PETITION FOR AN ADJUSTED NEED DETERMINATION

Petition to Adjust the Need Determination and Remove the Acute Care Beds in the Buncombe/Graham/Madison/Yancey County service area in the *2023 State Medical Facilities Plan*

PETITIONER

Margaret R. Pardee Memorial Hospital
800 North Justice Street
Hendersonville, North Carolina 28791

James Kirby, II, MHA, MBA
President and Chief Executive Officer
(828) 696-1144
james.kirby@unchealth.unc.edu

STATEMENT OF THE REQUESTED CHANGE

Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital (UNC Health Pardee or Pardee) respectfully requests that the State Health Coordinating Council remove from the *2023 State Medical Facilities Plan (2023 SMFP)* the acute care bed need in the Buncombe/Graham/Madison/ Yancey service area.

INTRODUCTION

Margaret R. Pardee Memorial Hospital is one of two hospitals located in Henderson County, which is adjacent to Buncombe County. Mission Hospital (Mission) is currently the only acute care hospital in the Buncombe/Graham/Madison/Yancey service area. While in a separate acute care bed service area, Pardee is located just 20 miles from Mission Hospital, Henderson County is part of the federally-designated Asheville Metropolitan Statistical Area (MSA)[1], and Mission serves more patients from Henderson County than from any other county outside the *SMFP*-defined service area. (*See* Attachment A.) As a result, acute care bed changes in Buncombe County have an impact on Pardee and the patients it serves.

According to page 8 of the *Proposed 2023 SMFP*, "petitioners may submit a written petition requesting an adjustment to the need determination in the Proposed SMFP if they believe that special attributes of a service area or institution give rise to resource requirements that differ from those provided by the standard methodologies and policies." As discussed below, the need determination in the Buncombe/Graham/Madison/Yancey service area should be removed from the *2023 SMFP.* There are many reasons for this request, including that the need has not been appropriately adjusted for the impact of COVID-19 volumes in the Buncombe/Graham/Madison/Yancey service area as intended by the Acute Care Services Committee. Additionally, there is a large acute care bed surplus within the Mission Hospital self-defined service area that is sufficient to accommodate any additional volume.

[1] https://www.bls.gov/oes/current/msa_def.htm#11700

BACKGROUND

At the outset, Pardee notes that this request is specific to the Buncombe/Graham/Madison/Yancey service area, as is appropriate for a summer petition, and is not intended to address the acute care bed need methodology (or the results of that methodology) statewide or in any other service area. UNC Health knows from its experience owning and managing hospitals across the state that different areas have different needs, and there is rarely a "one size fits all" solution. For example, while Pardee files this petition to remove beds from the Buncombe/Graham/Madison/Yancey service area in the western part of the state for the reasons described below, UNC Health Johnston is filing a petition to increase the bed need for the Johnston County service area based on the circumstances specific to that market east of the Triangle. Similarly, UNC Health is not filing any petition with respect to Wake County, because it does not believe the need determination generated for that service area should be adjusted. Each petition is based on the data and circumstances in each of these locations, as experienced by these local hospitals, and is not meant to address the methodology in a wholesale manner. These petitions collectively reflect that UNC Health has carefully evaluated the methodology and the resulting bed need determinations and is tailoring the petitions it files to the specific locations and circumstances where it believes the methodology does not accurately or appropriately capture the true bed need.

Prior to the *2022 SMFP*, no bed need had been generated in the *SMFP*-defined service area of Buncombe/Graham/Madison/Yancey counties in over 10 years (since 2011). No need has existed even though Mission Health, the only acute care provider in the *SMFP*-defined service area, operates as the area's only tertiary facility drawing patients from surrounding counties and even other states. Not coincidentally, bed need has been generated only in the two years since COVID-19 began impacting patient days.

