Comments Submitted by

Novant Health Asheville Medical Center, LLC

In Opposition to

Project ID # B-12232-22

MH Mission Hospital, LLLP

And

Project ID # B-12233-22

AdventHealth Asheville, Inc.

Comments Submitted by Novant Health Asheville Medical Center, LLC

Pursuant to N.C. Gen. Stat. § 131E-185, Novant Health Asheville Medical Center, LLC ("NH Asheville") submits the following comments in opposition to the application filed by MH Mission Hospital, LLLP ("Mission Hospital") to add 67 acute care beds to its main campus in Asheville and to the application filed by AdventHealth Asheville, Inc. ("AdventHealth Asheville") to develop a 67-bed acute care hospital in Candler.

Comments in Opposition to

Project ID # B-12232-22

MH Mission Hospital, LLLP

Overview

"The Department of Health and Human Services should deny Mission's application."[1]

NH Asheville agrees wholeheartedly with Attorney General Stein's position that Mission Hospital's application should be denied. Attorney General Stein's decision to comment on a CON application is extremely significant. NH Asheville is not aware of another instance in which any North Carolina Attorney General has commented on a CON application. Recognizing their unprecedented nature, the Agency should make special note of these comments. The Attorney General's Office is the Agency's legal counsel. By submitting these comments, the Agency's own lawyers are urging their client *not* to approve the Mission Hospital application. There are many sound reasons why the Agency should listen to the Attorney General. As the Attorney General wrote:

> *Currently, Mission has almost no competition for acute care in Buncombe County. The lack of competition is the result of Mission's unique history. Mission effectively operated as a legislatively authorized monopoly for over twenty years, and no new hospitals have opened even after Mission's arrangement with the State ended in 2016. This lack of competition harms residents of western North Carolina by increasing the cost, and reducing the quality, of health care services in the region. Awarding Mission this Certificate of Need would exacerbate the lack of competition and resulting harm. Accordingly, the Department should deny Mission's application and instead approve an application from a qualified competitor.*[2]

While the Stein Letter refrains from supporting either of the two competing applications, NH Asheville submits that it is <u>the qualified competitor</u> in this review.

In addition, for the reasons stated in these comments and any other reasons the Agency may discern, the Mission Hospital application is not approvable because it does not conform to all applicable review criteria and rules and is comparatively inferior to the NH Asheville application. NH Asheville has

[1] July 25, 2022 letter in opposition submitted regarding Project I.D. # B-012232-22 from Kevin Anderson, Special Deputy Attorney General, Director, Consumer Protection Division, North Carolina Department of Justice, on behalf of North Carolina Attorney General Josh Stein (the "Stein Letter"). Attachment 1.

submitted the most effective alternative to developing the 67 acute care beds in the 2022 Buncombe/Graham/Madison/Yancey Service Area Review. As demonstrated in its application, the NH Asheville CON application should be approved for the following reasons:

- The NH Asheville application fully conforms to all applicable review criteria and is comparatively superior to the Mission Hospital application.
- The NH Asheville application offers choice and competition within Buncombe County and the broader service area.
- Novant Health is a proven, effective operator of community hospitals in multiple North Carolina locations.
- Like all Novant Health facilities, NH Asheville will have generous and easy-to-understand charity care and related policies that ensure care for all.
- The NH Asheville application combines the expertise of two leading providers, Novant Health and Surgery Partners, both of which have extensive experience in North Carolina and in western North Carolina (Novant Health via its outpatient imaging affiliate, MedQuest, in Buncombe County, and Surgery Partners via Outpatient Surgery Center Asheville).
- Both Novant Health and Surgery Partners have received numerous accolades for quality care.
- Both Novant Health and Surgery Partners are employers of choice.
- NH Asheville will strongly support women's health by offering obstetrics, a health service that Mission Hospital has closed at other hospitals including Transylvania Regional Hospital (2015), Blue Ridge Regional Hospital (2017), and Angel Medical Center (2017). NH Asheville is not able to reopen Mission Hospital's closed obstetric services, but NH Asheville can offer women a meaningful choice in health care providers.

All CON reviews are important, but this particular review is especially significant, as evidenced by the Stein Letter. This is the first time in decades that there is a real chance to have another hospital in Buncombe County[3]. Competition has been missing in Buncombe County since 1995, when Mission Hospital and the former St. Joseph's Hospital united in a virtual merger, later followed by a full merger. Although this merger was investigated by the Antitrust Division of the United States Department of

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[2] Stein Letter, page 1. Attachment 1.

[3] The *2011 SMFP* contained a need determination for 51 acute care beds in the Buncombe/Madison/Yancey Service Area. Only Mission Hospital applied.

Justice, the hospitals applied for, and received, a Certificate of Public Advantage ("COPA") from the State of North Carolina which offered protection from antitrust scrutiny. The tradeoff for immunity was the hospitals' agreement to be actively supervised by the State of North Carolina. Almost from the beginning, though, there was widespread dissatisfaction with the merger in western North Carolina among patients, physicians, payors, and employees, with many asserting that the State was not actively supervising Mission Hospital under the COPA. The State investigated but the situation persisted for several more years. In 2015, the COPA law was repealed, and by 2018, Mission Hospital was up for sale. HCA was chosen as the winning bidder, though many, including North Carolina Attorney General Josh Stein, question how fair and transparent the sales process was, and whether the deck was stacked in HCA's favor from the beginning. In June 2021, the Attorney General noted a "concerning number" of complaints had been filed against Mission over the preceding year, and that he has dedicated one of his employees to keeping track of all the complaints about Mission Health.[4] As far as NH Asheville knows, this is unique; the Attorney General's Office does not have employees dedicated to keeping track of complaints at other hospitals. As recently as March 16, 2022, the Attorney General wrote to HCA again, describing the following concerns:

- *The high prices that Mission Health charges patients in Western North Carolina;*
- *Mission Health's price transparency efforts;*
- *Mission Health's alleged use of an anti-steering provision in contracts with physicians to stifle competition in western North Carolina; and*
- *Understaffing at Mission Health facilities.*

The March 16, 2022 letter concludes:

> *The complaints referenced above make troubling allegations regarding patients not receiving proper care, core functions being reduced and not replaced, and subpar conditions regarding basic sanitation and cleanliness. Our office will continue to review complaints we receive.*

Please refer to Attachment 1 for copies of the Attorney General letters.

Until the Agency approves a new entrant, patients, payors, physicians, and employees are left with few options. The frustration with the current state of health care in western North Carolina is palpable.

[4] https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed (visited June 12, 2022). Attachment 3.

This review presents a unique opportunity to improve healthcare in western North Carolina in a truly meaningful way. Applying the CON Law, the Agency can bring competition to western North Carolina. Recent CON reviews that have increased competition in a service area include:

- 2018 HSA III Inpatient Rehabilitation Bed Review;
- 2019 Mecklenburg County Acute Care Bed and OR Review; and
- 2021 Durham County Acute Care Bed and OR Review.

Mission Hospital has no competition in the four-county SMFP-defined service area, and it is many times larger than any other hospital in western North Carolina. All the Mission Hospital application proposes is to make the monopolist or near-monopolist hospital even larger, which harms service area residents, third-party payors, and other healthcare providers. This is clearly evident not only in the Stein Letter but also in the class action lawsuit filed in federal court on July 27, 2022 by Buncombe County and City of Asheville, which states:

> *4. Defendants have injured Plaintiffs and members of the Class through an anticompetitive scheme involving the illegal maintenance and enhancement of monopoly power in two health care service markets: (1) the market for inpatient general acute care ("GAC") in hospital, consisting of a broad group of medical and surgical diagnostic and treatment services that include overnight hospital stays: and (2) the market for outpatient care encompassing all medical services that are not GAC Services.*

Please refer to Attachment 2 for a copy of the class action complaint and related article, as well as copies of two previous class action complaints: Davis, et al v. HCA Healthcare, Inc., et al and City of Brevard v. HCA Healthcare, Inc. et al.

Novant Health strongly supports North Carolina's CON program and believes, as the above decisions show, that CON plays an important role in promoting competition to the benefit of patients, payors, physicians, and employees. As the Stein Letter correctly observes:

> *[t]he Certificate of Need application process for 67 acute care beds in Buncombe, Graham, Madison, and Yancey Counties provides a much-needed opportunity to introduce competition into western North Carolina's health care market. The*

Department should seize that opportunity, as required by N.C. Gen. Stat. § 131E-183(a)(18a), by denying Mission's application.[5]

Awarding this CON to Novant Health and Surgery Partners brings enormous benefits to patients, payors, physicians, and employees by giving them choices they have not had for decades. Awarding this CON to Novant Health and Surgery Partners will not harm Mission Hospital. To the contrary, awarding the CON to Novant Health and Surgery Partners will help Mission Hospital address its so-called capacity constraints. Mission Hospital will remain many times larger than NH Asheville. Nor is this review Mission Hospital's only chance to add capacity. While the Agency must decide the applications in front of it now, it should be noted that the 2023 Draft SMFP contains a need for 31 additional acute care beds in the Buncombe/Graham/Madison/Yancey Service Area.[6] Thus, Mission likely has another opportunity to apply in 2023, and if current growth trends continue, there will be other opportunities to apply after that. The time is now right to approve a new entrant with 67 acute care beds, and for the reasons shown in the NH Asheville application, the new entrant should be NH Asheville.

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[5] Stein Letter, page 3. Attachment 1.

[6] NH Asheville is aware that Margaret R. Pardee Memorial Hospital ("Pardee") in Hendersonville has filed a petition to eliminate this need determination from the 2023 SMFP. Pardee is not a provider in the Buncombe/Madison/Yancey County Acute Care Bed Service Area.

Application Specific Comments

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

Policy GEN-3: Basic Principles states:

> "A certificate of need applicant applying to develop or offer a new institutional health service for which there is a need determination in the North Carolina State Medical Facilities Plan **shall demonstrate how the project will promote safety and quality in the delivery of health care services while promoting equitable access and maximizing healthcare value for resources expended**. A certificate of need applicant shall document its plans for providing access to services for patients with limited financial resources and demonstrate the availability of capacity to provide these services. A certificate of need applicant shall also document how its projected volumes incorporate these concepts in meeting the need identified in the State Medical Facilities Plan as well as addressing the needs of all residents in the proposed service area."

Policy GEN-3, *2022 SMFP*, page 30, emphasis added.

Although Mission Hospital's application conforms to the need determination, it is not consistent with all applicable need determinations in the SMFP, including Policy GEN-3. Therefore, the application is non-conforming with Criterion (1), as explained in greater detail on the following pages.

On page 29, Mission Hospital states:

> *Quality at Mission Hospital is derived from its commitment to excellence in all aspects of care throughout the healthcare system.*

HCA's tenure in Asheville is not consistent with the above-quoted sentence. Rather, HCA's tenure has been difficult since the beginning, highlighting the need for a hospital in the Buncombe/Graham/Madison/Yancey service area that is operated by a different provider. The following timeline is a summary of some of the articles published in the *Asheville Citizen Times* newspaper relating to some of the issues since the purchase of Mission Health by HCA Healthcare in February 2019.

- January 2020 – Cashiers-area residents concerned with changes at Highland-Cashiers Hospital, no full-time doctor and sense of lower overall staffing levels negatively impacting quality of care.
- February 2020 – HCA-Mission Hospital independent monitor hears from residents concerning uncomfortable delays during hospital stays, inconsistent billing practices and charity care policies.
- August 2020 – Mission Health decides to "centralize" chemotherapy services from Mission Medical Oncology locations in Franklin, Brevard, Marion, and Spruce Pine to Asheville.
- September 2020 – Mission Health to stop primary care services in Biltmore Park and Candler.
- September 2020 – Mission Hospital registered nurses vote to unionize.
- May 2021 – Twelve providers leave Transylvania Regional Hospital. Twenty-five physicians from a single medical practice leave Mission Hospital. Mission Health contracts staffing through Team Health. Patients routinely wait 18-24 hours in the emergency department to get admitted due to shortage of nurses. Mission Hospital's Leapfrog and CMS ratings decrease between Fall 2020 and Spring 2021 to a Leapfrog "B" grade.
- August 2021 – HCA-Mission Hospital has class-action, antitrust lawsuit filed accusing the hospital of exorbitant prices and declining quality.
- September 2021 – NC Attorney General receives 290 complaints concerning HCA-Mission Health.
- January 2022 – Mission Health employees voice concerns about safe working conditions, thinning staffing levels, and national COVID-19 protections.

- March 2022 – 223 physicians have left Mission Hospital since 2019.
- April 2022 – Angered and dissatisfied, some Mission Hospital patients seek health care elsewhere.
- July 25, 2022 – Attorney General Stein takes the unprecedented step of filing comments in opposition to the Mission Hospital application.
- July 27, 2022 – Buncombe County and the City of Asheville file an antitrust lawsuit against Mission and HCA.

Please refer to the NH Asheville CON, Exhibit C.4. (Tab 10) and Attachment 3 for copies of the articles.

The Attorney General's March 16, 2022[7] letter to Greg Lowe of HCA describes circumstances that are dramatically different from Mission's so-called "commitment to excellence":

> - *Complaints note that, at the same time Mission Health charges high prices, Mission Health is enjoying significant profits while the quality of care at Mission declines.*
> - *This alleged practice [anti-steering clauses in insurance contracts], whereby HCA prohibits insurers from incentivizing or encouraging patients from receiving care from less expensive providers, limits consumers' understanding about the costs and quality of care from other providers in the area and forces patients and their insurers to pay more for healthcare. Moreover, when coupled with Mission Health's overwhelming market power in western North Carolina, and its alleged practice of requiring insurers to cover Mission Health services that are not competitively priced if the insurers wish to access Mission Health's 'must have' facilities in their plans, this practice leaves consumers little choice but to receive all medical care from Mission Health, regardless of the price or quality of care.*

Nurses are uniquely positioned to observe conditions in Mission Hospital. A May 31, 2022 press release[8] from National Nurses United, a national unition and professional organization representing nurses, states:

> *Registered nurses at HCA Healthcare's Mission Hospital in Asheville, N.C., will hold a rally on June 2 to demand that hospital management take immediate action toward recruiting and retaining staff nurses, National Nurses Organizing Committee/National Nurses United (NNOC/NNU) announced today. Mission RNs*

[7] *See* March 16, 2022 Letter. Attachment 1.

[8] https://www.nationalnursesunited.org/press/mission-hospital-nurses-to-rally-for-recruiment-retention-and-patient-safety. Attachment 7.

say dangerous conditions in their hospital necessitate immediate action to protect patient care and safety.

. . .

Nurses are demanding Mission Hospital stop creating unsafe conditions for patients. When nurses have too many patients to care for, patients do not get optimal care. Mission RNs say management must immediately implement safe RN-to-patient ratios and cease all efforts to undermine RNs' scope of practice.

On page 34, Mission Hospital states:

Mission Hospital is the regional tertiary provider and trauma center, the only acute care hospital and the only provider offering inpatient surgical services in CON-approved operating rooms in Buncombe, Madison, Yancey and Graham Counties.

This statement does not support the application's conformity with Criterion (1). Rather, it simply states the obvious: Mission Hospital has no competition in the four-county SMFP-defined service area, and it is many times larger than any other hospital in western North Carolina. All the Mission Hospital application proposes is to make the monopolist or near-monopolist hospital even larger. No new or innovative services are proposed in this application; it only proposes to maintain the status quo. As such, this application is non-conforming with Policy GEN-3 and Criterion (1).

For these stated reasons, in addition to any other reasons the Agency may discern, Mission Hospital's application is non-conforming with Criterion (1) and cannot be approved.

(3) The applicant shall identify the population to be served by the proposed project and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

On page 40, Mission Hospital states:

> *Because Mission Hospital is the only acute care provider in the Buncombe/Graham/Madison/Yancey County service area, the published need was driven solely by the utilization of Mission Hospital. Several factors have influenced the rapid and continued growth in need for Mission's inpatient services. Namely, Mission is the largest provider of tertiary and emergency services in Health Service Area.*

And on page 43, Mission Hospital states:

> *It will be clearly documented that Mission's proposed project is specifically and intentionally designed to meet the components of demand that drove the bed need in the 2022 SMFP, that this need is driven by patients that only Mission can serve, and that the project represents the best alternative to directly meet this need.*

These statements do not demonstrate Mission Hospital's need for additional acute care beds in this review. No one disputes that Mission Hospital is the only hospital in the acute care bed service area. It is irrelevant whether or not Mission Hospital's utilization drove the need for more beds in the service area. Mission Hospital is not entitled to the 67 acute care beds. The acute care beds are available to *any* "qualified" applicant per the requirements of page 37 in the 2022 SMFP. NH Asheville is unquestionably a qualified applicant. *All* applicants must demonstrate conformity with the review criteria and rules. Regardless of any data Mission Hospital may present about its utilization, a second acute care hospital in the service area, specifically in Buncombe County, would act as a relief valve for Mission Hospital's self-reported utilization and claims of capacity constraints. A second hospital would offer choice and competition that is sorely absent, as noted by the antitrust lawsuits that have been filed and the Attorney General's opposition to the Mission Hospital application.

Mission's status as "the largest provider of tertiary and emergency services in the Health Service Area" is also irrelevant. The acute care beds are not reserved for tertiary or emergency-related patients. A second acute care hospital in Buncombe County, even if it is not a tertiary facility, can provide care to the majority of service area patients. Mission Hospital self-reported 40,327 admissions for 2019 in its 2020 Hospital License Renewal Application, with 21,222 admissions or 52.6 percent [21,222 / 40,327] of admissions within the DRG codes to be served at NH Asheville. Acting as a relief valve, NH Asheville will allow Mission Hospital to admit more patients related to "tertiary and emergency services." Clearly, Mission Hospital is NOT the only provider that can serve patient needs. NH Asheville proposes to challenge the status quo, which Mission Hospital proposes to maintain, and introduce choice and competition in the service area. The acute care hospital proposed by Novant Health and Surgery Partners, two proven leaders in providing health care services in North Carolina, is the best alternative to meet the needs of service area patients.

On page 42, Mission Hospital states that the following factors support the need for the project:

- *The increase in the service area population, especially the aged 65+ population, is positively associated with increased healthcare needs, including the highest acuity services.*
- *The growing population of retirees migrating to western North Carolina, creating additional growth in the 65+ cohort in future years.*
- *The upsurge in the developmental activities in the proposed service area, galvanizing economic growth and consequently population growth.*
- *The overall growth in admissions and patient days at Mission is already creating significant capacity constraints, making it difficult for Mission to continue meeting the needs of the service area, particularly for high acuity patients.*
- *The national and statewide trend towards higher acuity patients in hospitals as lower acuity services continue to be shifted to alternative outpatient settings.*
- *The large increase in high acuity patients historically served by Mission Hospital, necessitating the need for more ICU and Stepdown beds in medical/surgical service lines.*
- *The impact of being the only provider in the region that can meet the need for beds to support higher acuity patients needing ICU, trauma, and other high-acuity specialized services and care.*

The first three factors also apply to NH Asheville. As previously noted, the patients of the service area have generated the need for the acute care beds and NH Asheville can address these needs in its proposed 67-bed acute care hospital. The next four factors are directly related to a lack of acute care choice and competition in Buncombe County which another acute care hospital would alleviate. These

factors also relate to Mission Hospital's apparent failure to use available tools to tackle these issues. The tools include the temporary increase in acute care beds, which only requires notification and approval of the Acute Care Licensure and Certification Section; the development of observation beds, which do not require CON approval; and/or the better utilization of the other HCA hospitals in western North Carolina (Angel Medical Center and Highlands-Cashier Hospital in Macon County, Mission Hospital McDowell in McDowell County, Blue Ridge Regional Hospital in Mitchell County, and Transylvania Regional Hospital in Transylvania County) that have 234 acute care beds available. These 234 acute care beds had a meager utilization rate 29.4 percent in 2021 [25,103 days of care / (234 beds X 365.25 days]. Clearly, these hospitals have capacity to take care of more patients. Unfortunately, Mission Hospital spent years closing health care service including oncology and women's services (obstetrics) at Transylvania Regional Hospital (2015), Blue Ridge Regional Hospital (2017), and Angel Medical Center (2017). If patients are not using these hospitals, Mission Hospital bears at least some of the responsibility for that situation.

Additionally, Mission Hospital may have an opportunity to submit a CON application for up to 31 acute care beds in 2023, based on the Proposed 2023 SMFP. The priority in the 2022 review should be approving a new hospital in Buncombe County with 67 beds. Mission's so-called need for these 67 beds is certainly not greater than the community's need for choice and competition that promotes higher quality and lower prices. A much smaller, 31-bed hospital would be limited in the scope of services that it could provide.

On page 49, Mission Hospital dismisses the idea of a community hospital. These self-serving statements do not support the need for more beds at Mission Hospital but instead show why beds are needed elsewhere:

- *It is also clear that additional Med/Surg beds are not needed in the community hospital setting for the service area and region. These truths are evidenced by several factors:*
    - *Smaller community and rural hospitals in the service area and region providing lower acuity care have excess capacity and, without exception, documented general med/surg bed surpluses.*
    - *Smaller community and rural hospitals in the service area and region have surplus ICU capacity presumably because they are not offering specialized and high-acuity services to support ICU demand. Additional beds at such hospitals would not serve the high-acuity patient population which is driving this demand. Instead, awarding beds to a smaller community or specialized*

hospital (e.g., an OB-focused hospital) would create an additional surplus of existing services while the region's tertiary care provider continues to experience capacity constraints.

- *Thus, an additional small community hospital is not needed.*
    - *Births are declining across the region, and the population of women ages 15-44 is growing notably slower than the state average.*
    - *Mission has capacity for Obstetric ("OB") services and supports the regional demand of high-risk mothers and infants. Obstetric need is not driving the demand for more beds.*
- *Thus, an additional base-level OB program in a community hospital is not needed.*
    - *No other provider in the region offers specialty pediatric services and pediatric intensive care {"PICU"). Mission has capacity for PICU and pediatric patients.*
- *Thus, no additional pediatric bed capacity is needed.*

Mission Hospital's unfounded attack on community hospitals, rural communities and women's health is troubling. HCA owns and operates 31.3 percent [5 hospitals / 16 hospitals] of the community hospitals in western North Carolina. Mission Hospital's contempt for smaller community hospitals is evident by the closing of hospital services, especially women's services (obstetrics), at its own community hospitals including Transylvania Regional Hospital (2015), Blue Ridge Regional Hospital (2017), and Angel Medical Center (2017).

A Carolina Public Press article from September 2017 reports:

> *Mission Health, a nonprofit hospital network headquartered in Asheville, has operated many longstanding small hospitals throughout the 19-county region — most notably in rural, low-population areas like Spruce Pine and Marion, which are north of the city, and Brevard, Franklin and Highlands to the south.*
>
> *Until two years ago, each of these communities had a labor-and-delivery center nearby. But in 2015, Mission began to close them. First, it was a unit at the Transylvania Regional Hospital in Brevard, servicing nearly 33,000 residents. Then in July 2017, Mission shuttered labor and delivery at Angel Medical Center in Franklin, affecting about 40,000 people in Macon County and surrounding counties. At the end of September, Blue*

Ridge Regional Hospital of Spruce Pine will also lose its labor-and-delivery unit, affecting the 33,000 people in Mitchell and Yancey counties who rely on that hospital.

At that point, Mission will provide birthing services only at its locations in Asheville and Marion. That means women in rural counties will have to drive at least 20 miles to give birth and — if they want to be able to see the same providers in the delivery room they saw throughout their pregnancies — to get prenatal care.

The roads through the mountains during labor pose a major concern, even without snow. The peaks in this region are the highest in the eastern United States. Except for a few major highways, such as Interstate 40, most roads weren't built by blasting through or tunneling under these hills. They wind around them, often with precipitous drops on one side.

Please refer to Attachment 4 for a copy of the article.

Mission Hospital and HCA's anti-obstetric and women's health attitude is forcing women in western North Carolina, especially women in Brevard, Franklin, and Spruce Pine, to travel 45, 75, and 68 minutes, respectively, to Mission Hospital or to a closer non-HCA owned and operated community hospital. Mission Hospital stresses that it has capacity for obstetric services in Asheville and that obstetrics and women's services are not needed at HCA-owned and operated community hospitals. But this decreases equitable access to timely, clinically appropriate, and high-quality health care, the foundational principles for the *North Carolina State Medical Facilities Plan*. Moreover, Mission Hospital's statements certainly do not support the proposition that *another provider* does not need OB and women's services. Mission Hospital is not the "voice" of health care in western North Carolina, and it certainly does not represent the patients, payors, physicians, and employees who are hungry for more and better health care options. NH Asheville will be a high-quality health care alternative to Mission Hospital and will provide the necessary obstetric and women's services to meet their needs.

On page 51, Mission Hospital states:

> *Once construction is complete, Mission Hospital will convert 5 acute care beds (2 beds on 4A East and 3 beds on 3 Fullerton) from Phase I back to much-needed observation beds, resulting in a total of 20 observation beds.*

In 2010, Mission Hospital was approved to develop 24 observation beds and now Mission Hospital proposes to operate fewer "much-needed" observation beds. Observation beds do not require an acute care bed need determination but can be developed at any time without requiring a CON, which can alleviate the need to hold patients in the Emergency Department waiting for admission.[9] The SMFP does not differentiate between ICU beds and Medical/Surgical beds, as an "acute care bed is an acute care bed." Mission Hospital can renovate any of its existing non-ICU beds to ICU standards without a CON application, as long as it does so on the main campus[10]. Mission Hospital clearly does not need more acute care beds to manage its ICU capacity. Mission Hospital proposes that only 22 out of the 67 available acute care beds will be designated as ICU beds.

On pages 54-57, Mission Hospital discusses the four-county service area:

Buncombe County:

- *While the vast majority of patients were able to stay in Buncombe County for care, the number of patients leaving the area increased due to Mission's bed constraints, as will be documented.*
    - *For example, there were significant increases in patients having to leave the region for tertiary services provided at Duke University Hospital and Atrium Wake Forest Baptist when Mission did not have a bed available.*
    - *Increasing numbers of patients had to leave the area and travel to Georgia, South Carolina and Tennessee hospitals, again due to Mission's bed constraints.*

Graham County:

- *An increasing number of patients had to leave the state to seek, in most instances, tertiary care in Georgia or other tertiary hospitals such as Atrium Carolinas Medical Center and Atrium Wake Forest Baptist, due to Mission's capacity constraints as will be discussed.*

Madison County:

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[9] Assuming the observation beds are developed on the hospital's "main campus," the additional observation beds could be developed using the main campus exemption of the CON Law. N.C. Gen. Stat. § 131E-184(g).
[10] N.C. Gen. Stat. § 131E-184(g).

- *Additional patients left the area for tertiary providers such as Duke University Hospital or providers in Tennessee, again due to Mission's capacity constraints.*

Yancey County:

- *An increasing number of patients had to be served by or stay in smaller community hospitals with significant increases in admissions for Blue Ridge Regional Hospital and Mission Hospital McDowell. In 2021, Mission was unable to accept 268 transfer requests from Blue Ridge Regional Hospital due to capacity constraints. Based on Blue Ridge's share of Yancey County, it is certain that a significant portion of these patients in need of higher acuity care were from Yancey County.*
- *In addition, there was an increase in patients having to leave the area for tertiary providers such as Atrium Wake Forest Baptist and Duke University Hospital or providers in Tennessee, again due to Missions capacity constraints.*

Mission Hospital anecdotally assumes that patients “have to leave” the region for tertiary services or travel out-of-state because of Mission Hospital’s so-called bed constraints. Mission Hospital does not validate these statements with any supporting data. These Buncombe County (4.6%), Graham County (21.0%), Madison County (5.7%), and Yancey County (10.0%) patients may be seeking specialty care at Duke University Hospital or Atrium Health that is not offered at Mission Hospital or in the case of out-of-state hospitals, patients may need hospital admissions during vacation, while at work, or because they live closer to the out-of-state hospital. Nothing indicates these patients leave Buncombe County “because of” a lack of beds at Mission Hospital. In regard to Yancey County patients, Mission Hospital again denigrates smaller community hospitals when it complains that “an increasing number of patients had to be served by or stay in smaller community hospitals.” If the appropriate level of care was provided at the smaller community hospital, then there was no need to travel to Mission Hospital. The Agency must be wary of accepting statements about Mission Hospital’s so-called capacity constraints at face value. These statements must be supported by data, which Mission Hospital did not do.[11]

NH Asheville will have the ability to serve a wide range of patients (most DRG codes) and serve those service area patients who can be better served at a community hospital that is focused on patient care, allowing Mission Hospital to gain capacity for “higher acuity” patients that they project to serve because they are a “tertiary” facility.

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[11] The Agency may recall that in the contested case that followed the 2019 Mecklenburg County Acute Care Bed Review, Atrium made similar claims of having to transfer significant numbers of patients due to capacity constraints, but these claims were disproved at the hearing. Credible data, not unsupported assertions, must be presented.

On page 60, Mission Hospital states:

An increasing number of patients are traveling from outside of Mission Hospital's service area and HSA I to receive the tertiary and trauma services available at Mission.

Figure 11

Mission Hospital Change in Patient Origin by Area - 2015-2021

Region	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	% Change
HSA I	36,689	36,891	37,712	38,149	41,317	38,485	39,289	7.1%
HSA II	63	55	63	57	57	71	78	23.8%
HSA III	100	113	93	108	144	146	157	57.0%
HSA IV	50	44	45	51	56	56	84	68.0%
HSA V	37	25	30	47	31	36	53	43.2%
HSA VI	52	46	47	77	70	82	78	50.0%
Out of State	1,096	1,217	1,253	1,231	1,345	1,451	1,753	59.9%
Total	38,087	38,391	39,243	39,720	43,020	40,327	41,492	8.9%

Source: 2016-2022 LRAs

Mission Hospital believes that patients travel from Wilmington, New Bern, Raleigh, Charlotte, etc. for tertiary and trauma services in Asheville. Patients do no such thing. They do not travel hundreds of miles to seek care at Mission Hospital. More likely, these non-HSA I residents are in in western North Carolina for *other* reasons, such as family visits, work, or vacation, and require hospital services while in western North Carolina for these *other* reasons. Essentially, these patients have to seek care at Mission Hospital because no competition exists in the service area for acute care services.

On pages 60 and 61, Mission Hospital states:

*There are seventeen existing providers of general acute care services in Mission's combined primary and secondary service areas that range in size from small critical access hospitals to Mission, the lone tertiary care center in western North Carolina. As shown in **Figure 12** below, the existing service area hospitals are categorized by bed size. The eight critical access hospitals in the service area each have less than 60 beds. Six community hospitals in the service area have between 62 and 137 beds. There are two larger community hospitals in western North Carolina, Margaret P. Pardee Memorial Hospital ("Pardee" and aka "UNC Health Pardee") and UNC Blue Ridge (composed of Morganton and Valdese locations), that have 201 and 293 beds, respectively. In contrast, Mission has 733 licensed general acute care beds, of which 151 are ICU beds {91 adult ICU, 51 NICU, and 9 pediatric ICU).*

Bed Size is not the only distinction between these facilities. The critical access hospitals and smaller community hospitals have few, if any, intensive care beds, specialty

designated beds, or other higher acuity care services. The two larger community hospitals offer an increased level of ICU and specialty bed designation, but do not come close to the multiple specialty ICU units, trauma designation, and high-acuity cardiac care designated units provided by Mission Hospital. In fact, the two larger community hospitals rely on Mission Hospital to provide this care when their patients need a higher level of care.

While this discussion is meant to show that competition exists in western North Carolina as there are seventeen hospitals, it actually does the opposite. The two "larger" community hospitals, Margaret R. Pardee Memorial Hospital (201 acute care beds) and UNC Blue Ridge (293 acute care beds), are 33 miles and 57 miles, respectively, from Mission Hospital. Mission Hospital, with 733 acute care beds, is many times larger than either of these hospitals. Throughout the application, Mission Hospital repeatedly reminds the reader that it is the primary, if not only, provider of Level IV neonatal services, pediatric ICU services, neuro/trauma ICU services, obstetric services, oncology services, and orthopedic services, as well as having more ICU beds (151 ICU beds) than the other sixteen hospital combined (117 ICU beds) and 2.5 times more general acute care beds than the next largest hospital (UNC Blue Ridge, 293 acute care beds).

Mission Hospital not only forces people to travel to Buncombe County for care by virtue of its size and range of services; it also works to siphon off patients who could easily remain in their local communities for care. Mission Hospital was recently approved to develop freestanding Emergency Departments ("FSED") proposed to be located in Arden and Candler in Buncombe County. Arden is located near the border of Henderson County, south of Asheville, and Candler is located near the border of Haywood County, west of Asheville. Mission Hospital located FSEDs close to county borders to better divert patients to Mission Hospital and away from existing Emergency Departments in adjacent counties. Mission Hospital's goal, of course, is not just to treat the emergency condition that happens to present itself at a particular moment in time but also to get patients "in the Mission Hospital system" and thereby make it more likely that patients will choose Mission Hospital for all, or most, of their health care needs. While in most situations this would be considered ordinary competition, the situation in western North Carolina generally and in Buncombe County specifically is anything but ordinary. A monopolist hospital continues to maintain its dominant position while it also attempts to weaken smaller providers in adjacent areas. Approval of the NH Asheville application is one meaningful step the Agency can take to end Mission Hospital's iron-clad grip on health care options in western North Carolina.

Please refer to Attachment 5 for copies of the Petition for Contested Case Hearing filed by AdventHealth Hendersonville and Pardee concerning the Mission Hospital FSEDs.

On page 68, Mission Hospital continues its anti-obstetric and women's services rhetoric by stating:

> *Females between the age of 15-44 represent the age cohort most likely to include the childbearing years. The females in this age cohort are estimated to increase in the total service area at a slower rate than the state of North Carolina, as shown in Figure 16 below. This cohort is also estimated to grow more slowly than the total population for most other age cohorts discussed previously from 2022 through 2027 and 2032. The females 15-44 growth rate is important because it indicates that services related to childbirth, such as OB and NICU, will not expect to grow as fast as other services. Thus, adding OB beds would not address the most rapidly growing population segments of the service area.*

Mission Hospital again emphasizes that obstetrics and women's services will not grow as fast as other services. But Mission Hospital and HCA did not maintain obstetrics and women's services at HCA-owned and operated community hospitals; they decreased equitable access to timely, clinically appropriate, and high-quality obstetrics and women's services. Moreover, the growth rate that Mission Hospital describes should not be misunderstood to mean that there is no need for an alternative provider of women's services. NH Asheville will be a high-quality health care alternative to Mission Hospital and will provide the necessary obstetric and women's services to meet their needs.

On page 73, Mission Hospital states:

> *The Agency's acute care bed need calculation as shown in the 2022 SMFP Chapter 5-Acute Care Beds, further demonstrates that the increasing demand for hospital services is focused on higher acuity need provided by major tertiary medical centers such as Mission.*
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> .
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> *Smaller community hospitals and rural providers by contrast all have a surplus of beds. Across the state, these smaller, lower acuity providers have an aggregate surplus of almost 4,300 beds. This analysis clearly demonstrates that the need for inpatient services is associated with higher acuity hospitals consistent with the trends towards overall higher acuity of inpatient care. Likewise, the bed-need for the Buncombe/Graham/Madison/Yancey service area was generated by Mission Hospital's complex and high acuity care as the regional, tertiary provider and trauma center.*

Nothing in the SMFP acute care bed need methodology or bed need determination indicates a preference for high acuity patients. All tertiary care hospitals serve both high acuity and lower acuity patients. Any patient is appropriate for admission to an acute care bed. Even Mission Hospital proposes to develop 45 of the available 67 beds (67%) as general medical/surgical beds appropriate for any acute care admission. Only 22 of the beds (33%) are intended for the ICU. If, as Mission Hospital claims, the "trend" is toward higher acuity, then Mission Hospital would be allocating more of the 67 beds for the ICU, but it did not. Again, any qualified applicant is eligible for these 67 beds, and NH Asheville is a qualified applicant. If Mission Hospital really needs more ICU capacity, it has the ability to transition some of its medical/surgical beds to ICU without adding new beds; all it would need to do is file a main campus exemption letter for any necessary structural modifications. It could add observation beds to backfill any re-distribution of acute care capacity among medical/surgical and ICU beds. It does not need to add more beds to solve these so-called problems.

Mission Hospital's assertion that acute care bed need only applies to tertiary hospitals is proven false when considering that the *Proposed 2023 SMFP* has acute care bed need determinations in Hoke County, Duplin County, Anson County, and Scotland Counties. These four counties are rural and have fewer than 53,000 residents each.

On Page 75, Mission Hospital provides the following table:

Figure 20

FY 2015 -FY 2021 Service Area Acute Care Occupancy of Licensed Beds

	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Mission Hospital	71.9%	73.6%	73.2%	74.9%	74.4%	77.4%	83.7%
Margaret R. Pardee Memorial Hospital	29.6%	28.7%	31.9%	31.5%	33.3%	32.9%	34.3%
AdventHealth Hendersonville	47.3%	41.8%	44.7%	44.2%	46.4%	44.7%	49.0%
Haywood Regional Medical Center	25.3%	28.9%	38.0%	40.9%	39.1%	40.5%	38.7%
Caldwell Memorial Hospital	43.3%	42.3%	44.6%	46.9%	48.4%	47.8%	60.8%
UNC Blue Ridge*	23.2%	22.7%	20.6%	20.3%	20.1%	19.2%	21.8%
Charles A. Cannon, Jr. Memorial Hospital	32.2%	22.2%	17.2%	15.8%	16.1%	11.5%	11.9%
Erlanger Western Carolina Hospital	32.2%	30.5%	28.6%	27.9%	28.2%	24.5%	25.7%
Harris Regional Hospital	41.8%	40.6%	39.9%	41.4%	43.7%	41.5%	42.4%
Angel Medical Center	30.0%	30.7%	25.9%	23.2%	26.5%	24.0%	24.1%
Highlands-Cashiers Hospital	6.1%	17.1%	31.1%	14.9%	31.5%	22.9%	9.3%
Mission Hospital McDowell	29.7%	30.6%	30.8%	32.3%	32.6%	31.1%	30.8%
Blue Ridge Regional Hospital	23.2%	21.6%	21.3%	12.6%	26.1%	22.4%	27.5%
St. Luke's Hospital	41.5%	43.6%	43.7%	44.6%	47.4%	40.3%	35.7%
Rutherford Regional Medical Center	32.6%	31.2%	29.2%	30.5%	25.8%	24.9%	22.1%
Swain Community Hospital	5.5%	5.1%	3.6%	2.6%	2.9%	10.5%	1.2%
Transylvania Regional Hospital	36.2%	28.2%	39.0%	35.3%	35.5%	34.6%	35.4%
North Carolina State	**57.0%**	**56.5%**	**57.6%**	**58.0%**	**59.9%**	**60.1%**	

Source: 2016-2022 SMFPs and 2022 LRAs

**Includes UNC Blue Ridge Morganton and Valdese locations on one license*

The data proves nothing. As Mission Hospital previous noted, most of these facilities are critical access hospitals or small community hospitals located in the mountainous regions of western North Carolina. The five HCA-owned and operated critical access and small community hospitals have experienced the elimination of obstetric and oncology services, as well as a decrease in fulltime physicians, and they only have occupancy rates of between 9.3 percent and 35.4 percent. This is not a glowing endorsement for Mission Health or HCA's leadership. Rather than strengthen local community access, the strategy is to force patients to Asheville.

On page 76, Mission Hospital states:

> *Mission's observation days also contribute to capacity constraints. With just 27 dedicated observation beds, Mission must serve observation patients within its licensed beds as well.*

As previously stated, observation beds can be developed at any time and without the need for a CON application. Furthermore, the actual number of observation beds is unknown. On page 76, Mission Hospital identifies 27 dedicated observation beds but has reported zero (0) observation beds on its

Hospital License Renewal Applications, since at least 2003. Please refer to Attachment 6 for a copy of the 2022 HLRA, Table B. If Mission Hospital does operate 27 observation beds, it proposes to decrease the number of observation beds to 20, which does not support the need argument presented in the application.

On page 81, Mission Hospital states:

> *Mission operates 160 total stepdown beds, which is over a third of the 433 general med/surg bed capacity. These beds are required to support Mission's large number of ICU beds and are also specialized.*
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> *.*
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> *.*
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> *.*
>
> *As mentioned earlier, the general Med/Surg bed category, which includes the stepdown beds, historically operated at close to 90 percent occupancy rate over the last two years. Stepdown beds play a role in driving up the Med/Surg Unit occupancy rate.*

As Mission Hospital highlights, only 160 of 433 general medical/surgical beds are stepdown beds. The vast majority of the general medical/surgical beds are for lower acuity admissions. NH Asheville will have the ability to serve a wide range of patients (most DRG codes) and serve those service area patients who can be better served at a community hospital that is focused on patient care, allowing Mission Hospital to gain capacity for “higher acuity” patients, including stepdown patients.

Mission Hospital spends ten pages, from page 82 through page 91, discussing trauma and Emergency Department patients to support the need for additional acute care beds. However, Mission Hospital’s status as a Level II Trauma Center is irrelevant. A “qualified” applicant only needs to provide a 24/7 Emergency Department, which NH Asheville will provide. Mission Hospital can also construct more Emergency Department bays/rooms on its main campus without a CON application and can also develop observation beds on its main campus without a CON application. In addition, Mission Hospital’s two FSEDs are projected to shift Emergency Department visits from the main campus to the FSEDs, as identified in Step 4, page 70 and Figure 24 of the application.

On page 90, Mission Hospitals repeats the same fallacy once again:

> Th*e high ED referral/transfer volume to Mission and capacity constraints detailed previously, juxtaposed with the under-utilization of small community hospitals in the service area, further demonstrates that the addition of beds at Mission is the only way to*

address the regional demand for complex and high acuity services. Only the project proposed by Mission can fully satisfy the need identified in the 2022 SMFP.

The acute care beds are also not reserved for complex and high acuity patients, and Mission Hospital's application is clearly not the only project that can satisfy the need for 67 new acute care beds in the Buncombe/Graham/Madison/Yancey acute care bed service area. A second acute care hospital in Buncombe County can provide safe and effective care to the majority of service area patients. The new hospital proposed by NH Asheville will act as a relief valve and will allow Mission Hospital to admit more "complex and high acuity patients." NH Asheville proposes to challenge the status quo, which Mission Hospital proposes to perpetuate, and introduce choice and competition in the service area. The acute care hospital proposed by Novant Health and Surgery Partners, two proven leaders in providing health care services in North Carolina, is the best alternative to meet the needs of service area patients.

On page 92, Mission Hospital provides the following table:

Figure 32

Mission Hospital Declined Transfers

	CY 2020	CY 2021	YTD 2022
Declined Transfers Due to Capacity Constraints	400	2,444	805
Total Declined Transfers	477	2,558	845
% Due to Capacity Constraints	83.9%	95.5%	95.3%

Source: Internal Data; January 2020-May 2022

CY = January to December (also equals Mission's fiscal year)

Note: YTD 2022 is through May 31, 2022

Mission Hospital fails to provide the underlying data for the table, which is extremely important if the analyst is to draw any reliable conclusion from the data. The underlying data may not support all of these "declined" transfers for the reasons stated on the chart. Moreover, Figure 21 on page 76, calculated average daily censuses for 2020 and 2021 of 551 and 614, respectively. This would indicate that on average every day there were 182 beds available in 2020 and 119 beds available in 2021. These available beds correspond to 67,000 patient days in 2020 and 44,000 patient days in 2021. It is hard to understand how transfers could be declined due to capacity constraints with so many available patient days. Further, if the data presented *is* accurate, it is reasonable to ask what Mission Hospital is doing to manage capacity. Is it increasing observation beds? Has it requested a temporary increase in acute care beds? What is HCA doing to better manage the outlying HCA hospitals? What is Mission Hospital doing

to address staffing shortages and address the concerns of its nursing workforce? Additionally, the data does not explain how long transfers were declined. Were they declined permanently or did a bed open up at some later point on the same day? Most important, were patients able to receive the care they needed elsewhere? Without the data, these questions remain unanswered, and the Agency cannot assume that Mission Hospital was unable to accept the patients because of bed capacity issues.

On page 95, Mission Hospital states:

> *There are also 6 dedicated ambulatory ORs (existing and approved) at two ambulatory surgery facilities as shown in **Figure 36** below. Of the 6 dedicated ambulatory ORs in a freestanding setting in Buncombe County, one is limited to performing eye surgeries-Asheville Eye Surgery. The remaining 5 dedicated ambulatory ORs are operated by Outpatient Surgery of Asheville, which is the only multispecialty freestanding ASF in the area. Two of the existing five ORs at Outpatient Surgery of Asheville were approved pursuant to a need determination in the 2018 SMFP, which was based specifically on the need for dedicated ambulatory surgery cases. With only one multispecialty ASC in Buncombe County, it is clear that these 5 rooms are needed in this capacity and could not appropriately be relocated to a new freestanding hospital. There are no other available ORs to support a proposal by any competing applicant to utilize the available 67 beds to create a new hospital in Buncombe County.*

Figure 36

Inventory of Buncombe County Operating Rooms

Provider	Inpatient ORs	Ambulatory ORs	Shared ORs	Excluded ORs*	CON Adjustments	Total Inventory
Mission Hospital	8	9	30	-3	0	44
Outpatient Surgery Center of Asheville	0	5	0	0	0	5
Asheville Eye Surgery	0	1	0	0	0	1
Total Buncombe County	**8**	**15**	**30**	**-3**	**0**	**50**

**Excluded rooms for trauma and C-Section*

Source: 2023 Draft SMFP, Operating Room Chapter

Mission Hospital is correct in its analysis but wrong in its conclusion. Surgery Partners d/b/a Outpatient Surgery Center of Asheville is partnering with NH Asheville and is a co-applicant in the NH Asheville application. Surgery Partners, not Mission Hospital, is in the best position to know the best way to use Surgery Partners' operating room capacity. The SMFP does not identify need determinations for dedicated ambulatory operating rooms; the SMFP only identifies need determinations for operating rooms. It just so happens that Outpatient Surgery Center of Asheville is an ambulatory surgical facility, so by definition no inpatient surgical cases are performed there. However, the Conditions of Approval for Project ID#: B-11514-18 do not include any condition restricting the approved operating rooms to only being dedicated to ambulatory surgery cases. Ambulatory is just a category, and the operating

rooms can be recategorized as shared or inpatient operating rooms with Agency approval via the NH Asheville application. Mission Hospital's supposition is not supported by reality.

