Comments on High Point Regional Health's Freestanding Emergency Department Certificate of Need Applications, Project IDs # G-012702-25 and G-012711-25

Comments on Guilford County
Freestanding Emergency Department Applications

submitted by

High Point Regional Health

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), The Moses H. Cone Memorial Hospital Operating Corporation (Cone Health) hereby submits the following comments related to two concurrent applications filed by High Point Regional Health (HPMC) to develop two freestanding emergency departments (FSEDs) in Guilford County. The locations for the two proposed FSEDs are 4007 South Elm-Eugene Street in southern Greensboro (Project ID # G-012702-25) and 3800 North Church Street in northeastern Greensboro (Project ID # G-012711-25).[1] Cone Health's comments include "*discussion and argument regarding whether, in light of the material contained in the applications and other relevant factual material, the applications comply with the relevant review criteria, plans and standards*." *See* N.C. GEN. STAT. § 131E-185(a1)(1)(c). In order to facilitate the Agency's ease in reviewing these comments, Cone Health has organized its discussion by issue, specifically noting the general Certificate of Need (CON) statutory review criteria and regulations creating the non-conformity of each issue, as they relate to one or both of HPMC's applications. Cone Health's comments include issue-specific comments on the two HPMC applications, detailing substantial issues that Cone Health believes render both applications non-conforming with applicable statutory and regulatory review criteria.

[1] The parent or holding company of the applicant is Wake Forest University Baptist Medical Center.

GENERAL COMMENTS

As detailed in the following issue-specific comments, Cone Health believes that the concurrent FSED applications submitted by HPMC exhibit numerous flaws and inappropriate assumptions that render the respective methodologies and projections both unreasonable and unsupported. First, the N. Church Street and S. Elm-Eugene Street locations proposed as the sites of the two prospective FSEDs are in close geographic proximity not only to each other but also to the approved but not yet developed Greensboro Medical Center (GMC) (Project ID # G-12330-23), which will also offer emergency care services. This results in significant overlap between the three facilities' services areas (SAs), overlap which is inadequately addressed in either the narrative or the capture rates and volume adjustments applied in the two applications' projections. With the two proposed FSEDs both opening in January 2028 and the approved but not yet developed hospital ED opening only a year later in January 2029, these three projects would result in unnecessary duplication.

The General Assembly explicitly defined unnecessary duplication as *'the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services,'* and further found that *'excess capacity of health service facilities places an enormous economic burden on the public who pay for the construction and operation of these facilities as patients, health insurance subscribers, health plan contributors, and taxpayers.'* N.C. GEN. STAT. § 131E-175(4) and (6).[2] HPMC's proposal to develop two nearly identical FSEDs with substantial service area overlap, combined with the previously approved GMC facility, all within a 13-month period, exemplifies precisely this type of unnecessary proliferation and excess capacity in overlapping service areas where actual acuity-adjusted ED visit utilization is declining.

Additionally, the narrative of the two applications puts forth several claims with respect to ED capacity constraints that are easily refuted using the applicant's own data. By emphasizing minimum capacity thresholds at HPMC's main hospital and affiliated Atrium Health Wake Forest Baptist (AHWFB) hospitals, calculated according to American College of Emergency Physician (ACEP) recommendations, the applicant misrepresents the capacity available systemwide and at HPMC specifically, which operates below even the minimum ACEP threshold. Similarly, general patient survey data cited by the applicant as evidence of ED crowding indicate a situation more accurately characterized by operational challenges, one that would be more effectively addressed through care delivery and protocol reform than new facility projects. It is also crucial to note that throughout the qualitative and quantitative portions of the concurrent applications, HPMC fails to demonstrate need for the proposed services in the defined SAs, focusing on countywide population growth and aging while ignoring SA-specific rates showing decline and deceleration in acuity-adjusted ED visit growth. Additionally, by developing FSEDs without the justification of proven need in the identified SAs, the proposed projects would also threaten staffing constraints at existing ED providers, harming competition without improving access for Guilford County residents.

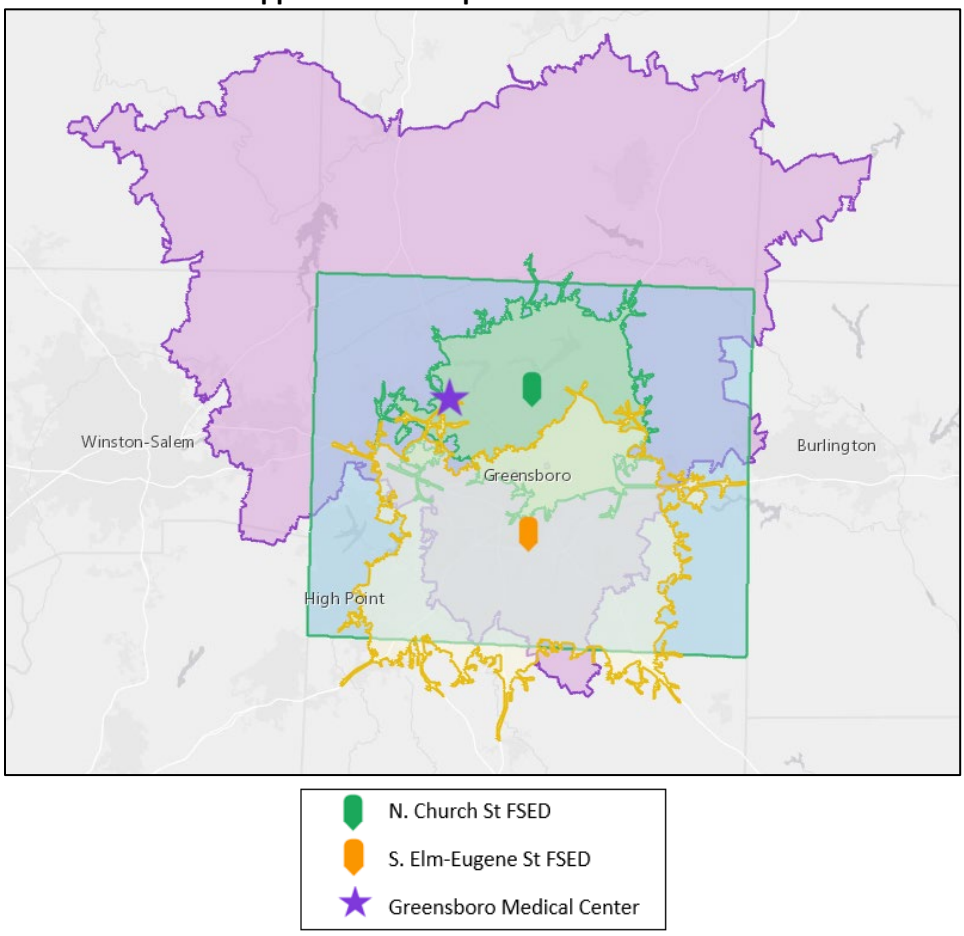
[2] N.C. GEN. STAT. § 131E-175. Findings of fact. https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_131E/GS_131E-175.pdf.

