WRITTEN COMMENTS REGARDING THE

2025 CABARRUS COUNTY ACUTE CARE BED REVIEW

SUBMITTED BY NOVANT HEALTH

March 31, 2025

Two CON applications were submitted in response to the State Medical Facilities Plan (SMFP) need determination for 126 additional acute care beds in Cabarrus County, including:

> CON Project ID# F-12588-25 Novant Health Cabarrus Medical Center: Develop a new 50-bed acute care hospital
>
> CON Project ID# F-12600-25 Atrium Health Cabarrus: Develop 126 additional acute care beds

As demonstrated above, the total number of acute care beds requested in this review exceeds the SMFP need determination for 2025. Atrium Health (AH) has applied for all 126 available beds, while Novant Health has applied for only 50—well below the 2025 SMFP need determination. As a new competitor in Cabarrus County with a clear, well-supported need for these beds, Novant Health's application should be approved in full.

The following comments clearly establish that AH's application is not approvable and that no additional beds should be awarded to AH. However, if the Agency determines otherwise, the absolute maximum number of beds that should be awarded to AH is 76.

These comments are submitted by Novant Health in accordance with N.C. Gen. Stat. § 131E-185(a1)(1) to provide a comparative analysis and a detailed review of the most significant issues related to AH's conformity with the statutory and regulatory review criteria outlined in N.C. Gen. Stat. § 131E-183(a) and (b). Additional errors and non-conformities may exist in the competing application, and Novant Health reserves the right to develop further opinions as necessary upon continued review and analysis.

Approving Novant Health's application will meet the county's growing demand while introducing long-overdue competition in Cabarrus County. This is undeniably in the best interest of patients, as increased competition leads to greater choice, lower costs, and higher quality care through innovation. As demonstrated in its application, Novant Health fully complies with all applicable review criteria and is the superior applicant in this review.

COMPARATIVE ANALYSIS

Pursuant to G.S. § 131E-183(a)(1) and the 2025 State Medical Facilities Plan, no more than 126 acute care beds may be approved for Cabarrus County in this review. Because the applications in this review collectively propose to develop 176 additional acute care beds in Cabarrus County, both applications cannot be approved for the total number of beds proposed. Therefore, a comparative review is required as part of the Agency findings after each application is reviewed independently against the applicable statutory review criteria. The following factors have recently been utilized by the Agency for competitive reviews regardless of the type of services or equipment proposed:

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

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

Conformity with CON Review Criteria and Rules

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

Conformity of Applicants

Applicant	Project I.D.	Conforming/ Non-Conforming
Novant Health Cabarrus Medical Center	F-12588-25	Yes
Atrium Health Cabarrus	F-12600-25	No

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

Scope of Services

NH Cabarrus proposes to develop a new, full-service 50-bed hospital designed to meet a broad range of patient needs in Cabarrus County. NH Cabarrus will offer comprehensive services, including emergency care, surgical services, intensive care (ICU), obstetrics, imaging, and therapy services. In contrast, AH's proposal merely expands an already large 400+ bed facility—a project that does not introduce meaningful competition or enhance patient choice.

Both facilities will provide a complete range of essential healthcare services, ensuring that Cabarrus County residents receive high-quality care. The difference in bed count does not reflect a difference in effectiveness—NH Cabarrus is designed to operate efficiently and effectively while delivering the same essential acute care services available at AH Cabarrus. This has been proven time and time again by Novant Health's numerous community hospitals beginning with NH Matthews, which opened in 1994 and most recently with NH Ballantyne Medical Center, which opened in 2023.[1] Therefore, both projects are equally capable of meeting the healthcare needs of the community, but NH Cabarrus does so while promoting competition, increasing patient access, and improving choice—key factors that benefit the residents of Cabarrus County.

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

Geographic Accessibility

Novant Health and AH both propose to develop new acute care beds in Cabarrus County. However, only NH Cabarrus seeks to establish a completely new hospital in Kannapolis—an area currently lacking any existing or approved acute care facilities.[2] In contrast, AH's proposal merely expands its existing monopoly over acute care services in Cabarrus County.