As the Agency is aware, the standard acute care bed methodology yielded no bed need in the Buncombe/Graham/Madison/Yancey service area in the *2022 SMFP*. The ultimate need determination for 67 beds was generated exclusively by the COVID-19 adjustments to the methodology. In other words, *actual patient days did not generate the need for additional beds in the Buncombe/Graham/Madison/Yancey service area*. COVID-19 impacted the *2022 SMFP* adjusted bed need calculation in two ways:

(1) 2020 patient days, used as the baseline for 2024 projections, were adjusted to be higher than actual patient days; and,
(2) Growth rates used to project 2024 patient days, which included the 2020 growth that was based on adjusted patient days, were also higher than actual.

The resulting bed need for this service area in 2022 was strictly the result of COVID-19 modifications to the methodology, not actual data. The additional bed need generated in the *2023 SMFP* for the Buncombe/Graham/Madison/Yancey service area is also the result of COVID-19 and is not reflective of future bed need. Adding more beds to the Buncombe/Graham/Madison/Yancey service area in the *2023 SMFP* would magnify excess bed capacity in Western North Carolina, as discussed herein.

REASON FOR THE PROPOSED CHANGE

The need for the proposed change is to prevent the unnecessary duplication of bed capacity within the Buncombe/Graham/Madison/Yancey service area and to promote competition. As described in the discussion that follows, the proposed need determination for this service area does not reflect the intention of the Acute Care Services Committee to address average length of stay (ALOS) increases resulting from the COVID-19 pandemic. The proposed change would avoid excess capacity that would otherwise be generated as COVID-19 inpatient volumes subside, and the ALOS returns to baseline levels. Moreover, appropriate and available capacity exists to serve patients in the western North Carolina region served by Mission Health. Continuing to add capacity in Buncombe County, especially unneeded capacity, reduces already restricted competition in the region.

1. The acute care bed need determination for the Buncombe/Graham/Madison/Yancey service area does not accomplish what the Acute Care Services Committee intended.

According to the Acute Care Services Committee,

> *"Finally, the Committee addressed continuing effects of the COVID-19 pandemic on bed need. Initial calculations showed that the state had a need for 1,481 additional beds. This number is about three to four times more than in a typical year. Analysis showed that the large number of needs was partly due to the fact that the overall average length of stay increased by about 20-25% from 2020 to 2021.* ***This increase is unprecedented, but not expected to be permanent****. Rather, it is most likely related to the lengthier stays of COVID patients. Therefore, in addition to removing NICU data in response to the Duke petition, the Committee approved an adjustment to the growth rate multiplier. Specifically, need determination calculations used the county growth rate multiplier from the 2021 SMFP, which reflects the 2015-2019 pre-pandemic reporting years."*[2]

Though the Committee partially addressed the COVID impact on projected patient days by using the previous growth multiplier, it did not address the COVID impact on average length of stay in the baseline data used to determine bed need. The methodology in the *Proposed 2023 SMFP* uses actual FFY 2021 patient days, excluding neonatal days, as the baseline year from which to project future growth. Specifically, the methodology ascribes 208,988 patient days to Mission for FFY 2021, which represents total actual acute care days, excluding neonatal days. As a result, the methodology assumes the FFY 2021 average length of stay—which the Committee notes is not expected to be permanent—will continue in the future.

Such an assumption has a dramatic impact on bed need in the Buncombe/Graham/Madison/Yancey service area. According to its 2022 License Renewal Application (LRA), Mission had 224,049 total days of care in FFY 2021[3], including neonatal days, representing an 11.5 percent increase over its 201,000 days of

[2] Acute Care Services Committee Recommendations to the NC State Health Coordinating Council on June 1, 2022 found here: https://info.ncdhhs.gov/dhsr/mfp/pdf/2022/shcc/04-ACSCommitteeReport-6-1-22-Final.pdf

[3] Both admissions and patient days are necessary to calculate ALOS. The *SMFP* does not include admission data, but the HLRA does. While the *SMFP* adjusted methodology excludes neonatal patient days, the HLRA does not delineate admissions by service; therefore, any calculation of ALOS from the HLRA data must include neonatal patient days. Pardee was able to use HIDI data to estimate the impact of ALOS on the *SMFP* data excluding neonatal days. Please see Attachment 2.

