COMPETITIVE COMMENTS ON

2025 MECKLENBURG COUNTY OPERATING ROOM APPLICATIONS

SUBMITTED BY NOVANT HEALTH

July 31, 2025

Three CON applications were submitted in response to the 2025 SMFP need determination for five (5) operating rooms (OR) in Mecklenburg County, including:

> CON Project ID# F-012654-25 Atrium Health Carolinas Medical Center (CMC): Add five ORs at CMC
>
> CON Project ID# F-012658-25 Novant Health Matthews Medical Center (NHMMC): Add two (ORs) at NHMMC.
>
> CON Project ID# F-012661-25 Novant Health Presbyterian Medical Center (NHPMC): Add two (ORs) at NHPMC.

As the foregoing list shows, the total number of ORs applied for exceeds the SMFP need determination. Atrium Health ("AH") has applied for all five ORs; Novant Health has applied for four ORs, which is less than the 2025 need determination. As the smaller health system in Mecklenburg County with a demonstrated need for the two ORs at its flagship, tertiary level medical center, and two ORs at its high-performing community-based hospital, the Novant Health applications should be approved for two ORs at NHPMC and two ORs at NHMMC.

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

This project will allow Novant Health to meet growing demand and enhance competition between it and the other health system in Mecklenburg County. This is in the best interests of patients because it promotes competition, which increases choices, leads to lower prices, and enhances quality and innovation. As the Novant Health application demonstrates, it conforms to all applicable review criteria and rules and is the comparatively 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 five ORs may be approved for Mecklenburg County in this review. Because the applications in this review collectively propose to develop nine additional ORs in Mecklenburg County, all applications cannot be approved for the total number of beds proposed. Therefore, a comparative review is required as part of the Agency findings after each application is reviewed independently against the applicable statutory review criteria. The following factors have recently been utilized by the Agency for all reviews regardless of the type of services or equipment proposed:

- Conformity with Statutory and Regulatory Review Criteria
- Scope of Services
- Geographic Accessibility
- Historical Utilization
- Access by Service Area Residents
- Access by Underserved Groups: 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

These factors are consistent with the factors the Agency used in the 2024 Mecklenburg County Acute Care Bed Review. The Agency may use its discretion to add other comparative factors based on the facts of the competitive review. 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
CMC	F-012654-25	Non-Conforming
Novant Health Matthews Medical Center	F-012658-25	Conforming
Novant Health Presbyterian Medical Center	F-012661-25	Conforming

The Novant Health applications are 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 applications are the **most effective** alternative regarding conformity with applicable review Criteria and rules.

Scope of Services

NHPMC and CMC each serve as the flagship hospital in Mecklenburg County for their respective health systems. Both institutions are full-service, tertiary and quaternary care hospitals that offer advanced specialty services and serve as referral centers for complex medical and surgical care across the region.

In prior reviews, including the 2024 Mecklenburg County acute care bed review, the Agency determined that CMC was a comparatively more effective alternative with respect to scope of services, citing its Level I trauma center status and its designation as an academic medical center (AMC). Novant Health respectfully disagrees with this conclusion and submits that NHPMC and CMC are equally effective regarding the scope and complexity of services offered. As demonstrated throughout NHPMC's 2025 CON OR application, both hospitals provide a full continuum of care, including highly specialized services that support their roles as regional centers of excellence.

The Agency has previously made the blanket statement that CMC "offers more services" than NHPMC; however, this assertion is no longer supported by the clinical reality. NHPMC offers a breadth of services that match those available at CMC, including cardiovascular care, neuroscience, comprehensive cancer care, transplant support, and complex orthopedic, spine, and trauma services. NHPMC also participates in innovative care models, advanced diagnostic techniques, and system-wide quality collaboratives, supported by its integration with the Novant Health system and partnerships such as the collaborative with Duke Health.

In 2024, NHPMC received designation as a Level II Trauma Center, reinforcing its role as a major regional provider of trauma care. While CMC maintains Level I status, the clinical differences between Level I and Level II trauma centers are minimal in practice, particularly at institutions like NHPMC that have robust trauma infrastructure, research involvement, and educational programs. According to Emergency Medical Services & Trauma Rules (10A NCAC 13P .0102), a Level II trauma center provides trauma care regardless of the severity of the injury and may lack only the trauma research focus that defines Level I centers. NHPMC, through the Novant Health Research & Innovation Institute, participates in research and ongoing performance improvement initiatives.