Currently, Cabarrus County residents have no choice but to rely on AH, as both the only existing and the only approved acute care hospitals in the county fall under its control. As a result, many residents—particularly those in Kannapolis, Stanly County, and parts of Rowan County—travel to Mecklenburg or Rowan County for acute care services within the Novant Health system.

The proposed NH Cabarrus hospital will fundamentally improve healthcare access by bringing high-quality acute care services closer to home for these communities. This project is not just about adding beds—it is about expanding options, fostering competition, and breaking the existing monopoly to enhance patient choice. By introducing a new, independent alternative, NH Cabarrus will help improve quality, increase accessibility, and drive down costs for local residents—ensuring better healthcare outcomes for all.

For these reasons, the **Novant Health** application is the **most effective** alternative regarding geographic accessibility.

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

[2] As described in Section K, the mailing address for the proposed site identifies Concord, NC; however, the physical address for the site is located in the city of Kannapolis.

Competition (Patient Access to a New or Alternate Provider)

The 2025 SMFP acute care bed methodology has identified the need for 126 additional acute care beds in the Cabarrus County service area by 2027. Novant Health is applying for 50 of these beds—approximately 40 percent of the total—while still leaving ample capacity for other approvable applicants. Unlike AH's proposal, which merely reinforces its existing monopoly, NH Cabarrus introduces a new, independent provider, creating true competition for the first time in Cabarrus County.

Approval of the NH Cabarrus application will expand patient access to high-quality care, address growing demand, and foster competition that benefits both patients and insurers. Increased competition lowers costs, enhances quality, and improves patient choice—fundamental objectives of the CON process. The Agency has previously recognized these benefits, most notably in the 2022 and 2024 Buncombe County acute care bed reviews. The same reasoning applies here: introducing a new provider in Cabarrus County is the most effective way to improve healthcare access and affordability.

By comparison, Atrium Health's application is the least effective alternative, as it seeks to tighten its grip on the market rather than promote genuine competition. Increased patient choice compels all providers to improve quality, enhance efficiency, and offer competitive pricing. The same outcome would occur in Cabarrus County with the approval of NH Cabarrus, making Novant Health's proposal the most effective alternative for the region's healthcare future.

For these reasons, the **Novant Health** application is the **most effective** alternative regarding enhanced competition.

Access By Service Area Residents

On page 33, the 2025 SMFP defines the service area for acute care beds as "the acute care bed service area in which the bed is located. The acute care bed service areas are the single and multicounty groupings shown in Figure 5.1." Figure 5.1, on page 38, shows Cabarrus County as a single-county acute care bed service area. Thus, the service area for this review is Cabarrus 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 Cabarrus County Residents, Project Year 3

Comparative	Novant Health Cabarrus	Atrium Health Cabarrus
# of Cabarrus County Patients	2,494	20,902
% of Cabarrus County Patients	**73.7%**	53.9%

Source: CON applications, Section C.3

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

It would be inappropriate to directly compare the absolute number of Cabarrus County patients served between NH Cabarrus (a 50-bed facility) and AH Cabarrus (a 400+ bed facility) because the size of the two facilities is vastly different. NH Cabarrus, with 50 proposed acute care beds, will naturally serve fewer patients simply because of its smaller capacity. In contrast, AH Cabarrus, with its significantly larger 400+ bed capacity, is able to serve a larger volume of patients simply by virtue of its scale. This disparity in bed size makes any direct comparison based on the absolute number of patients served misleading and unfair.

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

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

Access By Underserved Groups

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

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

For access by underserved groups, applications are typically compared with respect to Medicare patients and Medicaid patients. [3] Access by each group is treated as a separate factor.

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

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

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

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

Projected Medicare

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

Projected Medicare Revenue – 3rd Full FY

Applicant	Form F.2b Total Medicare Revenue	Form C.1b Discharges	Avg Medicare Rev. per Discharge	Form F.2b Gross Revenue	% of Gross Revenue
NH Cabarrus Medical Center	$53,823,115	3,384	$15,905	$121,468,773	44.3%
Atrium Health Cabarrus	$620,850,179	37,278	$16,655	$1,075,968,926	57.7%

Generally, the application projecting to provide the most service to Medicare patients, as measured by revenue, is the more effective alternative for this comparative factor.