care in FFY 2020. However, Mission's admissions increased by only 2.9 percent. Mission's historical volumes are as follows:

	FFY 2017	*FFY 2018*	*FFY 2019*	*FFY 2020*	*FFY 2021*
Patient Days of Care	190,158	193,739	204,907	201,000	224,049
Admissions	39,243	39,720	43,020	40,327	41,492
ALOS	4.85	4.88	4.76	4.98	5.40

Source: Mission HLRAs

As shown in the table above, Mission's average length of stay consistently remained well below 5.0 days from FFY 2017 to FFY 2019, averaging 4.83 during those years. During the COVID periods of FFY 2020 and FFY 2021, it increased to 4.98 and 5.40, respectively—an increase of 0.57 days per patient during the COVID-19 period (5.40 – 4.83 = 0.57).[3]

To exclude the impact of neonatal days on this increase in ALOS and to equate the analysis above to the *SMFP* methodology that excludes neonatal days, Pardee analyzed HIDI data to calculate Mission's ALOS for non-neonatal days in FFY 2021. (*See* Attachment 2 for calculations.) That analysis shows an ALOS increase of 0.44 non-neonatal days in FFY 2021 and applied to non-neonatal discharges results in 17,319 additional days.

Thus, despite the Acute Care Services Committee's intent to adjust the methodology for the impact of COVID, use of actual patient days in FFY 2021 (excluding neonatal days) as the baseline to apply the adjusted growth factor assumes the extraordinarily higher length of stay will continue in the Buncombe/Graham/Madison/Yancey service area.

If FFY 2021 patient days are adjusted to exclude those resulting from the impermanent increase in ALOS, the need determination for this service area would approximate the following:

	2023 SMFP Original	*2023 SMFP with COVID-19 Adjustment*
Inpatient Days of Care	208,988	208,988
COVID-19 Adjustment	-	(17,319)
Adjusted Inpatient Days of Care	208,988	191,669*
County Growth Rate Multiplier	1.0157	1.0157
Projected Days of Care	222,454	204,019
2025 ADC	609	559
2025 Beds Adjusted for Target Occupancy	780	715
Projected Deficit (Surplus)^	98	33
2022 SMFP Adjustment	(67)	(67)
2023 Need Determination (Surplus)	31	(34)

*FFY 2019 patient days excluding Neonatal were 190,630 per the 2020 LRA. This projection still shows growth in patient days of care. ^Based on current non-neonatal licensed capacity of 682 beds.

As shown above, there is no need for additional beds in this service area when FFY 2021 volumes are actually adjusted for the impact of COVID-19 ALOS as intended by the adjusted methodology.

2. Sufficient acute care bed capacity already exists.

Mission Hospital is a tertiary facility with a comprehensive range of services. Notwithstanding the tertiary services it provides, 70 percent of inpatient days provided at Mission consistently are appropriate for admission to community-based hospitals. For Mission's self-defined 19-county service area in Western North Carolina[4], Pardee analyzed volume by MS-DRG codes to determine patient days that are appropriate for community facilities[5].

*Mission's 19-County Patient Days**	*FFY 2019*	*FFY 2020*	*FFY 2021*
Community Hospital Appropriate	131,703	133,314	147,724
Specialty[6] or Not Community Appropriate	56,311	57,423	63,904
TOTAL	188,014	190,737	211,628
Community Appropriate % of Total	70%	70%	70%

Source: Hospital Industry Data Institute (HIDI)
*Excludes patient days originating from North Carolina but outside of the 19-county Mission-defined service area, as well as patient days from out of state.

In FFY 2021, these community-appropriate patient days equate to 518 beds at the target occupancy rate[7]. In other words, of Mission's existing 682 licensed, non-neonatal acute care beds, at least 518 are utilized by patients who could be served in community hospitals.

