COMPETITIVE COMMENTS ON

2025 MECKLENBURG COUNTY ACUTE CARE BED APPLICATIONS

SUBMITTED BY NOVANT HEALTH

July 31, 2025

Four CON applications were submitted in response to the 2025 SMFP need determination for 210 additional acute care beds in Mecklenburg County, including:

> CON Project ID# F-012652-25 Atrium Health University City (AHUC): Add 95 acute care beds at AHUC
>
> CON Project ID# F-012652-25 Atrium Health Carolinas Medical Center (CMC): Add 115 acute care beds at CMC
>
> CON Project ID# F-012570-24 Novant Health Huntersville Medical Center (NHHMC): Add 50 acute care beds at NHHMC.
>
> CON Project ID# F-012570-24 Novant Health Presbyterian Medical Center (NHPMC): Add 120 acute care beds at NHPMC.

As the foregoing list shows, the total number of beds applied for exceeds the SMFP need determination. Atrium Health ("AH") has applied for all 210 acute care beds; Novant Health has applied for less than the 2025 need determination. As the smaller health system in Mecklenburg County with a demonstrated need for the 120 beds at its flagship, tertiary level medical center, and 50 beds at its high-performing community-based hospital the Novant Health applications should be approved for 120 beds at NHPMC and 50 beds at NHHMC. The following comments demonstrate that the AH application is not approvable and that no beds should be awarded to AH. If the Agency determines otherwise, the maximum number of beds for which AH should be approved is 40.

As the Agency reviews the applications, the comments, responses to comments and public hearing speeches, the Agency should keep in mind that as of March 12, 2025, the date of the Agency's decision in the 2024 Mecklenburg County Acute Care Bed Review, Atrium had a stockpile of 405 approved and undeveloped beds. The Agency approved AH's 2024 application for 89 beds in its entirety, so the stockpile has increased to 494 acute care beds. This is larger than most hospitals in North Carolina. *See* Table 5A of the 2025 SMFP.

Tellingly, AH has also filed "comments" as part of the summer SMFP petitioning cycle in which it encourages the SHCC to reduce the bed need in all North Carolina counties showing a need for more acute care beds in the draft 2026 SMFP by either 5% or 10%, depending on whether the county in question is highly populated. Mecklenburg County, which is a highly populated county, would have its 2026 bed need

cut by 10% if the SHCC adopts AH's thesis. *See* Attachment A attached hereto. The stockpile plus the SMFP comments convey a clear and unmistakable message: AH does not need all the beds for which it has applied, and it is running out of places to put these beds. If AH's 2025 applications are approved in their entirety, the stockpile of undeveloped beds would grow to 704 beds, which is more than NHPMC's entire tertiary facility. The Agency should not allow this to happen because it hurts North Carolina residents who need these beds.

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 210 acute care beds may be approved for Mecklenburg County in this review. Because the applications in this review collectively propose to develop 380 additional acute care beds in Mecklenburg County, all applications cannot be approved for the total number of beds proposed. Therefore, a comparative review is required as part of the Agency findings after each application is reviewed independently against the applicable statutory review criteria. The following factors have recently been utilized by the Agency for all reviews regardless of the type of services or equipment proposed:

- Conformity with Statutory and Regulatory Review Criteria
- Scope of Services
- Geographic Accessibility
- Historical Utilization
- Access by Service Area Residents
- Access by Underserved Groups: 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 are 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
AH University City	F-012652-25	Non-Conforming
CMC	F-012655-25	Non-Conforming
Novant Health Huntersville Medical Center	F-012659-25	Conforming
Novant Health Presbyterian Medical Center	F-012660-25	Conforming

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 applications contain errors and flaws which result in one or more non-conformities with statutory and regulatory review Criteria. Therefore, the Novant Health application is the **most effective** alternative regarding conformity with applicable review Criteria and rules.

Scope of Services

NHPMC and CMC each 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 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 acute care beds proposed at CMC are not reserved exclusively for teaching purposes. Any patient may be admitted to those beds, and any credentialed provider may provide care. The SMFP does not grant priority status to AMCs in the acute care bed 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 acute care beds based on scope of services.

Separate from NHPMC and CMC, NHHMC and AHUC are both high-performing community hospitals that serve defined submarkets within Mecklenburg County. As such, NHHMC and AHUC are **equally effective** alternatives for meeting community-based need for acute care services.

Geographic Accessibility

All four applicants propose to develop additional acute care beds at existing facilities in Mecklenburg County. NHPMC, CMC, and AHUC each propose to develop incremental beds in Charlotte and NHHMC proposed to develop incremental beds in Huntersville.

As of June 2025, there are 2,689 existing and approved acute care beds in the Mecklenburg County Service Area, allocated across 10 hospitals operated by Novant Health and Atrium Health. The following table summarizes where the acute care beds are located in Mecklenburg County.

Geographic Distribution of Acute Care Beds in Mecklenburg County

City	System	Total Acute Care Bed Inventory*
Charlotte	Atrium	1,342
	Novant	502
Ballantyne	Novant	36
Steele Creek	Novant	32
Steele Creek	Atrium	26
University City	Atrium	151
	Charlotte Total	2,089
Pineville	Atrium	314
Huntersville	Novant	147
Matthews	Novant	166
Mint Hill	Novant	36
Cornelius	Atrium	23
Total Mecklenburg County		**2,775**

*Existing and approved acute care beds

As shown in the previous table, the existing and approved acute care beds are in Charlotte, Cornelius, Huntersville, Matthews, Mint Hill, and Pineville. The following table summarizes the ratio of acute care beds per 1,000 population among the respective municipalities.

Geographic Distribution of Acute Care Beds in Mecklenburg County
Ratio of Acute Care Beds per 1,000 Population

Area	2024 Population^	Beds Available*	Beds / 1K Population
Charlotte	**943,476**	**2,089**	**2.214**
Pineville	11,567	314	27.146
Huntersville	**67,087**	**147**	**2.191**
Matthews	32,048	166	5.180
Mint Hill	28,825	36	1.249
Cornelius	34,366	23	0.669
Mecklenburg County	1,180,037	2,775	2.352

^US Census Bureau Quick Facts
*Existing and approved acute care beds as of July 2025

Huntersville has a comparatively lower ratio of acute care bed per 1,000 population (2.191) compared to Charlotte (2.214). Therefore, the NHHMC is the **most effective** alternative regarding geographic access in this review.

Despite being home to the vast majority of Mecklenburg County residents, Charlotte has a lower bed-to-population ratio than several surrounding communities. The proposed project addresses this imbalance by developing additional acute care beds at NHPMC, an accessible and high-demand site in the urban core.

Novant Health has demonstrated its ongoing commitment to expanding access across the county. It has relocated and developed acute care beds and operating rooms from NHPMC to strengthen community hospitals in Matthews, Huntersville, Mint Hill, and Ballantyne. Notable projects include:

- 12 additional beds at NH Huntersville (approved 2018),
- 20 additional beds at NH Matthews (approved 2019), and
- 32 beds at the new NH Steele Creek Medical Center (approved 2021).

These projects enhanced geographic access, particularly in outlying areas. Nonetheless, demand for services at NHPMC has continued to rise, driven by increasing patient acuity and growth in patient days and average length of stay. To help meet this growing need, NHPMC was awarded:

- 15 beds in 2021 (Project ID #F-12144-21), and
- 14 beds in 2022 (Project ID #F-12293-22), both of which were developed in 2024.

Despite this added capacity, NHPMC operated at an 81.7 percent occupancy rate in FFY2024, exceeding its target occupancy of 75.2 percent. Moreover, 26 additional beds approved in 2023 (Project ID #F-12457-

23) are scheduled for development in 2026. Even with these future additions, the need for further expansion remains, as shown in the utilization projections in Section Q.

The proposed project will ensure that NHPMC continues to meet rising demand by developing incremental acute care bed capacity at a location that offers advanced clinical capabilities not available at Novant's community hospitals, such as high-acuity specialties.

Importantly, additional capacity at NHPMC means more opportunities to care for patients regardless of their ability to pay. Novant Health's longstanding financial assistance policies and community benefit programs support equitable access to high-quality care across Mecklenburg County.

After NHHMC, the NHPMC, CMC, and AHUC 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 120 additional acute care beds it proposes at NHPMC and the 50 additional acute care beds it proposes at NHHMC. This need is supported by robust historical inpatient 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 acute care services at NHPMC and NHHMC 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 SMFP defines a "qualified applicant" in narrow and objective terms. Notably, the definition does not include academic affiliation, case mix index, trauma designation, or any subjective evaluation of an applicant's institutional reputation or perceived role in the market. The Agency must exercise caution in applying the Historical Utilization factor to avoid applying considerations that fall outside the governing statutes and regulations.

Additionally, 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.

NHPMC's historical utilization record, supported by quantitative and qualitative evidence, clearly substantiates the need for the proposed beds. 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)

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

Mecklenburg County Acute Care Beds, 2025

	Licensed	Adjustments for CONs	Total	% of Total Available Beds
Atrium Health	1,342	494	1,836	67%
Novant Health	822	97	919	33%
Total	2,164	591	2,755	100.0%

Source: Table 5A, 2025 SMFP; 2024 Mecklenburg Co. Acute Care Bed Review

Despite years of sustained growth in the Charlotte region, Novant Health continues to operate with significantly fewer acute care beds than Atrium Health. The disparity in bed allocation has worsened over time. In 2010, the split between Atrium Health and Novant Health was approximately 60/40. By 2024, Atrium now controls 67 percent of the total beds in Mecklenburg County compared to Novant Health's 33 percent. See also the table on the following page.