On pages 100, 109, and 168, Mission Hospital presents conflicting numbers of admissions and patient days as the following tables illustrate:

Figure 38

Summary of Acute Care Beds										
	Actual	Actual	Annualized	Phase I - Interim				Project Completion		
Bed Category	CY 2020	CY 2021	2022	CY 2023	CY 2024	CY 2025	CY 2026*	CY 2027	CY 2028	CY 2029
Adult Med/Surg	519	519	519	521	521	521	543	564	564	564
Adult ICU	91	91	91	101	101	101	107	113	113	113
Ped ICU & M/S	28	28	28	28	28	28	28	28	28	28
NICU	51	51	51	51	51	51	51	51	51	51
Postpartum	44	44	44	44	44	44	44	44	44	44
Total Acute Care	**733**	**733**	**733**	**745**	**745**	**745**	**773**	**800**	**800**	**800**

**Proposed 67 beds will come online July 1, 2026 (one half of CY 2026)*

Summary of Patient Days										
	Actual	Actual	Annualized	Phase I - Interim				Project Completion		
Bed Category	CY 2020	CY 2021	2022	CY 2023	CY 2024	CY 2025	CY 2026*	CY 2027	CY 2028	CY 2029
Adult Med/Surg	151,442	168,488	171,852	173,022	174,200	175,386	176,580	177,782	178,992	180,210
Adult ICU	22,518	26,476	23,683	24,585	25,521	26,493	27,502	28,550	29,637	30,766
Ped ICU & M/S	4,477	4,572	4,626	4,632	4,638	4,644	4,650	4,656	4,662	4,668
NICU	12,577	12,556	12,951	12,997	13,044	13,091	13,138	13,185	13,232	13,280
Postpartum	11,093	11,443	12,425	12,470	12,514	12,559	12,604	12,649	12,695	12,740
Total Acute Care	**202,107**	**223,535**	**225,537**	**227,706**	**229,917**	**232,173**	**234,473**	**236,821**	**239,217**	**241,663**

Figure 39

Total Mission Projected Admissions and Patient Days

	CY 2027	CY 2028	CY 2029
Total Projected General Acute Care Admissions	42,973	43,470	43,979
Projected ALOS	5.5	5.5	5.5
Total Projected Patient Days	238,280	240,655	243,078
Projected ADC	652.8	659.3	666.0
Licensed General Acute Care Beds*	800	800	800
% Occupancy	**81.6%**	**82.4%**	**83.2%**

** General acute care beds following project completion, not including psych beds that are unaffected by this project.*

Form C.1b Projected Health Service Facility Bed Utilization upon Project Completion Mission Hospital	**Partial Year** F: 07/01/2026 T: 12/31/2026	**1st Full FY** F: 01/01/2027 T: 12/31/2027	**2nd Full FY** F: 01/01/2028 T: 12/31/2028	**3rd Full FY** F: 01/01/2029 T: 12/31/2029
Acute Care Hospital - All Beds				
Total # of Beds, including all types of beds	373	800	800	800
# of Admissions	21,030	42,551	43,053	43,568
# of Patient Days	117,237	236,821	239,217	241,663
Average Length of Stay	5.57	5.57	5.56	5.55
Occupancy Rate	86.2%	81.1%	81.9%	82.8%

It is unknown which of the six values are the correct values and calls into question the resulting pro forma financial statements and utilization.

Mission Hospital has not demonstrated the quantitative or qualitative need for 67 new acute care beds. For these stated reasons, in addition to any other reasons the Agency may discern, Mission Hospital's application is non-conforming with Criterion (3) and cannot be approved.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, … persons [with disabilities], and other underserved groups and the elderly to obtain needed health care.

Mission Hospital failed to accurately respond to Criterion (3a).

On page 110, Section D.2.a., the application asks:

> *Does the proposal in this application involve* ***reducing or eliminating some but not all*** *the service components at a health service facility?*

On page 9, health service is defined as:

> **Health service:** The term "health service," which is defined in G.S. 131E-176(9a), means "An organized, interrelated activity that is medical, diagnostic, therapeutic, rehabilitative, or a combination thereof and that is integral to the prevention of disease or the clinical management of an individual who is sick or injured or who has a disability. 'Health service' does not include administrative and other activities that are not integral to clinical management."
>
> For the purposes of completing this application form, the term health service includes but is not limited to the following services: hospital; adult care home; bone marrow transplantation; burn intensive care; cardiac catheterization; GI endoscopy; home health; hospice home care; hospice inpatient; hospice residential; inpatient psychiatric; inpatient rehabilitation; intermediate care for persons with intellectual disabilities; long-term care hospital; medical equipment; neonatal intensive care; nursing home facility; open heart; solid organ transplantation; substance use disorder treatment; and surgical (ORs).

Mission Hospital responds that it will not be reducing or eliminating some but not all of the service components at a health service facility. However, in several locations throughout the application, including pages 28, 40, 42, 48, 51, 106, 117, 118, 157, and 171; Mission Hospital states that it will be converting twelve observation beds to acute care beds with seven observation beds being permanently converted to acute care beds. An observation bed is "integral to clinical management" as Mission Hospital has noted that observation beds are "much-needed."

Additionally, Mission Hospital failed to respond to Section D.2.b.1), 2), 3), 4), and 5). A thorough review of the application shows no discussion of the reduced observation beds and their impact on Criterion (3a).

Mission Hospital failed to accurately respond to Criterion (3a) and cannot be found conforming to the criterion.

For these stated reasons, in addition to any other reasons the Agency may discern, Mission Hospital's application is non-conforming with Criterion (3a) and cannot be approved.

(4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

On page 116, Mission Hospital begins its discussion of five alternatives: 1) maintain the status quo, 2) build a separate 67-bed free-standing hospital in Buncombe County, 3) use only existing space in Mission Hospital to expand acute care beds, 4) build a vertical expansion on existing bed tower to accommodate new acute care beds, and 5) the proposed project.

However, Mission Hospital failed to discuss several alternatives to address the assumed capacity issues at Mission Hospital. These alternatives include:

- Increase Emergency Department bays/rooms – no CON application required
- Increase the number of observation beds – no CON application required
- Temporarily increase acute care beds – Licensure approval required but easy to obtain and can be renewed unlimited times, provided the requirements of the rule are satisfied.
- Convert medical/surgical beds to ICU beds – no CON application required
- Better utilize HCA-owned and operated hospitals with vacancy rates between 64.6 percent and 90.7 percent – no CON approval required.

The question is not whether 67 beds owned by Mission belong on the main campus, in a new vertical tower, or in a new hospital. The question for the Agency to decide is whether maintaining the status quo, *i.e.*, Mission Hospital as the only hospital in the acute care bed service area, is the least costly or most effective alternative. Clearly, it is not. As the Stein Letter aptly states, "[t]he continued lack of competition has predictably led to increased health care costs in western North Carolina."[12] Certainly, further expansion of Mission Hospital is not the least costly or most effective option for patients. Nor is it the least costly or most effective alternative for Mission itself, as there are multiple less costly and likely quicker ways to manage so-called capacity constraints, such as the options set out above.

For these stated reasons, in addition to any other reasons the Agency may discern, Mission Hospital's application is non-conforming with Criterion (4) and cannot be approved.

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

For the stated reasons in Criteria (3), (3a), (4), (6), (13), and (18a), in addition to any other reasons the Agency may discern, Mission Hospital's application is non-conforming with Criterion (5) and cannot be approved.

[12] Stein Letter, page 2. Attachment 1.

(6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

Mission Hospital's application is the quintessential example of unnecessary duplication. The monopolist hospital simply proposes to make itself bigger. As the Stein Letter emphasizes, this monopoly "harms residents of western North Carolina by increasing the cost, and reducing the quality, of health care services in the region."[13] Moreover, Mission Hospital fails to adequately demonstrate the need for the proposed project. *See* Criterion (3) for discussion. Consequently, Mission Hospital did not adequately demonstrate that its proposal will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

Additionally, Mission Hospital lists the 17 hospitals in western North Carolina and provides their FY2021 utilization. By the total number of hospitals in western North Carolina, Mission Hospital would have the analyst assume that acute care services are competitive, and that expanding Mission Hospital would thus not unnecessarily duplicate existing services. Throughout the application, Mission Hospital stigmatizes the smaller community hospitals as insignificant in both the services they offer, and the acute care patient days of care provided. However, those hospitals are not within the SMFP-defined acute care bed service area. These hospitals serve their local communities; they are not in direct competition with Mission Hospital.

For these stated reasons, in addition to any other reasons the Agency may discern, Mission Hospital's application is non-conforming with Criterion (6) and cannot be approved.

[13] Stein Letter, page 1. Attachment 1.

(7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

On page 131, Mission Hospital states:

> *It has historically been able to recruit and retain clinical and non-clinical personnel for all related healthcare facilities.*

This may be a true statement, historically, but currently may not be accurate. Since HCA acquired ownership of Mission Health, the nurses at Mission Hospital unionized do to poor working conditions, including short staffing and hundreds of physicians have left the medical staff of Mission Hospital.

In a letter from the registered nurses at Mission Hospital, under the letterhead of the National Nurses Organizing Committee and National Nurses United[14] as well as in the National Nurses United[15] press release, the nurses find conditions at the hospital are negatively affecting patient care and identify six factors to correct the issue, including:

- *Hire more full-time and part-time RNs, fully utilize PRNs and hire more support staff*
- *Utilize Registry/Travelers to fill staffing holes while positions are open*
- *Offer Extra Shift Bonuses and other incentives every time a unit is short*
- *Staff by acuity, not just by grid numbers and ensure that NUS's do not take patients*
- *Clearly post staffing grids on each unit and make daily assignment sheets accessible to RNs*
- *Stop disciplining RNs for discussing patient care issues and divert money from union busting into staffing*

A March 26, 2022 article by Asheville Watchdog asked the question, "How many doctors have left Mission?" The Asheville Watchdog compared the physician names on the Find a Doctor website from August 2019 to February 2022 and identified 223 doctors who no longer practice there and an additional 57 doctors still on the website but who are no longer listed as employed or affiliated with Mission Hospital.

Please refer to Attachment 7 for the related letter and articles.

[14] "The RNs of Mission" Letter. Attachment 7.

Mission Hospital has significant staffing issues. The Agency cannot know the true status of manpower at Mission Hospital or the likelihood that Mission Hospital can hire an additional 211 registered nurses or 130 clinical and support staff by the first year of the project, if it has difficulty staffing the hospital at the present time.

For these stated reasons, in addition to any other reasons the Agency may discern, Mission Hospital's application is non-conforming with Criterion (7) and cannot be approved.

[15] National Nurses United Press Release, Attachment 7.

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and … persons [with disabilities], 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 the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

(a) The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

(b) Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and … persons [with disabilities] to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

(c) That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

(d) That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

Major concerns related to HCA ownership were raised prior to the agreement to acquire Mission Health System. The concerns were so great that HCA had to agree to 15 Commitments that fall under the scope of an Independent Monitor before the North Carolina Attorney General's Office would authorize the acquisition. These Commitments are listed below and fall under four categories:

- Retain Services and Hospitals
- Invest in Community Health and Wellbeing
- Invest in Facilities
- Other Commitments

RETAIN SERVICES AND HOSPITALS	1	Keeping material facilities open for at least 10 years *(until 2029)*
	2	Continuing specified services for at least 10 years *(until 2029)*, with relief available under limited circumstances after 5 years for the five Local Hospitals
	3	Dogwood Health Trust has a right to bid if hospitals are planned to be closed or sold
	4	Continue Long Term Acute Care services at St. Joseph campus for 2 years *(Note this commitment expired on Jan 31, 2021)*
INVEST IN FACILITIES	5	Complete the new Mission Hospital North Tower *(Opened in late 2019)*
	6	Build a new 120-bed behavioral health hospital in Asheville within 5 years of obtaining the necessary permits
	7	Build a replacement hospital for Angel Medical Center within 5 years of obtaining the necessary permits
	8	Spend $232 million in general capital expenditure within five years
INVEST IN COMMUNITY HEALTH AND WELLBEING	9	Provide $25 million over five years for an innovation / investment fund
	10	Spend $750,000 per year in Community Contributions in years 2 through 10 *(Note this commitment applies from Jan 31, 2020)*
	11	Continue certain community activities, services and programs for at least 12 months *(Note this commitment expired Jan 31, 2020)*
	12	For 10 years *(until 2029)*, maintain the agreed Uninsured and Charity Care policy and thereafter, maintain policies for the treatment of indigent patients
OTHER COMMITMENTS	13	Provide graduate medical education ("GME") for 10 years at no less than the current [2018/19] levels, subject to the availability of similar GME funding
	14	Participate in Medicare and Medicaid programs for at least ten years
	15	Each year, provide an Annual Report and Cap Ex Report that summarize compliance with certain terms of the agreement

Because of a perceived lack of trust, HCA, and thus Mission Hospital, was required to sign commitments related to maintaining uninsured and charity care policies for a mere 10 years and to thereafter maintain a policy for the treatment of indigent patients. HCA was also required to commit to participating in the Medicare and Medicaid programs for at least 10 years.

Additionally, concerns are so great that an independent monitor had to be established; still, concerns and complaints are directed to the Attorney General Office relating to whether or not HCA is living up to these commitments. Please refer to Attachment 3 for copies of these articles.

While the Agency does not compare applicants' conformity to the review criteria, it is useful to review how Mission Hospital's charity care policy works in practice, when compared to the more generous Novant Health policy that will be used at NH Asheville Medical Center. The following table highlights the payments required for patient at or below 300% of the federal poverty guidelines.

Charity Care Policy Comparison

	Mission Hospital			Novant Health		
% of Federal Poverty Guideline	**0-100%**	**101-200%**	**201-300%**	**0-100%**	**101-200%**	**201-300%**
Less than $1,500 Balance	Balance up to $1,500			$0	$0	$0
Over $1,500 Balance	$0	$0	3% of annual household income	$0	$0	$0

For the above-stated reasons, in addition to any other reasons the Agency may discern, Mission Hospital's application is non-conforming with Criterion (13) and cannot be approved.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost-effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

On page 156, Mission Hospital states:

As described in detail in the response to GEN-3 Basic Principles in Section B, Mission's proposed project will have a positive impact on the cost-effectiveness, quality, and access by medically underserved groups for the proposed services.

Mission Hospital's response is typical for a hospital with strong community support and no issues. However, adding more beds to the monopolist hospital that has had a plethora of issues both before and after the 2019 acquisition does not have a positive impact on cost effectiveness, quality, and access. The Stein Letter plainly articulates the Criterion (18a) deficiency in the Mission Hospital application. The lack of competition is hurting residents of western North Carolina. The antitrust lawsuits are piling up, with local governments and citizens demanding relief from higher prices, lower quality and lack of options. There is clearly a need for another provider of acute care services in the Buncombe/Graham/Madison/Yancey service area, as well as western North Carolina, and that provider should be NH Asheville. The following table highlights the inpatient admission and inpatient surgery market shares for Mission Hospital, ranked by average market share, which indicate a significant lack of competition in western North Carolina.

Patient County Origin	Inpatient Admissions	Inpatient Surgery	Average Market Share
Madison	91.8%	87.7%	89.8%
Buncombe	90.7%	84.2%	87.5%
Yancey	63.2%	81.0%	72.1%
Mitchell	48.6%	74.4%	61.5%
McDowell	46.3%	58.6%	52.5%
Macon	43.2%	60.8%	52.0%
Swain	47.3%	55.2%	51.3%

Patient County Origin	Inpatient Admissions	Inpatient Surgery	Average Market Share
Transylvania	41.2%	59.3%	50.3%
Graham	43.3%	55.5%	49.4%
Haywood	43.5%	52.9%	48.2%
Jackson	39.2%	47.2%	43.2%
Clay	34.8%	48.6%	41.7%
Cherokee	27.4%	47.1%	37.3%
Henderson	31.3%	37.8%	34.6%
Polk	23.4%	30.0%	26.7%
Rutherford	13.0%	20.1%	16.6%

Source: Healthcare Planning 2022 Reports (2021 Data); https://info.ncdhhs.gov/dhsr/mfp/patientoriginreports.html#2022rpt

The Attorney General's March 16, 2022 letter details four significant problems at Mission Hospital that render this application inconsistent with Criterion (18a):

- *The high prices that Mission Health charges patients in Western North Carolina;*
- *Mission Health's price transparency efforts;*
- *Mission Health's alleged use of an anti-steering provision in contracts with physicians to stifle competition in western North Carolina; and*
- *Understaffing at Mission Health facilities.*[16]

In the section discussing the anti-steering provision, the Attorney General states:

> *Moreover, when coupled with Mission Health's overwhelming market power in western North Carolina, and its alleged practice of requiring insurers to cover Mission Health services that are not competitively priced if the insurers wish to include access to Mission Health's 'must have' facilities in their plans, this practice leaves consumers with little choice but to receive all medical care from Mission Health, regardless of the price or quality of care.*[17]

The Attorney General's July 25 comments in opposition specifically link the lack of competition and the problems caused by the lack of competition to Criterion (18a)[18]. It is difficult to think of a better example of an application that is non-conforming to Criterion (18a) than the Mission Hospital application.

[16] *See* March 16, 2022 Letter. Attachment 1.
[17] March 16, 2022 Letter. Attachment 1.
[18] *See* Stein Letter. Attachment 1.

HCA's tenure in Asheville has been difficult since the beginning, highlighting the need for a hospital in the Buncombe/Graham/Madison/Yancey service area that is operated by a different provider. The following timeline is a summary of the articles published in the *Asheville Citizen Times* newspaper, illustrating some of the problems since the purchase of Mission Health by HCA Healthcare in February 2019.

- February 2019 – HCA Healthcare acquires Mission Health for $1.5 billion.
- January 2020 – Cashiers-area residents concerned with changes at Highland-Cashiers Hospital, no full-time doctor, and sense of lower overall staffing levels negatively impacting quality of care.
- February 2020 – HCA-Mission Hospital independent monitor hears from residents concerning uncomfortable delays during hospital stays, inconsistent billing practices and charity care policies.
- August 2020 – Mission Health decides to "centralize" chemotherapy services from Mission Medical Oncology locations in Franklin, Brevard, Marion, and Spruce Pine to Asheville.
- September 2020 – Mission Health to stop primary care services in Biltmore Park and Candler.
- September 2020 – Mission Hospital registered nurses vote to unionize.
- May 2021 – Twelve providers leave Transylvania Regional Hospital. Twenty-five physicians from a single medical practice leave Mission Hospital. Mission Health contracts staffing through Team Health. Patients routinely wait 18-24 hours in the emergency department to get admitted due to shortage of nurses. Mission Hospital's Leapfrog and CMS ratings decrease between Fall 2020 and Spring 2021 to a Leapfrog "B" grade.
- August 2021 – HCA-Mission Hospital has class-action, anti-trust lawsuit filed accusing the hospital of exorbitant prices and declining quality.
- September 2021 – NC Attorney General receives 290 complaints concerning HCA-Mission Health.
- September 2021 – Two long-time members of the Transylvania Regional Hospital board of directors resign after previously supporting the sale of Mission Health to HCA Healthcare.
- January 2022 – Mission Health employees voice concerns about safe working conditions, thinning staffing levels, and national COVID-19 protections.
- March 2022 – 223 physicians have left Mission Hospital since 2019.

- March 2022 – Attorney General's Office had 'Great Concerns' Mission Health System – HCA Healthcare deal was rigged 'From the Beginning'
- April 2022 – Angered and dissatisfied, some Mission Hospital patients seek health care elsewhere.
- April 2022 – AG Stein hears western North Carolina leaders on Mission sale fallout, says he's eyeing merger law changes.
- May 2022 – HCA-Mission Hospital class-action, anti-trust lawsuit under review.
- June 2022 – HCA, Mission hit with 2nd Western North Carolina antitrust suit in a year by the city of Brevard.
- July 2022 – HCA-Mission Hospital class-action, anti-trust lawsuit continues.
- July 2022 – North Carolina Attorney General Josh Stein files comments in opposition to Mission Hospital's CON application.
- July 2022 – Buncombe County and the city of Asheville file joint class action lawsuit against HCA-Mission Hospital

The foregoing is not an exhaustive list of the problems. In June 2021, Attorney General Josh Stein noted a "concerning number" of complaints had been filed against Mission over the preceding year, and that he has dedicated one of his employees to keeping track of all the complaints about Mission Health. Please refer to the NH Asheville CON, Exhibit C.4. (Tab 10) for copies of the articles. To NH Asheville's knowledge, no other North Carolina hospital has a dedicated employee in the Attorney General tracking complaints.

For these stated reasons, in addition to any other reasons the Agency may discern, Mission Hospital's application is non-conforming with Criterion (18a) and cannot be approved.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

On page 28, Mission Hospital states:

> *MH Mission Hospital, LLLP has been providing high quality care to Buncombe, Graham, Madison and Yancey Counties and the surrounding region for well over 100 years.*

This may be a true statement, historically, but currently is not accurate. Since HCA acquired ownership of Mission Health, the nurses at Mission Hospital unionized due to poor working conditions, including short staffing and hundreds of physicians have left the medical staff of Mission Hospital.

In a letter from the registered nurses at Mission Hospital, under the letterhead of the National Nurses Organizing Committee and National Nurses United[19], the nurses state:

> *However, currently conditions at the hospital are such that patient care is suffering.*

A March 26, 2022 article by Asheville Watchdog asked the question, "How many doctors have left Mission?"[20] The Asheville Watchdog compared the physician names on the Find a Doctor website from August 2019 to February 2022 and identified 223 doctors who no longer practice there and an additional 57 doctors still on the website but who are no longer listed as employed or affiliated with Mission Hospital. In interviews, several physicians who left Mission Hospital stated:

- *Bedside care is knowing what patients and families are suffering. Patient suffering is off their (HCA management's) radar.*
- *When HCA came in, there were so many emails on metrics. We've gone from providing amazing care to mediocre care.*
- *When a patient is lying in a bed, it's not just the doctor, it's the whole team that care for the patient. If you don't have nurses, CNAs, and the whole ancillary staff, you can't do it properly. When you decimate the team, the patient suffers.*

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[19] "The RNs of Mission" Letter. Attachment 7.
[20] "How many doctors have left Mission?" Attachment 7.

Finally, the Stein Letter plainly articulates the Criterion (20) deficiency in the Mission Hospital application. The Stein Letter[21] states:

> *This lack of competition harms residents of western North Carolina by increasing costs and reducing the quality of health care services in the region. Awarding Mission this Certificate of Need would exacerbate the lack of competition and resulting harm.*

Please refer to Attachment 7 for the nurse's letter and Attachment 1 for the Attorney General letter.

For these stated reasons, in addition to any other reasons the Agency may discern, Mission Hospital's application is non-conforming with Criterion (20) and cannot be approved.

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[21] See Stein Letter. Attachment 1.

Comments in Opposition to

Project ID # B-12233-22

AdventHealth Asheville, Inc.

For the reasons stated in these comments and any other reasons the Agency may discern, the AdventHealth Asheville application is not approvable because it does not conform to all applicable review criteria and rules and is comparatively inferior to the NH Asheville application. NH Asheville has submitted the most effective alternative to developing the 67 acute care beds in the 2022 Buncombe/Graham/Madison/Yancey Service Area Review as demonstrated in its application, the NH Asheville CON application should be approved for the following reasons:

- The NH Asheville application fully conforms to all applicable review criteria and is comparatively superior to the AdventHealth Asheville application.
- The NH Asheville application offers choice and competition within Buncombe County and the broader service area.
- Novant Health is a proven, effective operator of community hospitals in multiple North Carolina locations.
- Like all Novant Health facilities, NH Asheville will have generous and easy-to-understand charity care and related policies that ensure care for all.
- The NH Asheville application combines the expertise of two leading providers, Novant Health and Surgery Partners, both of which have extensive experience in North Carolina and in western North Carolina (Novant Health via its outpatient imaging affiliate, MedQuest, in Buncombe County, and Surgery Partners via Outpatient Surgery Center Asheville).
- Both Novant Health and Surgery Partners have received numerous accolades for quality care.
- Both Novant Health and Surgery Partners are employers of choice.
- NH Asheville is a qualified applicant as defined in the *2022 SMFP*, whereas AdventHealth Asheville is not a qualified applicant.

Application Specific Comments

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

(2) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

On page 24, AdventHealth Asheville responds to Section B.1.b.2) as the following shows,

1. b. **Applications submitted in response to a need determination for acute care beds in Chapter 5 of the SMFP** – Document that the applicant meets all the requirements of a "qualified applicant," which are as follows:

(3) Does the hospital or will the hospital provide inpatient medical services to both surgical and non-surgical patients?

Yes

AdventHealth Asheville will provide inpatient medical services to both surgical and non-surgical patients. As documented in subpart 4 below and Section Q, AdventHealth Asheville projects to serve inpatient medical patients and inpatient surgical patients.

As the *2022 SMFP* does not include a need determination for any operating rooms within the Buncombe/Madison/Yancey OR Service Area, AdventHealth Asheville cannot propose the development of an operating room and, as a result, cannot be a qualified applicant.

As the following four tables highlight, an operating room is essential to being a licensed ambulatory surgical facility, excluding gastrointestinal endoscopy rooms as defined in General Statute 131E-176(1b), or licensed acute care hospital in North Carolina.

Ambulatory Surgical Facilities

General Statute 131E-176(1b) states:

(1b) Ambulatory surgical facility. – A facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional, or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide ***at least one designated operating room or gastrointestinal endoscopy room*** *and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under Part 4 of Article 6 of this Chapter, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program, and which are performed in a physician's or dentist's office does not make that office an ambulatory surgical facility.*

Note: **Bold** emphasis added.

According to the *2022 SMFP,* Table 6A, there are 59 licensed ambulatory surgical facilities in the state. The following table identifies the number of licensed ambulatory surgical facilities in North Carolina that are licensed without at least one operating room or gastrointestinal endoscopy room:

Healthcare Facility	# Licensed	# Licensed Without an Operating Room or Gastrointestinal Endoscopy Room
Ambulatory Surgical Facility	59	0

Source: 2022 SMFP, Table 6A.

As the table highlights, there are no licensed ambulatory surgical facilities in North Carolina that operate without at least one operating room or gastrointestinal endoscopy room.

According to the *2022 SMFP,* Table 6A, there are 27 ambulatory surgical facilities under development in the state. The following table identifies the number of ambulatory surgical facilities under development in North Carolina that are being developed without at least one operating room or gastrointestinal endoscopy room:

Healthcare Facility	# Under Development	# Licensed Without an Operating Room or Gastrointestinal Endoscopy Room
Ambulatory Surgical Facility	27	0

Source: 2022 SMFP, Table 6A.

As the table highlights, there are no ambulatory surgical facilities under development in North Carolina that will be licensed and operate without at least one operating room or gastrointestinal endoscopy room.

According to the Applications Logs[22], there is one ambulatory surgical facility under CON review in the state. The following table identifies the number of ambulatory surgical facilities under CON review in North Carolina that are being proposed without at least one operating room or gastrointestinal endoscopy room:

Healthcare Facility	# Under CON Review	# Licensed Without an Operating Room or Gastrointestinal Endoscopy Room
Ambulatory Surgical Facility	1	0

Source: CON Section, Application Logs.

As the table highlights, there are no ambulatory surgical facilities under CON review in North Carolina that are proposed without at least one operating room or gastrointestinal endoscopy room.

[22] https://info.ncdhhs.gov/dhsr/coneed/applicationlogs.html

Acute Care Hospitals

According to the *2022 SMFP,* page 33 and Table 5A, "There are 108 licensed acute care hospitals in the state." The following table identifies the number of licensed acute care hospitals in North Carolina that are licensed without at least one operating room:

Healthcare Facility	# Licensed	# Licensed Without an Operating Room
Acute Care Hospital	108	0

Source: 2022 SMFP, Table 5A and Table 6A.

As the table highlights, there are no licensed acute care hospitals in North Carolina that operate without at least one operating room.

According to the *2022 SMFP,* Table 6A, there are six acute care hospitals under development in the state. The following table identifies the number of acute care hospitals under development in North Carolina that are being developed without at least one operating room:

Healthcare Facility	# Under Development	# Under Development Without an Operating Room
Acute Care Hospital	6	0

Source: 2022 SMFP, Table 6A.

As the table highlights, there are no acute care hospitals under development in North Carolina that will be licensed and operate without at least one operating room.

According to the Applications Logs[23], there are three acute care hospitals under CON review in the state. The following table identifies the number of acute care hospitals under CON review in North Carolina that are being proposed without at least one operating room:

Healthcare Facility	# Under CON Review	# Under CON Review Without an Operating Room
Acute Care Hospital	3	1

Source: CON Section, Application Logs.

As the table highlights, AdventHealth Asheville is the only North Carolina healthcare facility out of the 204 licensed, under development, or under review in North Carolina without at least one operating room.

Additionally, AdventHealth Asheville identifies three reasons for their belief that they can be a qualified applicant without developing an operating room to provide inpatient medical services to surgical patients.

First, on page 41, AdventHealth attempts to avoid the necessity of developing an operating room by stating the following,

> *The following details the manner in which the proposed surgical procedure rooms will comply with state and federal requirements for the provision of surgical services at AdventHealth Asheville.*
>
> *DHSR Construction & Licensure Sections*
>
> *NC DHHS DHSR has determined that procedure rooms will be regulated in licensed hospitals only to the extent that such procedure rooms meet the Federal Life Safety Code requirements. See Exhibit C.1.2. AdventHealth Asheville will design and develop the proposed procedure rooms safely and appropriately to accommodate the surgical needs of the patients it projects to serve. As evidenced by Section 9.e of the annual hospital license renewal application form, the DHSR Licensure and Certification Section is cognizant of the fact that acute care hospitals routinely perform surgical procedures in hospital-based procedure rooms. Therefore, there is no prohibition on AdventHealth Asheville's ability to develop procedure rooms for the purposes of performing surgical services so long as the rooms meet Federal Life Safety Code requirements, which AdventHealth Asheville intends to do.*

In this statement, AdventHealth Asheville attempts to create a new classification of procedure room, that being "surgical procedure rooms." However, neither the NC DHHS DHSR letter included in Exhibit C.1.2. or the annual hospital license renewal application form refers to "surgical procedure rooms."

[23] https://info.ncdhhs.gov/dhsr/coneed/applicationlogs.html

The following is the referenced NC DHHS DHSR letter included in Exhibit C.1.2.

November 27, 2012

Mr. Frank Kirschbaum
Nexsen Pruet, LLC
4141 Parklake Avenue, Suite 200
Raleigh, NC 27612

RE: Surgical Care Affiliates v. DHHS, 12 CVS 09409 and 12 CVS 010478

Dear Mr. Kirschbaum,

Subject to any applicable statutory dollar thresholds, The North Carolina Department of Health And Human Services, Division of Health Service Regulation, has determined that procedure rooms will solely be regulated in licensed ambulatory surgical facilities and hospitals, and only to the extent required to ensure that such procedure rooms meet the requirements of the Federal Life Safety Code as referenced in the North Carolina Administrative Code. Neither the Acute and Home Care Licensure and Certification Section, nor the Construction Section will require any determination from the Certificate of Need Section prior to authorizing the use or establishment of a procedure room.

Sincerely,

Drexdal Pratt, Director
Division of Health Service Regulation

The NC DHHS DHSR letter clearly refers to "licensed" ambulatory surgical facilities and hospitals with the understanding that the ambulatory surgical facility and/or hospital is already licensed and as previously demonstrated, there are no licensed ambulatory surgical facilities or hospitals in North Carolina that do not have at least one operating room. There is no inference that the proposed use of procedure rooms can or will result in a "licensed" hospital.

Next, AdventHealth Asheville refers to "Section 9.e. of the annual hospital license renewal application form." However, even in their own 2022 Renewal Application for Hospitals: AdventHealth Hendersonville there is no mention of either "surgical procedure rooms" or procedure rooms as the following Section 9.e. shows:

9. Surgical Operating Rooms, Procedure Rooms, Gastrointestinal Endoscopy Rooms, Surgical and Non-Surgical Cases and Procedures

e) Surgical Cases by Specialty Area

Enter the number of surgical cases performed in licensed operating rooms only, by surgical specialty area. Count each patient undergoing surgery as one case regardless of the number of surgical procedures performed while the patient was having surgery. Categorize each case into one specialty area – the total number of surgical cases is an unduplicated count of surgical cases. **Count all surgical cases performed only in licensed operating rooms. The total number of surgical cases should match the total number of patients listed in the Patient Origin Tables on pages 28 and 29.**

Surgical Specialty Area	Inpatient Cases	Ambulatory Cases
Cardiothoracic (excluding Open Heart Surgery)	9	4
Open Heart Surgery (from 8.(a) 4. on page 9)	0	
General Surgery	136	773
Neurosurgery	158	186
Obstetrics and GYN (excluding C-Sections)	68	527
Ophthalmology	0	884
Oral Surgery/Dental	1	2
Orthopedics	360	1,426
Otolaryngology	24	556
Plastic Surgery	12	38
Podiatry	1	29
Urology	53	432
Vascular	17	105
Other Surgeries (specify)		
Number of C-Sections Performed in Dedicated C-Section ORs	209	
Number of C-Sections Performed in Other ORs	0	
Total Surgical Cases Performed Only in Licensed ORs	1,048	4,962

Never-the-less, AdventHealth cannot produce an annual hospital license renewal application form that shows the only location within a licensed acute care hospital where their surgical program is conducted is in "surgical procedure rooms" or procedure rooms.

Finally, AdventHealth Asheville identities the following Medicare Conditions of Participation regulation as support to not needing an operating room to be a licensed acute care hospital in North Carolina.

> (a) The hospital must be in compliance with applicable Federal laws **related to the health and safety of patients.**
>
> (b) The hospital must be -
>
> (1) **Licensed**; or
>
> (2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.[12]

The Medicare State Operations Manual, App. A, interprets this requirement as follows:

> Hospitals applying for initial Medicare certification as a hospital or hospitals currently participating in Medicare must, among other things, meet the statutory definition of a hospital under section 1861(e) of the Act. Section 1861(e)(7) of the Act further requires that a hospital located in a state which provides for the licensing of hospitals . . . **must be licensed in accordance with state law or approved as meeting standards for licensing as established by the agency of the State** or locality responsible for the licensing of hospitals. While a facility may have a license from a state to operate as a hospital or may have been approved by a state as a hospital under state or local standards and authorities, that facility may still not meet the Medicare definition of a hospital as per the Act. **The criteria used by a state to determine that a hospital meets the requirements for state licensure as a hospital [are] not the same criteria used to define a hospital for the purpose of participation in Medicare**, and each state has its own criteria and standards for licensure.[13]

A review of the Acute and Home Care Licensure and Certification Section website shows the following statement of purpose:

Establish an Acute Care Hospital

Purpose: This procedure describes the steps needed for the licensure and certification of a new acute care hospital. Pursuant to North Carolina General Statute 131E-79, the North Carolina Medical Care Commission has rulemaking authority for this category. Rules in Title 10A of the North Carolina Administrative Code (10A NCAC 13B) apply.

General Statute 131E-79 refers to Article 5. Hospital Licensure Act. Part 1. Article Title and Definitions. The terms "surgical procedure room" or procedure room are not identified in this statute as meeting the requirement for licensure. However, the term operating room is identified.

10A NCAC 13B refer to the "Licensing of Hospitals." The terms "surgical procedure room" or procedure room are not identified in this administrative code as meeting the requirements for licensure. However, the term operating room is identified. Specifically, under Section .4600 – Surgical and Anesthesia Services it states,

10A NCAC 13B .4603 SURGICAL AND ANESTHESIA STAFF

(a) The facility shall develop processes which require that each individual provides only those services for which proof of licensure and competency can be demonstrated.

(b) The facility shall require that:

(1) when anesthesia is administered, a qualified physician is immediately available in the facility to provide care in the event of a medical emergency;

(2) a roster of practitioners with a delineation of current surgical and anesthesia privileges is available and maintained for the service;

(3) an on-call schedule of surgeons with privileges to be available at all times for emergency surgery and for post-operative clinical management is maintained;

(4) the **operating room** is supervised by a qualified registered nurse or doctor of medicine or osteopathy; and

(5) an **operating room** register which shall include date of the operation, name and patient identification number, names of surgeons and surgical assistants, name of anesthetists, type of anesthesia given, pre- and post-operative diagnosis, type and duration of surgical procedure, and the presence or absence of complications in surgery is maintained.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996.

Note: **Bold** emphasis added.

And under Section .5500 – Supplemental Rules for Hospitals Providing Living Organ Donation Transplant Services it states,

10A NCAC 13B .5505 PERIOPERATIVE CARE AND FACILITY SUPPORT

(a) The donor surgical team shall have primary concern and responsibility for the donor's care and welfare throughout his or her entire hospital stay. The donor surgical team consists of the donor surgeon, his or her surgical and medical partners, fellows, residents, and physician assistants or nurse practitioners.

(b) Preoperative Preparation

(1) The facility shall have the ability to allow donors to bank a minimum of one unit of blood before surgery. Facilities shall have the ability to store and transfuse autologous blood;

(2) The transplant coordinator or another team member shall be assigned the responsibility of providing updates to the families of both the donor and transplant recipient during the surgical procedures; and

(3) For live donor liver procedures, surgeries shall be scheduled only when staffing will be available for the postoperative period. If surgery is scheduled on a Thursday or Friday, the hospital shall ensure that there is adequate attending physician, resident physician, physician assistant or nurse practitioner, and registered nursing coverage during the weekend.

(c) Postoperative Care

(1) After live donor nephrectomy, the patient shall receive post-operative care equivalent to that provided for abdominal procedures under general anesthesia; and

(2) For live liver donors:

(A) Day 0-1: The live adult liver donor shall receive care in the intensive care unit (ICU) or post-anesthesia care unit (PACU);

(B) Day 2: If stable and cleared for transfer by the donor surgical team, the donor shall be cared for in a hospital unit that is dedicated to the care of transplant recipients or a hospital unit in which patients who undergo hepatobiliary resectional surgery are provided care. Liver donors shall not at any time be cared for on any other unit unless a specific medical condition of the donor warrants such a transfer;

(C) The donor shall be evaluated at least daily by a liver transplant attending physician with documentation in the medical record;

(D) The donor surgical team shall be responsible for the clinical management of the donor;

(E) The patient care staff shall be familiar with the common complications associated with the donor and transplant recipient operations and have appropriate monitoring in place to detect these problems if they arise; and

(F) If there is an emergent complication requiring re-operation, these patients shall be prioritized for access to the **operating room** based on the facility's **operating room** policies and guidelines.

(d) Medical Staffing. For live donor nephrectomy patients, there shall be continuous physician coverage available for patient evaluation as needed. These patients shall be provided post-operative care equivalent to patients undergoing a nephrectomy.

History Note: Authority G.S. 131E-75; 131E-79; 143B-165;
Eff. April 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

Note: **Bold** emphasis added.

As the administrative code makes clear, it is within an operating room that surgical and anesthesia procedures are performed to be licensed as an acute care hospital. There is no mention of the terms "surgical procedure room" or procedure room within this administrative code for licensing of hospitals.

After completing their argument, on page 42, AdventHealth Asheville states,

> *For information purposes, if a need determination for ORs is established for the Buncombe/Graham/ Madison/Yancey county service area, AdventHealth Asheville would pursue a certificate of need application to develop ORs at the proposed facility. If approved, a portion of the procedure rooms proposed in this CON would instead be developed as licensed operating rooms. In an alternative scenario, if legislation were to be enacted that would allow the development of ORs without regard to CON approval, a portion of the procedure rooms proposed in this CON would instead be developed as licensed operating rooms. In either scenario, AdventHealth does not anticipate*

additional capital expenditure would be required because the procedure rooms will be designed and constructed to safely accommodate the surgical needs of patients proposed to be served by AdventHealth Asheville.

If AdventHealth Asheville's argument for supporting the licensure of an acute care hospital with no operating room is validated, then it makes no sense for AdventHealth Asheville to say at some time in the future AdventHealth Asheville will develop operating rooms. Under AdventHealth Asheville's reasoning, AdventHealth Asheville would never need to develop a single operating room because they could simply develop more "surgical procedure rooms" to accommodate their surgical services.

Implications

If AdventHealth Asheville's argument for being found in compliance with the requirements of a qualified applicant is approved by the Agency, then any future new acute care hospital can be developed without the need for operating rooms. More importantly, if a hospital can be licensed without an operating room by utilizing only procedure rooms, then so can an ambulatory surgical facility, excluding ambulatory surgical facility that are licensed by utilizing gastrointestinal endoscopy room. If the Agency agrees that surgical services can be performed in a procedure room to establish the licensure of an acute care hospital, then it will have to follow suit and agree that an ambulatory surgical facility can be licensed without an operating room utilizing only procedure rooms, excluding gastrointestinal endoscopy rooms. This would allow any person to develop an ambulatory surgical facility and bypass the Certificate of Need process, if they only develop procedure rooms and can develop the facility for less than $4,000,000 and be licensed.

AdventHealth Asheville proposes to be licensed and then operate as an acute care hospital in North Carolina without a licensed operating room.

For these stated reasons, in addition to any other reasons the Agency may discern, AdventHealth Asheville's application is non-conforming with Criterion (3) and cannot be approved.

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

For the stated reasons in Criteria (3) and (12), in addition to any other reasons the Agency may discern, AdventHealth Asheville's application is non-conforming with Criterion (5) and cannot be approved.

(12) “Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.”

AdventHealth Asheville is proposing a 67-bed acute care hospital, comprising 226,910 square feet of new construction, at 264 Enka Heritage Parkway.

In Section P – Proposed Timeline, AdventHealth proposes to receive its CON on January 2, 2023, and then begin construction on March 15, 2023. This is a mere 2 ½ months or 75 days after receiving its CON. AdventHealth Asheville also proposes to construct the 226,910 square foot facility in 20 months from March 15, 2023, through November 15, 2024. NH Asheville is proposing a construction period of 30 months.

35 Days from Projected Decision Date (1st date certificate may be issued)		January 2, 2023
4	Construction / Renovation Contract(s) Executed	03/15/2023
5	25% of Construction / Renovation Completed (25% of the cost is in place)	07/01/2023
6	50% of Construction / Renovation Completed	01/01/2024
7	75% of Construction / Renovation Completed	06/15/2024
8	Construction / Renovation Completed	11/15/2024

NovantHealth has recently constructed 3 acute care hospitals, with the pre-construction time period lasting up to 12 months and the construction period lasting up to 28 months. NH Asheville does not believe it is reasonable, especially during this period of labor and material shortages, to assume a 2 ½ month pre-construction time period or a 20-month construction period.

For these stated reasons, in addition to any other reasons the Agency may discern, AdventHealth Asheville’s application is non-conforming with Criterion (12) and cannot be approved.

COMPARATIVE ANALYSIS

The Agency has the discretion to choose the comparative factors it believes are most relevant to the review. Neither the number of factors nor the type of factors is dictated by statute or past decisions, as each review is unique. This review is especially unique because of the competitive landscape in this market. This is the first time in decades that anyone other than Mission Hospital has proposed to build a new hospital in Buncombe County. Likewise, it is the first time in decades that a provider not already routinely serving Buncombe County residents has proposed hospital services in the service area. Thus, like Mission Hospital, AdventHealth Asheville's application does not provide a new hospital competitor for service area residents.

The problems caused by the lack of competition in the service area are real and well documented. NH Asheville respectfully submits that in light of the unique circumstances of this review, the Agency make competition the focal point of the comparative analysis. In fact, the Agency would be within its authority to make competition the *only* comparative factor in this review. Even if a commonly used factor, such as "scope of services" were to favor Mission Hospital, because it is a tertiary hospital and NH Asheville is not, crediting Mission Hospital as the more effective alternative is contrary to the letter and purpose of the CON Law, due to the lack of competition. As earlier noted, and as the Stein Letter makes clear, this review has the potential to make a real and positive difference for patients, physicians, payors, and employees who struggle every day with the problems caused by the Mission Hospital monopoly. Accordingly, NH Asheville respectfully requests that the Agency take the opportunity to change the status quo.

CONCLUSION

For the reasons stated in these comments in addition to any other reasons the Agency may discern, Mission Hospital's CON application should be denied because Mission Hospital will not decrease costs, increase competition, or increase quality of care, AdventHealth Asheville's CON application should be denied because AdventHealth Asheville does not propose to develop operating rooms and, as such cannot be a "qualified applicant," and the NH Asheville CON application should be approved.

As demonstrated in its application and shown in these comments, the NH Asheville CON application should be approved for the following reasons:

- The NH Asheville application fully conforms to all applicable review criteria and is comparatively superior to the Mission Hospital application.
- The NH Asheville application offers choice and competition within Buncombe County and the broader service area.
- NH Asheville is a qualified applicant, whereas AdventHealth Asheville is not a qualified applicant.
- Novant Health is a proven, effective operator of community hospitals in multiple North Carolina locations.
- Like all Novant Health facilities, NH Asheville will have generous and easy-to-understand charity care and related policies that ensure care for all.
- The NH Asheville application combines the expertise of two leading providers, Novant Health and Surgery Partners, both of which have extensive experience in North Carolina and in western North Carolina (Novant Health via its outpatient imaging affiliate, MedQuest, in Buncombe County, and Surgery Partners via Outpatient Surgery Center Asheville).
- Both Novant Health and Surgery Partners have received numerous accolades for quality care.
- Both Novant Health and Surgery Partners are employers of choice.
- NH Asheville will strongly support women's health by offering obstetrics, a health service that Mission Hospital has closed at other hospitals including Transylvania Regional Hospital (2015), Blue Ridge Regional Hospital (2017), and Angel Medical Center (2017). NH Asheville is not able to reopen Mission Hospital's closed obstetric services, but NH Asheville can offer women a meaningful choice in health care providers.

Attachment 1

JOSH STEIN
ATTORNEY GENERAL

REPLY TO:
KEVIN ANDERSON
SENIOR DEPUTY
ATTORNEY GENERAL
kander@ncdoj.gov

July 25, 2022

Ms. Julie Faenza
Project Analyst
North Carolina Department of Health and Human Services
Healthcare Planning and Certificate of Need Section
Division of Health Service Regulation
2704 Mail Service Center
Raleigh, NC 27699-2704

[DELIVERED VIA EMAIL TO: dhsr.con.comments@dhhs.nc.gov]

RE: Mission Hospital's Certificate of Need Application (Project ID: B-012232-22)

Dear Ms. Faenza:

In accordance with N.C. Gen. Stat. § 131E-185(a1)(1), Attorney General Josh Stein submits these comments on the application (Project ID: B-012232-22) filed by Mission Hospital ("Mission") to add acute care beds to its facility in Asheville. Mission's application is one of three competing applications to meet the need identified in the 2022 State Medical Facilities Plan for 67 acute care beds in Buncombe, Graham, Madison, and Yancey Counties.

The Department of Health and Human Services should deny Mission's application.[1] Currently, Mission has almost no competition for acute care in Buncombe County. The lack of competition is the result of Mission's unique history. Mission effectively operated as a legislatively authorized monopoly for over twenty years, and no new hospitals have opened even after Mission's arrangement with the State ended in 2016. This lack of competition harms residents of western North Carolina by increasing the cost, and reducing the quality, of health care services in the region. Awarding Mission this Certificate of Need would exacerbate the lack of competition and resulting harm. Accordingly, the Department should deny Mission's application and instead approve an application from a qualified competitor.[2]

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[1] Comments to the Department may include "[d]iscussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with relevant review criteria, plans, and standards." N.C. Gen. Stat. § 131E-185(a1)(1)(c).

[2] The Attorney General takes no position as between the competing applications of AdventHealth (Project ID: B-012233-22) and Novant Health (Project ID: B-012230-22).

"Hospitals with a dominant position in their markets . . . are a major (perhaps *the* major) driver of cost in healthcare." Thomas L. Greaney and Barak D. Richman, Am. Antitrust Inst., Consolidation in Provider and Insurer Markets: Enforcement Issues and Priorities at 3 (2019). For many patients, health care costs are the product of negotiations between the patient's commercial insurer and health care providers. *See* Cong. Budget Off., The Prices That Commercial Health Insurers and Medicare Pay for Hospitals and Physicians Services at 3 (2022), *available at* www.cbo.gov/publication/57422. When a single health care provider dominates a region, it can charge commercial insurers higher rates, which the insurer passes on to patients and employers in the form of higher premiums. Greaney and Richman, *supra* at 3. The absence of choice, meanwhile, allows providers to charge higher rates even while offering lower quality care. *See* Heather Boushey and Helen Knudsen, White House Council of Economic Advisers, *The Importance of Competition for the American Economy* (July 9, 2021), *available at* https://www.whitehouse.gov/cea/written-materials/2021/07/09/the-importance-of-competition-for-the-american-economy/. Lack of competition and inordinate market power can also provide a health care provider with countless other ways to increase costs and harm consumers, especially in light of the complex, byzantine nature of our health care system.

The statutory criteria by which the Department reviews Certificate of Need applications recognizes the importance of competition. Applicants for a Certificate of Need must "demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed." N.C. Gen. Stat. § 131E-183(a)(18a).

Mission's application cannot demonstrate that it will enhance competition, lower costs, or improve quality. Mission has almost no competition for acute care services in Buncombe County, and has not for nearly three decades. In 1996, Mission merged with its only competitor, St. Joseph's Hospital, leaving Mission as the only provider of inpatient general acute care hospital services in Buncombe and Madison Counties. The State sanctioned this arrangement until 2016 by granting Mission a Certificate of Public Advantage ("COPA"). The COPA immunized Mission from State and Federal antitrust liability, while subjecting Mission Hospital to enhanced state oversight.[3]

In 2016, the General Assembly repealed the COPA. Although that repeal ended Mission's statutory immunity from antitrust suit, it also eliminated the State's enhanced oversight over Mission. And the elimination of the COPA did nothing to introduce competition into western North Carolina's health care market. In 2019, HCA Healthcare, Inc., an out-of-state, for-profit health care company, purchased Mission with full awareness of Mission's preexisting dominance of the health care market in western North Carolina.