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

Based on the differences in the presentation of pro forma financial statements, one cannot make a conclusive comparison of the Medicare access provided by each applicant for purposes of evaluating which application was more effective regarding this comparative factor. Accordingly, the Agency should determine that this factor is inconclusive.

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
NH Cabarrus Medical Center	$16,860,481	3,384	$4,982	$121,468,773	13.9%
Atrium Health Cabarrus	$134,727,967	37,278	$3,614	$1,075,968,926	12.5%

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

Based on the differences in the presentation of pro forma financial statements, one cannot make a conclusive comparison of the Medicaid access provided by each applicant for purposes of evaluating which application was more effective regarding this comparative factor. Accordingly, the Agency should determine that this factor is inconclusive.

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
NH Cabarrus Medical Center	3,384	$28,479,568	$8,416
Atrium Health Cabarrus	37,278	$248,757,072	$6,673

As previously described, Novant Health's pro formas are not structured the same way as those from Atrium Health. In the assumptions and methodology for Form F.2, Novant Health states the acute care gross charges include nursing units, inpatient surgery revenue, ED services, imaging, obstetrics/newborn costs, and all ancillary services. In the assumptions and methodology for Forms F.2 and F.3, Atrium Health states that gross revenue includes acute care bed charges and expenses only, and does not include any ancillary services such as lab, radiology, or surgery. Therefore, a comparison of projected net revenue per patient is inconclusive.

Projected Average Operating Expense per Patient

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

Projected Average Operating Expense per Patient – 3rd Full FY

Applicant	Form C.1b Discharge	Form F.2b Operating Expense	Average Operating Expense per Discharge
NH Cabarrus Medical Center	3,384	$85,066,831	$25,138
Atrium Health Cabarrus	37,278	$265,755,255	$7,129

As previously described, Novant Health's pro formas are not structured the same way as those from Atrium Health. In the assumptions and methodology for Form F.2, Novant Health states the acute care gross charges include nursing units, inpatient surgery revenue, ED services, imaging, obstetrics/newborn costs, and all ancillary services. In the assumptions and methodology for Forms F.2 and F.3, Atrium Health states that gross revenue includes acute care bed charges and expenses only, and does not include any ancillary services such as lab, radiology, or surgery. Therefore, a comparison of the projected average operating expense per patient is inconclusive.

Summary

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

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

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

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

COMMENTS REGARDING ATRIUM HEALTH'S CONFORMITY WITH STATUTORY REVIEW CRITERIA

COMMENTS REGARDING CRITERION (3)

Alleged Imperative to Maintain Capacity

The 2021 SMFP identified a need for 22 additional acute care beds in Cabarrus County, which were awarded to AH Cabarrus but remain undeveloped (Project ID # F-012116-21). This pattern repeated in 2023 and 2024, with 65 and 31 additional beds awarded to AH (Project ID #s F-012367-23 and F-012505-24), bringing AH Cabarrus's total awarded but undeveloped acute care bed total to 118. AH Cabarrus is therefore sitting on a considerable stockpile of *undeveloped* beds. When combined with its existing 427 acute care beds (excluding NICU beds), AH controls 100 percent of the 545 existing and approved acute care beds in Cabarrus County.

Despite this, AH Cabarrus's 2025 CON application claims inadequate capacity and seeks approval for 126 additional acute care beds—eight more than the 118 beds it has yet to develop. The application insists that "it is imperative that Atrium Health Cabarrus maintain sufficient acute care bed capacity" (page 51) yet fails to justify why its substantial inventory of undeveloped beds is insufficient to meet demand.

By contrast, Novant Health's application proposes developing 50 acute care beds—which will be the only beds in the county not controlled by AH. If Novant Health's request is approved alongside 76 of AH's requested 126 beds, Novant Health would hold just 7.5 percent of the county's acute care capacity (672 total beds: 545 existing/approved + 126 new). This modest share aligns with Novant Health's historical role in serving Cabarrus County, where it accounts for 10.5 percent of Core Acute Care (CAC) MSDRG discharges despite AH being the sole in-county provider. *See* the following table excerpted from the NH Cabarrus application.

Currently, Atrium Health is the sole provider of acute care services located within Cabarrus County and maintains an 87.6 percent share of Cabarrus County CAC MSDRGs discharges.