Mecklenburg County Acute Care Beds (Excluding Neonatal)

Year	AH Total Beds	NH Total Beds	Total	Atrium Health % of Total Beds	NH % of Total Beds
2010	1,115	762	1,877	59%	41%
2011	1,172	812	1,984	59%	41%
2012	1,172	812	1,984	59%	41%
2013	1,212	812	2,024	60%	40%
2014	1,212	812	2,024	60%	40%
2015	1,212	812	2,024	60%	40%
2016	1,212	812	2,024	60%	40%
2017	1,272	812	2,084	61%	39%
2018	1,310	824	2,134	61%	39%
2019	1,356	824	2,180	62%	38%
2020	1,450	876	2,326	62%	38%
2021	1,558	891	2,449	64%	36%
2022	1,609	893	2,502	64%	36%
2023	1,747	919	2,666	66%	34%
2024	1,836	919	2,755	67%	33%
Change	**721**	**157**	**878**	**82%**	**18%**

Source: SMFPs

Over the last 14 years, Atrium has been approved to add 721 beds, an 82 percent increase, while Novant Health has received approval for just 157 beds, an 18 percent increase. The great disparity in bed allocation is not due to a lack of demonstrated need. On the contrary, Novant Health has consistently pursued reasonable, data-supported expansion efforts through the Certificate of Need process. However, some of those efforts have either been denied or significantly downsized in comparative reviews.

In the 2024 Mecklenburg County Acute Care Bed Review, for example, Novant Health's application to expand NHPMC was denied, while Atrium Health was awarded 89 additional beds, despite Novant Health demonstrating need and presenting a conforming application. Similarly, Novant's prior proposals in 2023, 2022, and 2021 were substantially downsized.

Novant Health CON Applications for Additional Acute Care Beds in Mecklenburg County

Review Year	Requested Beds	Fully Conforming Application	Awarded Beds	% of Requested Beds Awarded
2021	22	Yes	15	68.2%
2022	30	Yes	14	46.7%
2023	54	Yes	26	48.1%
2024	80	Yes	0	0.0%

As discussed previously, AH is sitting on a stockpile of hundreds of undeveloped beds. The current stockpile (405 approved + 89 conditionally approved = 494 acute care beds) is almost as large as NHPMC's entire acute care bed inventory (502 acute care beds). If the Agency approves the two AH applications in their entirety, the stockpile would grow to 704 acute care beds, which is more than 200 beds larger than NHPMC. The bed count gap between the two systems is already wide; there is no reason for the Agency to allow the gap to grow any wider. As one of the largest metropolitan areas in the United States, the Charlotte-Mecklenburg area needs two strong health systems, not one "giant" system and one considerably smaller system. It is only through robust competition that patients and payors will reap the benefits of higher quality, lower prices, and greater innovation. Approving Novant Health's fully conforming applications will narrow the persistent disparity in bed distribution, strengthen system-level competition, and enhance access for patients throughout Mecklenburg County. It will also support the development of a more balanced and resilient hospital infrastructure to serve one of North Carolina's and the nation's fastest-growing metropolitan regions.

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

Access By Service Area Residents

On page 32, 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 36, shows Mecklenburg County as a single-county acute care bed service area. Thus, the service area for this review is Mecklenburg County. Facilities may also serve residents of counties not included in their service area.

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

Projected Service to Mecklenburg County Residents, Project Year 3

	AHUC	CMC	NHHMC	NHPMC
# of Mecklenburg County Patients	9,006	27,267	7,651	24,807
% of Mecklenburg County Patients	79.4%	50.8%	56.9%	68.2%

Source: CON applications, Section C.3

Novant Health acknowledges the Agency has determined in previous reviews that an analysis of access by service area residents was inconclusive in Mecklenburg County.

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.

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
AHUC	$120,368,648	11,335	$10,619	$292,841,865	41.1%
CMC	$691,779,629	53,640	$12,897	$1,872,580,703	36.9%
NHHMC	$125,621,369	13,453	$9,338	$222,962,227	56.3%
NHPMC	$360,499,375	36,385	$9,908	$606,398,693	59.4%

For this 2025 Mecklenburg acute care bed application, Novant Health developed the NHPMC and NHHMC Acute Care Bed Forms F.2 and F.3 to represent only the acute care bed charges and expenses. They are based on the financials for acute care inpatient units at NHPMC and NHHMC, respectively. They do not include ancillary services (lab, radiology, or surgery) that generate additional revenue and expenses for acute care 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 acute care bed applications. Accordingly, the financial pro formas submitted for the proposed acute care bed additions at NHPMC and NHHMC are presented in a manner that facilitates a reasonable comparison of revenues across Novant Health and Atrium Health applications in the 2025 review cycle. Thus, contrary to past reviews, the Agency is able to make conclusive comparisons between AH and Novant.

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 licensed beds and annual discharges. Larger hospitals like CMC, which projects to operate 1,241 acute

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

care beds, 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 $691.8 million in total Medicare revenue from 53,640 discharges, while NHHMC has $125.6 million from 13,453 discharges. 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 NHHMC and AHUC 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 $12,897 at CMC vs. $9,338 at NHHMC does not necessarily mean the hospital is more effective at serving Medicare patients. It simply reflects that patients are sicker and receive more complex services, 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.

% of Gross Revenue

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 59.4% of gross revenue from Medicare
- Novant Health Huntersville: 56.3%

- Atrium Health University City: 41.1%
- CMC: 36.9%

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 NHHMC are the **most effective** alternatives regarding access by Medicare.

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
AHUC	$57,183,943	11,335	$5,045	$292,841,865	19.5%
CMC	$429,343,871	53,640	$8,004	$1,872,580,703	22.9%
NHHMC	$21,496,392	13,453	$1,598	$222,962,227	9.6%
NHPMC	$104,228,583	36,385	$2,865	$606,398,693	17.2%

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 proposals by Atrium Health project 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 Discharge	Form F.2b Net Revenue	Average Net Revenue per Discharge
AHUC	11,335	$77,752,319	$6,859
CMC	53,640	$501,558,492	$9,350
NHHMC	13,453	$63,154,988	**$4,694**
NHPMC	36,385	$182,124,308	**$5,005**

For this 2025 Mecklenburg acute care bed application, Novant Health developed the NHPMC and NHHMC Acute Care Bed Forms F.2 and F.3 to represent only the acute care bed charges and expenses. They are based on the financials for acute care inpatient units at NHPMC and NHHMC, respectively. They do not include ancillary services (lab, radiology, or surgery) that generate additional revenue and expenses for acute care 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 acute care bed applications. Accordingly, the financial pro formas submitted for the proposed acute care bed additions at NHPMC and NHHMC are presented in a manner that facilitates a reasonable comparison of revenues and expenses across Novant Health and Atrium Health applications in the 2025 review cycle. Thus, contrary to past reviews, the Agency is able to make conclusive comparisons between AH and Novant in this 2025 acute care bed review.

Novant projects the lowest average net revenue per discharge among the competing applicants, demonstrating a more cost-efficient and accessible approach to inpatient care. Based on the data:

- NHPMC projects an average net revenue per discharge of $5,005, which is significantly lower than CMC's $9,350, despite both being tertiary referral centers and trauma centers.

- Similarly, NHHMC projects $4,694 per discharge, compared to AHUC's $6,859, even though both are community hospitals.

These comparisons illustrate that Novant's proposals offer the most affordable inpatient care on a per-patient basis, regardless of hospital type. Whether comparing tertiary hospitals or community facilities, Novant's average net revenue per discharge is markedly lower, suggesting more efficient resource use and a stronger commitment to maintaining affordability for patients and payers alike. Therefore, NHPMC and NHHMC 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 Discharge	Form F.2b Operating Expense	Average Operating Expense per Discharge
AHUC	11,335	$85,430,059	$7,537
CMC	53,640	$510,521,337	$9,518
NHHMC	13,453	$59,435,271	**$4,418**
NHPMC	36,385	$213,429,045	**$5,866**

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

- NHPMC projects an average operating expense of $5,866 per discharge, substantially lower than CMC's $9,518, despite both hospitals offering complex, tertiary-level services.

- Among the community hospitals, NHHMC projects $4,418 per discharge, compared to AHUC's $7,537.

These figures demonstrate that Novant Health's proposals are more efficient across both hospital types, effectively managing costs while maintaining access to high-quality care. Whether comparing tertiary or community settings, Novant Health delivers lower projected operating expenses per patient, a strong indicator of fiscal responsibility and value-driven care. Therefore, NHPMC and NHHMC 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	Atrium Health University City	Carolinas Medical Center	Novant Health Huntersville Medical Center	Novant Health Presbyterian Medical Center
Conformity with Review Criteria	Less Effective	Less Effective	**Most Effective**	**Most Effective**
Scope of Services	Less Effective	**Most Effective**	Less Effective	**Most Effective**
Geographic Accessibility	Equally Effective	Equally Effective	**Most Effective**	Equally Effective
Historical Utilization	Equally Effective	Equally Effective	Equally Effective	Equally Effective
Enhance Competition	Less Effective	Less Effective	**Most Effective**	**Most Effective**
Access by Service Area Residents: No. of Patients	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Access by Service Area Residents: % of Patients	Inconclusive	Inconclusive	Inconclusive	Inconclusive
Projected Access by Medicare Patients	Less Effective	Less Effective	**Most Effective**	**Most Effective**
Projected Access by Medicaid Patients	**Most Effective**	**Most Effective**	Less Effective	Less Effective
Projected Average Net Revenue per Patient	Less Effective	Less Effective	**Most Effective**	**Most Effective**
Projected Average Operating Expense per Patient	Less Effective	Less Effective	**Most Effective**	**Most Effective**

The applications submitted by NHPMC and NHHMC are more effective alternatives for six comparative analysis factors, while the application submitted by CMC is a more effective alternative for two comparative analysis factors and the application submitted by AHUC is a more effective alternative for only one comparative analysis factor. Therefore, the applications for NHPMC and NHHMC should be approved as submitted.

