WRITTEN COMMENTS REGARDING THE

2025 UNION COUNTY ACUTE CARE BED REVIEW

SUBMITTED BY NOVANT HEALTH

December 1, 2025

Three CON applications were submitted in response to the 2025 State Medical Facilities Plan (SMFP) need determination for 136 additional acute care beds in Union County, including:

> CON Project ID# F-012717-25 Novant Health Wesley Chapel Medical Center: Develop a new 32-bed acute care hospital
>
> CON Project ID# F-012701-25 Atrium Health Union: Develop 46 additional acute care beds
>
> CON Project ID# F-012707-25 Atrium Health Union West: Develop 90 additional acute care beds

As demonstrated above, the total number of acute care beds requested in this review exceeds the SMFP need determination for 2025. Atrium Health Union (AHU) and Atrium Health Union West (AHUW) have applied for a combined total of 136 available beds, while Novant Health has applied for only 32, well below the 2025 SMFP need determination. Atrium Health is the sole acute care hospital provider in Union County at the present time. As a new competitor in Union County with a clear, well-supported need for these beds, Novant Health's application should be approved in full.

The following comments clearly establish that AHU and AHUW's applications are not approvable and that no additional beds should be awarded. However, if the Agency determines otherwise, the absolute maximum number of beds that should be awarded to AH and AHUW is 104. The Agency followed a similar approach earlier this year in the Cabarrus County acute care bed review (Project I.D. Nos. F-12588-25 and F-12600-25). Atrium is currently the sole acute care hospital provider in that county. Recognizing the need for more competition, the Agency approved Novant Health's proposal for a 50-bed acute care hospital, and awarded Atrium the remaining beds. Atrium was approved for 76 beds. Atrium has appealed that decision, insisting that it should be awarded *all* of the beds, but Atrium's appeal in that case should not dissuade the Agency from making a similar decision here. Atrium controls 100% of the acute care beds in Union County now. There is no reason why Atrium's monopoly should continue, especially since Novant has presented a fully conforming application that will benefit patients, employers, and payors by offering competition on price and quality.

These comments are submitted by Novant Health in accordance with N.C. Gen. Stat. § 131E-185(a1)(1) to provide a comparative analysis and a detailed review of the most significant issues related to AH's conformity with the statutory and regulatory review criteria outlined in N.C. Gen. Stat. § 131E-183(a) and

(b). Additional errors and non-conformities may exist in the competing application, and Novant Health reserves the right to develop further opinions as necessary upon continued review and analysis.

Approving Novant Health's application will meet the county's growing demand while introducing long-overdue competition in Union County. This is undeniably in the best interest of patients, as increased competition leads to greater choice, lower costs, and higher quality care through innovation. Equally important is improved financial and geographic access for residents of Union County and surrounding areas. With its well-regarded suite of charity care policies, Novant Health's proposal will make quality health care a reality for more Union County residents, including those who cannot pay for their care. As demonstrated in its application, Novant Health fully complies with all applicable review criteria and is the superior applicant in this review.

COMPARATIVE ANALYSIS

Pursuant to G.S. § 131E-183(a)(1) and the 2025 State Medical Facilities Plan, no more than 136 acute care beds may be approved for Union County in this review. Because the applications in this review collectively propose to develop 168 additional acute care beds in Union 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 competitive reviews regardless of the type of services or equipment proposed:

- Conformity with Statutory and Regulatory Review Criteria
- Scope of Services
- Geographic Accessibility
- Access by Service Area Residents
- 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 Expense per Patient

The Agency may use its discretion to add other comparative factors based on the facts of the competitive review, but this discretion must be exercised reasonably and in accordance with the law. The following summarizes the competing applications relative to the potential comparative factors.

Conformity with CON Review Criteria and Rules

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
Novant Health Wesley Chapel Medical Center	F-012717-25	Yes
Atrium Health Union	F-012701-25	No
Atrium Health Union West	F-012707-25	No

The Novant Health application is based on reasonable and supported volume projections and adequate projections of cost and revenues. As discussed separately in this document, the AH application contains 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

NH Wesley Chapel proposes to develop a new, full-service 32-bed hospital expressly designed to meet the full spectrum of patient needs in Union County. The facility will provide comprehensive services including emergency care, surgical services, intensive care (ICU), obstetrics, imaging, and therapy services creating a new, accessible point of care for Union County residents.

By contrast, Atrium Health Union's proposal simply adds capacity to existing hospital facilities. Neither project creates a new access point, addresses geographic gaps in Union County, or provides residents with a genuine alternative to the dominant incumbent provider. Instead, both Atrium proposals reinforce existing concentration, offering no meaningful increase in competition, no improvement in patient choice, and no diversification of hospital providers within the county.

All facilities in this review will provide a complete range of essential healthcare services, ensuring that Union County residents receive high-quality care. The difference in bed count does not reflect a difference in effectiveness. NH Wesley is designed to operate efficiently and effectively while delivering the same essential acute care services available at both AHU and AHUW. This has been proven time and time again by Novant Health's numerous community hospitals beginning with NH Matthews, which opened in 1994 and most recently with NH Ballantyne Medical Center, which opened in 2023.[1] NH Steele Creek (32 beds), NH Mint Hill (36 beds), and NH Ballantyne (36 beds) are similarly-sized hospitals to the proposed NH Wesley Chapel hospital. Since opening, NH Mint Hill and NH Ballantyne have been extremely well received by their respective communities, quickly achieving strong utilization and positive quality measures. Their

[1] Other NH community hospitals include: NH Kernersville Medical Center; NH Clemmons Medical Center; NH Huntersville Medical Center; and NH Mint Hill Medical Center.

success underscores the effectiveness of Novant Health's community hospital model, which combines local accessibility with high-quality, integrated care supported by the broader Novant Health system.

Therefore, all projects are equally capable of meeting the healthcare needs of the community, but NH Union does so while promoting competition, increasing patient access, and improving choice, key factors that benefit the residents of Union County.

For these reasons, the projects are **equally effective** alternatives regarding scope of services.