Share of Cabarrus County CAC MSDRG Discharges, CY2023

Health System	CAC MSDRG Discharges	Share
Atrium Health	9,651	87.6%
Novant Health	1,161	10.5%
Other	206	1.9%
Total	11,018	100.0%

Source: HIDI Inpatient Database

Source: Page 109 of NH Cabarrus application

Alternatively, if AH's application were approved for 126 beds, AH would continue to maintain 100 percent control of acute care beds in Cabarrus County. Such a result would not be consistent with the purpose of the CON Statute and the 2025 SMFP for several reasons. First, it would unfairly tilt the competitive scales in AH's favor by preventing Novant Health from developing any acute care capacity in Cabarrus County, which would harm patients and payors. Second, it would eliminate any incentive for AH to manage its capacity constraints using its inventory of 545 existing and approved acute care beds. Third, it would allow AH, the incumbent monopoly provider, to further entrench its monopoly to the detriment of patients and payors. The Agency should reject AH Cabarrus's unfounded "imperative" and analyze its application based on statutory intent.

Failure to Address the Acute Care Needs of Cabarrus County

While AH's application begins its response to Section C.4 with a broad discussion of Cabarrus County's population growth and aging demographics, the analysis quickly narrows to focus exclusively on acute care services at AH Cabarrus. This approach fails to account for the full spectrum of acute care needs among Cabarrus County residents, instead presenting a self-serving view that equates countywide demand with AH Cabarrus's so-called internal capacity constraints.

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

Currently, Atrium Health is the sole provider of acute care services located within Cabarrus County and maintains an 87.6 percent share of Cabarrus County CAC MSDRGs discharges.

Share of Cabarrus County CAC MSDRG Discharges, CY2023

Health System	CAC MSDRG Discharges	Share
Atrium Health	9,651	87.6%
Novant Health	1,161	10.5%
Other	206	1.9%
Total	11,018	100.0%

Source: HIDI Inpatient Database

Source: Page 109 of NH Cabarrus application

AH Cabarrus' application entirely fails to address these Cabarrus County residents who leave the county for acute care services at Novant Health, AH Mecklenburg County facilities, or other acute care providers. Instead, AH Cabarrus equates Cabarrus County's acute care needs solely with its own bed capacity, ignoring the broader patient movement patterns and the lack of choice faced by county residents. AH's limited approach to demonstrating the need for its project is representative of the lack of choice that Cabarrus County residents face for acute care services in their home county.

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

Given AH Cabarrus's failure to adequately demonstrate countywide need beyond its own facility, its application is non-conforming with **Criterion (3)** and should be disapproved.

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

COMMENTS REGARDING CRITERION (4)

AH Cabarrus failed to address a clear and viable alternative: developing the 118 beds for which it has already received approval in Cabarrus County. This omission is significant because a fundamental principle of the CON process is to ensure the most efficient use of approved healthcare resources before additional capacity is authorized.

By not addressing the development of these previously approved beds, AH Cabarrus raises concerns about whether additional bed capacity is truly needed or whether the current approved beds could be optimized to meet patient demand. If AH Cabarrus has not yet implemented these 118 beds, questions arise regarding financial feasibility, operational priorities, or the actual necessity for further expansion. The Agency should not allow the stockpile of beds that AH is hoarding to grow yet again.

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

COMMENTS REGARDING CRITERION (5)

On page 130 of its application, AH Cabarrus provides the assumptions used to develop Form F.3 for the AH Cabarrus License. Notably, AH Cabarrus is approved to develop AH Harrisburg, a 44-bed acute care facility that will be licensed under AH Cabarrus (*see* page 36). However, Form F.3 fails to account for critical financial components of the AH Harrisburg project, including Interest Expense, Depreciation-Building, and Depreciation-Equipment costs.