POST-AWARD REALLOCATION OF ACUTE CARE BEDS AMONG ATRIUM FACILITIES

Atrium Health has previously applied for need-determined beds at CMC and received approval based in part on favorable evaluations of the Scope of Services and Historical Utilization comparative factors. However, as shown in the attached May 2024 Material Compliance Request, Atrium later requested to relocate a portion of the approved beds from CMC to other hospitals within its Mecklenburg County network. This post-award redistribution raises concerns about the appropriateness of awarding beds based on comparative metrics specific to CMC when the beds may ultimately be deployed at facilities with different utilization profiles and service scopes.

A recent example underscores this concern. In a July 2024 Material Compliance Request approved by the Agency, Atrium shifted 26 of the 112 previously approved beds from CMC to its Pineville and University

City campuses. *See* Attachment B. Although the original application emphasized CMC's tertiary capabilities and utilization to justify need, the subsequent relocation to other hospitals altered the basis on which the award was granted.

Such post-approval changes risk undermining the comparative analysis process central to Certificate of Need review. When beds are awarded based on the specific characteristics of a high-volume tertiary facility, subsequent transfers to smaller hospitals dilute the relevance of those original comparisons. This discrepancy calls into question whether the approved application accurately reflected the true destination and purpose of the proposed capacity.

COMMENTS REGARDING STATUTORY REVIEW CRITERIA

The following comments apply to both the CMC (F-012655-25) and AHUC (F-012652-25) CON applications.

COMMENTS REGARDING CRITERION (3)

The CMHA System is *Not* Chronically Underbedded

As it has done in each of the past several Mecklenburg County acute care bed reviews, Atrium Health's 2025 application advances the same "chronic underbedding" narrative that was included in its 2024, 2023, and 2022 filings. The 2025 application repackages the same arguments presented in 2024, including near-verbatim sections on systemwide underbedding, comparative throughput, and internal projections of future need. The Agency should not be swayed by Atrium Health's recycled and exaggerated claims, which have repeatedly been deemed irrelevant to determining Novant Health's conformity with Criterion (3).

Notably, Atrium again fails to reconcile its demand projections with the 494 acute care beds already approved or conditionally approved but not yet developed across its Mecklenburg County hospitals, including 343 approved or conditionally beds at CMC alone.[2] Despite this significant backlog, Atrium requests an additional 210 beds and portrays its situation as if it has been neglected by the Agency. On the contrary, the Agency has awarded beds to Atrium in every review for the past eight years.

Atrium Health's repeated attempts to frame the entire county's need around Atrium's internal constraints unfairly tilt the competitive scales and would, if accepted, result in a distorted and anticompetitive outcome. The Agency should once again decline to give weight to Atrium's self-serving "Overview of Unmet Need" and its unsupported claims of systemic underbedding. Each project must be evaluated on its own merits, not on recycled systemwide appeals that have already failed to meet statutory and regulatory standards.[3]

[2] 254 beds per Table 5A of the Proposed 2026 SMFP + 89 beds conditionally approved in 2024 Acute Care Bed Review

[3] Despite its repeated claims of chronic "underbeddedness," AH filed "comments" with the SHCC on July 23 in which it asks for a reduction in bed needs statewide, including Mecklenburg County. According to AH, the SHCC should reduce the Mecklenburg County bed need in the Proposed 2026 SMFP by 10%. These comments, especially when viewed in the context of AH's stockpile of undeveloped beds, contradict the claims of chronic "underbeddedness."

2025 SMFP Acute Care Bed Methodology

The CMC application includes a discussion of the projected bed need generated by Atrium Health facilities based on the 2025 SMFP acute care bed need methodology. However, similar narratives have been included in Atrium Health's 2024, 2023 and 2022 Mecklenburg County applications and were not influential in the Agency's analyses of conformity to Criterion (3).

Atrium Health is essentially attempting to persuade the Agency that its need for additional beds is greater than that of Novant Health, a comparative argument that is neither required by statute nor determinative of an applicant's ability to demonstrate conformity with Criterion (3). The CON review process does not prioritize applications based on relative need among competitors; rather, each applicant must independently establish that its proposed project is needed, based on objective evidence and consistent with the standards outlined in the SMFP and CON law.

As the Agency is well aware, the application process is not limited to the provider that shows a deficit or the greatest deficit for additional acute care beds. Any qualifying provider can apply to develop all or a portion of the 210 beds in Mecklenburg County. Furthermore, it is not necessary that an existing provider have a projected deficit of acute care beds to apply for more acute care beds. Rather, it is necessary that an applicant adequately demonstrates the need to develop its project, as proposed.

Projected Days of Care

Atrium Health's proposal for additional acute care beds at CMC relies on an inflated projection of inpatient days of care that does not align with CMC's historical utilization patterns. Specifically, Atrium Health projects a 4.43% annual growth rate in days of care at CMC beginning in CY2027, when its bed tower opens. This projected rate mirrors the Mecklenburg County growth rate multiplier used in the Acute Care Bed Need Methodology of the SMFP. However, this assumption is fundamentally flawed for two key reasons.

First, the 4.43% growth rate significantly exceeds CMC's historical growth trajectory. The projected growth rate is 33% higher than CMC's historical average. During 2019-2024, CMC experienced CAGR of just 3.4% in inpatient days of care. This lower growth rate reflects a mature, high-occupancy tertiary care center already operating at or near capacity. Given the scale and saturation of CMC's existing patient base, it is unreasonable to assume that CMC will suddenly outpace its historical performance by more than a full percentage point annually, particularly in a region with increasingly distributed access to inpatient services.

Second, Atrium's use of the 4.43% growth rate at CMC is inappropriate because that figure is derived from a county-level multiplier that includes substantial growth at other Atrium Health facilities, notably Atrium Health Pineville and AHUC. CMC's utilization trends, by contrast, have been lower, and its patient base less directly impacted by the suburban growth driving increases at Pineville and AHUC. Applying a county-wide growth rate to a single facility, without adjusting for the nuances of that facility's historical performance and local market dynamics, results in an unreasonable and unsupported projection.

In short, the projected increase in CMC's days of care is not grounded in facility-specific data. Instead, it reflects an arbitrary application of a generalized growth multiplier that inflates projected need and

undermines the reliability of Atrium's proposals. Therefore, the Atrium Health applications rely on unsupported utilization projections and should be found non-conforming to Criterion (3) and 10A NCAC 14C .3803(2)-(6).

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 (6)

AH is applying for 210 additional acute care beds across multiple facilities, despite already holding approvals for 362 acute care beds that have not yet been developed. This total exceeds the entire licensed bed inventory of most hospitals in North Carolina, as documented in Table 5A of the 2025 SMFP.

According to Table 5A of the Proposed 2026 SMFP, CMC alone has 254 approved but undeveloped beds. AH Pineville has 42 such beds, and AH University City has 66. While the application repeatedly emphasizes that additional capacity is needed "today," AH has yet to implement any short-term solutions to bring these approved beds online. The application does not demonstrate that the capacity constraints it cites will persist once these approved beds are developed.

Furthermore, given the scope and complexity of the ongoing CMC modernization, it will be many years before these additional beds become operational, undermining the applicant's claim of an immediate need for more capacity.

By contrast, Novant Health is approved for just 97 acute care beds across its system, less than one-third the number of AH's approved but undeveloped beds.

In light of the substantial capacity already approved but not developed, the current proposal represents an unnecessary duplication of existing resources and should therefore be disapproved.

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. Competitive balance serves the public by helping to restrain prices, improve quality, and prevent any one provider from exercising outsized influence over rates charged to commercial payors, self-insured employers, and individual consumers.

As noted in prior comments submitted in Mecklenburg County acute care bed reviews, Atrium Health has been the subject of multiple antitrust lawsuits alleging abuse of market dominance, 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 action concluded with a Final Judgment, which is included with these comments. *See* Attachment C.

The Certificate of Need program is the only policy mechanism 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 choice, driving down costs, and improving care. Accordingly, Novant Health urges the Agency to weigh the implications of its decisions on market concentration and the competitive distribution of acute care bed capacity.