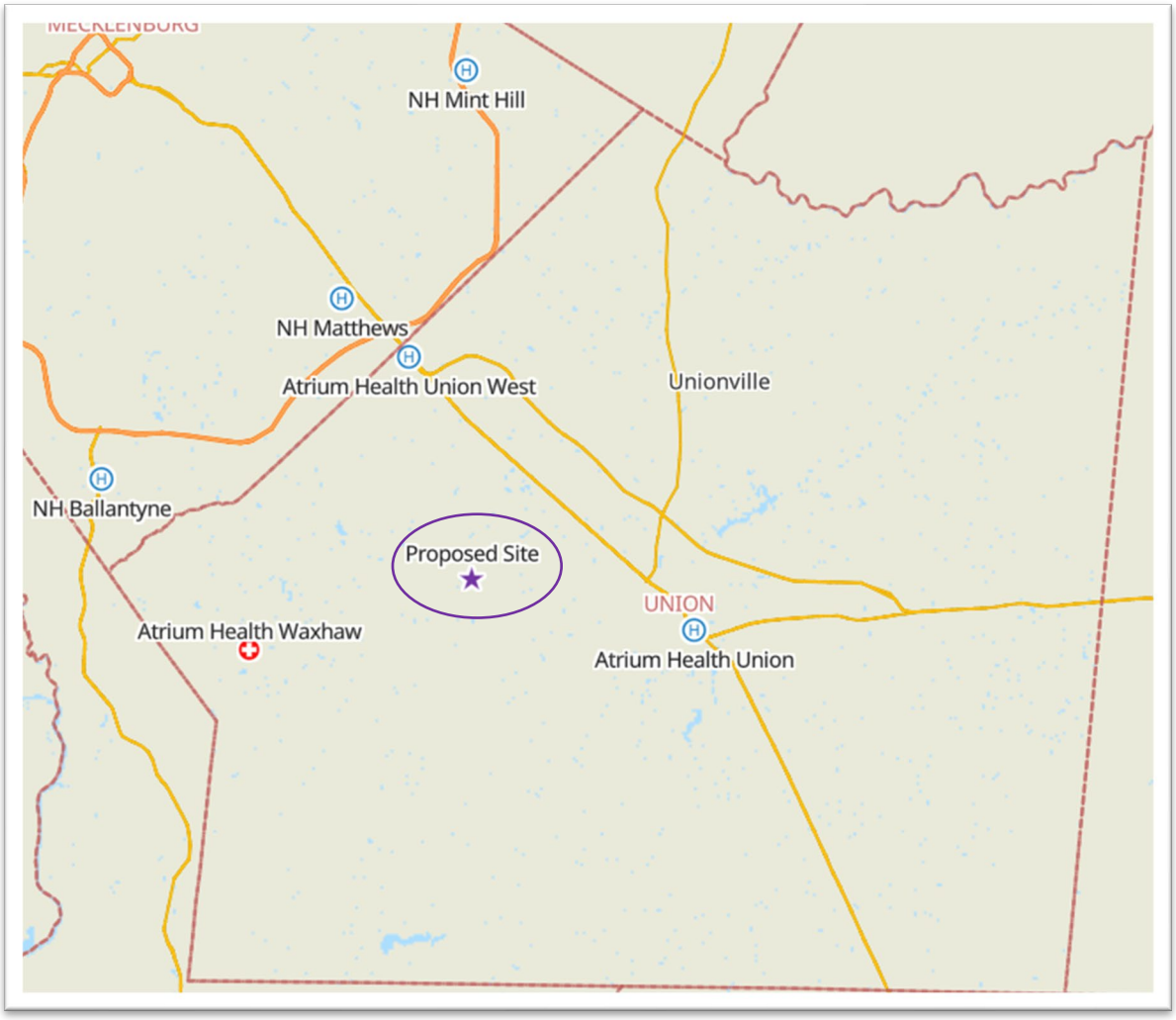
Geographic Accessibility

Novant Health and Atrium Health each propose to develop additional acute care beds in Union County. However, only NH Wesley Chapel seeks to establish a new hospital in a new geographic location. Atrium's two proposals merely add beds to its existing facilities, reinforcing, rather than diversifying, its longstanding control over acute care services in the county.

Union County residents currently have no meaningful choice of hospital provider. The existing acute care hospitals (AH Union and AHUW) are operated by Atrium Health. As a result, many residents who prefer or rely on Novant Health travel across the county line to Mecklenburg County for care. According to the FY2024 DHSR Healthcare Planning Patient Origin Report, more than half (51 percent) of Union County acute care discharges were served by Mecklenburg County facilities.

While the established hospitals in Monroe and Matthews primarily serve populations nearest those campuses, the proposed Wesley Chapel location creates a geographically complementary access point, filling the significant gap between them. Its location offers a more balanced distribution of hospital resources across the county, improving equitable access to inpatient, emergency, and obstetric services; reducing travel times; and easing congestion at existing facilities.

NH Wesley Chapel Proposed Location



The proposed NH Wesley Chapel hospital will materially enhance healthcare access by bringing high-quality acute care services closer to residents currently traveling out of the county for Novant Health care. The proposal is not simply about adding beds, it is about expanding options, strengthening competition, and providing Union County residents with the first meaningful alternative to Atrium's system-wide dominance.

For these reasons, the **Novant Health** application is clearly the **most effective** and impactful alternative with respect to geographic accessibility.

Competition (Patient Access to a New or Alternate Provider)

The 2025 SMFP acute care bed methodology has identified the need for 136 additional acute care beds in the Union County service area. Novant Health is applying for 32 of these beds, approximately 24 percent of the total, while still leaving ample capacity for other approvable applicants. Unlike AH's filings, which

simply deepen its entrenched position, the NH Wesley Chapel proposal introduces a new hospital provider to Union County for the first time, creating meaningful competition where none exists today.

Approval of the NH Wesley Chapel application will expand patient access to high-quality, conveniently located care; address documented population growth and demand; and, critically, foster competition that benefits patients, employers, and insurers alike. Increased competition is well-established to lower costs, improve quality, and enhance patient choice, core goals of the CON Law and the SMFP. The Agency has explicitly recognized these benefits in multiple recent reviews, including the 2022 and 2024 Buncombe County and 2025 Cabarrus County acute care bed decisions. The same principles apply squarely to Union County.

By contrast, Atrium Health's two applications do not offer an alternate provider or a new point of access. They merely expand capacity at facilities that Atrium already owns and controls, thereby reinforcing its countywide monopoly rather than promoting genuine choice. Approving either AH proposal would maintain the status quo, an outcome directly at odds with the competitive objectives of the CON Statute.

Introducing Novant Health as a second hospital operator will drive improvements that naturally arise from competition, e.g., higher quality, greater efficiency, more responsive service, and more affordable care. These benefits would accrue to all residents of Union County, regardless of which provider they ultimately choose.

For these reasons, the **Novant Health** application is unequivocally the **most effective** alternative with respect to enhancing competition and expanding patient access to a new, high-quality provider.

Access By Service Area Residents

On page 33, the 2025 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 Union County as a single-county acute care bed service area. Thus, the service area for this review is Union 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 Union County Residents, Project Year 3

Comparative	Novant Health Wesley Chapel	Atrium Health Union	Atrium Health Union West
# of Union County Patients	2,599	6,259	7,889
% of Union County Patients	**90.0%**	59.7%	59.2%

Source: CON applications, Section C.3

As shown in the previous table, Novant Health plans to serve a substantially higher percentage of patients from Union County during the third project year.

It would be inappropriate to directly compare the absolute number of Union County patients served between NH Wesley Chapel (a 32-bed facility) and either AHU (a 197 bed facility) or AHUW (a 184 bed facility) because the size of the two facilities is vastly different. NH Wesley Chapel, with 32 proposed acute care beds, will naturally serve fewer patients simply because of its smaller capacity. In contrast, AHU and AHUW, with their significantly larger bed capacities, are able to serve a larger volume of patients simply by virtue of their scale. This disparity in bed size makes any direct comparison based on the absolute number of patients served misleading and unfair.

Instead, the Agency should focus on the *percentage* of Union County patients served by each facility. This approach will provide a more accurate and equitable comparison of how each hospital is meeting the needs of the community. For example, a smaller hospital like NH Wesley Chapel could serve a higher percentage of the service area population relative to its size, demonstrating its efficiency and effectiveness in addressing the needs of the community. Meanwhile, a larger facility like AH Union could treat a larger number of patients simply due to its bed count, but this does not necessarily indicate that it is equally effective or adequately addressing the needs of *service area residents*.

By comparing the percentage of patients served, the Agency will be able to assess each hospital's role more accurately in meeting the healthcare needs of Union County, regardless of the differences in size of the facilities. This ensures a fairer and more meaningful comparison of how each applicant contributes to the overall healthcare landscape in the region. Therefore, regarding access by service area residents, the application submitted by **Novant Health** is the **most effective** alternative.