The scope of trauma services delivered at NHPMC is clinically comparable to those at CMC. A comparison of trauma-related discharges by Medicare Severity-Diagnosis Related Groups (MSDRGs) shows that NHPMC and CMC manage identical trauma case types.

Trauma-Related Discharges By MSDRG

MSDRG	MSDRG Description	CY2022		CY2023		CY2024*	
		CMC	PMC	CMC	PMC	CMC	PMC
533	FRACTURES OF FEMUR WITH MCC	1	2	2	3	4	3
534	FRACTURES OF FEMUR WITHOUT MCC	3	1	10	5	12	3
535	FRACTURES OF HIP AND PELVIS WITH MCC	5	4	7	6	3	12
536	FRACTURES OF HIP AND PELVIS WITHOUT MCC	16	2	41	18	36	41
913	TRAUMATIC INJURY WITH MCC	2		4		13	5
914	TRAUMATIC INJURY WITHOUT MCC	8	2	30	14	20	7
955	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	4		26	2	16	4
956	LIMB REATTACHMENT, HIP & FEMUR PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUM	34	3	151	9	125	49
957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITH MCC	40	3	193	4	179	23
958	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITH CC	33	2	175	17	115	31
959	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WITHOUT CC/MCC			12	3	12	3
963	OTHER MULTIPLE SIGNIFICANT TRAUMA WITH MCC	10	2	64	8	45	17
964	OTHER MULTIPLE SIGNIFICANT TRAUMA WITH CC	31	2	101	14	76	35
965	OTHER MULTIPLE SIGNIFICANT TRAUMA WITHOUT CC/MCC	5		17	1	25	5
Total		**192**	**23**	**833**	**104**	**681**	**237**

*Annualized based on Jan-Oct
Source: HIDI

Even prior to its formal Level II designation, NHPMC regularly treated nearly all of the same trauma DRGs as CMC. With full designation and expanded trauma leadership in place, NHPMC now operates on equal footing with CMC in terms of trauma capability and delivery.

Regarding academic affiliation, while CMC is an AMC, the additional ORs proposed at CMC are not reserved exclusively for teaching purposes. Any patient may receive surgical care in those ORs, and any credentialed provider may provide care. The SMFP does not grant priority status to AMCs in the OR methodology. The only relevant criteria are those on pages 36-37 of the 2025 SMFP, which require 24-hour emergency services and the provision of inpatient medical care to both surgical and non-surgical patients, criteria met by both CMC and NHPMC.

Furthermore, NHPMC offers a wide array of teaching and training programs, including accredited residencies in pharmacy, infectious diseases, oncology, and emergency medicine. These programs enhance workforce development and support NHPMC's position as a teaching institution in practice, if not in formal designation.

In summary, NHPMC and CMC are **equally effective** in terms of scope of services. NHPMC delivers a full range of complex, specialty, and trauma care services, is integrated into a regional referral network, participates in training and clinical research, and operates within a system committed to advancing health equity and access. The previously held view that CMC offers a broader scope of services is no longer accurate, and the record clearly supports the finding that NHPMC is an equally suitable site for the proposed ORs based on scope of services.

Geographic Accessibility

All three applicants propose to develop additional ORs at existing facilities in Mecklenburg County. NHPMC and CMC each propose to develop incremental ORs in Charlotte and NHMMC proposed to develop incremental ORs in Matthews.

According to the 2025 SMFP, there are 146 existing and approved hospital-based operating rooms in the Mecklenburg County Service Area, distributed across 10 hospitals operated by Novant Health and Atrium Health. The following table summarizes where the ORs are located in Mecklenburg County.

Geographic Distribution of ORs in Mecklenburg County

City	System	Total OR Inventory*
Charlotte	Atrium	68
	Novant	35
Ballantyne	Novant	2
Steele Creek	Novant	2
Steele Creek	Atrium	1
University City	Atrium	7
	Charlotte Total	115
Pineville	Atrium	12
Huntersville	Novant	7
Matthews	Novant	7
Mint Hill	Novant	3
Cornelius	Atrium	2
Total Mecklenburg County		**146**

*Existing and approved ORs
Source: 2025 SMFP

This distribution demonstrates that hospital-based OR access in Mecklenburg County is not limited to any single geographic area or provider, but is instead comprehensively and strategically located throughout the county's major population centers.

Therefore NHPMC, NHMMC, and CMC applications are equally effective alternatives regarding geographic accessibility.