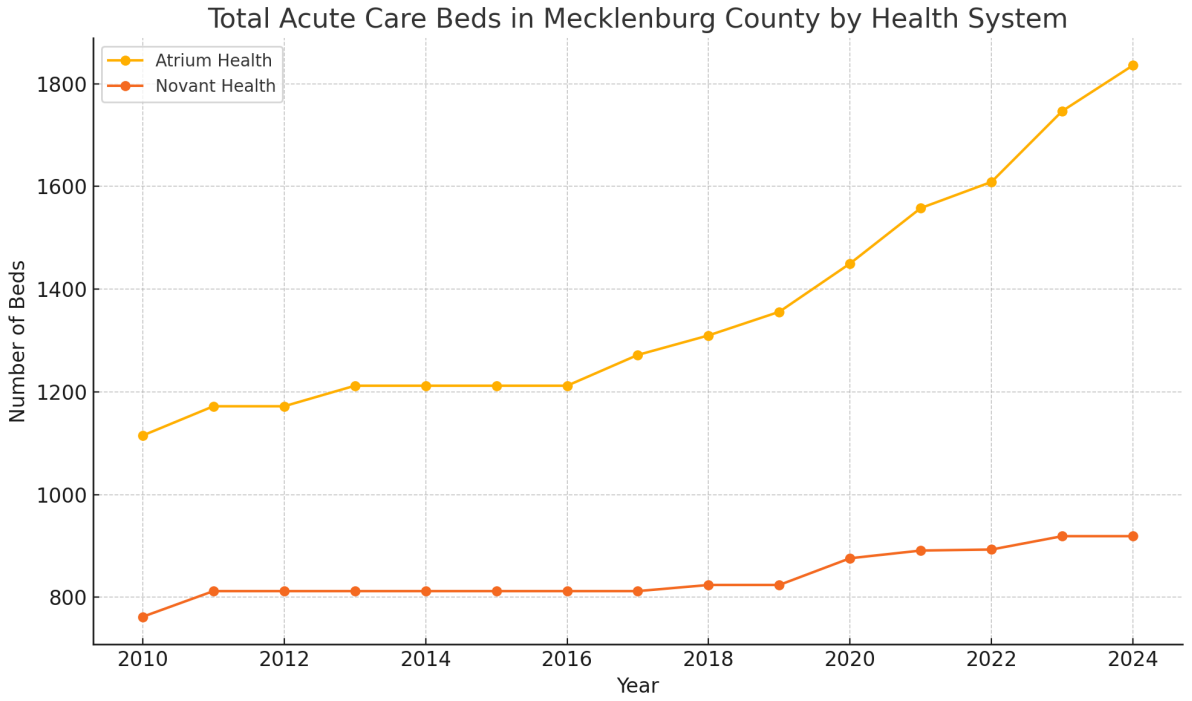
Despite years of sustained growth in the Charlotte region, Novant Health continues to operate with significantly fewer acute care beds than Atrium Health. The disparity in bed allocation has worsened over time. In 2010, the split between Atrium Health and Novant Health was approximately 60/40. By 2024, Atrium now controls 67 percent of the total beds in Mecklenburg County compared to Novant Health's 33 percent.

Mecklenburg County Acute Care Beds (Excluding NICU)

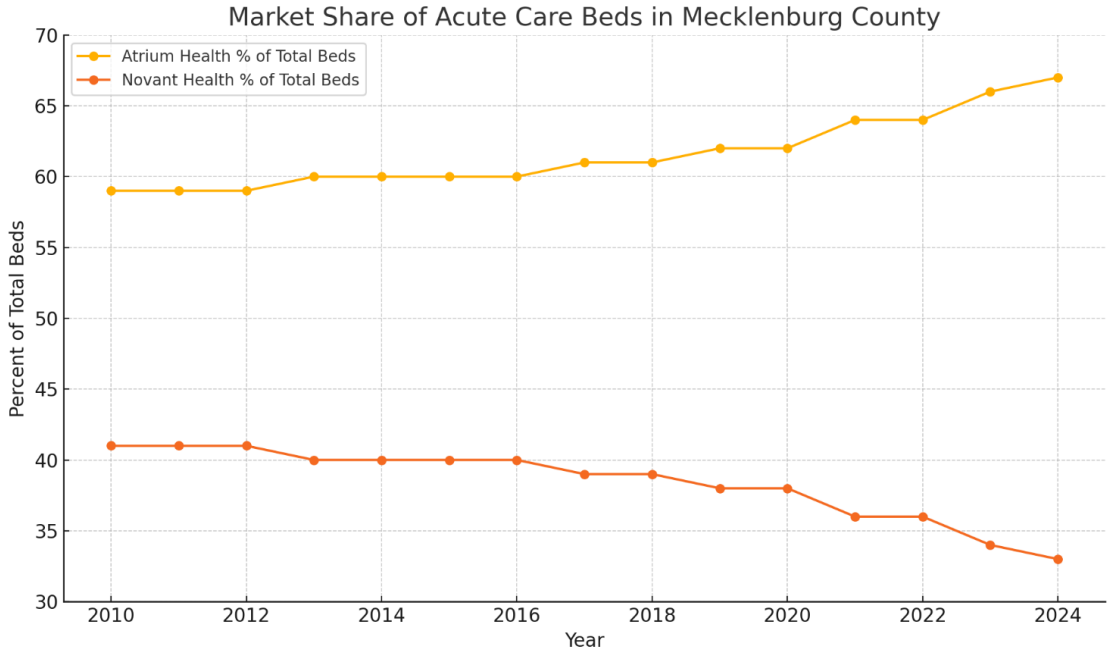
Year	AH Total Beds	NH Total Beds	Total	Atrium Health % of Total Beds	NH % of Total Beds
2010	1,115	762	1,877	59%	41%
2011	1,172	812	1,984	59%	41%
2012	1,172	812	1,984	59%	41%
2013	1,212	812	2,024	60%	40%
2014	1,212	812	2,024	60%	40%
2015	1,212	812	2,024	60%	40%
2016	1,212	812	2,024	60%	40%
2017	1,272	812	2,084	61%	39%
2018	1,310	824	2,134	61%	39%
2019	1,356	824	2,180	62%	38%
2020	1,450	876	2,326	62%	38%
2021	1,558	891	2,449	64%	36%
2022	1,609	893	2,502	64%	36%
2023	1,747	919	2,666	66%	34%
2024	1,836	919	2,755	67%	33%
Change	**721**	**157**	**878**	**82%**	**18%**

Source: SMFPs

Over the last 14 years, Atrium has been approved to add 721 beds, an 82 percent increase, while Novant Health has received approval for just 157 beds, an 18 percent increase.



The graph above shows that Atrium Health's bed capacity has steadily increased since 2010, while Novant Health's bed growth has remained modest, resulting in a widening disparity. The following chart illustrates the shift in market share of bed allocation, demonstrating Atrium Health's growing dominance in the Mecklenburg County acute care bed market.



The widening gap is not due to a lack of demonstrated need. On the contrary, Novant Health has consistently pursued reasonable, data-supported expansion efforts through the Certificate of Need process. However, some of those efforts have either been denied or significantly downsized in comparative reviews.

In the 2024 Mecklenburg County Acute Care Bed Review, for example, Novant Health's application to expand NHPMC was denied, while Atrium Health was awarded 89 additional beds, despite Novant Health demonstrating need and presenting a conforming application. Similarly, Novant's prior proposals in 2023, 2022, and 2021 were substantially downsized.

Novant Health CON Applications for Additional Acute Care Beds in Mecklenburg County

Review Year	Requested Beds	Fully Conforming Application	Awarded Beds	% of Requested Beds Awarded
2021	22	Yes	15	68.2%
2022	30	Yes	14	46.7%
2023	54	Yes	26	48.1%
2024	80	Yes	0	0.0%

Approving Novant Health's fully conforming applications will narrow the persistent disparity in bed distribution, strengthen system-level competition, and enhance access for patients throughout Mecklenburg County. It will also support the development of a more balanced and resilient hospital infrastructure to serve one of North Carolina's and the nation's fastest-growing metropolitan regions.

Given the substantial number of beds available in the 2025 State Medical Facilities Plan, the Agency can, and should, approve both the NHPMC and NHHMC applications in full. Ensuring that two strong, viable health systems operate in Mecklenburg County is unequivocally better for patients, providers, and payors than further consolidating capacity within a single dominant system. The decisions made in this review will shape the region's healthcare landscape for decades. Widening the competitive gap between Atrium and Novant now would have significant and lasting negative consequences for access, equity, and innovation in care delivery.

For these reasons, the Novant Health applications should be approved as submitted and if the Agency determines the Atrium Health applications are conforming, they should be awarded no more than 40 additional acute care beds.

CONCLUSION

With regard to acute care beds, 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 applications. Therefore, the NHPMC and NHHMC applications should be approved as submitted. If the Agency finds the Atrium Health applications conforming with all CON criteria and

performance standards, the CMC and AHUC applications are less effective alternatives than the NHPMC and NHHMC applications and should be denied or partially approved (for a maximum of 40 beds) on that basis. Fostering competitive balance in Mecklenburg County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high-quality care, lowering costs, and expanding patient choice.