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 typically compared with respect to Medicare patients and Medicaid patients. [2] 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 Medicare or Medicaid patients
- Medicare or Medicaid admissions as a percentage of total patients
- Total Medicare or Medicaid dollars
- Medicare or Medicaid dollars as a percentage of total gross or net revenues
- Medicare or Medicaid cases per patient

[2] Due to differences in definitions of charity care among applicants, comparisons of charity care are inconclusive.

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 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

Applicant	Form F.2b Total Medicare Revenue	Form C.1b Discharges	Avg Medicare Rev. per Discharge	Form F.2b Gross Revenue	% of Gross Revenue
Novant Health Wesley Chapel	$57,640,923	2,888	$19,959	$118,013,886	48.8%
Atrium Health Union	$131,297,681	10,486	$12,521	$253,932,062	51.7%
Atrium Health Union West	$154,822,933	13,327	$11,617	$359,340,092	43.1%

Generally, the application projecting to provide the greatest access to Medicare patients is the more effective alternative for this comparative factor.

Novant Health's pro formas are not structured the same way as those from Atrium Health. Specifically:

> In the assumptions and methodology for Form F.2, Novant Health states the gross patient revenue for inpatient services includes inpatient surgery, emergency department services provided to an admitted patient, and imaging revenue provided during an inpatient stay. Includes all ancillary services, including pharmacy, therapy, and laboratory that an inpatient receives (p. 160).
>
> In the assumptions and methodology for Forms F.2 and F.3, Atrium Health states, "CMHA's financial department provided the data used to develop Atrium Health Union West (Union West) Acute Care Beds Forms F.2 and F.3, which represent acute care bed charges and expenses only and do not include ancillary services such as lab, radiology or surgery that generate additional revenue and expense for acute care inpatients." (AHW p. 131; AHUW p. 139)

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.

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
Novant Health Wesley Chapel	$14,498,705	2,888	$5,020	$118,013,886	12.3%
Atrium Health Union	$53,552,677	10,486	$5,107	$253,932,062	21.1%
Atrium Health Union West	$63,470,842	13,327	$4,763	$359,340,092	17.7%

As previously described, Novant Health's pro formas are not structured the same way as those from Atrium Health.

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.

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 Discharge	Form F.2b Net Revenue	Average Net Revenue per Discharge
Novant Health Wesley Chapel	2,888	$35,643,847	$12,342
Atrium Health Union	10,486	$62,336,346	$5,945
Atrium Health Union West	13,327	$98,083,545	$7,360

As previously described, Novant Health's pro formas are not structured the same way as those from Atrium Health. Specifically:

> In the assumptions and methodology for Form F.2, Novant Health states the gross patient revenue for inpatient services includes inpatient surgery, emergency department services provided to an admitted patient, and imaging revenue provided during an inpatient stay. Includes all ancillary services, including pharmacy, therapy, and laboratory that an inpatient receives (p. 160).
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Based on the differences in the presentation of pro forma financial statements, one cannot make a conclusive comparison of projected net revenue per patient. Accordingly, the Agency should determine that this factor is inconclusive.

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 Discharge	Form F.2b Operating Expense	Average Operating Expense per Discharge
Novant Health Wesley Chapel	2,888	$27,532,595	$9,533
Atrium Health Union	10,486	$60,504,766	$5,770
Atrium Health Union West	13,327	$88,819,263	$6,665

As previously described, Novant Health's pro formas are not structured the same way as those from Atrium Health. Therefore, a comparison of the projected average operating expense per patient is inconclusive.

Summary

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

Comparative Factor	Novant Health	Atrium Health Union	Atrium Health Union West
Conformity with Review Criteria	**More Effective**	Less Effective	Less Effective
Scope of Services	Equally Effective	Equally Effective	Equally Effective
Geographic Accessibility	**More Effective**	Less Effective	Less Effective
Enhance Competition	**More Effective**	Less Effective	Less Effective
Access by Service Area Residents: % of Patients	**More Effective**	Less Effective	Less Effective
Projected Medicare	Inconclusive	Inconclusive	Inconclusive
Projected Medicaid	Inconclusive	Inconclusive	Inconclusive
Projected Average Net Revenue per Patient	Inconclusive	Inconclusive	Inconclusive
Projected Average Operating Expense per Patient	Inconclusive	Inconclusive	Inconclusive

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

- Conformity with Review Criteria
- Geographic Accessibility
- Enhance Competition
- Access by Service Area Residents: % of Patients

COMMENTS REGARDING CONFORMITY WITH STATUTORY REVIEW CRITERIA FOR BOTH ATRIUM HEALTH APPLICATIONS PROJECT ID # F-012701-25 & PROJECT ID # F-021707-25

COMMENTS REGARDING CRITERION (3)

Alleged Imperative to Add Capacity

The 2023 SMFP identified a need for 21 additional acute care beds in Union County. Of those, 13 beds were awarded to Atrium Health Union (Project ID #F-012442-23) and remain undeveloped, while 8 beds were awarded to Atrium Health Union West (Project ID #F-012440-23) and were only recently made operational in August 2025, according to AHUW's own application.

The pattern repeated under the 2024 SMFP: 46 additional acute care beds were awarded to AHUW (Project ID #F-012575-24). These beds also remain undeveloped, bringing Atrium's cumulative total of awarded but not yet implemented acute care beds to 59.

These 59 dormant beds represent nearly one-third (32 percent) of all licensed acute care beds currently operating in Union County. With two hospital campuses and 100 percent control of the 245 existing and approved acute care beds, Atrium is sitting on a considerable stockpile of *undeveloped* beds. Atrium stockpile of undeveloped beds in Union County is larger than the number of beds Novant proposes for its hospital by 27 beds or 84%.

Despite this, Atrium's two 2025 applications claim severe capacity constraints and request approval for another 136 acute care beds, a number that is only 50 beds fewer than the total number of beds currently operating in the entire county. AHU goes so far as to claim that "it is imperative that Atrium Health Union maintain sufficient acute care bed capacity" (page 53), yet offers no justification for why its existing 245 beds plus 59 undeveloped beds are inadequate to meet projected need.

Atrium's filings therefore present capacity problems of its own making, caused not by insufficient beds but by its decision to delay development of previously approved capacity.

In sharp contrast, Novant Health's application proposes developing 32 acute care beds, which will be the only beds in Union County not controlled by Atrium. Even if Novant Health's 32 beds were approved and the Agency approved 104 of Atrium's requested 136 beds, Novant Health would hold only 8.4 percent of total countywide acute care capacity (381 total beds: 245 existing/approved + 136 new).

This is a conservative and appropriate share, given that Novant Health already serves 33.0 percent of Union County Core Acute Care (CAC) MSDRG discharges despite having zero in-county beds today—a clear indicator of unmet need and patient preference. See the following table excerpted from the NH Wesley Chapel application.

Currently, Atrium Health is the sole provider of acute care services located within Union County and maintains 65.9 percent share of Union County CAC MSDRGs discharges.

