COMPETITIVE COMMENTS ON

2022 MECKLENBURG COUNTY ACUTE CARE BED APPLICATIONS

SUBMITTED BY NOVANT HEALTH

DECEMBER 1, 2022

Four CON applications were submitted in response to the 2022 SMFP need determination for 65 additional acute care beds in Mecklenburg County, including:

> CON Project ID# F-12280-22 Atrium Health Pineville: Add 11 acute care beds at Atrium Health (AH) Pineville
>
> CON Project ID# F-12281-22 Atrium Health CMC: Add 38 acute care beds at Carolinas Medical Center (CMC)
>
> CON Project ID# F-12282-22 Atrium Health University: Add 16 acute care beds at AH University City
>
> CON Project ID# F-12293-22 Novant Health Presbyterian Medical Center (NHPMC): Add 30 acute care beds at NHPMC.

As the foregoing list shows, Atrium Health ("AH") has applied for all 65 beds; Novant Health has applied for less than half of the 65 beds. As the smaller system in Mecklenburg County with a demonstrated need for the 30 beds at its flagship, tertiary level medical center, the Novant Health application should be approved for 30 beds at NHPMC.

These comments are submitted by Novant Health in accordance with N.C. Gen. Stat. § 131E-185(a1)(1) to address the representations in the applications, including a comparative analysis and a discussion of the most significant issues regarding the applicants' conformity with the statutory and regulatory review criteria ("the Criteria") in N.C. Gen. Stat. §131E-183(a) and (b). Other non-conformities and errors in the competing applications may exist and Novant Health reserves the right to develop additional opinions, as appropriate upon further review and analysis.

These comments demonstrate that the AH applications are not approvable and therefore, no beds should be awarded to AH in this review. In the event the Agency decides to award any beds to AH, Novant Health respectfully submits that the award to AH should be no greater than 35 beds in total. This would allow the Agency to approve the Novant Health application as proposed. As the Novant Health application demonstrates, it is conforming to all applicable review criteria and rules and is the comparatively superior applicant in this review.[1]

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[1] To be clear, Novant Health is not agreeing that Atrium Health should be approved for any beds, and it is not waiving any right to appeal an award of beds to Atrium Health.

COMPARATIVE ANALYSIS

Pursuant to G.S. § 131E-183(a)(1) and the 2022 State Medical Facilities Plan, no more than 65 acute care beds may be approved for Mecklenburg County in this review. Because the applications in this review collectively propose to develop 95 additional acute care beds in Mecklenburg County, all applications cannot be approved for the total number of beds proposed. Therefore, a comparative review is required as part of the Agency findings after each application is reviewed independently against the applicable statutory review criteria. The following factors have recently been utilized by the Agency for all reviews regardless of the type of services or equipment proposed:

- Conformity with Statutory and Regulatory Review Criteria
- Scope of Services
- Geographic Accessibility
- Historical Utilization
- Access by Service Area Residents
- Access by Underserved Groups: Charity Care
- Access by Underserved Groups: Medicaid
- Access by Underserved Groups: Medicare
- Competition (Access to a New or Alternate Provider)
- Projected Average Net Revenue per Patient
- Projected Average Total Operating Cost per Patient

Other comparative factors may be utilized based on the facts of the competitive review. The following summarizes the competing applications relative to the potential comparative factors.

<u>Conformity with CON Review Criteria and Rules</u>

Only applicants demonstrating conformity with all applicable review Criteria and rules can be approved, and only the application submitted by Novant Health demonstrates conformity to all Criteria:

Conformity of Applicants

Applicant	Project I.D.	Conforming/ Non-Conforming
AH Pineville	F-12280-22	No
CMC	F-12281-22	No
AH University City	F-12282-22	No
NHPMC	F-12264-22	Yes

The Novant Health application is based on reasonable and supported volume projections and adequate projections of cost and revenues. As discussed below, the competing applications contain errors and flaws which result in one or more non-conformities with statutory and regulatory review Criteria. Therefore, the Novant Health application is the most effective alternative regarding conformity with applicable review Criteria and rules.

Scope of Services

NHPMC and CMC each represent the flagship hospital in Mecklenburg County for their respective health systems. AH University City and AH Pineville are existing acute care hospitals that provide numerous types of medical services, but offer a lesser range of services with lower average acuity levels than patients treated at NHPMC and CMC.

Therefore, NHPMC and CMC are more effective alternatives regarding the scope of services, and AH Pineville and AH University City are less effective alternatives in this review.

Geographic Accessibility

All four applications propose to add new acute care beds to existing facilities. NHPMC, CMC, and AH University City each propose to develop new acute care beds in Charlotte. AH Pineville proposes to develop new acute care beds in Pineville, which already has 278 acute care beds (excluding NICU).

The following table summarizes the average population per existing and approved acute care beds in the Mecklenburg County Municipalities involved in this competitive review.

Municipality	Existing/Approved Beds (Excluding NICU)	2021 Population	Population/Bed
Charlotte	1,810	878,778	485.5
Pineville	278	10,651	38.3

Source: NCOSBM

Based on a comparison of population per bed in the applicable municipalities, the AH Pineville application is a less effective alternative.

Access can also be measured by when the services will be implemented. The sooner a service is implemented, the sooner it can benefit patients. Novant Health's proposed project effectively increases access to acute care services in Mecklenburg County. Novant Health can immediately develop the proposed additional acute care beds because the project does not require renovation or construction. Novant Health's proposed additional acute care beds will become operational by September 1, 2023, and the first project year will be CY2024. The 2022 SMFP acute care bed methodology forecasts need during 2024; therefore, Novant Health's project timetable is consistent with the SMFP planning horizon for the need determined acute care beds.

AH University City's project will not operationalize the proposed beds until June 1, 2025, a year and a half later than Novant Health's project and three years after the applicable SMFP was published. CMC's project will not operationalize the proposed beds until April 1, 2027, nearly three years later compared to Novant

Health and five years after the applicable SMFP was published. Therefore, Novant Health's proposal is the most effective alternative for increasing access to acute care beds in this review.

Historical Utilization

The following table illustrates historical acute care bed utilization for the existing facilities in this review based on acute care days as reported in Table 5A of the 2022 SMFP.

Facility	FFY 2020 Acute Care Days	ADC	# of Acute Care Beds	Utilization	Projected (Surplus)/Deficit
CMC	325,164	891	1,055	84.5%	**156**
AH Pineville	72,498	199	233	85.4%	**23**
AH University City	28,116	77	100	77.0%	**28**
NH Presbyterian	148,333	406	519	78.2%	**95**

Source: 2022 SMFP, Table 5A

Based on the acute care bed methodology, each of the facilities in this competitive review exhibits bed deficits that contributed to the 2022 Mecklenburg County acute care bed need determination. No single facility or system generated the need in the 2022 SMFP, and even if one facility or system did generate the need, it would not entitle that facility or system to any beds. Each applicant must demonstrate the need for the project proposed in its application.

The need for additional acute care beds in the 2022 SMFP is triggered by the utilization of the total number of existing and approved acute care beds within a given service area. To project inpatient days of care in 2024, the total annual percentage of change over each of the last five fiscal years is divided by four to determine the historical percentage change for the county. For positive annual percentages of change, as is the case for Mecklenburg County, add one to determine the county growth rate multiplier. For counties with a positive county growth rate multiplier, 2024 projected days of care are calculated by compounding the growth rate multiplier over the next four years. Mecklenburg County's growth rate multiplier is 1.036. The historical days of care used to calculate the Mecklenburg County growth rate multiplier are summarized in the following table.

Mecklenburg County Acute Care Days

	2016	2017	2018	2019	2020	CAGR	
Atrium Health Total Days of Care	382,846	395,604	405,977	421,703	425,778	**2.7%**	***Average Annual Change***
Novant Health Total Days of Care	182,594	185,596	190,746	217,163	225,108	**5.4%**	
Mecklenburg Co. Total Days of Care	565,440	581,200	596,723	638,866	650,886	**3.6%**	
							3.60%

Source: 2018 SMFP - 2022 SMFP, Table 5A: Acute Care Bed Need Projections

As illustrated in the previous table, Novant Health's systemwide acute days of care have experienced a higher rate of growth compared to Atrium Health. Mecklenburg County's historical acute care growth rate and the resulting county growth rate multiplier are attributed to Novant Health's robust historical utilization. In other words, regarding projected bed need per the acute care bed methodology, Atrium Health benefits from Novant Health's robust historical utilization via the application of a growth rate (3.6%) that is higher compared to Atrium Health's historical utilization (2.7%).

If Atrium Health's systemwide projected acute care bed need were calculated based on its historical rate of change (2.7%) instead of the Mecklenburg County rate of change (3.6%), the Atrium Health system projected bed need would be ***reduced*** from 176 beds in column K of Table 5A of the 2022 SMFP by nearly 70 beds. Please see the following table.

Atrium Health System Projected Acute Care Bed Need Based on Historical Growth

Growth Rate	2022 SMFP Bed Inventory	2024 Projected Days of Care	2024 Projected ADC	2024 Beds Adjusted for Target Occupancy	Projected 2024 Deficit or (Surplus)
2.7%	1,554	473,524	1,297	1,661	**107**

Source: Bed need calculated based on 2022 SMFP acute care bed methodology substituting Atrium Health's historical growth rate instead of county growth rate.