ISSUE-SPECIFIC COMMENTS

1. <u>Two nearly identical FSEDs serving overlapping populations create unnecessary duplication that is only compounded by the approved GMC facility opening one year later.</u>

One of the key issues resulting in the two applications' nonconformity with CON criteria is the fact that the proposed N. Church Street FSED, the proposed S. Elm-Eugene Street FSED, and the approved GMC hospital facility are closely located and would reasonably have a mutual impact on each other's utilization. In turn, **the collective effect of opening the two proposed and one approved ED facilities would be to create excess capacity in a concentrated area, capacity that is disproportionate to demonstrable need and therefore unnecessarily duplicative**. According to Google maps, analysis of drive times between the three facilities shows that the proposed N. Church Street FSED would be approximately 20 minutes or 12 miles away from the proposed S. Elm-Eugene Street FSED. With respect to GMC, the ED services at the hospital would be **only 12 minutes or 7 miles from the N. Church Street FSED** and **22 minutes or 18 miles from the S. Elm-Eugene Street FSED**. As shown in the map below depicting 15-minute drive-time radii (DTR) for the two FSEDs and the identified SA for GMC, the proximity of the sites gives rise to significant overlap in the populations projected to be served by each individual facility.

Approved and Proposed HPMC ED Facilities



Source: Esri.

As stated in the N. Church Street FSED and S. Elm-Eugene Street FSED applications, the former defines a SA comprised of fourteen ZIP codes while the latter defines a larger SA made up of twenty-three ZIP codes based on drive times of 15 minutes. **Between these two SAs, ten ZIP codes are shared**, representing 71.4 percent of the N. Church Street FSED SA and 43.5 percent of the S. Elm-Eugene Street FSED SA. In relation to GMC**, all fourteen, or 100 percent of the ZIP codes belonging to the N. Church Street FSED SA overlap** with those projected to be served by the hospital ED. Although GMC and the proposed S. Elm-Eugene Street FSED exhibit less overlap in SAs, both still **share twelve of the same ZIP codes**, the equivalent of 52.2 percent of the S. Elm-Eugene Street FSED's SA. As illustrated by the table below, if the two FSEDs are approved and developed, patients residing in ten Greensboro ZIP codes (27249, 27301, 27401, 27403, 27405, 27406, 27407, 27408, 27409, and 27410) will have access to three new AHWFB facilities providing emergency services, in addition to existing EDs, including those operated by other health systems.

Overlapping Projected Primary Service Area ZIP Codes

Proposed N. Church St.	*Proposed S. Elm-Eugene St.*	*Approved GMC*
27214		27214
	27235	27235
27249	27249	27249
27301	27301	27301
	27313	27313
27320		27320
27358		27358
27401	27401	27401
27403	27403	27403
27405	27405	27405
27406	27406	27406
27407	27407	27407
27408	27408	27408
27409	27409	27409
27410	27410	27410

Source: N. Church St. FSED CON application, p. 30; S. Elm-Eugene St. FSED CON application, p. 30-31; GMC CON application, p. 51-52.

Analysis of the population inhabiting the ten overlapping ZIP codes shared by the proposed FSED SAs, as well as the GMC SA, only further demonstrates the likelihood of double-counting in the two applications' volume projections. As illustrated in the table below, these ten ZIP codes collectively represent 331,742 residents, which is the equivalent of 62.2 percent of the 533,311 residents currently living within the twenty-three ZIP codes identified for the S. Elm-Eugene Street FSED SA, and 76.9 percent of the 431,385 residents living within the fourteen ZIP codes identified for the N. Church Street FSED SA.

Population Residing in Overlapping FSED Service Area ZIP Codes

ZIP Code	*2025 Population*
27249	14,457
27301	10,858
27401	22,936
27403	24,040
27405	53,434
27406	63,081
27407	49,836
27408	17,326
27409	19,801
27410	55,973
Total	**331,742**

Source: N. Church St. FSED CON application, p. 40; S. Elm-Eugene St. FSED CON application, p. 40.

Furthermore, given the degree of similarity in the design of the two proposed FSEDs, there is little to nothing differentiating one from the other. From the square footage (11,532) to the infrastructure and resources – each would operate the same number of ED exam rooms (8) and provide access to the same suite of imaging equipment (CT scanner, fixed and portable x-rays, ultrasound units) – the FSED facilities are virtually identical. The acuity levels projected to be served at the two locations are also the same, ranging from low to moderate acuity (levels 1 to 4).

In planning for the FSED, HPMC evaluated the levels of ED care that are provided to local residents at hospital EDs. At the proposed FSED, HPMC envisions predominantly seeing ED patients at acuity levels 1 - 4, according to the following ED visit acuity scale.

ED Visit Acuity Levels

CPT Code	Level of Service	Complexity	Typical Use Case
99281	Level 1	Straightforward	Minor issues, minimal risk
99282	Level 2	Low complexity	Simple infections, minor injuries
99283	Level 3	Moderate complexity	Conditions requiring more evaluation (e.g., asthma)
99284	Level 4	Moderate to high complexity	More serious conditions needing multiple interventions
99285	Level 5	High complexity	Life-threatening or potentially serious conditions
99291	Level 6	Critically Ill	Evaluation, management, monitoring, and treatment of complex medical conditions requiring immediate attention

Source: N. Church St. FSED CON application, p 118.; S. Elm-Eugene St. FSED CON application, p. 120.

Despite HPMC's identification of two supposedly distinct SA populations, contradicted by the reality of ten shared ZIP codes and more than 330,000 residents living within reach of both proposed facilities, there is no explanation demonstrating how each facility meets a unique need or why a patient would choose to seek care at one location versus the other, especially for populations where the facilities would be roughly equidistant.

In light of the significant overlap in SAs as well as the generally indistinguishable features of the proposed N. Church Street and S. Elm-Eugene Street FSEDs, HPMC fails to reasonably adjust for the presence and draw of each facility within the other's SA.

With respect to the terminology used throughout HPMC's concurrent applications, it is important to note that the word "shift" does not represent internal patient movement within the HPMC system. These volumes represent market share capture from "local hospital EDs", including those operated by competing providers. The applications do not distinguish between volumes HPMC already serves and those that would be captured from competing providers (N. Church Street application, p. 121; S. Elm-Eugene Street application, p. 124).

On page 129 of the S. Elm-Eugene Street FSED methodology, HPMC claims that its projected utilization tables for CY 2028, CY 2029, and CY 2030 "each reflect an adjustment to account for capture of some ED patients by the N. Church Street FSED from the overlapping ZIP codes in the identified FSED service area. HPMC estimates that 10% of these would overlap with the projected N. Church Street FSED ED visits, and thus accrue to the N. Church Street FSED." HPMC's adjustments for the S. Elm-Eugene Street FSED for each of the three project years are summarized in the table below.

S. Elm-Eugene St. FSED Adjustments

	CY2028	***CY2029***	***CY2030***
Shift Volume	10,858	12,897	14,364
N. Church St. Adjustment	853	1,007	1,108
GMC Adjustment	0	787	873
S. Elm-Eugene St. Final Total	10,005	11,102	12,382

Source: S. Elm-Eugene Street FSED CON p. 125-127.