Share of Union County CAC MSDRG Discharges, CY2024

Health System	CAC MSDRG Discharges	Share
Atrium Health	7,909	65.9%
Novant Health	3,959	33.0%
Other	132	1.1%
Total	12,000	100.0%

Source: HIDI Inpatient Database

Source: Page 55 of NH Wesley Chapel application

Alternatively, if AH's applications were approved for 136 beds, AH would continue to maintain 100 percent control of acute care beds in Union County. Such a result would not be consistent with the purpose of the CON Statute and the 2025 SMFP for several reasons.

1. It would unfairly consolidate market power by preventing Novant Health from entering the market, directly harming patients, payors, and employers who benefit from competition.
2. It would reward capacity mismanagement, allowing Atrium to stockpile underdeveloped beds while claiming new need.
3. It would further entrench Atrium's monopoly, eliminating the competitive pressure that drives improvements in cost, access, and quality.

For these reasons, the Agency should reject Atrium's unsupported "imperative" to add capacity and evaluate its applications in light of statutory intent, to promote competition, ensure efficient allocation of resources, and protect patients from unnecessary control of essential services.

Failure to Address the Acute Care Needs of Union County

While AH's applications begin their responses to Section C.4 with a broad discussion of Union County's population growth and aging demographics, the analysis quickly collapses into an exceedingly narrow focus on internal utilization at AH Union and AH Union West. This perspective treats Atrium's two facilities as synonymous with Union County's total acute care needs, a self-serving and analytically flawed approach that ignores how and where Union County residents actually receive care.

As Novant Health highlights throughout its application, and as evidenced in the excerpted table below, a significant number of Union County patients seek acute care outside the county, including at Novant Health and other providers, despite AH being the sole in-county acute care provider. Moreover, many Union County residents classified as "Atrium Health" patients receive care at AH facilities in Mecklenburg County rather than AHU or AHUW.

This reality undermines Atrium's core assumption that countywide need can be measured solely by its own bed census and occupancy trends.

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Health System	CAC MSDRG Discharges	Share
Atrium Health	7,909	65.9%
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Other	132	1.1%
Total	12,000	100.0%

Source: HIDI Inpatient Database

Source: Page 55 of NH Wesley Chapel application

Atrium's applications completely ignore these substantial patient migration patterns. They fail to acknowledge:

- Union County residents who leave the county for Novant Health acute care;
- Patients who must travel to Atrium's Mecklenburg County hospitals due to lack of in-county alternatives;
- The broader regional flows that reflect unmet need and a lack of local provider choice.

Instead, Atrium posits that Union County's needs equate to Atrium's operational needs, treating its internal capacity constraints as a proxy for community demand. This circular logic obscures the fundamental issue: Union County residents lack meaningful access to more than one hospital provider.

Atrium's limited and inward-facing analysis is not a reflection of county need, it is a reflection of monopoly dynamics. While Atrium might argue that the outmigration from Union County is due to the fact that it lacks sufficient bed capacity, the available evidence does not support this. As noted earlier, Atrium has a sizable stockpile of undeveloped beds in Union County. Further, the sheer number of patients leaving Union County to see acute care at Novant facilities outside of Union County (33% of CAC MSDRG Discharges) is indicative of patient preference, not lack of capacity at Atrium's Union County hospitals. Clearly, patients desire access to Novant acute care facilities, something they have not had in Union County.

In stark contrast to Atrium's narrow approach, Novant Health's application takes a comprehensive view, addressing the acute care needs of *all* Union County residents. It not only recognizes existing patient migration trends but also presents a solution that would introduce long-overdue competition and, for the first time, provide residents with a true local alternative for inpatient care.

Unreasonable Growth Assumptions

In its applications, AH assumes an extraordinary growth rate of 14.46 percent annually for AHUW acute care days, citing the 2025 SMFP's County Growth Rate Multiplier (CGRM) for Union County. However, a closer review of historical utilization data shows that this CGRM is largely the product of two factors:

1. A planned shift of patients from AH's Mecklenburg County hospitals to its Union County facilities, and,
2. An increase in average length of stay (ALOS) at the AH Union total license (AHU + AHUW).

Both of these are discrete, time-limited phenomena, not trends that can reasonably be projected to continue indefinitely.

1. CGRM Driven by Planned Shifts and Rising ALOS, Not Organic Demand Growth

The change in patient origin patterns reflects the ramp-up of a planned shift of AH volume from Mecklenburg County to Union County, first projected in the CON for the initial development of AHUW (Project ID #F-11618-18). That application explicitly projected that Union County residents who previously received care at Mecklenburg hospitals would shift to AH Union County hospitals over time. This shift, combined with the movement of higher acuity patients, is also likely responsible for the increase in ALOS at the AH Union total license.

AH's current applications, however, use the 14.46 percent CGRM to project that AHUW's acute care days will continue to grow at this rate through 2035, while failing to demonstrate that these underlying shifts and ALOS trends can or will continue, or even acknowledging them in its methodology. In fact, AH's applications explicitly assume that these drivers will not continue, making it unreasonable to carry forward the CGRM as a long-term growth rate. As such, AH fails to demonstrate why it is reasonable for AHUW's utilization to grow 14.46 annually through 2035, as detailed below.

Under the 2025 SMFP acute care bed methodology, CGRMs are based on historical utilization for all acute care facilities in each service area. Because AH Union (AHU + AHUW) is the sole acute care provider in Union County, the Union County CGRM is driven entirely by AH's historical utilization.

2. Discharge Growth Driven by Patient Shifts, Not Countywide Demand

As shown in the table below, NC DHSR Patient Origin Reports for FY 2019–2023 (the same years used in the 2025 SMFP CGRM calculation) indicate that discharges at the AH Union total license increased by 3,223 patients, producing a Growth Rate Multiplier for discharges of 8.7 percent.

Atrium Health Union Total License Inpatients by County of Origin

	2019	2020	2021	2022	2023	Change	GRM*
Union	5,587	4,938	5,463	5,854	7,263	1,676	7.6%
South Carolina	1,530	1,475	1,689	1,957	2,091	561	8.4%
Anson	1,352	1,122	1,134	1,229	1,426	74	2.1%
Mecklenburg	209	213	237	583	1,081	872	**61.1%**
Other	306	234	278	239	346	40	6.5%
Total	8,984	7,982	8,801	9,862	12,207	3,223	**8.7%**

Source: NC DHSR Patient Origin Reports, Patient Origin by Facility

*Growth Rate Multiplier calculated consistent the 2025 SMFP: For each of the last four reporting years, determine the percentage change from the previous reporting year by dividing the calculated difference in discharges by the total number of discharges provided

during the previous reporting year. Total the annual percentages of change and divide by four to determine the average annual change rate.

Approximately three-fifths of the 14.46 percent CGRM is attributable to this 8.7 percent GRM for discharges; the remaining roughly two-fifths is due to increasing ALOS for the AH Union total license.

This growth in discharges has been driven by:

- A 1,676-discharge increase in Union County patients served by the AH Union license (just over half of total growth), and
- An 872-discharge increase in Mecklenburg County patients, representing 27 percent of total growth, with a 61.1 percent GRM, the highest of any county.

Crucially, the growth in AH Union's discharges from Union and Mecklenburg residents exceeds the overall growth in acute care demand for those counties.

For Union County residents, total acute care demand grew at only a 2.5 percent GRM from 2019 to 2023, compared to a 7.6 percent GRM for Union County patients served by AH Union.