Conversely, if Novant Health's system projected bed need was calculated based on its historical rate of change (5.4%) instead of the county rate of change, the Novant Health system projected bed need would ***nearly quadruple*** from 12 beds in Column K of Table 5A of the 2022 SMFP to 47 beds.

Novant Health System Projected Acute Care Bed Need Based on Historical Growth

Growth Rate	2022 SMFP Bed Inventory	2024 Projected Days of Care	2024 Projected ADC	2024 Beds Adjusted for Target Occupancy	Projected 2024 Deficit or (Surplus)
5.4%	926	277,521	760	973	**47**

Source: Bed need calculated based on 2022 SMFP acute care bed methodology substituting Novant Health's historical growth rate instead of the Mecklenburg County growth rate.

Novant Health has conservatively proposed the addition of only 30 acute care beds at NHPMC, which is less than the systemwide deficit projected in the previous table, far less than the projected facility deficit of 95 beds per the standard acute care bed methodology, and less than half of the total new acute care beds needed in Mecklenburg County pursuant to the 2022 SMFP. Additionally, Novant Health can immediately develop the proposed additional acute care beds because the project does not require renovation or construction. Novant Health's proposed additional acute care beds will become operational by September 1, 2023, and the first project year will be CY2024. The 2022 SMFP acute care bed methodology forecasts need during 2024; therefore, Novant Health's project timetable is consistent with the SMFP planning horizon for the need determined acute care beds. The speed with which Novant Health can develop its proposed 30 beds at NHPMC is relevant to meeting the needs of patients.

For the foregoing reasons, Novant Health's proposal to develop 30 additional acute care beds at NHPMC is the most effective alternative regarding historical utilization.

Competition (Patient Access to a New or Alternate Provider)

The following table illustrates the existing and approved providers located in the service area. Considering the applicants in this competitive review are each existing providers in the service area, the expansion of an existing provider that currently controls fewer acute care beds than another provider would encourage all providers in the service area to improve quality or lower costs in order to compete for patients.

As of November 2022, there are 2,603 existing and approved acute care beds, allocated between 10 facilities operated by two providers (Novant Health and AH) in the Mecklenburg County Service Area, as illustrated in the following table.

Facility	Existing/ Approved Beds
AH Lake Norman	0 (+30)
AH Pineville	233 (+70)
AH University City	100 (+12)
CMC	1,055 (+162)
Atrium Total	**1,662**
NH Ballantyne Medical Center	0 (+36)
NH Huntersville Medical Center	139 (+12)
NH Health Matthews Medical Center	154 (+20)
NH Health Presbyterian Medical Center	519 (-7)
NH Mint Hill Medical Center	36
NH Steele Creek Medical Center	0 (+32)
Novant Total	**941**
Mecklenburg County Total	**2,603**

Source: Table 5A, 2022 SMFP; Proposed 2023 SMFP, applications under review; 2022 LRAs

Atrium Health currently controls 1,662 of the 2,603 acute care beds in Mecklenburg County, or 63.8%. Novant Health controls only 941 of the acute care beds in Mecklenburg County, or 36.2%.

If Atrium Health University City, Atrium Health Pineville, and Carolinas Medical Center all have their applications approved for a combined total of 65 acute care beds, Atrium would control 1,727 of the 2,668 existing or approved acute care beds (following this review) in Mecklenburg County, or 64.7 percent, and Novant would control 941 of the 2,668 existing or approved acute care beds, or 35.2 percent.

If NHPMC's application for 30 acute care beds is approved, and the remaining 35 acute care beds are awarded to Atrium Health University City, Atrium Health Pineville, and Carolinas Medical Center, Novant Health would control 971 of the 2,668 existing and approved acute care beds in Mecklenburg County, or 36.4 percent, and Atrium would control 1,697 of the 2,668 existing and approved acute care beds in Mecklenburg County, or 63.6 percent. Regardless of the ultimate conclusion of this comparative analysis, AH will control a larger percentage of acute care beds in Mecklenburg County than it currently does.

The Agency has repeatedly recognized that improving competition in Mecklenburg County is an important issue, and has repeatedly determined that Novant Health is the more effective alternative with regard to competition in Mecklenburg County acute care bed reviews. *See, e.g.*, Findings in 2021 Mecklenburg County Acute Care Bed Review, p. 129 (March 29, 2022); Findings in 2020 Mecklenburg County Acute Care Bed Review, p. 185 (May 4, 2021); Findings in 2019 Mecklenburg County Acute Care Bed Review, p. 223 (April 2, 2020); and Findings in 2018 Mecklenburg County Acute Care Bed Review, p. 172 (April 5, 2019). The facts have not changed. The Agency should analyze competition in the same way it has in the last several reviews and determine that the NHPMC Application is the more effective alternative with respect to competition.

Therefore, with regard to patient access to a new or alternate provider, the application submitted by Novant Health is the most effective alternative, and the applications submitted by AH are less effective alternatives.

<u>Access By Service Area Residents</u>

On page 32, the 2022 SMFP defines the service area for acute care beds as "the acute care bed service area in which the bed is located. The acute care bed service areas are the single and multicounty groupings shown in Figure 5.1." Figure 5.1, on page 38, shows Mecklenburg County as a single county acute care bed service area. Thus, the service area for this review is Mecklenburg County. Facilities may also serve residents of counties not included in their service area.

The following table illustrates access by service area residents during the third full fiscal year following project completion.

Projected Service to Mecklenburg County Residents, Project Year 3

	AH Pineville	CMC	AH University City	NHPMC
# of Mecklenburg County Patients	7,630	24,212	6,705	19,578
% of Mecklenburg County Patients	36.5%	49.3%	74.8%	68.6%

Source: CON applications, Section C.3

As shown in the previous table, NHPMC is the second most effective applicant regarding number and percentage of Mecklenburg County patients during the third project year.

Novant Health acknowledges the Agency has determined in previous reviews that an analysis of access by service area residents was inconclusive in Mecklenburg County. In the 2021 Mecklenburg County acute care bed review the Agency stated, "*the acute care bed need determination methodology is based on utilization of all patients that utilize acute care beds in Mecklenburg County and is not only based on patients originating from Mecklenburg County*." 2021 Findings, p. 121. The Agency stated that CMC's Level I trauma center and academic medical center status, "*is likely to pull in many patients from significant distances who are seeking the specialized level of health care offered by Carolinas Medical Center*." Id. Additionally, in its concurrent 2022 Mecklenburg County applications, AH contends that it is not appropriate to determine the comparative effectiveness of access by service area residents.

Novant Health respectfully disagrees with the Agency's 2021 inconclusive determination and AH's contention. Every acute care service area serves patients from counties outside the service area, i.e., in-migration. A comparison of acute care in-migration among other urban counties reveals that Mecklenburg County has a comparatively lower percentage of patients in-migrating compared to other counties. Please see the following table.

Percentage of Patients In-migrating to Service Area

County/Service Area	No. of Acute Care Beds (Existing & Approved)	In-Migration (% of Patients from Other Counties)
Orange	931	84.5%
Durham	1,428	64.7%
Moore	384	60.2%
Pitt	932	58.2%
Forsyth	1,761	56.8%
New Hanover	749	54.4%
Buncombe	733	52.5%
Mecklenburg	2,603	42.0%
Wake	1,547	30.8%

Source: 2022 SMFP, 2022 Acute Care Patient Origin Report: Patient Origin by County of Service

As shown in the previous table, the majority of acute care discharges that occurred in Mecklenburg County during FY2021 were residents of Mecklenburg County (58%). Only 42% of acute care discharges that occurred in Mecklenburg County were those of residents from other counties. Orange, Durham, Moore, Pitt, Forsyth, New Hanover, and Buncombe counties each have much higher percentages of patients in-migrating from counties outside the respective service area. Novant Health notes that the 2020 Forsyth Acute Care Bed Review included a conclusive determination of access by service area residents and Forsyth County has a comparatively higher percentage of in-migration compared to Mecklenburg County.[2]

The Agency's statement from the 2021 Mecklenburg County acute care bed review that "*the acute care bed need determination methodology is based on utilization of all patients that utilize acute care beds in Mecklenburg County and is not only based on patients originating from Mecklenburg County*" is true for any respective acute care service area. Novant Health would note the Agency has also determined that, "*regarding this comparative factor, the application projecting to serve the largest number of service area residents is the more effective alternative based on the assumption that residents of a service area should be able to derive a benefit from a need determination for additional acute care beds in the service area where they live*." See page 121 of Agency Findings for 2021 Mecklenburg Acute Care Bed Review. Therefore, consistent with the intent of the comparative factor and in consideration of the comparatively lower percentage of in-migration that occurred in Mecklenburg County during FY2021, it is reasonable and appropriate to reach a conclusive determination regarding access by service area residents in this review as shown in the following table.

[2] Agency Findings for 2020 Forsyth Acute Care Beds Review, pp. 59-60 (January 2, 2021).