In actuality, the adjustments of 853, 1,007, and 1,108 ED visits in CY 2028, CY 2029, and CY 2030 fall below the stated 10 percent overlap, and represent 7.9 percent, 7.8 percent, and 7.7 percent, respectively, of the total FSED-appropriate volumes projected to shift. **This mathematical inconsistency demonstrates that HPMC cannot accurately calculate even the minimal adjustments it claims to make, further undermining the reliability of its projections.**

Similarly, the N. Church Street FSED adjustments fall short of HPMC's stated assumptions. On page 125 of the N. Church Street FSED methodology, HPMC offers claims regarding adjustments to account for overlap, estimating that only "3% of [ED patients from shared ZIP codes] would overlap with the projected S. Elm-Eugene Street FSED visits." However, the actual adjustments of 219, 260, and 288 ED visits in CY 2028, CY 2029, and CY 2030 represent only approximately 2.5 percent of the total acuity-adjusted shift volume, again falling short of even the minimal stated overlap assumption.

N. Church St. FSED Adjustments

	CY2028	***CY2029***	***CY2030***
Shift Volume	8,704	10,313	11,412
S. Elm-Eugene St. Adjustment	219	260	288
GMC ED Adjustment	0	964	1,068
N. Church St. Final Total	8,484	9,088	10,057

Source: N. Church Street FSED CON p. 122-124.

When the N. Church Street and S. Elm-Eugene Street FSED adjustments are summed and divided by the total acuity-appropriate ED volume to be shifted, this results in an overlap of just 5.5 percent, an unrealistic figure that is highly out of proportion to the actual degree of geographic and population overlap represented by ten shared ZIP codes. Moreover, HPMC's stated overlap assumptions (10 percent and 3 percent) do not match the actual calculations shown in its own applications (7.7-7.9 percent and approximately 2.5 percent, respectively), demonstrating fundamental methodological errors that permeate both applications' projections. The effect of HPMC's understated adjustments is only further compounded when considered alongside those made for the future GMC ED services.

For these reasons, the applications are nonconforming with Criteria 3, 4, 5, 6, and 18a and should not be approved.

2. <u>The applications fail to adequately adjust for GMC's 20-treatment-bay hospital ED, grossly understating its impact and rendering both FSED projections unreasonable.</u>

Originally filed in 2023 with the Certificate of Need issued in July 2024, HPMC's GMC application proposed to establish a 36-bed acute care community hospital that would also provide emergency care via 20 ED treatment bays. This facility is set to begin offering services in January 2029, approximately one year after the start date for the proposed N. Church Street and S. Elm-Eugene Street FSEDs. The table below has been excerpted from the GMC application and shows the projected number of ED visits to be served at the facility, increasing from over 16,700 ED visits in FY 2027 to more than 20,700 ED visits in FY 2029. HPMC utilizes the original PY3 (FY 2029) ED visit projections from the 2023 application to calculate volume adjustments at the proposed FSED facilities.

Projected ED Visits at Greensboro Medical Center

	FY2027	FY2028	FY2029
Total GMC Discharges	1,669	1,865	2,065
Total GMC Discharges Admitted via ED	1,242	1,388	1,537
% of ED Visits Admitted	7.41%	7.41%	7.41%
Projected ED Visits at GMC	**16,757**	**18,731**	**20,736**

Totals may not foot due to rounding.

Source: HPMC GMC CON application, p. 154

While the methodologies of the two recently submitted applications acknowledge the opening of the hospital and its future delivery of ED care, the corresponding adjustments in FSED volume projections are simply unrealistic. To facilitate evaluation of HPMC's actual adjustments for the impact of GMC's ED services, Cone Health has calculated what it believes to be more reasonable adjustments for the number of ED visits that would shift from the two FSED locations to GMC following that facility's opening.

Cone Health's Recalculated S. Elm-Eugene St. Adjustments

The following table summarizes the acuity-adjusted SA shift volume projected for the proposed S. Elm-Eugene Street FSED as well as the adjustments HPMC applied to account for the simultaneous opening of the N. Church Street facility and GMC's opening approximately a year later.

S. Elm-Eugene St. FSED Projected Shift Volume and Adjustments

	CY2028	*CY2029*	*CY2030*
Shift Volume	10,853	12,897	14,364
N. Church St. Adjustment	853	1,007	1,108
GMC ED Adjustment	0	787	873
S. Elm-Eugene St. Final Total	10,005	11,102	12,382

Source: S. Elm-Eugene Street FSED CON application, p. 125-127.

Notably, HPMC adjusts for GMC by only 787 visits in CY 2029 (PY1 for GMC and PY2 for the S. Elm-Eugene Street FSED), increasing to 873 visits in CY 2030. On page 128 of the application, HPMC justifies these figures by claiming a 47.9 percent overlap in SA markets and a limited 10 percent overlap in projected acuity-adjusted ED visits, disregarding the twelve shared ZIP codes between the two facilities and the hospital's operating more than twice as many ED bays and having a broader overall scope of services.

> In 2023 the Agency approved a Certificate of Need application submitted by High Point Medical Center to develop an additional hospital campus in Greensboro (identified as Greensboro Medical Center, CON Project ID# G-12330-23)[30]. The GMC facility is planned to become operational in 2029, and will include an emergency room. Therefore, the previous tables for CY2029 and CY2030 reflect an adjustment to account for capture of some ED patients by GMC from the identified S. Elm-Eugene Street FSED service area. For example, HPMC projected 20,736 GMC ED visits in CY2030. 47.9% of those visits were projected from ZIP Codes within the S. Elm-Eugene Street FSED service area, 95% of the visits would be acuity-appropriate for the FSED, and HPMC estimates that 10% of these would overlap with the projected FSED ED visits. Thus, (20,736 * .479) * .95 * .1 = 873.
>
> Source: S. Elm-Eugene Street FSED CON application p. 128

To produce a more reasonable alternative to HPMC's calculations, Cone Health first multiplied GMC's projected ED visits by the stated 47.9 percent capture rate, resulting in 9,933 ED visits from the overlapping S. Elm-Eugene Street SA ZIP codes (20,736 x 0.479 = 9,933 visits). Next, Cone Health isolated visits representing FSED-appropriate acuity levels, applying HPMC's own assumption of a 95 percent rate, resulting in a little over 9,400 ED visits (9,933 x 0.95 = 9,436). In other words, despite an overlap of over 9,400 visits that could choose to go to either location – GMC or the S. Elm-Eugene Street FSED – HPMC assumes that only 10 percent would choose to go to a community hospital and that 90 percent would choose the FSED. This would include Level 4 visits, described as Moderate to High Complexity/More Serious Conditions Needing Multiple Interventions.

With no reasonable basis for the 10 percent assumption that is grossly understated, any reasonable assumption – though variable – would have a significant impact on the need and financial feasibility of the FSED.

Allowing for a certain amount of variation in capture rates between the FSED and hospital ED, Cone Health calculated potential adjustments for three different scenarios: 1) 50/50 division of ED visits; 2) 40/60 division of ED visits, favoring GMC; and 3) 30/70 division of ED visits, favoring GMC.