ATTACHMENTS:

Attachment A: Atrium Health Comments on 2026 SMFP Acute Care Bed Need Determinations

Attachment B: May 2024 Material Compliance Request To Reallocate Approved Acute Care Beds

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

Attachment A: Atrium Health Comments on 2026 SMFP Acute Care Bed Need Determinations

Comments on Acute Care Bed Need Determinations and High Growth Rate Multipliers in the Proposed 2026 State Medical Facilities Plan

COMMENTER:

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Atrium Health, Inc. (Atrium), part of Advocate Health, is filing these comments to address the unprecedented number of acute care bed need determinations across the state. Atrium supports the acute care bed need methodology and is not proposing a change to the methodology. Atrium is asking the State Health Coordinating Council (SHCC) to consider the impact the unprecedented bed need of 2,361 beds in the Proposed 2026 State Medical Facilities Plan (SMFP) will have on the State and the hospitals and health systems in the counties with a high bed need. This request is based on the following factors described in more detail below:

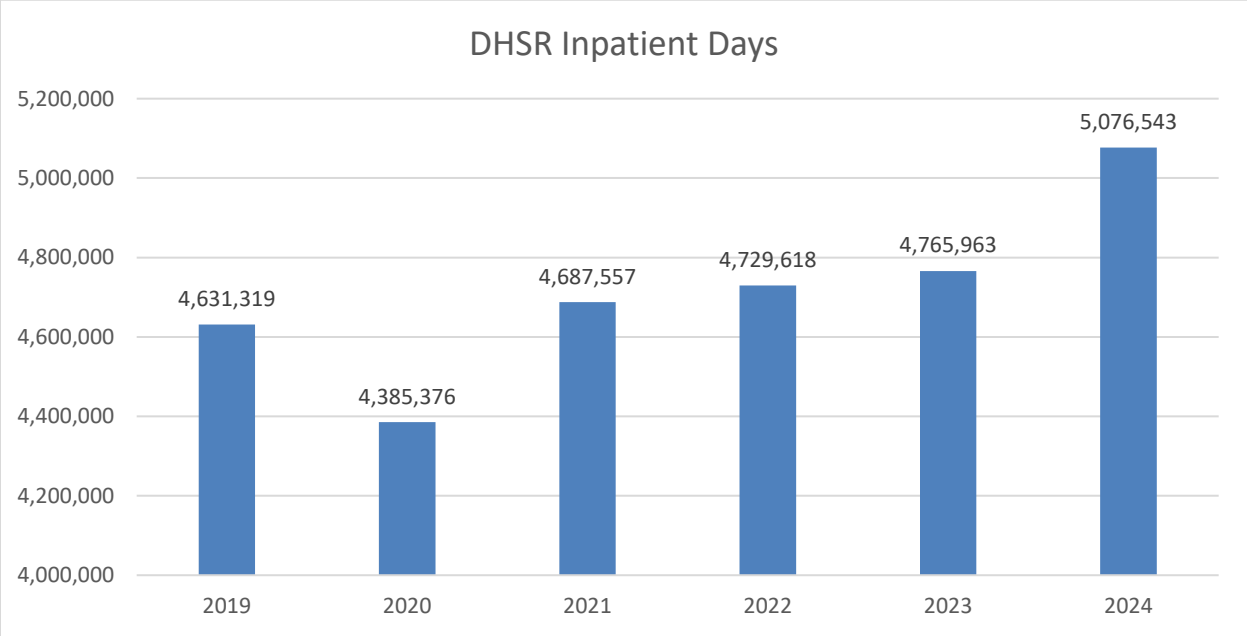
- COVID-19 Impact and Methodology Adjustments
- Historical County Bed Need
- Bed Need Compared to Existing Licensed Beds in a County
- Historical County Growth Rate Multipliers and Sustainability of Current GRMs
- Cost to Develop Acute Care Beds
- Historical Actions by SHCC to Limit a Need Determination

COVID-19 Impact and Methodology Adjustments

The COVID-19 pandemic had a significant impact on acute care bed utilization in North Carolina in 2020 by reducing the acute care bed utilization during the initial months when elective admissions and surgical procedures were halted and/or delayed. To address this impact on SMFP acute care bed need, beginning with the 2022 SMFP the SHCC reviewed options to adjust the acute care methodology to account for the impact of the COVID-19 pandemic on acute care bed utilization. The standard methodology using FFY 2020 days resulted in no acute care bed need anywhere in the state. The SHCC decided to use a three-year average of patient days for March, April, May, and June in place of

actual FFY 2020 days. For the 2023 and 2024 SMFPs the Growth Rate Multiplier (GRM) was based on the pre-COVID data from 2015 to 2019. For the 2025 SMFP, the SHCC voted to return to the normal methodology of calculating the GRM from the prior five years of data. The return to the normal GRM calculation in the 2025 SMFP resulted in a significant increase in growth rates due to the increase from the low volume in 2020 with resumption of elective admissions and procedures and additional growth in patient volumes. In the Proposed 2026 SMFP, the GRMs are even higher. The chart below demonstrates the significant growth of inpatient days of care from 2021 to 2024. The 2024 data is still being updated and refreshed and will likely change before the 2026 SMFP is finalized, but we expect there will still be significant bed need determinations.

SMFP Year	2021	2022	2023	2024	2025	2026
Data Year	2019	2020	2021	2022	2023	2024
DHSR IP Days	4,631,319	4,385,376	4,687,557	4,729,618	4,765,963	5,076,543
Annual Change in Days		-245,943	302,181	42,061	36,345	310,580
Annual % Change		-5.31%	6.89%	0.90%	0.77%	6.52%



Historical County Bed Need

The increase in inpatient days and the GRMs in the 2025 SMFP resulted in a bed need nearly 2.5 times higher than any prior year bed need over the last 10 years. The table below shows the acute care bed need determinations for the last 10 years of SMFPs. The

Proposed 2026 SMFP did show a need for 605 beds in Pender County, but those beds are not included in the table because the exorbitantly high bed need appears to be the result of a recurring data issue that was highlighted in a summer petition in 2025.

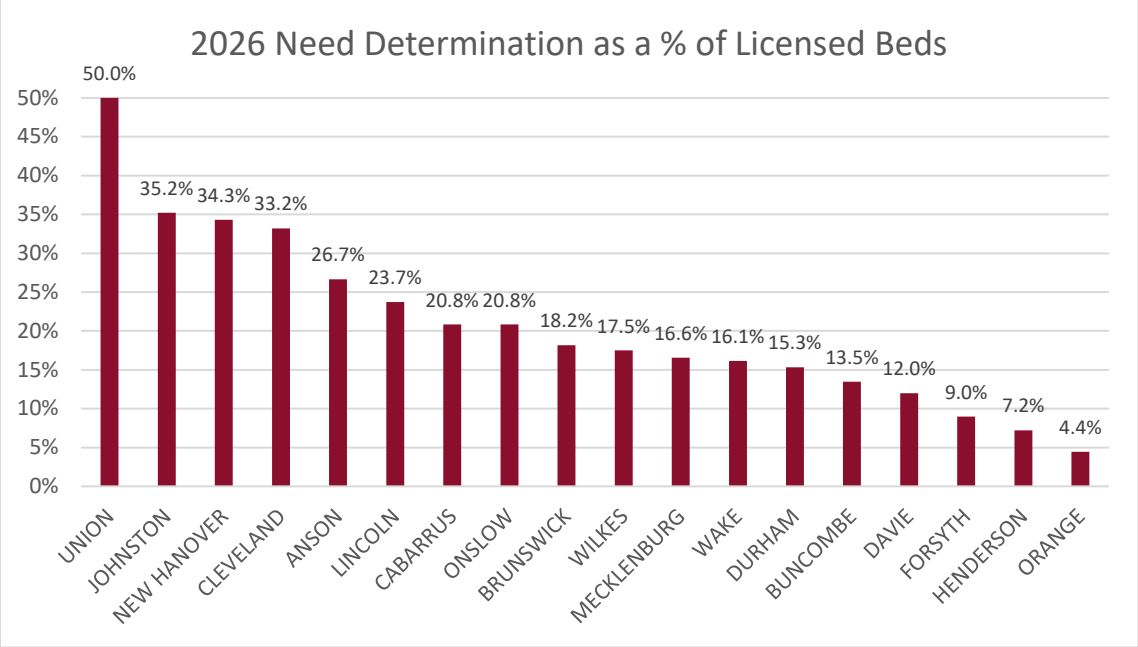
Even without the beds for Pender County, the 1,756 beds in the Proposed 2026 SMFP is higher than the 1,737 beds needed in the previous eight years combined from the 2017 SMFP to the 2024 SMFP.

Acute Care Bed Need by NC County

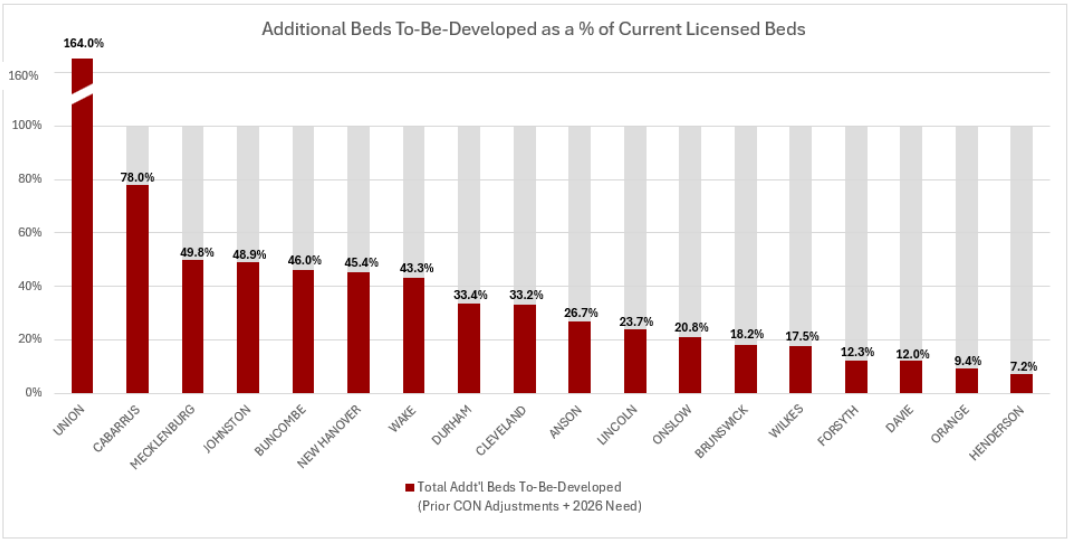
SMFP Year	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Data Year	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
ANSON							7	9		4
BRUNSWICK										18
BUNCOMBE						67		26	129	92
CABARRUS					22		65	31	126	89
CLEVELAND										93
DAVIE										6
DURHAM	96		34		40	68		38	82	199
FORSYTH				68						141
HENDERSON										19
JOHNSTON								*24*	21	62
LINCOLN										23
MECKLENBURG	60	50	76	126	123	65	164	89	210	369
NEW HANOVER				36	35		25			225
ONSLOW										30
ORANGE	41							26		37
UNION							21	46	136	89
WAKE						45	44	70	267	239
WILKES										21
Grand Total	**197**	**50**	**110**	**230**	**220**	**245**	**326**	**359**	**971**	**1,756**

Bed Need Compared to Existing Licensed Beds in a County

Another cause for concern with the size of the bed needs is how they compare to the existing licensed beds and prior bed needs in the county. Each of these bed needs represent a significant increase in the licensed beds for the county. The chart below shows the 2026 SMFP bed need as a percentage of the licensed and SMFP need determinations for the county.