Comparative Factor	Novant Health	AH Pineville	AH CMC	AH University City
Access by Service Area Residents: No. of Patients	**More Effective**	Less Effective	Most Effective	Least Effective
Access by Service Area Residents: % of Patients	**More Effective**	Least Effective	Less Effective	Most Effective

Access By Underserved Groups

Underserved groups are defined in G.S. § 131E-183(a)(13) as follows:

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

For access by underserved groups, applications are compared with respect to three underserved groups: charity care patients (i.e., medically indigent or low-income persons), Medicare patients and Medicaid patients. Access by each group is treated as a separate factor.

The Agency may use one or more of the following metrics to compare the applications:

- Total charity care, Medicare or Medicaid patients
- Charity care, Medicare or Medicaid admissions as a percentage of total patients
- Total charity care, Medicare or Medicaid dollars
- Charity care, Medicare or Medicaid dollars as a percentage of total gross or net revenues
- Charity care, Medicare or Medicaid cases per patient

The above metrics the Agency uses are determined by whether or not the applications included in the review provide data that can be compared as presented above and whether or not such a comparison would be of value in evaluating the alternative factors.

Projected Charity Care

The following table compares projected charity care in the third full fiscal year following project completion for the applicants.

Projected Charity Care – 3rd Full FY

	Form F.2b	Form C.1b		Form F.2b	
Applicant	**Total Charity Care**	**Discharges**	**Avg Charity Care per Discharge**	**Gross Revenue**	**% of Gross Revenue**
AH Pineville	$17,555,060	20,933	$839	$395,775,029	4.4%
CMC	$97,169,863	49,070	$1,980	$1,935,047,001	5.0%
AH University City	$13,448,851	8,959	$1,501	$204,292,236	6.6%
NHPMC	$54,784,215	28,552	$1,919	$58,372,941	2.4%

NHPMC projects the second-highest average charity care per discharge of the competing applications.

There are notable differences among the competing applications that result in an analysis of charity care being inconclusive. In Section L, page 93, Novant Health states that it provides charity care to both insured and uninsured patients. Additionally, on page 95 Novant Health states that it makes no differentiation between charity care and reduced-cost care patients.

In Section L, page 121, AH University City says its internal data does not track charity care as a payor source and charity care is provided to patients across all payor categories. However, in the assumptions immediately following Forms F.2 and F.3, the applicant states that projected charity care is the difference between projected gross revenue and projected net revenue for self-pay patients.

In Section L, page 123, AH Pineville says its internal data does not track charity care as a payor source and charity care is provided to patients across all payor categories. However, in the assumptions immediately following Forms F.2 and F.3, the applicant states that projected charity care is the difference between projected gross revenue and projected net revenue for self-pay patients.

In Section L, page 125, CMC says its internal data does not track charity care as a payor source and charity care is provided to patients across all payor categories. However, in the assumptions immediately following Forms F.2 and F.3, the applicant states that projected charity care is the difference between projected gross revenue and projected net revenue for self-pay patients.

Additionally, NHPMC's pro formas are not structured the same way as those from AH University City, AH Pineville, and CMC. NHMPC's pro formas capture the entire patient stay. In the assumptions and methodology for Form F.2, Novant Health states that the acute care gross charges include nursing units, inpatient surgery revenue, ED services, imaging, obstetrics/ newborn costs, and all ancillary services. In the assumptions and methodology for Forms F.2 and F.3, AH University City, AH Pineville, and CMC all state the gross revenue includes acute care bed charges and expenses only, and do not include any ancillary services such as lab, radiology, or surgery.

Based on the differences in how each applicant categorizes charity care and the differences in the presentation of pro forma financial statements, one cannot make a valid comparison of the charity care provided by each applicant for purposes of evaluating which application was more effective regarding this comparative factor. Accordingly, the Agency should determine that this factor is inconclusive. *See also* Findings in 2021 Mecklenburg County Acute Care Bed Review, p. 123.

Projected Medicare

The following table compares projected access by Medicare patients in the third full fiscal year following project completion for all the applicants in the review.

Projected Medicare Revenue – 3rd Full FY

	Form F.2b	Form C.1b		Form F.2b	
Applicant	Total Medicare Revenue	Discharges	Avg Medicare Rev. per Discharge	Gross Revenue	% of Gross Revenue
AH Pineville	$228,281,502	20,933	$10,905	$395,775,029	57.7%
CMC	$708,126,534	49,070	$14,431	$1,935,047,001	36.6%
AH University City	$94,557,738	8,959	$10,554	$204,292,236	46.3%
NHPMC	$974,117,055	28,552	$34,117	$2,281,372,363	42.7%

Generally, the application projecting to provide the most revenue to Medicare patients is the more effective alternative for this comparative factor. As shown in the previous table, NHPMC is the most effective alternative with respect to average Medicare revenue per discharge.

As previously described, NHPMC's pro formas are not structured the same way as those from AH University City, AH Pineville, and CMC. In the assumptions and methodology for Form F.2, Novant Health states that the acute care gross charges include nursing units, inpatient surgery revenue, ED services, imaging, obstetrics/newborn costs, and all ancillary services. In the assumptions and methodology for Forms F.2 and F.3, AH University City, AH Pineville, and CMC all state the gross revenue includes acute care bed charges and expenses only, and do not include any ancillary services such as lab, radiology, or surgery.

Based on the differences in the presentation of pro forma financial statements, one cannot make a conclusive comparison of the Medicare access provided by each applicant for purposes of evaluating which application was more effective regarding this comparative factor. Accordingly, the Agency should determine that this factor is inconclusive. *See also* Findings in 2021 Mecklenburg County Acute Care Bed Review, p. 124.

Projected Medicaid

The following table compares projected access by Medicaid patients in the third full fiscal year following project completion for all the applicants in the review.

Projected Medicaid Revenue – 3rd Full FY

Applicant	Form F.2b Total Medicaid Revenue	Form C.1b Discharges	Avg Medicaid Rev. per Discharge	Form F.2b Gross Revenue	% of Gross Revenue
AH Pineville	$40,687,198	20,933	$1,944	$395,775,029	10.3%
CMC	$546,992,248	49,070	$11,147	$1,935,047,001	28.3%
AH University City	$32,997,726	8,959	$3,683	$204,292,236	16.2%
NHPMC	$315,700,645	28,552	$11,057	$2,281,372,363	13.8%

Generally, the application projecting to provide the most revenue to Medicaid patients is the more effective alternative for this comparative factor. As shown in the previous table, NHPMC projects the second-highest average Medicaid revenue per discharge.

As previously described, NHPMC's pro formas are not structured the same way as those from AH University City, AH Pineville, and CMC. In the assumptions and methodology for Form F.2, Novant Health states the acute care gross charges include nursing units, inpatient surgery revenue, ED services, imaging, obstetrics/newborn costs, and all ancillary services. In the assumptions and methodology for Forms F.2 and F.3, AH University City, AH Pineville, and CMC all state that gross revenue includes acute care bed charges and expenses only, and do not include any ancillary services such as lab, radiology, or surgery.

Based on the differences in the presentation of pro forma financial statements, one cannot make a conclusive comparison of the Medicaid access provided by each applicant for purposes of evaluating which application was more effective regarding this comparative factor. Accordingly, the Agency should determine that this factor is inconclusive. *See also* Findings in 2021 Mecklenburg County Acute Care Bed Review, p. 125.

Projected Average Net Revenue per Patient

The following table shows the projected average net revenue per patient in the third year of operation for each of the applicants, based on the information provided in the applicants' pro forma financial statements (Section Q). Generally, the application proposing the lowest average net revenue is the more effective alternative regarding this comparative factor since a lower average may indicate a lower cost to the patient or third-party payor.

Projected Average Net Revenue per Patient – 3rd Full FY

Applicant	Form C.1b	Form F.2b	Average Net Revenue per Discharge
	Discharge	Net Revenue	
AH Pineville	20,933	$102,434,256	$4,893
CMC	49,070	$530,338,548	$10,808
AH University City	8,959	$58,372,941	$6,516
NHPMC	28,552	$651,710,978	$22,825

As previously described, NHPMC's pro formas are not structured the same way as those from AH University City, AH Pineville, and CMC. In the assumptions and methodology for Form F.2, Novant Health states the acute care gross charges include nursing units, inpatient surgery revenue, ED services, imaging, obstetrics/newborn costs, and all ancillary services. In the assumptions and methodology for Forms F.2 and F.3, AH University City, AH Pineville, and CMC all state that gross revenue includes acute care bed charges and expenses only, and do not include any ancillary services such as lab, radiology, or surgery.

Therefore, a comparison of projected net revenue per patient is inconclusive. *See also* Findings in 2021 Mecklenburg County Acute Care Bed Review, pp. 125-126.

Projected Average Operating Expense per Patient

The following table shows the projected average operating expense per patient in the third full fiscal year following project completion for each facility. Generally, the application projecting the lowest average operating expense per patient is the more effective alternative with regard to this comparative factor to the extent it reflects a more cost-effective service which could also result in lower costs to the patient or third-party payor.