Historical Utilization

With respect to the Historical Utilization comparative factor in this review, Novant Health has clearly demonstrated a need for the two additional ORs it proposes at NHPMC and the two additional ORs it proposes at NHMMC. This need is supported by robust historical surgical utilization trends, service area demographic data, and qualitative indicators detailed throughout Novant Health's applications.

Collectively, these data points reflect sustained and growing demand for surgical services at NHPMC and NHMMC and underscore the necessity of expanding bed capacity to meet current and future patient needs.

Novant Health respectfully emphasizes that the CON review process does not grant any applicant a presumption of entitlement or preference based on institutional status, history of prior approvals, or academic affiliation. Each applicant must independently demonstrate need consistent with the review criteria outlined in G.S. 131E-183 and the SMFP, and the Agency's evaluation of Historical Utilization must remain firmly grounded in these objective standards.

The origin of a need determination, such as which hospital's data most significantly contributed to the identification of need in the SMFP, is legally irrelevant. Need determinations published in the SMFP are explicitly excluded from contested case challenges pursuant to 10A NCAC 14C .0402. Consequently, the Agency may not rely on the source of utilization data as a comparative advantage during the review. This principle was affirmed in *Surgical Care Affiliates, LLC v. NCDHHS*, 2014 WL 5770252, at *8 (N.C. Ct. App. Oct. 21, 2014), where the Court held that the Agency must base its evaluation on the defined service area and refrain from considering broader or subjective metrics that lack regulatory support.

Novant Health's historical utilization record, supported by quantitative and qualitative evidence, clearly substantiates the need for the proposed ORs at NHPMC and NHMMC. The Agency should evaluate the Historical Utilization factor based on the objective data and statutory framework presented in the application, without incorporating external or discretionary considerations that are inconsistent with North Carolina law or the SMFP.

In summary, while historical utilization is relevant to the evaluation of Criterion (3), it should not be used as a comparative factor to suggest that one applicant is more deserving of approval than another, particularly when all applicants must independently demonstrate the need for their proposed projects consistent with applicable statutory and regulatory requirements.

Competition (Patient Access to a New or Alternate Provider)

According to the 2025 SMFP, there are 146 existing and approved hospital-based ORs in Mecklenburg County, allocated across 10 hospitals operated by Atrium Health and Novant Health. Considering the applicants in this competitive review are each existing providers in the service area, the expansion of an existing provider that currently controls fewer ORs than another provider would encourage all providers in the service area to improve quality and lower costs in order to compete for patients.

Mecklenburg County Hospital-Based ORs
(Based on Adjusted Planning Inventory)

	OR Adjusted Planning Inventory	% of Total Hospital-Based ORs* (Adjusted Inventory)
Atrium Health	90	61.6%
Novant Health	56	38.4%
Total	146	100.0%

Source: Table 6B, 2025 SMFP
*Excludes freestanding ASC ORs

As shown, Atrium Health currently controls 61.6% of the hospital-based ORs in the county. A similar disparity exists in licensed acute care bed capacity, where Atrium maintains a significantly larger share. This dual imbalance, across both inpatient beds and surgical platforms, limits patients' ability to access timely care across systems and places disproportionate strain on Novant Health facilities as they seek to meet growing demand with fewer resources.

Enhancing Novant Health's OR capacity will contribute to a more level playing field and promote a healthier competitive environment. Increased competition is strongly associated with:

- Enhanced quality of care driven by innovation and performance benchmarking;
- Greater cost-effectiveness through efficiency initiatives and value-based strategies; and
- Improved access for underserved groups who benefit from expanded provider choice and reduced wait times.

As the system with fewer hospital-based ORs and a smaller share of acute care beds, Novant Health's growth represents a positive and necessary competitive force in Mecklenburg County. Expanding Novant Health's surgical platform ensures patients have meaningful alternatives across health systems.

To put this into further perspective, assuming that as a result of the 2025 Mecklenburg County OR review, five additional ORs are added, and further assuming that both NHPMC and NHMMC's OR applications are approved, Novant Health's percentage of the total number of ORs in Mecklenburg County increases to 40%. Atrium Health's percentage of the total would still be approximately 60%. A modest gain in Novant Health's surgical capacity offers significant tangible benefits for patients and payors, such as greater choice, and enhanced competition with respect to price, quality, and innovation. At the same time, Atrium Health remains the larger competitor by a significant margin and suffers no loss in its ability to meet the demands for its surgical services.

Therefore, regarding patient access to a new or alternate provider, the applications submitted by Novant Health are the **most effective** alternative, and the application submitted by Atrium Health is the least effective alternative.