The continued lack of competition has predictably led to increased health care costs in western North Carolina. One lawsuit brought by individual health care consumers in western North Carolina alleges that premiums in western North Carolina are more than 50% higher than in the State's metropolitan areas. *See* Compl. ¶ 235, *Davis v. HCA Healthcare, Inc.*, No. 21-

[3] *See* Hospital Cooperation Act of 1993, N.C. Sess. L. 1993-529, § 5.2 (*codified at* N.C. Gen Stat. §§ 131E-192.1 through 131E-192.13 (repealed)).

CVS-3276 (N.C. Super. Ct. Aug. 10, 2021). The Attorney General, meanwhile, has received numerous complaints about the cost and quality of Mission's care.

The Certificate of Need application process for 67 acute care beds in Buncombe Graham, Madison, and Yancey Counties provides a much-needed opportunity to introduce competition into western North Carolina's health care market. The Department should seize that opportunity, as required by N.C. Gen. Stat. § 131E-183(a)(18a), by denying Mission's application.

Sincerely,

Kevin Anderson
Senior Deputy Attorney General
Director, Consumer Protection Division

JOSH STEIN
ATTORNEY GENERAL

REPLY TO:
LLOGAN R. WALTERS
ASSISTANT ATTORNEY
GENERAL
LWALTERS@NCDOJ.GOV

March 16, 2022

Greg Lowe
President, North Carolina Division
HCA Healthcare
509 Biltmore Avenue
Asheville, NC 28801

Dear Mr. Lowe:

Thank you for your July 2, 2021 response to my letter of June 11, 2021. Our office has reviewed your response as well as the responses to individual complaints that your counsel provided our office in November 2021. We have concluded that we need additional information to evaluate the complaints and your replies. Additionally, since my last letter, the North Carolina Department of Justice has received additional complaints regarding Mission Health. Our office would also appreciate your response to the problems alleged in those complaints. Thus, I write to express concerns regarding the following issues:

- The high prices that Mission Health charges patients in Western North Carolina;
- Mission Health's price transparency efforts;
- Mission Health's alleged use of an anti-steering provision in contracts with physicians to stifle competition in western North Carolina; and
- Understaffing at Mission Health facilities.

Mission Health's High Prices

The Department is extremely concerned about the high price of health care in western North Carolina. For many services, Mission Health charges insurers prices far higher than the state-wide average price for the same service. Unsurprisingly, these costs are passed onto consumers. For example, insurance premiums within Mission Health's service area are 30% higher than premiums in nearby counties, and over 50% higher than premiums in the State's other large metropolitan areas. Complaints note that, at the same time Mission Health charges high prices, Mission Health is enjoying significant profits while the quality of care at Mission Health facilities declines. Given that health care costs in North Carolina are already higher than in many other states, Mission Health's high prices are especially concerning. Our office is interested in any information you can provide that explains the high cost of care at Mission Health facilities.

Mission Health's Price Transparency Efforts

In addition to allegations that Mission Health's prices are exceptionally high, our office is also aware of allegations that Mission Health is not transparent about its prices. Although our office determined that Mission Hospitals complied with the basic minimum federal regulations regarding hospital price transparency, we informed you of our concern that Mission Hospitals' federally mandated machine-readable list of standard charges is confusing and, in some cases, functionally inoperable. Mission Health's duty to patients in western North Carolina may demand greater transparency. We hope to continue to improve pricing transparency for patients and seek to understand Mission Health's efforts regarding its machine-readable list of standard charges.

Anti-Steering Provision

In light of Mission Health's high prices, our office is concerned about allegations that Mission Health has included provisions in its contracts with insurers that preclude insurers from directing patients to lower-cost facilities in western North Carolina. This alleged practice, whereby HCA prohibits insurers from incentivizing or encouraging patients from receiving care from less expensive providers, limits consumers' understanding about the costs and quality of care from other providers in the area and forces patients and their insurers to pay more for health care. Moreover, when coupled with Mission Health's overwhelming market power in western North Carolina, and its alleged practice of requiring insurers to cover Mission Health services that are not competitively priced if the insurers wish to include access to Mission Health's "must have" facilities in their plans, this practice leaves consumers little choice but to receive all medical care from Mission Health, regardless of the price or quality of care. In your response, I request that you provide the most recent coverage contracts that Mission Health has entered with insurers.

Understaffing at Mission Health Facilities

Finally, our office continues to receive complaints that Mission Health facilities are chronically understaffed. As you recall, my previous letter specifically addressed complaints about primary care and OB/GYN physicians leaving Mission Health facilities, reduced nursing and administrative staff in emergency departments, and a reduction in core services. Additional complaints received after your response raise similar concerns. Specifically, our office has received complaints that Transylvania County Regional Hospital had no mammogram technician and was not offering mammogram services, that Mission Hospitals' mental health facilities are inadequately staffed, and ENT and cancer treatment practices have left Mission Health. Additionally, several complaints reported that, because of understaffing, Mission Health facilities were unclean, and patients experienced long wait times.

Your response to my last letter explained that Mission Health's understaffing was the result of a "challenging labor market" and have also cited the ongoing COVID-19 pandemic as reasons for understaffing. However, health care systems across the state face these same issues without resulting in the same high number of complaints to this office. In your letter, you mentioned that Mission Health was implementing sign-on bonuses and increased hourly rates to attract workers. In your response, I request that you provide information about whether those measures succeeded and, if not, what other measures Mission Health intends to take to ensure its facilities are fully staffed.

* * *

The complaints referenced above make troubling allegations regarding patients not receiving proper care, core functions being reduced and not replaced, and subpar conditions regarding basic sanitation and cleanliness. Our office will continue to review complaints we receive. We expect HCA to fully abide by the promises and legal commitments it made in its Asset Purchase Agreement and to otherwise remain in full compliance with all applicable legal requirements.

Please provide all information or documentation that HCA believes will either provide an explanation for or contest the assertions above within ten (10) days of the date of this letter.

I look forward to your response to this letter. Please do not hesitate to contact me if you any questions.

Sincerely,

Llogan R. Walters
Assistant Attorney General

cc: Ron Winters, Independent Monitor
Rachel Ryan, Dogwood Health Trust
Jason Ehrlinspiel, Counsel for HCA
Kevin Anderson, Senior Deputy Attorney General
Tiffany Y. Lucas, Deputy General Counsel
W. Swain Wood, First Assistant Attorney General and General Counsel

Attachment 2

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NORTH CAROLINA

BUNCOMBE COUNTY, NORTH CAROLINA and CITY OF ASHEVILLE, NORTH CAROLINA, on their own behalf and on behalf of all others similarly situated, **Plaintiffs,** **v.** **HCA HEALTHCARE, INC., HCA MANAGEMENT SERVICES, LP, HCA, INC., MH MASTER HOLDINGS, LLLP, MH HOSPITAL MANAGER, LLC, MH MISSION HOSPITAL, LLLP, ANC HEALTHCARE, INC. f/k/a MISSION HEALTH SYSTEM, INC., and MISSION HOSPITAL, INC.,** **Defendants.**	**No.: 1:22-cv-147** **JURY TRIAL DEMANDED**

CLASS ACTION COMPLAINT

Plaintiffs Buncombe County, North Carolina ("Buncombe") and City of Asheville, North Carolina ("Asheville") ("Asheville," and "Buncombe" together, "Plaintiffs"), individually, and on behalf of all others similarly situated, bring this action against Defendants HCA Healthcare, Inc., HCA Management Services, LP, and HCA, Inc. (collectively "HCA"), and MH Master Holdings, LLLP, MH Hospital Manager, LLC, MH Mission Hospital, LLLP, ANC Healthcare, Inc. f/k/a Mission Health System, Inc, and Mission Hospital, Inc. (collectively, "Mission") ("Mission" and "HCA" together, "Defendants"). Plaintiffs allege as follows:

I. NATURE OF THE ACTION

1. This case arises at a time when providing affordable health care insurance plans for working families and governmental employees, such as firefighters, police, and teachers, and controlling health care costs have been top priorities for Plaintiffs and members of the proposed Class, the business communities they serve, and state and local governments in Western North Carolina. As described in detail in this Complaint, Defendants' conduct has restricted competition in the health care markets defined herein, thereby substantially and artificially inflating health care prices paid by Plaintiffs and proposed Class member health plans. This proposed class action for unlawful restraint of trade and monopolization seeks to redress these harms. Plaintiffs seek damages and injunctive and equitable relief under Sections 1 and 2 of the Sherman Antitrust Act, 15 U.S.C. §§ 1 and 2.

2. Plaintiffs are a North Carolina county (Buncombe) and a North Carolina municipality (Asheville) which operate self-funded health insurance plans for their employees and their families. Plaintiffs directly pay one or more Defendant(s) for health care for their insureds and have been and continue to be injured thereby because Defendants' prices are artificially inflated due to the ongoing anticompetitive conduct alleged herein.

3. Plaintiffs seek to represent a class of similarly situated North Carolina health insurance plans, including self-funded and commercial insurers ("health plans" or the "Class," which is more specifically defined in paragraph 190 below), each of which paid directly to one or more Defendant(s) on behalf of their insureds for health care services in the relevant markets alleged herein.

4. Defendants have injured Plaintiffs and members of the Class through an anticompetitive scheme (the "Scheme") involving the illegal maintenance and enhancement of

monopoly power in two health care services markets (the "Relevant Services Markets"): (1) the market for inpatient general acute care ("GAC") in hospitals ("GAC Market"), consisting of a broad group of medical and surgical diagnostic and treatment services that include overnight hospital stays ("GAC Services"); and (2) the market for outpatient care ("Outpatient Market"), encompassing all the medical services that are not GAC Services ("Outpatient Services").

5. Defendants dominate the Relevant Services Markets in at least two geographic areas (the "Relevant Geographic Markets"): (1) the "Asheville Region," consisting of Buncombe and Madison Counties; and (2) the "Outlying Region," consisting of Macon, McDowell, Mitchell, Transylvania, and Yancey Counties, or in the alternative with respect to Outlying Region, (3) each of the separate counties in the Outlying Region. Together, the Relevant Services Markets and the Relevant Geographic Markets are, collectively, the "Relevant Markets."

6. In 1995 Mission Health System merged with St. Joseph's Hospital, Mission's only significant competitor in the Relevant Geographic Markets. As a result, Mission's flagship Asheville hospital ("Mission Hospital-Asheville") became the dominant provider of GAC Services in the Asheville Region with substantial monopoly power in the GAC Market in that region.

7. From 1995 until 2016, Mission was immunized from antitrust liability by a state statute under which it was issued a Certificate of Public Advantage ("COPA"). The COPA is a form of regulation in which a hospital is permitted to operate with monopoly power in exchange for subjecting itself to state oversight.

8. In 2016, after years of lobbying at the behest of Mission executives, the State repealed the COPA, leaving in place an unregulated organization with monopoly power. After

repeal, Mission and HCA Healthcare, Inc. (the parent company of the subsequent purchaser of Mission's assets) lost any immunity from suit under the Sherman Act.[1]

9. In January 2019, Mission sold its assets to MH Master Holdings, LLLP, an HCA subsidiary and part of one of the world's largest for-profit hospital chains. HCA owns over 200 hospitals across the United States. HCA has been the subject of approximately twenty Federal Trade Commission ("FTC") antitrust proceedings over the past two decades. HCA purchased Mission's assets, in significant part, because Mission had monopoly power in the GAC Market in the Asheville Region—monopoly power that HCA knew it could exploit to maintain and enhance Mission's monopoly power in the Relevant Markets.

10. Today, HCA controls more than 85 percent of the GAC Market, based on patient volume,[2] in the Asheville Region with an 89.1% share in Madison County and an 88.6% share in Buncombe County. The commercial insurers and self-funded payors (collectively, "health plans") that comprise the proposed Class, at all times relevant to this Complaint, had no choice but to include Mission's hospital system in the GAC Market in their insurance networks. There is no practical alternative for these services in this region.

11. Due to the conduct challenged in this Complaint, HCA also enjoys monopoly power in the GAC Market in the Outlying Region, with a 70-plus% market share in each county in the Outlying Region: Yancey (88.3% market share); Mitchell (85.4% market share); Transylvania (78.7% market share); McDowell (76.4% market share); and Macon (74.7% market share).

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[1] Hereinafter, unless otherwise indicated, "HCA" refers to the parent company that bought Mission and that parent's subsidiaries, while the term "Defendants" refers to HCA and the remnant companies of the former Mission.

[2] These market shares and all others reported in the Complaint are based on patient volume unless otherwise indicated.

12. One of the reasons HCA found Mission attractive as a business opportunity is that, beginning in or about 2017, Mission, under its immediate pre-buyout executive management team, had embarked on a continuing, multifaceted coercive Scheme designed to foreclose competition from rivals, to maintain or to enhance its monopoly power in the Relevant Markets, and ultimately to charge supracompetitive prices—prices above their competitive level—for GAC and Outpatient Services. The anticompetitive conduct challenged in this Complaint began before HCA's acquisition of Mission, and HCA supercharged the Scheme after it acquired Mission. The Scheme includes, among other anticompetitive features: (1) "all-or-nothing" tying arrangements requiring health insurance plans to contract with all of Mission's (and later HCA's) GAC and Outpatient Services as a bundle, *i.e.*, take everything together or nothing at all; (2) exclusionary requirements in the form of anti-steering and anti-tiering provisions, which prevent insurance companies from steering insureds to less expensive and/or higher quality options as a means to promote competition and reduce prices; (3) "gag" clauses that prevent insurers from communicating with employers and patients about the prices they pay for health care and thus determine how best to reduce costs; and (4) other anticompetitive conduct relating to the negotiation of pricing for GAC Services. HCA continued and reinforced each of the foregoing elements of the Scheme after it acquired Mission in January 2019.

13. Mission, and then HCA after purchasing Mission, have abused their monopoly power in GAC Market in the Asheville Region (the "tying market") to maintain or enhance their monopoly power in multiple "tied" markets, including the Outpatient Market in the Asheville Region, and the GAC Market and Outpatient Market in the Outlying Region (or, alternatively, in the five individual counties that make up that region). The Defendants have accomplished this, in part, by tying GAC and Outpatient Services together, in both the Asheville Region and Outlying

Region, and giving all health plans no choice but to include all of Defendants' services together as "in network" services.

14. As explained below, when health services are "out of network" for a health plan, they typically will be much more costly to patients than if included "in network." By tying their services and regions together, Defendants coercively rob health plans of the ability to choose which service and providers are in or out of network. At the heart of the Scheme is this immutable fact: because of Mission's monopoly power, health plans require in-network access to HCA's GAC Services in the Asheville Region in order to offer any minimally viable health plan in the Relevant Geographic Markets. But because HCA ties access to that (tying) product to the other (tied) products and regions, HCA can coerce and has coerced health plans to contract for HCA's tied services. This tying prevents health plans from using the presence of actual or potential competing services in the tied markets as leverage to negotiate lower prices from HCA. Additionally, this coercive tying reinforces HCA's monopoly power in the tying market because it substantially reduces the ability of actual or potential competitors in the tying market to compete against HCA's all-or-nothing bundle. The tying thus enables HCA to discourage the sort of competition that lowers prices and improves quality. As a result, the Scheme has enabled HCA to continue to charge higher prices and to offer lower quality for its services in both the tying and tied markets as compared to a more competitive state of affairs in which HCA did not engage in the anticompetitive Scheme.

15. In addition, and also as part of the Scheme, Mission and HCA have abused their monopoly power in GAC Market in the Asheville Region to impose exclusionary requirements in the form of coercively imposed anti-steering provisions in their contracts with health plans for both GAC and Outpatient Services in all Relevant Geographic Markets. These anti-steering

provisions prevent health plans from providing information or from encouraging patient use of less expensive and higher quality non-Defendant providers of GAC and Outpatient Services in the Relevant Geographic Markets. As a result, and together with the other conduct challenged in this Complaint, these anti-steering provisions prevent health plans from encouraging price competition between Mission/HCA and actual and potential rivals, and also reduce the incentive for rivals and potential rivals to use lower prices as a means to gain patients in all of the Relevant Markets (including both product and geographic markets).

16. Mission and HCA have further abused their monopoly power in the GAC Market in the Asheville region by imposing exclusionary requirements in the form of tiering prohibitions. Tiered networks, a form of steering, enable health plans to sort providers into tiers based on their cost and, often, quality relative to other similar providers who treat comparable patients. Health plans with tiering provisions give preferred rankings to providers with higher quality and lower cost, incentivizing members to use providers in the higher tiers. Tiering is an important means by which the plans help control their costs and reduce health care prices. Like its use of anti-steering provisions, its imposition of anti-tiering provisions forecloses competition and otherwise impedes beneficial competitive outcomes.

17. Defendants also have abused their monopoly power in the GAC Market in the Asheville Region to impose "gag" clauses that inhibit the ability of employer self-funded health plans to know the prices they pay for their employees' health care and use that information to help reduce health care costs.

18. By preventing health plans that must offer access to HCA's GAC Services in the Asheville Region from contracting with, or steering patients to, HCA's actual or potential competitors in the Relevant Markets, Defendants' Scheme substantially forecloses competition in

all of the Relevant Markets. The abilities to (a) assemble different combinations of in-network providers, including a mix of HCA and non-HCA providers, and/or (b) use incentives to steer patients to less expensive or higher quality alternatives, are essential methods that health plans use to promote competition among health care providers and thus control health care costs and ultimately prices to health plans. By substantially foreclosing these avenues of promoting competition, HCA has maintained and bolstered its monopoly power in the Relevant Markets, causing anticompetitive effects including higher health care prices and lower quality health care.

19. There are no legitimate procompetitive benefits for HCA's Scheme let alone benefits that could offset the competitive harms caused by the Scheme.

20. HCA itself has recognized the negative effects that unregulated hospital monopolies inflict on our nation's health care system. Indeed, in 2018—while it was negotiating its takeover of Mission—HCA complained to the Florida Agency for Health Care Administration about a competitor's "monopolistic dominance," stating that "patients suffer from lack of access to care in their community" and "have little to no health care provider choice," and "[t]his type of monopolistic environment within the health care market stifles innovation and breeds a culture that negatively impacts the cost and quality of care."

21. Defendants' Scheme has had clear and continuing anticompetitive effects. It has enabled Defendants to raise prices substantially above competitive levels, to reduce health care choices, to reduce quality through dramatically worsened facility conditions and patient service, and to reduce patient access to GAC and Outpatient Services in the Relevant Markets. Relatedly, HCA has refused to comply with a federal rule implemented by the Department of Health and Human Services in January 2021 that was intended to increase transparency in health care pricing.[3]

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[3] https://www.cms.gov/hospital-price-transparency/hospitals.

Were HCA to comply and reveal to consumers and regulators the true prices that it charges, the public would know that HCA's prices in the Relevant Markets are by far the highest in North Carolina.

22. The Scheme has caused antitrust injury to Plaintiffs and the proposed Class of similarly situated health plans, each of whom has paid supracompetitive prices for lower quality services in the Relevant Markets.

23. Without this Court's intervention, the future of health care competition in Western North Carolina—traditionally a destination for many, including retirees from across the nation, in part because of its prior reputation for high-quality, low-cost health care—is at risk. Plaintiffs and the proposed Class have been and continue to be injured by the artificially inflated supracompetitive prices due to Defendants' Scheme and Plaintiffs bring this action for damages and equitable relief to enjoin the continuation of HCA's unlawful conduct.

II. THE PARTIES

A. Plaintiffs

24. Plaintiff **Buncombe County** ("Buncombe") is a county in Western North Carolina, with a population of 269,452 as of the 2020 Census. Out of 100 counties in North Carolina, it is the seventh largest county by population. Included within Buncombe are parts of the Blue Ridge Parkway, Pisgah National Forest, and Nantahala National Forest. Buncombe has had for over 30 years, and continues to have, a self-funded health plan for its employees and their families. The plan covers 1,416 active Buncombe employees and over 3,700 people total, including employees' families and retirees. Buncombe has paid artificially inflated prices directly to one or more Defendants for GAC and Outpatient Services in the Asheville and Outlying Region markets due

to Defendants' unlawful conduct challenged herein. The Buncombe County Board of Commissioners has duly authorized this lawsuit to be brought in Buncombe's name.

25. Plaintiff **City of Asheville** ("Asheville") is a city in Buncombe County, North Carolina, with a population of 94,589 as of the 2020 Census. It is the county seat of Buncombe County. Asheville is the eleventh most populous city in North Carolina out of 532 incorporated municipalities. Asheville has had for over 10 years, and continues to have, a self-funded health plan for its employees and their families. The plan covers 1,122 active Asheville employees. Asheville has paid artificially inflated prices directly to one or more Defendants for GAC and Outpatient Services in the Asheville and Outlying Region markets due to Defendants' unlawful conduct challenged herein. The Asheville City Council has duly authorized this lawsuit to be brought in Asheville's name.

B. Defendants

26. Defendant **HCA Healthcare, Inc.** is a Delaware corporation with a principal place of business in Nashville, Tennessee. Its principal office address is One Park Plaza, Nashville TN 37203, and its registered agent, The Corporation Trust Company, is located at Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware 19801.

27. Through its subsidiary, MH Master Holdings, LLLP, HCA Healthcare, Inc. purchased the assets of Mission in 2019.

28. HCA Healthcare, Inc. is publicly held and listed with the Securities and Exchange Commission ("SEC"). HCA Healthcare, Inc. or its predecessors in interest have been named as respondents in prior antitrust proceedings brought by the FTC and/or the U.S. Department of Justice ("DOJ"), including with regard to hospital acquisitions and divestments of improper mergers.

29. HCA Healthcare, Inc. is a defendant in a class-action lawsuit filed in the Superior Court of North Carolina, Buncombe County, on August 10, 2021, brought by a proposed class of insured residents in Western North Carolina, alleging similar conduct to that alleged herein, and claiming artificially inflated out-of-pocket costs and health insurance premiums for GAC and outpatient services. *See Davis, et al. v. HCA Healthcare, Inc., et al.*, No. 21-CV-03276 (N.C. Super. Ct.). The proposed Class of health plans here does not include class members from the *Davis* lawsuit.

30. HCA Healthcare, Inc. is the world's largest for-profit hospital chain. It owns and operates over 200 hospitals in 21 states. HCA's revenues were over $51 billion for 2020.[4] Its net income was over $3.7 billion in 2020.

31. Defendant **HCA Management Services, LP** is a Delaware limited partnership with its principal place of business in Nashville, Tennessee. Its principal office address is One Park Plaza, Nashville TN 37203, and its North Carolina registered agent, CT Corporation System, is located at 160 Mine Lake Court, Suite 200, Raleigh, NC 27601.

32. HCA Management Services, LP was formed in 1999. It applied for a certificate of authority to do business in North Carolina on December 28, 2005 and is currently registered to do business in North Carolina. It is listed on the HCA Healthcare website as the entity responsible for that website.[5]

33. HCA Management Services, LP entered into a confidentiality and nondisclosure agreement with ANC Healthcare, Inc. f/k/a Mission Health System, Inc. on or about July 11, 2017.

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[4] By comparison, according to the National Association of State Budget Officers, North Carolina's total expenditures in fiscal year (FY) 2020 were $60.2 billion, including general funds, other state funds, bonds, and federal funds. HCA Healthcare is number 62 on the Fortune 500.

[5] https://hcahealthcare.com.

At that time, MH Master Holdings, LLLP which was only first organized on August 23, 2018, did not yet exist. Pursuant to negotiations conducted under that nondisclosure agreement, various Mission and HCA entities entered into an Asset Purchase Agreement ("APA"), dated August 2018, and an amended Asset Purchase Agreement ("Amended APA"), dated January 2019, facilitating the sale of relevant Mission system assets to HCA.

34. Defendant **HCA, Inc.** is a Delaware corporation with its principal place of business in Nashville, Tennessee. Its principal office address is One Park Plaza, Nashville TN 37203.

35. HCA, Inc. is the plan sponsor of a defined contribution plan established January 1, 1983, which provides retirement benefits for all eligible employees of HCA, Inc. or its affiliates (and their families). It is the sponsor of the HCA 401(k) Plan, with employer identification number 75-2497104, and a total number of participants of 387,421 as of 2019. On information and belief, HCA, Inc. is the plan sponsor of a retirement benefit plan for numerous employees associated with the North Carolina Division of HCA Healthcare, Inc. HCA, Inc. has been a respondent or defendant in prior proceedings challenging various aspects of HCA's business practices.[6]

36. Defendant **MH Master Holdings, LLLP** applied for a certificate of authority to do business in North Carolina on August 23, 2018. It filed its most recent annual report with the North Carolina Secretary of State, Department of Corporations, on or about April 6, 2021, describing itself as being engaged in the "healthcare related business."

37. MH Master Holdings, LLLP's general partner is MH Hospital Manager LLC. MH Master Holdings, LLLP is a 99% limited partner in MH Mission Hospital, LLLP. Under the

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[6] *See, e.g.,* U.S. DOJ press release, dated June 26, 2003. (https://www.justice.gov/archive/opa/pr/2003/June/03_civ_386.htm).

Amended APA, MH Master Holdings, LLLP is authorized to do business under brand names including "Mission Health," "Mission Health System," and the "HCA" brand.

38. The "corporate bio" used at the end of many HCA NC press releases, opens, under the header "ABOUT MISSION HEALTH," by stating that "Mission Health [is] an operating division of HCA Healthcare [and] is based in Asheville, North Carolina…."

39. Defendant MH Master Holdings, LLLP identifies itself as and holds itself out as being a part of the North Carolina Division of HCA Healthcare, Inc. *See, e.g.*, job postings on websites like "Health Careers," listing open positions at "HCA Healthcare—North Carolina Division."

40. HCA states in public website content that its "North Carolina Division," also known as, "Mission Health," is "based in Asheville, North Carolina."

41. Per HCA press releases, since February 2019, Greg Lowe has been "president of the newly created Asheville-based North Carolina Division, which comprises the recently purchased Mission Health system of six hospitals in western North Carolina." Upon information and belief, Mr. Lowe resides in North Carolina.

42. Defendant **MH Hospital Manager, LLC** is a Delaware limited liability company with a principal place of business in Tennessee or North Carolina. Its registered agent, c/o CT Corporation System, is located at 160 Mine Lake Court, Suite 200, Raleigh NC 27615, or, at its office at 509 Biltmore Avenue, Asheville, NC 28801, or c/o HCA Healthcare, One Park Plaza, Nashville, TN 37203.

43. Defendant MH Hospital Manager, LLC applied for a certificate of authority to do business in North Carolina on August 22, 2018. Its annual report dated April 6, 2021, describes the nature of its business as "healthcare related business."

44. Defendant MH Hospital Manager uses the assumed business name, "North Carolina Division," pursuant to an assumed name certificate dated April 22, 2019, filed with the Buncombe County Register of Deeds. It described the counties where the assumed business name will be used to engage in business as "All 100 North Carolina counties."

45. Defendant **MH Mission Hospital, LLLP** is a Delaware limited liability limited partnership, with a principal place of business in North Carolina. Its registered agent's office address, c/o CT Corporation System, is 160 Mine Lake Court, Suite 200, Raleigh, NC 27615, and its principal office is located at 509 Biltmore Avenue, Asheville, NC 28801.

46. Effective July 2019, Chad Patrick became the Chief Executive Officer of what HCA describes as "HCA Healthcare's North Carolina Division's flagship 763-bed Mission Hospital" and has resided in Asheville since Summer 2019. On information and belief, the HCA corporate entity employing Mr. Patrick is MH Mission Hospital, LLLP.

47. Defendant **ANC Healthcare, Inc. f/k/a Mission Health System, Inc.** is a North Carolina nonprofit corporation which had its principal place of business in Asheville, North Carolina through 2019. It remains an active corporation incorporated under North Carolina law. In or about February 2019, its principal office was moved to Florida. Its registered agent, Corporation Service Company, is located at 2626 Glenwood Avenue, Suite 550, Raleigh, NC 27608. Its current office address is 425 West New England Avenue, Suite 300, Winter Park, FL 32789.

48. ANC Healthcare, Inc. f/k/a Mission Health System, Inc. was incorporated in 1981 as a North Carolina nonprofit corporation. As of the date of the filing of this lawsuit, it remains a nonprofit corporation incorporated under North Carolina law. *See* Articles of Restatement for

Nonprofit Corporation filed February 1, 2019. The corporation is not defunct, nor has it been dissolved and in its most recent Articles of Restatement it describes its duration as "unlimited."

49. As of 2015, ANC Healthcare, Inc. described itself as an "integrated healthcare system," which provided "medical care, hospital care" and "the delivery of health care services to persons resident in Western North Carolina and surrounding areas."

50. During the period commencing in or about 2010 and continuing through and including January 2019, Ronald Paulus ("Paulus") was the President and Chief Executive Officer of ANC Healthcare, Inc. f/k/a Mission Health System, Inc.

51. Defendant **Mission Hospital, Inc.** is a North Carolina nonprofit corporation, which had its principal place of business in Asheville, North Carolina for many years through 2019. It remains an active nonprofit corporation incorporated under North Carolina law. In or about February 2019, its principal office was moved to Florida. Its registered agent, Corporation Service Company, is located at 2626 Glenwood Avenue, Suite 550, Raleigh, NC 27608. Its current office address is 425 West New England Avenue, Suite 300, Winter Park, FL 32789.

52. Defendant Mission Hospital, Inc. was incorporated in 1951 as a North Carolina nonprofit corporation. As of the date of the filing of this lawsuit, it remains a nonprofit corporation incorporated under North Carolina law. *See* Articles of Restatement for Nonprofit Corporation filed February 1, 2019. The corporation is not defunct, nor has it been dissolved and in its most recent Articles of Restatement it describes its duration as "unlimited."

53. Defendants ANC Healthcare, Inc. f/k/a Mission Health System, Inc. and Mission Hospital, Inc. are each identified as sellers under the Amended APA. *See* Amended APA, p. 1. Under the Amended APA's terms, ANC Healthcare, Inc. f/k/a Mission Health System, Inc. and Mission Hospital, Inc. remain liable for pre-asset sale ownership or operations of the hospital

business. *See* Amended APA, § 2.4 (in which the HCA entities who function as the buyers under the Amended APA purported to exclude from their liability "any Liabilities related to the ownership or operation of the Business or the Purchased Assets prior to the Effective Time").

54. Under the Amended APA, the sellers represented and warranted that they "have operated, and are operating, the Business… and their properties in compliance in all material respects with all applicable Laws," up through the sale date. Amended APA, § 4.11(a)(i). However, they did not comply with numerous such laws, as alleged herein.

III. JURISDICTION AND VENUE

55. This Court has jurisdiction over this action under Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 & 2; Sections 4 and 16 of the Clayton Act, 15 U.S.C. §§ 15c & 26; and under 28 U.S.C. §§ 1331 and 1337.

56. This Court has personal jurisdiction over Defendants because they are domiciled and/or registered to transact business in North Carolina, and they have transacted business in North Carolina relevant to this antitrust action.

57. Venue is proper in this District under Section 12 of the Clayton Act, 15 U.S.C. § 22, and 28 U.S.C. § 1391. Defendants conduct substantial business in this district and their conduct both gives rise to Plaintiffs' claims occurring in this district and also affected interstate commerce.

IV. RELEVANT HISTORICAL BACKGROUND

A. Mission Acquired Monopoly Power Under the COPA

58. Mission Hospital was originally formed over a century ago as a local Asheville charitable institution. When founded in the 1880s, the Dogwood Mission, also known as the Flower Mission, provided charity care to Asheville's sick and poor.

59. After World War II, Mission Hospital joined with other Buncombe County hospitals to become a major medical center in Western North Carolina. In 1951, Mission Hospital was incorporated as a nonprofit. Although it was a nonprofit, it was not under the patronage or the control of the State of North Carolina, nor was it a local health authority.

60. As of the early 1990s, the only two private acute care hospitals in Asheville were Mission Hospital-Asheville and St. Joseph's Hospital. Mission had 381 beds. St. Joseph's Hospital had 285 beds. The two hospitals sought to partner and lobbied the General Assembly to enact an initial version of the COPA law to facilitate a partnership in 1993.[7]

61. The two hospitals claimed that their plans did not call for a merger and that each hospital would maintain its distinct corporate identity, governance structure, and assets. Nonetheless, in 1994 the FTC opened a merger investigation out of a concern that the combination of St. Joseph's and Mission would result in a single large hospital dominating upwards of 80% or 90% of the market for GAC Services in Asheville.

62. In response, the hospitals lobbied the North Carolina General Assembly to amend the COPA to further immunize them from antitrust scrutiny.[8] The General Assembly did so in December 1995, and Mission and St. Joseph's then entered into their proposed partnership.

63. Subsequently, in 1998, Mission sought to buy St. Joseph's outright, acquire all of its assets, and combine operations under one license as Mission Health System. The COPA was amended in October 1998 to facilitate the merger.

64. The purpose of the COPA statute, as amended in 1998, was to strike a deal: in exchange for the State to allow the combination of Mission and St. Joseph's, which would be

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[7] Hospital Cooperation Act of 1993, Session Law 1993-529.

[8] *See* N.C.G.S. §§ 131E-192.1 through 131E-192.13 (repealed).

exempt from antitrust laws, Mission would accept price regulation designed to prevent it from charging monopoly prices or otherwise abusing its market power by agreeing to "limit health care costs" and "control prices of health care services."[9]

65. The 1998 amended COPA law acknowledged that conduct that might be lawful under the COPA would be unlawful without it, noting that "federal and State antitrust laws may prohibit or discourage" the "cooperative arrangements" that the COPA allowed.[10]

66. When the COPA was amended in 1998 to allow the Mission-St. Joseph's merger, the State accepted the hospitals' representations that the merger "will not likely have an adverse effect on costs or prices of health care."[11]

67. The 1998 amended COPA documented the dominant market share of the merged Mission institution: "The two Hospitals dominate the market share in two counties. 91% of Madison County admissions and 87% of Buncombe County admissions are either Memorial Mission or St. Joseph's Hospital. Memorial Mission and St. Joseph's are located in Buncombe County. Madison County, which has no hospital, is closer to the two Asheville hospitals than to any other acute care hospital."[12]

68. A second amended COPA dated June 2005 stated: "Mission Health dominates the market share in two counties. 93.8% of Madison County admissions and 90.6% of Buncombe County admissions are at Mission Hospitals' facilities, which are located in Buncombe County.

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[9] *See* former N.C.G.S. §§ 90-21.24, 90-21.28 (enacted by Physician Cooperation Act of 1995, SL 1995-395 (1995)); recodified at N.C.G.S. §§ 131E-192.1 through 131E-192.13 (repealed by Session Laws 2015-288, s. 4, as amended by Session Laws 2016-94, s. 12G.4(a), effective Sept. 30, 2016).

[10] *See* former N.C.G.S. §§ 90-21.24(5).

[11] 1998 COPA, p. 13; *see also id.*, p. 14 (reciting that merger will "not likely have an adverse impact on … price of health care services").

[12] *Id.*, pp. 7-8.

Madison County, which has no hospital, is closer to Mission Hospitals in Asheville than to any other acute care hospital."

69. A 2011 report by economist Greg Vistnes ("Vistnes Report") commissioned to study the efficacy of the COPA confirmed that a potential for regulatory evasion existed and that the COPA created an incentive for Mission to acquire facilities outside of Asheville because, while the COPA limited Mission's ability to raise prices and margins, the price increase cap was tied *only* to Mission Hospital-Asheville. This limitation meant that if Mission increased prices by acquiring facilities outside Asheville, then it could raise prices in theory, and did in practice, without technically violating the COPA's margin cap. Evidence presented at an FTC workshop in 2019 indicated that, in fact, Mission appeared to have evaded the restrictions of the COPA on price increases in precisely this way.

70. As of 2016, Mission continued to have a 93% share of the GAC Market in the Asheville Region. This dominant market share, which reflects Mission's acquisition of five smaller hospitals in these countries between 1995 and 2016, conferred upon Mission monopoly power. HCA has itself conceded in public statements about another health care system in Florida that an 85% share is sufficient to confer monopoly power.

71. In late 2015, the North Carolina General Assembly repealed COPA, effective January 1, 2018. After this date, the North Carolina government no longer exercised any direct regulatory authority over the prices that Mission could charge, even though Mission's monopoly power continued unabated.

B. HCA's Purchase of Mission's Assets

72. In or around 2017, knowing that the COPA was soon to expire, Mission's executives entered into private, non-public negotiations to sell its assets to HCA, the nation's

largest hospital chain, via an HCA subsidiary as was subsequently documented in the APA.[13] The negotiation process was conducted without any public notice or input, despite HCA's and Mission's purported commitment to transparency and Mission's status as a charitable nonprofit with a fiduciary duty to the citizens of Western North Carolina. Non-executive doctors and staff were excluded from the negotiation process and the decision to sell to HCA.

73. On March 21, 2018, Mission and HCA announced that HCA would be acquiring the assets of Mission. HCA pursued the Mission asset purchase primarily because of Mission's monopoly power in the GAC Market in the Asheville Region and the other Relevant Markets.

74. On August 30, 2018, Mission and HCA executed an APA, which was amended in January 2019. The purchase price was approximately $1.5 billion. Mission's annual revenue at that time was estimated to be approximately $1.75 billion.

75. Under terms of the asset transfer completed in January 2019, HCA and Mission formed the new North Carolina Division of HCA Healthcare.

V. HOSPITAL/INSURANCE MARKETS

A. Hospital/Insurer Negotiations in a Competitive Market

76. Markets for hospital services are different from other product/services markets because the persons consuming the hospital services (the patients) do not typically negotiate—and in many cases, do not even know beforehand (or sometimes ever)—the costs of the services they are consuming. Instead, health plans—consisting of commercial payors (such as Blue Cross and Aetna) and self-funded payors whose claims are administered by insurers or third-party administrators (or "TPAs")—purchase medical services for the benefit of their members.

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[13] https://www.searchwnc.org/asset-purchase-agreement.

77. Health insurance plans negotiate with hospitals for bundles of services that they will offer to members as "in-network" benefits. If a health plan and heath care provider (like a hospital system) reach a deal for a bundle of services (for instance, all acute inpatient hospital services), the hospital will be considered in-network for every service in that bundle. This means that for any service in that bundle, if a health plan's member receives that service from the hospital, the health plan will pay the hospital the "allowed amount" the two parties negotiated for that service (with insureds responsible for any deductibles and co-payments under the health plans).

78. In competitive health care markets, when health insurance plans negotiate for a bundle of services, the health insurance plans may choose to include as in-network only *some* services (or facilities) and to exclude others from the bundle. For example, the health insurance plan may choose to have one hospital be in-network for all GAC Services but choose not to include that hospital in-network for some Outpatient Services because the plan could purchase higher quality or less expensive Outpatient Services from other providers. Similarly, in a competitive market, a health insurance plan might decline to purchase any services from a hospital if that hospital's prices or quality of care are not competitive with other nearby providers. This ability to choose among different providers of services for a single health plan helps to control health care costs because it compels health care providers to compete with each other to be included in health plans.

79. For a health insurance plan to be a viable product that consumers wish to purchase for themselves, or that employers wish to purchase or self-fund for their employees, the plan must include a comprehensive bundle of services that members can access in their geographic region. A health insurance plan will not be commercially viable or acceptable if it does not offer in-

network services or facilities that individuals commonly desire or that individuals may need to access in the case of unforeseen health problems.

80. In competitive markets, hospitals compete to be selected for inclusion in health plans. Likewise, health insurance plans compete to be selected by employers to offer to their workers or compete to be selected by individuals. Because of the unique way that health care services are purchased and consumed, this competition is essential for there to be services of acceptable quality at competitive prices and to control health care costs and prices. By short-circuiting this competition, the Scheme enabled HCA to exploit its monopoly power to bolster and to maintain that power and ultimately to charge supracompetitive prices for lower quality care.

B. Hospital/Insurer Negotiations in the Absence of Competition

81. The unique features of health care markets, as just described, provide an opportunity for health care providers with significant market power to restrain trade and bolster monopoly power illegally through unduly restrictive agreements with health plans that foreclose competition and thereby extract supracompetitive prices for health care services. As alleged above, supracompetitive prices are rates that are higher than what would be found in the context of normal competition. Normal competition can occur only where dominant hospitals do not unlawfully restrain trade and/or abuse monopoly power.

82. When a health insurer or self-funded plan seeks to offer a plan in a geographic region where a significant area is serviced by a single hospital that provides essential health care services, that hospital is essential for health plans to include in their networks, and is, in effect a "must have" hospital for that health plan. Individuals and employers seeking insurance will not choose any health plan that does not include necessary services provided by that hospital.

83. If a "must have" hospital decides to engage in anticompetitive behavior, it can cause significant financial harm to health plans, and to employers offering such plans. If the "must have" hospital is part of a system that has other facilities that *do* face at least some fringe competition or potential competition, the hospital system can leverage its monopoly power to refuse to offer medical services at the "must have" facility unless health plans also agree, *inter alia*, to (a) purchase medical services from the system's other facilities at artificially high prices dictated by the hospital system, and (b) impose restrictive terms that prevent health plans from steering patients to less expensive and/or higher quality alternative providers, which would in turn put pressure on those high prices.

84. "Must have" hospitals, by definition, therefore, leave health plans with no other effective choices and can and sometimes do use that status to perpetuate their dominance and the dominance of the other facilities in their systems. In this way, "must have" hospitals coerce health plans to accept terms the health plans otherwise would not agree to in a competitive environment, eliminating or impairing the ability of health plans to spur price competition between providers.

85. The foregoing factors and others have led to a consensus in the field of health care economics that monopolization of hospital markets significantly increases prices for hospital services paid by health plans, employers, and individuals, in the form of, *inter alia*, artificially inflated direct payments to hospitals from insurers and self-funded payors. The economic literature also demonstrates that there are no concomitant improvements in quality from such monopolization. To the contrary, medical providers with monopoly power exercise that power not only by charging higher prices, but by cutting corners, including by reducing locations where they operate, reducing staffing, and otherwise by allowing the quality of their services to deteriorate. HCA itself stated in a regulatory filing in Florida that "there is documented empirical evidence of

the negative aspects of lack of competition in a health care market on charges, costs, and quality of care" and "economic studies consistently demonstrate that a reduction in hospital competition leads to higher prices for hospital care."[14]

86. Hospitals with monopoly power also use that power to erect artificial barriers to competing health care providers, as Defendants have done here in both the GAC and Outpatient Relevant Markets. They can, as Defendants have done here, compel health plans to accept: (a) "all or nothing" tying arrangements that require health plans to contract with all of the facilities and services offered by the organization owning "must have" hospitals with substantial market power; (b) exclusionary arrangements in the form of anti-steering and anti-tiering provisions that prevent or discourage health plans from informing and/or incentivizing their members to use other less expensive and/or higher quality providers of health care; and (c) "gag" clauses that prevent patients, other providers, other health plans, and existing or potential entrants, from knowing the prices that monopoly providers charge. Gag clauses effectively eliminate information about prices, which are the lifeblood of competitive markets, and thus inhibit the ability of purchasers of health care services to control health care costs.

87. Taken together, the foregoing exclusionary contractual provisions imposed on health plans by hospital systems with monopoly power, like Defendants have utilized here, can and do foreclose competition, entrench that provider's monopoly power in its own "tying market" and in other "tied markets," and cause substantial anticompetitive effects across markets, including here, the Relevant Markets.

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[14] HCA (Medical Center of Southwest Florida LLC) Certificate of Need Application #10523, Florida Agency for Health Care Administration, April 11, 2018. ("HCA Certificate of Need Application").

VI. THE RELEVANT MARKETS

88. Monopoly power may be proven by using direct evidence of the ability to (a) coerce buyers to accept unwanted contractual terms, or (b) charge supracompetitive prices, reduce quality, or reduced output. Monopoly power may, alternatively, be proven by demonstrating substantial market shares in a relevant or geographic market. Defendants have the ability to impose anticompetitive contract terms in its agreements with health plans covering a substantial share of those using health care services in the Relevant Geographic Markets, and thereby to (i) foreclose competition from actual and potential health care provider rivals, (ii) persistently charge supracompetitive prices, (iii) reduce output, and (iv) reduce quality of their services. The foregoing effects constitute direct evidence of Defendants' monopoly power over the health care services in question and in the regions at issue.

89. Nonetheless, and in the alternative, the Relevant Markets at issue in this case are defined in detail below. For each, the service market includes only the purchase of medical services by private health plans, namely commercial insurance plans and employer self-funded payors. The service markets do not include sales of such services to government payers, including Medicare (and Medicare Advantage), Medicaid, and TRICARE (covering military families), because health care providers' negotiations with commercial insurers and employer self-funded plans are separate from the process used to determine the rates paid by government payers.

A. The Relevant Product/Service Markets

90. As discussed above, there are two product or service markets that are relevant in this action. First, the GAC Market includes GAC Services, which consist of a broad group of medical, surgical, anesthesia, diagnostic, nursing, laboratory, radiology, dietary, and other treatment services provided in a hospital setting to patients requiring one or more overnight stays.

Because GAC Services are not substitutes from a patient's perspective for each other (*e.g.*, orthopedic surgery is not a substitute for gastroenterology), health insurance plans typically contract for various individual inpatient GAC Services as a package in a single negotiation with a hospital system and/or set of providers. That is precisely how Defendant HCA negotiates (and how Mission before it negotiated) with health plans with respect to GAC Services at Mission Hospital-Asheville. Non-hospital facilities, such as outpatient facilities, specialty facilities (such as nursing homes), and facilities that provide long-term psychiatric care, substance abuse treatment, and rehabilitation services are not viable substitutes for acute inpatient hospital services.

91. The second product or service market is the Outpatient Market, which encompasses a broad group of medical, diagnostic, and treatment services that are not inpatient medical services (*i.e.*, health care services that do not require an overnight stay). Although individual Outpatient Services are not substitutes for each other (*e.g.*, a CT scan is not a substitute for an annual physical), health plans typically contract for various individual outpatient medical services as a package in a single negotiation with a hospital, hospital system and/or set of providers, and that is how Defendant HCA negotiates (and how Mission before it negotiated) with health insurance plans with respect to Outpatient Services at Mission Hospital-Asheville.

92. The Outpatient Market is a separate market from the GAC Market because the two types of services are not interchangeable and can be sold separately. Health insurance plans can, and often do, purchase Outpatient Services from different providers (*i.e.*, non-hospital providers), unlike the purchase of GAC Services, which can only be purchased from hospitals. The existence of non-hospital competitors, in a competitive market absent any anticompetitive behavior, reduces the price health insurance plans pay a hospital for Outpatient Services, but those non-hospital

outpatient competitors would not affect the price a hospital could charge for GAC Services. The GAC Market and Outpatient Markets are therefore distinct.

93. The distinction between the two types of health care services—GAC and Outpatient—is also widely recognized in the academic and government regulatory literature on health care.

94. Both relevant service markets at issue satisfy the conditions for market definition used by the federal antitrust enforcement agencies under what is widely known as the "SSNIP test." Each of these service markets constitutes a distinct group of services in which a hypothetical monopolist provider would profitably impose at least a small but significant non-transitory increase in price above competitive levels (*i.e.*, at least 5%).

95. Defendant HCA provides GAC Services and Outpatient Services in each of the Relevant Geographic Markets alleged below.

B. The Relevant Geographic Markets

96. There are at least two geographic markets that are relevant to this action. These market definitions reflect the fact that plan members, and thus plans, typically choose GAC hospital and Outpatient care within reasonable proximity to members' homes or workplaces. Each geographic market definition below meets the SSNIP test: each market is an area in which a hypothetical monopoly provider of GAC Services and/or Outpatient Services in each of the Relevant Geographic Markets would profitably raise its prices above competitive levels by at least a small but significant non-transitory amount (*i.e.*, at least 5%).