Recalculated S. Elm-Eugene Street Adjustments for GMC

Facility	*Capture Rate*	*Acuity-adjusted ED Visits*
S. Elm-Eugene St. FSED	50%	4,718
Greensboro Medical Center	50%	4,718
S. Elm-Eugene St. FSED	40%	3,774
Greensboro Medical Center	60%	5,662
S. Elm-Eugene St. FSED	30%	2,831
Greensboro Medical Center	70%	6,605

Compared against this range of adjustment values, HPMC's actual adjustment of 873 visits in CY 2030 is grossly understated and would be more realistically increased to some 4,700 visits, assuming an equal 50 percent distribution of acuity-appropriate ED patients, or 6,600 visits, assuming a distribution that favors GMC by 70 percent.

Cone Health's Recalculated N. Church St. Adjustments

The following table summarizes the acuity-adjusted SA shift volume projected for the proposed N. Church Street FSED as well as the adjustments HPMC applied to account for the simultaneous opening of the S. Elm-Eugene facility and GMC's opening approximately a year later.

N. Church St. FSED Projected Shift Volume and Adjustments

	CY2028	*CY2029*	*CY2030*
Shift Total	8,704	10,313	11,412
S. Elm-Eugene St. Adjustment	219	260	288
GMC ED Adjustment	0	964	1,068
N. Church St. Final Total	8,484	9,088	10,057

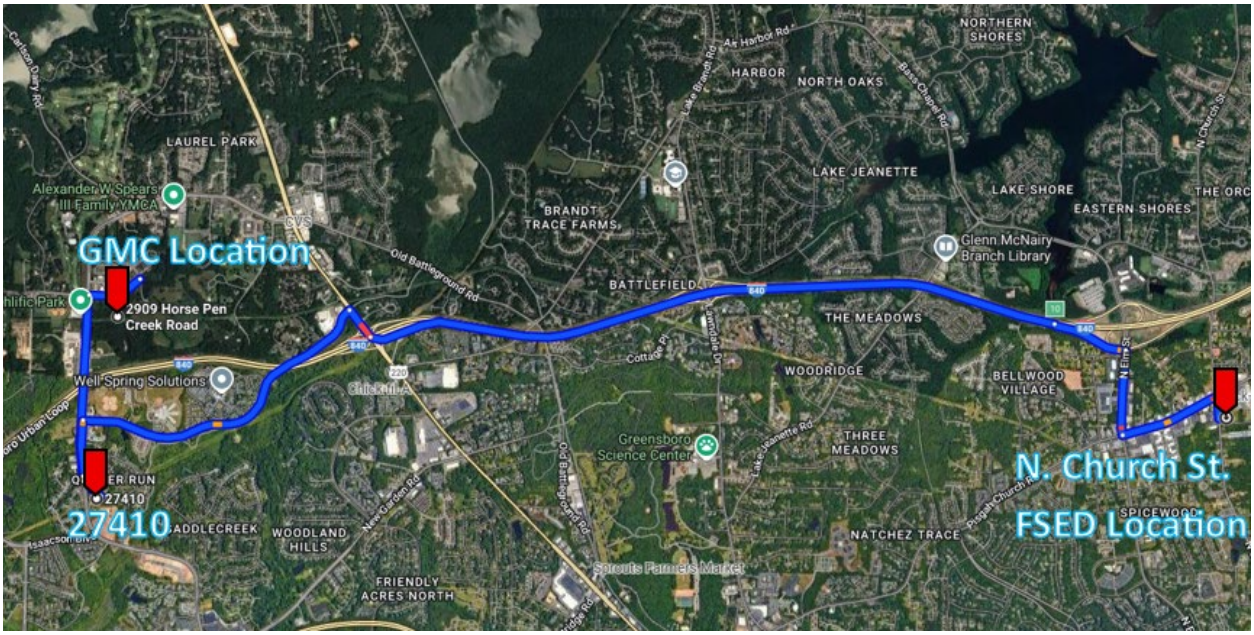
Source: N. Church Street FSED CON application, p. 122-124.

As with the S. Elm-Eugene Street facility, HPMC minimizes GMC adjustments for the N. Church Street FSED, projecting an impact of only 964 ED visits in CY 2029 and 1,068 ED visits in CY 2030. On page 124 of the application, HPMC justifies these adjustments by claiming an overlap of only 54.2 percent in SA markets, the same 95 percent rate for acuity-appropriate visits, and **a mere 10 percent overlap in projected acuity-adjusted ED visits, ignoring the fact that the two facilities are a mere 7 miles apart, or 12 minutes away.**

> In 2023 the Agency approved a Certificate of Need application submitted by High Point Medical Center to develop an additional hospital campus in Greensboro (identified as Greensboro Medical Center, CON Project ID# G-12330-23)[30]. The GMC facility is planned to become operational in 2029, and will include an emergency room. Therefore, the previous tables for CY2029 and CY2030 reflect an adjustment to account for capture of some ED patients by GMC from the identified N. Church Street FSED service area. For example, in CY2030 HPMC projected 20,736 GMC ED visits. 54.2% of those visits were projected from ZIP Codes within the N. Church Street FSED service area, 95% of the visits would be acuity-appropriate for the FSED, and HPMC estimates that 10% of these would overlap with the projected FSED ED visits. Thus, (20,736 * .542) * .95 * .1 = 1,068.

Source: N. Church Street FSED CON application, p. 124.

Additionally, as pointed out in Issue 1 of these comments, the projected GMC SA encompasses the whole of the N. Church Street SA. **For many residents living in overlapping ZIP codes (e.g., 27407, 27409, 27410), GMC would also represent the more geographically proximate option**, as demonstrated in the following example comparing relative drive distances from the 27410 ZIP code.



Source: Google maps.

Cone Health calculated a range of reasonable adjustments for the N. Church Street FSED following the same methodology it applied in calculating its recommended S. Elm-Eugene Street FSED adjustments. Multiplying GMC's projected 20,736 ED visits by the assumption of a 54.2 percent overlap produces 11,239 ED visits originating from the N. Church Street SA (20,736 x 0.542 = 11,239). When adjusted to reflect low to moderate acuity levels, a rate of 95 percent, there are a resulting 10,677 FSED-appropriate ED visits to be distributed among the two facilities (11,239 x 0.95 = 10,677). In other words, despite an overlap of over 10,600 visits that could choose to go to either location – GMC or the S. Elm-Eugene Street FSED – HPMC assumes that only 10 percent would choose to go to a community hospital and that 90 percent would choose the FSED. This would include Level 4 visits, described as Moderate to High Complexity/More Serious Conditions Needing Multiple Interventions.

Similar to the S. Elm-Eugene Street facility, with no reasonable basis for the 10 percent assumption that is grossly understated, any reasonable assumption – though variable – would have a significant impact on the need and financial feasibility of the FSED.

Distribution of these 10,677 acuity-adjusted ED visits according to the 50/50, 40/60, and 30/70 scenarios described above produces the adjustment volumes shown in the table below.

Recalculated N. Church Street Adjustments for GMC

Facility	*Capture Rate*	*Acuity-adjusted ED Visits*
N. Church St FSED	50%	5,339
Greensboro Medical Center	50%	5,339
N. Church St. FSED	40%	4,271
Greensboro Medical Center	60%	6,406
N. Church St. FSED	30%	3,203
Greensboro Medical Center	70%	7,434

In comparison, HPMC's actual adjustment of 1,068 visits in CY 2030 is grossly understated and would be more realistically increased to around 5,300 visits, assuming an equal 50 percent distribution of acuity-appropriate ED patients, or around 7,400 visits, assuming a distribution that favors GMC by 70 percent.