Projected Average Operating Expense per Patient – 3rd Full FY

Applicant	Form C.1b	Form F.2b	Average Operating Expense per Discharge
	Discharge	Operating Expense	
AH Pineville	20,933	$86,259,603	$4,121
CMC	49,070	$422,079,060	$8,602
AH University City	8,959	$43,604,117	$4,867
NHPMC	28,552	$645,215,145	$22,598

As previously described, NHPMC's pro formas are not structured the same way as those from AH University City, AH Pineville, and CMC. In the assumptions and methodology for Form F.2, Novant Health states the acute care gross charges include nursing units, inpatient surgery revenue, ED services, imaging, obstetrics/newborn costs, and all ancillary services. In the assumptions and methodology for Forms F.2 and F.3, AH University City, AH Pineville, and CMC all state that gross revenue includes acute care bed charges and expenses only, and do not include any ancillary services such as lab, radiology, or surgery.

Therefore, a comparison of the projected average operating expense per patient is inconclusive. *See also* Findings in 2021 Mecklenburg County Acute Care Bed Review, p. 126.

Access to Proposed New Acute Care Beds: Services Offered

If the Agency determines its analysis of "Access by Service Area Residents" and "Access by Medically Underserved" to be inconclusive, Novant Health believes the Agency should include a comparative factor that can result in a meaningful and conclusive comparison of access among the competing applications in this review. One such factor is a comparison of when the projected acute care beds will become operational. Regarding this comparative factor, the application that projects to develop new acute care beds the fastest is the more effective alternative based on the assumption that patients utilizing acute care beds in the service area will benefit from the need-determined acute care beds expeditiously. For information purposes, the 2022 SMFP acute care bed methodology forecasts acute care bed need during 2024. The following table compares the project completion dates for the applications in this review.

Projected Service to Mecklenburg County Residents, Project Year 3

	AH Pineville	CMC	AH University	NHPMC
# of Mecklenburg County Patients	1/1/2025	4/1/2027	6/1/2025	**9/1/2023**

Source: CON applications, Section P

Novant Health's proposed project effectively increases access to acute care services in Mecklenburg County. Novant Health can immediately develop the proposed additional acute care beds because the project does not require renovation or construction. Novant Health's proposed additional acute care bed would become operational by September 1, 2023, and the first project year will be CY2024 which is consistent with the 2022 SMFP acute care bed methodology forecasted need.

AH University City's project will not operationalize the proposed beds until June 1, 2025, a year and a half later than Novant Health's project. CMC's project will not operationalize the proposed beds until April 1, 2027, nearly three years later compared to Novant Health. Therefore, Novant Health's proposal is the most effective alternative for increasing access to acute care beds in this review.

In conclusion, NHPMC's proposed project timetable is the most effective alternative regarding this factor.

Summary

The following table lists the comparative factors and states which application is the more effective alternative.

Comparative Factor	Novant Health	AH Pineville	CMC	AH University City
Conformity with Review Criteria	**Most Effective**	Least Effective	Least Effective	Least Effective
Scope of Services	Equally Effective	Less Effective	Equally Effective	Least Effective
Geographic Accessibility	**Most Effective**	Least Effective	Most Effective	Most Effective
Historical Utilization	**Most Effective**	Least Effective	Least Effective	Least Effective
Enhance Competition	**Most Effective**	Least Effective	Least Effective	Least Effective
Access by Service Area Residents: No. of Patients	**More Effective**	Less Effective	Most Effective	Least Effective
Access by Service Area Residents: % of Patients	**More Effective**	Least Effective	Less Effective	Most Effective
Access by Underserved Groups				
Projected Charity Care	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Projected Medicare	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Projected Medicaid	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Projected Average Net Revenue per Patient	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Projected Average Operating Expense per Patient	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Access to Proposed New Acute Care Beds: Services Offered	**Most Effective**	More Effective	Least Effective	Less Effective

For each of the comparative factors previously discussed, NHPMC's application is determined to be the most or more effective alternative for the following factors:

- Conformity with Review Criteria
- Scope of Services
- Geographic Accessibility
- Historical Utilization
- Enhance Competition
- Access by Service Area Residents: Number of Patients
- Access by Service Area Residents: % of Patients
- Access to Proposed New Acute Care Beds: Services Offered

COMMENTS REGARDING CRITERION (3)

<u>AH System Need</u>

The CMC, AH Pineville, and AH University City applications each contain identical discussions of "Overview of Unmet Need" and "The CMHA System is Chronically Underbedded (Unlike Any Other Hospital or System in NC)," which announce, in dramatic fashion, that AH as a health system has a need for additional acute care beds. However, AH's alleged system-based need and comparisons to other North Carolina health systems do not inform the Agency why the specific projects proposed by the applications conform to Criterion (3). The applicant must still demonstrate the need for the specific project it proposes.

Similar irrelevant narratives were included in AH's 2021 Mecklenburg County applications and were rejected in the Agency's analyses of conformity to Criterion (3). Specifically, the following provides excerpts from the Agency's findings in the 2021 Mecklenburg Acute Care Bed Review.

2021 Mecklenburg Acute Care Bed Review
Project I.D. #s: F-12144-21, F-12146-21, F-12147-21, & F-12149-21
Page 20

<u>Analysis of Need</u> – In Section C, pages 39-75, the applicant combined its discussion of need for additional acute care beds at AH University City with discussion of the AH System need for acute care beds and comparisons which are not part of the analysis of whether the application is conforming with Criterion (3). In a competitive review, every application is first evaluated independently, as if there are no other applications in the review, to determine whether the application is conforming to all statutory and regulatory review criteria. Therefore, the discussion in this section focuses only on the need as it relates to AH University City in this specific application under review.

In Section C, Atrium discusses how acute care bed need determinations in Mecklenburg County have been generated entirely by Atrium facilities. However, on page 46 in Chapter 5 of the 2021 SMFP, it states:

> *"Any person can apply to meet the need, not just the health service facility or facilities that generated the need."*

2021 Mecklenburg Acute Care Bed Review
Project I.D. #s: F-12144-21, F-12146-21, F-12147-21, & F-12149-21
Page 30

Analysis of Need – In Section C, pages 40-78, the applicant combined its discussion of need for additional acute care beds at AH Pineville with discussion of the AH System need for acute care beds and comparisons which are not part of the analysis of whether the application is conforming with Criterion (3). In a competitive review, every application is first evaluated independently, as if there are no other applications in the review, to determine whether the application is conforming to all statutory and regulatory review criteria. Therefore, the discussion in this section focuses only on the need as it relates to AH Pineville in this specific application under review.

In Section C, Atrium discusses how acute care bed need determinations in Mecklenburg County have been generated entirely by Atrium facilities. However, on page 46 in Chapter 5 of the 2021 SMFP, it states:

> *"Any person can apply to meet the need, not just the health service facility or facilities that generated the need."*

2021 Mecklenburg Acute Care Bed Review
Project I.D. #s: F-12144-21, F-12146-21, F-12147-21, & F-12149-21
Page 39

Analysis of Need – In Section C, pages 42-78, the applicant combined its discussion of need for additional acute care beds at CMC with discussion of the AH System need for acute care beds and comparisons which are not part of the analysis of whether the application is conforming with Criterion (3). In a competitive review, every application is first evaluated independently, as if there are no other applications in the review, to determine whether the application is conforming to all statutory and regulatory review criteria. Therefore, the discussion in this section focuses only on the need as it relates to CMC in this specific application under review.

In Section C, Atrium discusses how acute care bed need determinations in Mecklenburg County have been generated entirely by Atrium facilities. However, on page 46 in Chapter 5 of the 2021 SMFP, it states:

> *"Any person can apply to meet the need, not just the health service facility or facilities that generated the need."*

Consistent with the Agency's previous decision to properly disregard AH's description of system-based need, the Agency should decline to give credit to Atrium's self-serving and irrelevant "Overview of Unmet Need" and "The CMHA System is Chronically Underbedded (Unlike Any Other Hospital or System in NC)."

Atrium's claims of chronic under-beddedness are nothing new. The Agency has heard these arguments many times before, and, as the chart on page 52 of the CMC application shows, has always awarded Atrium at least some beds every time it has applied in the last five reviews. Still, Atrium is not satisfied, and seems to believe that if it keeps making exaggerated claims of capacity constraints, cherry-picking[3]

[3] In each application, Atrium Health picks a single day in August 2022 to illustrate its capacity constraints. *See, e.g.,* Atrium University application, p. 46; Atrium CMC application, p. 46 ; Atrium Pineville application, p. 47. Although the applications describe these single days in August as "typical," the data provided in the application does not indicate how "typical" these specially-selected August days really are. For information purposes, Atrium provided average daily census data on page 69 of the CMC application; however, occupancy rates were determined based on CMC's 652 currently licensed acute care beds and did not include the additional 115 beds it operates under the

days when its utilization is especially high, the Agency will capitulate and award Atrium everything it asks for, every time it asks. The CON Law and the SMFP do not support this distorted result for several reasons. First, it unfairly tilts the competitive scales in Atrium's favor, which harms patients and payors. Second, it encourages the Agency to avoid analyzing the applications according to their individual merit and conducting a reasonable comparative analysis. Third, it eliminates any incentive Atrium has to try to manage its capacity constraints using a massive inventory of 1,662 existing and approved acute care beds in Mecklenburg County. The Agency should disregard Atrium's hyperbole and analyze the applications according to the law.