Access By Service Area Residents

The service area for ORs per 10A NCAC 14C .2101 (7) means the operating room service area as defined in Chapter 6 in the annual State Medical Facilities Plan. This project is in response to the OR need determination in Mecklenburg County set forth in the 2025 SMFP. Facilities may also serve residents of counties not included in their service area.

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

Projected Service to Mecklenburg County Residents, Project Year 3

	CMC	NHMMC	NHPMC
# of Mecklenburg County Patients	15,134	3,347	23,473
% of Mecklenburg County Patients	41%	47%	56%

Source: CON applications, Section C.3

NHPMC projects both the highest number and percentage of service area residents. NHMMC projects the second highest percentage of service area residents. Therefore, the Novant Health applications are the **most effective** alternatives regarding access by service area residents.

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. [1] Access by each group is treated as a separate factor.

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.

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

Projected Medicare Revenue – 3rd Full FY

Applicant	Form F.2b Total Medicare Revenue	Form C.1b Discharges	Avg Medicare Rev. per Case	Form F.2b Gross Revenue	% of Gross Revenue
CMC	$1,123,213,304	36,900	$30,439	$3,482,320,400	32.3%
NHMMC	$108,515,513	7,122	$15,237	$265,740,423	**40.8%**
NHPMC	$779,974,468	42,225	$18,472	$1,818,525,645	**42.9%**

For the 2025 Mecklenburg OR applications, Novant Health developed Forms F.2 and F.3 for NHPMC and NHMMC ORs to represent only the surgical, pre-surgical unit, and post-surgical unit charges and expenses. They are based on the financials for these units at NHPMC and NHMMC, respectively. They do not include ancillary services (lab, radiology, or surgery) that generate additional revenue and expenses for surgical patients. This approach differs from prior years, in which Novant Health included ancillary services in Forms F.2 and F.3. Novant Health believes this revised methodology aligns with the format used by Atrium Health in its 2025 Mecklenburg County OR application for CMC. Accordingly, the financial pro formas submitted for the proposed OR additions at NHPMC and NHMMC are presented in a manner that facilitates a reasonable comparison of revenues across Novant Health and Atrium Health applications in the 2025 review cycle.

Total Medicare Revenue

In this review, it is not appropriate to compare the competing applicants based on total Medicare revenue because this metric is heavily influenced by the overall size of the facility, particularly the number of ORs and annual surgical patients. Larger hospitals like CMC, which projects to operate 62 ORs (nearly twice the number of NHPMC), will naturally report higher total Medicare revenue due to their greater patient volume, even if their payer mix or commitment to Medicare patients is proportionally lower than smaller hospitals.

For example, CMC projects $3.5B in total Medicare revenue from 36,900 cases, while NHMMC projects $265.7 million from 7,122 cases. However, this difference reflects volume and scale, not necessarily a greater institutional commitment to serving Medicare patients.

Average Medicare Revenue per Discharge

Average Medicare revenue per discharge does not provide a fully meaningful or equitable comparison when hospitals differ significantly in their scope and complexity of services.

Facilities like NHPMC and CMC serve as regional referral centers and offer more complex, tertiary-level services (e.g., cardiothoracic surgery, neurosurgery, trauma care). These types of services carry higher Diagnosis Related Group (DRG) weights, which in turn lead to higher Medicare reimbursement per discharge.

In contrast, hospitals like NHMMC are typically community hospitals with comparatively fewer high-acuity cases. Their DRGs are more likely to reflect routine, lower-intensity services, which generate lower average Medicare revenue per discharge compared to NHPMC and CMC.

A higher average Medicare revenue per discharge, such as $30,439 at CMC vs. $15,237 at NHMMC does not necessarily mean the hospital is more effective at serving Medicare patients. It simply reflects that patients are sicker and services are more complex, which skews the financial metric upward.

If this metric is used in comparative analysis without adjustment for case mix index (CMI) or service line differentiation, it effectively penalizes community hospitals that serve large Medicare populations with less complex needs and rewards larger tertiary centers for complexity rather than access or proportional Medicare reliance.

Because the comparative analysis separately evaluates scope of services, it would be inappropriate to duplicate that consideration by relying on Average Medicare Revenue Per Discharge, which primarily reflects service complexity rather than access or proportional Medicare commitment.

<u>% of Gross Revenue</u>

The percentage of gross revenue attributable to Medicare provides a much more meaningful and equitable comparison across hospitals of varying sizes and scope. This metric reflects the relative importance of Medicare patients in the hospital's overall financial and operational profile, regardless of scale.