1. Asheville Region.

97. Buncombe and Madison Counties (together the "Asheville Region") are one relevant geographic market. HCA participates in the Asheville Region Geographic Market predominately through its flagship facility, Mission Hospital-Asheville.

98. The predecessor entity whose assets HCA purchased, Mission, defined its service area as consisting of Buncombe and Madison Counties, or the Asheville Region.[15]

99. The 2020 Census reported the population of Buncombe County was 269,452 and the population of Madison County was 21,193.

100. The 2010 Census reported the population of Buncombe County was 238,318 and the population of Madison County was 20,764.

101. Given the broad scope of GAC Services offered in the Asheville Region and the extensive travel times required to obtain them elsewhere, there are no reasonable substitutes or alternatives to GAC Services in the Asheville Region for health plans and their members, who are persons living or working in that area. Consequently, competition from providers of GAC Services located outside the Asheville Region would not likely be sufficient to prevent a hypothetical monopolist provider of GAC Services in the Asheville Region from profitably imposing at least a small but significant price increases above competitive levels for those services over a sustained period of time.

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[15] *E.g.*, Mission Hospital Implementation Strategy, 2013-15, p. 1 ("Our community, defined for the purposes of community health needs assessment and this related implementation strategy, is comprised of Buncombe and Madison Counties."), https://missionhealth.org/wp-content/uploads/2018/04/2013-Mission-Hospital-Implementation-Strategy.pdf. *See also* IRS Form 990 for period ending September 2019, Schedule H, supplemental information ("Mission Hospital primarily serves Buncombe and Madison Counties").

102. There are no reasonable substitutes or alternatives to Outpatient Services in the Asheville Region from Outpatient Services outside the Asheville Region for health plans and their members. People who live and work in the Asheville Region strongly prefer to obtain Outpatient Services in that area (indeed, it is often medically inappropriate to require them to travel farther). Consequently, competition from providers of Outpatient Services located outside the Asheville Region would not likely be sufficient to prevent a hypothetical monopolist provider of Outpatient Services located in the Asheville area from profitably imposing at least a small but significant price increases above competitive levels for those services over a sustained period of time.

2. Outlying Region.

103. A second relevant geographic market consists of the area encompassed by the following counties in or near where Defendant HCA's hospitals operate: Macon, McDowell, Mitchell, Transylvania, and Yancey Counties (collectively, the "Outlying Region"). In the alternative, each of these counties in the Outlying Region constitutes its own separate Relevant Geographic Market.

104. HCA has hospital facilities (the "Outlying Facilities") serving each the above-described geographic areas: Transylvania Regional Hospital, Transylvania County; Angel Medical Center, Macon County; Highlands-Cashiers Hospital, Macon County; Mission Hospital McDowell, McDowell County; and Blue Ridge Regional Hospital, Mitchell County.

105. HCA faces a fringe of some actual or potential competition for GAC Services and Outpatient Services in the Outlying Region from other hospitals and non-hospital providers. Thus, due to the somewhat heightened level of competition (as compared to Mission Hospital-Asheville), in the absence of Defendants' anticompetitive conduct, health plans seeking to build a viable

insurance network would not be required to include all Outlying Facilities in-network in order to be viable.

106. The Outlying Region constitutes a separate geographic market from the Asheville Region because GAC and Outpatient Services in the Outlying Region are not interchangeable with, and can be sold separately from, the GAC and Outpatient Services provided in the Asheville Region. These Relevant Geographic Markets involve different facilities, operating primarily in different geographic regions, and different types of service are offered in each. For instance, in the Asheville Region, Defendants offer acute trauma care, whereas this service is not offered by any of Defendants' facilities in the Outlying Region. Moreover, some of Defendants' facilities in the Outlying Region face some competition from other providers, which is more competition than Defendants' facility at Mission Hospital-Asheville faces, particularly for GAC Services.

107. In general, in competitive health care markets, health plans can and often do purchase Outpatient Services from different providers (*i.e.*, non-hospital providers), which distinguishes Outpatient Services from GAC Services, which can only be purchased from hospitals. The actual and potential competition that the facilities in the Outlying Region face (and would face) both from other hospitals and non-hospital facilities, in a competitive market absent any anticompetitive behavior, would reduce the prices health plans would pay the facilities in the Outlying Region for GAC and Outpatient Services.

108. In the alternative, each of the individual counties that make up the Outlying Region are separate geographic markets. In the alternative, the hospital facilities in each of these counties are sufficiently far apart from the hospital facilities in the other counties that no more than an insignificant number of patients would use the GAC and Outpatient Services outside the county in which they live or work.

VII. DEFENDANTS' MONOPOLY POWER

109. Due to the Scheme, Defendants have maintained, acquired, and/or bolstered monopoly power in all Relevant Services and Geographic Markets.

110. HCA has a market share of approximately 80% to 90% in the GAC Market in the Asheville Region, primarily due to the dominance of Mission Hospital-Asheville. HCA acquired this market dominance when it bought the assets of Mission and maintains that dominance through the Scheme. This market dominance was reflected in the market shares of the Mission Hospital-Asheville in the top three zip codes, by population, in the Asheville Region for the calendar year ending December 31, 2019: 88.9% for zip code of residence 28806; 86.5% for zip code of residence 28803; and 87% for zip code of residence 28715.[16]

111. Defendants' market share in the GAC Market in the Asheville Region is significant enough to stifle competition and restrict freedom of commerce, and, at all times relevant to this Complaint, and due to the Scheme alleged herein that has helped Defendants maintain that monopoly power, Defendants have had the ability to inflate prices above competitive levels in this market.

112. Mission also had high shares of patients in the GAC Market in the Asheville Region, as well as in the other counties in the Outlying Region (*i.e.*, Macon, McDowell, Mitchell, Transylvania, and Yancey Counties). In a Certificate of Need ("CON") application dated June 15, 2022, HCA admitted that "Mission is the largest provider of acute care services to Buncombe, its home county, as well as Graham, Madison and Yancey Counties." More specifically, the most recent GAC market share data, by county, are as follows:

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[16] *See* American Hospital Directory, available at https://www.ahd.com/free_profile/340002/Mission_Hospital_-_Memorial_Campus/Asheville/North_Carolina/.

- Yancey: 88.3%
- Madison: 89.1%
- Buncombe: 88.6%
- Mitchell: 85.4%
- Transylvania: 78.7%
- McDowell: 76.4%
- Macon: 74.7%

113. Given the high entry barriers facing new hospitals, and also Defendants' Scheme alleged herein, these market shares have not been materially reduced, and have likely increased, since HCA bought Mission.

114. Although the market share data are not publicly available for all Outpatient Services in all Relevant Geographic Markets, for ambulatory surgical services, Mission has approximately 79% of the Buncombe County market based on data obtained from hospital annual license renewal applications reflecting 2021 data aggregated from the six Mission hospitals, plus the hospitals owned by Advent, Haywood, UNC Blue Ridge, Pardee and Harris in the western North Carolina service area. Defendants control approximately 80% of the market for all Outpatient Services in Buncombe County. Likewise, for all Outpatient Services in other Relevant Geographic Markets, Defendants have the ability to charge supracompetitive prices, reduce output, and decrease the quality of service—indeed, while maintaining very high market shares—which they could not do unless they had monopoly power.

115. For example, since HCA's acquisition of the Mission system, HCA has cut Outpatient Services in the Outlying Region, compelling patients to travel to HCA's Asheville facilities to obtain care. Outpatient clinics for primary, geriatric, and cancer care in the Outlying Region have been especially targeted for cuts. More specifics regarding HCA's reduction in quality are further alleged below.

116. Likewise, as shown in more detail below, HCA's ability, like Mission's before it, to maintain prices for key medical services at levels and growth rates substantially above the statewide average for those procedures demonstrates HCA's monopoly power in all Relevant Markets.

VIII. DEFENDANTS' UNLAWFUL CONDUCT

A. HCA's Unlawful Scheme

117. Defendants engaged in a multifaceted Scheme to gain, maintain, and bolster monopoly power in the Relevant Markets, substantially foreclose competition, and thereby impose supracompetitive prices on Plaintiffs and members of the proposed Class. Defendants use the Scheme to generate these anticompetitive effects by leveraging the monopoly power that HCA has in GAC Services in the Asheville Region to force health plans to accept terms that reduce payors' ability to promote competition by, *inter alia*, steering patients to lower priced, higher quality options.

118. Defendants' Scheme involves a web of contracts that Defendants have imposed on insurers, which include, but are not limited to: (1) "all-or-nothing" offers that tie Defendants' must-have GAC Services in the Asheville Region to accepting GAC Services in the Outlying Region as a whole (or, in the alternative, in each of the five county markets in the Outlying Region), as well as to Outpatient Services in all Relevant Geographic Markets; (2) exclusionary arrangements in the form of anti-steering and anti-tiering contractual provisions that prevent or discourage patients from dealing with Defendants' rivals and potential rivals; and (3) "gag" clauses that prevent price transparency.

119. Individually and in combination, the elements of the Scheme are designed to suppress competition and transparency in the Relevant Markets, foreclose competition, and

thereby to increase the prices Defendants charge for health care to Plaintiffs and the proposed Class above competitive levels.

120. Anticompetitive contractual provisions and negotiating tactics are particularly problematic when a provider controls "must have" services, as HCA does with GAC Services through Mission Hospital-Asheville. It is not practically possible to assemble a commercially viable insurance plan covering both GAC and Outpatient Services that excludes Mission Hospital-Asheville. In a market with a "must have" hospital, even the limited use of these contractual provisions or negotiating tactics causes much greater competitive harm than the use of such practices and provisions in a competitive market.

121. Certain of the anticompetitive contractual provisions and negotiating tactics at issue here have been the subject of judicial scrutiny in the Western District of North Carolina in *United States of America, et al. v. The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Health Care System*, No. 3:16-cv-00311-RJC-DCK, 2019 WL 2767005, 2019-1 Trade Cases P 80,752 (W.D.N.C. April 24, 2019), where the defendant health care system ultimately entered into a consent decree, approved by the court, not to enforce anti-steering provisions in its contracts with health plans.

122. HCA has a pattern and practice of using similar negotiating tactics and including similar unlawfully restrictive provisions in contracts with health plans to those alleged here in other parts of the United States, including but not limited to Colorado and Virginia. The kinds of contractual provisions or arrangements alleged here also have been found to be illegal even in markets with more robust provider competition than exists here, because they inherently harm consumer welfare and competition. However, because Defendants have monopoly power in all the

Relevant Markets, the impact on Plaintiffs and the proposed Class is much more severe than in those other markets.

1. HCA's "All or Nothing" Requirements.

123. HCA has used its monopoly power in the GAC Market in the Asheville Region, derived from its "must have" Mission Hospital-Asheville, to impose "all or nothing" contracts on health plans operating in all other Relevant Markets. Under these provisions, HCA coerces health plans to include all of HCA's GAC and Outpatient Services in the Outlying Region in the plans, as well as HCA's Outpatient Services in the Asheville Region. HCA significantly disadvantages health plans that do not commit to include in the health plan's top tier and promote all of the GAC and Outpatient Services provided by HCA facilities in the Relevant Geographic Markets.

124. These "all or nothing" contractual provisions constitute unlawful tying under the antitrust laws. Tying occurs when an entity that has market power in one market (the "tying market") leverages that market power in order to gain, maintain, or enhance monopoly power in another market or markets (the "tied market(s)"). Under such tying arrangements, the defendant will sell one service or set of services (the "tying service(s)") only under the condition that the purchaser buys a second service or set of services (the "tied service(s)"). Where the defendant has monopoly power in the tying market, and where the tie allows the defendant to gain, maintain, or enhance monopoly power in the tied market, such tying arrangements are considered anticompetitive and unlawful under the antitrust laws.

125. When a hospital system is the only entity in a given region to offer a product or service that health plans must include in their networks to be viable, that hospital system can refuse to sell services to health plans, or sell only with a significant price penalty, unless those health plans also agree to purchase other services from the hospital system, including services that the

health plan would otherwise purchase from a different hospital system or set of providers for lower prices. Either orally during negotiations or in the contracts themselves, a hospital system can give the health plan what effectively is an "all-or-nothing" choice: Include everything the hospital system wants to sell at the price the hospital system dictates or pay much higher penalty prices or even get nothing at all. That is what HCA has done here.

126. In this case, the "tying market" is the GAC Market in the Asheville Region, enabled by HCA's (and prior to that, Mission's) monopoly power through Mission-Asheville Hospital. The "tied markets" include the Outpatient Market in the Asheville Region and both the GAC Market and Outpatient Market in the Outlying Region, or in the alternative, in each of the five counties that comprise the Outlying Region. As a result of the Scheme, HCA has monopoly power in all these markets, measured either by its dominant market shares and/or by its supracompetitive prices, which are inflated by Defendants' Scheme.

127. Mission began forcing health insurance plans to accept "all or nothing" contractual provisions as early as 2017. For example, in 2017 during Mission's negotiations with Blue Cross, Mission asked for exorbitant price increases for GAC and Outpatient Services, and further insisted on the inclusion of services from HCA covering both inpatient and outpatient care in all Relevant Geographic Markets in the Blue Cross contract. When Blue Cross did not agree to Mission's "all or nothing" demand for all these services, Mission took itself out of the Blue Cross network for GAC and Outpatient Services in the Relevant Markets, including the "must have" Mission Hospital-Asheville. Mission's actions meant that the 260,000 people in Western North Carolina insured by Blue Cross could not seek care at Mission facilities unless they paid much higher "out of network" prices out of their own pockets.

128. While hospital systems and insurers regularly negotiate over rates and terms, a hospital system taking an insurer out of network—especially where the hospital system has such monopoly power—is considered "go[ing] nuclear." With respect to the 2017 negotiation between Mission and Blue Cross, Mission's imposition of the "nuclear" option disrupted the administration of health care in the entire region, requiring tens of thousands of Blue Cross members to switch doctors, forgo medical care, or drive long distances to receive care at a non-Mission facility. Mission remained out of network for Blue Cross for two months, until Blue Cross capitulated, accepting both a rate increase and inclusion of the entirety of the Mission system in all Relevant Markets in network. Given that Blue Cross is the largest health plan in North Carolina and in the Relevant Markets, HCA's ability to bully Blue Cross into accepting its "all or nothing" (and other anticompetitive terms as part of the Scheme) leaves little room for doubt that HCA was also able to compel the other health plans comprising the Class to accept the same restrictive provisions.

2. HCA's Anti-Steering and Anti-Tiering Provisions.

129. HCA has also abused its monopoly power in the GAC Market in the Asheville Region to impose so-called anti-steering provisions on health plans operating in all Relevant Geographic Markets. Anti-steering provisions prohibit health plans from encouraging their members (through financial incentives or otherwise) to use other, less expensive and/or higher quality providers of GAC or Outpatient Services that compete or could compete with HCA's facilities. These contractual provisions discourage rivals from using price as a means of competition (because rivals cannot effectively use price to attract customers), and thus they lead to less competition, and higher market-wide prices. These anti-steering provisions are anticompetitive and constitute unlawful exclusionary conduct.

130. To try to reduce costs and induce competition among health care providers, Health plans can incentivize their plan subscribers to use lower-cost facilities by including language in insurance plan documents encouraging subscribers to choose one facility rather than another or by conditioning the selection of a higher-cost facility on a higher copay or deductible from the subscriber.

131. Because the individual choosing the health care service provider is not paying the full cost, and the payer—here, the health plan—is not choosing services at or before the point of care, steering is a critical means of ensuring competition for health care services and, thus, reducing health care prices, particularly in consolidated markets. Where steering is not barred, health care providers are incentivized to use price or quality as a means of encouraging plans to steer business their way. As such, plans' use of steering can foster healthy competition between providers and encourage the growth of new providers that have a means of breaking into a market and gaining sales if they can lower price and/or improve quality. Many of the most innovative healthcare plans in the country today are based on steering to more efficient providers.

132. Hospital systems' attempts to impose anti-steering provisions, like those Mission and HCA have coerced health plans in Western North Carolina to accept as part of the Scheme, are anticompetitive because they block the ability of health plans to incentivize less expensive and higher quality options and thereby stymie competition and lead to higher prices and lower quality, especially as here, when employed in conjunction with other anticompetitive contractual provisions. In November 2018, the Assistant Attorney General in charge of the Antitrust Division of the DOJ chastised another North Carolina hospital system's "use of anticompetitive steering restrictions in its contracts with major health insurers," restrictions which "prevented health insurers from promoting innovative health plans and more cost-effective health care providers. . .

[and which] inhibited competition among health care providers to provide higher quality, lower-cost services."[17] Likewise, Senator Chuck Grassley, then chairman of the Senate Judiciary Committee said the anti-steering practices of HCA and several other systems were, "restrictive contracts deliberately designed to prevent consumers' access to quality, lower cost care."[18]

133. Tiered networks allow health plans to sort providers into tiers based on their price and, often, quality relative to other similar providers who treat comparable patients. Health plans that have tiered networks assign providers with higher quality and lower prices to higher tiers. Health plans use tiering to incentivize members to use providers in the higher tiers and are an important means by which the plans help reduce prices for their members.

134. At all times relevant to this Complaint, Defendants have limited health plans' ability to use steering or tiering, as a condition of those plans' obtaining access to Defendants' "must have" Mission Hospital-Asheville. Such limitations include, at a minimum, limits on insurers' ability even to provide information about less expensive providers that compete with HCA.

135. Investigative reporting has shown that HCA has a history of using anti-steering, anti-tiering, or similarly restrictive contractual language in their contracts with health plans in other states and regions.

3. HCA's Gag Clauses and Lack of Transparency.

136. Defendants abused their monopoly power in the Relevant Markets to obscure their price increases and anticompetitive contracts from regulators and the public through use of gag

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[17] https://www.justice.gov/opa/speech/assistant-attorney-general-makan-delrahim-remarks-american-bar-association-antitrust.

[18] Cited in https://www.law360.com/articles/1091446/grassley-seeks-ftc-probe-of-hospital-insurer-contracts.

clauses that prevent insurers from revealing their agreements' terms. Gag clause language is anticompetitive because it prevents competitors, insurers, and consumers from understanding in a transparent manner the pricing and other terms and arrangements being used by hospital systems, which in turn inhibits the ability of employers to control health care costs.

137. Moreover, HCA has continued to refuse to release the prices it charges for its GAC and Outpatient Services in a fully transparent manner despite a recent change in federal law requiring it to do so. Effective January 1, 2021, a new federal regulation required the public disclosure of certain aspects of HCA's negotiated price terms in agreements with private insurance companies. *See* 45 C.F.R. § 180.50. HCA has however failed to fully disclose this information in a timely, complete, and understandable manner, in violation of federal law.

138. By violating this price disclosure regulation, and by including gag clauses in HCA/Mission's provider agreements with insurers, Defendants have kept community members, regulators, and the general public from learning of the artificially inflated prices that are being charged.

139. This rule was first created by the Trump Administration over the opposition of HCA's lobbying and then proactively continued by the Biden Administration—signaling growing bipartisan consensus that the lack of price transparency with regard to hospital services leads to higher prices for consumers and employers.

B. Defendants' Scheme Has Foreclosed Substantial Competition in Each of the Relevant Markets

140. As a direct and proximate result of Defendants' Scheme, Defendants have foreclosed a substantial share of competition in each of the Relevant Markets.

141. By prohibiting health plans from "mixing and matching" different sets of providers, Defendants' all-or-nothing tying requirement anticompetitively and artificially impairs the ability

of actual or potential rival providers of the tied products and/or services to compete with HCA's products and/or services. Likewise, Defendants' tying impairs the ability of health plans to assemble networks of the highest quality, lowest cost providers to offer to employers.

142. Moreover, Defendants' anti-steering and anti-tiering provisions anticompetitively and artificially drive business away from less expensive and/or higher quality providers of GAC and Outpatient Services in all Relevant Geographic Markets, impairing the ability of actual or potential rival providers to compete or to use price or quality as a means of gaining patients and market share. Indeed, rival providers have no incentive to offer lower prices to health plans, because health plans cannot, because of Defendants' contracts, do anything to reward them with a higher patient volume.

143. Similarly, Defendants' gag clauses that prevent the dissemination of price information—essential to any well-functioning competitive market—impair the ability of rival providers both to attract business and for health plans to assemble the highest quality, lowest cost menu of in-network providers.

144. Defendants have used their dominance in inpatient GAC at Mission Hospital-Asheville to gain, maintain, and enhance monopoly power through their Scheme in GAC and Outpatient Services in all Relevant Geographic Markets. For example, through the Scheme, Defendants have shielded their smaller, regional hospitals, including Angel Medical Center and Highlands-Cashiers Hospital (Macon County), Blue Ridge Regional Hospital (Mitchell County), and Transylvania Regional Hospital (Transylvania County) from competition. In short, through their Scheme, Defendants have substantially foreclosed competition from rival hospitals in each of the Relevant Markets, keeping Defendants' rivals' market shares at levels that are too low to constrain Defendants' ability to raise prices above competitive levels.

145. For example, HCA has an 85.3% market share in zip code 28712 in Brevard, NC, the top inpatient zip code for HCA's Transylvania Regional Hospital in Brevard, Transylvania County.[19] In contrast, Pardee UNC Hospital only holds 10.4% market share, despite being about half the driving distance from Brevard and substantially lower cost than Mission Hospital-Asheville. Due to its unlawful Scheme, HCA prevents health plans from steering patients to rival facilities and blocks the ability of rivals to gain share by cutting price and/or increasing quality. As a result, HCA's hospital maintains a far greater market share in Transylvania County than the Pardee UNC Hospital.

146. Similarly, HCA has a 92.4% market share in zip code 28741 in Highlands, NC, the top inpatient zip code for HCA's Highlands-Cashiers Hospital in Highlands, NC, located in Macon County.[20] Northeast Georgia Medical Center only holds 7.6% market share, despite being closer driving distance from Highlands and substantially lower cost than Mission Hospital-Asheville. HCA has used its Scheme to maintain and entrench its monopoly power in GAC Services in Macon County through its Scheme.

147. Moreover, because of Defendants' unlawful conduct, Outpatient Services facilities have closed or relocated to more competitive markets and would-be competitors for Outpatient Services have declined to operate in Buncombe and Madison Counties, which has decreased the quantity of Outpatient Services and increased prices paid by insurers for Outpatient Services.

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[19] This aggregate HCA market share comes from HCA's Transylvania Regional Hospital's 44.8% market share in the zip code and HCA's Mission Hospital-Asheville's 40.5% market share in the same zip code.

[20] This aggregate HCA market share comes from HCA's Highland-Cashiers Hospital's 43.8% market share in the zip code and HCA's Mission Hospital-Asheville's 48.7% market share in the same zip code.

IX. THE ANTICOMETITVE EFFECT OF DEFENDANTS' SCHEME: ARTIFICIALLY INFLATED PRICES, REDUCED OUTPUT, DECLINING QUALITY

148. Defendants' Scheme has caused supracompetitive prices, artificially reduced output, and reduced quality of health care by, among other things: (1) protecting Defendants' monopoly power and enabling Defendants in each Relevant Market to raise prices, reduce output, and reduce quality of GAC Services and Outpatient Services substantially beyond what would be tolerated in a competitive market, to the detriment of consumer welfare; (2) restricting the ability of health plans to use reasonable cost control methods, or otherwise induce competition between providers, including through the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for GAC Services and Outpatient Services; and (3) reducing the ability of health plans to incentivize consumers to use more cost-effective and higher quality providers of GAC Services and Outpatient Services in the Relevant Markets.

A. Defendants Have Used the Scheme to Inflate Prices Above Competitive Levels in Each of the Relevant Markets

149. As alleged above, Defendants' Scheme has allowed them to harm competition and, thus, to raise prices above the competitive level in each of the Relevant Markets, including in the GAC Market in the Asheville Region.

150. One indication that Defendants' Scheme has artificially and anticompetitively inflated prices is that HCA/Mission prices for routine "plausibly undifferentiated" or standardized GAC and Outpatient Services have increased at a faster rate than the prices for those services statewide over the past five years.

151. A recent RAND analysis of nationwide hospital pricing data, which compared the prices negotiated between hospitals and health plans to the fee schedule set by Medicare, shows

how HCA has been able to raise prices continually well above the typical prices for routine services and procedures in the Relevant Markets.

152. Medicare prices act as a relative baseline (given the federal government's regulatory and buying power). RAND's most recent analysis reports price data at the hospital systemwide level, averaged over the 2018-2020 period, without revealing the prices charged for specific procedures. According to RAND data, Mission Hospital-Asheville, where Defendants have monopoly power, charged commercial insurers 305% above the Medicare price, on average, for GAC Services, versus the North Carolina average of 211% above Medicare. For Outpatient Services, Mission Hospital-Asheville prices are 343% above Medicare prices, on average, versus 331% for the North Carolina average. The substantially higher prices for GAC and Outpatient Services at Mission Hospital-Asheville compared to those charged by hospitals elsewhere in North Carolina are due in large part to the Scheme alleged herein.

153. HCA itself stated in recent regulatory filings in Florida that, in a county with a hospital system with monopoly power, insurers have "limited ability" to "negotiate market-driven rates for hospital services" and that, "[a] large and growing body of literature suggests that health care providers with significant market power can (and do) negotiate higher-than-competitive payment rates."[21]

154. The pricing data for specific standardized medical procedures from a large private, commercial database of health price and claims information (the "Commercial Database") are consistent with the systemwide RAND results, and further demonstrate that the alleged anticompetitive conduct has caused artificially inflated prices. The examples below are

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[21] *See* HCA Certificate of Need Application.

representative of artificial price inflation on a broad array of medical procedures caused by Defendants' Scheme.

155. For example, based on a study involving the Commercial Database, Mission/HCA's average price to health plans for C-sections without complications at the Mission Hospital-Asheville ($10,076 in 2020) was more than double the statewide average ($4,373 in 2020). Further, prices for this procedure over the 2017-2020 period grew faster at Mission Hospital-Asheville than in the rest of the state (17.3 percent vs. 14.4 percent).

156. Similar patterns exist for the prices of other procedures for which data are available. While the average price for cardiovascular stress tests declined statewide between 2017 and 2020 by 10 percent, it increased by 29 percent at Mission Hospital-Asheville during this period. Moreover, the average allowed price for this procedure at HCA was roughly double that of the average allowed price in the rest of North Carolina in 2020.

157. For a shoulder arthroscopy, the price increase at the Mission-Asheville Hospital over the 2017-2020 period was 75 versus 19 percent statewide. In 2020, the Mission-Asheville price for this procedure was $2,419—nearly three times the statewide average of $897.

158. Even low-cost but high-volume procedures like a lipid panel have seen significant price increases since 2017. Mission's average allowed amount for lipid panels increased by approximately 31 percent, while the average price in the rest of the state *declined* by 19 percent.

B. HCA's Scheme Has Led to Artificially Inflated Prices in the Outlying Region

159. HCA's Scheme has enabled it to inflate prices in the Outlying Region substantially above competitive levels—for example, prices at Mission Hospital-McDowell, located about 45 minutes driving time to the east of Asheville, are substantially above competitive levels due to the Scheme.

160. A rival hospital, Carolinas HealthCare System Blue Ridge Morganton, is located fewer than 30 minutes away to the east of Mission Hospital-McDowell. Mission Hospital-McDowell and Carolinas HealthCare System Blue Ridge Morganton are potential competitors.

161. Price data available in the Commercial Database for Mission Hospital-McDowell reflect that for a variety of procedures where there is a significant volume of those procedures for each year, such as, e.g., CT scans, Mission Hospital-McDowell is not only consistently one of the most expensive in the State, but it charges more than three times the average cost for such routine procedures. Mission Hospital-McDowell could not maintain such price disparities unless it had monopoly power through the Scheme.

162. For example, available price data reflect that the average allowed amount for a CT scan of the abdomen and pelvis is about $2,000 at Mission Hospital-McDowell, whereas the average in the State is just under $500. This divergence in price cannot be explained by a quality difference because CT scans are standard commodified procedures. Instead, the price differences are due to Defendants' Scheme.

163. When the COPA was in effect, Mission Hospital-McDowell pricing was well below the State average with respect to prices for Outpatient Services. Today, Mission Hospital-McDowell charges approximately 50% above the State average for Outpatient Services—corresponding with the period in which HCA/Mission were free to couple their anticompetitive contracting practices with unregulated price increases. Using an overall analysis of Outpatient Services pricing, from 2017 to 2020, Mission Hospital-McDowell's overall prices for Outpatient Services increased substantially relative to other providers in North Carolina and are now in the top 3% of prices of providers of Outpatient Services in North Carolina.

164. Mission Hospital-McDowell is not only significantly more expensive than the State average for Outpatient Services, it is also significantly more costly than its only potentially significant competitor, Carolinas HealthCare System Blue Ridge Morganton, which is less than a 30-minute drive away. Health plans do not consider either hospital to be of significantly higher quality than the other, particularly for "plausibly undifferentiated procedures" such as a CT scan.

C. Defendants' Unlawful Scheme Has Reduced Output and Quality of Care

165. In addition to using its unlawful conduct to increase prices above competitive levels, Defendants' Scheme has reduced output and quality in each of the Relevant Markets.

166. As a result of the Scheme, there are fewer doctors and less of the needed health care services than there would have been absent the Scheme. HCA's bolstered monopoly power is reflected in, among other things, its failure to adhere to various quality commitments included in its APA with Mission.

167. Under Section 7.13(j) of the APA, Defendants had asserted they had "no present intent to discontinue any of the community activities, programs or services provided" prior to the buyout. Less than a year later, in October 2019, however, HCA closed outpatient rehabilitation clinics in Candler and Asheville. In 2020, it closed primary care practices in Candler and Biltmore Park and ended chemotherapy services at Mission Medical Oncology locations in Brevard, Franklin, Marion, and Spruce Pine.

168. Section 7.13(a) and Schedule 7.13of the Amended APA require HCA to provide until January 2029 numerous defined services at Mission Hospital-Asheville. However, contrary to its obligations under the APA, HCA has reduced budgets and staffing, making it more difficult for medical staff to provide the same quality of service as before.

169. Section 7.13(b) and Schedule 7.13(b) of the APA required HCA to provide until January 2029 numerous services at its five smaller regional hospitals. However, contrary to its obligations under the APA, HCA has cut budgets, staffing and quality there too.

170. HCA's reductions in services are the product of its deliberate effort to reduce or drive out medical personnel. As of March 2021, at least 79 doctors had left or planned to leave the system since HCA's takeover. Other doctors describe new employment contracts with HCA in which the compensation equations remove quality of care metrics and focus almost entirely on the number of patients seen and amount billed. A significant number of patients have lost their preferred family doctors either due to doctors leaving the system or from HCA's clinic restructurings and closures.

171. Similarly, nurses working at HCA have described their units as "inhumanely understaffed," with conditions so bad that even travel nurses hired to fill in gaps were leaving before their contracts expired. Patients and families describe situations where, for example, their nurse admitted that "she cries every single night because she knows she is not giving appropriate, competent patient care."

172. HCA's cutbacks in service, driven by its exploitation of the additional monopoly power it has gained through the Scheme, have been criticized by regulators. Among other things, the North Carolina Attorney General stated in February 2020 that the Defendants' "decision to focus on emergent care appears inconsistent with the Asset Purchase Agreement" and that the Defendants' website incorrectly claimed its charity care policy covered "non-elective" services. The Attorney General's office also said it had received a "surge" of complaints, including "harrowing" complaints about quality of care and staffing cuts.

173. If Defendants were operating in a competitive market for all of their services in the Relevant Markets, they would not have been able to take these anticompetitive actions. However, due to the Scheme alleged herein, health plans and patients have no choice but to endure the rising prices and worsening quality of service.

174. In a March 16, 2022 letter from North Carolina's Assistant Attorney General Llogan Walters to Greg Lowe, president of HCA Healthcare's North Carolina division, the North Carolina Department of Justice highlighted earlier complaints about primary care and OB/GYN physicians leaving Mission facilities, reduced nursing and administrative staff in emergency departments, a reduction in core services, and higher prices.[22]

175. Since then, the North Carolina Department of Justice has received additional complaints that Mission's Transylvania County Regional Hospital (which HCA acquired as part of the 2019 Mission transaction) had no mammogram technician and was offering no mammogram services at all; that Mission hospital mental health facilities are inadequately staffed; that ENT cancer treatment practices have left Mission Health; and that because of understaffing, HCA's health facilities were unclean and that patients are experiencing long wait times. The letter noted that while HCA justified these outcomes because of pandemic-related labor shortages, other medical establishments elsewhere in the State facing the same labor market conditions, did not have the same high numbers of complaints.

176. Other officials, including representatives of Plaintiffs such as the Mayor of Asheville and Buncombe County officials, have also publicly expressed "deep concerns" about HCA's dramatic cuts and the pressure put on doctors and nurses. Doctors, nurses, and patients have also called the situation created by HCA's cost cutting "dangerous," and have noted that

[22] https://www.scribd.com/document/567469487/NC-DOJ-Letter-to-HCA-16-March-2022.

HCA's policies force doctors and nurses to see more patients to maximize profit at the expense of patient care.

177. On February 10, 2020, the Chairman of the Buncombe County Commissioners Brownie Newman, Asheville Mayor Esther Manheimer, and most of the delegation of Buncombe County's elected officials in the North Carolina statehouse lambasted these conditions, finding that "numerous, aggressive staff cuts over the past year, put[] patient safety at risk" and that "HCA has aggressively pursued contract renegotiations with multiple physician practices, resulting in unfortunate outcomes."

178. Due to the Scheme, leading national agencies that assess quality of care factors such as safety, accidents, injuries, infections, and readmissions lowered their ratings for the Defendants' hospital system. The Leapfrog Group, an independent agency, downgraded Mission Hospital-Asheville to a "B" from an "A." According to Leapfrog, the hospital fell short in various measures, including infections, high-risk baby deliveries, some cancer treatment procedures, and the patient experience regarding elective surgeries.

179. The Centers for Medicare & Medicaid Services ("CMS") also downgraded Mission. CMS uses surveys of patients' experiences, including how responsive hospital staff were to their needs and the cleanliness of the hospital environment. In 2020, CMS even threatened to terminate its contract with HCA/Mission over patient safety concerns, a rare and particularly serious step.

180. CMS's most recent ratings graded the Mission-Asheville hospital two out of a possible five stars, compared to four stars at both AdventHealth Hendersonville (formerly Park Ridge Health) and Pardee UNC Health Care in Hendersonville

181. Between August 2018 and January 2019, the Attorney General of North Carolina required Mission and HCA to include certain provisions in the APA to secure his approval. Under these provisions, Defendants promised to uphold certain commitments set forth in the Amended APA.

182. Certain of these commitments have been the subject of multiple public complaints, providing additional evidence of the dramatic reduction in necessary medical care provided by HCA in the Relevant Markets.

183. HCA promised that until January 2029 it would maintain the same level of charity care coverage for poor patients as it had previously. However, contrary to its promises, HCA has (a) reduced coverage for non-emergency services, (b) implemented a threshold such that out-of-pocket expenses must exceed $1,500 to qualify for charity care coverage, and (c) ended pre-approval for charity care coverage such that patients are forced to risk taking on substantial debt or forgo needed care.

184. Due to the Scheme, the Mission Health System now controlled by HCA has rapidly declined, going from one of the most respected hospitals in the nation and a "crown jewel" of North Carolina's health care system to facilities with deteriorating, even dangerous conditions. At the same time, HCA's profits are at an all-time high, driven by the new addition of Mission Hospital-Asheville as the HCA chain's second highest revenue generating hospital out of all 100-plus in the chain.[23] HCA's revenues from Mission Hospital-Asheville were recently reported to be over $1.2 billion, ahead of all but one of the other 100-plus hospitals in the HCA chain and second only to HCA's Methodist Hospital (Texas) which has over twice as many beds.

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[23] Top 50 HCA Hospitals by Net Patient Revenue, https://www.definitivehc.com/blog/top-hca-hospitals-nationwide (reflecting that Mission Hospital-Asheville has the second-highest revenues of all of the HCA hospitals, at $1,209,452,518).

185. In a competitive market, insurers contracting with a hospital can discipline such pricing behavior by threatening in their negotiations, *inter alia*, to take the hospital out of network and to purchase services from a competitor and/or to steer patients to less expensive or higher quality alternatives. But because of Defendants' monopoly power and Scheme to maintain and enhance it, insurance plans are forced to pay artificially inflated prices and endure substandard care.

186. Defendants' Scheme has no procompetitive benefits at all, let alone benefits that could outweigh the foregoing substantial anticompetitive effects.

X. DEFENDANTS' SCHEME HAS CAUSED ANTITRUST INJURY AND DAMAGES TO PLAINTIFFS AND THE CLASS

187. Defendants' Scheme has caused antitrust injury to Plaintiffs and the proposed Class by artificially inflating prices they have paid for GAC and Outpatient Services directly to Defendants in the Relevant Geographic Markets. The alleged unlawful conduct, and Plaintiffs' injuries, are continuing through the present.

188. Plaintiffs' injuries are of the type that the antitrust laws were intended to prevent and flow from that which makes Defendants' acts unlawful under the antitrust laws.

189. More specifically, Plaintiffs' injuries flow from the Scheme, which violates Sections 1 and 2 of the Sherman Act.

XI. CLASS ALLEGATIONS

190. Plaintiffs bring this action on behalf of themselves and as representatives of a Class of similarly situated entities defined as follows:

> All insurers and health plans that paid for GAC Services and/or Outpatient Services in the Asheville Region and/or the Outlying Region directly from one or more Defendants at any time during the period from June 3, 2018 up to the time the alleged ongoing anticompetitive conduct has ceased (the "Class Period"). The Class excludes all federal governmental entities.

191. This class definition is subject to revision or amendment as the matter proceeds.

192. This action is suitable for resolution on a class-wide basis under the requirements of Fed. R. Civ. P. 23.

193. The Class is composed of at least hundreds of members, the joinder of whom in one action is impractical. The Class is ascertainable and identifiable from, inter alia, Defendants' records and documents.

194. Questions of law and fact common to the Class exist as to all members of the Class and predominate over any questions affecting only individual members of the Class. These common issues include, but are not limited to:

a. Whether Defendants have monopoly power demonstrated either through direct or indirect evidence;

b. The definition of the relevant services and geographic markets;

c. Whether Defendants engaged in anticompetitive conduct by willfully or otherwise unlawfully maintaining or enhancing their monopoly power or attempting to do so through the Scheme alleged herein;

d. Whether Defendants' abuse of their monopoly power has substantially foreclosed competition in the Relevant Markets;

e. Whether Defendants' Scheme, or any part thereof, is an unlawful restraint of trade;

f. Whether the Scheme has artificially inflated prices, reduced output, and/or reduced quality in any or all of the Relevant Markets;

g. Whether Plaintiffs and the proposed Class have suffered injury caused by the alleged anticompetitive conduct; and

h. Whether and to what extent Plaintiffs and the proposed Class members are entitled to an award of compensatory damages and/or injunctive, declaratory, or equitable relief.

195. Plaintiffs' claims are typical of the claims of the other Class members. Plaintiffs and the other Class members have been injured by the same wrongful practices. Plaintiffs' claims arise from the same practices and course of conduct that give rise to the other Class members' claims and are based on the same legal theories.

196. Plaintiffs will fully and adequately assert and protect the interests of the other Class members. Plaintiffs have retained class counsel who are experienced and qualified in prosecuting class action cases. Neither Plaintiffs nor their attorneys have any interests conflicting with Class members' interests.

197. This class action is appropriate for certification because questions of law and/or fact common to the members of the Class predominate over questions affecting only individual members, and a class action is superior to other available methods for the fair and efficient adjudication of this controversy, since individual joinder of all members of the Class is impracticable. Should individuals be required to bring separate actions, courts would be confronted with a multiplicity of lawsuits burdening the court system while also creating the risk of inconsistent rulings and contradictory judgments. This class action presents fewer management difficulties while providing unitary adjudication, economies of scale and comprehensive supervision by a single court.

198. The prosecution of the claims of the Class in part for injunctive relief, declaratory, or equitable relief, is appropriate because Defendants have acted, or refused to act, on grounds generally applicable to the Class, thereby making appropriate final injunctive relief, or corresponding declaratory relief, for the Class as a whole.

XII. CLAIMS FOR RELIEF

COUNT ONE

UNLAWFUL MONOPOLIZATION IN VIOLATION OF SECTION 2 OF THE SHERMAN ANTITRUST ACT

199. The above-alleged paragraphs 1 through 198 are incorporated by reference.

200. Defendants have monopolized, and continue to monopolize, the Relevant Services and Geographic Markets alleged herein in violation of Section 2 of the Sherman Act.

201. At all relevant times, including the last four years, Defendants possessed monopoly power in each of the Relevant Markets. Defendants' monopoly power was durable rather than fleeting and included the ability to raise prices profitability above those that would be charged in a competitive market.

202. Defendants unlawfully maintained and/or enhanced the monopoly power through the Scheme alleged herein.

203. Through the Scheme, Defendants were able to charge supracompetitive prices and reduce output in the Relevant Markets.

204. The Scheme caused injury to Plaintiffs and the proposed Class by causing them to pay supracompetitive prices. Plaintiffs and the proposed Class seek to recover for these injuries.

COUNT TWO

RESTRAINT OF TRADE IN VIOLATION OF SECTION 1 OF THE SHERMAN ANTITRUST ACT

205. The above-alleged paragraphs 1 through 204 are incorporated by reference.

206. Through the Scheme alleged herein, Defendants have entered into agreements with health plans that unreasonably restrained trade in each of the Relevant Markets, in violation of Section 1 of the Sherman Act.

207. Defendants possessed market power in each of the Relevant Markets.

208. Defendants' contractual Scheme restrained competition by imposing all-or-nothing contracting, by prohibiting steering and tiered networks, and by preventing the disclosure of price information.

209. There are no pro-competitive justifications for the Scheme.

210. Through the Scheme, Defendants were able to charge supracompetitive prices and reduce output and quality in the Relevant Markets.

211. The Scheme caused injury to Plaintiffs and the proposed Class by causing them to pay supracompetitive prices. Plaintiffs and the proposed Class seek to recover for these injuries.

JURY DEMAND

Plaintiffs demand a trial by jury for all claims so justiciable.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray that this Court enter judgment on their behalf and that of the proposed Class and adjudge and decree as follows:

A. certifying the proposed Class, designating the named Plaintiffs as class representatives and the undersigned counsel as class counsel, and allowing the Plaintiffs and the Class to have trial by jury;

B. finding that Defendants have monopolized, and continue to monopolize, the Relevant Markets alleged herein in violation of Section 2 of the Sherman Act, and that Plaintiffs and the members of the Class have been damaged and injured in their business and property as a result of this violation;

C. finding that Defendants have unlawfully restrained trade in the Relevant Markets alleged herein in violation of Section 1 of the Sherman Act and that Plaintiffs and the members of the Class have been damaged and injured in their business and property as a result of this violation;

D. ordering that Plaintiffs and members of the proposed Class recover threefold the damages determined to have been sustained by them as a result of Defendants'

misconduct complained of herein, and that judgment be entered against Defendants for the amount so determined;

E. awarding reasonable attorneys' fees, costs, expenses, prejudgment and post-judgment interest, to the extent allowable by law;

F. awarding equitable, injunctive, and declaratory relief, including but not limited to declaring Defendants' misconduct unlawful and enjoining Defendants, their officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on their behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts competition in the manner as alleged hereinabove; and

G. awarding such other and further relief as the Court may deem just and proper.

Dated: July 27, 2022.

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*Applications for admission *pro hac vice* forthcoming

Citizen Times

NEWS

Asheville, Buncombe file joint class action lawsuit against HCA Healthcare, Mission Health

Andrew Jones
Asheville Citizen Times

Published 8:51 a.m. ET July 28, 2022

ASHEVILLE - Buncombe County and the city of Asheville have filed a joint class-action lawsuit against HCA Healthcare and Mission Health, alleging the companies have been involved in anti-competitive practices.

The lawsuit is the third of its kind filed in less than a year by Western North Carolina entities. The first was filed in August 2021 by six Asheville-area residents. The second was filed by the city of Brevard.

Previous coverage: Plaintiffs in HCA/Mission antitrust lawsuit double down on anti-steering accusations

“The County Commissioners are concerned that HCA’s business operations monopolize healthcare while artificially inflating prices, and self-insured organizations like ours have no other recourse," Buncombe County Board of Commissioners Chair Brownie Newman said in a news release.

"On behalf of our public employees and our community, we have a responsibility to challenge these unfair business practices that harm patients and families at a time they are often most vulnerable.”

Asheville Mayor Esther Manheimer said the legal action was taken with careful consideration.

Buncombe expansion: 3 hospitals compete for Buncombe expansion: Which does your doctor, mayor support?

“The Asheville City Council and the Buncombe County Board of Commissioners felt it was necessary to take this step to bring an end to predatory practices that limit HCA Healthcare’s competition and clearly result in overpriced and limited choices in people’s healthcare," Manheimer said. "We believe this lawsuit will not only address the damages sustained by local

governments and other self-insured organizations, but will also result in a fair and improved healthcare system for our entire community."

The 59-page complaint "details an extensive pattern of behavior by HCA intended to monopolize healthcare markets in western North Carolina," according to the release. It was filed in the U.S. District Court of Western North Carolina.

The result of these practices, the city and county allege, is artificially high prices for healthcare services and a reduced standard of care that has damaged, and continues to damage, local governments and private entities who act as self-insurers for their employees.

This story will be updated.

Andrew Jones is Buncombe County government and health care reporter for the Asheville Citizen Times, part of the USA TODAY Network. Reach him at @arjonesreports on Facebook and Twitter, 828-226-6203 or arjones@citizentimes.com. Please help support this type of journalism with a subscription to the Citizen Times.

NORTH CAROLINA

BUNCOMBE COUNTY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
No. 21CV 03276

FILED
2021 AUG 10 A 8: 25
BUNCOMBE COUNTY C.S.C.
BY

WILLIAM ALAN DAVIS, RICHARD NASH, WILL OVERFELT, Ed.S BCBA, JONATHAN POWELL, FAITH C. COOK, Psy.D., and KATHERINE BUTTON, on their own behalf and on behalf of all others similarly situated,

Plaintiffs,

v.

HCA HEALTHCARE, INC., HCA MANAGEMENT SERVICES, LP, HCA, INC., MH MASTER HOLDINGS, LLLP, MH HOSPITAL MANAGER, LLC, MH MISSION HOSPITAL, LLLP, ANC HEALTHCARE, INC. f/k/a MISSION HEALTH SYSTEM, INC., and MISSION HOSPITAL, INC.,

Defendants.

CLASS ACTION COMPLAINT

Plaintiffs William Alan Davis, Richard Nash, Will Overfelt, Ed.S BCBA, Jonathan Powell, Faith C. Cook, Psy.D., and Katherine Button, individually, and on behalf of all others similarly situated, bring this action against Defendants HCA Healthcare, Inc. and its affiliates (collectively "HCA"), and Mission Health System, Inc. and its affiliate (collectively "Mission"), and state as follows:

I. NATURE OF THE ACTION

1. This is an action for restraint of trade and unlawful monopolization seeking class-wide damages and injunctive and equitable relief under the North Carolina Constitution (Art. 1, § 34), and North Carolina's antitrust and consumer protection statute (N.C.G.S. § 75-1 *et seq.*).

2. Article 1, Section 34 of the North Carolina Constitution states: "Perpetuities and monopolies are contrary to the genius of a free state and shall not be allowed." However, from 1995 until 2019, Mission operated its hospital system as a monopoly. In January 2019, HCA acquired Mission and to this day continues to operate it as a for-profit monopoly.

3. The original monopoly was created in 1995, when Mission merged with its only significant competitor in the region, St. Joseph's Hospital. As a result of that merger, Mission's flagship Asheville hospital ("Mission Hospital-Asheville") effectively became the only provider of inpatient general acute care ("GAC") hospital services in Buncombe and Madison Counties. From 1995 until 2016, Mission was immunized from antitrust liability by a state statute under which it was issued a Certificate of Public Advantage ("COPA"). COPAs are a form of regulation in which a hospital is permitted to operate as a monopoly in exchange for subjecting itself to state oversight.