<u>2022 SMFP Acute Care Bed Methodology</u>

The CMC, AH Pineville, and AH University City applications each include a discussion of the projected bed need generated by AH facilities based on the 2022 SMFP acute care bed need methodology. However, similar narratives were included in AH's 2021 Mecklenburg County applications and were not influential in the Agency's analyses of conformity to Criterion (3). Specifically, the following provides excerpts from the Agency's findings in the 2021 Mecklenburg Acute Care Bed Review.

2021 Mecklenburg Acute Care Bed Review
Project I.D. #s: F-12144-21, F-12146-21, F-12147-21, & F-12149-21
Page 20

In Section C, Atrium discusses how acute care bed need determinations in Mecklenburg County have been generated entirely by Atrium facilities. However, on page 46 in Chapter 5 of the 2021 SMFP, it states:

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2021 Mecklenburg Acute Care Bed Review
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Page 30

In Section C, Atrium discusses how acute care bed need determinations in Mecklenburg County have been generated entirely by Atrium facilities. However, on page 46 in Chapter 5 of the 2021 SMFP, it states:

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COVID-19 waiver. Therefore, the occupancy rates portrayed in AH's applications are not an accurate representation of facility utilization.

> 2021 Mecklenburg Acute Care Bed Review
> Project I.D. #s: F-12144-21, F-12146-21, F-12147-21, & F-12149-21
> Page 39
>
> In Section C, Atrium discusses how acute care bed need determinations in Mecklenburg County have been generated entirely by Atrium facilities. However, on page 46 in Chapter 5 of the 2021 SMFP, it states:
>
> *"Any person can apply to meet the need, not just the health service facility or facilities that generated the need."*

The following table summarizes projected acute care bed deficits for existing facilities based on the acute care bed methodology in the 2022 SMFP.

Facility	FFY 2020 Acute Care Days	ADC	# of Acute Care Beds	Utilization	Projected (Surplus)/Deficit
CMC	325,164	891	1,055	84.5%	**156**
AH Pineville	72,498	199	233	85.4%	**23**
AH University City	28,116	77	100	77.0%	**28**
NH Presbyterian	148,333	406	519	78.2%	**95**

Source: 2022 SMFP, Table 5A

Each of the facilities in this competitive review has a projected bed deficit that contributed to the 2022 Mecklenburg County acute care bed need determination. No single applicant drove the need or is entitled to any beds.

As previously described, the 2022 SMFP Mecklenburg County growth rate multiplier is 1.036. The historical days of care used to calculate the multiplier are summarized in the following table.

Mecklenburg County Acute Care Days

	2016	2017	2018	2019	2020	CAGR	
Atrium Health Total Days of Care	382,846	395,604	405,977	421,703	425,778	**2.7%**	***Average Annual Change***
Novant Health Total Days of Care	182,594	185,596	190,746	217,163	225,108	**5.4%**	
Mecklenburg Co. Total Days of Care	565,440	581,200	596,723	638,866	650,886	**3.6%**	
							3.60%

Source: 2018 SMFP - 2022 SMFP, Table 5A: Acute Care Bed Need Projections

As illustrated in the previous table, Novant Health's systemwide acute days of care experienced a much higher rate of growth compared to Atrium Health. Mecklenburg County's growth rate multiplier is therefore attributed to Novant Health's robust historical utilization. In other words, regarding projected bed need per the acute care bed methodology, Atrium Health artificially benefits from Novant Health's robust historical utilization via the application of a growth rate (3.6%) that is higher compared to Atrium Health's historical utilization (2.7%).

If Atrium Health's systemwide projected acute care bed need were calculated based on its historical rate of change (2.7%) instead of the county rate of change, the Atrium Health system projected bed need would be reduced by nearly 70 beds. Please see the following table.

Atrium Health System Projected Acute Care Bed Need Based on Atrium Health Historical Growth Rate

AH Growth Rate Multiplier	2022 SMFP Bed Inventory	2024 Projected Days of Care	2024 Projected ADC	2024 Beds Adjusted for Target Occupancy	Projected 2024 Deficit or (Surplus)
1.027	1,554	473,524	1,297	1,661	**107**

Source: Bed need calculated based on 2022 SMFP acute care bed methodology substituting Atrium Health's historical rate of growth for acute care days instead of the Mecklenburg County growth rate for acute care days.

Conversely, if Novant Health's system projected bed need was calculated based on its historical rate of change (5.4%) instead of the county rate of change, the Novant Health system projected bed need would nearly quadruple from 12 beds to 47 beds.

Novant Health System Projected Acute Care Bed Need Based on Novant Health Historical Growth Rate

Growth Rate	2022 SMFP Bed Inventory	2024 Projected Days of Care	2024 Projected ADC	2024 Beds Adjusted for Target Occupancy	Projected 2024 Deficit or (Surplus)
5.4%	926	277,521	760	973	**47**

Source: Bed need calculated based on 2022 SMFP acute care bed methodology substituting Novant Health's historical growth rate instead of the Mecklenburg County growth rate for acute care days.

The previous analyses are provided for illustrative purposes and to underscore the fact that AH is not entitled to any need-determined acute care beds in this review. If the Agency determines that the AH applications conform to all statutory review criteria and administrative rules, then the decision is ultimately based on the comparative analysis. As previously described, the Novant Health application is comparatively superior to the AH applications, and should be approved for all 30 beds proposed in its application.

NICU Beds & Days of Care

In light of the decision by the State Health Coordinating Council to remove NICU utilization from the 2023 SMFP acute care methodology, Novant Health's application included historical utilization including NICU and separate tables excluding NICU. Additionally, Novant Health is aware of the Agency findings for the 2022 Durham/Caswell Acute Care Bed Review dated September 23, 2022. In its analysis of Criterion (3), the Agency considered Duke's historical utilization of NICU beds. The following table summarizes CMC's utilization by bed type and the impact of NICU beds on CMC's occupancy rate.

Carolinas Medical Center

	FY17	FY18	FY19	FY20	FY21
NICU	28,264	29,922	28,888	28,907	29,802
All Other Acute	280,716	283,601	295,296	284,014	314,236
Total Acute Care Days	308,980	313,523	324,184	312,921	344,038
NICU Beds	85	85	85	85	85
Non-NICU	970	970	970	970	970
Total	1,055	1,055	1,055	1,055	1,055
NICU Occupancy	91.1%	96.4%	93.1%	93.2%	96.1%
Non-NICU Occupancy	79.3%	80.1%	83.4%	80.2%	88.8%
Total Occupancy	80.2%	81.4%	84.2%	81.3%	89.3%

Source: CMC License Renewal Applications

Utilization of CMC's non-NICU beds has historically been lower compared to CMC's NICU beds. In other words, excluding NICU days from CMC's utilization results in lower occupancy rates than portrayed in CMC's CON application. CMC is approved for 153 additional acute care beds that have not been developed.[4] CMC's occupancy rate during FY2021 excluding NICU days based on the facility's existing and approved acute care beds is 76.7% [314,236 ÷ 365 = 861 ADC ÷ (970 existing + 153 approved acute care beds) = .766]. AH failed to provide any discussion of the need for additional acute care bed capacity based on the exclusion of NICU utilization from the acute care bed methodology.

[4] CMC was approved to develop 87 additional acute care beds pursuant to Project ID # F-12006-20. Pursuant to Project ID # F-12149-21, CMC was approved to develop 75 additional acute care beds; nine of the 75 beds became operational in July 2022.

Form C Utilization – Assumptions and Methodology

AH's Form C Utilization – Assumptions and Methodology only contain statements regarding projected days of care at AH facilities. AH failed to provide any discussion regarding its assumptions for projecting the average length of stay and the reasonableness of projected discharges. Forms C.1 of the concurrent applications assume varying and fluctuating average lengths of stay for each AH facility through the third project year. For example, the following tables summarize the projected average length of stay and discharges at CMC.

Carolinas Medical Center

	Last Full FY	Interim Full FY	Interim Full FY	Interim Full FY	Interim Full FY	Interim Full FY	Partial FY	1st Full FY	2nd Full FY	2nd Full FY	*22-30 CAGR*
	CY2021	CY2022	CY2023	CY2024	CY2025	CY2026	CY2027	CY2028	CY2029	CY2030	
Discharges	41,895	40,754	41,834	43,460	45,312	45,919	46,689	47,471	48,264	49,070	*2.3%*
Patient Days	292,676	305,899	309,569	312,910	317,184	321,434	326,822	332,294	337,850	343,493	*1.5%*
ALOS	**7.0**	**7.5**	**7.4**	**7.2**	**7.0**	**7.0**	**7.0**	**7.0**	**7.0**	**7.0**	

Source: CMC application, Section Q, Form C

AH projects discharges at CMC will increase by a CAGR of 2.3% between CY2022 and CY2030. However, AH does not explain in the application as submitted what, if any, correlation exists between an increase in acute care days and an increase in discharges. According to data reported in CMC's License Renewal Applications, discharges between FY2016 and FY2021 decreased by a total of -13.3%, or a CAGR of -2.8%. Please refer to the following table.