As shown in the previous table:

- NHPMC projects 42.9% of gross revenue from Medicare
- Novant Health Matthews: 40.8%
- CMC: 32.3%

Despite its large size, CMC derives the lowest proportion of its gross revenue from Medicare, suggesting a lower relative commitment to serving Medicare beneficiaries than the competing applications. In contrast, Novant Health's facilities show a significantly higher share, indicating a greater reliance on, and dedication to, Medicare patients.

Total Medicare revenue skews comparisons in favor of large institutions. Evaluating percentage of gross revenue from Medicare offers a normalized and equitable metric that more accurately reflects a provider's commitment to Medicare populations and should be prioritized in comparative analysis.

For these reasons, NHPMC and NHMMC are the **most effective** alternatives regarding access by Medicare patients.

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 Case	Form F.2b Gross Revenue	% of Gross Revenue
CMC	$738,960,229	36,900	$20,026	$3,482,320,400	21.2%
NHMMC	$21,072,982	7,122	$2,959	$265,740,423	7.9%
NHPMC	$208,184,645	42,225	$4,930	$1,818,525,645	11.4%

The same rationale applies to total Medicaid revenue and average Medicaid revenue per discharge because both are heavily influenced by hospital size and service complexity, not by proportional service to Medicaid patients. Larger, tertiary hospitals naturally generate higher totals and per-discharge averages due to volume and acuity. In contrast, percent of gross revenue from Medicaid offers a normalized, equitable measure of a hospital's relative commitment to serving Medicaid patients, regardless of size or scope. Among the competing applications, the proposal by Atrium Health projects higher percentage of gross revenue compared to Novant Health's proposals.

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 Cases	Form F.2b Net Revenue	Average Net Revenue per Case
CMC	36,900	$920,108,526	$24,935
NHMMC	7,122	$84,691,848	**$11,892**
NHPMC	42,225	$542,209,287	**$12,841**

For the 2025 Mecklenburg OR applications, Novant Health developed Forms F.2 and F.3 for NHPMC and NHMMC ORs to represent only the surgical, pre-surgical unit, and post-surgical unit charges and expenses. They are based on the financials for these units at NHPMC and NHMMC, respectively. They do not include ancillary services (lab, radiology, or surgery) that generate additional revenue and expenses for surgical patients. This approach differs from prior years, in which Novant Health included ancillary services in Forms F.2 and F.3. Novant Health believes this revised methodology aligns with the format used by Atrium Health in its 2025 Mecklenburg County OR application for CMC. Accordingly, the financial pro formas submitted for the proposed OR additions at NHPMC and NHMMC are presented in a manner that

facilitates a reasonable comparison of revenues across Novant Health and Atrium Health applications in the 2025 review cycle.

Novant Health projects the lowest average net revenue per discharge compared to CMC. Based on the data:

- NHPMC projects an average net revenue per case of $12,841, which is significantly lower than CMC's $24,935, despite both being tertiary referral centers and trauma centers.

- NHMMC projects an average net revenue of $4,694 per case.

These comparisons illustrate that Novant's proposals offer the most affordable surgical care on a per-patient basis. Therefore, NHPMC and NHMMC are the **most effective** alternatives regarding average net revenue per discharge.

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 regarding 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 Case	Form F.2b Operating Expense	Average Operating Expense per Case
CMC	36,900	$410,897,425	$11,135
NHMMC	7,122	$40,302,089	**$5,659**
NHPMC	42,225	$292,912,786	**$6,937**

Novant Health also projects the lowest average operating expense per discharge compared to CMC.

- NHPMC projects an average operating expense of $5,659 per case, substantially lower than CMC's $11,135, despite both hospitals offering complex, tertiary-level services.

- NHMMC projects an average operating expense of $5,659 per case.

These figures demonstrate that Novant Health's proposals are more efficient and effective at managing costs while maintaining access to high-quality care. Therefore, NHPMC and NHMMC are the **most effective** alternatives regarding average operating expense per discharge.