As shown in the excerpt below, AH Cabarrus states that Form F.3 for AH Cabarrus License accounts for previously approved capital expenditures related to its 2021 and 2023 bed additions at AH Cabarrus Main Campus, but does not mention the 2022 and 2024 projects that comprise the development of AH Harrisburg (Project ID # F-012255-22 and subsequent change of scope, Project ID # F-012505-24).

f	Interest Expense is based on the CY 2023 Atrium Health Cabarrus experience, inflated 3.0 percent annually through the third project year. In addition, CMHA expects to fund the proposed project along with the 2021 Atrium Health Cabarrus beds project (Project ID # F-012116-21) and the 2023 Atrium Health Cabarrus beds project (Project ID # F-012367-23) with accumulated reserves, but has conservatively included interest expense in the event that the project is funded with bond financing. Interest expense for the previously approved projects are based on the respective applications. Interest expense for the proposed project is based on the project cost, assuming a 4.0 percent interest rate based on CMHA's current weighted average cost of capital.
g	Depreciation-Building is based on the CY 2023 Atrium Health Cabarrus experience, inflated 3.0 percent annually through the third project year. Depreciation - Buildings also includes building depreciation expense for the proposed project along with the 2021 Atrium Health Cabarrus beds project (Project ID # F-012116-21) and the 2023 Atrium Health Cabarrus beds project (Project ID # F-012367-23). Depreciation - Buildings is calculated using the straight line method of depreciation over a useful life of 30 years.
h	Depreciation-Equipment is based on the CY 2023 Atrium Health Cabarrus experience, inflated 3.0 percent annually through the third project year. Depreciation - Equipment also includes equipment depreciation expense for the proposed project along with the 2021 Atrium Health Cabarrus beds project (Project ID # F-012116-21) and the 2023 Atrium Health Cabarrus beds project (Project ID # F-012367-23). Depreciation - Equipment is calculated using the straight line method of depreciation over a useful life of seven years.

Source: Page 130 of AH Cabarrus application

AH Harrisburg's total approved capital expenditure is $233,463,216, consisting of:

- $85,822,000 for Project ID # F-012255-22
- $147,641,216 for the change of scope (Project ID # F-012505-24)

Despite this significant investment, AH Cabarrus entirely omits any interest expense or depreciation costs associated with AH Harrisburg from its financial projections. As a result, the projected expenses for the AH Cabarrus License are artificially understated, distorting the financial outlook.

Furthermore, as shown on page 132 of its application, AH Cabarrus (Main Campus) Acute Care Beds—the project's service component—projects negative net income throughout the Partial and Project Years.

Given these ongoing losses, the application must provide a clear demonstration of the project's financial feasibility. However, as outlined above, the application understates expenses, fails to include all required financial obligations, and presents an incomplete picture of the project's fiscal sustainability. As such, AH Cabarrus has failed to demonstrate that the financial feasibility of the project is reasonable and adequately supported.

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

COMMENTS REGARDING CRITERION (6)

AH is seeking approval for 126 additional acute care beds despite already having 118 approved but undeveloped beds across its facilities (AH Cabarrus and AH Harrisburg). This request exceeds Novant Health's proposed bed expansion by more than double, yet AH has failed to present any near-term solutions for addressing its alleged capacity constraints.

While AH claims that AH Cabarrus lacks adequate capacity, its application does not demonstrate that these capacity challenges will persist once its approved beds are developed. Furthermore, AH provides no clear timeline for bringing these 118 beds online, meaning it will likely be years before any meaningful increase in capacity occurs. This delay undermines AH's assertion that the proposed project is "imperative." This is also inconsistent with the General Assembly's directive that CONs need to be developed promptly and should not be stockpiled. *See* N.C. Gen. Stat. § 131E-189. Simply stated, before AH is given more beds in Cabarrus County, it should be required to develop the beds for which it has CON approval. Another applicant, NH Cabarrus, should be given a chance to introduce beneficial choice and competition in Cabarrus County.

In reality, AH's request represents an unnecessary duplication of already approved capacity rather than a justified expansion of need. Accordingly, the AH Cabarrus application does not conform to Criterion (6) should be denied.

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

COMMENTS REGARDING CRITERION (12)

The AH Cabarrus application fails to demonstrate that its proposed cost, design, and construction approach represent the most reasonable alternative, as required by Criterion (12). The application proposes a massive $208 million capital investment for 126 additional acute care beds, yet AH Cabarrus has already been approved for 118 acute care beds that remain undeveloped.