The combined impact of Cone Health's recommended adjustments for the GMC ED would result in the loss of approximately 5,300 to 7,400 visits for the N. Church Street FSED and the loss of 4,700 to 6,600 visits for the S. Elm-Eugene Street FSED. **Measured against the adjustments HPMC actually applied, which total 1,941 visits, these more reasonable adjustments (10,000 to 14,000 visits) reveal a collective understatement of nearly 8,000 to 12,000 visits.** Without making any other changes to HPMC's CY 2030 projections for the two proposed facilities, this increased shift to GMC leaves the S. Elm-Eugene Street FSED with 6,600 to 8,500 acuity-adjusted ED visits while the N. Church Street FSED retains some 3,600 to 5,700 acuity-adjusted ED visits. The table below shows the remaining visits at each FSED location after the recommended adjustments for GMC have been applied, including figures for the three distribution scenarios previously described.

Remaining FSED Visits After Recalculated GMC Adjustments

Facility	*Capture Rate*	*Acuity-adjusted ED Visits*
S. Elm-Eugene St. FSED	50%	8,538
S. Elm-Eugene St. FSED	40%	7,594
S. Elm-Eugene St. FSED	30%	6,651
N. Church St. FSED	50%	5,785
N. Church St. FSED	40%	4,718
N. Church St. FSED	30%	3,690

Ultimately, neither the S. Elm-Eugene Street FSED nor N. Church Street FSED application accounts for patients choosing between three new competing AHWFB emergency options, nor do the applications take sufficient precautions against the risk of double-counting demand from overlapping ZIP codes. Thus, the applications failed to demonstrate the need the population has for the services proposed to be developed, failed to demonstrate that the two FSEDs would not result in unnecessary duplication, and failed to demonstrate financial feasibility based upon reasonable costs and charges.

For these reasons, both applications are nonconforming with Criteria 3, 4, 5, 6, and 18a, and should not be approved.

3. <u>The applicant's own data demonstrate that ED growth rates across the AHWFB system and proposed FSED SAs have stalled or declined, contradicting claims that there is a need for the proposed facilities.</u>

One of the many flaws contained in HPMC's quantitative arguments regarding need and capacity constraints, both FSED applications reference AHWFB ED data beginning in CY 2021, a year generally perceived as reflective of the suppressed utilization trends caused by the COVID-19 pandemic. By including this year as a baseline, HPMC artificially inflates its four-year compound annual growth rates (CAGRs), misrepresenting recovery in the years after the pandemic as organic growth.

Atrium Health Wake Forest Baptist
Historical Emergency Department Visits, CY2021 - CY2025

Facility	CY2021	CY2022	CY2023	CY2024	CY2025*	4-Year CAGR
DMC	20,906	25,963	29,007	27,722	29,038	8.56%
HPMC	**45,965**	**46,099**	**50,201**	**51,631**	**52,843**	**3.55%**
LMC	33,527	34,612	35,118	35,464	34,809	0.94%
NCBH	94,502	99,169	101,772	101,746	102,093	1.95%
Combined Total	194,900	205,843	216,098	216,563	218,782	2.93%

*Annualized based on seven months data (January – July)

Source: AHWFB internal data

Source: N. Church St. FSED CON application, p 115.; S. Elm-Eugene St. FSED CON application, p. 117.

Closer examination of ED visits across four AHWFB hospitals during the same four-year period **reveals slowing growth** as evidenced by a significant decline from 5.6 percent compounded annual growth for 2021 to 2022 to just 1.0 percent for 2024 to annualized 2025.

AHWFB ED Visits Annual Growth Rates

2021-2022	*2022-2023*	*2023-2024*	*2024-2025**
5.6%	5.0%	0.2%	1.0%

*Note: 2025 annualized based on seven months data (January – July)

This **systemwide deceleration in ED visit growth is also notable at the flagship HPMC hospital facility**, where growth has stalled from 8.9 percent for 2022 to 2023 to 2.3 percent during the 2024 to 2025 annualized period.

HPMC ED Visits Annual Growth Rates

2022-2023	*2023-2024*	*2024-2025**
8.9%	2.8%	2.3%

*Note: 2025 annualized based on seven months data (January – July)

Further analysis demonstrates that these **patterns of consistently flat or negative growth are also present in the smaller, more defined N. Church Street and S. Elm-Eugene Street SAs**. In fact, the HIDI data cited in both applications show that the number of acuity-adjusted ED visits originating from the SAs for the two proposed FSEDs have decreased. From 2023 to 2024 specifically, there was a 3.5 percent decrease in ED

visits from the S. Elm-Eugene Street SA and a 1.8 percent decrease in ED visits from the N. Church Street SA.

N. Church Street and S. Elm-Eugene Street SA Growth Rates

SA	*2022*	*2023*	*2024*	*2023-2024 Change*	*2-Year CAGR*
N. Church Street	95,133	97,815	96,031	**-1.8%**	0.47%
S. Elm-Eugene Street	124,974	129,595	124,991	**-3.5%**	0.01%

Source: N. Church Street FSED CON application, p. 119; S. Elm-Eugene Street FSED CON application, p. 121.

Even in the context of the positive two-year CAGRs, overall growth for these two SAs is essentially flat from 2022 to 2024, less than half a percent for the N. Church Street SA and only one hundredth of a percent for the S. Elm-Eugene Street SA. As the most immediately relevant metric to identify need, these circumstances contradict HPMC's general arguments concerning increased demand and call both applications' volume projections and growth assumptions into question.

For these reasons, both applications are non-conforming with Criteria 3, 4, 5, 6, and 18a and should not be approved.

4. <u>The applications' methodologies rely on unsupported and unreasonable market share capture assumptions contradicted by declining utilization and internal inconsistencies.</u>

In addition to the ZIP code-based SAs already described in Issue 1, the applicant identifies three distinct distance-based zones to project volumes for the proposed FSEDs during the first three years of operation. Zone 1 is defined as the full or partial ZIP codes that fall within a zero to 10-minute drive time, Zone 2 includes those within a 10- to 15-minute drive time, and Zone 3 includes those outside a 15-minute drive time. As stated on page 121 of the N. Church Street FSED application and 124 of the S. Elm-Eugene Street FSED application, the applicant expects a ramp up in volumes originating from each of these three zones, such that Zone 1 will capture 20.0 percent of acuity-adjusted ED visits in PY1 increasing to 24.0 percent by PY3, while Zone 2 will ramp up from 10.0 percent to 14.0 percent and Zone 3 will ramp up from 1.0 percent to 1.5 percent during the same timeframe. As previously stated, the applications describe the projected volumes calculated using this methodology as "shifts" (i.e., market share capture) from "local hospital EDs" (N. Church Street application, p. 121; S. Elm-Eugene Street application, p. 124), meaning these projections represent volumes diverted from competing providers, including Cone Health.