Summary

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

Comparative Factor	Carolinas Medical Center	Novant Health Matthews Medical Center	Novant Health Presbyterian Medical Center
Conformity with Review Criteria	Less Effective	**Most Effective**	**Most Effective**
Scope of Services	**Most Effective**	Less Effective	**Most Effective**
Geographic Accessibility	Equally Effective	Equally Effective	Equally Effective
Historical Utilization	Equally Effective	Equally Effective	Equally Effective
Enhance Competition	Less Effective	**Most Effective**	**Most Effective**
Access by Service Area Residents: No. of Patients	Less Effective	Less Effective	**Most Effective**
Access by Service Area Residents: % of Patients	Less Effective	Less Effective	**Most Effective**
Projected Access by Medicare Patients	Less Effective	**Most Effective**	**Most Effective**
Projected Access by Medicaid Patients	**Most Effective**	Less Effective	Less Effective
Projected Average Net Revenue per Patient	Less Effective	**Most Effective**	**Most Effective**
Projected Average Operating Expense per Patient	Less Effective	**Most Effective**	**Most Effective**

The application submitted by NHPMC is a more effective alternative for eight comparative analysis factors. The application submitted by NHMMC is a more effective alternative for five comparative analysis factors. The application submitted by CMC is a more effective alternative for two comparative analysis factors. Therefore, the applications for NHPMC and NHMMC should be approved as submitted and the CMC application should be denied.

COMMENTS REGARDING STATUTORY REVIEW CRITERIA

COMMENTS REGARDING CRITERION (3)

CMC OR Deficit

CMC emphasizes that it generated the largest projected OR deficit among all facilities providing surgical services in Mecklenburg County. This echoes a similar argument Atrium made in its acute care bed applications, where it claimed entitlement to new resources because its facilities generated the need determination. However, from a competitive perspective, this argument is irrelevant when comparing Atrium's proposal to Novant Health's applications to develop new ORs at NHPMC and NHHMC.

The fact that CMC generated the largest projected OR deficit does not confer any entitlement or priority for additional ORs. Each applicant must independently demonstrate the need for its proposed project. Novant Health's applications clearly do so by showing rising utilization at both NHPMC and NHMMC, growing demand for surgical services among their respective service area populations, and facility-specific data that justifies the proposed OR expansions.

The SMFP methodology is designed to assess countywide need, not to allocate all new capacity to the institution with the largest footprint. Concentrating all new ORs at a single tertiary center like CMC undermines access, efficiency, and competition. In contrast, Novant's proposals at NHPMC and NHMMC promote broader geographic access by enhancing surgical capacity in both the central and eastern portions of the county. This improves convenience for patients and referring physicians while reducing pressure on centralized tertiary facilities.

CMC's large contribution to the OR deficit is driven in part by Atrium's long-standing market dominance in Mecklenburg County, not by a lack of available surgical options elsewhere. The purpose of the CON law is to promote competition and enhance system capacity in a balanced and equitable way. Novant's proposals achieve these goals by enhancing access across tertiary and community hospitals providing patients with a meaningful choice beyond Atrium's dominant system.

While Atrium focuses on how CMC "generated" the greatest share of the need, that argument misses the core purpose of a competitive CON review. The question is not which provider historically consumed the most resources, but which provider(s) will most effectively meet future needs. Novant Health's applications to develop additional ORs at NHPMC and NHMMC do exactly that, by expanding access, enhancing competition, and aligning with the SMFP's basic planning principles.

CMC's Abandonment of OR Replacement Plan Undermines Projected Utilization

Atrium Health states that the proposed ORs at CMC will be developed in space that had previously been allocated for five replacement ORs intended to relocate existing capacity from the main hospital campus. *See* application pages 37 and 94. This change in course fundamentally undermines the rationale for five incremental ORs.

Conceptually, the original plan to replace existing ORs implies that those ORs were either functionally obsolete, physically constrained, or otherwise inadequate to meet current standards of care. However, CMC's original intent acknowledged that some existing ORs were no longer suitable. Now, however, CMC proposes to retain those same ORs and add five new ones, resulting in a net increase of five ORs.

This change raises significant concerns about the reasonableness of CMC's utilization projections and the integrity of its planning assumptions. If the five ORs originally marked for replacement are inadequate, it is not reasonable to assume they will be fully and efficiently utilized going forward. Either way, the proposal relies on a questionable assumption: that both old and new ORs will operate at high utilization levels, despite prior acknowledgment that part of the inventory required replacement.

This inconsistency calls into question the validity of CMC's projected surgical volumes and its overall justification for five additional ORs. The proposed shift from a replacement strategy to a capacity

expansion, without corresponding evidence that ***all*** ORs, old and new, are needed and will be effectively used, undermines the credibility of the application.

In contrast, Novant Health's applications to develop new ORs at NHPMC and NHMMC are grounded in transparent, site-specific planning that aligns facility capacity with demonstrated and growing patient need. Novant does not rely on shifting justifications or repurposed space allocations. Instead, it proposes to expand surgical capacity in a balanced way across tertiary and community settings, enhancing geographic access and patient choice.