Carolinas Medical Center

	FY16	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**CAGR**
Discharges	61,312	61,064	56,105	55,753	52,279	53,167	-2.8%

Source: CMC License Renewal Applications

Absent any assumptions contained in the AH applications as submitted regarding ALOS and methodology for projecting discharges at AH facilities, AH's projected discharges are not supported. Implications of unsupported utilization projections result in findings of non-conformity to review Criteria (1), (3), (4), (5), (6), and (18a) and 10A NCAC 14C .3803(a).

COMMENTS REGARDING CRITERION (6)

AH is applying for 65 additional acute care beds when the respective AH facilities collectively have 186 approved beds that have yet to be developed. CMC is approved for 153 additional acute care beds that have not been developed.[5] AH Pineville is approved for 25 additional acute care beds that have not been developed (Project ID F-12147-21). AH University City is approved for eight (8) additional acute care beds that have not been developed (Project ID F-12146-21). Despite claims that additional acute care bed capacity is needed "today," AH has failed to identify any solutions for implementing incremental acute care bed capacity in the near term. AH has not demonstrated in the applications as submitted that the current or past capacity issues raised in its applications will exist once the approved beds are developed. Additionally, it will be many years before these beds are developed at AH facilities, thus discrediting the claim that Atrium needs capacity "today."

Accordingly, the AH applications propose an unnecessary duplication of existing *or approved* capacity, and should be disapproved.

COMMENTS REGARDING CRITERION (18a)

Since the AH applications fail to conform to Criterion (3), these are also non-conforming with other criteria, such as Criterion (18a). Further, in deciding which conforming applications to approve or partially approve, the Agency should consider the public interest in maintaining a competitive balance in the largest healthcare market in North Carolina. There is a public interest in creating, maintaining, and improving competitive balance to keep AH from becoming even more dominant and enabling Atrium to dictate rates to commercial payors, self-insured employers, and individuals. As the Agency is aware from comments submitted in previous Mecklenburg County acute care bed reviews, Atrium Health has been sued on antitrust grounds by the United States Department of Justice and private parties for abusing its dominance. *See, e.g., United States v. The Charlotte-Mecklenburg Hospital Authority*, 3:16-cv-00311 (W.D.N.C.); *Benitez v. The Charlotte-Mecklenburg Hospital Authorit*y, 992 F.3d 229 (4th Cir. 2021); *DiCesare v. The Charlotte-Mecklenburg Hospital Authority*, 376 N.C. 63, 852 S.E.2d 146 (2020). The USDOJ's antitrust case against Atrium Health culminated in a Final Judgment, a copy of which is attached to these comments. The only policy tool the Agency has to improve competitive balance in Mecklenburg County is its CON decisions. Therefore, the Agency should continue to evaluate the competitive balance of acute care beds in Mecklenburg County.

As previously described, AH controls 62.8% of the existing and approved acute care beds in Mecklenburg County. Novant Health controls only 37.2% of the existing and approved acute care beds in Mecklenburg County. Despite CON approval of 15 additional acute care beds during the 2021 Mecklenburg Acute Care Bed Review, Novant Health continues to maintain a minority share of acute care beds in the service area. Therefore, the proposed additional acute care bed capacity at NHPMC will positively impact competition by narrowing the gap of control that remains between Novant Health and AH in Mecklenburg County.

[5] CMC was approved to develop 87 additional acute care beds pursuant to Project ID # F-12006-20. Pursuant to Project ID # F-12149-21, CMC was approved to develop 75 additional acute care beds; nine of the 75 beds became operational in July 2022.

CONCLUSION

With regard to acute care beds, only the application submitted by Novant Health is fully conforming to all applicable Criteria and rules and the Novant Health Application is also comparatively superior to the AH applications. Therefore, the Novant Health application should be approved as submitted. These comments demonstrate that there are flaws in the AH applications that render them unapprovable. If the Agency finds the AH applications conforming with all CON criteria and performance standards, the CMC, AH Pineville, and AH University applications are less effective proposals than the NHPMC application and should be denied or partially approved (for a maximum of 35 beds) on that basis. Fostering competitive balance in Mecklenburg County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high-quality care, lowering costs, and expanding patient choice.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
3:16-cv-00311-RJC-DCK

UNITED STATES OF AMERICA and THE STATE OF NORTH CAROLINA, Plaintiffs, v. THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM, Defendant.	**ORDER**

FINAL JUDGMENT

THIS MATTER comes before the Court on Plaintiff United States' Unopposed Motion for Entry of Modified Proposed Final Judgment, (Doc. No. 98), and the parties' associated briefs and exhibits. WHEREAS, Plaintiffs, the United States of America and the State of North Carolina (collectively "Plaintiffs"), filed their Complaint on June 9, 2016; Plaintiffs and Defendant The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health f/k/a Carolinas HealthCare System (collectively the "Parties"), by their respective attorneys, have consented to the entry of this Final Judgment without trial or adjudication of any issue of fact or law;

AND WHEREAS, this Final Judgment does not constitute any evidence against or admission by any party regarding any issue of fact or law;

AND WHEREAS, the Plaintiffs and Defendant agree to be bound by the provisions of this Final Judgment pending its approval by this Court;

AND WHEREAS, the essence of this Final Judgment is to enjoin Defendant from prohibiting, preventing, or penalizing steering as defined in this Final Judgment;

NOW THEREFORE, before any testimony is taken, without trial or adjudication of any issue of fact or law, and upon consent of the parties, it is ORDERED, ADJUDGED, AND DECREED:

I. JURISDICTION

The Court has jurisdiction over the subject matter of and each of the Parties to this action. The Complaint states a claim upon which relief may be granted against Defendant under Section 1 of the Sherman Act, as amended, 15 U.S.C. § 1.

II. DEFINITIONS

For purposes of this Final Judgment, the following definitions apply:

A. "Benefit Plan" means a specific set of health care benefits and Healthcare Services that is made available to members through a health plan underwritten by an Insurer, a self-funded benefit plan, or Medicare Part C plans. The term "Benefit Plan" does not include workers' compensation programs, Medicare (except Medicare Part C plans), Medicaid, or uninsured discount plans.

B. "Carve-out" means an arrangement by which an Insurer unilaterally removes all or substantially all of a particular Healthcare Service from coverage in a Benefit Plan during the performance of a network-participation agreement.

C. "Center of Excellence" means a feature of a Benefit Plan that designates Providers of certain Healthcare Services based on objective quality or quality-and-price criteria in order to encourage patients to obtain such Healthcare Services from those designated Providers.

D. "Charlotte Area" means Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union counties in North Carolina and Chester, Lancaster, and York counties in South Carolina.

E. "Co-Branded Plan" means a Benefit Plan, such as Blue Local with Carolinas HealthCare System, arising from a joint venture, partnership, or a similar formal type of alliance or affiliation beyond that present in broad network agreements involving value-based arrangements between an Insurer and Defendant in any portion of the Charlotte Area whereby both Defendant's and Insurer's brands or logos appear on marketing materials.

F. "Defendant" means The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health f/k/a Carolinas HealthCare System, a North Carolina hospital authority with its headquarters in Charlotte, North Carolina; and its directors, commissioners, officers, managers, agents, and employees; its successors and assigns; and any controlled subsidiaries (including Managed Health Resources), divisions, partnerships, and joint ventures, and their directors, commissioners, officers, managers, agents, and employees; and any Person on whose behalf Defendant negotiates contracts with, or consults in the negotiation of contracts with, Insurers. For purposes of this Final Judgment, an entity is controlled by

Defendant if Defendant holds 50% or more of the entity's voting securities, has the right to 50% or more of the entity's profits, has the right to 50% or more of the entity's assets on dissolution, or has the contractual power to designate 50% or more of the directors or trustees of the entity. Also for purposes of this Final Judgment, the term "Defendant" excludes MedCost LLC and MedCost Benefits Services LLC, but it does not exclude any Atrium Health director, commissioner, officer, manager, agent, or employee who may also serve as a director, member, officer, manager, agent, or employee of MedCost LLC or MedCost Benefit Services LLC when such director, commissioner, officer, manager, agent, or employee is acting within the course of his or her duties for Atrium Health. MedCostLLC and MedCost Benefits Services LLC will remain excluded from the definition of "Defendant" as long as Atrium does not acquire any greater ownership interest in these entities than it has at the time that this Final Judgment is lodged with the Court.

G. "Healthcare Provider" or "Provider" means any Person delivering any Healthcare Service.

H. "Healthcare Services" means all inpatient services (*i.e.*, acute-care diagnostic and therapeutic inpatient hospital services), outpatient services (*i.e.*, acute-care diagnostic and therapeutic outpatient services, including but not limited to ambulatory surgery and radiology services), and professional services (*i.e.*, medical services provided by physicians or other licensed medical professionals) to the extent offered by Defendant and within the scope of services covered on an in-network basis pursuant to a contract between Defendant and an Insurer.