4. In 2016, after years of lobbying by Mission executives, the State repealed the COPA, leaving in place an unregulated monopoly. Once that repeal occurred, both Mission and any later purchasers of its assets, including HCA, lost any immunity from suit under the antitrust laws.

5. After the COPA was repealed, and prior to when HCA purchased the assets, Mission engaged in improper restraints on competition by enforcing unlawful terms and arrangements with private payers, including commercial health plans, and third-party administrators ("TPAs") of self-insured plans. These improper restraints included tying, all-or-nothing arrangements, gag clauses, and, on information and belief, other anticompetitive terms and negotiating devices. Each of Mission's anticompetitive acts, together and individually,

increased the prices of hospital services, insurance premiums, copays or deductibles paid by residents of Mission's overall 18-County Western North Carolina service area.

6. In 2019, Mission sold its assets to HCA, the world's largest for-profit hospital chain, and a company that has been subject to approximately 20 prior Federal Trade Commission ("FTC") antitrust proceedings. When HCA purchased Mission's assets effective January 2019, HCA did so precisely because of Mission's outsized ability to dictate prices and other contract terms to its customers.

7. Like Mission before it, HCA has used improper restraints in its agreements and arrangements with commercial health plans and TPAs, including tying, all-or-nothing arrangements, gag clauses, and on information and belief, other anticompetitive terms and negotiating devices. HCA has also refused to fully comply with a rule enacted by President Trump's Administration to increase transparency in healthcare pricing. Were HCA to comply and reveal to consumers and regulators the true prices that it charges, the public would know that HCA/Mission's prices for key services are by far the highest in North Carolina. For instance, according to a large commercial dataset, HCA currently charges ***more than two times the State average for a C-Section without complications***. This price disparity—one matched and exceeded by numerous other procedures—can only exist because of the system's unbridled monopoly power and its status as a "must have" system in Western North Carolina. As a result, individual insurance premiums, which are primarily driven by healthcare costs, are significantly higher in Mission's service area than in surrounding counties and even North Carolina's largest cities.

8. At the same time, to maximize profits, HCA has been cutting costs and staff at an alarming rate, leaving Western North Carolinians with increasingly bad healthcare at an ever-growing price. It has also taken steps to drive business to its more expensive flagship facility in

Asheville, reducing access and increasing travel times for citizens in affected areas. As stated in a July 9, 2021, Executive Order by President Biden: "Hospital consolidation has left many areas, particularly rural communities, with inadequate or more expensive healthcare options." HCA/Mission perfectly encapsulates this troubling trend and the harms consolidation inflicts on the population a hospital purports to serve.

9. Within the applicable damages period commencing on August 10, 2017, Defendants' improper conduct has harmed consumers through higher health insurance premiums, copays, deductibles, and coinsurance payments. Consumers have also lost access to preferred physicians and healthcare providers and experienced worsening facility conditions and service.

10. Reduced quality and higher prices are the hallmark effects of an unregulated monopoly. Today, HCA holds ***an approximate 90% market share*** in the market for inpatient GAC hospital care in Buncombe County, the most populous county in Western North Carolina, and in nearby Madison County. Because insurers and consumers in the region have no choice but to use HCA, HCA has free rein to dictate the prices it charges insurers and consumers while at the same time undermining quality to cut costs.

11. In fact, in the Outlying Regions Inpatient Services-Only Market (defined below), HCA has monopoly (70%-plus)[1] market power across seven Counties: Yancey – 90.9% market share; Madison -- 90%; Buncombe -- 86.6%; Mitchell – 85.4%; Transylvania -- 78.7%; McDowell -- 76.4%; and Macon -- 74.7%.

12. HCA cannot deny the negative effects that unregulated hospital monopolies inflict on our Nation's healthcare system. Indeed, in 2018—while it was negotiating its takeover of

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[1] "Generally speaking, a 70% to 75% market share is necessary to sustain a monopolization claim." *Sitelink Software, LLC v. Red Nova Labs, Inc.*, No. 14 CVS 9922, 2016 NCBC 43, 2016 NCBC LEXIS 45, *29 (N.C. Super. Ct., Wake County June 14, 2016).

Mission—HCA complained to an agency in Florida about a competitor's "monopolistic dominance," stating that "patients suffer from lack of access to care in their community," they "have little to no healthcare provider choice," and "[t]his type of monopolistic environment within the healthcare market stifles innovation and breeds a culture that negatively impacts the cost and quality of care."

13. HCA's behavior since taking over Mission, and Mission's prior abuse of its monopoly power, exemplify why healthcare in the United States costs so much more than elsewhere.

14. Without this Court's intervention, the future of healthcare in Western North Carolina—traditionally a destination for many, including retirees, in part because of its reputation for high-quality, low-cost healthcare—is at risk. Accordingly, Plaintiffs, who each have commercial or self-funded health coverage and have been and continue to be injured by Defendants' practices, sue for class-wide damages and for equitable relief seeking to enjoin the continuation of Defendants' unlawful abuse of their monopoly power.

II. PARTIES

A. Plaintiffs

15. Plaintiff **William Alan Davis** is a citizen of North Carolina who resides in Clyde, Haywood County. Mr. Davis is a participant in a private group healthcare plan and has had to pay higher amounts due to Defendants' conduct.

16. Plaintiff **Richard Nash** is a citizen of North Carolina who resides in Candler, Buncombe County. Mr. Nash is a participant in a private group healthcare plan and has had to pay higher amounts due to Defendants' conduct.

17. Plaintiff **Will Overfelt, Ed.S BCBA** is a citizen of North Carolina who resides in Asheville, Buncombe County. Mr. Overfelt holds an individual Affordable Care Act policy through Blue Cross and has had to pay higher amounts due to Defendants' conduct.

18. Plaintiff **Jonathan Powell** is a citizen of North Carolina who resides in Morganton, Burke County. Mr. Powell holds group health insurance with Blue Cross through his place of employment and has had to pay higher amounts due to Defendants' conduct.

19. Plaintiff **Faith C. Cook, Psy.D.** is a citizen of North Carolina who resides in Asheville, Buncombe County. Dr. Cook holds group health insurance with Blue Cross through an Affordable Care Act plan and has had to pay higher amounts due to Defendants' conduct.

20. Plaintiff **Katherine Button** is a citizen of North Carolina who resides in Asheville, Buncombe County. Ms. Button is a member of a self-funded health insurance plan, and has had to pay higher amounts due to Defendants' conduct.

B. <u>Defendants</u>

21. Defendant **HCA Healthcare, Inc.** is a Delaware corporation with a principal place of business in Nashville, Tennessee. It may be served with process through its principal office address of One Park Plaza, Nashville TN 37203, or through its registered agent, The Corporation Trust Company, at Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware 19801.

22. HCA Healthcare, Inc. is the ultimate parent company of the HCA enterprise and was directly and materially involved through its officers and directors in making the pertinent decisions and undertaking the pertinent actions herein. It is publicly held and listed with the Securities and Exchange Commission ("SEC"). HCA Healthcare, Inc. or its predecessors in interest have been named as respondents in prior antitrust proceedings brought by the FTC and/or

the U.S. Department of Justice ("DOJ"), including with regard to hospital acquisitions and divestments of improper mergers.

23. HCA is the world's largest for-profit hospital chain. It owns and operates over 180 hospitals in 21 states. HCA's revenues were over $51 billion for 2020.[2] Its net income was over $3.7 billion in 2020.

24. Defendant **HCA Management Services, LP** is a Delaware limited partnership with its principal place of business in Nashville, Tennessee. It may be served with process through its principal office address of One Park Plaza, Nashville TN 37203, or through its North Carolina registered agent, CT Corporation System, 160 Mine Lake Court Suite 200, Raleigh, NC 27601.

25. HCA Management Services, LP was formed in 1999. It applied for a certificate of authority to do business in North Carolina on December 28, 2005. It is currently registered to do business in North Carolina. It is listed on the HCA Healthcare website[3] as being the entity responsible for that website.

26. HCA Management Services, LP entered into a confidentiality and nondisclosure agreement with Defendant ANC Healthcare, Inc. f/k/a Mission Health System, Inc. in or about July 11, 2017. At that time, MH Master Holdings, LLLP which was only first organized on August 23, 2018 did not yet exist. Pursuant to negotiations conducted under that nondisclosure agreement, various Mission and HCA entities entered into an Asset Purchase Agreement ("APA") dated August 2018, and an amended Asset Purchase Agreement ("Amended APA") dated January 2019, facilitating the asset sale of relevant Mission system assets to HCA.

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[2] By comparison, according to the National Association of State Budget Officers , North Carolina's total expenditures in fiscal year (FY) 2020 were $60.2 billion, including general funds, other state funds, bonds, and federal funds. HCA Healthcare is at number 62 on the Fortune 500.

[3] https://hcahealthcare.com.

27. Defendant **HCA, Inc.** is a Delaware corporation with its principal place of business in Nashville, Tennessee. It may be served with process through its principal office address of One Park Plaza, Nashville TN 37203.

28. HCA, Inc. is the plan sponsor of a defined contribution plan established January 1, 1983, which provides retirement benefits for all eligible employees of HCA, Inc. or its affiliates. It is the sponsor of the HCA 401(k) Plan, with employer identification number 75-2497104, and a total number of participants of 387,421 as of 2019. On information and belief, HCA, Inc. is the plan sponsor of a retirement benefit plan for numerous employees associated with the North Carolina Division of HCA Healthcare, Inc. It has been a party to prior proceedings challenging various aspects of HCA's business practices. *E.g.,* US DOJ press release dated June 26, 2003.

29. Defendant **MH Master Holdings, LLLP** is a Delaware limited liability limited partnership. HCA has stated in press releases that "Mission Health, an operating division of HCA Healthcare, is based in Asheville, North Carolina, and is the state's sixth largest health system." On information and belief, the "Mission Health" entity to which HCA refers as being "based in Asheville" is MH Master Holdings, LLLP. Accordingly, MH Master Holdings, LLLP has a principal place of business in Asheville, North Carolina. It may be served with process at its registered office address, c/o CT Corporation System, 160 Mine Lake Ct Ste 200, Raleigh, NC 27615, or, at its principal office at 509 Biltmore Avenue, Asheville, NC 28801, or, c/o HCA Healthcare, Inc., One Park Plaza, Nashville, TN 37203.

30. MH Master Holdings, LLLP is listed as the buyer in the asset sale documented by the APA and Amended APA. It purchased the Mission system assets via the Amended APA and is the current owner of the former Mission system assets.

31. MH Master Holdings, LLLP applied for a certificate of authority to do business in North Carolina on August 23, 2018. It filed its most recent annual report with the North Carolina Secretary of State, Department of Corporations ("NC SOS"), on or about April 6, 2021, describing itself as being engaged in the "healthcare related business."

32. MH Master Holdings, LLLP's general partner is MH Hospital Manager LLC. MH Master Holdings, LLLP is a 99% limited partner in MH Mission Hospital, LLLP. Under the Amended APA, MH Master Holdings, LLLP is authorized to do business under brand names including "Mission Health," "Mission Health System" and the "HCA" brand.

33. The "corporate bio" used at the end of many HCA NC press releases, opens, under the header "ABOUT MISSION HEALTH," by stating that "Mission Health [is] an operating division of HCA Healthcare [and] is based in Asheville, North Carolina…."

34. On information and belief, MH Master Holdings, LLLP identifies itself as and holds itself out as being a part of the North Carolina Division of HCA Healthcare, Inc. See, e.g., job postings on websites like "Health Careers," listing open positions at "HCA Healthcare -- North Carolina Division."

35. HCA states in public website content that its "North Carolina Division," also known as, "Mission Health," is "based in Asheville, North Carolina."

36. Per HCA press releases, since February 2019, Greg Lowe has been "president of the newly created Asheville-based North Carolina Division, which comprises the recently purchased Mission Health system of six hospitals in western North Carolina." Upon information and belief, Mr. Lowe resides in North Carolina.

37. Defendant, **MH Hospital Manager, LLC,** is a Delaware limited liability company with a principal place of business in Tennessee or North Carolina. It may be served with process

through its registered agent, c/o CT Corporation System, 160 Mine Lake Court Suite 200, Raleigh NC 27615, or, at its office at 509 Biltmore Avenue, Asheville, NC 28801, or c/o HCA Healthcare, One Park Plaza, Nashville, TN 37203.

38. MH Hospital Manager, LLC applied for a certificate of authority to do business in North Carolina on August 22, 2018. Its annual report dated April 6, 2021, describes the nature of its business as "healthcare related business."

39. MH Hospital Manager uses the assumed business name, "North Carolina Division," pursuant to an assumed name certificate dated April 22, 2019, filed with the Buncombe County Register of Deeds. It described the counties where the assumed business name will be used to engage in business as "All 100 North Carolina counties."

40. Defendant, **MH Mission Hospital, LLLP** is a Delaware limited liability limited partnership. According to Defendants, it is "located in Asheville, North Carolina" and has a principal place of business in North Carolina. It may be served with process at its registered office address, c/o CT Corporation System, 160 Mine Lake Ct Ste 200, Raleigh, NC 27615, or, at its principal office at 509 Biltmore Avenue, Asheville NC 28801, or c/o HCA Healthcare, One Park Plaza, Nashville, TN 37203.

41. Effective July 2019, Chad Patrick became the Chief Executive Officer of what HCA describes as "HCA Healthcare's North Carolina Division's flagship 763-bed Mission Hospital" and resided in Asheville since Summer 2019. On information and belief, the HCA corporate entity employing Mr. Patrick is MH Mission Hospital, LLLP.

42. Defendant **ANC Healthcare, Inc. f/k/a Mission Health System, Inc.** is a North Carolina nonprofit corporation which had its principal place of business in Asheville, North Carolina through 2019. It remains an active corporation incorporated under North Carolina law.

In or about February 2019, its principal office was moved to Florida. It may be served with process through its registered agent, c/o Corporation Service Company, 2626 Glenwood Avenue Suite 550, Raleigh NC 27608, or at its current office address of 425 West New England Avenue Suite 300, Winter Park, FL 32789.

43. ANC Healthcare, Inc. f/k/a Mission Health System, Inc. was incorporated in 1981 as a North Carolina nonprofit corporation. As of the date of the filing of this lawsuit, it remains a nonprofit corporation incorporated under North Carolina law. See Articles of Restatement for Nonprofit Corporation filed February 1, 2019. The corporation is not defunct nor has it been dissolved and in its most recent Articles of Restatement it describes its duration as "unlimited."

44. As of 2015, it described itself as an "integrated healthcare system" which provided "medical care, hospital care" and "the delivery of health care services to persons resident in Western North Carolina and surrounding areas."

45. During the time period commencing in or about 2010 and continuing through and including January 2019, Ronald Paulus ("Paulus") was the President and Chief Executive Officer of ANC Healthcare, Inc. f/k/a Mission Health System, Inc.

46. Defendant **Mission Hospital, Inc.** is a North Carolina nonprofit corporation which had its principal place of business in Asheville, North Carolina through 2019. It remains an active corporation incorporated under North Carolina law. In or about February 2019, its principal office was moved to Florida. It may be served with process through its registered agent, c/o Corporation Service Company, 2626 Glenwood Avenue Suite 550, Raleigh NC 27608, or at its current office address of 425 West New England Avenue Suite 300, Winter Park, FL 32789.

47. Defendant Mission Hospital, Inc. was incorporated in 1951 as a North Carolina nonprofit corporation. As of the date of the filing of this lawsuit, it remains a nonprofit corporation

incorporated under North Carolina law. See Articles of Restatement for Nonprofit Corporation filed February 1, 2019. The corporation is not defunct nor has it been dissolved and in its most recent Articles of Restatement it describes its duration as "unlimited."

48. Defendants ANC Healthcare, Inc. f/k/a Mission Health System, Inc. and Mission Hospital, Inc. are each identified as sellers under the Amended APA. *See* Amended APA, p. 1. Under the Amended APA's terms, ANC Healthcare, Inc. f/k/a Mission Health System, Inc. and Mission Hospital, Inc. remain liable for pre-asset sale ownership or operations of the hospital business. *See* Amended APA, § 2.4 (in which the HCA entities who function as the buyers under the Amended APA purported to exclude from their liability "any Liabilities related to the ownership or operation of the Business or the Purchased Assets prior to the Effective Time").

49. Under the Amended APA, the sellers represented and warranted that they "have operated, and are operating, the Business... and their properties in compliance in all material respects with all applicable Laws," up through the sale date. Amended APA, § 4.11(a)(i). In fact, they did not comply with the laws, as alleged herein.

III. JURISDICTION AND VENUE

50. The Court has subject matter jurisdiction over Plaintiffs' claims under N.C. Const. Art. 1, § 34 and N.C.G.S. § 75-1 *et seq.*

51. The Court has personal jurisdiction over Defendants because they are domiciled in the State or they have transacted business in the State relevant to this antitrust action.

52. Venue is proper in this Court because a substantial part of the events giving rise to Plaintiffs' claims occurred in Buncombe County.

53. The case falls under the local controversy exception to federal jurisdiction under the Class Action Fairness Act. 28 U.S.C. § 1332(d)(4)(A)[4] and (B).[5]

54. The case is properly designated a mandatory complex business case. Under N.C.G.S. § 7A-45.4(a)(3), the case involves disputes under antitrust law, including disputes arising under Chapter 75 of the General Statutes that do not arise solely under G.S. 75-1.1 or Article 2 of Chapter 75 of the General Statutes. Under N.C.G.S. § 7A-45.4(b)(2), the amount in controversy computed in accordance with G.S. 7A-243 is at least five million dollars ($5,000,000) when the claims of the putative class are taken into account.

55. Under the Amended APA, a choice of forum provision specifies the Business Court. Amended APA § 13.2, entitled, Choice of Law and Forum. While Plaintiffs are nonparties to the Amended APA, the Business Court remains the appropriate venue for the instant matter.

56. All Defendants during the pertinent times have participated in significant interstate commerce and the relevant hospital operations have affected interstate commerce.

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[4] "A [federal] district court shall decline to exercise jurisdiction … (A) (i) over a class action in which— (I) greater than two-thirds of the members of all proposed plaintiff classes in the aggregate are citizens of the State in which the action was originally filed; (II) at least 1 defendant is a defendant— (aa) from whom significant relief is sought by members of the plaintiff class; (bb) whose alleged conduct forms a significant basis for the claims asserted by the proposed plaintiff class; and (cc) who is a citizen of the State in which the action was originally filed; and (III) principal injuries resulting from the alleged conduct or any related conduct of each defendant were incurred in the State in which the action was originally filed; and (ii) during the 3-year period preceding the filing of that class action, no other class action has been filed asserting the same or similar factual allegations against any of the defendants on behalf of the same or other persons…." 28 U.S.C. § 1332(d)(4)(A).

[5] A "district court shall decline to exercise jurisdiction" [where] "two-thirds or more of the members of all proposed plaintiff classes in the aggregate, and the primary defendants, are citizens of the State in which the action was originally filed." 28 U.S.C. § 1332(d)(4)(B).

IV. RELEVANT HISTORICAL BACKGROUND

A. Mission acquires monopoly power under the COPA

57. Mission Hospital was originally formed over a century ago as a local Asheville charitable institution. When founded in the 1880s, the Dogwood Mission, also known as the Flower Mission, provided charity care to Asheville's sick and poor.

58. After World War II, Mission Hospital joined with other Buncombe County hospitals to become a major medical center in western North Carolina. In 1951, Mission Hospital was incorporated as a nonprofit. Although it was a nonprofit, it was not under the patronage or the control of the State nor was it a local health authority.

59. As of the early 1990s, the two private acute care hospitals in Asheville were Mission Hospital-Asheville and St. Joseph's Hospital. Mission had 381 beds. St. Joseph's Hospital had 285 beds. The two hospitals sought to partner and lobbied the General Assembly to enact an initial version of the COPA law to facilitate a partnership in 1993.[6]

60. The hospitals claimed that their plans did not call for a merger and that each hospital would maintain its corporate identity, governance structure and assets. Nonetheless, in 1994 the FTC opened an antitrust investigation out of a concern that the combination of St. Joseph's and Mission would result in a single large hospital dominating upwards of 80% or 90% of the market, an undeniable monopoly under the concentration metric the FTC uses.

61. In response, the hospitals lobbied the North Carolina General Assembly to amend the COPA[7] to further immunize them from antitrust scrutiny. The General Assembly did so in December 1995. Mission and St. Joseph's then entered into their partnership.

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[6] Hospital Cooperation Act of 1993, Session Law 1993-529.

[7] *See* N.C.G.S. §§ 131E-192.1 through 131E-192.13 (repealed).

62. Subsequently, in 1998, Mission determined that it desired to buy St. Joseph's, acquire all of its assets, and combine operations under one license as Mission Health System. The COPA was amended in October 1998 to facilitate the merger which then occurred.

63. The COPA statute contemplated that Mission would "limit health care costs" and "control prices of health care services."[8] Effectively, the government and Mission had a deal: If Mission accepted regulation to prevent it from charging monopoly prices or otherwise abusing its monopoly market power, North Carolina would exempt Mission from the antitrust laws.

64. The COPA law acknowledged that the same conduct that may be lawful under the COPA may be unlawful without it, noting that "federal and State antitrust laws may prohibit or discourage" the "cooperative arrangements" that the COPA allowed.[9]

65. When the COPA was amended in 1998 to allow the Mission-St. Joseph's merger, the State accepted the hospitals' representations that the merger "will not likely have an adverse effect on costs or prices of health care."[10]

66. The 1998 amended COPA documented the dominant market share of the merged Mission institution: "The two Hospitals dominate the market share in two counties. 91% of Madison County admissions and 87% of Buncombe County admissions are either Memorial Mission or St. Joseph's Hospital. Memorial Mission and St. Joseph's are located in Buncombe County. Madison County, which has no hospital, is closer to the two Asheville hospitals than to any other acute care hospital."[11]

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[8] *See* former N.C.G.S. §§ 90-21.24, 90-21.28 (enacted by Physician Cooperation Act of 1995, SL 1995-395 (1995)); recodified at N.C.G.S. §§ 131E-192.1 through 131E-192.13 (repealed by Session Laws 2015-288, s. 4, as amended by Session Laws 2016-94, s. 12G.4(a), effective Sept. 30, 2016).

[9] *See* former N.C.G.S. §§ 90-21.24(5).

[10] 1998 COPA, p. 13. *See also id.* at p. 14 (reciting that merger will "not likely have an adverse impact on ... price of health care services").

[11] *Id.*, pp. 7-8.

67. A second amended COPA dated June 2005 stated: "Mission Health dominates the market share in two counties. 93.8% of Madison County admissions and 90.6% of Buncombe County admissions are at Mission Hospitals' facilities, which are located in Buncombe County. Madison County, which has no hospital, is closer to Mission Hospitals in Asheville than to any other acute care hospital."

68. In 2011, a hospital protesting Mission's anticompetitive practices publicized comments by Mission's Communications Director at a conference in which the Director said, "There was a lot of talk about the fact that we are a monopoly, and we are.... We're kinda the 500-pound gorilla in Western North Carolina." The Director was subsequently terminated.

69. As of 2016, Mission continued to have a 93% market share in its primary service area—Buncombe and Madison Counties—for inpatient GAC hospital services. Under modern antitrust law, generally a market share of over 60% constitutes a monopoly. And HCA itself has described a competitor's 85% inpatient market share as a monopoly in another state.

B. Mission engages in anticompetitive conduct under the COPA

70. While the COPA was in effect, it had provisions that sought to limit the ability of Mission to charge supracompetitive monopoly prices for healthcare or otherwise engage in anticompetitive behavior.

71. However, Mission evaded the COPA's substantive restrictions, to the detriment of competition and consumer welfare. Between 1995 and 2016, Mission engaged in anticompetitive conduct by using its monopoly income from Mission Hospital-Asheville to pressure smaller hospitals in the counties surrounding Buncombe and Madison Counties to allow Mission to manage or acquire their businesses. Each time Mission managed to acquire one of the smaller hospitals in the counties surrounding its Buncombe and Madison County primary service area, this

eliminated a potential competitor and expanded the scope of Mission's dominance. Between 1995 and 2016-17, Mission successfully acquired five of the hospitals in those counties.

72. During the same period, Mission acquired and associated with many physician groups and eliminated many of them.

73. From time to time, Mission executives admitted that the purpose of these acquisitions was to reduce competition in those regions. For example, in 2004, when Mission acquired McDowell Hospital, CEO Bob Burgin was quoted as saying that the acquisition would "prevent another provider from entering a local market."

74. In 2004, a group of four large employers in Western North Carolina issued a report on rising medical prices, which noted that Mission refused to cooperate and threatened to sue. The employers expressed their concern that the COPA was "allowing Mission to negotiate reimbursement rates that are higher than in other major counties...." Mission denied that any of this was occurring.

75. In 2011-12, with the COPA coming up for renewal, physicians and other hospitals publicly protested Mission's business practices. One physician described "Mission's abuse of the COPA," which was "a law that was enacted at their request to protect the citizens of [Western North Carolina] from monopolies and high medical prices." He described that by using its Asheville monopoly to charge "higher payments from insurers," Mission was able to "build an unprecedented empire," buying so many practices and other hospitals that competitors, including "those of us in private practice will not be able to survive." This physician described that when he met with Mission executives to try to protect his practice, Mission's response was that they would "crush us."

76. During this period, Mission was publicly claiming that its costs and prices were low. In fact, its prices were high, but they were concealed from regulators and the public due to Mission's use of gag clauses with commercial health plans.

77. A 2011 report by economist Greg Vistnes ("Vistnes Report") commissioned to study the efficacy of the COPA confirmed that a potential for regulatory evasion existed and that "[t]he incentive problems associated with the COPA regulation appear to be consistent with MHS' [Mission Hospital System] observed conduct and complaints about MHS' conduct that have been voiced by certain parties." The report found in part that the COPA created an incentive for Mission to acquire facilities outside of Asheville, because while the COPA limited Mission's ability to raise costs and margins, the cost increase cap was tied *only* to Mission Hospital-Asheville—meaning that if Mission increased costs by acquiring outlying facilities it could raise prices without technically violating the COPA's margin cap. Evidence presented at an FTC workshop in 2019 indicated that this was in fact what Mission appeared to have done.

C. The COPA is repealed in 2016

78. In 2010, Paulus became the new President and CEO of Mission. Paulus almost immediately began an effort to reduce or lift the COPA restrictions while retaining its immunity protection.

79. Paulus claimed that the Mission system could not survive unless the COPA restraints were repealed. These representations were false.

80. In a 2012 video, Paulus criticized the anticompetitive effect of "much larger out-of-area health systems that have entered our region." Paulus claimed that the COPA prevented Mission from competing with these predatory for-profit out-of-state multi-market systems.

81. After years of pressure by Paulus and other Mission executives, the Legislature obliged and passed a bill that repealed the COPA, terminating state oversight effective September 30, 2016.

82. While Mission prices had risen under the COPA, after its repeal they grew even more substantially, as described below.

83. On information and belief, within a year of the COPA's repeal, Mission executives had begun meeting with HCA about selling the system to HCA, an out-of-state system. Upon information and belief, Paulus anticipated the sale to a for-profit chain at the time he lobbied to repeal the statute. However, he did not inform Legislators about that fact.

D. Mission assets are sold to HCA

84. By 2017, Mission's executives had entered secret negotiations to sell assets from the Mission system to HCA, a multi-state health system that has been subject to at least 20 antitrust proceedings brought by the FTC. The negotiation process was conducted without any public notice or input, despite both companies' purported commitment to transparency and Mission's status as a charitable nonprofit with a fiduciary duty to the citizens of Western North Carolina. Non-executive doctors and staff were excluded from the negotiation process and the decision to sell to HCA.

85. Upon information and belief, there were inadequate efforts made to solicit other bidders and any other bids submitted were not taken seriously, resulting in an undervaluation of Mission.

86. Mission and HCA announced the deal on March 21, 2018. It was followed by execution of the 2018 APA on August 30, 2018, and the Amended APA in January 2019. The

purchase price was approximately $1.5 billion. Mission's annual income was estimated to be in the same range, at approximately $1.75 billion, reflecting the undervalued nature of the deal.

87. From approximately 2017 through January 2019, HCA and Mission negotiated the terms of the asset purchase which would form the new North Carolina Division of HCA Healthcare. On information and belief, HCA was interested in the transaction primarily because of the built-in monopoly power Mission had as a result of the COPA.

88. The HCA takeover was hugely beneficial to Mission's executives. In his last four months as CEO of Mission—which, at that point, was still technically a nonprofit—Paulus was paid $4 million in compensation from Mission's 501(c)(3) arm (i.e., its charity). He also secured a contract for himself as a consultant with HCA, under terms that have been kept secret and has, on information and belief, secured other lucrative business related to HCA that is ongoing.

E. HCA engages in post-acquisition conduct that adversely affects physicians, staff, consumers, and the community

89. Defendants' monopolistic practices have caused reduced quality of service in HCA/Mission hospitals. After the sale to HCA, there have been numerous news reports, public protests, over 100 citizen complaints sent into the Attorney General, and statements from area politicians protesting declining quality at the system.

90. Because the asset sale involved the sale of a nonprofit to a for-profit business, it was necessary for Defendants to obtain regulatory approval from the North Carolina Attorney General.

91. Between August 2018 and January 2019, the Attorney General required Mission and HCA to include certain provisions in the Amended APA to secure his approval. Under these provisions, Defendants promised to uphold certain commitments set forth in the Amended APA.

The Amended APA affords the Attorney General the authority to enforce the commitments in the Business Court.

92. The scope of the Amended APA commitments is narrow and is not coextensive with this lawsuit. The Amended APA agreement with the negotiated HCA commitments did not cover quality of care or pricing. However, some of the commitments do cover relevant ground and have been the subject of multiple public complaints:

- HCA promised that until January 2029 it would maintain the same level of charity care coverage for poor patients as before. However, HCA has a) reduced coverage for non-emergency services, b) implemented a threshold such that out-of-pocket expenses must exceed $1,500 to qualify for charity care coverage, and c) ended pre-approval for charity care coverage such that patients are forced to risk taking on substantial debt or forgo needed care.

- Section 7.13(a) and Schedule 7.13(a) require HCA to provide until January 2029 numerous defined services at Mission Hospital-Asheville. However, patients and staff have publicly noted that HCA has reduced budgets and staffing, making it more difficult for medical staff to provide the same quality of service as before.

- Section 7.13(b) and Schedule 7.13(b) required HCA to provide until January 2029 numerous services at its five smaller regional hospitals. HCA has cut budgets, staffing and quality there too. Nurses were so outspoken about their concerns that they voted to unionize, a drastic and effectively unprecedented step.

- Under Section 7.13(j), Defendants asserted they had "no present intent to discontinue any of the community activities, programs or services provided" prior to the buyout. Less than a year later in October 2019, however, HCA closed outpatient rehabilitation clinics in Candler and Asheville. In 2020, it closed primary care practices in Candler and Biltmore Park, and ended chemotherapy services at Mission Medical Oncology locations in Franklin, Brevard, Marion, and Spruce Pine.

93. These cutbacks and profit-driven decisions drew criticism from regulators. Among other things, the Attorney General wrote in February 2020 that the Defendants' "decision to focus on emergent care appears inconsistent with the Asset Purchase Agreement" and that the Defendants' website incorrectly claimed its charity care policy covered "non-elective" services. The Attorney General's office also said they had received a "surge" of complaints after the HCA

sale, including "harrowing" complaints about quality of care and staffing cuts. Other officials, such as the Mayor of Asheville and Buncombe County officials, also publicly expressed "deep concern" about HCA's dramatic cuts and the pressure put on doctors and nurses. Doctors, nurses, and patients have also called the situation created by HCA's cost cutting "dangerous," and have noted that HCA's policies force doctors and nurses to see more patients to maximize profit at the expense of patient care.

94. After the HCA purchase, leading national agencies that assess quality of care factors such as safety, accidents, injuries, infections, and readmissions lowered their ratings for the hospital system. The Leapfrog Group, an independent agency, downgraded Mission Hospital-Asheville to a "B" from an "A." According to Leapfrog, the hospital fell short in various measures, including infections, high-risk baby deliveries, some cancer treatment procedures, and the patient experience regarding elective surgeries.

95. The Centers for Medicare & Medicaid Services ("CMS") also downgraded Mission. CMS uses surveys of patients' experiences, including how responsive hospital staff were to their needs and the cleanliness of the hospital environment. In 2020, CMS even threatened to terminate its contract with HCA/Mission over patient safety concerns, a rare and particularly serious step given Mission's large share of Medicare and Medicaid patients.

96. The Mission Health System HCA now controls has quickly gone from one of the most respected hospitals in the Nation and a "crown jewel" of North Carolina's healthcare system to a facility known for declining, dangerous conditions. Amid the decline, HCA's profits are at an all-time high, driven by the new addition of Mission Hospital-Asheville as the HCA chain's second highest revenue hospital out of all 100-plus ones in the chain.

V. HOSPITAL/INSURANCE MARKETS AND EFFECTS OF CONSOLIDATION

A. Hospital/insurance negotiations in a competitive market.

97. The market for hospital services is different from other product/services markets because the person consuming the hospital services (the patient) does not negotiate—and in many cases, does not even know beforehand—the costs of the services they are consuming.

98. Instead, commercial health plans, such as Blue Cross and Aetna, purchase medical services for the benefit of their insured members, the consumers. Commercial health plans negotiate with hospitals for the price the plans will pay for medical services, known as the "allowed amount," before services are consumed by members.

99. Commercial health plans generally do not negotiate with hospitals on a service-by-service basis; rather, commercial health plans negotiate with hospitals for bundles of services that the health plan will offer to members as "in-network" benefits. If the commercial health plan and hospital reach a deal for a bundle of services (for instance, all acute inpatient hospital services), the hospital will be considered in-network for every service in that bundle. This means that for any service in that bundle, if a commercial health plan's member receives that service from the hospital, the commercial health plan will pay the hospital the allowed amount those two parties negotiated for that service.

100. In competitive markets—markets with multiple hospitals—commercial health plans will enter into a contract with a hospital for a bundle of services when the hospital offers competitively priced and sufficiently high-quality services. In competitive markets, commercial health plans may choose to include as in-network some bundles of services at a hospital but not others; for instance, the commercial health plan may choose to have one hospital be in-network for all acute inpatient hospital services, but the plan may choose not to include that hospital in-

network for some acute outpatient hospital services (visits not requiring an overnight stay) because the plan could purchase higher quality versions of those outpatient services from a nearby competing hospital or other outpatient provider at a lower price. Similarly, in a competitive market, a commercial health plan may decline to purchase any services from a hospital if that hospital's price or quality of care are not competitive with other nearby providers.

101. If a commercial health plan wishes to be a viable product that consumers wish to purchase for themselves (or employers wish to purchase for their employees), the plan must include a comprehensive bundle of services that members can access in their region. A commercial health plan that does not offer in-network services that individuals commonly desire or that individuals may need in the case of unforeseen health problems will not be a viable insurance plan. Similarly, if a commercial health plan only offers certain services (such as acute inpatient hospital services) in-network at a hospital that is a long distance from many individuals' residences, that plan will not be viable, because individuals may not be able or willing to travel so far to receive those services.

102. The costs that commercial health plans pay hospitals for the in-network services they offer members are ultimately passed onto their members, such as the Plaintiffs, in the form of commercial health insurance premiums. Thus, the insurance premiums paid by commercial health plan members increase when the plans are forced to purchase services from hospitals at higher rates. Health plan members also pay directly for the costs of medical services provided by hospitals in the form of co-insurance payments and other out of pocket payments, such as co-pays.

103. In a competitive market, hospitals compete to be selected for inclusion in commercial health plans. Then, commercial health plans compete to be selected by employers to offer to their workers, or they compete to be selected by individuals.

B. Hospital/Insurance negotiations in the absence of competition.

104. The unique mechanics of the healthcare market described above provide an opportunity for hospital conglomerates with significant market power to illegally restrain trade through unduly restrictive negotiations and agreements with commercial health plans that extract supracompetitive prices. Supracompetitive prices are rates that are higher than what would be found in the context of normal competition. In the market for hospital services, supracompetitive prices come in the form of inflated allowed amounts, which directly lead to higher insurance premiums and coinsurance payments.

105. When a commercial health plan seeks to offer a plan in a region where a significant area is controlled by a single hospital, that hospital is in effect a "must have" hospital for that health plan: Individuals and employers seeking insurance will not choose any health plan that does not include necessary services provided by that hospital.

106. If a "must have" hospital decides to engage in anticompetitive behavior, it can cause significant financial harm to both commercial health plans as well as employers and individuals purchasing such plans. First, a "must have" hospital can demand from commercial health plans allowed amounts that are grossly above what the hospital could obtain if it faced competition. This is true both by virtue of the hospital's extant market power, as well as the enormously high barriers to entry when it comes to many services hospitals provide. These barriers to entry, which include the costs of building facilities and hiring skilled staff (such as surgeons and anesthesiologists) as well as regulatory hurdles such as obtaining a certificate of need from the State before opening a new facility, prevent new entrants from entering the market and reining in the price the "must have" hospital can charge. Second, if the "must have" hospital is part of a system that has other facilities that *do* face competition, the hospital system can refuse to offer medical services at the

"must have" facility unless commercial health plans also agree to purchase medical services from the system's other facilities at high prices dictated by the hospital system.

107. These factors and others have led to a consensus in the field of healthcare economics that monopolization of hospital markets significantly increases prices for hospital services paid by commercial health plans and by employers and individuals, in the form of higher direct payments to hospitals and higher insurance premiums. And the economic literature strongly suggests that there are no concomitant improvements in quality from such monopolization. HCA itself stated in a regulatory filing in Florida, "there is documented empirical evidence of the negative aspects of lack of competition in a healthcare market on charges, costs, and quality of care" and that "economic studies consistently demonstrate that a reduction in hospital competition leads to higher prices for hospital care."

C. Relevant markets

108. Judgment may be entered against Defendants for the illegal conduct described in this complaint without defining the particular economic markets that Defendants' conduct has harmed. Defendants' ability to impose anticompetitive contract terms in all, or nearly all, of its agreements with commercial insurers and their ability to persistently charge supracompetitive prices are direct evidence of Defendants' market power that obviates any need for further analysis of competitive effects in particular defined markets. Moreover, market definitions are unnecessary because Defendants' anticompetitive behavior is a per se violation of N.C.G.S. § 75-1 *et seq*.

109. Notwithstanding the foregoing, the relevant markets at issue in this case are defined herein. For each, the product market includes only the purchase of medical services by commercial health plans, including individual, group, fully insured, and self-funded health plans, as well as related payments by patients directly to providers through coinsurance or otherwise. The relevant

product markets do not include sales of such services to government payers, e.g., Medicare, Medicaid, and TRICARE (covering military families), because a healthcare providers' negotiations with commercial health plans are separate from the process used to determine the rates paid by government payers.

110. The three markets that are relevant to the illegal conduct described in this complaint are properly defined as follows:

1. Primary Relevant Market: Asheville Region Inpatient Services

111. A relevant market in which Defendants have unlawfully maintained and leveraged their monopoly power is the sale of inpatient general acute care hospital services to insurers (or self-funded TPAs) in Buncombe and Madison Counties (the "Asheville Region Inpatient Services Market"). Defendants participate in the Asheville Region Inpatient Services Market predominately through their flagship facility, Mission Hospital-Asheville.

112. The sale of acute inpatient general acute care (previously defined as GAC) hospital services is a relevant product market. Acute inpatient hospital services consist of a broad group of medical and surgical diagnostic and treatment services that include a patient's overnight stay in the hospital. Although individual acute inpatient hospital services are not substitutes for each other (e.g., orthopedic surgery is not a substitute for gastroenterology), commercial health plans typically contract for various individual acute inpatient hospital services as a cluster in a single negotiation with a hospital system. That is how Defendants negotiate with insurers with respect to acute inpatient hospital services at Mission Hospital-Asheville. Moreover, non-hospital facilities, such as outpatient facilities, specialty facilities (such nursing homes), and facilities that provide long-term psychiatric care, substance abuse treatment, and rehabilitation services are not viable substitutes for acute inpatient hospital services. Consequently, commercial health plans'

and consumers' demand for acute inpatient hospital services is generally inelastic because such services are often necessary to prevent death or long-term harm to health. Thus, such services can be treated analytically as a single product market.

113. The relevant geographic market for this product market is Buncombe and Madison Counties (the "Asheville Region"). Defendants themselves have specified Mission Hospital-Asheville's service area to include Buncombe and Madison Counties.[12] The Dartmouth Atlas of Health Care—a well-established industry authority that defines geographic hospital markets—defines the "Health Referral Region" for all of the Mission System hospitals as "NC-ASHEVILLE."[13] The 2010 census reported the population of Buncombe County was 238,318 and the population of Madison County was 20,764.

114. Commercial health plans contract to purchase acute inpatient hospital services from hospitals within the geographic area where their enrollees are likely to seek medical care. Such hospitals are typically close to their enrollees' homes or workplaces. Insurers who seek to sell commercial health plans to individuals and employers in the Asheville Region must include hospitals in that region in their provider networks, because people who live and work in the Asheville Region strongly prefer to obtain acute inpatient hospital services in that area and it could be medically inappropriate and unfeasible to require them to travel farther. Consumers in the Asheville Region have little or no willingness or practical ability to enroll in a commercial health plan that provides no network access to acute inpatient hospital services located in the Asheville Region.

[12] *E.g.*, Mission Hospital Implementation Strategy, 2013-15, p. 1 ("Our community, defined for the purposes of community health needs assessment and this related implementation strategy, is comprised of Buncombe and Madison Counties."), https://missionhealth.org/wp-content/uploads/2018/04/2013-Mission-Hospital-Implementation-Strategy.pdf (accessed June 2, 2021). *See also* IRS Form 990 for period ending September 2019, Schedule H, supplemental information ("Mission Hospital primarily serves Buncombe and Madison Counties").
[13] Dartmouth Atlas of Health Care, https://www.dartmouthatlas.org/about/ (accessed July 12, 2021).

115. For these reasons, there are no reasonable substitutes or alternatives to acute inpatient hospital services in the Asheville Region for insurers wishing to offer commercial health plans in that area. Nor is it viable for patients to seek acute inpatient hospital services elsewhere. Consequently, competition from providers of acute inpatient hospital services located outside the Asheville Region would not likely be sufficient to prevent a hypothetical monopolist provider of acute hospital services located in the Asheville Region from profitably imposing small but significant price increases for those services over a sustained period of time.

116. Defendants have a market share of approximately 80% to 90% for acute inpatient hospital services in Buncombe County and Madison County, primarily due to the regional dominance of Mission Hospital-Asheville. Defendants' market share in this market is significant enough to stifle competition and restrict freedom of commerce, and, during the relevant period, Defendants have had the ability to control the price for this market.

2. *Other Relevant Markets*

a. *Asheville Region Outpatient Services*

117. A second relevant market is the sale of outpatient medical services to insurers in Buncombe and Madison Counties ("Asheville Region Outpatient Services Market"). In general, outpatient medical services encompass all the medical services a hospital provides that are not inpatient medical services (i.e., services that do not require an overnight stay). Defendants participate in this market through their flagship facility, Mission Hospital-Asheville, and other HCA/Mission outpatient facilities in Buncombe and Madison counties.

118. The sale of outpatient medical services is a relevant product market. Outpatient medical services consist of a broad group of medical, diagnostic, and treatment services that do not include a patient's overnight stay in the hospital. Although individual outpatient medical

services are not substitutes for each other (e.g., a CT scan is not a substitute for an annual physical), commercial health plans typically contract for various individual outpatient medical services as a cluster in a single negotiation with a hospital system, and that is how Defendants negotiate with insurers with respect to outpatient hospital services at Mission Hospital-Asheville.

119. Unlike for acute inpatient hospital services, non-hospital facilities—such as independent primary care providers, specialty facilities, ambulatory surgical centers, nursing homes and facilities that provide long-term psychiatric care, substance abuse treatment, and rehabilitation services—can be substitutes for outpatient medical services provided at a hospital. Consequently, insurers' and consumers' demand for outpatient medical services *from a hospital* is generally more elastic because, if given the opportunity, they could obtain some of these services from non-hospital providers. But demand for outpatient medical services *in general* is inelastic because such services are often necessary to prevent illness, loss of physical mobility, or long-term harm to health. Thus, outpatient medical services can be treated analytically as a single product market.

120. As with the primary relevant market described above, Asheville Region Inpatient Services, the relevant geographic market for this market is the Asheville Region.

121. Insurers contract to purchase outpatient medical services from hospitals and non-hospital providers within the geographic area where their enrollees are likely to seek medical care. Such providers are typically close to their enrollees' homes or workplaces. Insurers who seek to sell insurance plans to individuals and employers in the Asheville Region must include providers in that Region in their provider networks, because people who live and work in the Asheville Region strongly prefer to obtain outpatient medical services in that area, and it could be medically inappropriate to require them to travel farther. Consumers in the Asheville Region have little or

no willingness or practical ability to enroll in an insurance plan that provides no network access to outpatient medical services located in the Asheville Region.

122. For these reasons, there are no reasonable substitutes or alternatives to outpatient medical services in the Asheville Region for insurers wishing to offer insurance plans in that area. Nor is it viable for patients to seek outpatient medical services elsewhere. Consequently, competition from providers of outpatient medical services located outside the Asheville Region would not likely be sufficient to prevent a hypothetical monopolist provider of outpatient medical services located in the Asheville area from profitably imposing small but significant price increases for those services over a sustained period of time.

123. The Asheville Region Outpatient Services Market is a separate market from the Asheville Region Inpatient Services Market because they are not interchangeable and can be sold separately. Commercial health plans can and often do purchase outpatient services from different providers (i.e., non-hospital providers) than they purchase acute inpatient hospital services, which can only be purchased from hospitals. The existence of non-hospital competitors would, in a competitive market absent any anticompetitive behavior, reduce the price commercial health plans would pay a hospital for outpatient medical services, but those competitors would not affect the price a hospital could charge for acute inpatient hospital services. The markets are therefore distinct.

b. Outlying Regions Inpatient and Outpatient Services

124. Other relevant markets at issue in this case involve the markets for (a) acute inpatient hospital services, and (b) outpatient medical services, in Outlying Regions in Western North Carolina in which or near where Defendants operate five Outlying Facilities. ("Outlying Regions Inpatient and Outpatient Services Market").

125. The relevant products in these markets—acute inpatient hospital services and outpatient medical services—are defined the same as for the Asheville Region, and those definitions in the preceding paragraphs are realleged here.

126. The relevant geographic markets for these markets include the regions inclusive of Macon, McDowell, Mitchell, Transylvania and Yancey Counties (the "Outlying Regions") in which, or near which, Defendants' five outlying facilities (the "Outlying Facilities") operate:

- **Transylvania Regional Hospital**, Transylvania County
- **Angel Medical Center,** Macon County
- **Highlands-Cashiers Hospital**, Macon County
- **Mission Hospital McDowell,** McDowell County
- **Blue Ridge Regional Hospital,** Mitchell County

127. Unlike Mission Hospital-Asheville, several of these Outlying Facilities face some competition for acute inpatient hospital services and compared to Mission Hospital-Asheville they face more significant competition for outpatient medical services, from other hospitals and non-hospital providers in the geographic regions in which they operate. Thus, due to this heightened level of competition, commercial health plans seeking to build a viable insurance network may not, absent Defendants' anticompetitive conduct, be required to include all these facilities in-network in order to be viable. Or commercial health plans would be able to negotiate a lower price for acute inpatient hospital services or outpatient medical services at these facilities.