Currently, Mission is the only hospital provider in the Buncombe/Graham/Madison/Yancey service area and holds approximately 79.0% inpatient market share (of discharges) of the *SMFP* defined service area. However, a notable portion—more than 40%—of Mission's community-appropriate patient days originate from the other 15 counties in its self-defined service area. Even though the *SMFP*-defined service area consists of four counties, the purported need generated by Mission is the result of volume throughout Mission's broader service area.

[4] As defined by Mission in its application for 67 additional acute care beds, Project ID # B-12232-22. According to Pardee's analysis of HIDI data for FFY 2021, patients from these 19-counties account for approximately 94% of Mission's total volume from all geographies.
[5] Pardee, Advent Hendersonville, and Haywood Regional—the community hospitals closest to Mission—serve patients in virtually all of the community-appropriate MS-DRGs. The community-appropriate MS-DRGs that do not have any patient volume at those three facilities make up less than 4% of Mission's community-appropriate volume. In other words, 96% of Mission's community-appropriate volume is from MS-DRGs that could be served at Pardee, Advent Hendersonville and Haywood Regional.
[6] Includes Hematology/Oncology, High Risk OB, Neonatal, Thoracic Surgery, Trauma
[7] 147,724 / 365 = 404.7 average daily census x 1.28 target occupancy factor = 518 beds

*Origin of Mission Community-Appropriate Days**	*FFY 2019*	*FFY 2020*	*FFY 2021*
Buncombe/Graham/Madison/Yancey	78,165	76,358	84,863
Remaining 15 Counties in Defined Service Area	53,538	56,956	62,861
Defined Service Area Total	131,703	133,314	147,724
15 Counties % of Total	41%	43%	43%

Source: Hospital Industry Data Institute (HIDI)

In FFY 2021, the community-appropriate patient days originating from these 15 counties equates to 220 beds at the target occupancy rate.[8]

According to the *Proposed 2023 SMFP*, sufficient bed capacity exists at community hospitals within the region where these patients originate to accommodate the volume that is appropriately served closer to patients' homes. The bed surplus and utilization for the entire Mission self-defined service area is as follows:

Hospital (Beds and Patient Days Exclude Neonatal)	*County*	*Acute Care Beds*	*FY 2021 Patient Days*	*Bed Deficit (Surplus)*	*Utilization*
Mission Hospital	Buncombe	682	208,988	98	84.0%
*2022 Acute Care Bed Need Determination	Buncombe	67		(67)	
Margaret R. Pardee Memorial Hospital	Henderson	201	24,467	(92)	33.3%
UNC Blue Ridge	Burke	289	22,546	(196)	21.4%
AdventHealth Hendersonville	Henderson	62	11,341	(11)	50.1%
Caldwell UNC Health Care	Caldwell	110	23,346	(3)	58.1%
Harris Regional Hospital	Jackson	82	13,947	(22)	46.6%
Haywood Regional Medical Center	Haywood	121	19,840	(21)	44.9%
Mission Hospital McDowell	McDowell	65	6,735	(35)	28.4%
Rutherford Regional Medical	Rutherford	129	10,347	(87)	22.0%
Swain Community Hospital	Swain	48	2,971	(36)	17.0%
Transylvania Regional Hospital	Transylvania	42	5,877	(18)	38.3%
Blue Ridge Regional Hospital	Mitchell	46	4,774	(12)	28.4%
Angel Medical Center	Macon	30	5,335	(1)	48.7%
Charles A Cannon Jr Memorial Hospital	Avery	30	1,020	(26)	9.3%
Erlanger Murphy Medical Center	Cherokee	57	5,133	(36)	24.7%
Highlands-Cashiers Hospital	Macon	24	1,971	(13)	22.5%

[8] 62,861 / 365 = 172.2 average daily census x 1.28 target occupancy factor = 220 beds

St. Luke's Hospital	Polk	25	3,053	(11)	33.5%
Grand Total		**2,110**	**371,691**	**(589)**	**48.3%**

Source: Table 5A: Acute Care Bed Need Projections excluding NICU data and includes adjusted CGRM - Draft 6/01/2022

As shown above, the *2023 SMFP* Table 5A: Acute Care Bed Need Projections show a bed surplus at every Western North Carolina hospital except Mission. In fact, only two additional hospitals are operating at over 50 percent capacity. With a bed surplus of 589 acute care beds in Western North Carolina, there is adequate capacity for patients in the broader service area. Moreover, outside the Buncombe/Graham/Madison/Yancey service area, more of Mission's volume originates from (in rank order) Henderson, Haywood, McDowell, Macon, Transylvania and Jackson counties. (*See* Attachment 1.) The table above shows that these six counties alone have a surplus of over 200 acute care beds.