Patient Shift Percentages, CY2028 – CY2030

	Zone 1	Zone 2	Zone 3
CY2028	20.0%	10.0%	1.0%
CY2029	23.0%	12.0%	1.25%
CY2030	24.0%	14.0%	1.5%

Source: N. Church St. FSED CON application, p 121.; S. Elm-Eugene St. FSED CON application, p. 124.

While HPMC characterizes its volume projections as "reasonable and conservative" based on a 1.11 percent population growth rate, the actual methodology produces dramatically different results. The combination of zone-based 'ramp-up' percentages and minimal adjustments for competing facilities results in effective compound annual growth rates of 8.9 percent for the N. Church Street FSED and 11.3 percent for the S. Elm-Eugene Street FSED – rates that are **8 to 10 times higher** than the stated

“conservative” baseline. This disconnect reveals that what HPMC labels as gradual facility 'ramp-up' is actually aggressive market share capture from existing providers, including Cone Health. The applications fail to reconcile this fundamental inconsistency between claiming conservative growth assumptions while simultaneously projecting market share gains that far exceed organic population-driven demand growth.

Notably, the applications do not explain how the percentage allocation of each ZIP code to each zone was determined. The applications state only that the allocations are "based on geography," but fail to specify whether this refers to total surface area, population distribution within the drive-time boundaries, or some other metric. This lack of transparency makes it impossible to evaluate the reasonableness of the zone assignments or to replicate the methodology. Moreover, the “shift” (e.g., market share capture) assumptions applied uniformly across each zone do not account for the declining utilization trends observed in the service areas or for the impact of three competing AHWFB facilities opening within 13 months.

While “shift” (e.g., market share capture) assumptions based on drive-time zones can be a reasonable approach when properly supported, HPMC's projected capture rates are contradicted by actual historical utilization data showing declining ED visits in both service areas (−1.8 percent and −3.5 percent respectively). The applications fail to explain how these capture rates can be achieved when actual demand in the service areas is declining. The applications' failure to demonstrate support for the “shift” (e.g., market share capture) assumptions is highlighted by the fact that the applications do rely on AHWFB's actual experience for other projections. For example, for ancillary services, the applications cite "historic experience at existing Atrium Health CMHA satellite ED locations" to project the number of patients that will receive X-rays, ultrasounds, and CT scans. This selective use of empirical data undermines the overall quality and reliability of the applications' projections and suggests that actual ED visit market share data from comparable facilities, if included, would not support the stated capture rate assumptions.

Moreover, the zone-based 'ramp-up' assumptions HPMC applies are fundamentally inconsistent with the applicant's claimed reliance on conservative 1.11 percent population growth. While HPMC frames these escalating capture percentages (from 20.0 percent to 24.0 percent in Zone 1 and 10.0 percent to 14.0 percent in Zone 2) as a natural ramp-up of a new facility, this framing obscures the reality that the projected volumes represent aggressive market share capture from existing providers. As demonstrated in the tables below, the applications project that the two FSEDs will collectively serve 22,439 acuity-adjusted ED visits by PY3, yet organic market growth in the combined service areas during this period produces only 12,564 additional visits. **This 10,000-visit gap can only be achieved through significant diversion from existing providers – not through population growth or gradual facility maturation.** By characterizing what is effectively aggressive market share capture as conservative 'ramp-up,' HPMC obscures the competitive impact of these proposals while understating the methodological flaws inherent in the projections.

Comparison of Projected Market Growth vs. Projected FSED Volumes

Metric	*CY 2028*	*CY 2029*	*CY 2030*	*28-30 CAGR*
N. Church Street				
Total SA Market Volume	100,327	101,430	102,546	1.11%
Zone 1 Market Volume	26,594	26,886	27,182	1.11%
Zone 2 Market Volume	29,415	29,739	30,066	1.11%
Zone 3 Market Volume	44,317	44,805	45,298	1.11%
Church Street FSED Projected Volume	8,484	9,088	10,057	8.9%
FSED Market Share	8.5%	9.0%	9.8%	--
S. Elm-Eugene Street				
Total SA Market Volume	130,582	132,018	133,471	1.11%
Zone 1 Market Volume	30,150	30,481	30,817	1.11%
Zone 2 Market Volume	42,482	42,949	43,422	1.11%
Zone 3 Market Volume	57,950	58,588	59,232	1.11%
S. Elm-Eugene Street FSED Projected Volume	10,005	11,102	12,382	11.2%
FSED Market Share	7.7%	8.4%	9.3%	--

Source: N. Church Street FSED CON application, pages 119-126; S. Elm-Eugene Street FSED CON application, pages 121-129; Cone Health analysis.

FSED Projected Volumes Exceed Organic Market Growth

Service Area	*Total Market Growth CY 2025-2030*	*FSED Projected Volume (CY 2030)*	*FSED Volume as % of Market Growth*
N. Church Street	5,459	10,057	184%
S. Elm-Eugene Street	7,105	12,382	174%
Combined	12,564	22,439	179%

Source: Cone Health analysis based on applicant projections.

Additionally, it must be noted that **44 percent of the total projected market volume in each SA is allocated to Zone 3, representing areas more than 15 minutes away from the proposed FSEDs**. By including such a large proportion of volumes from more distant areas, the applicant understates what appears to be a conservative market share capture when, in reality, the capture rates from closer proximity zones are quite aggressive.

Lastly, the applications exhibit a **fundamental internal inconsistency in the assumptions made regarding patient choice**, specifically, how geographic proximity factors into the decision of where to seek care. The applicant projects that 20.0 to 24.0 percent of patients in Zone 1 currently using local hospital EDs will shift to the proposed FSEDs based on improved geographic access. However, when accounting for GMC—an AHWFB hospital located seven to 12 miles from the proposed FSEDs—the applicant assumes only 10 percent of FSED-appropriate patients in overlapping service areas would choose GMC over the FSEDs. As detailed in Issue 2, this 10 percent assumption is grossly inadequate given the complete geographic overlap and represents a significant internal inconsistency. Furthermore, this assumption implies that 90 percent of patients would select an eight-room FSED over a 36-bed acute care hospital with 20 ED

treatment bays. If geographic proximity drives 20 to 24 percent of patients to shift from existing local EDs to a new FSED, it is unreasonable to assume only 10 percent would shift to GMC, which is part of the same health system and offers more comprehensive services in an equally proximate location.

Given the lack of support for the zone allocation methodology and "shift" (e.g., market share capture) percentage assumptions, combined with the internal inconsistency between claimed conservative growth rates and aggressive market share capture projections, the applications' methodologies fail to demonstrate the need the population has for the proposed services.

For these reasons, both applications are nonconforming with Criteria 3, 4, 5, 6, and 18a and should not be approved.

5. The applicant fails to demonstrate that the SAs it defines are actually in need of the specific services proposed, on an individual facility basis or collectively.

In addition to the issues already noted regarding SA overlaps and unsupported projections, the applications provide inadequate evidence of need specific to the defined SAs, instead relying heavily on county, statewide, and national data that do not reflect the actual utilization trends in the N. Church Street and S. Elm-Eugene Street SAs. Criterion 3 requires that "[t]he applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed." However, both applications fail to meet this criterion by substituting broad demographic trends for concrete evidence of SA-specific demand.