Union County Residents by County Served

	2019	2020	2021	2022	2023	Change	GRM*
Mecklenburg Facilities	8,907	7,996	8,745	8,444	8,553	-354	-0.8%
Union Facilities (AH Union Total License)	5,587	4,938	5,463	5,854	7,263	1,676	**7.6%**
Other Facilities	651	512	610	665	637	-14	0.6%
Total	15,145	13,446	14,818	14,963	16,453	1,308	**2.5%**

Source: NC DHSR Patient Origin Reports, Patient's County of Residence at Admission.
*Growth Rate Multiplier calculated consistent the 2025 SMFP: For each of the last four reporting years, determine the percentage change from the previous reporting year by dividing the calculated difference in discharges by the total number of discharges provided during the previous reporting year. Total the annual percentages of change and divide by four to determine the average annual change rate.

For Mecklenburg County residents, total inpatient demand actually declined, with a negative 0.5 percent GRM, compared to a 61.1 percent GRM for Mecklenburg residents served by AH Union.

Mecklenburg County Residents by County Served

	2019	2020	2021	2022	2023	Change	GRM*
Mecklenburg Facilities	75,563	68,892	71,766	70,419	72,346	-3,217	-0.9%
Cabarrus Facilities	2,408	2,301	2,513	2,698	3,123	715	7.0%
Union Facilities (AH Union Total License)	209	213	237	583	1,081	872	**61.1%**
Other Facilities	2,976	2,339	2,501	2,137	2,444	-532	-3.7%
Total	81,156	73,745	77,017	75,837	78,994	-2,162	**-0.5%**

Source: NC DHSR Patient Origin Reports, Patient's County of Residence at Admission.
*Growth Rate Multiplier calculated consistent the 2025 SMFP: For each of the last four reporting years, determine the percentage change from the previous reporting year by dividing the calculated difference in discharges by the total number of discharges provided during the previous reporting year. Total the annual percentages of change and divide by four to determine the average annual change rate.

Taken together, these data show that the apparent "growth" at AH Union is largely the result of:

- Reduced outmigration of Union County residents away from Union County facilities, at a faster rate than overall demand growth, and
- Increased inmigration of Mecklenburg County residents into Union County facilities, at a much higher rate than the small decline in overall Mecklenburg demand.

These trends closely track the planned shift described in the Agency Findings for the initial development of AHUW (Project ID #F-11618-18), which noted that:

> "*Some Union County residents who currently seek services in Mecklenburg County hospitals will shift to Atrium Union County hospitals (2018 days of care = 23,627). The applicant projects 43% of the 2018 days of care (10,172 patient days) will shift to* [AHU] *or AHUW in future years at an annual growth rate of 1.75%, based on the Union County projected population growth according to the North Carolina Office of State Budget and Management (NC OSBM). The shift will begin in CY2019 and ramp up to a 100% shift of the identified days (11,289) in CY2024*" (page 15). [3]

Because the historical growth underpinning the 2025 CGRM is the consequence of this planned and finite ramp-up, it is not reasonable to assume that AH Union facilities will continue to grow at these historical rates once the shifts completed in CY2024, especially when AH does not project any further shifts in its current applications.

[3] See https://info.ncdhhs.gov/dhsr/coneed/decisions/2019/feb/union_ahuw_find.pdf

3. AH's Own Patient Origin Assumptions Contradict Its Use of the CGRM

The change in patient origin for the AH Union total license confirms these shifts. Mecklenburg County patients increased from 2.3 percent to 8.9 percent of AH Union's total discharges between 2019 and 2023, while Union County residents declined from 62.2 percent to 59.5 percent of total discharges.

Atrium Health Union Total License Inpatients by County of Origin - Percent of Total

	2019	2020	2021	2022	2023
Union	62.2%	61.9%	62.1%	59.4%	59.5%
South Carolina	17.0%	18.5%	19.2%	19.8%	17.1%
Anson	15.0%	14.1%	12.9%	12.5%	11.7%
Mecklenburg	**2.3%**	2.7%	2.7%	5.9%	**8.9%**
Other	3.4%	2.9%	3.2%	2.4%	2.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Source: NC DHSR Patient Origin Reports, Patient Origin by Facility
*Growth Rate Multiplier calculated consistent the 2025 SMFP: For each of the last four reporting years, determine the percentage change from the previous reporting year by dividing the calculated difference in discharges by the total number of discharges provided during the previous reporting year. Total the annual percentages of change and divide by four to determine the average annual change rate.

Despite this clear evidence that historical growth at Union County facilities has been driven by patient shifts and migration changes, AH's applications assume no future change in patient origin. Specifically:

- AHU states in Section C.3: *"The proposed addition of 46 acute care beds to Atrium Health Union is not expected to have any impact on patient origin. Atrium Health Union's projected patient origin for its acute care beds is based on its existing patient origin"* (page 42).

- AHUW similarly states: *"The proposed addition of 90 acute care beds to Atrium Health Union West is not expected to have any impact on patient origin. Atrium Health Union West's projected patient origin for its acute care beds is based on its existing patient origin"* (page 43).

By assuming no change in patient origin, AH is implicitly assuming that the very trends that drove the historical CGRM (i.e., reduced outmigration and increased inmigration) will not continue, while simultaneously using that CGRM to drive future projections. AH also does not assume any continued shift of patients from its Mecklenburg County facilities to Union County, despite those shifts being:

- Explicitly projected in the initial AHUW CON, and

- Evident in the inmigration and outmigration trends described above.

Thus, AH's exceedingly high projected growth at AHUW is not grounded in reasonable, internally consistent assumptions.

4. Failure to Justify Continued Growth in Acute Care Days When ALOS is Projected to Decline

As previously noted, roughly 60 percent of the 14.46 percent CGRM is due to discharge growth and 40 percent is due to an increase in ALOS at the AH Union total license.

Using data from AH's own applications, ALOS for the AH Union total license increased from 4.5 to 5.4 days between 2020 and 2025, an average annual increase of 3.9 percent. Over the same period:

- Total discharges grew 8.1 percent annually, and
- Total inpatient days grew 12.3 percent annually.

AH Union Total License Inpatient Utilization

	2020	2021	2022	2023	2024	2025	CAGR*
AHU Days	36,441	46,754	48,350	48,740	51,554	51,190	7.0%
AHUW Days	-	-	8,717	12,538	14,421	13,994	
Total License Days	36,441	46,754	57,067	61,278	65,975	65,184	12.3%
AHU Discharges	8,144	8,899	8,365	8,964	8,721	8,240	0.2%
AHUW Discharges	-	-	1,986	3,059	3,581	3,786	
Total License Discharges	8,144	8,899	10,351	12,023	12,302	12,026	8.1%
Total License ALOS	**4.5**	**5.3**	**5.5**	**5.1**	**5.4**	**5.4**	**3.9%**

Source: AHUW application page 50 and AHU application page 48.

This data clearly shows that growth in ALOS has been a material driver of growth in acute care days at AH's Union County facilities.

Yet AH's projections assume that ALOS will decline in the future. In each application, AH states that historical averages provide an appropriate baseline for projecting discharges (AHUW page 132, AHU page 124), and AH's combined ALOS is projected to decline from 5.4 to 4.8 days over the projection period (as shown in AHUW Form C.1a).