Continuing to generate unnecessary bed capacity in Buncombe County will foster greater consolidation of healthcare services in Buncombe County and less competition in the region, to the detriment of patients throughout Western North Carolina. Heightened since the acquisition of Mission Health by HCA are concerns that services in more rural parts of the service area have been diminished, forcing more patients to travel to Buncombe County for care.

> "Community members contend services have been reduced at Mission's rural hospitals....
>
> But while [Nancy Lindell, a spokesperson for HCA's North Carolina division] says the company is preparing TRH for 'explosive population growth,' [Brevard's mayor, Maureen] Copelof and others see a slow, quiet erosion of services."[9]
>
> "Once Mission took over, focus began to shift toward Asheville, and when HCA took over from Mission, Angel 'became even more of a teeny, tiny little cog in a huge machine,' she [Linda Tyler, a public health nurse in Macon County for 25 years who's now retired] said....
>
> Franklin Mayor Bob Scott shares Tyler's concern. 'My concern is that the type of services that we once had at our community hospital, you're now shipped to Asheville to have the same,' Scott said. '(Franklin is a) minimum of an hour away from Asheville under the absolute best of circumstances.'"[10]

In addition to these news reports, Mission Health and HCA are now facing two anti-trust lawsuits, alleging in part that cuts to services in outlying communities are "compelling patients to travel to HCA's Asheville facilities to obtain care."[11]

An analysis of discharges from HCA-owned hospitals in Western North Carolina supports these anecdotal reports. According to HIDI data, four of the six HCA hospitals have experienced declines in inpatient volume; only two hospitals have experienced an increase, with Mission's the highest.

[9] https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/

[10]https://www.citizen-times.com/story/news/2021/05/27/mission-health-breaks-ground-franklin-service-concerns-community-care/7429932002/

[11] https://www.citizen-times.com/story/news/2022/06/06/brevard-files-class-action-antitrust-lawsuit-against-mission-hca/7531321001/

HCA Hospital	*FFY 2017*	*FFY 2018*	*FFY 2019*	*FFY 2020*	*FFY 2021*	*CAGR*
Mission Hospital	38,680	39,038	40,250	39,108	40,112	0.9%
Mission Hospital McDowell	2,016	2,183	2,277	2,100	2,061	0.6%
Angel Medical Center	1,889	1,478	1,495	1,189	1,298	-9.0%
Transylvania Regional Hospital	1,512	1,462	1,509	1,227	1,377	-2.3%
Blue Ridge Regional Hospital	1,222	642	1,342	1,041	1,083	-3.0%
Highlands-Cashiers Hospital	301	169	344	206	273	-2.4%

Source: Hospital Industry Data Institute (HIDI), for patients originating from the 19-county Mission defined service area of Western North Carolina.

Other systems in North Carolina, including UNC Health and Atrium Health, have demonstrated through public statements and data that they are working to shift community-appropriate volume to facilities closer to patients' homes. In contrast, Mission appears to be pushing more volume to Asheville. Given the circumstances in Western North Carolina, generating need determinations for excess acute care beds in *SMFP*-defined service area when there are sufficient beds in the region to accommodate patients suitable for admission to other facilities will work to suppress, not foster, competition.

