COMMENTS BY CAROMONT HEALTH, INC AND GASTON MEMORIAL HOSPITAL, INC. ON THE PETITION FOR CHANGE IN POLICY AC-3 SUBMITTED BY NOVANT HEALTH, INC.

CaroMont Health, Inc. ("CaroMont") is the parent corporation of Gaston Memorial Hospital, Inc. located in Gastonia, North Carolina. Founded in 1946, the hospital began as a 70-bed facility, and has grown to be licensed for 435 beds (372 acute care beds). While CaroMont's flagship facility, Gaston Memorial Hospital, is located in Gaston County, CaroMont has facilities in surrounding counties as well, including Cleveland, Lincoln, and Mecklenburg Counties in North Carolina, and York County in South Carolina. CaroMont's services include a Community Hospital, Comprehensive Cancer Center, a Women's Center, a Neonatal Intensive Care Unit, an Open Heart Program, Cardiac Catheterization and Psychiatric Services, and a comprehensive array of diagnostic and therapeutic outpatient services.

As a large, independent health care system in North Carolina, CaroMont is attuned to the trends in health care and the intense competition for limited health care resources. CaroMont recognizes the importance of the health planning process, and the critical role of the Certificate of Need ("CON") process in limiting the proliferation of unnecessary health services. CaroMont believes that Policy AC-3 in the State Medical Facilities Plan ("SMFP") is fundamentally at odds with the purpose and the language of the CON Law, because it gives unlawful special treatment to four academic medical centers ("AMCs"): Duke University Health System, Inc. d/b/a Duke University Hospital ("Duke"), North Carolina Baptist Hospital ("Baptist"), Pitt County Memorial Hospital ("Pitt"), and UNC Hospitals at Chapel Hill ("UNC").

CaroMont, as a non-AMC, is bound by the need determinations in the SMFP. *See* N.C. Gen. Stat. § 131E-183(a)(1), which states that the need determinations in the SMFP

constitute a determinative limitation. Unless there is a need determination in the SMFP for a regulated health care asset, CaroMont cannot develop the asset. CaroMont understands the purpose behind the restrictive limitation of the need determinations in the SMFP, and it submits to the State health planning process and the authority of the CON Section to regulate providers in North Carolina with respect to the CON Law. Policy AC-3, however, undermines the State's health planning process to which CaroMont is subject. Because CaroMont believes that Policy AC-3 in the SMFP is at odds with the purpose and the language of the CON Law, it submits these comments in support of the Petition filed by Novant Health Inc. ("Novant"), which proposes that Policy AC-3 be repealed or revised.

A. CaroMont's Interest.

Despite being subject to the restrictive need determinations of the SMFP, CaroMont understands the purpose behind the regulation and submits to the State health planning process and the authority of the CON Section to regulate providers in North Carolina with respect to the CON Law.

CaroMont is similarly situated to Novant, in that it is disadvantaged by Policy AC-3 as currently written. Like Novant, CaroMont is a large, independent health care system that does not have the luxury of submitting a CON application pursuant to the existing Policy AC-3. Yet, despite this handicap, it is forced to compete in the extremely competitive health care marketplace with AMCs who can take advantage of the policy.

The Petition filed by the AMCs forecasts even greater concerns about the competition CaroMont will face from AMCs. The AMCs are seeking to have Policy AC-3 extend to satellite campuses of existing medical schools; specifically, UNC has been approved to develop campuses in Charlotte and Asheville, presumably at Carolinas Medical Center ("CMC") in

Charlotte and Mission Health System ("Mission") in Asheville. This is of particular concern to CaroMont, because it has facilities in Mecklenburg County where CMC is located, and Carolinas Healthcare System, the parent of CMC, has facilities in Gaston County where Gaston Memorial Hospital is located. With any expansion of Policy AC-3, CaroMont will be forced to compete on an unequal playing field with CMC.

CaroMont agrees with Novant that currently, there is not a level playing field among providers when certain chosen providers play by one set of rules, and every other provider is forced by law to play by a different set of rules. For this reason, CaroMont supports the Petition submitted by Novant, urging either the complete elimination of Policy AC-3, or in the alternative, significant modifications to the policy as outlined in Novant's Petition.[1]

B. CaroMont Shares Novant's Concerns with Policy AC-3 as Currently Written.

1. Policy AC-3 Violates the CON Law.

The language of Policy AC-3, which is not a statute but instead is a policy adopted by the SHCC for inclusion in the SMFP, directly contravenes the statutory mandate of Criterion 1, and thus Policy AC-3 is invalid.

N.C. Gen. Stat. § 131E-183 provides in pertinent part:

> (a) The Department shall review **all** applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.
>
> (1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service

[1] CaroMont is also submitting comments in opposition to the Petition filed with the SHCC by the four AMCs on March 2, 2011.

> facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

(Emphasis added).

Despite the mandatory and unambiguous legislative directive that the "Department shall review all applications utilizing the criteria outlined in [N.C. Gen. Stat. § 131E-183(a)]" quoted above, Policy AC-3 purports to exempt applications submitted by certain favored providers from scrutiny under the first of these criteria. Policy AC-3 provides in relevant part:

> Projects for which certificates of need are sought by academic medical center teaching hospitals may qualify for exemption from the need determinations of this document. . . .

Policy AC-3 purports to grant a preferred status to certain "academic medical center teaching hospitals" which have been designated as such prior to January 1, 1990. According to Policy AC-3, regardless of the plain words of the statute, such favored hospitals "may qualify for exemption from the need determinations" applicable to all other applications, if they are deemed to comply with different criteria appearing nowhere in the CON Law.

Further, N.C. Gen. Stat. § 131E-183(a), which sets forth the statutory review criteria for CON applications, does not mention AMCs, or draw any distinction between those providers and other applicants. The only mention of AMCs in the statute is in N.C. Gen. Stat. § 131E-183(b), which limits the Department's ability to adopt certain rules affecting such entities, and which has nothing to do with the statutory review criteria set forth in N.C. Gen. Stat. § 131E-183(a).

Policy AC-3 violates the plain language of the CON Law, and CaroMont agrees with Novant that for that reason alone, the policy should be repealed.

2. Policy AC-3 Conflicts with North Carolina's Health Policy.

The health planning process of the SHCC, and the development of the SMFP, are sound, and they are essential to avoiding the unnecessary duplication of health service facilities and capabilities. The goal of avoiding unnecessary duplication of health service facilities and capabilities is paramount, and is one of the foundations of the CON Law. In the General Assembly's own statement of its reasons for adopting the CON Law, it found in pertinent part:

> The General Assembly of North Carolina makes the following findings:
> ...
>
> (4) That 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.
> ...
>
> (6) 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.
>
> (7) That the general welfare and protection of lives, health, and property of the people of this State require that new institutional health services to be offered within this State be subject to review and evaluation as to need, cost of service, accessibility to services, quality of care, feasibility, and other criteria as determined by provisions of this Article or by the North Carolina Department of Health and Human Services pursuant to provisions of this Article prior to such services being offered or developed in order that only appropriate and needed institutional health services are made available in the area to be served.

N.C. Gen. Stat. § 131E-175(4), (6), (7).

These findings make crystal clear the Legislature's concern over the development of costly, unneeded facilities. By contrast, the findings make absolutely no mention of AMCs, or

of the factors by which the Department would consider them for exemption from the need determinations of the SMFP. Thus, the General Assembly's own statement of its intent reinforces the State's health policy to rigorously scrutinize proposals submitted by all applicants, under the same statutory criteria and including the need determinations of the SMFP, with no special, privileged status for any provider. Policy AC-3, which allows for the development of unneeded health care services or facilities, is contrary to North Carolina's health policy, as reflected by the General Assembly's statement of intent and the relevant statutory authorities.

3. Policy AC-3 Has Outlived Its Useful Life.

The days when AMCs were the only facilities that could provide care for high acuity patients in a technically sophisticated setting are long gone. CaroMont is not an AMC, but it provides an advanced level of patient care. CaroMont was also the only North Carolina hospital selected as a Top 100 Hospital by Thomson Reuters in 2010.

CaroMont is currently pursuing designation as a Level III Trauma Center, and anticipates receiving that designation in December of 2011 when a site visit by the North Carolina Office of Emergency Medical Services is conducted. *See* Exhibit A. As the service gap between community hospitals and AMCs closes, any potential rationale for Policy AC-3 diminishes. In addition to the examples provided by Novant in its Petition about the expansion of tertiary level services throughout North Carolina, CaroMont also notes another recent example reflecting how the AMCs have changed over time. Recently, Duke announced that it was partnering with LifePoint, a for-profit company, to create a joint venture that will own and operate a system of highly functioning community hospitals. *See* Exhibit B. Such a joint venture between an AMC and a for-profit hospital operations company was unthinkable back in

1983 when the predecessor to Policy AC-3 was first adopted. The AMCs are no longer content to remain on their campuses focusing on just teaching and research; they also want to provide mainstream medicine on the community level. This phenomenon is also reflected in Baptist's affiliations with Lexington Memorial Hospital and Davie County Hospital. Since the AMCs are seeking to diversify into the community setting, they must also play by the same rules to which the community hospitals are bound: before anyone can add SMFP-regulated services, there must be a need determination in the SMFP. Whatever special privileges the AMCs might have warranted back in the early 1980s are no longer deserved; the world has changed too much since that time, and it is manifestly unfair to allow the two-tier system of health planning to persist in North Carolina almost thirty years later.