128. The Outlying Regions Inpatient and Outpatient Market is a separate market from the Asheville Region Inpatient Services Market because they are not interchangeable and can be sold separately. Despite some geographic overlap, the two markets involve different facilities, operating primarily in different regions, and they offer different types of service. For instance, in the Asheville Region, Defendants offer acute trauma care, whereas this service is not offered by any of the Outlying Facilities. Moreover, some of Defendants' Outlying Facilities face more

competition from other providers than Defendants' facility at Mission Hospital-Asheville faces, particularly for acute inpatient hospital services. Commercial health plans can and often do purchase outpatient services from different providers (i.e., non-hospital providers) than they purchase acute inpatient hospital services from, which can only be purchased from hospitals. The competition the Outlying Facilities face from both other hospitals and non-hospital facilities would, in a competitive market absent any anticompetitive behavior, reduce the price commercial health plans would pay the Outlying Facilities for inpatient and outpatient services, but those competitors would not have an effect on the price a hospital could charge for acute inpatient hospital services in the Asheville Region. The markets are therefore distinct.[14]

D. Defendants' Market Power

129. Since the repeal of the COPA in 2016, Defendants have operated an unregulated monopoly in the Asheville Region, particularly with respect to acute inpatient hospital services. Defendants have likewise leveraged their monopolistic market power to increase their dominance and pricing in the markets for Asheville Region Outpatient Services and the Outlying Regions Inpatient and Outpatient Facilities. This has resulted in a situation where, both within the Asheville Region and its surrounding areas, Defendants are able to control the prices paid by commercial health plans and patients.

130. Defendants have a market share of 80 to 90% for acute inpatient hospital services in both Buncombe County and Madison County, i.e., the Asheville Region Inpatient Services Market. The Medicare Hospital Market Service Area File for the calendar year ending December 31, 2019, reflects that, with regard to inpatient origin for the top three zip codes, Mission Hospital-Asheville's market share was as follows: market share of 88.9% for zip code of residence 28806;

[14] See also alternative market allegations under Count I.

market share of 86.5% for zip code of residence 28803; and market share of 87% for zip code of residence 28715.[15]

131. While sometimes not as high as in Asheville, Defendants also have significant market share in certain surrounding geographic regions, in part because they can exert control over referrals in those regions through their dominance at Mission Hospital-Asheville. Outside of Asheville, Defendants' market share often exceeds 75% in areas where Defendants have only a small hospital with less than 30 beds but where a large portion of patients are also directed to the more distant Mission Hospital-Asheville. Defendants have used their monopoly in acute inpatient hospital services in Buncombe and Madison Counties to attempt to monopolize inpatient and outpatient services in other counties like Macon, McDowell, and Mitchell—each of which where they now hold above 70% market share for inpatient hospital services when combining inpatient referrals to Asheville and their small regional hospitals' inpatient services. Alternatively, Defendants have established additional monopolies in each of these counties where they hold over a 70% market share (See Count I below).

132. Defendants have maintained this market share since the COPA's repeal because of the anticompetitive negotiating and contracting practices at issue in this suit. These anticompetitive practices, described in more detail hereafter, have led directly to significant price increases at all of Defendants' facilities, for both inpatient and outpatient care, and these higher prices have led directly to severely increased premiums paid by Plaintiffs and the putative class.

[15] See American Hospital Directory, available at https://www.ahd.com/free_profile/340002/Mission_Hospital_-_Memorial_Campus/Asheville/North_Carolina/ (accessed June 26, 2021).

VI. DEFENDANTS' ANTICOMPETITIVE PRACTICES HAVE HARMED COMPETITION, RESULTING IN HIGHER PRICES AND WORSE QUALITY

133. During the pertinent times and within the last four years, Defendants have engaged in anticompetitive negotiating tactics with commercial health plans and/or have insisted on contract terms including one or more anticompetitive provisions with insurers. These negotiating tactics and contract clauses have included: tying arrangements and all-or-nothing arrangements, gag clauses, and, on information and belief, non-participating provider rate clauses and anti-tiering or anti-steering arrangements. The use of anticompetitive provisions and arrangements is consistent with the areas of regulatory evasion identified in the Vistnes Report and with HCA's documented use of similar provisions and negotiating tactics in other states.

134. Individually and in combination, these contract provisions are designed to suppress competition and transparency in the market for the sale of acute hospital services and increase the prices Defendants can charge commercial health plans. Defendants use their market power to force insurers to accept these restrictions which have the following anticompetitive effects:

- protecting Defendants' market power and enabling Defendants to raise prices and reduce quality of acute inpatient hospital services substantially beyond what would be tolerated in a competitive market, to the detriment of consumer welfare;
- substantially lessening competition among providers in their sale of acute inpatient hospital services;
- preventing the entry of potential competitors into the market by forcing insurers to agree to terms that bar them from sharing competitive pricing information;
- preventing the entry of potential competitors into the market by forcing insurers to agree to terms that bar them from directing consumers to lower cost providers;
- restricting the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for acute inpatient hospital services;
- reducing consumers' incentives and ability to seek or even be aware of acute inpatient hospital services from more cost-effective providers; and

- depriving consumers of the benefits of a competitive market for their purchase of inpatient hospital services.

135. These types of arrangements and agreements have been found to be illegal even in markets with more robust provider competition than exists here, due to their inherent harm to consumer welfare and competition. However, because Defendants have an unregulated monopoly (instead of a built-out market power in a free market), the illegal anticompetitive impacts on consumers are much more severe. Most obviously, healthcare costs in the Western North Carolina market area that Defendants control are now dramatically higher than the North Carolina average and still rising while quality is declining.

136. Anticompetitive contract provisions and negotiating tactics are particularly problematic when a provider controls a "must have" hospital, as HCA acquired here when it acquired Mission Hospital-Asheville. It is not practically possible to assemble a commercially viable insurance plan in Western North Carolina that excludes Mission Hospital-Asheville. In a market with a "must have" hospital, even the limited use of these contract provisions or negotiating tactics causes much greater harm to consumers and potential competitors than the use of such practices and provisions in a competitive market.

137. On information and belief, HCA/Mission has been among the most intransigent of all systems in North Carolina during contract renewals and other negotiations with insurers. Defendants have continued to insist on higher prices for declining quality of service because they are aware of their "must have" status for commercial health plans and TPAs.

138. An insurance official summed up the problem with HCA/Mission in two words: "their price." The excessive price increases being billed directly and indirectly to Plaintiffs and other patients would have been unlawful under the COPA, unsustainable in a competitive market, and unrealistic before the HCA takeover.

A. **<u>Defendants willfully and unlawfully acquired and/or maintained monopoly power</u>**

139. Neither Mission nor HCA acquired monopoly power by outcompeting rivals on price and quality as our antitrust laws envision. Instead, Mission became a monopoly solely by virtue of a merger that would have been unlawful under the antitrust law but that was shielded from suit by the protection the COPA gave from antitrust scrutiny.

140. Once Mission became so large as to be both indispensable to commercial health plans and insulated from any meaningful competition, particularly for acute inpatient hospital services, Mission's executives sought and obtained the COPA's repeal, freeing it from any relevant government restrictions. HCA then purchased the monopoly in a cross-market merger and has further exploited the system's market dominance by raising prices and cutting costs in ways that have harmed quality of care. Now and for the last several years, neither Mission nor HCA has immunity from antitrust liability, meaning their unlawful acquisition and maintenance of this monopoly is properly the subject of this lawsuit.

1. While the COPA was in effect, Mission circumvented its restrictions to gain additional market power and raise prices

141. The COPA did not directly regulate the prices Mission could charge for services, but it sought to do so indirectly through several limitations on the way Mission could do business. Most notably, the COPA imposed three purported caps on Mission's operations: a margin cap, a cost cap, and an employed-physician cap.

142. The COPA's margin cap on Mission was systemwide—Mission as a whole was not allowed to raise its profit margin by more than a certain amount compared to comparable hospitals. But the cost cap was specific only to Mission Hospital-Asheville: That facility could only increase

its costs at the same rate as a national index, but there was no limit on how much Mission could increase its costs at other facilities.

143. In 2011, the Vistnes Report concluded that this structure gave Mission an incentive to increase spending on Outlying Facilities—including by purchasing new ones—so as to push its overall costs up, thereby allowing it raise prices to earn a higher profit while still meeting the percentage margin cap.

144. Under the COPA, Mission grew its market share in Western North Carolina. It did so by acquiring the five smaller Outlying Facilities, each time eliminating a competitor in the process. In doing so, Mission could increase its costs without affecting the cost cap, thereby allowing it to increase prices at all of its facilities without violating the COPA's margin cap.

145. Thus, while the COPA was designed to ensure Mission's recognized monopoly power in the market for acute inpatient hospital services did not harm consumers in the region, Mission grew substantially more dominant by acquiring competing practices, expanding its geographic reach, and moving costs from Mission Hospital-Asheville to its Outlying Facilities. This caused Mission's prices to raise across the board, including for acute inpatient hospital services.

146. In 2019, after the COPA was repealed, two FTC economists, Lien Tran and Rena Schwarz, concluded that the COPA's margin and caps did not prevent Mission from raising prices 20 percent more than similarly situated hospitals: "The evidence suggests that, despite the margin/cost regulations, the COPA oversight did not prevent [Mission] from raising prices."

147. As a result of these findings, the FTC in 2020 held up the example of the Mission Hospital COPA as a reason why a COPA proposed for another State, Texas, should not be allowed:

> In 2015, the North Carolina legislature repealed the state's COPA statute as a result of lobbying efforts by Mission Health, and the Mission Health COPA was

terminated as of September 2016 – leaving no meaningful competitive or regulatory constraint on Mission Health's monopoly market power. In February 2019, Mission Health was acquired by HCA Healthcare.

At the FTC COPA Workshop, empirical research was presented on the price effects of the Mission Health COPA for inpatient hospital services from 1996 to 2008. The study showed that Mission Health increased its prices by at least 20% more than the control hospitals during the COPA period, suggesting that despite the margin and cost regulations, state COPA oversight did not prevent Mission Health from raising prices….

Kip Sturgis, from the North Carolina Attorney General's office, was responsible for overseeing the Mission Health COPA for nearly 20 years. Mr. Sturgis explained that in hindsight, he would have implemented more quality metrics and financial incentives for the hospital to control costs. He does not recommend that states use COPAs due to the potential for regulatory evasion during the COPA period, and the ability of hospitals to eventually be freed of COPA oversight, which leaves the community with an unregulated monopoly.

2. HCA purchased Mission in order to acquire a monopoly system and exploit that market power

148. After the COPA was repealed, HCA acquired Mission precisely because of its (now unregulated) monopoly power, and with the knowledge that, as a larger national for-profit chain, it would be better positioned to exploit Mission Health's monopoly power in Western North Carolina. As noted at the time:

- A former HCA executive remarked: "[I]t is a high growth market *where they have no competition* and their margins are already strong" and "HCA is parachuting into Asheville and getting the benefit of a COPA *without any restrictions*." (Emphases added).

- A leading healthcare finance reporter observed that the Mission acquisition "fits with HCA's longstanding strategy of scooping up facilities that dominate their markets, which helps the company negotiate better rates with health insurers."

- HCA in communicating with Wall Street analysts has called Mission a "market maker" that "need[ed] to be a part of something bigger," citing the acquisition as a "model" for acquiring market power. Shortly after the acquisition, HCA executives told Wall Street analysts that the company's "market share has reached an all-time high using the most recently available data. *But we are pushing for more.*" (Emphasis added).

149. Prior to the HCA acquisition of the Mission system, HCA owned hospitals in a variety of important markets across the country, but not in North Carolina. Thus, when HCA acquired Mission, it was not the case of one competitor in the same town or region acquiring another. Rather, a dominant hospital owner in many other markets (HCA) acquired the dominant hospital system in the Western North Carolina market (Mission).

150. According to peer-reviewed published studies, one effect of a cross-market or multi-market merger is to cause an increase in healthcare prices.

151. On information and belief, HCA uses its market power via its ownership of hospitals in other markets to leverage insurance companies to agree to higher prices at HCA/Mission hospitals, and vice versa.

152. The FTC has on multiple occasions challenged in-market mergers due to the anticompetitive effect of such mergers.

153. A cross-market merger of the type that has occurred here likewise has an anticompetitive effect.

154. In 2019, 61 percent of US workers with employer-sponsored health coverage were enrolled in self-insured plans, including 17 percent in small firms and 80 percent in large firms.[16]

155. Large firms likely have territories extending beyond the 18-county scope of the Western North Carolina region identified by HCA as Mission's extended service area.

156. When large self-funded employers negotiate with HCA, it becomes relevant to the negotiation that HCA not only owns hospitals in NC but also in many other states.

[16] Kaiser Family Foundation, 2019 Employer Health Benefits Survey, Sept. 25, 2019, https://www.kff.org/report-section/ehbs-2019-summary-of-findings/ (accessed Aug. 3, 2021).

157. Large self-funded employers are currently unable to restrain increases in healthcare prices caused by the concentration of market power into large for-profit hospital chains like HCA.[17]

158. Allowing HCA to join into its national network the monopoly in Western North Carolina increases the anticompetitive effect of the monopoly far beyond where it was when only local nonprofit Mission owned it.

159. Large self-funded employers and their TPAs pay more for access to the Mission hospital monopoly as part of HCA's Western North Carolina region than they would pay for that access if Mission was only part of a western North Carolina hospital network.

160. The antitrust law restrains mergers to the extent that such combinations may tend to lessen competition.

161. The asset sale of the Mission Hospital monopoly from old owner Mission to new owner HCA was an unlawful merger or acquisition because it resulted in a lessening of competition.

B. Defendants abuse their monopoly power by unreasonably negotiating with commercial health plans and charging supracompetitive prices

1. *Mission unreasonably withheld essential services from commercial health plans and raised prices to supracompetitive levels after the COPA's repeal*

162. As noted above, Mission raised prices much more than regulators anticipated—or were even aware about—while the COPA was in effect. These high prices were the result of regulatory evasion by Mission and they were concealed by gag clauses. Mission's public statements regarding its costs and prices were inaccurate, unfair, and deceptive.

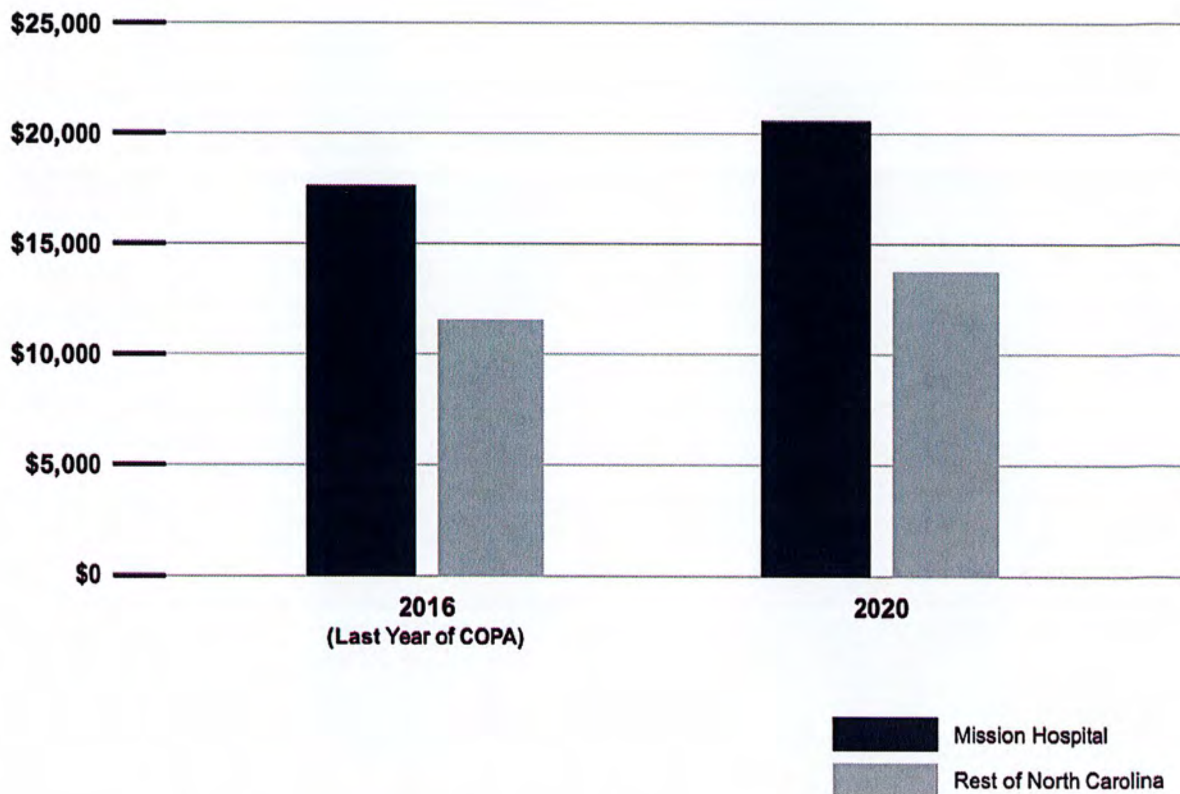
[17] Matthew D. Eisenberg, Mark K. Meiselbach, Ge Bai, Aditi P. Sen, Gerard Anderson, Large Self-insured Employers Lack Power to Effectively Negotiate Hospital Prices, The American Journal of Managed Care, July 13, 2021, Volume 27, Issue 7, https://www.ajmc.com/view/large-self-insured-employers-lack-power-to-effectively-negotiate-hospital-prices (accessed Aug. 3, 2021).

163. But the situation got worse after the COPA was repealed and Mission was free from any semblance of State oversight. Specifically, after the COPA was repealed, two things relevant to healthcare cost and quality in Western North Carolina happened almost immediately: (1) Mission negotiated with insurers for price increases in aggressive ways the COPA would have prevented, and (2) Mission executives began secretly negotiating a sale to HCA.

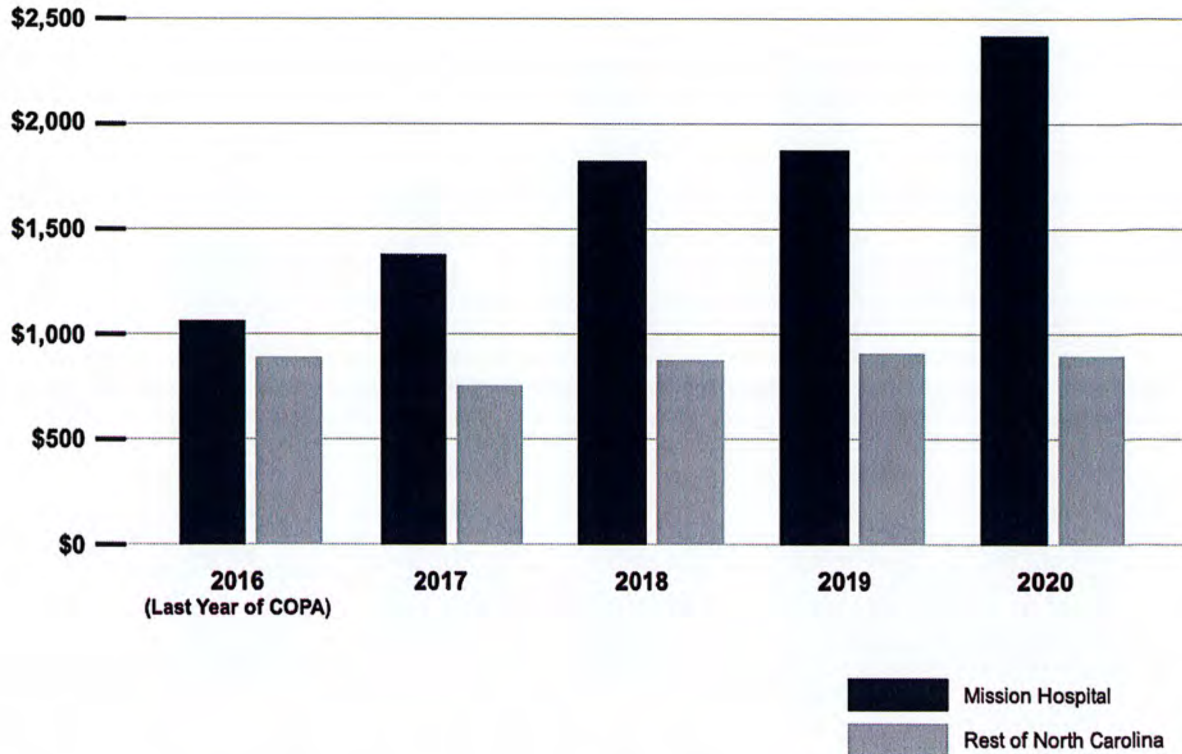
164. In 2017, Mission engaged in its first major post-COPA negotiation with Blue Cross, the State's largest health plan, over reimbursement rates. While details of the negotiations were kept secret, on information and belief Mission asked for exorbitant increases in the prices Blue Cross and its members were paying. When Blue Cross did not agree, Mission took its entire system "out of network," meaning that the 260,000 people in Western North Carolina insured by Blue Cross could not seek care at Mission facilities unless they paid much higher prices out of their own pocket. While hospital systems and insurers regularly negotiate over rates, a hospital system taking an insurer out of network is considered "go[ing] nuclear." This disrupted the administration of healthcare in the region, requiring Blue Cross members to switch doctors, forgo medical care, or drive long distances to receive care at a non-Mission facility. Mission remained out of network for Blue Cross for two months, until the two parties reached an agreement in which on information and belief Mission still received a rate increase but not as high as originally demanded. On information and belief, Mission's aggressive and unreasonable stance in these negotiations would not have occurred under the COPA.

165. While the resolution of that dispute was kept secret, available data confirms that Mission got much of what it wanted: significantly higher prices for GAC services. After the COPA was repealed, the allowed amount Mission received from commercial health plans increased substantially, beyond what would be found in a competitive market. For example, within a large

commercial claims dataset, the average allowed amount paid by most commercial insurers to Mission, and later HCA, for knee replacements, was higher than for the rest of North Carolina, and stayed higher, with the gap the same or growing over time:



166. For a shoulder arthroscopy, the rest of North Carolina's costs have stayed relatively stable with allowed amounts averaging just under $1,000 from 2016 to 2020. However, Mission's average allowed amount in the same dataset went up from about $1,000 in the last year of the COPA to about $2,400 in 2020—an increase of close to 150% in four years:



167. According to the same large claims commercial dataset, these allowed amount increases were consistent across most services lines, particularly (but not exclusively) at Mission Hospital-Asheville and for acute inpatient hospital services. Thus, while Mission could move costs around under the COPA and increase prices, the data show that once freed from the COPA's restrictions Mission could effectively dictate the prices it charged in a manner that no other system in North Carolina could.

2. *HCA increased prices substantially after acquiring the hospital from Mission while cutting staff and reducing quality*

168. Once the nonprofit Mission became the for-profit HCA, prices rose at an even higher rate than the State average, while at the same time HCA cut staffing to dangerously low

levels to further increase its profit. This resulted in more expensive and lower quality care for Plaintiffs and other members of the putative class.

169. HCA/Mission is currently one of the most expensive hospitals in the State, and for many procedures—including "plausibly undifferentiated" procedures for which quality does not meaningfully vary by provider—it is *the* most expensive provider in the State.

170. A recent RAND analysis of nationwide hospital pricing data compared the prices negotiated between hospitals and commercial health plans to the fee schedule set by Medicare, with the Medicare price acting as a relative baseline (given the federal government's regulatory power). RAND reported this data analysis at the hospital systemwide level, without revealing the prices charged for specific procedures.

171. According to RAND data, at Mission Hospital-Asheville Defendants charged commercial insurers 372% above the Medicare price, on average, for inpatient and outpatient services, and 393% above the Medicare price, on average, for inpatient services alone. That compares with a mean of 262% and a median of 277% above Medicare for all hospitals in North Carolina for which RAND released metrics (including Mission).

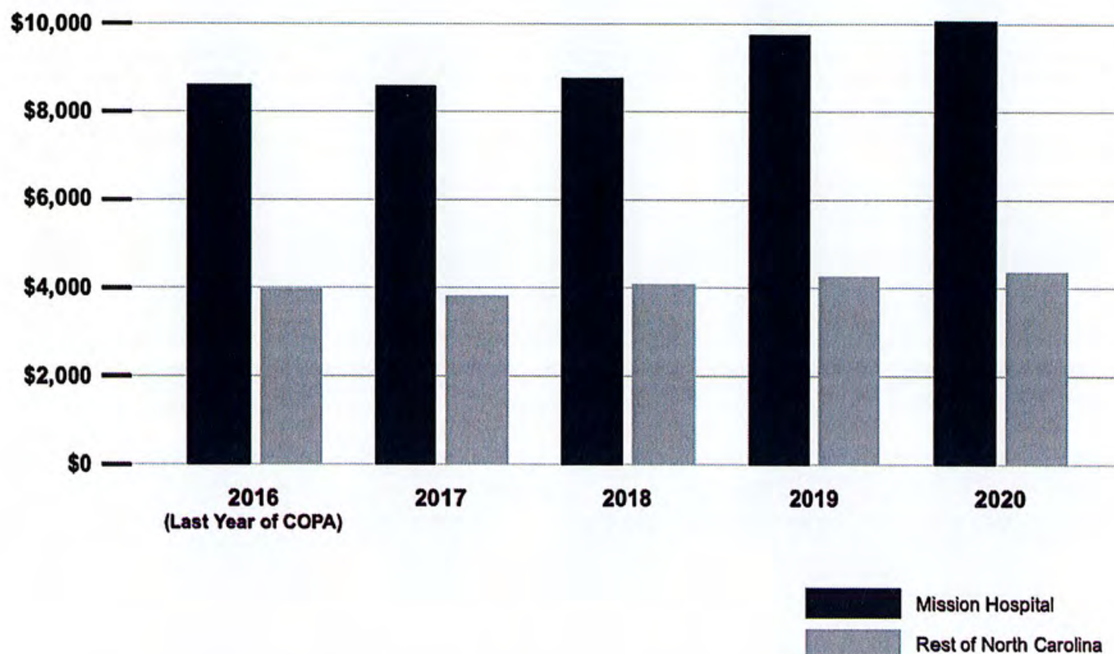
172. Defendants could not charge this much more than other North Carolina hospitals if they were not (1) unlawfully leveraging monopoly power to force insurers to accept rates they would not accept in a competitive market and (2) using anticompetitive means to prevent new entrants from competing.

173. In much the same way that Mission in 2017 took Blue Cross out of network as part of a price dispute, a similar fight unfolded two years later, this time with HCA in control. In 2019, HCA used aggressive contract negotiating tactics to attempt to force Cigna, another major insurer, to accept significant price increases. Cigna said that HCA/Mission's "excessively high rates they

are demanding from our clients and customers" would "put affordable healthcare at risk." HCA/Mission's price demands were so excessive that, once again, there was the risk of all customers of a large insurer losing access to the only hospital in their area. Two contract disputes of this level within two years are rare for almost any hospital system and would have been barred by the COPA.

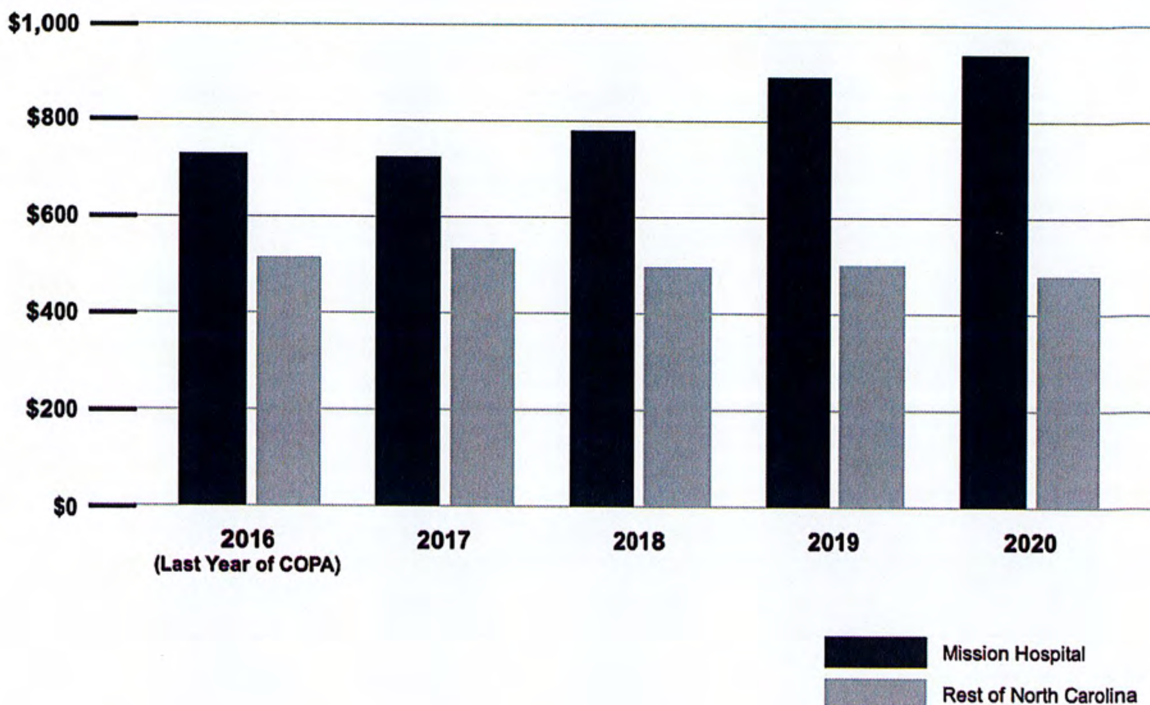
174. HCA itself stated in recent regulatory filings in Florida that, in a county with a monopoly hospital system, insurers have "limited ability" to "negotiate market-driven rates for hospital services" and that, "A large and growing body of literature suggests that health care providers with significant market power can (and do) negotiate higher-than-competitive payment rates."

175. Data analysis of specific procedures comports with the systemwide RAND results. For example, within a large commercial claims dataset, HCA's average allowed amount earned from commercial health plans for C-sections without complications at Mission Hospital-Asheville was approximately $9,764 in 2019 and $10,077 in 2020. By contrast, the average allowed amount at all other North Carolina hospitals was $4,287 in 2019 and $4,373 in 2020. The HCA price is over 2.2 times greater than the rest of North Carolina. And while the price of C-sections at all other North Carolina hospitals was relatively stable from 2016 to 2020 near $4,000, the prices at Mission/HCA rose from $8,621 to over $10,000 for service at the Asheville hospital. The data may be visualized as follows:

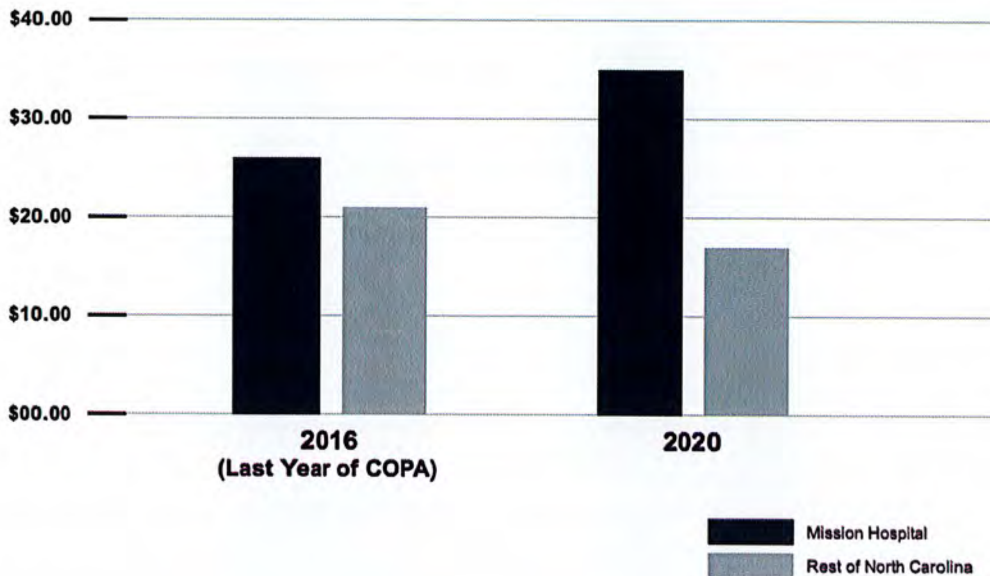


176. Similarly, within that same claims data, HCA's average allowed amount for a coronary bypass is nearly *double* the North Carolina average and, after the repeal of the COPA, Mission Hospital-Asheville has been the most expensive major hospital in the entire State for coronary bypasses.

177. Likewise, with regard to cardiovascular stress tests, an average allowed amount for this procedure at HCA was roughly double that of the average allowed amount in the rest of North Carolina in 2020. While the cost for this procedure slightly declined in the rest of North Carolina from 2016 to 2020, the cost at Mission increased about 30% from the last year of the COPA to 2020:



178. Even low cost but high-volume procedures like a lipid panel have seen significant price increases after the repeal of the COPA. Within a large commercial insurance claims dataset, Mission's average allowed amount for lipid panels increased by about a third while the allowed amount in the rest of the state declined:



179. As prices for these services and others have risen, HCA has reduced the quality of its care by aggressively cutting staff and budgets and by encouraging those doctors who have stayed to focus on maximizing the volume of patients they see so as to maximize profits.

180. As of March 2021, at least 79 doctors had left or planned to leave the system since HCA's takeover. Other doctors describe new employment contracts with HCA in which the compensation equations remove quality of care metrics and focus almost entirely on the number of patients seen and amount billed. As one departing doctor explained, "The change in ownership has shifted this system's priority away from the health of Western North Carolina to the health of the stockholders." A significant number of patients have lost their preferred family doctors either due to doctors leaving the system or from HCA's clinic restructurings and closures.

181. Similarly, nurses working at HCA have described their units as "inhumanely understaffed," with conditions so bad that even travel nurses hired to fill in gaps were leaving before their contracts expired. Patients and families describe situations where, for example, their

nurse told them, "... she cries every single night because she knows she is not giving appropriate, competent patient care."

182. Were Defendants operating in a competitive market for acute care services, they would not have been able to take these anticompetitive actions. However, commercial health plans and patients have no choice but to endure the worsening quality of service.

183. As noted, on February 10, 2020, the Chairman of the Buncombe County Commissioners Brownie Newman, Asheville Mayor Esther Manheimer, and most of the delegation of Buncombe County's elected officials in the North Carolina statehouse lambasted these conditions, finding that "numerous, aggressive staff cuts over the past year, put[] patient safety at risk" and that "HCA has aggressively pursued contract renegotiations with multiple physician practices, resulting in unfortunate outcomes."

184. Both anecdotal reports and expert watchdogs have confirmed that these actions have led directly to a decrease in the quality of care. As noted, the Leapfrog Group dropped Mission Hospital's patient safety rating from an "A" to a "B" after HCA's takeover, and CMS also downgraded Mission per surveys of patients' experiences regarding, among other things, responsiveness of hospital staff and the cleanliness of the hospital.

3. *HCA abuses its market power by charging for costly, unnecessary procedures*

185. After the repeal of the COPA, Defendants began more frequently billing for procedures that academic literature has determined are ineffective and are nearly always considered overuse. In fact, Mission Hospital-Asheville now ranks 88 out of 89 hospitals in North Carolina for unnecessary procedures and is in the highest 2% of all hospitals nationwide for billing for unnecessary procedures.[18] It has a "Value of Care" rating of "D-minus."

[18] https://lownhospitalsindex.org/hospital/memorial-mission-hospital-and-asheville-surgery-center/.

186. But at the same time, Mission Hospital-Asheville is one of HCA's most profitable in the country, and in fact has immediately become the second largest revenue hospital in the entire HCA chain.[19] HCA revenues from Mission Hospital-Asheville were recently reported to be over $1.2 billion, ahead of all but one of the other 100-plus hospitals in the HCA chain and second only to HCA's Methodist Hospital (Texas) which has over twice as many beds.

187. In a competitive market, insurers contracting with a hospital can discipline such behavior by threatening in their next negotiation not to cover certain services, to negotiate for caps on particular procedures likely to be unnecessary, or to threaten to take the hospital out of network and purchase services from a competitor. But because of Defendants' unregulated monopoly status, the all-or-nothing tying schemes described herein, and the lack of any significant competitor for inpatient hospital services, insurance plans and consumers are forced to pay for some of the highest rates of unnecessary procedures anywhere in the country.

188. Because HCA controls the only hospital in the Asheville market and because consumers generally do not question provider recommendations while in the hospital, HCA's practice of adding costly and unnecessary procedures to a consumer's bill represents a clear abuse of market power.

189. For example, routine blood tests are a frequent source of price disparities and overbilling by providers with both the volume of tests per patient and the cost of tests per patients varying dramatically by provider. However, in competitive markets, insurers can incentivize providers who do not overuse or overcharge for tests.

[19] Top 50 HCA Hospitals by Net Patient Revenue, https://www.definitivehc.com/blog/top-hca-hospitals-nationwide (accessed Aug. 4, 2021) (reflecting that Mission Hospital-Asheville has the second-highest revenues of all of the HCA hospitals, at $1,209,452,518).

190. On information and belief, Defendants have exploited the lack of competition in the market to charge a substantially higher price than both the North Carolina average and the price that would be tolerated in a hypothetically competitive Asheville market. Defendants have increased prices for routine blood tests, despite no evidence that the actual cost of providing such tests has increased at all. In fact, based on available data, for one routine blood test, Defendants have increased the allowed amount charged to many insurers for the test by about 20% since they acquired Mission Hospital. This leads directly to Plaintiffs and other putative class members paying higher co-insurance for these unnecessary procedures, and it leads to their paying higher insurance premiums because commercial health plans are also liable for their share of the payments for the unnecessarily costly procedures as well.

191. In a competitive market, such overpricing would be aggressively policed by insurers, patients, and competing providers. In this case, since the COPA's repeal left the system unregulated, Defendants have increased prices for often overbilled procedures knowing that commercial health plans and patients have no meaningful choice but to accept these practices. These practices have led directly to the increased costs of commercial insurance for affected consumers.

192. Finally, HCA has charged exorbitant rates for forensic exams such as rape kits, which should be free. Assistant Director of victim advocacy organization REACH of Macon County, Jennifer Turner-Lynn explained that "prior to the [HCA-Mission] merger, we never had an issue with rape victims being charged for the use of the emergency room.... The last victim that I took over received a bill for $1,000. The only services that she received in the emergency room was to have the rape kit performed." Billing a sexual assault victim for a forensic exam is prohibited under state and federal law. Under N.C.G.S. § 143B-1200, a medical facility cannot

bill a sexual assault victim or commercial health plan for a forensic medical exam. Additionally, the Violence Against Women Act mandates that states must cover the "full out-of-pocket costs of forensic medical examinations for victims of sexual assault" to maintain eligibility for funding. The full cost is defined as "any expense that may be charged to a victim in connection with a forensic medical examination for the purpose of gathering evidence of a sexual assault."[20]

4. *HCA abuses its trauma center monopoly*

193. HCA has shown a pattern of using emergency care, and especially trauma centers, to saddle patients with unnecessary, exorbitant charges. Trauma centers employ specialists equipped to deal with major traumatic injuries and receive substantially higher reimbursements for the theoretically complex care. However, in what appears to be a business practice across the nation documented by investigative reporting,[21] HCA has been shown to be significantly more likely than other providers to admit patients with only mild injuries to trauma centers in order to obtain higher reimbursement rates.

194. In competitive markets, this costly practice can be policed by competitor providers or by insurers who can pressure providers to reduce deceptive trauma center admissions with the threat of taking a provider out-of-network for non-compliance. In a monopoly market with a "must have" hospital and one monopoly trauma center, like the one HCA intentionally acquired from Mission, such policing effectively cannot take place. Absent HCA's unlawful monopoly power, it would not be able to carry on this practice.

195. As the only state-designated trauma center in Western North Carolina, HCA can set prices far above the market rate. In Asheville, HCA's trauma center "activation fees"—the

[20] 28 C.F.R. § 90.13(b)

[21] Jay Hancock, In alleged health care 'money grab,' nation's largest hospital chain cashes in on trauma centers, Kaiser Health News, June 14, 2021, https://khn.org/news/article/in-alleged-health-care-money-grab-nations-largest-hospital-chain-cashes-in-on-trauma-centers/ (accessed Aug. 3, 2021).

charges applied automatically when a patient is routed to the trauma center—are about twice as high as the North Carolina average, costing consumers over $9,000 for every unnecessary admission, before they even incur procedure charges.

196. Similarly, Defendants have a history of pushing patients into more expensive Emergency Department ("ED") care. Nationally, a recent study sponsored by shareholders of HCA found that HCA's Medicare ED admissions were "well-above the national average, growing over time, and not explained by patient case mix," which resulted in excess Medicare payments of $1.1 billion over five years.[22]

197. On information and belief, HCA engages in this practice in North Carolina, regularly running patients, including those with commercial health plans, through the ED for tests that do not require such an admission and thus charging commercial health plans and patients significantly more. In North Carolina specifically, HCA's ability to push patients into more expensive ED care is even more unrestrained due to Mission Hospital-Asheville's effective total control over the market.

198. In a competitive market, a provider that pushed individuals towards higher cost ED care would face strong pressure from commercial health plans and local governments to reduce the practice. In a market with only one hospital, HCA is able to push individuals towards higher cost ED care while simultaneously reducing the quality of the ED. Because of HCA's market power and use of anti-competitive contract clauses, insurers are less able to push back and may even be contractually blocked from informing consumers about the full extent of the ED practices.

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[22] Notice of exempt solicitation, CtW investment group, April 1, 2021, https://www.sec.gov/Archives/edgar/data/860730/000137773921000007/hca21shletter.htm (accessed Aug. 3, 2021); Oct. 16, 2020 letter from CtW to Charles O. Holliday, Chairman, audit & compliance committee, HCA Healthcare, Inc., https://s3-prod.modernhealthcare.com/2021-03/CtW%20to%20HCA.pdf (accessed Aug. 3, 2021).

C. **Defendants have engaged in illegal tying of services through all-or-nothing contracting practices and other anticompetitive contracting terms**

199. Both Mission and HCA have engaged in unlawful tying agreements, through which they have used their monopoly in one market—acute inpatient hospital services in Buncombe and Madison Counties—to extract profits in other markets.

200. Under antitrust law, tying occurs when an entity that has market power in one market leverages that market power in order to reap profits in another market. The market in which the defendant has an existing monopoly is called the "tying" market, and the separate market in which the defendant extracts profits is called the "tied" market. Under a tying arrangement, the entity will sell one product (the tying product) only under the condition that the purchaser buy a second product (the tied product). Where the defendant has significant market power or a monopoly in the tying market, such tying arrangements are considered anticompetitive and unlawful under the antitrust laws.

201. One way tying occurs in hospital markets is through a dominant hospital's use of "all-or-nothing" practices in their negotiations with insurers. When a hospital system is the only entity in a given region to offer a product or service that commercial health plans must include in their network to be viable, that hospital system can refuse to sell that product or service to insurers unless insurers also agree to purchase other services from the hospital system, including services that the insurer would otherwise purchase from a different hospital system for a lower price. Either orally during negotiations or in the contracts themselves, the hospital system gives the insurer an "all-or-nothing" choice: Take everything the hospital wants to sell at the price the hospital dictates, or get nothing at all. This paradigm was apparent in Mission's 2017 contract dispute with Blue Cross, where it responded to Blue Cross' specific concern about proposed price increases at

Mission Hospital-Asheville by making the entire Mission system unavailable to Blue Cross—across multiple geographic markets and both inpatient and outpatient markets.

202. Here, Defendants offer a product that any commercial insurer operating in Western North Carolina needs: the only acute inpatient hospital services in Buncombe and Madison Counties. Due to Mission Hospital-Asheville's dominant market share for acute inpatient hospital care in Buncombe and Madison Counties, a commercial health plan could not offer a plan that does not include these services and remain commercially viable. Thus, insurers functionally do not have a choice: They must purchase from Defendants acute inpatient hospital care at Mission Hospital-Asheville. Thus, this is the "tying" product. And Mission and HCA have tied it to two different products over which they have less market power: (1) outpatient medical care at Mission Hospital-Asheville and the rest of Buncombe and Madison Counties, and (2) inpatient and outpatient care at Mission's and HCA's Outlying Facilities.

1. *Tying inpatient services at Mission Hospital-Asheville to outpatient services at Mission Hospital-Asheville*

203. One way in which Defendants engage in anticompetitive tying is by only offering acute inpatient hospital services at Mission Hospital-Asheville to commercial health plans if those insurers will also contract to purchase outpatient medical services at Mission Hospital-Asheville from Defendants at supracompetitive rates (the "Inpatient/Outpatient Tying Scheme"). When Defendants engage in all-or-nothing contracting in this manner, acute inpatient hospital services at Mission Hospital-Asheville is the "tying" product, and outpatient services at Mission Hospital-Asheville are the "tied" product.

204. While Defendants' Mission Hospital-Asheville has a 80 to 90 percent market share in the market for acute inpatient hospital services in Buncombe and Madison Counties, Defendants' face somewhat more competition for outpatient medical services in those markets.

This competition comes from, for example, ambulatory service centers, rehabilitation facilities, and independent physicians. On information and belief, insurers negotiating with Defendants would, absent Defendants' Inpatient/Outpatient Tying Scheme, choose either not to contract for certain outpatient hospital services from HCA at Mission Hospital-Asheville and its other facilities in Buncombe and Madison Counties, or those insurers would negotiate a lower price for those services, given the competition from other outpatient providers in the region. But because Defendants can threaten to withhold their must-have acute inpatient hospital services as part of the same negotiation, commercial health plans must acquiesce to Defendants' demands related to outpatient care.

205. Defendants' Inpatient/Outpatient Tying Scheme has resulted directly in higher costs, both in terms of allowed amounts paid for services at that facility and increased co-pays, premiums, and deductibles for Plaintiffs and the putative class. The Scheme has also harmed competition for outpatient medical services in Buncombe and Madison Counties, because independent providers of outpatient services are unable to fairly compete with Defendants on price or quality. When independent providers cannot compete, they eventually go out of business, which leads to even less competition. On information and belief, because of Defendants' Inpatient/Outpatient Tying Scheme, outpatient facilities have closed or relocated to more competitive markets and would-be competitors for outpatient care have declined to operate in Buncombe and Madison Counties, which has decreased the quantity of outpatient care and increased prices paid by insurers, ultimately, patients for outpatient care.

2. *Tying inpatient services at Mission Hospital-Asheville to inpatient and outpatient services at HCA/Mission's five outlying hospitals*

206. A second tying scheme Defendants have engaged in is the tying of acute inpatient hospital services in Buncombe and Madison Counties to inpatient and outpatient care at the

Outlying Facilities ("Asheville/Outlying Facilities Tying Scheme"). Because any insurer offering a network that includes Western North Carolina must include in that network acute inpatient hospital services at Mission Hospital-Asheville, Defendants are able to force those insurers to also include inpatient and outpatient services at Defendants' Outlying Facilities in network, at supracompetitive prices. As in the Inpatient/Outpatient Tying Scheme, the "tying" market in the Asheville/Outlying Facilities Tying Scheme is the same: acute inpatient hospital care in Buncombe and Madison Counties. The "tied" markets are both acute inpatient hospital services and outpatient medical services at Defendants' five Outlying Facilities.

207. As a direct and proximate result of Defendants' Asheville/Outlying Facilities Tying Scheme, a substantial amount of competition is foreclosed.

208. On information and belief, for each of the Outlying Facilities, Defendants in their negotiations with commercial health plans generally condition the inclusion of Mission Hospital-Asheville's acute inpatient hospital services on those insurers also offering both inpatient and outpatient services at the Outlying Facilities. Defendants generally insist on the Outlying Facilities' inclusion even if insurers would otherwise choose to put a different, competing hospital in network, or even if insurers would not otherwise be willing to pay the allowed amounts Defendants insist on for inpatient and outpatient care at the Outlying Facilities.

209. One example of how the Asheville/Outlying Facilities Tying Scheme works in practice is Defendants' hospital in McDowell County, Mission Hospital-McDowell. It is located at 430 Rankin Drive, Marion, NC 28752, about 45 minutes driving time to the east of Asheville.

210. Mission Hospital McDowell has significant market power, but not monopoly power, in its region.[23] Data reflects the following approximate market shares in the three most proximate zip codes: in zip code 28752, 37.4%; in code 28761, 36.1%; and in code 28762, 35.3%.