Summary

Pardee acknowledges that the Acute Care Services Committee, the SHCC, and Planning staff have an extremely difficult task of eliminating the temporary impact of COVID-19 while also not underestimating future need—effecting the right balance between ensuring enough capacity where appropriate without unnecessary duplication, across North Carolina. Pardee believes that the current circumstances in Western North Carolina in particular argue for caution: 1) the clear, significant and temporary increase in ALOS only during the COVID-19 years; 2) the surplus of acute care beds in every other county in Mission's self-defined service area, when 70% of the inpatient care delivered at the facility that generated the need is provided to patients with community-appropriate diagnoses; and, 3) the COVID-19 driven need determination for beds in this service area in the *2022 SMFP* for which applications are currently under review. It also makes sense in this situation to delay any further bed need determinations in this service area until after the three pending applications for additional acute care beds in Buncombe County in response to the *2022 SMFP* can be subjected to public comment and reviewed by the Agency. Additional time also affords a better, longer-term evaluation of the expected decrease in patient days as COVID related hospitalizations subside. For all these reasons, Pardee requests that the SHCC err on the side of preventing unnecessary duplication by removing from the *Proposed 2023 SMFP* the acute care bed need in the Buncombe/Graham/Madison/Yancey service area.

ADVERSE EFFECTS IF PETITION IS NOT APPROVED

The most obvious adverse effect if this petition is not approved is the continued reduction in competition through the development of unnecessary acute care bed capacity in Buncombe County, which will serve to encourage consolidation of services in Asheville and force patients to travel for care. As noted in the references cited previously, the reduction in services in many rural Western North Carolina communities

is already a concern of citizens and local leaders; denial of this petition will provide the means to escalate the circumstances underlying those concerns.

Beyond Mission Health in Asheville, most of the hospitals in Western North Carolina are small, rural facilities. Continued erosion in the competitive position of these facilities threatens their viability. According to the Center for Healthcare Quality and Payment Reform, more than 600 rural hospitals in the United States are at risk of closing in the near future. Specifically in North Carolina, 11 hospitals have closed since 2005 and 11 more are at risk of closing.[12] Based on the described characteristics of at-risk hospitals, it is likely that at least three of these hospitals are located in Western North Carolina. The further shift of community-appropriate volume to Buncombe County would exacerbate these hospitals' ongoing struggle to survive.

Furthermore, competition will be enhanced if rather than having to focus resources on addressing unnecessary bed duplication in Buncombe County, the larger community hospitals in the area can continue to build an expanded scope and depth of services for patients that live closer to such facilities, providing alternatives to Mission for these types of services. Such efforts are already underway. For example, in February 2021, the North Carolina Emergency Management Services ("EMS") medical director designated Pardee as a Percutaneous Coronary Intervention ("PCI") Hospital for Henderson and Transylvania Counties.[13] As a PCI Capable Hospital, Pardee has the ability to provide quality care around the clock for ST Elevation Myocardial Infarction, or STEMI cases. A STEMI is a heart attack caused by clots in one or more of the patient's coronary arteries. The PCI Capable Hospital designation builds upon the Chest Pain Center Accreditation that the American College of Cardiology (ACC) awarded to Pardee in October 2021, based on rigorous onsite evaluation of the staff's ability to evaluate, diagnose and treat patients who report chest pain and may be experiencing a heart attack.

The approval of this petition is consistent with the SHCC's own policies, as expressed in the Access Basic Principle in Chapter 2 of the *Proposed 2023 SMFP*:

> *"The needs of rural and small communities that are distant from comprehensive urban medical facilities merit special consideration. In rural and small communities, selective competition that disproportionately captures profitable services may threaten the viability of sole providers of comprehensive care and emergency services. For this reason, methodologies that balance value, quality, and access in urban and rural areas may differ quantitatively. The SHCC planning process will promote access to an appropriate spectrum of health services at a local level, whenever feasible, under prevailing quality and value standards."* (emphasis added)

Pardee believes that the allocation of additional acute care beds in the Buncombe/Graham/ Madison/Yancey service area at this time would violate the SHCC's Basic Principle of ensuring access, protecting rural and small communities, and allowing appropriate health services to be provided locally.