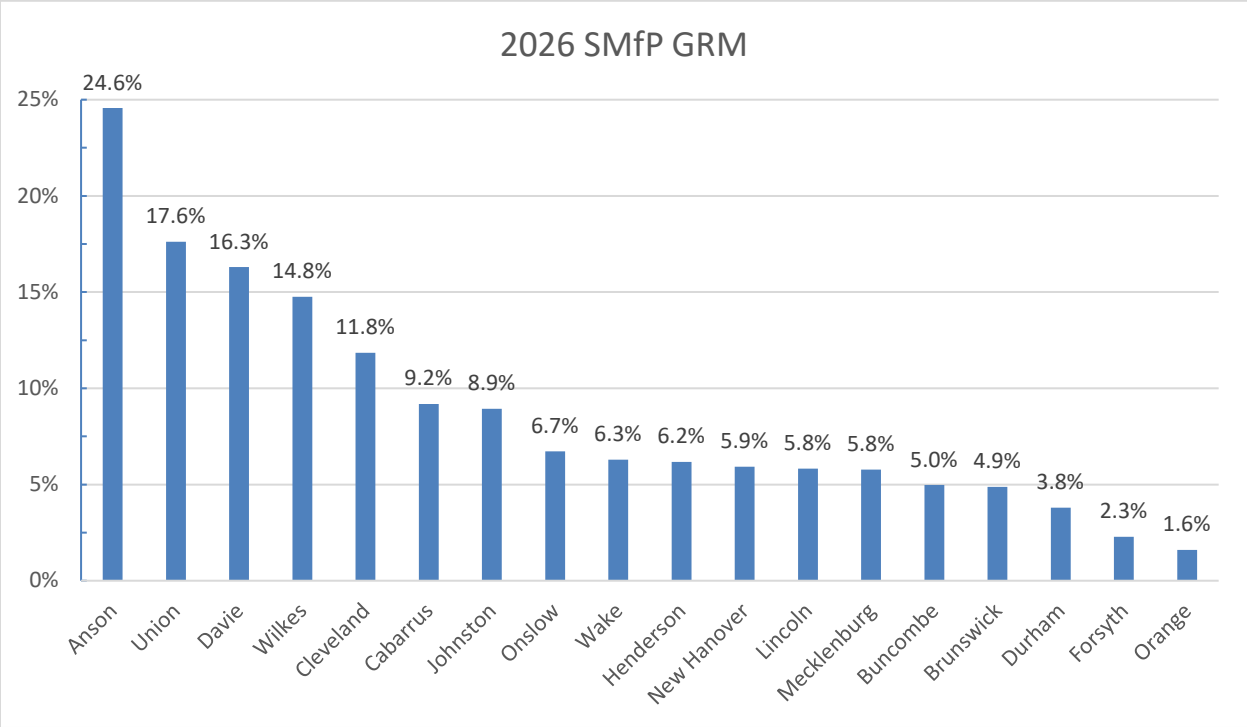


The unreasonableness of the current bed need and the high county GRMs is even more apparent when the percentage of licensed beds is calculated against the licensed and placeholder beds from recent need determinations. The chart below shows the combination of prior CON adjustments and 2026 bed need for Union County represents 164 percent of the current licensed beds in the county. There are seven other counties where the current bed need and placeholders exceed 40 percent of the current licensed beds. Each of these counties are large counties that have experienced population growth and inpatient utilization growth and do need additional bed capacity. The key question to be addressed is the reasonableness of increasing bed capacity by such a significant percentage based on growth rates that are likely unsustainable in the future.



Historical County Growth Rate Multipliers (GRMs) and Sustainability of Current GRMs

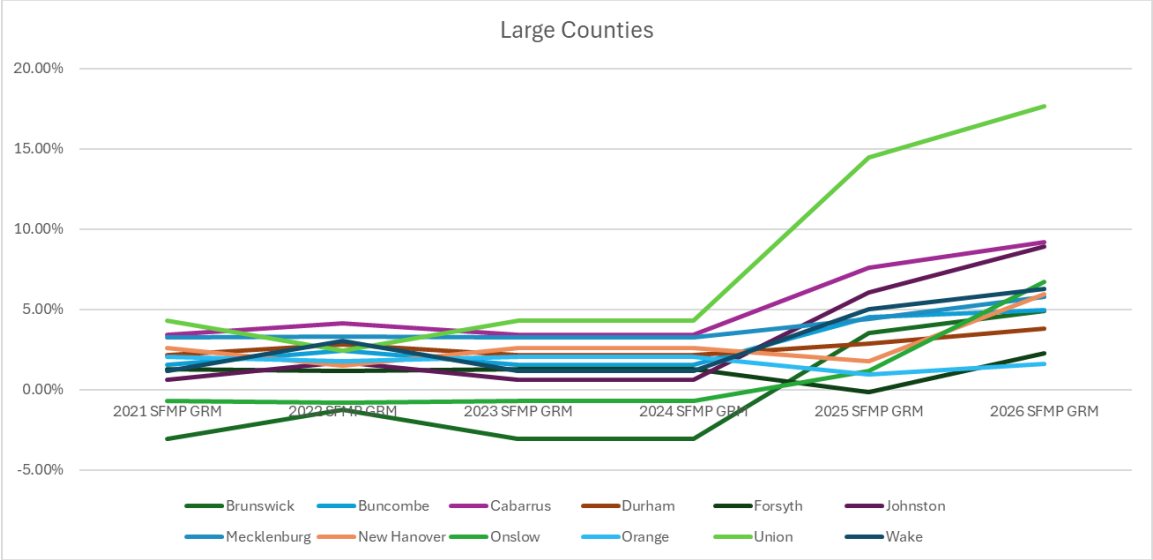
One of the key factors driving the high bed needs in the 2026 SMFP is the high Growth Rate Multipliers in many counties. There are five counties where the GRM is over 10 percent with the highest in Anson County of 24.56 percent. All but five of the counties showing a bed need in the 2026 SMFP have a GRM above 5 percent.



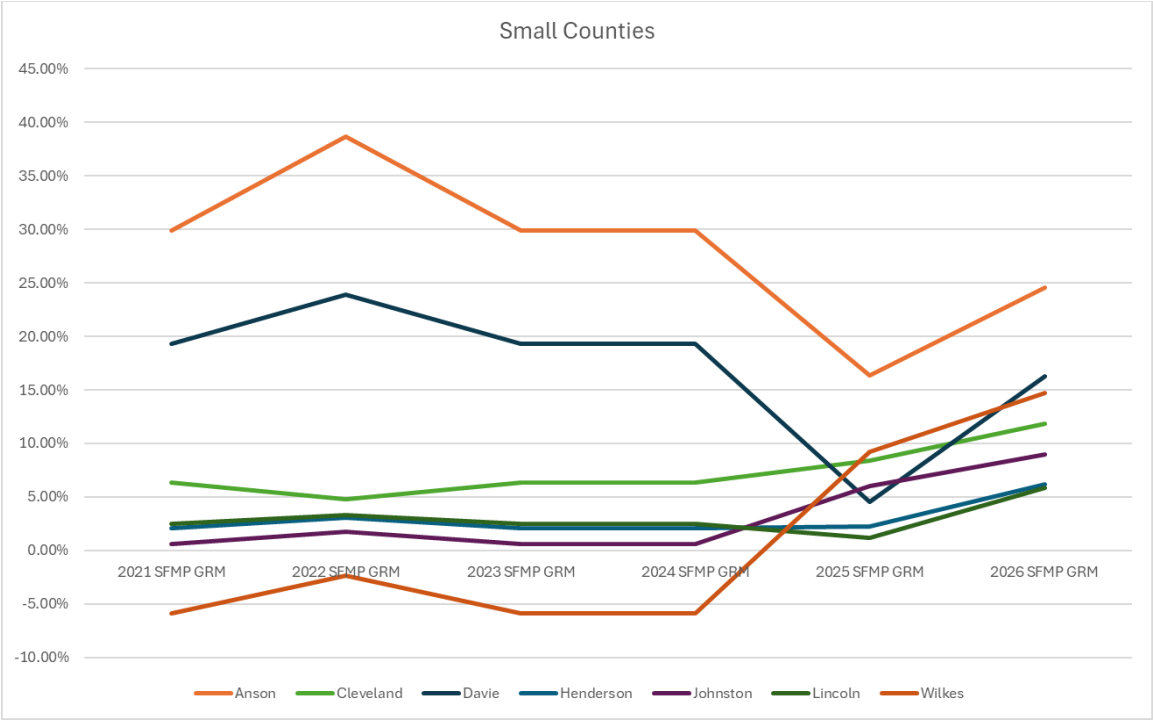
One key area of concern is the sustainability of these growth rates. The table below shows the county growth rate multipliers used in the SMFP over the last 10 years. The data show that most of the 2026 county growth rates are significantly higher than any prior year. The red highlighted cells are the highest growth rates over the period. Only four counties have experienced a higher growth rate than what is included in the 2026 SMFP.