211. A rival hospital, Carolinas HealthCare System Blue Ridge Morganton, is located less than 30 minutes away to the east of Mission Hospital-McDowell. It is located at 2201 S Sterling St, Morganton NC 28655.

212. Mission Hospital-McDowell has approximately 30 beds. Carolinas HealthCare System Blue Ridge Morganton has approximately 184 beds. Mission Hospital-McDowell and Carolinas HealthCare System Blue Ridge Morganton are competitors.

213. Cost data available in a large commercial dataset for Mission Hospital-McDowell reflects that for a variety of procedures where there is a significant volume of those procedures for each year, such as CT scans, Mission Hospital-McDowell is not only consistently one of the most expensive in the State but is more than triple the average cost for some routine procedures.

214. For example, available price data reflects that the average allowed amount for a CT scan of the abdomen and pelvis (CPT 74176) is about $2,000 at Mission Hospital-McDowell, whereas the average in the State is just under $500. This divergence is particularly stark because it is unable to be explained by a quality difference, as CT scans are relatively standard. Instead, the cost differences are explained by contract negotiations between insurers and hospitals.

215. When the COPA was in effect, Mission Hospital-McDowell was well below the State average with respect to prices for outpatient care. Today, Mission Hospital-McDowell charges approximately 50% above the State average for outpatient care—corresponding with the period in which HCA/Mission were free to engage in unregulated price increases and

[23] But the combination of Mission McDowell and Mission Asheville might be enough to exceed 60 to 70% market share, which may be viewed as a monopoly share. See allegations at paragraph 225 below.

anticompetitive contracting practices. Using an overall analysis of outpatient procedure costs, Mission Hospital-McDowell has gone from being less expensive than 60% of facilities in the State for outpatient medical service in 2016 to among the top 3% most expensive facilities in the entire State now. This dramatic pricing shift coincides with the removal of COPA regulations in late 2016 that prevented excessive price increases or abusive contracting practices.

216. Mission Hospital-McDowell is not only significantly more expensive than the State average for outpatient care—it is also significantly costlier than its only significant competitor, Carolinas HealthCare System Blue Ridge Morganton, which is less than a 30-minute drive away. Moreover, on information and belief, commercial health plans do not consider either hospital to be of significantly higher quality than the other, particularly for "plausibly undifferentiated procedures" such as a CT scan.

217. In a competitive market, commercial health plans would encourage members to seek lower cost care just minutes away. However, on information and belief, because of the Asheville/Outlying Facility Tying Scheme, Defendants have foreclosed real competition on price or quality in other markets that appear competitive on paper. Furthermore, on information and belief, Defendants use contracting provisions to prevent commercial health plans from fully informing consumers of price differences or from directing consumers to the lower cost option. Defendants are thereby using, or leveraging, their monopoly market power over acute inpatient hospital services in the Asheville Region to anticompetitive effect in the Marion NC-area market.

218. Mission has similarly used its monopoly dominance in inpatient acute care at Mission Hospital-Asheville in Buncombe and Madison County to attempt to monopolize several outlying inpatient and outpatient markets where its other small regional hospitals are located,

namely, Angel Medical Center and Highlands-Cashiers Hospital (Macon County), Blue Ridge Regional Hospital (Mitchell County), and Transylvania Regional Hospital (Transylvania County).

219. For example, according to the Medicare Hospital Market Service Area File for 2019 for inpatient origin, HCA has an 85.3% market share in zip code 28712 in Brevard, NC, the top inpatient zip code for HCA's Transylvania Regional Hospital in Brevard, Transylvania County. This total HCA market share comes from Transylvania Regional Hospital's 44.8% market share in the zip code and Mission Hospital-Asheville's 40.5% market share in the zip code. Pardee UNC Hospital only holds 10.4% market share, despite being about half the driving distance from Brevard and substantially lower cost than Mission Hospital-Asheville. This monopolization cannot be explained in a competitive market without tying and/or contracting provisions that prevent insurers from encouraging members to seek care at a closer and lower cost facility.

220. In total, HCA/Mission controls over 75% of the inpatient market share in Transylvania County and charges significantly higher prices the closest non-HCA facilities.

221. Similarly, according to the Medicare Hospital Market Service Area File for 2019 for inpatient origin, HCA has a 92.4% market share in zip code 28741 in Highlands, NC, the top inpatient zip code for HCA's Highlands-Cashiers Hospital in Highlands, NC. This total HCA market share comes from Highland-Cashiers Hospital's 43.8% market share in the zip code and Mission Hospital-Asheville's 48.7% market share in the zip code. Northeast Georgia Medical Center only holds 7.6% market share, despite being closer driving distance from Highlands and substantially lower cost than Mission Hospital-Asheville.

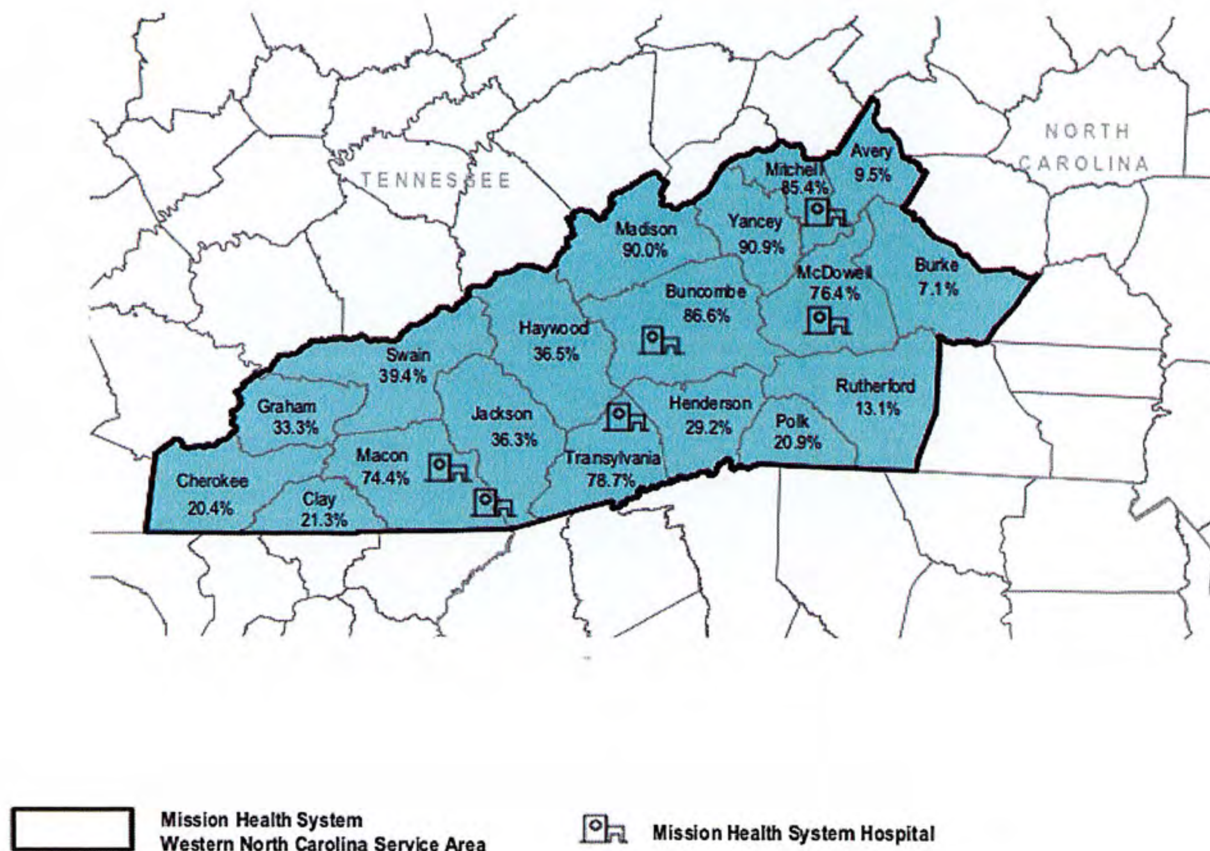
222. In total, HCA/Mission controls over 70% of the inpatient market share in Macon County despite charging significantly higher prices than the closest non-HCA facility. Similarly, this monopolization cannot be explained in a competitive market without tying and/or contracting

provisions that prevent insurers from encouraging members to seek care at a closer and lower cost facility, as discussed below.

223. Stated differently, at the time of the 1995 COPA, Mission only had a monopoly in the Buncombe and Madison County markets.

224. By contrast, the HCA system in North Carolina now has a monopoly (above 70%) market share both in Buncombe and Madison Counties, as well as in <u>other</u> Counties:

Mission Health Inpatient Market Share, 2018



225. Now, because of the combined market power of the facilities it acquired in the asset purchase from the former Mission system, HCA has a market share in the range which may be considered monopoly market power (above 60 to 70%), in seven different counties:

- Yancey – 90.9%
- Madison -- 90%
- Buncombe -- 86.6%
- Mitchell – 85.4%
- Transylvania -- 78.7%
- McDowell -- 76.4%
- Macon -- 74.7%

3. *Use of anti-steering, anti-tiering contracting practices*

226. Steering arrangements are arrangements by which a commercial health plan is able to steer plan subscribers to a lower-cost rather than a higher-cost facility. Commercial health plans may seek to steer patients by including language in insurance plan documents encouraging subscribers to choose one facility rather than another or conditioning the selection of a higher-cost facility on a higher copay or deductible from the subscriber.

227. In addition, or alternatively, commercial health plans may seek to place providers in tiers, with the insurance plan subscriber being encouraged through a variety of means to choose the provider in the tier of better-value providers over a discouraged tier of more costly providers.

228. Steering is an important tool commercial health plans can use to control healthcare costs, particularly in consolidated markets. President Trump's Assistant Attorney General for Antitrust criticized the type of contracting provisions and negotiating tactics HCA uses, saying, "Without these provisions, insurers could promote competition by 'steering' patients to medical providers that offer lower priced, but comparable or higher-quality services. Importantly, that practice benefits consumers, but the anti-steering restrictions prevented it." Likewise, Senator Chuck Grassley, then chairman of the Senate Judiciary Committee said the anti-steering practices

of HCA and several other systems were, "restrictive contracts deliberately designed to prevent consumers' access to quality, lower cost care."

229. During the pertinent times, on information and belief, Defendants have required one or more insurers not to use steering or tiering language, or to use weaker language or provisions than the insurers would have desired to use, as a condition of obtaining access to Defendants' "must have" Mission Hospital-Asheville for their commercial health plans.

230. Investigative reporting has shown that HCA has a history of using anti-steering or similar contract language.

4. *Use of gag clauses and lack of transparency.*

231. For years, Defendants have obscured their price increases and anticompetitive contracts from regulators and the public through use of gag clauses that prevent insurers from revealing their agreements' terms. The effect of this gag clause language is anticompetitive as it prevents competitors, insurers, and consumers from understanding in a transparent manner the pricing and other terms and arrangements being used by Defendants.

232. Moreover, HCA has continued to refuse to release the prices it charges for these and other procedures in a fully transparent manner despite a recent change in federal law requiring it to do so. Effective January 1, 2021, a new federal regulation required the public disclosure of certain aspects of HCA's negotiated price terms in agreements with private insurance companies. *See* 45 C.F.R. § 180.50. HCA has however failed to fully disclose this information in a timely, complete, and understandable manner.

233. By violating this price disclosure regulation, and by including gag clauses in HCA/Mission's provider agreements with insurers, Defendants have kept community members,

regulators, and the general public from learning of the grossly inflated, monopolistic prices that are being charged.

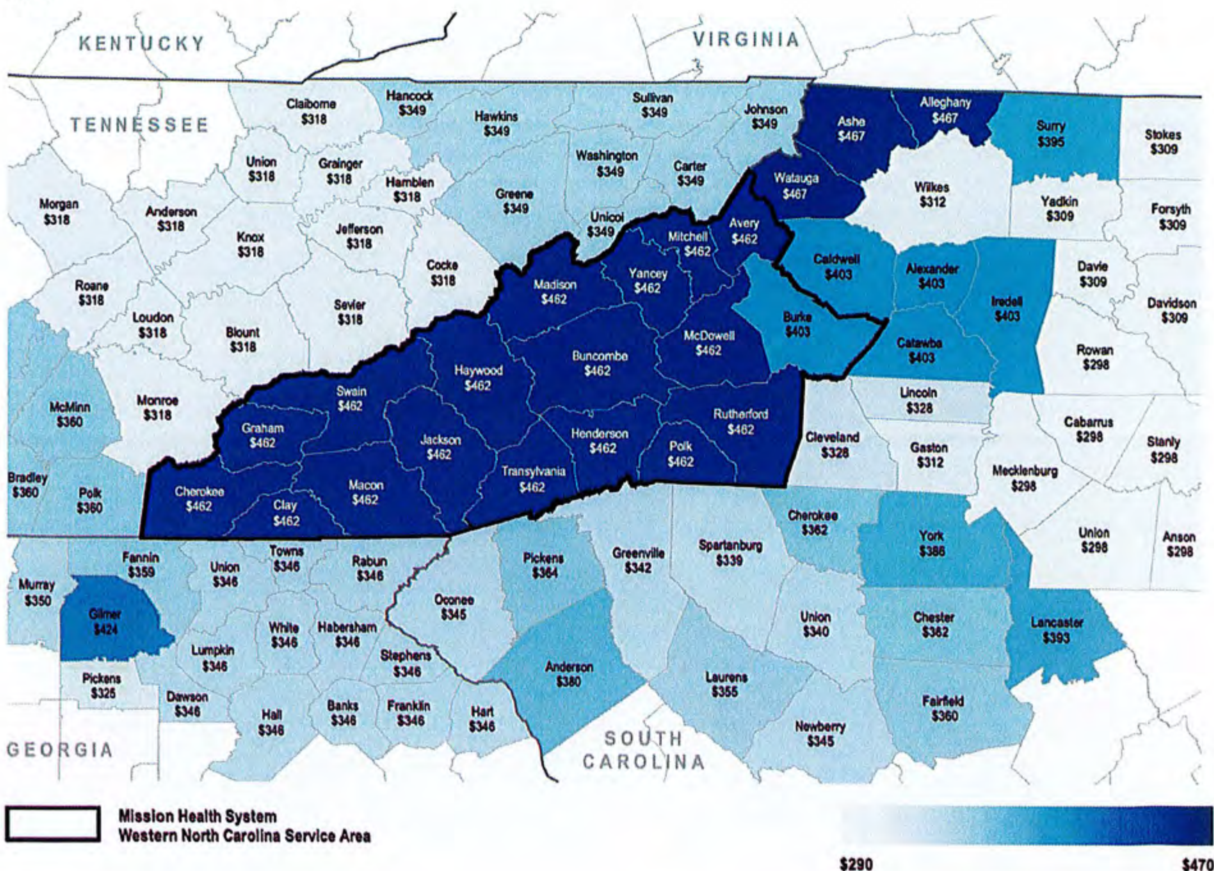
234. This rule was first created by the Trump Administration over the opposition of HCA's lobbying and then proactively continued by the Biden Administration—signaling growing bipartisan consensus that the lack of price transparency with regard to hospital services leads to higher prices for consumers and employers.

D. Defendants' unlawful course of conduct has led directly to substantially higher insurance premiums and other costs for Plaintiffs and the putative class

235. Insurance premiums in the counties where Mission operates are substantially higher than the state average and substantially higher than areas with higher costs of living. For example, individual insurance premiums are now approximately 50% higher in Mission's self-defined service area than Winston-Salem; about 55% higher in Mission's service area than Durham, Raleigh, or Charlotte; and about 60% higher than Greensboro.

236. Mission's anticompetitive impact on prices is perhaps most obvious for an individual who simply moved across a county line outside of Mission's 18 county service area. For example, crossing the county line from Rutherford County (in Mission's self-defined service area) to Cleveland County (outside of Mission's service area), an individual would see premiums ***drop immediately by 29%.*** Similarly, driving East from Cherokee County or South from Macon County (in Mission's self-defined service area) into Tennessee or Georgia, an individual would see an immediate premium decline of over 20% as visualized below:

KFF Lowest Cost Plan in the County for 40-Year-Old Male
2020



237. These dramatic differences can be primarily attributed to market power, according to academic studies. For example, a Harvard University analysis found that, "Variation in spending in the commercial insurance market is due mainly to differences in price markups by providers rather than to differences in the utilization of health care services . . . 70 percent of variation in total commercial spending is attributable to price markups, most likely reflecting the varying market power of providers." And the US government's official guide to shopping for individual health insurance indicates that "differences in competition" are one of the primary sources of variation in premiums.

238. During the pertinent times, Defendants' anticompetitive practices have allowed them to charge of supracompetitive prices to commercial health plans and TPA payers.

239. When private insurance and TPA payers have been obligated to pay these supracompetitive prices to Defendants, the payers in turn have passed the prices along to their insurance plan subscriber base.

240. Patients also are directly harmed by Defendants' supracompetitive prices through direct payments made by patients to Defendants, in the form of copays, coinsurance payments, and deductibles. These direct payments are often calculated as a percentage of the allowed amount for which the patient is responsible for, so when allowed amounts reach supracompetitive levels, as they have at HCA/Mission, patients who must go to Defendants' system for care suffer direct financial injury.

241. As a result of Defendants' supracompetitive prices, and the pass-through by insurance and TPA payers of the amounts at issue, ordinary insurance and healthcare consumers have been injured by having to pay higher premiums, copays, coinsurance payments, and deductibles.

E. Antitrust Injury

242. As a result of the Defendants' monopoly power, monopolization and attempted monopolization, and the anticompetitive practices Defendants have used to increase negotiated prices with insurers and self-funded TPAs, reduce provider competition, and reduce quality of services, patients such as Plaintiffs and other putative class members throughout Western North Carolina have paid within the last four years, and continue today to pay higher prices for health insurance coverage (including premiums, employee contributions, copays, deductibles and out-of-pocket payments) and pay higher coinsurance payments directly to Defendants for services than

they otherwise would, while receiving lower quality care than they would in a competitive market. In addition, Defendants' conduct has caused injury to competition for the reasons stated herein.

F. Additional facts regarding the named Plaintiffs

1. *William Davis*

243. William Alan Davis is a citizen and resident of North Carolina with a residence address in Clyde, North Carolina, Haywood County. Mr. Davis resides to the west of Candler. In the last several years, Mr. Davis received medical care from Timothy Plaut, M.D. in Candler. Dr. Plaut worked for Mission MyCare Plus in Candler.

244. After HCA bought the Mission system, HCA announced that it was shutting down the Candler primary care practice. Mr. Davis learned from Dr. Plaut about the shutdown. Pursuant to a news article dated February 23, 2021,[24] Dr. Plaut was described as stating that he was shocked to learn that the clinic and job he loved would be gone in just 45 days. He stated that "[i]t created a lot of hardship for our patients." Dr. Plaut estimated that more than 7,000 patients total, many without insurance, were treated at the two clinics. "Our practice in Candler was one of the original safety nets through Mission and we took care of a lot of Medicaid and Medicare; we had homeless folks and severe mental illness."

245. Recently, when Mr. Davis visited his father at the hospital in Asheville, he noted that the hospital environment and his father's room was dirty. Mr. Davis and his wife noticed there was a trash can which had not been emptied. When Mr. Davis' father was in the hospital, it appeared that the nurses who took care of him for the most part were all "travelling nurses,"

[24] Karen Zatkulak, Clinics closed, dozens of doctors leave Mission Health since HCA takeover, Feb. 23, 2021, https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover (accessed June 28, 2021).

including his main nurse and the phlebotomist who treated him. There appeared to be a shortage of certified nurse assistants and unit coordinators.

246. When Mr. Davis himself was a Mission Hospital patient, he went to the emergency room. It was his impression that one or more unnecessary tests were ordered.

247. Mr. Davis also received care at Mission WorkWell, located in Asheville, NC, including in the time period from 2018 onward.

248. During the relevant period, Plaintiff paid premiums in order to be enrolled as a plan member in the respective health plans. As a result of HCA's anticompetitive conduct, he, and each other Plaintiff described below, within the last four years paid artificially high premiums, co-payments, deductibles, co-insurance payments, and/or out-of-pocket payments not covered by the health plans.

2. *Richard Nash*

249. Richard Nash is a citizen and resident of North Carolina with a residence address in Candler, North Carolina, Buncombe County. Mr. Nash was born in 1960.

250. Mr. Nash has health insurance with Blue Cross through his wife's employment which she has held for over 25 years.

251. Mr. Nash worked in construction for years and later worked in a plant. Mr. Nash was injured on the job several years ago and has significant medical issues. During his time working in the construction industry, Mr. Nash helped during the construction of the cardiology ward at the Mission Asheville hospital during the time period of approximately 1991 until 1995.

252. In 2017, while covered by his insurance with Blue Cross, Mr. Nash was scheduled to receive cataract surgery in both eyes. He was scheduled to receive the cataract surgery from a physician he was assured was very renowned. Then, Mission allowed its contract with Blue Cross

to expire due to a dispute over Mission's demand to increase the amount the insurance company, and by extension its policyholders, would have to pay. When Mission fell out of the Blue Cross network, Mr. Nash had to cancel his surgery. He subsequently had to reschedule the procedure through a different facility.

253. During the relevant period, Plaintiff paid premiums in order to be enrolled as a plan member in the health plan. As a result of HCA's anticompetitive conduct, he paid additional amounts similar to the other Plaintiffs.

3. *Will Overfelt*

254. Will Overfelt is a citizen and resident of Asheville, NC. Mr. Overfelt has lived in the Asheville area for approximately 20 years.

255. In February 2020, Mr. Overfelt's father was ill. He was sent to the Mission Hospital Asheville emergency room by his primary care physician and was found to have advanced cancer.

256. Mr. Overfelt's father was admitted to Mission Hospital Asheville for approximately one week. During that time, Mr. Overfelt and his mother frequently visited Mr. Overfelt's father and noticed that the conditions at the hospital were deteriorated compared to how they had been in years past when family members had gone to the hospital.

257. Mr. Overfelt noticed that the rooms were dirty. It was hard to get information. He had trouble getting his father his pain medications timely.

258. He would push the call button and an excessive amount of time would lapse before someone would come to his father's room. The quality of care was clearly worse that it had been in years past.

259. Mr. Overfelt recalls early on, he saw a napkin on the floor in his father's hospital room. He left it where it was, wondering if any cleaning was really being done. The napkin was still there on the floor a week later when his father was discharged.

260. There were delays in getting help so his father could go to the bathroom. There were delays in obtaining water and various other items of sustenance and comfort. His father apparently was never bathed while there.

261. His father was discharged to go to a nursing home/rehabilitation facility, where he passed away approximately three days thereafter from his cancer. The date of death was February 18, 2020.

262. Mr. Overfelt applied for an insurance policy under the Affordable Care Act ("Obamacare") in December 2020. He was approved for a policy through Blue Cross. The health policy coverage began on January 1, 2021.

263. Since that time, Mr. Overfelt has paid a premium of approximately $168 per month. He believes the total premium cost is approximately $480 / month but that part of it is covered by a subsidy component of the Act.

264. During the relevant period, Plaintiff paid premiums in order to be enrolled as a plan member in the health plan. As a result of HCA's anticompetitive conduct, he paid additional amounts similar to the other Plaintiffs.

4. *Jonathan Powell*

265. Jonathan Walton Powell is a citizen and resident of North Carolina who resides at 2960 Henderson Mill Rd, Morganton, NC 28655, in Burke County.

266. Mr. Powell has been employed as a machinist for a local company and has worked at that company for approximately 28 years. He has been and continues to be a very good worker

at his job. In fact, his father worked in the same building that he works in today for many years. Mr. Powell grew up in Burke County and most of his family continues to reside there.

267. Mr. Powell has been fortunate to be insured through his employer with group health insurance. His insurance is with Blue Cross Blue Shield and he has had that insurance for over the last 20 years.

268. For the last several years, Mr. Powell has had the need to seek medical care. His primary care physician had always been associated with Mission Hospital and as a result, when he has begun ill and needed additional care and testing, his primary care physician has sent him to the Mission facilities. Mr. Powell had great confidence in his primary care physician as he had taken very good care of Mr. Powell for over the last ten years.

269. Unfortunately, after the sale of Mission Hospital and the other Mission facilities, his physician spoke to him about his inability to continue Mr. Powell's care. He was told by his physician that the new owner, HCA, overloaded him with so many patients, he could not continue to provide the proper care for them and he had had enough. He shared with Mr. Powell that he was going to work for another hospital. Since this past March, 2021, Mr. Powell's former physician has provided medical care for others in an adjoining town.

270. Mr. Powell believes that if HCA had not purchased Mission, his care would have continued to be provided by the physician who was most knowledgeable about him and his condition and who had treated him for years.

271. Since March, 2021, the former medical office that he went to in Morganton, which was called Mission Community Medicine, Burke, was completely closed down by HCA.

272. Because he lost his physician and the practice was closed, Mr. Powell is now being treated at Mission Health, Nebo Family Medicine, Nebo, N.C. He is being cared for by a

Physician's Assistant and he still has not had another physician assigned to him since his primary care physician left.

273. Mr. Powell has been recently treated at Mission Hospital in Asheville, having last been seen there on June 10, 2021, where he remained for over two hours.

274. Mr. Powell has been seen a number of times at the Urgent Care Office at Mission McDowell Hospital. Numerous tests have been ordered on his behalf. He is scheduled for an appointment at Mission McDowell Hospital this month on August 17, 2021.

275. Mr. Powell has lung problems and his pulmonologist at Asheville Pulmonology, a clinic also associated with Mission Hospital, sends him to Mission McDowell Hospital, which is closer than Mission Hospital, Asheville, for his CT scans.

276. During the pertinent times, Mr. Powell has received medical care both from HCA-Mission facilities related to the Mission McDowell Hospital in Marion, NC, as well as from facilities related to the Mission Asheville Hospital. Mr. Powell believes that while there is another community hospital, Grace Hospital, in his county, he is being referred to the Mission hospitals because his physicians are affiliated with those hospitals.

277. Mr. Powell has continued to and plans to continue to receive care from and including at My Care Now-McDowell, 472 Rankin Drive, Marion NC 28752; from Mission Hospital, Memorial Campus, 509 Biltmore Avenue, Asheville NC 28801; at Mission McDowell Hospital, 430 Rankin Dr, Marion, NC 28752; and at Asheville Pulmonary & Critical Care Associates, P.A., 30 Choctaw Street, Asheville NC 28801 who are affiliated with Mission Asheville Hospital.

278. As a result of HCA's anticompetitive conduct, Mr. Powell paid additional amounts similar to the other Plaintiffs.

5. ***Faith C. Cook, Psy.D***

279. Faith C. Cook, Psy.D. is a citizen and resident of North Carolina who resides in Black Mountain, North Carolina, Buncombe County.

280. Dr. Cook is a Clinical Psychologist who received her Doctorate from the University of Hartford and her Bachelor's Degree from the University of Georgia. She practices with Sylva Clinical Psychology in Sylva NC.

281. Dr. Cook has health insurance through a Blue Cross policy under the Affordable Care Act.

282. As a dedicated health care provider, Dr. Cook has a great interest in ensuring that her patients and others have access to very good and reasonably priced health care. She has concerns regarding the Mission monopoly and the resulting increasing costs since HCA took over Mission while simultaneously the quality of the patient care has been significantly deteriorating.

283. During the pertinent times, Dr. Cook has excessive amounts as a proximate result of Defendants charging supra-competitive prices for healthcare, similar to the other Plaintiffs.

6. ***Katherine Button***

284. Ms. Button is the executive chef and in a leadership role with a restaurant group. The restaurant group has a self-insured plan through Roundstone.

285. During the pertinent times, Ms. Button and her family have had insurance through a self-funded plan which includes Mission hospital in the plan. She and her family have received medical care through Mission, including from Mission Hospital-Asheville.

286. One reason why her business switched over to a self-funded format was due to the crushing costs of regular health insurance in the Asheville area, due to HCA/Mission. However,

even with self-funding, the costs are still high. The self-funded administrator, Roundstone, has advised that the reason why the costs are so high in the Asheville region is due to HCA/Mission.

287. During the pertinent times, Ms. Button has paid excessive amounts as a proximate result of Defendants charging supra-competitive prices for healthcare, similar to the other Plaintiffs.

VII. CLASS ALLEGATIONS

A. Class definition

288. Plaintiffs define the putative class in this litigation as follows:

> Any individual or entity in the Relevant Region who is a North Carolina resident and who, during all or part of the period beginning August 10, 2017 to the present, with regard to Defendants' acute care hospital services or ancillary products, paid some portion of premiums, deductibles, copays or coinsurance for a self-insured or fully-insured product offered by or administered by Aetna, Blue Cross Blue Shield, BMS TPA, Cigna, Coventry, CWI Benefits, Crescent TPA, Humana, Healthgram TPA, Key Benefits Administrators TPA, MedCost, MedCost Ultra, MultiPlan PHCS, United Healthcare, Wellpath, and Western North Carolina Healthcare Coalition.[25]

289. The "Relevant Region" in this case is the 18 Counties that comprise Defendants' total service area: Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania and Yancey. This is identical to the 17-County western North Carolina geographic market known as Rating Area 1 under the Affordable Care Act, except that Burke County is added.

290. Excluded from the class are the Presiding Judge, employees of this Court, and any appellate judges exercising jurisdiction over these claims as well as employees of that appellate court(s).

291. This class definition is subject to revision or amendment as the matter proceeds.

[25] This class definition with regard to identities of insurers and TPAs relies on public information from Defendants. Plaintiffs reserve the right to modify or amend this definition as they receive additional information.

B. Rule 23 requirements

292. This action is suitable for resolution on a class-wide basis under the requirements of North Carolina Rule of Civil Procedure 23.

293. Numerosity: The class is composed of hundreds and thousands of class members, the joinder of whom in one action is impractical. The class is ascertainable and identifiable from Defendants' records and documents.[26]

294. Commonality: Questions of law and fact common to the class exist as to all members of the class and predominate over any questions affecting only individual members of the class. These common issues include, but are not limited to:

a. Whether Defendants have a monopoly in a defined product market in Buncombe County;

b. Whether Defendants have a monopoly in a defined product market in Madison County;

c. Whether Defendants have a monopoly in a defined product market in the Counties of Yancey; Mitchell; Transylvania; McDowell; and/or Macon.

d. Whether Defendants, including Mission, and HCA, whether either or both have acted willfully or otherwise unlawfully to acquiring or maintaining their monopoly or attempting to do so;

e. Whether Defendants have used their market power and anticompetitive means to impose prices far above those that would be charged in a competitive market, causing harm to Plaintiffs and others;

f. Whether Defendants have engaged in improper tying practices with regard to their provider agreements with insurance companies and TPAs;

g. Whether Defendants have engaged in improper anticompetitive practices with regard to the terms and provisions that they have required to be included in their payer/provider agreements;

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[26] Populations per US Census information for the 18 Counties include: Avery (17,506), Buncombe (256,886), Burke (89,968), Cherokee (27,969), Clay (10,946), Graham (8,509), Haywood (61,053), Henderson (114,913), Jackson (42,938), Macon (34,813), Madison (21,499), McDowell (45,227), Mitchell (15,004), Polk (20,557), Rutherford (66,599), Swain (14,260), Transylvania (33,775) and Yancey (17,760).

h. Whether Defendants have willfully abused their monopoly power by reducing output and quality, including by reducing budgets and staffing at facilities;

i. Whether Defendants' conduct has violated the North Carolina State Constitution's prohibition on monopolies;

j. Whether Defendants' conduct has violated N.C.G.S. § 75-1 *et seq.*;

k. Whether Defendants COPA immunity defense at most only applies to some period of time for Buncombe County and Madison County, and does not apply to a monopoly during some or all of the pertinent times in the Counties of Yancey; Mitchell; Transylvania; McDowell; or Macon;

l. Whether Defendants COPA immunity defense does not even apply for Buncombe or Madison Counties, due to regulatory evasion;

m. Whether Defendants' breaches of state law caused antitrust injury to the Plaintiffs and class members, injured competition and/or injured consumer welfare; and

n. Whether the Plaintiffs and the class members are entitled to an award of compensatory damages and/or injunctive, declaratory or equitable relief.

295. Typicality: Plaintiffs' claims are typical of the claims of the other class members. Plaintiffs and the other class members have been injured by the same wrongful practices. Plaintiffs' claims arise from the same practices and course of conduct that give rise to the other class members' claims and are based on the same legal theories.

296. Adequate Representation: Plaintiffs will fully and adequately assert and protect the interests of the other class members. Plaintiffs have retained class counsel who are experienced and qualified in prosecuting class action cases. Neither Plaintiffs nor their attorneys have any interests conflicting with class members' interests.

297. Predominance and Superiority: This class action is appropriate for certification because questions of law and fact common to the members of the class predominate over questions affecting only individual members, and a class action is superior to other available methods for the fair and efficient adjudication of this controversy, since individual joinder of all members of the

class is impracticable. Should individuals be required to bring separate actions, courts would be confronted with a multiplicity of lawsuits burdening the court system while also creating the risk of inconsistent rulings and contradictory judgments. This class action presents fewer management difficulties while providing unitary adjudication, economies of scale and comprehensive supervision by a single Court.

298. Injunctive, Declaratory, Equitable Relief: The prosecution of the claims of the putative class in part for injunctive relief, declaratory or equitable relief, is appropriate because Defendants have acted, or refused to act, on grounds generally applicable to the putative class, thereby making appropriate final injunctive relief, or corresponding declaratory relief, for the putative class as a whole.

VIII. CLAIMS FOR RELIEF

COUNT ONE
MONOPOLIZATION IN VIOLATION OF STATE ANTITRUST LAW
(N.C. Const. Art. 1 § 34; N.C.G.S. § 75-1 *et seq.*)

299. The above-alleged paragraphs 1 through 299 are incorporated by reference.

300. Article 1, Section 34 of the North Carolina State Constitution states: "Perpetuities and monopolies are contrary to the genius of a free state and shall not be allowed."

301. N.C.G.S. § 75-2.1, entitled, "Monopolizing and attempting to monopolize prohibited," provides: "It is unlawful for any person to monopolize, or attempt to monopolize, or combine or conspire with any other person or persons to monopolize, any part of trade or commerce in the State of North Carolina."

302. N.C.G.S. § 75-8, entitled, "Continuous violations separate offenses," provides: "Where the things prohibited in this Chapter are continuous, then in such event, after the first

violation of any of the provisions hereof, each week that the violation of such provision shall continue shall be a separate offense."

303. N.C.G.S. § 75-16, entitled, "Civil action by person injured; treble damages," states: "If any person shall be injured or the business of any person, firm or corporation shall be broken up, destroyed or injured by reason of any act or thing done by any other person, firm or corporation in violation of the provisions of this Chapter, such person, firm or corporation so injured shall have a right of action on account of such injury done, and if damages are assessed in such case judgment shall be rendered in favor of the plaintiff and against the defendant for treble the amount fixed by the verdict."

304. N.C.G.S. § 75-16.1, entitled, "Attorney fee," provides, in pertinent part: "In any suit instituted by a person who alleges that the defendant violated G.S. 75-1.1, the presiding judge may, in his discretion, allow a reasonable attorney fee to the duly licensed attorney representing the prevailing party, such attorney fee to be taxed as a part of the court costs and payable by the losing party, upon a finding by the presiding judge that: (1) The party charged with the violation has willfully engaged in the act or practice, and there was an unwarranted refusal by such party to fully resolve the matter which constitutes the basis of such suit...."

305. Defendants have monopolized, and continue to monopolize, the relevant market alleged herein in violation of Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes Section 75-2.1.

306. During the pertinent times including the last four years, Defendants possessed monopoly power in the relevant market.

307. During the pertinent times, including after the 2016 repeal of the COPA but prior to its 2019 asset sale to HCA, Mission possessed monopoly power in the relevant market. From

August 10, 2017 onward, Mission possessed an approximate 80 to 90% market share in Buncombe and Madison Counties. Mission's market power was durable rather than fleeting and included the ability to raise prices profitability above those that would be charged in a competitive market.

308. During the pertinent times, including after the asset sale from Mission, HCA possessed monopoly power in the relevant market. From 2019 onward, HCA has possessed an approximate 90% market share in Buncombe and Madison Counties. HCA's market power was durable rather than fleeting and included the ability to raise prices profitability above those that would be charged in a competitive market.

309. During the pertinent times including the last four years, Defendants engaged in the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident; and, Defendants accompanied their possession of monopoly power with an element of anticompetitive conduct.

310. Regardless of whether Mission unlawfully acquired a monopoly in light of the COPA, during the pertinent times, including after the COPA was repealed in September 2016, Mission unlawfully maintained a monopoly.

311. Mission engaged in continuing violations within the meaning of N.C.G.S. § 75-8 while under the COPA and after the COPA was repealed in 2016.

312. From January 2019 forward, HCA has unlawfully created and maintained a monopoly.

313. During the pertinent times, Defendants have engaged in the willful creation or maintenance of their monopoly power.

314. In addition to or in the alternative to the above-stated monopolization claim, the Plaintiffs also allege, as actionable monopolization: A relevant market in this case is the product market for general acute care (GAC) inpatient hospital services in the Outlying Regions in Western North Carolina where Defendants operate the Outlying Facilities. ("Outlying Regions Inpatient Services-Only Market").

315. The relevant product in this market—acute inpatient hospital services—is defined the same as for Asheville Region Inpatient Services market, Asheville Region.

316. HCA today owns and controls monopoly market shares for inpatient care in seven counties in Western North Carolina. In the Outlying Regions Inpatient Services-Only Market, HCA has monopoly market power in the Counties of Yancey – 90.9%; Madison -- 90%; Buncombe -- 86.6%; Mitchell – 85.4%; Transylvania -- 78.7%; McDowell -- 76.4%; and Macon -- 74.7%.

317. The geographic market for present purposes is defined as the Outlying Regions in which or near where Defendants' Outlying Facilities operate.

318. At the time of the performance of the COPA from 1995 to 2016, the State reasonably relied on Mission's representations that Mission had monopoly market power in Buncombe and Madison Counties only. The scope of the COPA did not authorize monopolies in any other Counties including in the Outlying Regions.

319. The COPA did not authorize Mission (or HCA) to monopolize the Outlying Regions.

320. Defendants have unlawfully monopolized the Outlying Regions.

321. Defendants have willfully created or maintained a monopoly with regard to the Outlying Regions Inpatient Services-Only Market.

322. Defendants' conduct has had an anticompetitive effect including by acquiring and closing down competitors. All five of the Outlying Facilities now in HCA's Outlying Regions counties once were owned by other owners who were actual or potential competitors of HCA Mission Hospital-Asheville.

323. Wherefore, Plaintiffs and class members are entitled to an award of classwide damages in excess of $25,000; and are entitled to award of reasonable costs and attorney's fees to the extent allowable by law.

COUNT TWO
ATTEMPTED MONOPOLIZATION

324. The above-alleged paragraphs 1 through 323 are incorporated by reference.

325. N.C.G.S. § 75-2.1, entitled, "Monopolizing and attempting to monopolize prohibited," provides, in pertinent part: "It is unlawful for any person to ... attempt to monopolize ... any part of trade or commerce in the State of North Carolina."

326. During the pertinent times, including within the last four years, Defendants possessed monopoly power in markets including, but not limited to, the Buncombe and Madison County market.

327. During the pertinent times, Defendants engaged in the willful and unlawful attempt to obtain, create, maintain or expand their monopoly power.

328. During the pertinent times, Defendants attempted to acquire, maintain, or expand their monopoly through illegitimate means.

329. During the pertinent times, Defendants had a specific intent to monopolize a relevant market, including by attempting to monopolize the Asheville Region Outpatient Services Market; the Outlying Regions Inpatient and Outpatient Services Market; and/or the Outlying Regions Inpatient Services-Only Market.

330. During the pertinent times, Defendants engaged in predatory or anticompetitive acts, as more specifically alleged above.

331. Absent Court intervention, due to the Defendants' actions, there is a dangerous probability of successful monopolization, specifically in the Asheville Region as to Asheville Region Outpatient Services; and in the Outlying Regions as to Outlying Regions Inpatient and Outpatient Services.

332. Wherefore, Plaintiffs and class members are entitled to an award of classwide damages in excess of $25,000; and are entitled to award of reasonable costs and attorney's fees to the extent allowable by law.

COUNT THREE
RESTRAINT OF TRADE IN VIOLATION OF STATE ANTITRUST LAW
(N.C.G.S. § 75-1 *et seq.*)

333. The above-alleged paragraphs 1 through 332 are incorporated by reference.

334. N.C.G.S. § 75-1, entitled, "Combinations in restraint of trade illegal," states: "Every contract, combination in the form of trust or otherwise, or conspiracy in restraint of trade or commerce in the State of North Carolina is hereby declared to be illegal. Every person or corporation who shall make any such contract expressly or shall knowingly be a party thereto by implication, or who shall engage in any such combination or conspiracy shall be guilty of a Class H felony."

335. N.C.G.S. § 75-2, entitled, "Any restraint in violation of common law included," states: "Any act, contract, combination in the form of trust, or conspiracy in restraint of trade or commerce which violates the principles of the common law is hereby declared to be in violation of G.S. 75-1."

336. During the pertinent times, Defendants have engaged in the use of contracts and agreements in restraint of trade as alleged hereinabove. Defendants have negotiated and enforced contracts containing anticompetitive provisions restrictions with insurers or TPAs which are contracts, combinations, and conspiracies within the meaning of North Carolina General Statutes Sections 75-1 and 75-2.

337. The challenged contractual restrictions unreasonably restrain trade in violation of North Carolina General Statutes Sections 75-1.1 and 75-2.

338. Wherefore, Plaintiffs and class members are entitled to an award of classwide damages in excess of $25,000; and are entitled to award of reasonable costs and attorney's fees to the extent allowable by law.

COUNT FOUR
INJUNCTIVE, EQUITABLE, DECLARATORY RELIEF

339. The above-alleged paragraphs 1 through 338 are incorporated by reference.

340. The Court has authority to award declaratory, injunctive or equitable relief under the Declaratory Judgment Act, which states at N.C.G.S. § 1-253: "Courts of record within their respective jurisdictions shall have power to declare rights, status, and other legal relations, whether or not further relief is or could be claimed. No action or proceeding shall be open to objection on the ground that a declaratory judgment or decree is prayed for. The declaration may be either affirmative or negative in form and effect; and such declarations shall have the force and effect of a final judgment or decree."

341. Further, under G.S. § 1-254: "Any person interested under a deed, will, written contract or other writings constituting a contract, or whose rights, status or other legal relations are affected by a statute, municipal ordinance, contract or franchise, may have determined any question of construction or validity arising under the instrument, statute, ordinance, contract, or

franchise, and obtain a declaration of rights, status, or other legal relations thereunder. A contract may be construed either before or after there has been a breach thereof."

342. Plaintiffs show that to the extent the facts and law allow for the imposition of equitable, declaratory or injunctive remedies, they plead recourse to any and all such remedies.

343. Plaintiffs request that the Court order the reformation of Defendants' practices, and/or contractual and agreement terms, including, for example, to require greater pricing transparency, express language against use of "all or nothing" arrangements, express provisions committing not to use anti-tiering or anti-steering provisions, and other such remedies.

344. Plaintiffs in addition to their damages claims, request injunctive, declaratory or equitable relief and show that the injunctive relief will prevent Defendants from imposing anticompetitive all-or-nothing, anti-tiering, and anti-transparency provisions in their contracts, thus allowing health plans to steer patients away from lower value providers.

345. Plaintiffs and the Class members have standing to and do seek equitable relief against Defendants, including an injunction to prohibit Defendants' illegal conduct as well as an order of equitable restitution and disgorgement of the monetary gains that Defendants obtained from their unfair competition.

IX. JURY DEMAND

346. Plaintiffs demand a trial by jury.

X. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray that this Court enter judgment on their behalf and that of the proposed class and adjudge and decree as follows:

A. certifying the proposed class, designating the named Plaintiffs as class representatives and the undersigned counsel as class counsel, and allowing the Plaintiffs and the class to have trial by jury;

B. finding that Defendants have monopolized, and continue to monopolize, the relevant market alleged herein in violation of Article I, Section 34 of the North Carolina Constitution and North Carolina General Statutes Section 75-2.1, and that Plaintiffs and the members of the class have been damaged and injured in their business and property as a result of this violation;

C. finding that Defendants have engaged in a trust, contract, combination, or conspiracy in violation of North Carolina General States Sections 75-1 and 75-2, and that Plaintiffs and the members of the class have been damaged and injured in their business and property as a result of this violation;

D. ordering that Plaintiffs and members of the class recover threefold the damages determined to have been sustained by them as a result of Defendants' misconduct complained of herein, and that judgment be entered against Defendants for the amount so determined;

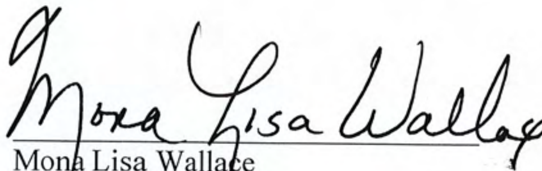
E. entering judgment against Defendants and in favor of Plaintiffs and the class awarding restitution and disgorgement of ill-gotten gains to the extent such an equitable remedy may be allowed by law;

F. awarding reasonable attorney's fees, costs, expenses, prejudgment and post-judgment interest, to the extent allowable by law;

G. awarding equitable, injunctive and declaratory relief, including but not limited to declaring Defendants' misconduct unlawful and enjoining Defendants, their officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on their behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts competition in the manner as alleged hereinabove; and

H. awarding such other and further relief as the Court may deem just and proper.

Dated: August 10, 2021.



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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NORTH CAROLINA

CITY OF BREVARD, NORTH CAROLINA, on its own behalf and on behalf of all others similarly situated, **Plaintiff,** **v.** **HCA HEALTHCARE, INC., HCA MANAGEMENT SERVICES, LP, HCA, INC., MH MASTER HOLDINGS, LLLP, MH HOSPITAL MANAGER, LLC, MH MISSION HOSPITAL, LLLP, ANC HEALTHCARE, INC. f/k/a MISSION HEALTH SYSTEM, INC., and MISSION HOSPITAL, INC.,** **Defendants.**	**No.: 1:22-cv-114** **JURY TRIAL DEMANDED**

CLASS ACTION COMPLAINT

Plaintiff City of Brevard, North Carolina ("Brevard" or "Plaintiff"), individually, and on behalf of all others similarly situated, brings this action against Defendants HCA Healthcare, Inc. and HCA Management Services, LP (collectively "HCA"), and MH Master Holdings, LLLP, MH Hospital Manager, LLC, MH Mission Hospital, LLLP, ANC Healthcare, Inc. f/k/a Mission Health System, Inc, and Mission Hospital, Inc. (collectively, "Mission") ("Mission" and "HCA" together, "Defendants"). Plaintiff alleges as follows:

I. NATURE OF THE ACTION

1. This a proposed class action for unlawful restraint of trade and monopolization. Plaintiff seeks damages and injunctive and equitable relief under Sections 1 and 2 of the Sherman Antitrust Act, 15 U.S.C. §§ 1 and 2.

2. Plaintiff is a North Carolina municipality (Brevard) which operates a self-funded health insurance plan for its employees and their families. Plaintiff directly pays one or more Defendant(s) for health care for its insureds and has been and continues to be injured thereby because Defendants' prices are artificially inflated due to the ongoing anticompetitive conduct alleged herein.

3. Plaintiff seeks to represent a class of similarly situated North Carolina health insurance plans, including self-funded and commercial insurers ("health plans" or the "Class," which is more specifically defined in paragraph 190 below), each of which paid directly to one or more Defendant(s) on behalf of their insureds for health care services in the relevant markets alleged herein. This action is brought at a time when providing affordable health care insurance plans for working families and governmental employees, such as firefighters, police, and teachers, and controlling health care costs have been top priorities for Plaintiff and members of the proposed Class, the business communities they serve, and state and local governments in western in North Carolina. As described in detail in this Complaint, Defendants' conduct has impeded these objectives by impairing competition in the health care markets defined herein and substantially and artificially inflating health care prices paid by Plaintiff and proposed Class member health plans.