4. Policy AC-3 Has Been Abused.

CaroMont understands that at times, an AMC will have a unique need for an academic purpose. However, there are other existing avenues in the health planning process to address those needs. Specifically, as outlined in Novant's Petition, an AMC can file a special needs petition with the SHCC, or the AMC can apply for a research exemption pursuant to N.C. Gen. Stat. § 131E-179. In 2007, Pitt filed a special needs petition with the SHCC to have operating rooms added to the SMFP. That request was granted, and Pitt applied for those rooms and was approved to develop them. Pitt's example demonstrates that the AMCs have sufficient methods in the health planning process, besides Policy AC-3, to meet their needs.

Policy AC-3 has been abused, and has been used as an end run around the State's health planning process. By way of example, Baptist recently applied for seven additional operating rooms in Forsyth County pursuant to Policy AC-3 to do routine outpatient surgery, despite the fact that the SMFP showed a surplus of 5.52 operating rooms. The application for

such a project under the guise of Policy AC-3, and the approval of that project, offend North Carolina's careful health planning process and illustrate how Policy AC-3 can be manipulated to undermine the purpose of the CON Law. In order to eliminate the possibility for such abuse to continue, Policy AC-3 should be repealed or revised in accordance with the proposed revisions in Novant's Petition.

5. Policy AC-3 is Not in the Public Interest.

The public interest is expressed quite plainly in the General Assembly's legislative findings of fact. As made clear by N.C. Gen. Stat. § 131E-175(4), (6), (7), all cited above, the CON Law plays a crucial role in preventing the unnecessary proliferation of excess health service facilities and capabilities, which ultimately benefits the public because it reduces the burden of costs. Policy AC-3 provides the opportunity for AMCs to contravene the intent of the General Assembly, and apply for health care assets above and beyond what the State health planning section has determined are needed. As discussed in further detail above, Policy AC-3 does not hold the AMCs to the same standard as other CON applicants, and does not require them to comply with the need determinations in the SMFP. By allowing AMCs a method by which they are permitted to develop unnecessary health service facilities, Policy AC-3 is not only contrary to the CON Law but is also contrary to the public interest.

6. Policy AC-3 Gives AMCs an Unfair Advantage.

AMCs have a tremendous advantage by virtue of being able to ignore the SMFP, and apply for what they want pursuant to Policy AC-3. CaroMont is concerned that in addition to the four AMCs, other facilities will seek to get such an advantage, especially CMC. These concerns are real and legitimate, given the admission in the AMCs' Petition filed with the SHCC that UNC has obtained approval to develop satellite campuses in Charlotte and

Asheville. CaroMont is forced to compete with these AMCs, and may be forced to compete with additional satellite campuses of these AMCs, while suffering a distinct disadvantage due to its inability to use Policy AC-3 and its obligation to follow the need determinations in the SMFP. In the extremely competitive health care marketplace, it is fundamentally unfair for the four AMCs to be able to use Policy AC-3, while their non-AMC competitors are forced to sit idly by and allow the AMCs to gain an unearned competitive advantage.

C. The SHCC Should Either Repeal Policy AC-3 or Revise it in Accordance with the Changes Proposed in Novant's Petition.

For all the reasons stated above, and all the reasons stated in Novant's Petition, CaroMont agrees with Novant's recommendation that Policy AC-3 be repealed. In the alternative, CaroMont agrees with the proposed revisions to Policy AC-3 that Novant sets forth in its Petition.

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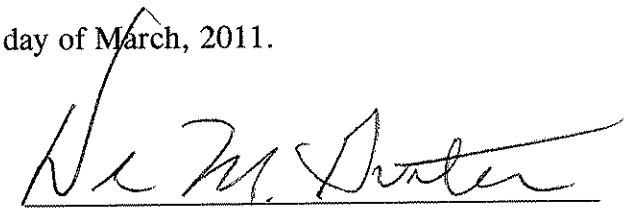
This the 23rd day of March, 2011.



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Rcv'd NP
MAR 15 2011

March 8, 2011

Ms. Valinda Rutledge
Gaston Memorial Hospital
2525 Court Drive
Gastonia, NC 28054

Dear Ms. Rutledge:

We have received your request for initial designation as a Level III Trauma Center. We have made the determination to approve the submission of a complete RFP following notification of your intent to both your primary RAC and the Board of County Commissioners of your primary catchment area.

Your hospital has completed an abbreviated Request for Proposal (RFP) and data from that should be reviewed, updated where necessary and transferred to the new, updated RFP which can be found on FTP site FTP://ftp.ncagrgis.com/oems/trauma. Please ensure all questions on the RFP are completed and submit the document and attachments to our office via the FTP site by September 8, 2011. This FTP site is password protected. Please contact Susan Rogers at (919) 855-4698 or email her at susan.rogers@dhhs.nc.gov for the user name and password.