County/Service Area	2017 SMFP GRM	2018 SMFP GRM	2019 SMFP GRM	2020 SMFP GRM	2021 SMFP GRM	2022 SMFP GRM	2023 SMFP GRM	2024 SMFP GRM	2025 SMFP GRM	2026 SMFP GRM
Anson	-1.3115	-1.3602	-1.2061	1.1233	1.2993	1.3867	1.2993	1.2993	1.1633	1.2456
Brunswick	1.0379	1.0250	-1.0182	-1.0226	-1.0307	-1.0124	-1.0307	-1.0307	1.0351	1.0488
Buncombe	1.0009	1.0130	1.0073	1.0173	1.0157	1.0245	1.0157	1.0157	1.0452	1.0497
Cabarrus	-1.0003	1.0043	1.0211	1.0469	1.0343	1.0412	1.0343	1.0343	1.0759	1.0919
Cleveland	-1.0311	-1.0133	-1.0093	1.0209	1.0633	1.0480	1.0633	1.0633	1.0836	1.1184
Davie	-1.4021	-1.3180	-1.2500	1.1174	1.1932	1.2392	1.1932	1.1932	1.0451	1.1630
Durham	1.0285	1.0262	1.0248	1.0177	1.0216	1.0281	1.0216	1.0216	1.0285	1.0379
Forsyth	1.0029	1.0066	1.0041	1.0198	1.0127	1.0115	1.0127	1.0127	-1.0017	1.0229
Henderson	-1.0014	1.0083	1.0160	1.0231	1.0204	1.0303	1.0204	1.0204	1.0223	1.0618
Johnston	-1.0195	1.0135	1.0210	1.0115	1.0062	1.0174	1.0062	1.0062	1.0603	1.0893
Lincoln	1.0389	1.0490	1.0288	1.0402	1.0245	1.0328	1.0245	1.0245	1.0114	1.0582
Mecklenburg	1.0039	1.0097	1.0136	1.0278	1.0325	1.0331	1.0325	1.0325	1.0443	1.0578
New Hanover	1.0330	1.0255	1.0187	1.0237	1.0260	1.0148	1.0260	1.0260	1.0178	1.0593
Onslow	-1.0111	1.0792	-1.0386	1.0063	-1.0068	-1.0079	-1.0068	-1.0068	1.0115	1.0672
Orange	1.0367	1.0284	1.0301	1.0205	1.0202	1.0176	1.0202	1.0202	1.0093	1.0160
Pender	-1.0247	-1.0320	-1.0681	-1.0585	-1.0945	-1.1866	-1.0945	-1.0945	1.3552	2.6993
Union	-1.0198	1.0121	1.0404	1.0455	1.0432	1.0244	1.0432	1.0432	1.1446	1.1762
Wake	1.0140	-1.0001	1.0115	1.0162	1.0119	1.0306	1.0119	1.0119	1.0501	1.0629
Wilkes	1.0291	-1.0344	-1.0790	-1.0475	-1.0592	-1.0238	-1.0592	-1.0592	1.0923	1.1475

The first graph below shows the historical GRMs of large counties (population over 125,000). The graph indicates the GRMs for 2025 and 2026 SMFPs showed significant increases over the prior five years.



The graph below shows the smaller counties (population under 125,000) and indicates more variability in GRM than in the large counties but also higher growth rates in the 2026 SMFP for the group as a whole.



The reason for concern with these high growth rates is the sustainability of the growth. If the bed need is driven by an artifact of post-COVID growth, it would not be reasonable to assume that continued rate of growth is sustainable.

Cost to Develop Acute Care Beds

A review of CON Application Logs for the last year included 19 CON applications for new acute care beds. The capital cost figures for these projects show the average cost to develop acute care beds can range from around $1 million per bed for development in existing buildings to upwards of $8 million per bed for a new hospital campus. The highest cost for a new campus was over $17 million per bed. The average cost per bed for all 19 applications was $3.7 million. Using the $3.7 million average cost per bed, the total cost to develop the 1,934 beds in the Proposed 2026 SMFP would be over $7.16 billion. One of the goals of health planning and certificate of need is to control overall health costs by controlling the supply of healthcare facilities and equipment. If the use of potentially unsustainable growth rates leads to unnecessary spending to develop beds that are not truly needed the system will have failed in a significant and very costly manner.

Historical Actions by SHCC to Limit a Need Determination

One potential option the SHCC could consider is to limit the bed need determinations based on changes in methodology. This approach was used by the SHCC for the 2018 SMFP after significant changes in the operating room methodology resulted in a need for 16 ORs in Mecklenburg County. The following language was inserted into the

methodology steps to reduce the need in any county to a maximum of six operating rooms.

c. For the 2018 State Medical Facilities Plan, the Service Area Need must be at least two to show an Operating Room Need Determination in Table 6C. If the Service Area Need is greater than six, then the Operating Room Need Determination in Table 6C is equal to six.

Recommendation

Atrium is recommending the SHCC consider a temporary adjustment to the methodology similar to what was done in the 2018 SMFP related to operating room need. One option for consideration is listed below.

- A maximum need of 10 percent of licensed beds for small counties (less than 125,000).
- A maximum need of 5 percent of licensed beds for large counties (greater than 125,000).

If this option were implemented the total number of beds needed across the state would decrease from 1,756 to 560 beds. The reduced total is still higher than any total bed need in the prior ten years except for the 2025 SMFP.

County	Total Licensed Beds	2026 Need	Max Need	2026 SMFP Adjusted Need
ANSON	15	4	2	2
BRUNSWICK	99	18	5	5
BUNCOMBE	682	92	34	34
CABARRUS	427	89	21	21
CLEVELAND	280	93	28	28
DAVIE	50	6	5	5
DURHAM	1,297	199	65	65
FORSYTH	1,573	141	79	79
HENDERSON	263	19	26	19
JOHNSTON	176	62	9	9
LINCOLN	97	23	10	10
MECKLENBURG	2,226	369	111	111
NEW HANOVER	656	225	33	33
ONSLOW	144	30	7	7
ORANGE	834	37	42	37
UNION	178	89	9	9
WAKE	1,482	239	74	74
WILKES	120	21	12	12
Grand Total	**10,599**	**1,756**	**572**	**560**

Note: ***Large Counties*** > 125,000 population

Conclusion

In conclusion, Atrium supports the robust health planning process in North Carolina under the supervision of the SHCC and the Division of Health Service Regulation (DHSR)

Healthcare Planning and Certificate of Need Section staff. Atrium requests the SHCC consider these proposed adjustments to the unprecedented acute care bed need determinations in the 2026 SMFP. Atrium appreciates the opportunity to provide these comments.

Attachment B: May 2024 Material Compliance Request To Reallocate Approved Acute Care Beds

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

VIA EMAIL ONLY

June 2, 2025

Elizabeth Kirkman
Elizabeth.kirkman@atriumhealth.org
Brighid Knoll Huber
Brighid.Huber@advocatehealth.org

Exempt from Review

Record #:	**4787**
Date of Request:	May 15, 2025
Facility:	Atrium Health University City
Project Description:	Construct a new patient tower on the main campus
County:	Mecklenburg
FID #:	923516

Dear Elizabeth Kirkman:

The Healthcare Planning and Certificate of Need Section, Division of Health Service Regulation (Agency), determined that the above referenced proposal is exempt from certificate of need review in accordance with G.S. 131E-184(g). Therefore, you may proceed to offer, develop or establish the above referenced project without a certificate of need.

It should be noted that this determination is binding only for the facts represented by you. Consequently, if changes are made in the project or in the facts provided in your correspondence referenced above, a new determination as to whether a certificate of need is required would need to be made by the Agency. Changes in a project include but are not limited to: (1) increases in the capital cost; (2) acquisition of medical equipment not included in the original cost estimate; (3) modifications in the design of the project; (4) change in location; and (5) any increase in the number of square feet to be constructed.

If you have any questions concerning this matter, please feel free to contact this office.

Sincerely,

Chalice L. Moore
Project Analyst

Micheala Mitchell
Chief

cc: Acute and Home Licensure and Certification Section, DHSR
Construction Section, DHSR

May 15, 2025

Ms. Micheala Mitchell, Chief
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
809 Ruggles Drive
Raleigh, NC 27603

RE: Exemption Request for The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health University City to Develop a New Patient Tower on the Main Campus

Dear Ms. Mitchell:

Please accept this letter as notification of The Charlotte-Mecklenburg Hospital Authority's (CMHA's) intent to construct a new patient tower on the main campus of Atrium Health University City (AH University City) pursuant to N.C. Gen. Stat. § 131E-184(g). CMHA intends to construct a six-story patient tower on AH University City's main campus located at 8800 North Tryon Street, Charlotte, NC 28262. The site plan included in Attachment A shows the location of the proposed patient tower as well as the existing hospital facility. As indicated on the site plan, the new patient tower will be developed adjacent and connected to the existing hospital building. The proposed project involves necessary infrastructure work that will need to be completed prior to/in order to allow construction of the new patient tower, as well as relocation/expansion of dietary services, administrative office space, and other existing ancillary and support services, such as sterile processing, lab, and pharmacy. It also includes the relocation of the mobile technology pad. Other components of this project include reconfiguration of access roads, construction of additional parking and expansion of the central energy plant, all of which are exempt pursuant to N.C. Gen. Stat. §131E-184(a)(4).