"Healthcare Services" does not mean management of patient care, such as through population health programs or employee or group wellness programs.

I. "Insurer" means any Person providing commercial health insurance or access to Healthcare Provider networks, including but not limited to managed-care organizations, and rental networks (*i.e.*, entities that lease, rent, or otherwise provide direct or indirect access to a proprietary network of Healthcare Providers), regardless of whether that entity bears any risk or makes any payment relating to the provision of healthcare. The term "Insurer" includes Persons that provide Medicare Part C plans, but does not include Medicare (except Medicare Part C plans), Medicaid, or TRICARE, or entities that otherwise contract on their behalf.

J. "Narrow Network" means a network composed of a significantly limited number of Healthcare Providers that offers a range of Healthcare Services to an Insurer's members for which all Providers that are not included in the network are out of network.

K. "Penalize" or "Penalty" is broader than "prohibit" or "prevent" and is intended to include any contract term or action with the likely effect of significantly restraining steering through Steered Plans or Transparency. In determining whether any contract provision or action "Penalizes" or is a "Penalty," factors that may be considered include: the facts and circumstances relating to the contract provision or action; its economic impact; and the extent to which the contract provision or action has potential or actual procompetitive effects in the Charlotte Area.

L. “Person” means any natural person, corporation, company, partnership, joint venture, firm, association, proprietorship, agency, board, authority, commission, office, or other business or legal entity.

M. “Reference-Based Pricing” means a feature of a Benefit Plan by which an Insurer pays up to a uniformly-applied defined contribution, based on an external price selected by the Insurer, toward covering the full price charged for a Healthcare Service, with the member being required to pay the remainder. For avoidance of doubt, a Benefit Plan with Reference-Based Pricing as a feature may permit an Insurer to pay a portion of this remainder.

N. “Steered Plan” means any Narrow Network Benefit Plan, Tiered Network Benefit Plan, or any Benefit Plan with Reference-Based Pricing or a Center of Excellence as a component.

O. “Tiered Network” means a network of Healthcare Providers for which (i) an Insurer divides the in-network Providers into different sub-groups based on objective price, access, and/or quality criteria; and (ii) members receive different levels of benefits when they utilize Healthcare Services from Providers in different sub-groups.

P. “Transparency” means communication of any price, cost, quality, or patient experience information directly or indirectly by an Insurer to a client, member, or consumer.

III. APPLICABILITY

This Final Judgment applies to Defendant, as defined above, and all other Persons in active concert with, or participation with, Defendant who receive actual notice of this Final Judgment by personal service or otherwise.

IV. PROHIBITED CONDUCT

A. The contract language reproduced in Exhibit A is void, and Defendant shall not enforce or attempt to enforce it. The contract language reproduced in Exhibit B shall not be used to prohibit, prevent, or penalize Steered Plans or Transparency, but could remain enforceable for protection against Carve-outs. For the Network Participation Agreement between Blue Cross and Blue Shield of North Carolina and Defendant's wholly-owned subsidiary Managed Health Resources, effective January 1, 2014, as amended, Defendant shall exclude from the calculation of total cumulative impact pursuant to Section 6.14 of that agreement any impact to Defendant resulting from Blue Cross and Blue Shield of North Carolina disfavoring Defendant through Transparency or through the use of any Steered Plan.

B. For Healthcare Services in the Charlotte Area, Defendant will not seek or obtain any contract provision which would prohibit, prevent, or penalize Steered Plans or Transparency including:

1. express prohibitions on Steered Plans or Transparency;

2. requirements of prior approval for the introduction of new benefit plans (except in the case of Co-Branded Plans); and

3. requirements that Defendant be included in the most-preferred tier of Benefit Plans (except in the case of Co-Branded Plans). However, notwithstanding this Paragraph IV(B)(3), Defendant may enter into a contract with an Insurer that provides Defendant with the right to participate in the most-preferred tier of a Benefit Plan under the same terms and conditions as any other Charlotte Area Provider, provided that if Defendant declines to participate in the most-preferred tier of that Benefit Plan, then Defendant must participate in that Benefit Plan on terms and conditions that are substantially the same as any terms and conditions of any then-existing broad-network Benefit Plan (*e.g.*, PPO plan) in which Defendant participates with that Insurer. Additionally, notwithstanding Paragraph IV(B)(3), nothing in this Final Judgment prohibits Defendant from obtaining any criteria used by the Insurer to (i) assign Charlotte Area Providers to each tier in any Tiered Network; and/or (ii) designate Charlotte Area Providers as a Center of Excellence.

C. Defendant will not take any actions that penalize, or threaten to penalize, an Insurer for (i) providing (or planning to provide) Transparency, or (ii) designing, offering, expanding, or marketing (or planning to design, offer, expand, or market) a Steered Plan.

V. PERMITTED CONDUCT

A. Defendant may exercise any contractual right it has, provided it does not engage in any Prohibited Conduct as set forth above.

B. For any Co-Branded Plan or Narrow Network in which Defendant is the most-prominently featured Provider, Defendant may restrict steerage within that Co-Branded Plan or Narrow Network. For example, Defendant may restrict an Insurer from including at inception or later adding other Providers to any (i) Narrow Network in which Defendant is the most-prominently featured Provider, or (ii) any Co-Branded Plan.

C. With regard to information communicated as part of any Transparency effort, nothing in this Final Judgment prohibits Defendant from reviewing its information to be disseminated, provided such review does not delay the dissemination of the information. Furthermore, Defendant may challenge inaccurate information or seek appropriate legal remedies relating to inaccurate information disseminated by third parties. Also, for an Insurer's dissemination of price or cost information (other than communication of an individual consumer's or member's actual or estimated out-of-pocket expense), nothing in the Final Judgment will prevent or impair Defendant from enforcing current or future provisions, including but not limited to confidentiality provisions, that (i) prohibit an Insurer from disseminating price or cost information to Defendant's competitors, other Insurers, or the general public; and/or (ii) require an Insurer to obtain a covenant from any third party that receives such price or cost information that such third party will not disclose that information to Defendant's competitors, another Insurer, the general public, or any other third party lacking a reasonable need to obtain such competitively sensitive information. Defendant may seek all appropriate remedies (including injunctive relief) in the event that dissemination of such information occurs.

VI. REQUIRED CONDUCT

Within fifteen (15) business days of entry of this Final Judgment, Defendant, through its designated counsel, must notify in writing Aetna, Blue Cross and Blue Shield of North Carolina, Cigna, MedCost, and UnitedHealthcare, that:

A. This Final Judgment has been entered (enclosing a copy of this Final Judgment) and that it prohibits Defendant from entering into or enforcing any contract term that would prohibit, prevent, or penalize Steered Plans or Transparency, or taking any other action that violates this Final Judgment; and

B. For the term of this Final Judgment Defendant waives any right to enforce any provision listed in Exhibit A and further waives the right to enforce any provision listed in Exhibit B to prohibit, prevent, or penalize Steered Plans and Transparency.

VII. COMPLIANCE

A. It shall be the responsibility of the Defendant's designated counsel to undertake the following:

1. within fifteen (15) calendar days of entry of this Final Judgment, provide a copy of this Final Judgment to each of Defendant's commissioners and officers, and to each employee whose job responsibilities include negotiating or approving agreements with Insurers for the purchase of Healthcare Services, including personnel within the Managed Health Resources subsidiary (or any successor organization) of Defendant;

2. distribute in a timely manner a copy of this Final Judgment to any person who succeeds to, or subsequently holds, a position of commissioner, officer, or other position for which the job responsibilities include negotiating or approving agreements with Insurers for the purchase of Healthcare Services, including personnel within the Managed Health Resources subsidiary (or any successor organization) of Defendant; and

3. within sixty (60) calendar days of entry of this Final Judgment, develop and implement procedures necessary to ensure Defendant's compliance with this Final Judgment. Such procedures shall ensure that questions from any of Defendant's commissioners, officers, or employees about this Final Judgment can be answered by counsel (which may be outside counsel) as the need arises. Paragraph 21.1 of the Amended Protective Order Regarding Confidentiality shall not be interpreted to prohibit outside counsel from answering such questions.

B. For the purposes of determining or securing compliance with this Final Judgment, or any related orders, or determining whether the Final Judgment should be modified or vacated, and subject to any legally-recognized privilege, from time to time authorized representatives of the United States or the State of North Carolina, including agents and consultants retained by the United States or the State of North Carolina, shall, upon written request of an authorized representative of the Assistant Attorney General in charge of the Antitrust Division or the Attorney General for the State of North Carolina, and on reasonable notice to Defendant, be permitted:

1. access during Defendant's office hours to inspect and copy, or at the option of the United States, to require Defendant to provide electronic copies of all books, ledgers, accounts, records, data, and documents in the possession, custody, or control of Defendant, relating to any matters contained in this Final Judgment; and

2. to interview, either informally or on the record, Defendant's officers, employees, or agents, who may have their individual counsel present, regarding such matters. The interviews shall be subject to the reasonable convenience of the interviewee and without restraint or interference by Defendant.