Novant Health's proposals are also more consistent with the intent of the Certificate of Need law, which seeks to promote competition, prevent unnecessary duplication, and encourage cost-effective, community-based delivery of care. While Atrium's application reflects a reactive revision of its internal space planning, potentially masking surplus capacity, Novant's applications represent targeted, strategic expansions based on actual service area utilization and unmet need.

Failure to Consider Change in CON Statute

Atrium Health's application for additional operating rooms at CMC fails to acknowledge a significant and imminent change in North Carolina's CON law. Specifically, the exemption for Qualified Urban Ambulatory Surgical Facilities (QUASFs) from CON review beginning in November 2025, as enacted by Session Law 2023-7 (HB 76). This omission is problematic for several reasons.

First, the policy change is highly relevant to any projection of future surgical demand in Mecklenburg County. Beginning November 2025, ambulatory surgery centers that meet the QUASF criteria, including all existing and approved ASFs in Mecklenburg County, will be able to add licensed operating rooms without CON approval. This regulatory shift is designed to increase access to outpatient surgical services in high-growth urban counties and is expected to reshape the surgical services landscape over time.

By failing to address this upcoming change, Atrium Health has overlooked a key external factor that could influence the volume and distribution of future surgical cases. Ignoring this policy development raises concerns about the completeness of CMC's planning assumptions and the reliability of its long-range projections, particularly its assertion that all proposed operating rooms, in addition to its existing inventory, will be needed and efficiently utilized.

In contrast, Novant Health has explicitly acknowledged and assessed the potential implications of the new law in its applications for additional operating rooms at NHPMC and NHMMC. Novant's analysis recognizes that while hospitals will still require CON approval to expand surgical capacity, ambulatory surgical facilities will face fewer regulatory barriers, potentially accelerating ASF development over time.

Importantly, Novant Health does not assume an exaggerated impact from the law change; instead, it offers a thoughtful and measured response. Novant Health outlines why the QUASF exemption is unlikely to materially reduce surgical demand at Novant Health facilities. In addition, Novant's physician partners have affirmed their continued commitment to hospital-based surgical care, further supporting the sustainability of hospital surgical volumes.

This omission raises concerns about whether CMC's application fully accounts for the evolving regulatory environment and the implications for surgical capacity planning. In an application that projects significant growth in surgical utilization and proposes a substantial expansion of surgical capacity, the absence of any discussion of the most consequential policy change affecting the ambulatory surgery market in decades is a material deficiency.

Unreasonable Growth Assumptions

Atrium Health's application projects inpatient surgical utilization at CMC-Mercy to grow in line with the Mecklenburg County population growth rate of 1.5%. However, this assumption is inconsistent with the facility's actual historical performance and lacks empirical support.

Between CY2019 and CY2024, CMC-Mercy experienced a compound annual growth rate (CAGR) of –5.4% in inpatient surgical cases (p. 140), despite population growth throughout the county. More recent trends are similarly negative:

- CY2021–CY2024 CAGR: –5.1%
- CY2022–CY2024 CAGR: –2.5%

These figures clearly show that inpatient surgical volume at CMC-Mercy has steadily declined in recent years, even as the Mecklenburg County population has increased. This decoupling of population growth and surgical demand suggests that other factors, such as shifting referral patterns, migration of lower-acuity cases to ambulatory settings, or broader changes in clinical practice, are exerting downward pressure on inpatient utilization at this facility.

It is therefore unreasonable to assume that inpatient surgical cases at CMC-Mercy will begin growing at 1.5% annually simply because the population is projected to grow at that rate. To do so ignores five years of consistent inpatient surgical decline and substitutes a generalized countywide demographic trend for site-specific utilization data. This approach inflates projected surgical demand and overestimates the projected inpatient surgical utilization at CMC-Mercy.

For the foregoing reasons, the CMC application relies on unsupported utilization projections and should be found non-conforming to Criterion (3) and 10A NCAC 14C .2103.

Based on the reasons the CMC application is non-conforming to Criterion (3), it is also non-conforming to Criteria (4), (5), (6), and (18a).

COMMENTS REGARDING CRITERION (18a)

In evaluating which conforming applications to approve or partially approve, the Agency should consider the public interest in preserving and enhancing competitive balance within North Carolina's largest healthcare market. A competitive healthcare environment serves the public by helping to restrain prices, improve quality, and prevent any single provider from exercising outsized influence over rates charged to commercial payors, self-insured employers, and individual consumers.