[12] Center for Healthcare Quality and Payment Reform, retrieved July 21, 2022 from Saving Rural Hospitals: https://ruralhospitals.chqpr.org/Solutions.html

[13] https://www.hendersonvillelightning.com/news/10051-pardee-steps-up-cardiac-care-with-stemi-designation.html

ALTERNATIVES CONSIDERED

There is only one alternative to the petition: for Pardee to not file the petition and allow the unnecessary beds to remain in the *Proposed 2023 SMFP*. As discussed previously, the need determination as presented in the *Proposed 2023 SMFP* is based on an assumed length of stay at Mission that is driven by COVID-19, a temporary circumstance as cited by the Acute Care Services Committee. Furthermore, no additional beds are needed in the service area as there is considerable available capacity in Western North Carolina, Mission's self-defined service area. Given the negative impact that additional, unneeded beds in Buncombe County will have on citizens in the region, as well as small, rural hospitals, failing to file the petition is not a reasonable alternative.

UNNECESSARY DUPLICATION

Pardee has filed this petition to avoid unnecessary duplication. As previously discussed, the *Proposed 2023 SMFP* acute care bed need determination is based on an extraordinary ALOS resulting from the COVID-19 pandemic. In addition, there is available capacity in hospitals throughout Western North Carolina. Over 70% of inpatient volume served by Mission Health is appropriate for community-based inpatient services. Altogether, the remaining hospitals in Mission's 19-county service area have a surplus of more than 500 beds available to serve these patients, many of whom reside in those local communities. Simply put, without approval of this petition, the resulting additional beds will create unneeded capacity and unnecessarily duplicate capacity that is already available.

BASIC PRINCIPLES

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

Safety and Quality

Because the acute care bed need for the Buncombe/Graham/Madison/Yancey service area in the *Proposed 2023 SMFP* results from Mission's extraordinary ALOS created by the COVID-19 pandemic, there is no permanent bed need and thus no quality or safety reason demanding the development of 31 beds in this service area.

In addition, Mission Health is currently the only provider of acute care services in the *SMFP*-defined service area. According to the Attorney General, his office has received numerous complaints regarding the quality of care at Mission Health. In his February 25, 2020, letter to HCA's North Carolina Division President, Mr. Stein indicated that his office had received 30 written complaints about Mission Health since January 1, 2020, with many of those "harrowing to read" concerns about quality of care.[14] More recently than 2020, news reports cited more than 100 complaints to the AG's office over a 12-month period.[15]

[14] https://ncdoj.gov/wp-content/uploads/2020/02/Stein-Letter-to-HCA-_02252020.pdf

[15] https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed

Under these alleged circumstances, it is unlikely that the continued consolidation of acute care beds in Buncombe County, particularly when those beds are not needed, will improve quality and safety for residents of Western North Carolina.

Access

As previously discussed, there is adequate capacity throughout the Western North Carolina region to accommodate community-appropriate inpatients as every one of the 17 hospitals in Western North Carolina, other than Mission Health, is operating at a bed surplus according to the *Proposed 2023 SMFP*. At least 70% of inpatients served at Mission have a diagnosis appropriate to be served at these community hospitals. Creating additional capacity in the *SMFP*-defined service area discourages geographic access for residents of Western North Carolina as it promotes consolidation of services in Buncombe County and forces patients to travel some distance for care. Furthermore, when the impact of COVID-19 is eliminated from Mission's projected patient days, the *SMFP*-defined service area also shows a surplus of beds. Thus, access already exists and under the circumstances that exist in Western North Carolina, the development of additional capacity in Buncombe County is likely to diminish, rather than improve, access, which is contrary to the Access Basic Principle as discussed previously.

Value

Healthcare value will be maintained with the approval of this petition as it prevents unnecessary duplication of services. In particular, acute care bed additions come with a steep cost. Capital costs in the three applications filed in response to the *2022 SMFP* need determination ranged from $125 to $329 million for 67 additional beds. While 31 additional beds would likely cost less than these projects, they will still come at a substantial cost, particularly when not necessary to meet ongoing patient demand. By approving this petition, that capital can be deployed to other healthcare initiatives within the service area that are not duplicative in nature.