The total capital cost of the proposed project is estimated to exceed $4,119,200. The new patient tower is planned as follows:

- Level 01 – Administrative Space, Ancillary/Support Services, Dietary Services/Café
- Level 02 – Mechanical
- Level 03 – Shell
- Level 04 – Shell
- Level 05 – Shell
- Level 06 – Shell

Please note, the proposed services detailed above are all replacement and/or relocated services as well as shell space.

Under N.C. Gen. Stat. § 131 E-184(g), the Certificate of Need law provides that an applicant's proposal to replace or expand the entirety or a portion of an existing health service facility on the

same main campus site that exceeds the $4,000,000[1] threshold set forth in N.C. Gen. Stat. § 131E-176(16b) is nonetheless exempt from review if all of the following conditions are met:

(1) the sole purpose of the capital expenditure is to renovate, replace on the same site, or expand the entirety or a portion of an existing health service facility that is located on the main campus;
(2) the capital expenditure does not result in (i) a change in bed capacity as defined in N.C. Gen. Stat. § 131E-176(5) or (ii) the addition of a health service facility or any other new institutional health service other than that allowed in N.C. Gen. Stat. § 131E-176(16)b; and
(3) the licensed health service facility proposing to incur the capital expenditure provides prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of N.C. Gen. Stat. § 131 E-184(g).

Further, pursuant to N.C. Gen. Stat. § 131E-176(14n), "main campus" as referenced in N.C. Gen. Stat. § 131E-184(g), means the following:

a. The site of the main building from which a licensed health service facility provides clinical patient services and exercises financial and administrative control over the entire facility, including the buildings and grounds adjacent to that main building.
b. Other areas and structures that are not strictly contiguous to the main building but are located within 250 yards of the main building.

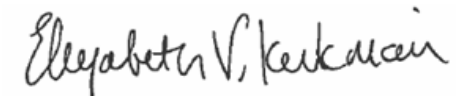
The AH University City new patient tower project meets each of the applicable conditions set forth above.

- The estimated capital cost of the project exceeds $4,119,200.
- The sole purpose of the capital expenditure is to expand an existing health service facility (AH University City) on the main campus, which is located at 8800 North Tryon Street, Charlotte, NC 28262. Please see the site plan included in Attachment A. The proposed patient tower will be located on the main campus, which is the site from which AH University City provides clinical patient services and exercises financial and administrative control over the entire facility (please see Attachment B for a copy of AH University City's hospital license). AH University City Facility Executive's office is currently located on the first floor of the main hospital building.
- The proposed project will not result in a change in bed capacity (increase or decrease) as defined in N.C. Gen. Stat. § 131E-176(5) or the addition of a health service facility or a new institutional health service other than that allowed in N.C. Gen. Stat. § 131E-176(16b). The project will not increase the number of operating rooms or gastrointestinal rooms. The project will not result in the acquisition of major medical equipment, or the offering of health services not currently provided.
- This letter constitutes the required prior written notice under N.C. Gen. Stat. § 131 E-184(g)(3).

[1] The current cost threshold amount is $4,119,200.

Based on the above facts, the project is exempt from Certificate of Need review. We are requesting that you please confirm in writing that AH University City's new patient tower project is exempt from Certificate of Need review and that CMHA may proceed as planned with this project.

Sincerely,

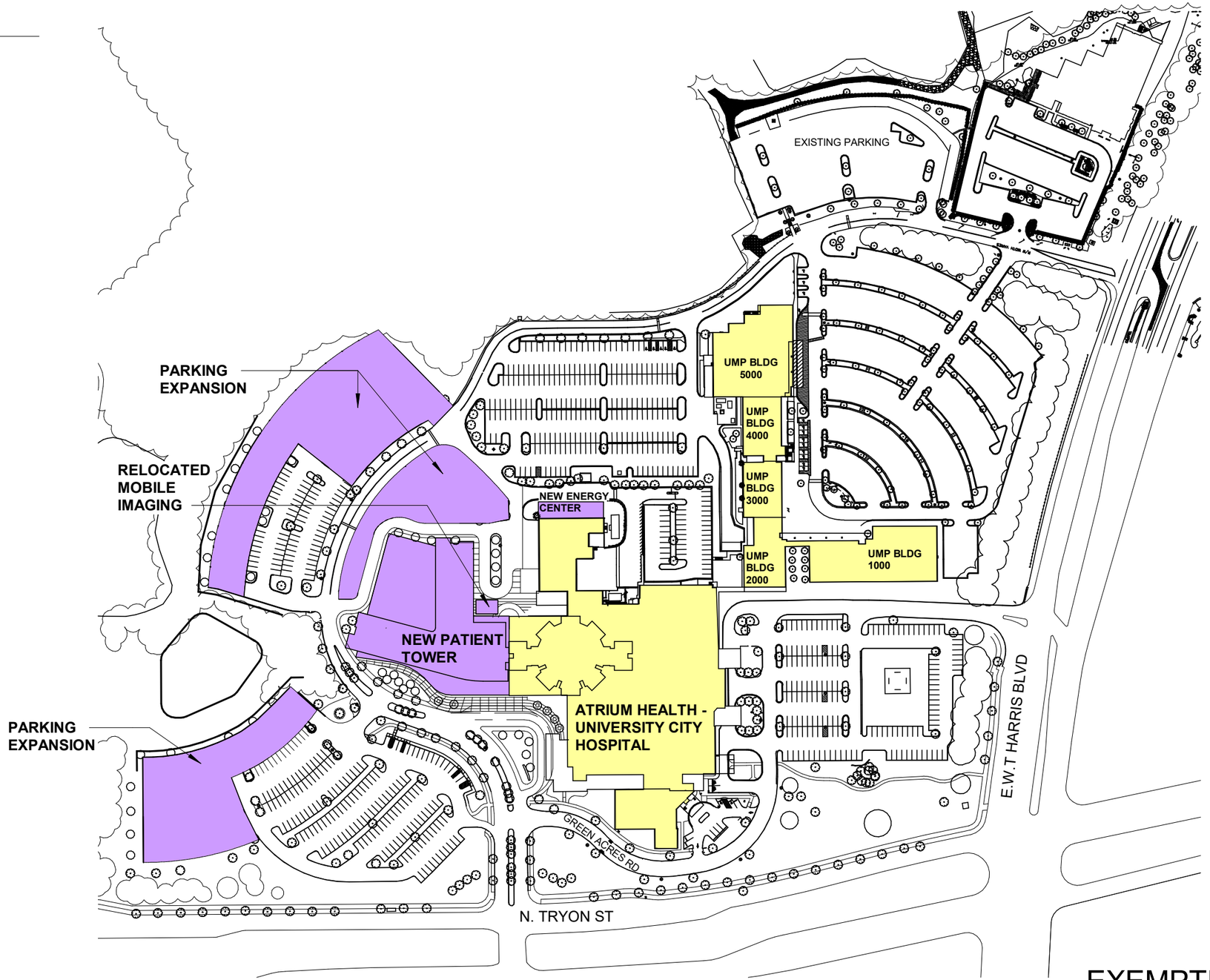


Elizabeth Kirkman
Assistant Vice President
Core Market Growth Business Development

Attachment A

COLOR KEY

- EXISTING BUILDING
- NEW CONSTRUCTION



SITE PLAN

EXEMPTION REQUEST

Atrium Health

05/14/2025

Atrium Health University City

Attachment B

State of North Carolina

Department of Health and Human Services
Division of Health Service Regulation

Effective January 1, 2025, this license is issued to

The Charlotte-Mecklenburg Hospital Authority

to operate a hospital known as

Atrium Health University City

located at Charlotte, NC, Mecklenburg County.

This license is issued subject to the statutes of the State of North Carolina, is not transferable and shall remain in effect until amended by the issuing agency.

Facility ID: 923516 ***License Number: H0255***

*Bed Capacity:**117***

General Acute: **117**

*Dedicated Inpatient Surgical Operating Rooms: **1***

Shared Surgical Operating Rooms: 7

*Dedicated Ambulatory Surgical Operating Rooms:**0***

*Dedicated Endoscopy Rooms: **1***

License Categories:

Authorized by:

Secretary, N.C. Department of Health and Human Services

Director, Division of Health Service Regulation

From: Huber, Brighid K
To: Moore, Chalice L; Stancil, Tiffany C
Subject: [External] Exemption Request for The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health University City
Date: Thursday, May 15, 2025 4:42:08 PM
Attachments: CMHA dba AH University City Exemption Request.pdf

Good afternoon,

I hope you both are having a good week! Please find attached an exemption request submitted by The Charlotte-Mecklenburg Hospital Authority ("CMHA") d/b/a Atrium Health University City to develop a new patient tower on the main campus.

Thank you,

Brighid

Brighid Knoll Huber, MHA, ATC
Core Market Growth Business Development
Mobile: 724-986-6214

Atrium Health

Attachment C: 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."