As one example, both applications cite Guilford County's overall population growth rate of 1.11 percent and the aging of the county's population as evidence of a need for the proposed FSEDs, but provide no additional analysis demonstrating that these county trends are present in smaller, more specific geographies. To the contrary, population data provided in the table below show that the N. Church Street SA is anticipated to experience **annual growth of only 0.49 percent**, less than half the county rate, while the S. Elm-Eugene Street SA is expected to see **growth of only 0.54 percent**, also less than half the county rate.

Total Population Growth

Service Area	*2025*	*2030*	*% Growth*	*5-Year CAGR*
Total Population				
N. Church Street	431,385	442,105	2.49%	0.49%
S. Elm-Eugene Street	533,311	547,801	2.72%	0.54%
Guilford County	560,760	592,680	5.69%	1.11%
Population Aged 65 and Older				
N. Church Street	75,846	86,490	14.03%	2.66%
S. Elm-Eugene Street	94,515	107,945	14.21%	2.69%
Guilford County	94,338	105,755	12.1%	2.31%

Source: N. Church Street FSED CON application, p. 38 and 40; S. Elm-Eugene Street FSED CON application, p. 38 and 40.

Most critically, the applications ignore the fundamental disconnect between general population trends and actual acuity-adjusted ED visit growth in the proposed SAs. As detailed in Issue 4 above, acuity-

adjusted ED visits originating from both the N. Church Street SA and the S. Elm-Eugene Street SA have declined in recent years, decreasing by 1.8 and 3.5 percent, respectively, over the course of the 2023 to 2024 period.

As such, the applicant cannot reasonably rely on national or countywide data to demonstrate need when the specific service area populations exhibit substantially different – and lower – utilization rates. This disconnect between the general trends cited and the service area-specific reality directly contradicts the fundamental requirement of Criterion 3 that applicants demonstrate the need that the identified population has for the proposed services.

For these reasons, the applications are nonconforming with Criteria 3 and 6 and should not be approved.

6. The applicant's own data show available ED capacity at HPMC and systemwide, and patient satisfaction issues reflect operational problems rather than facility constraints.

In Section C.4 of both applications, HPMC references guidelines set by ACEP with respect to recommended visits per space ratios for facilities providing emergency services. HPMC misleadingly interprets the minimum visits per space recommendation as a mandated ceiling rather than the lower threshold of a wider range, emphasizing that AHWFB EDs are operating at 113.2 percent of capacity according to this metric. The ACEP guidelines establish both minimum (1,250 visits per space) and maximum (1,500 visits per space) thresholds to assess capacity utilization. Comparison against the maximum visits per space ratio and corresponding maximum facility capacity shows that **AHWFB EDs as a whole are operating with available capacity** at only 89.8 percent of maximum capacity. In particular, **HPMC, with 44 treatment bays and 52,843 annualized ED visits in CY 2025, demonstrates the most available capacity at 74.5 percent** of maximum capacity. In fact, the ED utilization rate at this flagship facility is only 1,201 average visits per treatment room, which is below even the minimum 1,250 visits per space threshold identified by the applicant.

AHWFB Emergency Department Utilization and Capacity Estimates

Hospital	# of Treatment Bays	CY25 Annualized ED Visits	Min Visits/Space	Max Visits/Space	Min Capacity	Max Capacity	Actual % of Min Capacity	Actual % of Max Capacity
NCBH	65	102,093	1,221	1,567	79,365	101,855	128.6%	100.2%
HPMC	44	52,843	1,250	1,613	55,000	70,972	96.1%	74.5%
DMC	23	29,038	1,200	1,429	27,600	32,867	105.2%	88.4%
LMC	25	34,809	1,250	1,522	31,250	38,050	111.4%	91.5%
Total	157	218,782	1,250	1,500	193,215	243,744	113.2%	89.8%

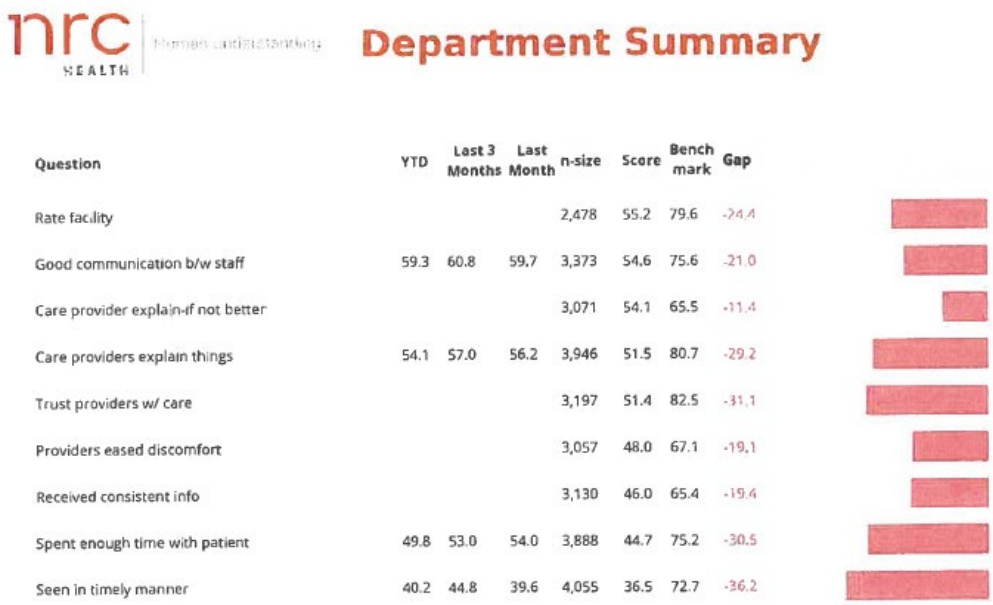
Sources: ED treatment bays from 2025 hospital LRAs. Min/Max Visits/Space per ACEP ED Design Guidelines (Exhibit C.4.1).

Source: N. Church Street FSED CON application, p. 47; S. Elm-Eugene Street FSED CON application, p. 49.

Although the narrative in both applications claims that part of the need identified is due to ED crowding, **HPMC does not provide adequate evidence that its operational issues are due to a lack of capacity rather than boarding** – e.g., ED patients waiting to be admitted to an available inpatient bed, psychiatric holds without placement, patients facing a lack of post-acute care options, and other inefficiencies that affect ED throughput or discharge processes.

Specifically, on pages 48 and 40 of the N. Church Street and S. Elm-Eugene Street FSED applications, HPMC points to NRC Health patient survey responses, particularly the lower score received for delivering care "in

a timely manner" (36.5 or 36.2 points under the 72.7 target), as proof of long wait times, drawing the conclusion that this is indicative of ED crowding. However, broader analysis of the same survey data shows lower scores across several metrics that are more closely aligned with operational practices than physical capacity constraints.



