support the need for technologically and programmatically current acute care bed capacity on smaller campuses in different locations under the same hospital license rather than concentration of all hospital resources on one main campus.

Fourth, elimination of Policy AC-5 allows more prompt flexibility to consider the current health care climate, new approaches to care delivery and updated data on appropriate utilization levels rather than maintaining a rigid census target structure that may no longer reflect more recent data, research and experience.

Finally, as also described previously, the need for the proposed change is highlighted by the current healthcare climate. Of note, the ongoing COVID-19 pandemic has required acute care hospital providers to be flexible and to maintain capacity as needed in such abnormal situations. Given the importance of acute care capacity, particularly in the current healthcare environment, the ability for providers to maintain existing acute care bed capacity and flexibility is critical and should not be constrained by application of an outdated and superfluous policy in the *SMFP*.

#### **ADVERSE EFFECTS IF PETITION IS NOT APPROVED**

If Policy AC-5 remains unchanged, it will continue to have an adverse impact on acute care hospital facilities that seek to replace existing acute care bed capacity on a new site or at an existing facility that is licensed as a campus of another acute care hospital facility and not located on the “main campus.” More importantly, if providers that need to replace outdated acute care bed capacity are discouraged or prohibited from undertaking such projects, patients also will be adversely impacted.

As noted above, Policy AC-5 requires providers to “*clearly demonstrate the need for maintaining the acute care bed capacity proposed within the application.*” Notably, there is no requirement under Policy AC-5 that an applicant must achieve the requisite target occupancy rates within a specified timeframe. Without a change such as proposed in this petition, the providers that fall under Policy AC-5 as currently applied must not only demonstrate the need for the proposed replacement in the context of the CON review process (which Blue Ridge maintains is an appropriate burden to demonstrate relative to the replacement of existing beds), but also must demonstrate the need for maintaining such existing beds in accordance with Policy AC-5. Such an additional requirement is simply not necessary, particularly given the fact that such provider must already demonstrate the need in the context of the CON review process. Moreover, the additional requirement that a provider demonstrate conformity with Policy AC-5 when seeking to replace existing acute care beds on a new site or at an existing facility not designated as the “main campus” on its license may serve to unnecessarily prohibit existing providers from undertaking needed projects to replace existing acute care bed capacity.

If providers continue to serve patients in antiquated physical facilities, patients will be negatively impacted. Outdated physical facilities not only require more maintenance, but also may be configured in such a manner as to not support current healthcare delivery methods and/or equipment. New technology is constantly being developed for the healthcare industry. It is expected that new healthcare technologies will continue to emerge throughout the foreseeable future. Advances in technology require that hospitals acquire new and additional equipment in order to keep pace with modern standards of care. New technologies not only require more space, but also require the support of upgraded electrical systems and HVAC systems. Older physical structures may not be designed to accommodate, or even adapt to, the increased presence of equipment. As a result, such providers often are constrained with respect to the services they can provide their patients. As new technologies become available, outdated physical facilities are limited in their ability to support them. As a result, patients may be negatively impacted as existing, outdated facilities may not meet modern hospital design standards or be designed to best meet the needs of the community and adapt over time.

#### **ALTERNATIVES CONSIDERED**

As discussed in detail above, Blue Ridge believes that the current application of Policy AC-5 is not equitable as it places a greater burden on providers seeking to replace acute care bed capacity not on the main campus. As a result, Blue Ridge maintains that the most effective approach is to eliminate Policy AC-5

from the 2023 SMFP. However, and as noted previously, in the alternative, Blue Ridge requests that the first sentence of Policy AC-5 be amended as follows:

Proposals to construct new space for either partial or total replacement of acute care beds under the same hospital license on either a new campus location or an existing campus location that does not have any acute care beds, regardless of the current location of the acute care beds to be replaced, shall be evaluated against the utilization of the total number of acute care beds under the applicant's hospital license in relation to utilization targets found below.

This alternative, while inferior to elimination of the policy as requested in this petition, would promote equitable treatment of all providers seeking to replace existing acute care bed capacity as it would eliminate the need for providers to demonstrate conformity with Policy AC-5 when replacing existing acute care bed capacity in CON-exempt space, whether or not on the main campus designated on the hospital's license.

#### **UNNECESSARY DUPLICATION**

Blue Ridge does not believe the proposed change will result in unnecessary duplication of health resources. As noted above, Blue Ridge is not suggesting that providers seeking to replace a portion of or all of their existing acute care beds that are not located on the main campus or facilities that are licensed as a campus of another acute care hospital facility and are not located on the "main campus" be exempt from the CON process. Rather, in such instances, Blue Ridge maintains that the need for such replacement can be determined in the context of the CON review process without the need for demonstrating conformity with Policy AC-5. As noted above, applicants seeking to replace beds other than on the main campus (and over the prevailing capital threshold) would still need to obtain a CON, which would include demonstrating that the project would not result in unnecessary duplication under Statutory Review Criterion 6, N.C. Gen. Stat. § 131E-183(a)(6).

#### **BASIC PRINCIPLES**

Blue Ridge believes the petition is consistent with the three basic principles: safety and quality, access, and value.

##### Safety and Quality

Providers that are able to replace acute care bed capacity as needed (via the CON review process) will be able to provide safer and higher quality services compared to those confined to existing outdated facilities. Notably, outdated physical facilities may be configured in a manner that does not support current healthcare delivery methods and/or equipment. As a result, patients may be forced to seek care elsewhere. If patients and physicians are forced to access care at another facility with modern physical facilities and available capacity, they may encounter disruptions in continuity of care. Physicians and providers work every day to improve the systems of care which leverage information technology, multidisciplinary teams, and processes of care to deliver the right care at the right time to the right person. A facility under the control of another healthcare system cannot provide the same continuity of care to an unfamiliar physician and patient. As a result, safety and quality may be reduced without the proposed change.



### Access

The proposed change will enable providers to replace existing acute care bed capacity without having to demonstrate conformity with an outdated and superfluous *SMFP* policy, Policy AC-5. This will allow for replacement of existing acute care bed capacity when needed (as demonstrated via the CON review process) and will improve access to modern acute care hospital services throughout the state.

### Value

As noted previously, providers that are able to replace acute care bed capacity as needed (via the CON review process) will be able to provide safer and higher quality services compared to those confined to existing outdated facilities. Notably, as it relates to healthcare value, outdated physical facilities require more maintenance, which results in additional expenses. In addition, and as noted above, outdated physical facilities may be configured in a manner that does not support current healthcare delivery methods and/or equipment. The proposed change will help ensure that modern, state-of-the-art acute care hospital services are available for patients. As a result, the proposed change will allow providers to offer greater healthcare value.

### **CONCLUSION**

In conclusion, Blue Ridge asks the SHCC to approve this petition to remove Policy AC-5 from the *2023 SMFP* or, alternatively, to amend it as proposed. Ultimately, removing Policy AC-5 from the *2023 SMFP* (or amending it) will serve to eliminate or alleviate the issues of concern regarding the current application of Policy AC-5.

Thank you for your consideration.