Form C.1a Historical and Interim Health Service Facility Bed Utilization Atrium Health Union License	Last Full FY F: 01/01/2024 T: 12/31/2024	Interim Full FY F: 01/01/2025 T: 12/31/2025	Interim Full FY F: 01/01/2026 T: 12/31/2026	Interim Full FY F: 01/01/2027 T: 12/31/2027	Interim Full FY F: 01/01/2028 T: 12/31/2028	Interim Full FY F: 01/01/2029 T: 12/31/2029	Interim Full FY F: 01/01/2030 T: 12/31/2030	Interim Full FY F: 01/01/2031 T: 12/31/2031	Interim Full FY F: 01/01/2032 T: 12/31/2032
Acute Care Hospital - All Beds									
Total # of Beds, including all types of beds	178	186	186	186	274	274	333	333	333
# of Discharges	12,302	12,026	12,911	13,889	14,757	15,615	16,805	18,016	19,373
# of Patient Days	65,975	65,184	68,378	71,891	75,767	79,426	84,808	90,094	95,985
Average Length of Stay	5.4	5.4	5.3	5.2	5.1	5.1	5.0	5.0	5.0
Occupancy Rate	101.5%	96.0%	100.7%	105.9%	75.8%	79.4%	69.8%	74.1%	79.0%

Form C.1b Projected Health Service Facility Bed Utilization upon Project Completion Atrium Health Union License	1st Full FY F: 01/01/2033 T: 12/31/2033	2nd Full FY F: 01/01/2034 T: 12/31/2034	3rd Full FY F: 01/01/2035 T: 12/31/2035
Acute Care Hospital - All Beds			
Total # of Beds, including all types of beds	381	381	381
# of Discharges	20,897	22,614	24,548
# of Patient Days	102,564	109,928	118,185
Average Length of Stay	4.9	4.9	4.8
Occupancy Rate	73.8%	79.0%	85.0%

If ALOS is expected to decline, then a major driver of the historical growth embedded in the CGRM is eliminated. AH does not explain how acute care days at Union County facilities can reasonably be expected to grow at rates consistent with historical trends once this ALOS-driven component of growth is removed.

5. Misuse of Partial-Year Data to Claim "Conservative" Projections

Despite the above, AHUW asserts that its projected 14.46 percent growth rate is "conservative" compared to its historical CAGR, stating:

> *"Both rates are conservative – the CGRM used to project utilization at Atrium Health Union West is less than its historical CAGR …"* (AHUW pages 130–131; emphasis added).

However, AHUW's cited 17.1 percent historical CAGR is artificially inflated because it is based on partial-year CY 2022 data, the facility's first year of operation. As AHUW notes, "CY22 reflects partial-year data as Atrium Health Union West opened in February 2022" (page 128).

Atrium Health Union License Historical Acute Care Bed Utilization

	CY20	*CY21*	*CY22*	*CY23*	*CY24*	*Annualized CY25**	*CAGR***
Atrium Health Union Acute Care Days	36,441	46,754	48,350	48,740	51,554	51,190	7.0%
Atrium Health Union West Acute Care Days^			8,717^	12,538	14,421	13,994	17.1%
Total Acute Care Days	36,441	46,754	57,067	61,278	65,975	65,184	12.3%
Average Daily Census	99.8	128.1	156.3	167.9	180.8	178.6	
Acute Care Beds in Operation	178	178	178	178	178	186^^	
Occupancy Rate	56.1%	72.0%	87.8%	94.3%	101.5%	96.0%	

Source: CMHA internal data
* CY 2025 acute care days are annualized based on actual January – June utilization
** Compound annual growth rate: Atrium Health Union CAGR is CY 20 to CY 25 annualized; Atrium Health Union West CAGR is CY 22 to CY 25 annualized.
^ CY 2022 reflects partial-year data as Atrium Health Union West opened in February 2022
^^ Includes the development of eight additional acute care beds at Atrium Health Union West approved pursuant to Project ID # F-012440-23, which became operational in August 2025. To be conservative, these acute care beds have been included in the occupancy rate calculation in the table above for the full CY 2025 period despite only being operational for part of that year. Using a weighted bed count of 181 beds (178 beds for the first seven months and 186 beds for the remaining five months of CY 2025), the adjusted occupancy rate is 98.5 percent. During the January to June 2025 period, Atrium Health Union operated at 101.7 percent occupancy across the license.

When CY 2022 days are properly annualized, AHUW's CY22–CY25 CAGR is only 13.7 percent, demonstrating that the projected 14.46 percent growth rate is not conservative and in fact exceeds AHUW's corrected historical growth.

AHUW Historical CAGR Corrected

	CY22 Annualized*	2023	2024	2025	CAGR
AHUW Days	9,509	12,538	14,421	13,994	13.7%

*CY22 Annualized = 8,717 days for 11 months, partial year / 11 months x 12 months to annualize.

Moreover, it is unreasonable to use growth recorded during AHUW's initial ramp-up period, when utilization is expected to climb rapidly from 50 to 100 percent of "potential days" for appropriate cases, as a benchmark for long-term, mature operations. As the Agency Findings for AHUW's initial CON application explain, AH projected a ramp-up from 50 percent to 75 percent to 100 percent of potential days over the first three years of operation. [4]

Atrium Health Union West Acute Care Beds

- To determine the projected number of acute care days to be served at AHUW, the applicant determines *"Atrium Health Union West-appropriate"* acute care utilization by first assuming that any patient days related to services that are not proposed to be provided at AHUW will be provided at CHS Union only. Second, the applicant assumes that AHUW would serve only patients with a Primary or Secondary Acuity Level MS-DRG, as defined by Atrium Health. The applicant then limits the utilization at AHUW to a percent of the CY2018 patient days from geographies identified as convenient to the proposed AHUW campus, growing by 1.75% annually through 2024, resulting in the following potential days of care, ramped up from 50% in CY2022 to 100% in CY2024. (pages 18-20 of Section Q, Form C A&M)

	CY2018	INTERIM CY2019	INTERIM CY2020	INTERIM CY2021	FFY1 CY2022	FFY 2 CY2023	FFY3 CY2024
Potential Days of Care based on AHUW-Appropriate Services	8,919	9,076	9,235	9,396	9,561	9,729	9,899
Ramp-up					50%	75%	100%
Acute Care Days of Care at AHUW					4,781	7,296	9,899

Totals may not sum due to rounding

See pages 15-16 of Agency Findings for AHUW.

Using AHUW's initial ramp-up window to justify sustained double-digit growth through 2035 is unrealistic and methodologically unsound.

6. Inconsistency with AH's Mecklenburg County Acute Care Bed Applications

If, despite the above flaws, AH's projections for Union County were accepted as reasonable, then the only way to sustain such growth through 2035 would be for continued shifts of patients from AH Mecklenburg County hospitals to AH Union County facilities. Yet AH's two 2025 Mecklenburg County acute care bed

[4] See https://info.ncdhhs.gov/dhsr/coneed/decisions/2019/feb/union_ahuw_find.pdf

applications (Project IDs #F-012652-25 Atrium Health University City and #F-012652-25 Atrium Health Carolinas Medical Center) do not assume any continued shifts to Union County.

If those shifts were to occur as implied by the Union County projections, they would necessarily alter utilization forecasts in Mecklenburg County, rendering AH's Mecklenburg projections unreasonable and non-conforming. AH cannot have it both ways.

Given AH's:

- Failure to demonstrate countywide need beyond its existing and approved capacity,
- Reliance on unreasonable and internally inconsistent growth assumptions, and
- Misuse of the 2025 SMFP CGRM divorced from the underlying drivers of historical growth,

both AH applications are **non-conforming with Criterion (3)** and should be disapproved.