C. Within 270 calendar days of entry of this Final Judgment, Defendant must submit to the United States and the State of North Carolina a written report setting forth its actions to comply with this Final Judgment, specifically describing (1) the status of all negotiations between Managed Health Resources (or any successor organization) and an Insurer relating to contracts that cover Healthcare Services rendered in the Charlotte Area since the entry of the Final Judgment, and (2) the compliance procedures adopted under Paragraph VII(A)(3) of this Final Judgment.

D. Upon the written request of an authorized representative of the Assistant Attorney General in charge of the Antitrust Division or the Attorney General for the State of North Carolina, Defendant shall submit written reports or responses to written interrogatories, under oath if requested, relating to any of the matters contained in this Final Judgment as may be requested.

E. The United States may share information or documents obtained under Paragraph VII with the State of North Carolina subject to appropriate confidentiality protections. The State of North Carolina shall keep all such information or documents confidential.

F. No information or documents obtained by the means provided in Paragraph VII shall be divulged by the United States or the State of North Carolina to any Person other than an authorized representative of (1) the executive branch of the United States or (2) the Office of the North Carolina Attorney General, except in the course of legal proceedings to which the United States or the State of North Carolina is a party (including grand jury proceedings), for the purpose of securing compliance with this Final Judgment, or as otherwise required by law.

G. If at the time that Defendant furnishes information or documents to the United States or the State of North Carolina, Defendant represents and identifies in writing the material in any such information or documents to which a claim of protection may be asserted under Rule 26(c)(1)(G) of the Federal Rules of Civil Procedure, and Defendant marks each pertinent page of such material, "Subject to claim of protection under Rule 26(c)(1)(G) of the Federal Rules of Civil Procedure," the United States and the State of North Carolina shall give Defendant ten (10) calendar days' notice prior to divulging such material in any legal proceeding (other than a grand jury proceeding).

H. For the duration of this Final Judgment, Defendant must provide to the United States and the State of North Carolina a copy of each contract and each amendment to a contract that covers Healthcare Services in the Charlotte Area that it negotiates with any Insurer within thirty (30) calendar days of execution of such contract or amendment. Defendant must also notify the United States and the State of North Carolina within thirty (30) calendar days of having reason to believe that a Provider which Defendant controls has a contract with any Insurer with a provision that prohibits, prevents, or penalizes any Steered Plans or Transparency.

VIII. RETENTION OF JURISDICTION

The Court retains jurisdiction to enable any Party to this Final Judgment to apply to the Court at any time for further orders and directions as may be necessary or appropriate to carry out or construe this Final Judgment, to modify any of its provisions, to enforce compliance, and to punish violations of its provisions.

IX. ENFORCEMENT OF FINAL JUDGMENT

A. The United States retains and reserves all rights to enforce the provisions of this Final Judgment, including the right to seek an order of contempt from the Court. Defendant agrees that in any civil contempt action, any motion to show cause, or any similar action brought by the United States regarding an alleged violation of this Final Judgment, the United States may establish a violation of the decree and the appropriateness of any remedy therefor by a preponderance of the evidence, and Defendant waives any argument that a different standard of proof should apply.

B. The Parties hereby agree that the Final Judgment should be interpreted using ordinary tools of interpretation, except that the terms of the Final Judgment should not be construed against either Party as the drafter. The parties further agree that the purpose of the Final Judgment is to redress the competitive harm alleged in the Complaint, and that the Court may enforce any provision of this Final Judgment that is stated specifically and in reasonable detail, *see* Fed. R. Civ. P. 65(d), whether or not such provision is clear and unambiguous on its face.

C. In any enforcement proceeding in which the Court finds that Defendant has violated this Final Judgment, the United States may apply to the Court for a one-time extension of this Final Judgment, together with such other relief as may be appropriate. In connection with any successful effort by the United States to enforce this Final Judgment against Defendant, whether litigated or resolved prior to litigation, Defendant agrees to reimburse the United States for the fees and expenses of its attorneys, as well as any other costs including experts' fees, incurred in connection with that enforcement effort, including in the investigation of the potential violation.

X. EXPIRATION OF FINAL JUDGMENT

Unless the Court grants an extension, this Final Judgment shall expire ten (10) years from the date of its entry, except that after five (5) years from the date of its entry, this Final Judgment may be terminated upon notice by the United States to the Court and Defendant that the continuation of the Final Judgment is no longer necessary or in the public interest.

XI. PUBLIC INTEREST DETERMINATION

Entry of this Final Judgment is in the public interest. The Parties have complied with the requirements of the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16, including making copies available to the public of this Final Judgment, the Competitive Impact Statement, any comments thereon, and the United States' responses to comments. Based upon the record before the Court, which includes the Competitive Impact Statement and any comments and responses to comments filed with the Court, entry of this Final Judgment is in the public interest.

XII. CONCLUSION

IT IS THEREFORE ORDERED THAT Plaintiff United States' Unopposed Motion for Entry of Final Judgment, (Doc. No. 98), is **GRANTED**.

Signed: April 24, 2019

Robert J. Conrad, Jr.
United States District Judge

<u>Exhibit A</u>

<u>Aetna</u>

Section 2.8 of the Physician Hospital Organization Agreement between and among Aetna Health of the Carolinas, Inc., Aetna Life Insurance Company, Aetna Health Management, LLC, and Defendant states in part:

> "Company may not . . . steer Members away from Participating PHO Providers other than instances where services are not deemed to be clinically appropriate, subject to the terms of Section 4.1.3 of this Agreement."

In addition, Section 2.11 of the above-referenced agreement states in part:

> "Company reserves the right to introduce in new Plans . . . and products during the term of this Agreement and will provide PHO with ninety (90) days written notice of such new Plans, Specialty Programs and products. . . . For purposes under (c) and (d) above, Company commits that Participating PHO Providers will be in-network Participating Providers in Company Plans and products as listed on the Product Participation Schedule. If Company introduces new products or benefit designs in PHO's market that have the effect of placing Participating PHO Providers in a non-preferred position, PHO will have the option to terminate this Agreement in accordance with Section 6.3. Notwithstanding the foregoing, if Company introduces an Aexcel performance network in PHO Provider's service area, all PHO Providers will be placed in the most preferred benefit level. As long as such Plans or products do not directly or indirectly steer Members away from a Participating PHO Provider to an alternative Participating Provider for the same service in the same level of care or same setting, the termination provision would not apply."

<u>Blue Cross and Blue Shield of North Carolina</u>

The Benefit Plan Exhibit to the Network Participation Agreement between Blue Cross and Blue Shield of North Carolina and Defendant (originally effective January 1, 2014), as replaced by the Fifth Amendment, states in part:

> "After meeting and conferring, if parties cannot reach agreement, then, notwithstanding Section 5.1, this Agreement will be considered to be beyond the initial term, and you may terminate this Agreement upon not less than 90 days' prior Written Notice to us, pursuant to Section 5.2."

Cigna

Section II.G.5 of the Managed Care Alliance Agreement between Cigna HealthCare of North Carolina, Inc. and Defendant states in part:

> "All MHR entities as defined in Schedule 1 will be represented in the most preferred benefit level for any and all CIGNA products for all services provided under this Agreement unless CIGNA obtains prior written consent from MHR to exclude any MHR entities from representation in the most preferred benefit level for any CIGNA product. . . . As a MHR Participating Provider, CIGNA will not steer business away from MHR Participating Providers."

Medcost

Section 3.6 of the Participating Physician Hospital Organization agreement between Medcost, LLC and Defendant states in part:

> "Plans shall not directly or indirectly steer patients away from MHR Participating Providers."

UnitedHealthcare

Section 2 of the Hospital Participation Agreement between UnitedHealthcare of North Carolina, Inc. and Defendant states in part:

> "As a Participating Provider, Plan shall not directly or indirectly steer business away from Hospital."

<u>Exhibit B</u>

<u>Cigna</u>

Section II.G.5 of the Managed Care Alliance Agreement between Cigna HealthCare of North Carolina, Inc. and Defendant states in part:

> "CIGNA may not exclude a MHR Participating Provider as a network provider for any product or Covered Service that MHR Participating Provider has the capability to provide except those carve-out services as outlined in Exhibit E attached hereto, unless CIGNA obtains prior written consent from MHR to exclude MHR Participating Provider as a network provider for such Covered Services."

<u>UnitedHealthcare</u>

Section 2 of the Hospital Participation Agreement between UnitedHealthcare of North Carolina, Inc. and Defendant states in part:

> "Plan may not exclude Hospital as a network provider for any Health Service that Hospital is qualified and has the capability to provide and for which Plan and Hospital have established a fee schedule or fixed rate, as applicable, unless mutually agreed to in writing by Plan and Hospital to exclude Hospital as a network provider for such Health Service."

In addition, Section 3.6 of the above-referenced agreement states in part:

> "During the term of this Agreement, including any renewal terms, if Plan creates new or additional products, which product otherwise is or could be a Product Line as defined in this Agreement, Hospital shall be given the opportunity to participate with respect to such new Product Line."