Atrium Health has long maintained a dominant position in Mecklenburg County and has been the subject of multiple antitrust lawsuits alleging abuse of market power, including actions brought by the United States Department of Justice and private plaintiffs. *See 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); and *DiCesare v. The Charlotte-Mecklenburg Hospital Authority*, 376 N.C. 63, 852 S.E.2d 146 (2020). The DOJ's enforcement action concluded with a Final Judgment, which is included with these comments.

The Certificate of Need (CON) program is the only policy tool available to the Agency to promote a more balanced and competitive healthcare landscape in Mecklenburg County. The Agency's decisions should reflect the understanding that competition benefits patients and communities by:

- Fostering patient choice,
- Driving down healthcare costs,
- Improving quality and innovation,
- And preventing overconcentration of resources in a single system.

According to the 2025 SMFP, there are 146 existing and approved hospital-based operating rooms in Mecklenburg County across hospitals operated by Atrium Health and Novant Health:

Mecklenburg County Hospital-Based ORs
(Based on Adjusted Planning Inventory)

	OR Adjusted Planning Inventory	% of Total Hospital-Based ORs* (Adjusted Inventory)
Atrium Health	90	61.6%
Novant Health	56	38.4%
Total	146	100.0%

Source: Table 6B, 2025 SMFP
*Excludes freestanding ASC ORs

As shown, Atrium Health controls nearly two-thirds of all hospital-based ORs in the county. A similar imbalance exists in acute care bed capacity, where Atrium Health holds a significantly larger share as well. This dual concentration in both inpatient and surgical resources limits patients' ability to access timely care across systems and places disproportionate strain on Novant Health facilities, which must meet growing demand with comparatively fewer resources.

Novant Health's proposed addition of two ORs at NHPMC will modestly reduce this disparity while allowing the hospital to fully leverage its recent acute care bed expansion. This alignment is essential, as operating rooms serve as a primary gateway to inpatient care, particularly for complex, high-acuity surgical cases. Without a proportional increase in surgical capacity, the hospital's ability to accommodate such patients is constrained, regardless of available bed space. Surgical expansion at NHMMC will allow a busy suburban hospital to keep up with growing demand.

Enhancing Novant Health's OR capacity also contributes to a healthier competitive dynamic, which is associated with:

- Improved quality through innovation, transparency, and performance benchmarking;
- Greater efficiency and cost-effectiveness via value-based strategies and process optimization; and
- Expanded access, especially for underserved populations who benefit from more provider options and reduced wait times.

As the system with fewer hospital-based ORs and a smaller share of inpatient beds, Novant Health's proposed growth represents a positive and necessary counterbalance within Mecklenburg County's surgical landscape. Expanding NHPMC's surgical platform strengthens its role as a regional referral center for high-acuity care and ensures patients have meaningful alternatives between health systems.

Assuming five ORs are approved in this review cycle, and assuming both Novant Health applications (NHPMC and NHMMC) are approved, Novant's share of hospital-based ORs in Mecklenburg County would increase to just 40%, while Atrium Health would still control approximately 60%. This modest shift would offer significant benefits to patients and payors, such as expanded choice, more competitive pricing, and enhanced innovation, while still allowing Atrium Health to maintain its position as the dominant surgical provider in the region.

Atrium routinely argues that the Agency should not consider competition in the context of reviews in which Novant Health is involved because Novant is an existing provider. Atrium has also recently taken the position that there is nothing Novant Health (or any other provider, for that matter), could do to cause Atrium to improve its quality because Atrium's quality – at least in Atrium's eyes – is already so high. These arguments are specious. All providers, including Atrium, can continually improve their quality, and competition stimulates quality improvements. Without competition, patients are left to rely on providers' good intentions, which is simply not enough. Criterion (18a) is the law and it must be followed. Similarly, the Agency should continue to resist any of Atrium's repeated efforts to abandon competition as a competitive factor.

CONCLUSION

With regard to ORs, the applications submitted by Novant Health are fully conforming to all applicable Criteria and rules and the Novant Health applications are also comparatively superior to the Atrium Health application. Therefore, the NHPMC and NHMMC applications should be approved as submitted. If the Agency finds the Atrium Health applications conforming with all CON criteria and performance standards, the CMC application is a less effective alternative than the NHPMC and NHMMC applications and should be denied or partially approved (for a maximum of one OR) on that basis. Fostering competitive balance in Mecklenburg County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high-quality care, lowering costs, and expanding patient choice.

ATTACHMENT:

FINAL JUDGEMENT, 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."