The date for the site visit has been scheduled for December 8, 2011. In conjunction with this visit, the North Carolina Office of Emergency Medical Services hereby requests written verification by April 8, 2011 that the hospital recognizes and accepts financial responsibility for the site visit. The state will handle all the personal service contracts, collect receipts and make the payments to the site team members. Gaston Memorial Hospital will be asked to reimburse the state in one check. Documentation of expenses will be provided, usually within sixty days of the visit. Site team members will be reimbursed for meals in keeping within state regulations for state employees. Individuals representing OEMS are not members of the survey team, therefore their expenses are not billed to the hospital.

If you or your staff should have any questions, please feel free to contact me at (919) 855-3960.

Sincerely,

Nadine Pfeiffer, RN, BSN
Assistant Chief, Health Systems

cc: Regina Godette-Crawford, Interim Chief
Tom Mitchell, Interim Assistant Chief, Administration
Jeff Powell, Regional Specialist
Danny Harbinson, Western Regional Manager
Angel Ross, RN, BSN, Trauma Program Coordinator
James O'Connor, MD, Trauma Medical Director
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Michael Thomason, MD, OEMS Trauma Medical Advisor

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News

Duke University Health System and LifePoint Hospitals Pa to Create Innovative Options for Community Hospitals

By Duke Medicine News and Communications

Duke University Health System Inc. and LifePoint Hospitals have formed DLP Healthcare LLC (Duke/LifePoint), a joint venture designed to strengthen and improve health care delivery throughout North Carolina and the surrounding regions by creating flexible affiliation options for community hospitals.

The unique joint venture combines LifePoint's extensive operational resources and experience in successfully managing community-based hospitals with Duke's renowned expertise and leadership in the development of clinical services and quality systems.

Duke/LifePoint is one of the first joint ventures between an academic health system and a hospital operations company. Its mission is to own and operate a system of highly functioning community hospitals. It will provide local hospitals with extensive clinical and operational support, quality measurement tools, and resources to effectively grow and expand services to better serve their communities.

Maria Parham Medical Center, a private, non-profit, hospital located in Henderson, North Carolina, today signed a memorandum of understanding with Duke/LifePoint which will make it the first hospital in the new Duke/LifePoint network. Maria Parham has served communities throughout north central North Carolina and southern Virginia for nearly 85 years. It has a team of more than 150 physicians and 700 clinical and support staff and offers a wide range of health care services.

"This is a challenging time for many community hospitals as the health care environment undergoes significant change and costs continue to rise," said

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William F. Carpenter III, chairman and chief executive officer of LifePoint Hospitals.

"Duke/LifePoint has the ability to help hospitals not only weather the months and years ahead, but also prosper and offer their communities even better care. This joint venture will provide community hospitals in North Carolina and the surrounding area with Duke's outstanding clinical leadership and resources plus the strong financial and operational experience of LifePoint. We have an exciting opportunity to build a hospital system that will transform health care in this region."

LifePoint will bring the Duke/LifePoint partnership a range of financial and operational resources, including access to capital for ongoing investments in new technology and facility renovations.

Duke will offer Duke/LifePoint hospitals guidance in clinical service development and support for enhancing quality systems as well as access to highly specialized medical services to help meet their communities' needs. Duke/LifePoint hospitals also will have the ability to share best practices with hospitals, clinics, and health care providers throughout the Duke and LifePoint systems.

"Duke and LifePoint share a commitment to working collaboratively with communities, physicians, and hospital staffs to optimize the availability of innovative health care services locally, while applying proven operational strategies that are more important than ever in the era of health care reform," said William J. Fulkerson Jr., MD, executive vice president of Duke University Health System.

"We're pleased to become LifePoint's programmatic, safety, quality, and clinical service development partner and believe that Duke/LifePoint offers an attractive option for community hospitals."

LifePoint Hospitals operates 52 hospital campuses in 17 states. The company specializes in operating community hospitals in non-urban markets where the hospital is the sole community provider in most of the communities it serves. Duke University Health System has inpatient and ambulatory locations throughout North Carolina and surrounding areas. It has partnered with many hospitals throughout its region to establish specialized medical services in their communities.

Duke and LifePoint have worked together through an existing affiliation for improving cardiovascular services at Danville Regional Medical Center in Danville, Virginia. This collaboration has resulted in the establishment of a systematic

approach for heart attack patients that has received recognition by the American College of Cardiology National Cardiovascular Data Registry for achieving consistency in adhering to evidence-based standards of heart attack care for the past year.

For more information, please visit www.DLPHealthcare.com.

About This Page
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