Based on these facts for which the AH applications are non-conforming with Criterion (3), both applications should also be found non-conforming with Criteria (1), (4), (5), (6), (18a), and 10A NCAC 14C .3803.

COMMENTS REGARDING CRITERION (4)

AH's applications fail to address a clear and viable alternative: developing the 59 beds for which it has already received approval in Union County. This omission is significant because a fundamental principle of the CON process is to ensure the most efficient use of approved healthcare resources before additional capacity is authorized.

By not addressing the development of these previously approved beds, AH raises concerns about whether additional bed capacity is truly needed or whether the existing approved beds could be optimized to meet patient demand. If AHU and AHUW have not yet implemented these 59 beds, questions arise regarding financial feasibility, operational priorities, or the actual necessity for further expansion. The Agency should not allow the stockpile of beds that AH is hoarding to grow yet again, especially if the result is to disapprove the Novant CON application and deprive Union County residents the choice and competition they deserve..

By failing to explore this obvious alternative, AH not only weakens its argument for additional bed need but also raises concerns about the responsible and strategic allocation of healthcare resources in Union County.

COMMENTS REGARDING CRITERION (6)

AH is seeking approval for 136 additional acute care beds despite already having 59 approved but undeveloped beds across its facilities (AHU and AHUW). The current request exceeds Novant Health's proposed bed expansion by more than four times, yet AH has failed to present any near-term solutions for addressing its alleged capacity constraints.

While AH claims that its hospital campuses lack adequate capacity, its applications do not demonstrate that these capacity challenges will persist once its approved beds are developed. Furthermore, AH's applications indicate that it will be years before any meaningful increase in capacity occurs. This delay undermines AH's assertion that the proposed project is "imperative." This is also inconsistent with the General Assembly's directive that CONs need to be developed promptly and should not be stockpiled. *See* N.C. Gen. Stat. § 131E-189. Simply stated, before AH is given more beds in Union County, it should be required to develop the beds for which it has CON approval. Another applicant, NH Wesley Chapel, should be given a chance to introduce beneficial choice and competition in Union County.

In reality, AH's requests represent unnecessary duplications of already approved capacity rather than a justified expansion of need. Accordingly, the AH's applications do not conform to **Criterion (6)** should be denied.

Based on these facts for which the AH applications are non-conforming with Criterion (6), both applications should also be found non-conforming with Criteria (1), (3), (4), (5), (12), (18a), and 10A NCAC 14C .3803.

COMMENTS REGARDING CRITERION (12)

The AH applications fais to demonstrate that their proposed cost, design, and construction approaches represent the most reasonable alternative, as required by Criterion (12). The applications propose a $264 million capital investment for 136 additional acute care beds, yet AH has already been approved for 59 acute care beds that remain undeveloped.

Critically, the application does not justify why this substantial inventory of unused beds is inadequate to meet projected demand and indicates that it be years before any meaningful increase in capacity occurs. Instead of efficiently utilizing its existing and approved resources, AH seeks approval for an expensive expansion without demonstrating that it has exhausted more cost-effective and practical alternatives. This raises serious concerns about the necessity and fiscal responsibility of the proposed project.

Given these deficiencies, the AH applications fais to meet the requirements of **Criterion (12)** and do not represent the most reasonable or efficient use of healthcare resources.

COMMENTS REGARDING CRITERION (18a)

In evaluating which conforming applications to approve or partially approve, the Agency must consider the critical public interest in maintaining and enhancing competitive balance in both Union County and the broader Charlotte region—the largest healthcare market in North Carolina. Preserving competition is essential to preventing AH from further solidifying its dominance and gaining unchecked power to dictate rates to commercial payors, self-insured employers, and individual patients.

As the Agency is well aware, AH has a documented history of antitrust concerns. The United States Department of Justice (USDOJ) and private parties have sued AH for abusing its market dominance, as evidenced in multiple cases:

- *United States v. The Charlotte-Mecklenburg Hospital Authority*, 3:16-cv-00311 (W.D.N.C.)

- *Benitez v. The Charlotte-Mecklenburg Hospital Authority*, 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 AH culminated in a Final Judgment, a copy of which is attached to these comments. Despite this legal history, AH continues to expand its control, threatening competitive balance and patient choice.

The Agency's CON decisions are the only policy tool available to counteract AH's market power and foster competition in Union County and the Charlotte region. The CON Law exists to protect patients, and competition directly benefits patients by lowering costs and improving care quality.

As demonstrated in the 2025 SMFP:

- AH controls 100% of the existing and approved acute care beds in Union County.
- AH controls 65.5% of existing and approved acute care beds in Mecklenburg County, the population center of the Charlotte region.
- Novant Health holds just 34.5% of the acute care bed capacity in Mecklenburg County.

Approving Novant Health's proposed acute care bed development at NH Wesley Chapel will directly enhance competition, providing Union County residents with a long-overdue alternative and reducing AH's control on the region.

In contrast, approving AH's applications would reinforce its market dominance, stifle competition, and harm patients. Given these concerns, AH's applications are non-conforming with **Criterion (18a)** and should be disapproved.

COMMENTS REGARDING CONFORMITY WITH STATUTORY REVIEW CRITERIA FOR ATRIUM HEALTH UNION APPLICATION PROJECT ID # F-012701-25

COMMENTS REGARDING CRITERION (5)

AHU's Form F.2b on page 128 provides an incorrect calculation of Net Cash Flow; when corrected, AHU's project will have negative cash flow during the first three years of its proposed project. As such, AHU fails to demonstrate the financial feasibility of its project.

As shown in the excerpt below, AHU's Form F.2b from page 128 shows negative Net Income and erroneously positive Net Cash Flow in each of the three full fiscal years of the project.

Form F.2b Projected Revenues and Net Income upon Project Completion Atrium Health Union Acute Care Beds	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Patient Services Gross Revenue[a]			
Self Pay	$10,321,255	$10,873,956	$11,456,254
Insurance *	$56,740,302	$59,778,732	$62,979,870
Medicare *	$139,895,568	$147,386,945	$155,279,483
Medicaid *	$57,059,516	$60,115,040	$63,334,187
Other (Specify)	$6,543,889	$6,894,312	$7,263,501
Total Patient Services Gross Revenue	$270,560,528	$285,048,985	$300,313,296
Other Revenue (1)[b]			
Total Gross Revenue (2)	$270,560,528	$285,048,985	$300,313,296
Adjustments to Revenue			
Charity Care[c]	$10,222,858	$10,770,290	$11,347,036
Bad Debt[d]	$10,780,813	$11,358,123	$11,966,348
Contractual Adjustments[c]	$183,138,484	$192,945,509	$203,277,699
Total Adjustments to Revenue	$204,142,154	$215,073,922	$226,591,083
Total Net Revenue (3)	$66,418,374	$69,975,063	$73,722,213
Total Operating Costs (from Form F.3)	$77,064,092	$80,290,118	$83,687,643
Net Income (4)	($10,645,718)	($10,315,054)	($9,965,430)
Net Cash Flow (5)	$87,709,810	$90,605,172	$93,653,072

*** Including any managed care plans**
F: = From
T: = To

(1) Identify each type of revenue included on this line and explain how the dollar amount for each type was determined.
(2) Total Gross Revenue = Total Patient Services Gross Revenue + Other Revenue
(3) Total Net Revenue = Total Gross Revenue - Total Adjustments to Revenue
(4) Net Income = Total Net Revenue - Total Operating Costs
(5) Net Cash Flow = Net Income + Depreciation

Footnote (5) for Net Cash Flow states that it equals Net Income + Depreciation. However, AHU made an error in calculating the Net Cash Flow presented in Form F.2b. As shown below, from AHU's F.3b on page 130, Depreciation expenses in the first three full fiscal years of the project total between $9.5 and $9.7 million approximately.