As the only current provider of acute care services in the *SMFP*-defined service area, Mission Health's ability to promote value is questionable. Again, the Attorney General has raised concerns about the high price of healthcare in Western North Carolina, specifically citing in his March 16, 2022 letter that "Mission Health charges insurers prices far higher than the state-wide average price for the same service….insurance premiums within Mission Health's service area are 30% higher than premiums in nearby counties, and over 50% higher than premiums in the State's other large metropolitan areas."[16]

Value is best maintained by approving this petition, avoiding unnecessary duplication of services, and preventing the development of unneeded capacity in Buncombe County where healthcare prices are reportedly higher than most other areas of the state.

[16] https://www.scribd.com/document/567469487/NC-DOJ-Letter-to-HCA-16-March-2022

CONCLUSION

Pardee believes that the Acute Care Services Committee's intent to avoid bed need determinations that were based on temporary, COVID-19 generated volume has, unfortunately, not been fully addressed in the Buncombe/Graham/Madison/Yancey service area and has resulted in an unsupported "need" for beds in this service area. Granting this petition will rectify the bed need in Buncombe/Graham/Madison/Yancey service area and ensure that beds based on temporary spikes in volume are not developed.

Pardee appreciates your careful consideration of this petition. Please let us know if we can assist the Council, its committees, or the staff during the process.

Thank you.

ATTACHMENT 1

COUNTY	FFY 2021	
	DISCHARGES	PATIENT DAYS
BUNCOMBE	19,854	98,524
MADISON	1,840	8,913
YANCEY	1,201	6,326
GRAHAM	299	1,955
ACUTE CARE BED SERVICE AREA TOTAL	**23,194**	**115,718**
HENDERSON	3,129	17,156
HAYWOOD	2,951	15,463
MCDOWELL	2,216	12,821
MACON	1,683	9,712
TRANSYLVANIA	1,383	7,267
JACKSON	1,282	7,746
SWAIN	863	5,410
RUTHERFORD	839	5,004
MITCHELL	718	4,295
BURKE	502	3,278
CHEROKEE	422	2,524
POLK	352	1,868
CALDWELL	223	1,440
AVERY	238	1,217
CLAY	117	709
GRAND TOTAL MISSION SELF-DEFINED 19-COUNTY SERVICE AREA	**40,112**	**211,628**

Sources: Service area as defined by Mission in its application for 67 additional acute care beds, Project ID # B-12232-22. Data from Hospital Industry Data Institute (HIDI).

ATTACHMENT 2

Mission FFY 2021 Data from HIDI (19-County Service Area)	*Discharges*	*Days of Care*
Neonatology	2,384	17,186
Total	40,112	211,628
Percent of Total	5.90%	8.10%

Mission FFY 2021 Data from HLRA (Total Volume)	*Discharges*	*Days of Care*	*ALOS (Calculated)*
Total	41,492	224,049	5.4
Neonatal Estimate*	2,448	18,148	7.4
Non-Neonatal Estimate^	39,044	205,901	5.3

*Total HLRA Data x Percent of Total from HIDI Data

^Total HRLA Data - Neonatal Estimate

Average ALOS FFY 2017-FFY 2019 per HLRA	4.83
Change in ALOS During COVID*	0.44
Additional days resulting from Temporary ALOS^	17,319

*Non-Neonatal ALOS - Average ALOS FFY 2017-2019. Although the Average ALOS from FFY 2017-2019 using HLRA data includes neonatal days, the resulting calculation is conservative because it is subtracting a higher ALOS (the total ALOS is higher than the non-neonatal ALOS) from the Non-Neonatal ALOS. If a lower ALOS were subtracted from the Non-Neonatal ALOS, the Change in ALOS During COVID would be higher.

^Change in ALOS During COVID x Non-Neonatal Discharges from HLRA data, which results in the exclusion of neonatal services from the calculations of differences in ALOS