Critically, the application does not provide a clear or definitive timeline for bringing these previously approved beds online, nor does it justify why this substantial inventory of unused beds is inadequate to meet projected demand. Instead of efficiently utilizing its existing resources, AH Cabarrus seeks approval for an expensive expansion without demonstrating that it has exhausted more cost-effective and practical

alternatives. This raises serious concerns about the necessity and fiscal responsibility of the proposed project.

Given these deficiencies, the AH Cabarrus application fails to meet the requirements of Criterion (12) and does not represent the most reasonable or efficient use of healthcare resources.

COMMENTS REGARDING CRITERION (18a)

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

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

- *United States v. The Charlotte-Mecklenburg Hospital Authority*, 3:16-cv-00311 (W.D.N.C.)
- *Benitez v. The Charlotte-Mecklenburg Hospital Authority*, 992 F.3d 229 (4th Cir. 2021)
- *DiCesare v. The Charlotte-Mecklenburg Hospital Authority*, 376 N.C. 63, 852 S.E.2d 146 (2020)

The USDOJ's antitrust case against AH culminated in a Final Judgment, a copy of which is attached to these comments. Despite this legal history, AH continues to expand its control, threatening competitive balance and patient choice.

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

As detailed in the NH Cabarrus application:

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

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

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

CONCLUSION

With regard to acute care beds, only the application submitted by Novant Health is fully conforming to all applicable Criteria and rules and the Novant Health application is also comparatively superior to the Atrium Health application. Therefore, the Novant Health application should be approved as submitted. If the Agency finds the Atrium Health application conforming with all CON criteria and performance standards, the Atrium Health application is a less effective alternative than the Novant Health application and should be denied or partially approved (for a maximum of 76 beds) on that basis. Fostering competitive balance in Cabarrus County, or not unnecessarily worsening competitive imbalance, will maximize healthcare value by incentivizing high-quality care, lowering costs, and expanding patient choice.

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

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

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

FINAL JUDGMENT

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

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

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

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

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

I. JURISDICTION

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

II. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. APPLICABILITY

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

IV. PROHIBITED CONDUCT

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

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

1. express prohibitions on Steered Plans or Transparency;

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

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

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

V. PERMITTED CONDUCT

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

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

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

third party will not disclose that information to Defendant's competitors, another Insurer, the general public, or any other third party lacking a reasonable need to obtain such competitively sensitive information. Defendant may seek all appropriate remedies (including injunctive relief) in the event that dissemination of such information occurs.

VI. REQUIRED CONDUCT

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

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

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

VII. COMPLIANCE

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

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

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

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

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

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

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

C. Within 270 calendar days of entry of this Final Judgment, Defendant must submit to the United States and the State of North Carolina a written report setting forth its actions to comply with this Final Judgment, specifically describing (1) the status of all negotiations between Managed Health Resources (or any

successor organization) and an Insurer relating to contracts that cover Healthcare Services rendered in the Charlotte Area since the entry of the Final Judgment, and (2) the compliance procedures adopted under Paragraph VII(A)(3) of this Final Judgment.

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

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

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

G. If at the time that Defendant furnishes information or documents to the United States or the State of North Carolina, Defendant represents and

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

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

VIII. RETENTION OF JURISDICTION

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

IX. ENFORCEMENT OF FINAL JUDGMENT

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

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

C. In any enforcement proceeding in which the Court finds that Defendant has violated this Final Judgment, the United States may apply to the Court for a one-time extension of this Final Judgment, together with such other relief as may be appropriate. In connection with any successful effort by the United States to enforce this Final Judgment against Defendant, whether litigated or resolved prior to litigation, Defendant agrees to reimburse the United States for the

fees and expenses of its attorneys, as well as any other costs including experts' fees, incurred in connection with that enforcement effort, including in the investigation of the potential violation.

X. EXPIRATION OF FINAL JUDGMENT

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

XI. PUBLIC INTEREST DETERMINATION

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

XII. CONCLUSION

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

Signed: April 24, 2019

Robert J. Conrad, Jr.
United States District Judge

Exhibit A

Aetna

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

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

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

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

Blue Cross and Blue Shield of North Carolina

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

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

Cigna

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

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

Medcost

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

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

UnitedHealthcare

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

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

Exhibit B

Cigna

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

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

UnitedHealthcare

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

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

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

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