Form F.3b Projected Operating Costs upon Project Completion Atrium Health Union Acute Care Beds	1st Full FY F: 01/01/2030 T: 12/31/2030	2nd Full FY F: 01/01/2031 T: 12/31/2031	3rd Full FY F: 01/01/2032 T: 12/31/2032
Salaries (from Form H Staffing)[a]	$46,971,350	$49,486,655	$52,136,655
Taxes and Benefits[b]	$7,608,567	$8,016,004	$8,445,260
Independent Contractors (Consultants) (1)[c]	$59,785	$61,578	$63,426
Medical Supplies[d]	$3,211,787	$3,383,778	$3,564,978
Other Supplies[d]	$834,989	$879,702	$926,810
Pharmacy (2) incl. in Medical Supplies	$0	$0	$0
Dietary (2) incl. in Other Supplies	$0	$0	$0
Housekeeping / Laundry (2) incl. in Other Supplies	$0	$0	$0
Equipment Maintenance (2) incl. in Independent Contractors	$0	$0	$0
Building & Grounds Maintenance (2) incl. in Central Office Overhead	$0	$0	$0
Central Office Overhead[e]	$3,320,919	$3,498,753	$3,686,111
Professional Fees[f]	$0	$0	$0
Utilities incl. in Central Office Overhead	$0	$0	$0
Insurance incl. in Central Office Overhead	$0	$0	$0
Interest Expense[g]	$5,412,022	$5,244,315	$5,068,029
Rental Expense incl. in Other Operating Expense	$0	$0	$0
Property and Other Taxes (except Income) incl. in Central Office Overhead	$0	$0	$0
Depreciation - Buildings[h]	$5,927,228	$5,968,498	$6,011,006
Depreciation - Equipment[i]	$3,601,210	$3,628,373	$3,656,351
Other Operating Expenses[j]	$116,236	$122,460	$129,018
Total Expenses	$77,064,092	$80,290,118	$83,687,643

When these Depreciation expenses are added to AHU's project Net Income to determine Net Cash Flow, the resulting corrected calculations demonstrate that AHU is projected to have negative Net Cash Flow in each of its three full fiscal years, as shown below.

AHU Net Cash Flow Corrected

	2023	2024	2025
Net Income (4)	($10,645,718)	($10,315,054)	($9,965,430)
Depreciation - Buildings	$5,927,228	$5,968,498	$6,011,006
Depreciation - Equipment	$3,601,210	$3,628,373	$3,656,351
Corrected Net Cash Flow (5)	($1,117,280)	($718,183)	($298,073)

Source: AHU Forms F.2b and F.3b

Given its projected negative Net Income and negative Net Cash Flow, AHU fails to demonstrate the financial feasibility of its project.

Accordingly, the AHU application is non-conforming with **Criterion (5)** and should be disapproved. Based on these facts for which the AHU is non-conforming with Criterion (5), it should also be found non-conforming with Criteria (1), (4), (5), (6), and (18a).

COMMENTS REGARDING CONFORMITY WITH STATUTORY REVIEW CRITERIA FOR ATRIUM HEALTH UNION WEST APPLICATION PROJECT ID# F-012707-25

COMMENTS REGARDING CRITERION (5)

A comparison of financial projections for AHUW and AHU's projects reveals that AHUW, a smaller hospital campus that provides community hospital services and treats lower acuity patients, projects higher average charges and expenses per patient day than AHU, a larger, regional hospital with a broader scope of services and higher acuity patients. As such, AHUW does not demonstrate that its costs and charges are reasonable and supported.

As shown below, based on data from AHU and AHUW's Forms F.2 and F.3, in comparison to AHU, AHUW projects gross charges per patient day that are 22% higher, Independent Contractors expense per bed that is 154% higher, Medical Supplies expense per patient day that is 35% higher, Other Supplies expense per patient day that is 74% higher, and Other Expenses per patient day that is 67% higher.

CY2032 AHU and AHUW Charges and Expenses

	AHU	AHUW	% Difference
Gross Charges	$300,313,295	$219,297,043	
Patient Days	59,967	36,018	
Gross Charge per Patient Day	**$5,007.98**	**$6,088.54**	**22%**
Independent Contractors	$63,426	$111,338	
Beds	197	136	
Independent Contractors Expense Per Bed	**$321.96**	**$818.66**	**154%**
Medical Supplies	$3,564,978	$2,885,842	
Other Supplies	$926,810	$967,917	
Other Expenses	$129,018	$129,107	
Patient Days	59,967	36,018	
Medical Supplies per Patient Day	**$59.45**	**$80.12**	**35%**
Other Supplies per Patient Day	**$15.46**	**$26.87**	**74%**
Other Expenses per Patient Day	**$2.15**	**$3.58**	**67%**

Source: AHU and AHUW Forms F.2 and F.3

Both applications state that projected costs and charges are based on the historical experience of their respective hospital campuses and there is no discussion of any adjustment for acuity changes over time. Further, both applications state that the financial statements assume 3.0 percent annual inflation based

on expected annual inflation. Thus, the comparison above is not impacted by inflation. As such, AHUW does not demonstrate that these projected costs and charges are reasonable given the differences between the two hospital campuses. AHU discusses "*its critical role as the regional referral hub that receives higher acuity patients from Atrium Health Union West, Atrium Health Anson, and the surrounding area"* (page 51) and how its project "*will allow Atrium Health Union to focus its capacity on quality, timely care for higher acuity patients while ensuring Atrium Health Union West has expanded capacity to continue serving the growing number of patients in Western Union County closer to home"* (page 53).

As shown in prior comments, AHU's ALOS has been and is projected to be higher than AHUW, indicating that it treats more complex, higher acuity patients. In fact, in both applications, AH states "*Atrium Health Union's ALOS has increased over recent years as lower acuity patients have shifted to Atrium Health Union West, leaving Atrium Health Union to focus on more complex cases requiring longer stays*" (AHU page 123, AHUW page 131).

Given these differences, AHUW does not demonstrate that its projection of higher costs and charges than AHU are reasonable. Accordingly, the AHUW application is non-conforming with **Criterion (5)** and should be disapproved. Based on these facts for which the AHUW is non-conforming with Criterion (5), it should also be found non-conforming with Criteria (1), (4), (5), (6), and (18a).

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 Atrium Health applications. Therefore, the Novant Health application should be approved as submitted. If the Agency finds the Atrium Health applications conforming with all CON criteria and performance standards, the Atrium Health applications are less effective alternatives than the Novant Health application and should be denied or partially approved (for a maximum of 104 beds) on that basis. Fostering competitive balance in Union County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high-quality care, lowering costs, and expanding patient choice.

ATTACHMENT: FINAL JUDGMENT, United States v. The Charlotte-Mecklenburg Hospital Authority, 3:16-cv-00311 (W.D.N.C.)

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

Exhibit A

Aetna

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."

Blue Cross and Blue Shield of North Carolina

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."

Exhibit B

Cigna

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."

UnitedHealthcare

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."