Question	YTD	Last 3 Months	Last Month	n-size	Score	Benchmark	Gap
Rate facility				2,478	55.2	79.6	-24.4
Good communication b/w staff	59.3	60.8	59.7	3,373	54.6	75.6	-21.0
Care provider explain-if not better				3,071	54.1	65.5	-11.4
Care providers explain things	54.1	57.0	56.2	3,946	51.5	80.7	-29.2
Trust providers w/ care				3,197	51.4	82.5	-31.1
Providers eased discomfort				3,057	48.0	67.1	-19.1
Received consistent info				3,130	46.0	65.4	-19.4
Spent enough time with patient	49.8	53.0	54.0	3,888	44.7	75.2	-30.5
Seen in timely manner	40.2	44.8	39.6	4,055	36.5	72.7	-36.2

Source: Exhibits C.4-2 of the N. Church Street and S. Elm-Eugene Street FSED CON applications.

Among these are communication, providers explaining things, and time spent with patients. Ultimately, these are operational, quality, staffing, and patient care issues that would not be resolved by the development of new facilities. In fact, spreading patient visits over additional facilities could serve to stretch limited staffing even more.

Given the available capacity at several AHWFB EDs, operational improvements targeting staffing, communication protocols, and care coordination may more effectively address the identified issues and be less costly than developing two FSEDs.

For these reasons, both applications are nonconforming with Criteria 3, 4, 6, and 18a and should not be approved.

7. Omitting GMC's 20 treatment bays artificially inflates system capacity constraints and misrepresents AHWFB's actual available ED capacity in Guilford County.

Another key flaw in the applicant's capacity analysis is the complete omission of the approved GMC hospital ED, which will open in January 2029 and operate 20 ED treatment rooms. With the inclusion of these additional resources, the equivalent of 12.7 percent of existing inventory, the AHWFB system will operate a total of 177 ED treatment bays upon completion of that project. Under the ACEP standards that HPMC applied in its two applications, it is reasonable to assume that these new treatment rooms will be able to accommodate a minimum capacity of 25,000 ED visits and maximum capacity of 28,850 ED visits, or a minimum average of 1,250 visits per room and maximum average of 1,429 visits per room. The table below corrects HPMC's capacity analysis (displayed in the issue above and from pages 47 and 49 from the

N. Church Street and S. Elm-Eugene Street applications, respectively) by including the approved GMC facility and demonstrates the effects of this substantial increase in capacity.

Corrected AHWFB ED Utilization and Capacity Estimates Including Approved GMC Facility

Hospital	*Treatment Bays*	*Annualized Visits*	*Min Visits/Space*	*Max Visits/Space*	*Min Capacity*	*Max Capacity*	*% of Max Capacity*
NCBH	65	102,093	1,221	1,567	79,365	101,855	100.2%
HPMC	44	52,843	1,250	1,613	55,000	70,972	74.5%
DMC	23	29,038	1,200	1,429	27,600	32,867	88.4%
LMC	25	34,809	1,250	1,522	31,250	38,050	91.5%
GMC*	**20**	**20,736**	**1,250**	**1,429**	**25,000**	**28,580**	**72.6%**
Total	**177**	**239,519**	**1,250**	**1,500**	**221,250**	**265,500**	**90.2%**

*Note: The GMC facility has been approved but not yet developed.

While the opening of GMC will increase overall ED capacity within the AHWFB system, the corrected capacity analysis demonstrates that utilization varies significantly by facility and county. Notably, HPMC relies on system-wide capacity data that includes facilities located outside Guilford County to argue for capacity constraints, despite the fact that both existing and approved AHWFB ED facilities actually located in Guilford County have substantial available capacity. HPMC, the only existing AHWFB facility in Guilford County, operates at just 74.5 percent of maximum capacity. GMC's projected utilization similarly places it at only 72.6 percent of maximum capacity upon opening. **Despite both current and approved AHWFB facilities in Guilford County operating well below capacity, HPMC proposes to add two nearly identical 24/7 FSEDs in the same county within 13 months of opening a new hospital ED**.

By relying on capacity constraints at facilities in other counties to justify development in Guilford County where capacity clearly exists, HPMC misrepresents the actual need for additional emergency services in the proposed service areas. This concentration of new emergency services capacity in an area already demonstrating AHWFB available capacity contradicts the applications' claims of need and capacity constraints.

For these reasons, the applications are nonconforming with Criteria 3, 4, and 6, and should not be approved.

8. <u>The applications fail to demonstrate adequate staffing resources are available for three concurrent 24/7 ED facilities.</u>

In the period from January 2028 to January 2029, a span of only 13 months, the applicant is proposing to develop three 24/7 emergency services facilities, representing 36 ED treatment rooms requiring simultaneous staffing. This timeframe and scale of expansion naturally raises concerns about the availability of adequate, qualified staffing for the two FSEDs and hospital ED.

Generally speaking, ED staffing requires specialized training and experience that distinguishes it from other clinical fields. In North Carolina, like in many other states, there are currently nursing, physician, and other provider shortages that have negatively impacted the ability to maintain full staffing levels in various departments, including emergency medicine. The near simultaneous opening of three 24/7 emergency facilities would require HPMC to recruit, train, and deploy a substantial ED workforce in a compressed

timeframe. The presence of a limited pool of qualified individuals in a regional market means that all providers in the SA or overlapping SAs are competing for the same workforce.

Given the limited pool of qualified ED personnel in the Greensboro market, HPMC's recruitment efforts to staff three new facilities within 13 months would necessarily impact existing ED providers throughout Guilford County and the surrounding area. To meet its own personnel requirements, HPMC would likely need to recruit experienced staff from established facilities, including those operated by Cone Health and other health systems in the region. **This could threaten the resources and stability of EDs currently providing care to the community.** If qualified staff are recruited away from existing facilities, those providers may be forced to operate short-staffed, reduce services, or rely more heavily on expensive travel nurses, any and all of which would decrease efficiency and contribute to higher healthcare costs.

By simultaneously recruiting for three new EDs, operating 24/7 and representing a total of 36 treatment rooms and supporting lab, pharmacy, and imaging services, HPMC would place considerable strain on the existing emergency services workforce. **This represents a competitive impact that is not offset by demonstrated need for the additional facilities, particularly given the declining and stagnant ED utilization** trends discussed in the issue-specific comments outlined above.

For these reasons, the applications are nonconforming with Criteria 3, 6, 7, 8, and 18a, and should not be approved.

SUMMARY

In summary, both FSED applications submitted by HPMC are fundamentally flawed and nonconforming with multiple statutory review criteria. Most critically, HPMC fails to demonstrate that the populations in the defined Greensboro SAs actually need the development of three ED facilities (two proposed and one approved but not yet operational), much less within a 13-month period and all proposing to serve the same acuity levels. The disproportionate nature of the two proposals is directly evidenced by the numerous inconsistencies and methodological flaws enumerated above, which fail to obscure the reality that acuity-adjusted ED visits are decreasing in the identified SAs and that the approved but not yet developed GMC facility (frequently omitted from the applicant's analysis) will increase capacity within a health system already operating below maximum ED utilization. As such, HPMC's concurrent applications would result in unnecessary duplication, poor financial feasibility, and increased staffing burdens for existing ED providers. These substantial deficiencies, stemming from an overall disconnect with historical data, SA characteristics, and health planning principles, render both applications nonconforming with Criteria 3, 4, 5, 6, 7, 8, and 18a. Neither application should be approved.