4. Defendants have injured Plaintiff and members of the Class through an anticompetitive scheme (the "Scheme") involving the illegal maintenance and enhancement of

monopoly power in two health care services markets (the “Relevant Services Markets”): (1) the market for inpatient general acute care (“GAC”) in hospitals (“GAC Market”), consisting of a broad group of medical and surgical diagnostic and treatment services that include overnight hospital stays (“GAC Services”); and (2) the market for outpatient care (“Outpatient Market”), encompassing all the medical services that are not GAC Services (“Outpatient Services”).

5. Defendants dominate the Relevant Services Markets in at least two geographic areas (the “Relevant Geographic Markets”): (1) the “Asheville Region,” consisting of Buncombe and Madison Counties; and (2) the “Outlying Region,” consisting of Macon, McDowell, Mitchell, Transylvania, and Yancey Counties, or in the alternative with respect to Outlying Region, (3) each of the separate counties in the Outlying Region. Together, the Relevant Services Markets and the Relevant Geographic Markets are, collectively, the “Relevant Markets.”

6. In 1995 Mission Health System merged with St. Joseph’s Hospital, Mission’s only significant competitor in the Relevant Geographic Markets. As a result, Mission’s flagship Asheville hospital (“Mission Hospital-Asheville”) became the dominant provider of GAC Services in the Asheville Region with substantial monopoly power in the GAC Market in that region.

7. From 1995 until 2016, Mission was immunized from antitrust liability by a state statute under which it was issued a Certificate of Public Advantage (“COPA”). The COPA is a form of regulation in which a hospital is permitted to operate with monopoly power in exchange for subjecting itself to state oversight.

8. In 2016, after years of lobbying at the behest of Mission executives, the State repealed the COPA, leaving in place an unregulated organization with monopoly power. After

repeal, Mission and HCA Healthcare, Inc. (the parent company of the subsequent purchaser of Mission's assets) lost any immunity from suit under the Sherman Act.[1]

9. In January 2019, Mission sold its assets to MH Master Holdings, LLLP, an HCA subsidiary and part of one of the world's largest for-profit hospital chains. HCA owns over 200 hospitals across the United States. HCA has been the subject of approximately twenty Federal Trade Commission ("FTC") antitrust proceedings over the past two decades. HCA purchased Mission's assets, in significant part, because Mission had monopoly power in the GAC Market in the Asheville Region—monopoly power that HCA knew it could exploit to maintain and enhance Mission's monopoly power in the Relevant Markets.

10. Today, HCA controls more than 85 percent of the GAC Market, based on patient volume,[2] in the Asheville Region with a 90% share in Madison County and an 86.6% share in Buncombe County. The commercial insurers and self-funded payors (collectively, "health plans") that comprise the proposed Class, at all times relevant to this Complaint, had no choice but to include Mission's hospital system in the GAC Market in their insurance networks. There is no practical alternative for these services in this region.

11. Due to the conduct challenged in this Complaint, HCA also enjoys monopoly power in the GAC Market in the Outlying Region, with a 70-plus% market share in each county in the Outlying Region: Yancey (90.9% market share); Mitchell (85.4% market share); Transylvania (78.7% market share); McDowell (76.4% market share); and Macon (74.7% market share).

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[1] Hereinafter, unless otherwise indicated, "HCA" refers to the parent company that bought Mission and that parent's subsidiaries, while the term "Defendants" refers to HCA and the remnant companies of the former Mission.

[2] These market shares and all others reported in the Complaint are based on patient volume unless otherwise indicated.

12. One of the reasons HCA found Mission attractive as a business opportunity is that, beginning in or about 2017, Mission, under its immediate pre-buyout executive management team, had embarked on a continuing, multifaceted coercive Scheme designed to foreclose competition from rivals, to maintain or to enhance its monopoly power in the Relevant Markets, and ultimately to charge supracompetitive prices—prices above their competitive level—for GAC and Outpatient Services. The anticompetitive conduct challenged in this Complaint began before HCA's acquisition of Mission, and HCA supercharged the Scheme after it acquired Mission. The Scheme includes, among other anticompetitive features: (1) "all-or-nothing" tying arrangements requiring health insurance plans to contract with all of Mission's (and later HCA's) GAC and Outpatient Services as a bundle, *i.e.*, take everything together or nothing at all; (2) exclusive dealing requirements in the form of anti-steering and anti-tiering provisions, which prevent insurance companies from steering insureds to less expensive and/or higher quality options as a means to promote competition and reduce prices; (3) "gag" clauses that have deliberately impeded price transparency, inhibiting employers from knowing the prices they pay for health care and thus determine how best to reduce costs; and (4) other anticompetitive conduct relating to the negotiation of pricing for GAC Services. HCA continued and reinforced each of the foregoing elements of the Scheme after it acquired Mission in January 2019.

13. Mission, and then HCA after purchasing Mission, have abused their monopoly power in GAC Market in the Asheville Region (the "tying market") to maintain or enhance their monopoly power in multiple "tied" markets, including the Outpatient Market in the Asheville Region, and the GAC Market and Outpatient Market in the Outlying Region (or, alternatively, in the five individual counties that make up that region). The Defendants have accomplished this, in part, by tying GAC and Outpatient Services together, in both the Asheville Region and Outlying

Region, and giving all health plans no choice but to include all of Defendants' services together as "in network" services.

14. As explained below, when health services are "out of network" for a health plan, they typically will be much more costly to patients than if included "in network." By tying their services and regions together, Defendants coercively rob health plans of the ability to choose which service and providers are in or out of network. At the heart of the Scheme is this immutable fact: because of Mission's monopoly power, health plans require in-network access to HCA's GAC Services in the Asheville Region in order to offer any minimally viable health plan in the Relevant Geographic Markets. But because HCA ties access to that (tying) product to the other (tied) products and regions, HCA can coerce and has coerced health plans to contract for HCA's tied services. This tying prevents health plans from using the presence of actual or potential competing services in the tied markets as leverage to negotiate lower prices from HCA. Additionally, this coercive tying reinforces HCA's monopoly power in the tying market because it substantially reduces the ability of actual or potential competitors in the tying market to compete against HCA's all-or-nothing bundle. The tying thus enables HCA to discourage the sort of competition that lowers prices and improves quality. As a result, the Scheme has enabled HCA to continue to charge higher prices and to offer lower quality for its services in both the tying and tied markets as compared to a more competitive state of affairs in which HCA did not engage in the anticompetitive Scheme.

15. In addition, and also as part of the Scheme, Mission and HCA have abused their monopoly power in GAC Market in the Asheville Region to impose exclusive dealing requirements in the form of coercively imposed anti-steering provisions in their contracts with health plans for both GAC and Outpatient Services in all Relevant Geographic Markets. These

anti-steering provisions prevent health plans from providing information or from encouraging patient use of less expensive and higher quality non-Defendant providers of GAC and Outpatient Services in the Relevant Geographic Markets. As a result, and together with the other conduct challenged in this Complaint, these anti-steering provisions prevent health plans from encouraging price competition between Mission/HCA and actual and potential rivals, and also reduce the incentive for rivals and potential rivals to use lower prices as a means to gain patients in all of the Relevant Markets (including both product and geographic markets).

16. Mission and HCA have further abused their monopoly power in the GAC Market in the Asheville region by imposing exclusive dealing requirements in the form of prohibiting tiering. Tiering provisions enable health plans to sort providers into tiers based on their cost and, often, quality relative to other similar providers who treat comparable patients. Health plans with tiering provisions give preferred rankings to providers with higher quality and lower cost, incentivizing members to use providers in the higher tiers. Tiering is an important means by which the plans help control their costs and reduce health care prices. Like its use of anti-steering provisions, its imposition of anti-tiering provisions forecloses competition and otherwise impedes beneficial competitive outcomes.

17. Defendants also have abused their monopoly power in GAC Market in the Asheville Region to impose "gag" clauses that inhibit the ability of employer self-funded health plans to know the prices they pay for their employees' health care and use that information to help reduce health care costs.

18. By preventing health plans that must offer access to HCA's GAC Services in the Asheville Region from contracting with, or steering patients to, HCA's actual or potential competitors in the Relevant Markets, Defendants' Scheme substantially forecloses competition in

all of the Relevant Markets. The abilities to (a) assemble different combinations of in-network providers, including a mix of HCA and non-HCA providers, and/or (b) use incentives to steer patients to less expensive or higher quality alternatives are essential ways that health plans endeavor to promote competition among health care providers and thus control health care costs and ultimately prices to health plans. By substantially foreclosing these avenues of promoting competition, HCA has maintained and bolstered its monopoly power in the Relevant Markets, causing anticompetitive effects including higher health care prices and lower quality health care.

19. There are no legitimate procompetitive benefits for HCA's Scheme let alone benefits that could offset the competitive harms caused by the Scheme.

20. HCA itself has recognized the negative effects that unregulated hospital monopolies inflict on our nation's health care system. Indeed, in 2018—while it was negotiating its takeover of Mission—HCA complained to the Florida Agency for Health Care Administration about a competitor's "monopolistic dominance," stating that "patients suffer from lack of access to care in their community," they "have little to no health care provider choice," and "[t]his type of monopolistic environment within the health care market stifles innovation and breeds a culture that negatively impacts the cost and quality of care."

21. Defendants' Scheme has had clear and continuing anticompetitive effects. It has enabled Defendants to raise prices substantially above competitive levels, to reduce health care choices, to reduce quality through dramatically worsened facility conditions and patient service, and to reduce patient access to GAC and Outpatient Services in the Relevant Markets. Relatedly, HCA has refused to comply with a federal rule implemented by the Department of Health and Human Services in January 2021 that was intended to increase transparency in health care pricing.[3]

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[3] https://www.cms.gov/hospital-price-transparency/hospitals.

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Were HCA to comply and reveal to consumers and regulators the true prices that it charges, the public would know that HCA's prices in the Relevant Markets are by far the highest in North Carolina.

22. The Scheme has caused antitrust injury to Plaintiff and the proposed Class of similarly situated health plans, each of whom has paid supracompetitive prices for lower quality services in the Relevant Markets.

23. Without this Court's intervention, the future of health care competition in Western North Carolina—traditionally a destination for many, including retirees from across the nation, in part because of its prior reputation for high-quality, low-cost health care—is at risk. Plaintiff and the proposed Class have been and continue to be injured by the artificially inflated supracompetitive prices due to Defendants' Scheme and Plaintiff brings this action for damages and equitable relief to enjoin the continuation of HCA's unlawful conduct.

II. THE PARTIES

A. Plaintiff

24. Plaintiff **City of Brevard** ("Brevard") is a city in Transylvania County, North Carolina, with a population of 7,609 as of the 2010 Census. It is the county seat of Transylvania County. Brevard is located at the entrance to Pisgah National Forest and has become a noted tourism, retirement, and cultural center in western North Carolina. Brevard employs approximately 100 people and has had during the past five years, and continues to have, a self-funded health plan for its employees and their families. Brevard has paid artificially inflated prices directly to one or more Defendants for GAC and Outpatient Services in the Asheville and Outlying Region markets due to Defendants' unlawful conduct challenged herein. Brevard has duly authorized this lawsuit to be brought in its name under relevant state statutes requiring a resolution of the City Council.

B. Defendants

25. Defendant **HCA Healthcare, Inc.** is a Delaware corporation with a principal place of business in Nashville, Tennessee. Its principal office address is One Park Plaza, Nashville TN 37203, and its registered agent, The Corporation Trust Company, is located at Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware 19801.

26. Through its subsidiary, MH Master Holdings, LLLP, HCA Healthcare, Inc. purchased the assets of Mission in 2019.

27. HCA Healthcare, Inc. is publicly held and listed with the Securities and Exchange Commission ("SEC"). HCA Healthcare, Inc. or its predecessors in interest have been named as respondents in prior antitrust proceedings brought by the FTC and/or the U.S. Department of Justice ("DOJ"), including with regard to hospital acquisitions and divestments of improper mergers.

28. HCA Healthcare, Inc. is a defendant in a class-action lawsuit filed in the Superior Court of North Carolina, Buncombe County, on August 10, 2021, brought by a proposed class of insured residents in Western North Carolina, alleging similar conduct to that alleged herein, and claiming artificially inflated out-of-pocket costs and health insurance premiums for GAC and outpatient services. *See Davis, et al. v. HCA Healthcare, Inc., et al.*, No. 21-CV-03276 (N.C. Super. Ct.). The proposed Class of health plans here does not include class members from the *Davis* lawsuit.

29. HCA Healthcare, Inc. is the world's largest for-profit hospital chain. It owns and operates over 200 hospitals in 21 states. HCA's revenues were over $51 billion for 2020.[4] Its net income was over $3.7 billion in 2020.

30. Defendant **HCA Management Services, LP** is a Delaware limited partnership with its principal place of business in Nashville, Tennessee. Its principal office address is One Park Plaza, Nashville TN 37203, and its North Carolina registered agent, CT Corporation System, is located at 160 Mine Lake Court, Suite 200, Raleigh, NC 27601.

31. HCA Management Services, LP was formed in 1999. It applied for a certificate of authority to do business in North Carolina on December 28, 2005 and is currently registered to do business in North Carolina. It is listed on the HCA Healthcare website as the entity responsible for that website.[5]

32. HCA Management Services, LP entered into a confidentiality and nondisclosure agreement with ANC Healthcare, Inc. f/k/a Mission Health System, Inc. on or about July 11, 2017. At that time, MH Master Holdings, LLLP which was only first organized on August 23, 2018, did not yet exist. Pursuant to negotiations conducted under that nondisclosure agreement, various Mission and HCA entities entered into an Asset Purchase Agreement ("APA"), dated August 2018, and an amended Asset Purchase Agreement ("Amended APA"), dated January 2019, facilitating the sale of relevant Mission system assets to HCA.

33. Defendant **HCA, Inc.** is a Delaware corporation with its principal place of business in Nashville, Tennessee. Its principal office address is One Park Plaza, Nashville TN 37203.

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[4] By comparison, according to the National Association of State Budget Officers, North Carolina's total expenditures in fiscal year (FY) 2020 were $60.2 billion, including general funds, other state funds, bonds, and federal funds. HCA Healthcare is number 62 on the Fortune 500.

[5] https://hcahealthcare.com.

34. HCA, Inc. is the plan sponsor of a defined contribution plan established January 1, 1983, which provides retirement benefits for all eligible employees of HCA, Inc. or its affiliates (and their families). It is the sponsor of the HCA 401(k) Plan, with employer identification number 75-2497104, and a total number of participants of 387,421 as of 2019. On information and belief, HCA, Inc. is the plan sponsor of a retirement benefit plan for numerous employees associated with the North Carolina Division of HCA Healthcare, Inc. HCA, Inc. has been a respondent or defendant in prior proceedings challenging various aspects of HCA's business practices.[6]

35. Defendant **MH Master Holdings, LLLP** applied for a certificate of authority to do business in North Carolina on August 23, 2018. It filed its most recent annual report with the North Carolina Secretary of State, Department of Corporations, on or about April 6, 2021, describing itself as being engaged in the "healthcare related business."

36. MH Master Holdings, LLLP's general partner is MH Hospital Manager LLC. MH Master Holdings, LLLP is a 99% limited partner in MH Mission Hospital, LLLP. Under the Amended APA, MH Master Holdings, LLLP is authorized to do business under brand names including "Mission Health," "Mission Health System," and the "HCA" brand.

37. The "corporate bio" used at the end of many HCA NC press releases, opens, under the header "ABOUT MISSION HEALTH," by stating that "Mission Health [is] an operating division of HCA Healthcare [and] is based in Asheville, North Carolina…."

38. Defendant MH Master Holdings, LLLP identifies itself as and holds itself out as being a part of the North Carolina Division of HCA Healthcare, Inc. *See, e.g.*, job postings on

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[6] *See, e.g.,* U.S. DOJ press release, dated June 26, 2003. (https://www.justice.gov/archive/opa/pr/2003/June/03_civ_386.htm).

websites like "Health Careers," listing open positions at "HCA Healthcare—North Carolina Division."

39. HCA states in public website content that its "North Carolina Division," also known as, "Mission Health," is "based in Asheville, North Carolina."

40. Per HCA press releases, since February 2019, Greg Lowe has been "president of the newly created Asheville-based North Carolina Division, which comprises the recently purchased Mission Health system of six hospitals in western North Carolina." Upon information and belief, Mr. Lowe resides in North Carolina.

41. Defendant **MH Hospital Manager, LLC** is a Delaware limited liability company with a principal place of business in Tennessee or North Carolina. Its registered agent, c/o CT Corporation System, is located at 160 Mine Lake Court, Suite 200, Raleigh NC 27615, or, at its office at 509 Biltmore Avenue, Asheville, NC 28801, or c/o HCA Healthcare, One Park Plaza, Nashville, TN 37203.

42. Defendant MH Hospital Manager, LLC applied for a certificate of authority to do business in North Carolina on August 22, 2018. Its annual report dated April 6, 2021, describes the nature of its business as "healthcare related business."

43. Defendant MH Hospital Manager uses the assumed business name, "North Carolina Division," pursuant to an assumed name certificate dated April 22, 2019, filed with the Buncombe County Register of Deeds. It described the counties where the assumed business name will be used to engage in business as "All 100 North Carolina counties."

44. Defendant **MH Mission Hospital, LLLP** is a Delaware limited liability limited partnership, with a principal place of business in North Carolina. Its registered agent's office

address, c/o CT Corporation System, is 160 Mine Lake Court, Suite 200, Raleigh, NC 27615, and its principal office is located at 509 Biltmore Avenue, Asheville, NC 28801.

45. Effective July 2019, Chad Patrick became the Chief Executive Officer of what HCA describes as "HCA Healthcare's North Carolina Division's flagship 763-bed Mission Hospital" and has resided in Asheville since Summer 2019. On information and belief, the HCA corporate entity employing Mr. Patrick is MH Mission Hospital, LLLP.

46. Defendant **ANC Healthcare, Inc. f/k/a Mission Health System, Inc.** is a North Carolina nonprofit corporation which had its principal place of business in Asheville, North Carolina through 2019. It remains an active corporation incorporated under North Carolina law. In or about February 2019, its principal office was moved to Florida. Its registered agent, Corporation Service Company, is located at 2626 Glenwood Avenue, Suite 550, Raleigh, NC 27608. Its current office address is 425 West New England Avenue, Suite 300, Winter Park, FL 32789.

47. ANC Healthcare, Inc. f/k/a Mission Health System, Inc. was incorporated in 1981 as a North Carolina nonprofit corporation. As of the date of the filing of this lawsuit, it remains a nonprofit corporation incorporated under North Carolina law. *See* Articles of Restatement for Nonprofit Corporation filed February 1, 2019. The corporation is not defunct, nor has it been dissolved and in its most recent Articles of Restatement it describes its duration as "unlimited."

48. As of 2015, ANC Healthcare, Inc. described itself as an "integrated healthcare system," which provided "medical care, hospital care" and "the delivery of health care services to persons resident in Western North Carolina and surrounding areas."

49. During the period commencing in or about 2010 and continuing through and including January 2019, Ronald Paulus ("Paulus") was the President and Chief Executive Officer of ANC Healthcare, Inc. f/k/a Mission Health System, Inc.

50. Defendant **Mission Hospital, Inc.** is a North Carolina nonprofit corporation, which had its principal place of business in Asheville, North Carolina for many years through 2019. It remains an active nonprofit corporation incorporated under North Carolina law. In or about February 2019, its principal office was moved to Florida. Its registered agent, Corporation Service Company, is located at 2626 Glenwood Avenue, Suite 550, Raleigh, NC 27608. Its current office address is 425 West New England Avenue, Suite 300, Winter Park, FL 32789.

51. Defendant Mission Hospital, Inc. was incorporated in 1951 as a North Carolina nonprofit corporation. As of the date of the filing of this lawsuit, it remains a nonprofit corporation incorporated under North Carolina law. *See* Articles of Restatement for Nonprofit Corporation filed February 1, 2019. The corporation is not defunct, nor has it been dissolved and in its most recent Articles of Restatement it describes its duration as "unlimited."

52. Defendants ANC Healthcare, Inc. f/k/a Mission Health System, Inc. and Mission Hospital, Inc. are each identified as sellers under the Amended APA. *See* Amended APA, p. 1. Under the Amended APA's terms, ANC Healthcare, Inc. f/k/a Mission Health System, Inc. and Mission Hospital, Inc. remain liable for pre-asset sale ownership or operations of the hospital business. *See* Amended APA, § 2.4 (in which the HCA entities who function as the buyers under the Amended APA purported to exclude from their liability "any Liabilities related to the ownership or operation of the Business or the Purchased Assets prior to the Effective Time").

53. Under the Amended APA, the sellers represented and warranted that they "have operated, and are operating, the Business… and their properties in compliance in all material

respects with all applicable Laws," up through the sale date. Amended APA, § 4.11(a)(i). However, they did not comply with numerous such laws, as alleged herein.

III. JURISDICTION AND VENUE

54. This Court has jurisdiction over this action under Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 & 2; Sections 4 and 16 of the Clayton Act, 15 U.S.C. §§ 15c & 26; and under 28 U.S.C. §§ 1331 and 1337.

55. This Court has personal jurisdiction over Defendants because they are domiciled and/or registered to transact business in North Carolina, and they have transacted business in North Carolina relevant to this antitrust action.

56. Venue is proper in this District under Section 12 of the Clayton Act, 15 U.S.C. § 22, and 28 U.S.C. § 1391. Defendants conduct substantial business in this district and their conduct both gives rise to Plaintiff's claims occurring in this district and also affected interstate commerce.

IV. RELEVANT HISTORICAL BACKGROUND

A. Mission Acquired Monopoly Power Under the COPA

57. Mission Hospital was originally formed over a century ago as a local Asheville charitable institution. When founded in the 1880s, the Dogwood Mission, also known as the Flower Mission, provided charity care to Asheville's sick and poor.

58. After World War II, Mission Hospital joined with other Buncombe County hospitals to become a major medical center in western North Carolina. In 1951, Mission Hospital was incorporated as a nonprofit. Although it was a nonprofit, it was not under the patronage or the control of the State of North Carolina, nor was it a local health authority.

59. As of the early 1990s, the only two private acute care hospitals in Asheville were Mission Hospital-Asheville and St. Joseph's Hospital. Mission had 381 beds. St. Joseph's Hospital

had 285 beds. The two hospitals sought to partner and lobbied the General Assembly to enact an initial version of the COPA law to facilitate a partnership in 1993.[7]

60. The two hospitals claimed that their plans did not call for a merger and that each hospital would maintain its distinct corporate identity, governance structure, and assets. Nonetheless, in 1994 the FTC opened a merger investigation out of a concern that the combination of St. Joseph's and Mission would result in a single large hospital dominating upwards of 80% or 90% of the market for GAC Services in Asheville.

61. In response, the hospitals lobbied the North Carolina General Assembly to amend the COPA to further immunize them from antitrust scrutiny.[8] The General Assembly did so in December 1995, and Mission and St. Joseph's then entered into their proposed partnership.

62. Subsequently, in 1998, Mission sought to buy St. Joseph's outright, acquire all of its assets, and combine operations under one license as Mission Health System. The COPA was amended in October 1998 to facilitate the merger.

63. The purpose of the COPA statute, as amended in 1998, was to strike a deal: in exchange for the State to allow the combination of Mission and St. Joseph's, which would be exempt from antitrust laws, Mission would accept price regulation designed to prevent it from charging monopoly prices or otherwise abusing its market power by agreeing to "limit health care costs" and "control prices of health care services."[9]

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[7] Hospital Cooperation Act of 1993, Session Law 1993-529.

[8] *See* N.C.G.S. §§ 131E-192.1 through 131E-192.13 (repealed).

[9] *See* former N.C.G.S. §§ 90-21.24, 90-21.28 (enacted by Physician Cooperation Act of 1995, SL 1995-395 (1995)); recodified at N.C.G.S. §§ 131E-192.1 through 131E-192.13 (repealed by Session Laws 2015-288, s. 4, as amended by Session Laws 2016-94, s. 12G.4(a), effective Sept. 30, 2016).

64. The 1998 amended COPA law acknowledged that conduct that might be lawful under the COPA would be unlawful without it, noting that "federal and State antitrust laws may prohibit or discourage" the "cooperative arrangements" that the COPA allowed.[10]

65. When the COPA was amended in 1998 to allow the Mission-St. Joseph's merger, the State accepted the hospitals' representations that the merger "will not likely have an adverse effect on costs or prices of health care."[11]

66. The 1998 amended COPA documented the dominant market share of the merged Mission institution: "The two Hospitals dominate the market share in two counties. 91% of Madison County admissions and 87% of Buncombe County admissions are either Memorial Mission or St. Joseph's Hospital. Memorial Mission and St. Joseph's are located in Buncombe County. Madison County, which has no hospital, is closer to the two Asheville hospitals than to any other acute care hospital."[12]

67. A second amended COPA dated June 2005 stated: "Mission Health dominates the market share in two counties. 93.8% of Madison County admissions and 90.6% of Buncombe County admissions are at Mission Hospitals' facilities, which are located in Buncombe County. Madison County, which has no hospital, is closer to Mission Hospitals in Asheville than to any other acute care hospital."

68. A 2011 report by economist Greg Vistnes ("Vistnes Report") commissioned to study the efficacy of the COPA confirmed that a potential for regulatory evasion existed and that the COPA created an incentive for Mission to acquire facilities outside of Asheville because, while

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[10] *See* former N.C.G.S. §§ 90-21.24(5).

[11] 1998 COPA, p. 13; *see also id.*, p. 14 (reciting that merger will "not likely have an adverse impact on … price of health care services").

[12] *Id.*, pp. 7-8.

the COPA limited Mission's ability to raise prices and margins, the price increase cap was tied *only* to Mission Hospital-Asheville. This limitation meant that if Mission increased prices by acquiring facilities outside Asheville, then it could raise prices in theory, and did in practice, without technically violating the COPA's margin cap. Evidence presented at an FTC workshop in 2019 indicated that, in fact, Mission appeared to have evaded the restrictions of the COPA on price increases in precisely this way.

69. As of 2016, Mission continued to have a 93% share of the GAC Market in the Asheville Region. This dominant market share, which reflects Mission's acquisition of five smaller hospitals in these countries between 1995 and 2016, conferred upon Mission monopoly power. HCA has itself conceded in public statements about another health care system in Florida that an 85% share is sufficient to confer monopoly power.

70. In late 2015, the North Carolina General Assembly repealed COPA, effective January 1, 2018. After this date, the North Carolina government no longer exercised any direct regulatory authority over the prices that Mission could charge, even though Mission's monopoly power continued unabated.

B. HCA's Purchase of Mission's Assets

71. In or around 2017, knowing that the COPA was soon to expire, Mission's executives entered into private, non-public negotiations to sell its assets to HCA, the nation's largest hospital chain, via an HCA subsidiary as was subsequently documented in the APA.[13] The negotiation process was conducted without any public notice or input, despite HCA's and Mission's purported commitment to transparency and Mission's status as a charitable nonprofit

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[13] https://www.searchwnc.org/asset-purchase-agreement.

with a fiduciary duty to the citizens of Western North Carolina. Non-executive doctors and staff were excluded from the negotiation process and the decision to sell to HCA.

72. On March 21, 2018, Mission and HCA announced that HCA would be acquiring the assets of Mission. HCA pursued the Mission asset purchase primarily because of Mission's monopoly power in the GAC Market in the Asheville Region and the other Relevant Markets.

73. On August 30, 2018, Mission and HCA executed an APA, which was amended in January 2019. The purchase price was approximately $1.5 billion. Mission's annual revenue at that time was estimated to be approximately $1.75 billion.

74. Under terms of the asset transfer completed in January 2019, HCA and Mission formed the new North Carolina Division of HCA Healthcare.

V. HOSPITAL/INSURANCE MARKETS

A. Hospital/Insurer Negotiations in a Competitive Market

75. Markets for hospital services are different from other product/services markets because the persons consuming the hospital services (the patients) do not typically negotiate—and in many cases, do not even know beforehand (or sometimes ever)—the costs of the services they are consuming. Instead, health plans—consisting of commercial payors (such as Blue Cross and Aetna) and self-funded payors whose claims are administered by insurers or third-party administrators (or "TPAs")—purchase medical services for the benefit of their members.

76. Health insurance plans negotiate with hospitals for bundles of services that they will offer to members as "in-network" benefits. If a health plan and heath care provider (like a hospital system) reach a deal for a bundle of services (for instance, all acute inpatient hospital services), the hospital will be considered in-network for every service in that bundle. This means that for any service in that bundle, if a health plan's member receives that service from the hospital,

the health plan will pay the hospital the "allowed amount" the two parties negotiated for that service (with insureds responsible for any deductibles and co-payments under the health plans).

77. In competitive health care markets, when health insurance plans negotiate for a bundle of services, the health insurance plans may choose to include as in-network only *some* services (or facilities) and to exclude others from the bundle. For example, the health insurance plan may choose to have one hospital be in-network for all GAC Services but choose not to include that hospital in-network for Outpatient Services because the plan could purchase higher quality or less expensive Outpatient Services from other providers. Similarly, in a competitive market, a health insurance plan might decline to purchase any services from a hospital if that hospital's prices or quality of care are not competitive with other nearby providers. This ability to choose among different providers of services for a single health plan helps to control health care costs because it compels health care providers to compete with each other to be included in health plans.

78. For a health insurance plan to be a viable product that consumers wish to purchase for themselves, or that employers wish to purchase or self-fund for their employees, the plan must include a comprehensive bundle of services that members can access in their geographic region. A health insurance plan will not be commercially viable or acceptable if it does not offer in-network services or facilities that individuals commonly desire or that individuals may need to access in the case of unforeseen health problems.

79. In competitive markets, hospitals compete to be selected for inclusion in health plans. Likewise, health insurance plans compete to be selected by employers to offer to their workers or compete to be selected by individuals. Because of the unique way that health care services are purchased and consumed, this competition is essential for there to be services of acceptable quality at competitive prices and to control health care costs and prices. By short-

circuiting this competition, the Scheme enabled HCA to exploit its monopoly power to bolster and to maintain that power and ultimately to charge supracompetitive prices for lower quality care.

B. Hospital/Insurer Negotiations in the Absence of Competition

80. The unique features of health care markets, as just described, provide an opportunity for health care providers with significant market power to restrain trade and bolster monopoly power illegally through unduly restrictive agreements with health plans that foreclose competition and thereby extract supracompetitive prices for health care services. As alleged above, supracompetitive prices are rates that are higher than what would be found in the context of normal competition. Normal competition can occur only where dominant hospitals do not unlawfully restrain trade and/or abuse monopoly power.

81. When a health insurer or self-funded plan seeks to offer a plan in a geographic region where a significant area is serviced by a single hospital that provides essential health care services, that hospital is essential for health plans to include in their networks, and is, in effect a "must have" hospital for that health plan. Individuals and employers seeking insurance will not choose any health plan that does not include necessary services provided by that hospital.

82. If a "must have" hospital decides to engage in anticompetitive behavior, it can cause significant financial harm to health plans, and to employers offering such plans. If the "must have" hospital is part of a system that has other facilities that *do* face at least some fringe competition or potential competition, the hospital system can leverage its monopoly power to refuse to offer medical services at the "must have" facility unless health plans also agree, *inter alia*, to (a) purchase medical services from the system's other facilities at artificially high prices dictated by the hospital system, and (b) impose restrictive terms that prevent health plans from steering patients to less expensive and/or higher quality alternative providers.

83. "Must have" hospitals, by definition, therefore, leave health plans with no other effective choices and can and sometimes do use that status to perpetuate their dominance and the dominance of the other facilities in their systems. In this way, "must have" hospitals coerce health plans to accept terms the health plans otherwise would not agree to in a competitive environment, eliminating or impairing the ability of health plans to spur price competition between providers.

84. The foregoing factors and others have led to a consensus in the field of health care economics that monopolization of hospital markets significantly increases prices for hospital services paid by health plans, employers, and individuals, in the form of, *inter alia*, artificially inflated direct payments to hospitals from insurers and self-funded payors. The economic literature also demonstrates that there are no concomitant improvements in quality from such monopolization. To the contrary, medical providers with monopoly power exercise that power not only by charging higher prices, but by cutting corners, including by reducing locations where they operate, reducing staffing, and otherwise by allowing the quality of their services to deteriorate. HCA itself stated in a regulatory filing in Florida that "there is documented empirical evidence of the negative aspects of lack of competition in a health care market on charges, costs, and quality of care" and "economic studies consistently demonstrate that a reduction in hospital competition leads to higher prices for hospital care."[14]

85. Hospitals with monopoly power also use that power to erect artificial barriers to competing health care providers, as Defendants have done here in both the GAC and Outpatient Relevant Markets. They can, as Defendants have done here, compel health plans to accept: (a) "all or nothing" tying arrangements that require health plans to contract with all of the facilities and

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[14] HCA (Medical Center of Southwest Florida LLC) Certificate of Need Application #10523, Florida Agency for Health Care Administration, April 11, 2018. ("HCA Certificate of Need Application").

services offered by the organization owning "must have" hospitals with substantial market power; (b) exclusive dealing arrangements in the form of anti-steering and anti-tiering provisions that prevent or discourage health plans from informing and/or incentivizing their members to use other less expensive and/or higher quality providers of health care; and (c) "gag" clauses that prevent patients, other providers, other health plans, and existing or potential entrants, from knowing the prices that monopoly providers charge. Gag clauses effectively eliminate information about prices, which are the lifeblood of competitive markets, and thus inhibit the ability of purchasers of health care services to control health care costs.

86. Taken together, the foregoing exclusionary contractual provisions imposed on health plans by hospital systems with monopoly power, like Defendants have utilized here, can and do foreclose competition, entrench that provider's monopoly power in its own "tying market" and in other "tied markets," and cause substantial anticompetitive effects across markets, including here, the Relevant Markets.

VI. THE RELEVANT MARKETS

87. Monopoly power may be proven by using direct evidence of the ability to (a) coerce buyers to accept unwanted contractual terms, or (b) charge supracompetitive prices, reduce quality, or reduced output. Monopoly power may, alternatively, be proven by demonstrating substantial market shares in a relevant or geographic market. Defendants have the ability to impose anticompetitive contract terms in its agreements with health plans covering a substantial share of those using health care services in the Relevant Geographic Markets, and thereby to (i) foreclose competition from actual and potential health care provider rivals, (ii) persistently charge supracompetitive prices, (iii) reduce output, and (iv) reduce quality of their services. The foregoing effects constitute direct evidence of Defendants' monopoly power over the health care services in

question and in the regions at issue. Accordingly, there is no explicit requirement to analyze or allege market or monopoly power indirectly, by assessing shares of, or competitive effects in, specifically defined relevant service or geographic markets.

88. Nonetheless, and in the alternative, the Relevant Markets at issue in this case are defined in detail below. For each, the service market includes only the purchase of medical services by private health plans, namely commercial insurance plans and employer self-funded payors. The service markets do not include sales of such services to government payers, including Medicare (and Medicare Advantage), Medicaid, and TRICARE (covering military families), because health care providers' negotiations with commercial insurers and employer self-funded plans are separate from the process used to determine the rates paid by government payers.

A. The Relevant Product/Service Markets

89. As discussed above, there are two product or service markets that are relevant in this action. First, the GAC Market includes GAC Services, which consist of a broad group of medical, surgical, anesthesia, diagnostic, nursing, laboratory, radiology, dietary, and other treatment services provided in a hospital setting to patients requiring one or more overnight stays. Because GAC Services are not substitutes from a patient's perspective for each other (*e.g.*, orthopedic surgery is not a substitute for gastroenterology), health insurance plans typically contract for various individual inpatient GAC Services as a package in a single negotiation with a hospital system and/or set of providers. That is precisely how Defendant HCA negotiates (and how Mission before it negotiated) with health plans with respect to GAC Services at Mission Hospital-Asheville. Non-hospital facilities, such as outpatient facilities, specialty facilities (such nursing homes), and facilities that provide long-term psychiatric care, substance abuse treatment, and rehabilitation services are not viable substitutes for acute inpatient hospital services.

90. The second product or service market is the Outpatient Market, which encompasses a broad group of medical, diagnostic, and treatment services that are not inpatient medical services (*i.e.*, health care services that do not require an overnight stay). Although individual Outpatient Services are not substitutes for each other (*e.g.*, a CT scan is not a substitute for an annual physical), health plans typically contract for various individual outpatient medical services as a package in a single negotiation with a hospital system and/or set of providers, and that is how Defendant HCA negotiates (and how Mission before it negotiated) with health insurance plans with respect to Outpatient Services at Mission Hospital-Asheville.

91. The Outpatient Market is a separate market from the GAC Market because the two types of services are not interchangeable and can be sold separately. Health insurance plans can, and often do, purchase Outpatient Services from different providers (*i.e.*, non-hospital providers), unlike the purchase of GAC Services, which can only be purchased from hospitals. The existence of non-hospital competitors, in a competitive market absent any anticompetitive behavior, reduces the price health insurance plans pay a hospital for Outpatient Services, but those non-hospital outpatient competitors would not affect the price a hospital could charge for GAC Services. The GAC Market and Outpatient Markets are therefore distinct.

92. The distinction between the two types of health care services—GAC and Outpatient—is also widely recognized in the academic and government regulatory literature on health care.

93. Both relevant service markets at issue satisfy the conditions for market definition used by the federal antitrust enforcement agencies under what is widely known as the "SSNIP test." Each of these service markets constitutes a distinct group of services in which a hypothetical

monopolist provider would profitably impose at least a small but significant non-transitory increase in price above competitive levels (*i.e*., at least 5%).

94. Defendant HCA provides GAC Services and Outpatient Services in each of the Relevant Geographic Markets alleged below.

B. The Relevant Geographic Markets

95. There are at least two geographic markets that are relevant to this action. These market definitions reflect the fact that plan members, and thus plans, typically choose GAC hospital and Outpatient care within reasonable proximity to members' homes or workplaces. Each geographic market definition below meets the SSNIP test: each market is an area in which a hypothetical monopoly provider of GAC Services and/or Outpatient Services in each of the Relevant Geographic Markets would profitably raise its prices above competitive levels by at least a small but significant non-transitory amount (*i.e*., at least 5%).

1. Asheville Region.

96. Buncombe and Madison Counties (together the "Asheville Region") are one relevant geographic market. HCA participates in the Asheville Region Geographic Market predominately through its flagship facility, Mission Hospital-Asheville.

97. The predecessor entity whose assets HCA purchased, Mission, defined its service area as consisting of Buncombe and Madison Counties, or the Asheville Region.[15]

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[15] *E.g*., Mission Hospital Implementation Strategy, 2013-15, p. 1 ("Our community, defined for the purposes of community health needs assessment and this related implementation strategy, is comprised of Buncombe and Madison Counties."), https://missionhealth.org/wp-content/uploads/2018/04/2013-Mission-Hospital-Implementation-Strategy.pdf. *See also* IRS Form 990 for period ending September 2019, Schedule H, supplemental information ("Mission Hospital primarily serves Buncombe and Madison Counties").

98. The 2020 Census reported the population of Buncombe County was 269,452 and the population of Madison County was 21,193.

99. The 2010 Census reported the population of Buncombe County was 238,318 and the population of Madison County was 20,764.

100. Given the broad scope of GAC Services offered in the Asheville Region and the extensive travel times required to obtain them elsewhere, there are no reasonable substitutes or alternatives to GAC Services in the Asheville Region for health plans and their members, who are persons living or working in that area. Consequently, competition from providers of GAC Services located outside the Asheville Region would not likely be sufficient to prevent a hypothetical monopolist provider of GAC Services in the Asheville Region from profitably imposing at least a small but significant price increases above competitive levels for those services over a sustained period of time.

101. There are no reasonable substitutes or alternatives to Outpatient Services in the Asheville Region from Outpatient Services outside the Asheville Region for health plans and their members. People who live and work in the Asheville Region strongly prefer to obtain Outpatient Services in that area (indeed, it is often medically inappropriate to require them to travel farther). Consequently, competition from providers of Outpatient Services located outside the Asheville Region would not likely be sufficient to prevent a hypothetical monopolist provider of Outpatient Services located in the Asheville area from profitably imposing at least a small but significant price increases above competitive levels for those services over a sustained period of time.

2. Outlying Region.

102. A second relevant geographic market consists of the area encompassed by the following counties in or near where Defendant HCA's hospitals operate: Macon, McDowell,

Mitchell, Transylvania, and Yancey Counties (collectively, the "Outlying Region"). In the alternative, each of these counties in the Outlying Region constitutes its own separate Relevant Geographic Market.

103. HCA has hospital facilities (the "Outlying Facilities") serving each the above-described geographic areas: Transylvania Regional Hospital, Transylvania County; Angel Medical Center, Macon County; Highlands-Cashiers Hospital, Macon County; Mission Hospital McDowell, McDowell County; and Blue Ridge Regional Hospital, Mitchell County.

104. HCA faces a fringe of some actual or potential competition for GAC Services and Outpatient Services in the Outlying Region from other hospitals and non-hospital providers. Thus, due to the somewhat heightened level of competition (as compared to Mission Hospital-Asheville), in the absence of Defendants' anticompetitive conduct, health plans seeking to build a viable insurance network would not be required to include all Outlying Facilities in-network in order to be viable.

105. The Outlying Region constitutes a separate geographic market from the Asheville Region because GAC and Outpatient Services in the Outlying Region are not interchangeable with, and can be sold separately from, the GAC and Outpatient Services provided in the Asheville Region. These Relevant Geographic Markets involve different facilities, operating primarily in different geographic regions, and different types of service are offered in each. For instance, in the Asheville Region, Defendants offer acute trauma care, whereas this service is not offered by any of the facilities in the Outlying Region. Moreover, some of Defendants' facilities in the Outlying Region face some competition from other providers, which is more competition than Defendants' facility at Mission Hospital-Asheville faces, particularly for GAC Services.

106. In general, in competitive health care markets, health plans can and often do purchase Outpatient Services from different providers (*i.e.*, non-hospital providers), which distinguishes Outpatient Services from GAC Services, which can only be purchased from hospitals. The actual and potential competition that the facilities in the Outlying Region face (and would face) both from other hospitals and non-hospital facilities, in a competitive market absent any anticompetitive behavior, would reduce the prices health plans would pay the facilities in the Outlying Region for GAC and Outpatient Services.

107. In the alternative, each of the individual counties that make up the Outlying Region are separate geographic markets. In the alternative, the hospital facilities in each of these counties are sufficiently far apart from the hospital facilities in the other counties that no more than an insignificant number of patients would use the GAC and Outpatient Services outside the county in which they live or work.

VII. DEFENDANTS' MONOPOLY POWER

108. Due to the Scheme, Defendants have maintained, acquired, and/or bolstered monopoly power in all Relevant Services and Geographic Markets.

109. HCA has a market share of approximately 80% to 90% in the GAC Market in the Asheville Region, primarily due to the dominance of Mission Hospital-Asheville. HCA acquired this market dominance when it bought the assets of Mission and maintains that dominance through the Scheme. This market dominance was reflected in the market shares of the Mission Hospital-Asheville in the top three zip codes, by population, in the Asheville Region for the calendar year

ending December 31, 2019: 88.9% for zip code of residence 28806; 86.5% for zip code of residence 28803; and 87% for zip code of residence 28715.[16]

110. Defendants' market share in the GAC Market in the Asheville Region is significant enough to stifle competition and restrict freedom of commerce, and, at all times relevant to this Complaint, and due to the Scheme alleged herein that has helped Defendants maintain that monopoly power, Defendants have had the ability to inflate prices above competitive levels in this market.

111. Mission also had high shares of patients in the GAC Market in the Asheville Region, as well as in the other counties in the Outlying Region (*i.e.*, Macon, McDowell, Mitchell, Transylvania, and Yancey Counties):

- Yancey: 90.9%
- Madison: 90%
- Buncombe: 86.6%
- Mitchell: 85.4%
- Transylvania: 78.7%
- McDowell: 76.4%
- Macon: 74.7%

112. Given the high entry barriers facing new hospitals, and also Defendants' Scheme alleged herein, upon information and belief, these market shares have not been materially reduced, and have likely increased, since HCA bought Mission.

113. Although the market share data are not publicly available for Outpatient Services in all Relevant Geographic Markets, Defendants have the ability to charge supracompetitive prices, reduce output, and decrease the quality of service—indeed, while maintaining very high market shares—which they could not do unless they had monopoly power.

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[16] *See* American Hospital Directory, available at https://www.ahd.com/free_profile/340002/Mission_Hospital_-_Memorial_Campus/Asheville/North_Carolina/.

114. For example, since HCA's acquisition of the Mission system, HCA has cut Outpatient Services in the Outlying Region, compelling patients to travel to HCA's Asheville facilities to obtain care. Outpatient clinics for primary, geriatric, and cancer care in the Outlying Region has been especially targeted for cuts. More specifics regarding HCA's reduction in quality are further alleged below.

115. Likewise, as shown in more detail below, HCA's ability, like Mission's before it, to maintain prices for key medical services at levels and growth rates substantially above the statewide average for those procedures demonstrates HCA's monopoly power in all Relevant Markets.

VIII. DEFENDANTS' UNLAWFUL CONDUCT

A. HCA's Unlawful Scheme

116. Defendants engaged in a multifaceted Scheme to gain, maintain, and bolster monopoly power in the Relevant Markets, substantially foreclose competition, and thereby impose supracompetitive prices on Plaintiff and members of the proposed Class. Defendants use the Scheme to generate these anticompetitive effects by leveraging the monopoly power that HCA has in GAC Services in the Asheville Region to force health plans to accept terms that reduce payors' ability to promote competition by, *inter alia*, steering patients to lower priced, higher quality options.

117. Defendants' Scheme involves a web of contracts that Defendants have imposed on insurers, which include, but are not limited to: (1) "all-or-nothing" offers that tie Defendants' must-have GAC Services in the Asheville Region to accepting GAC Services in the Outlying Region as a whole (or, in the alternative, in each of the five county markets in the Outlying Region), as well as to Outpatient Services in all Relevant Geographic Markets; (2) exclusive dealing arrangements

in the form of anti-steering and anti-tiering contractual provisions that prevent or discourage patients from dealing with Defendants' rivals and potential rivals; and (3) "gag" clauses that prevent price transparency.

118. Individually and in combination, the elements of the Scheme are designed to suppress competition and transparency in the Relevant Markets, foreclose competition, and thereby to increase the prices Defendants charge for health care to Plaintiff and the proposed Class above competitive levels.

119. Anticompetitive contractual provisions and negotiating tactics are particularly problematic when a provider controls "must have" services, as HCA does with GAC Services through Mission Hospital-Asheville. It is not practically possible to assemble a commercially viable insurance plan covering both GAC and Outpatient Services that excludes Mission Hospital-Asheville. In a market with a "must have" hospital, even the limited use of these contractual provisions or negotiating tactics causes much greater competitive harm than the use of such practices and provisions in a competitive market.

120. Certain of the anticompetitive contractual provisions and negotiating tactics at issue here have been the subject of judicial scrutiny in the Western District of North Carolina in *United States of America, et al. v. The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Health Care System*, No. 3:16-cv-00311-RJC-DCK, 2019 WL 2767005, 2019-1 Trade Cases P 80,752 (W.D.N.C. April 24, 2019), where the defendant health care system ultimately entered into a consent decree, approved by the Court, not to enforce anti-steering provisions in its contracts with health plans.

121. HCA has a pattern and practice of using similar negotiating tactics and including similar unlawfully restrictive provisions in contracts with health plans to those alleged here in

other parts of the United States, including but not limited to Colorado and Virginia. The kinds of contractual provisions or arrangements alleged here also have been found to be illegal even in markets with more robust provider competition than exists here, because they inherently harm consumer welfare and competition. However, because Defendants have monopoly power in all the Relevant Markets, the impact on Plaintiff and the proposed Class is much more severe than in those other markets.

1. HCA's "All or Nothing" Requirements.

122. HCA has used its monopoly power in the GAC Market in the Asheville Region, derived from its "must have" Mission Hospital-Asheville, to impose "all or nothing" contracts on health plans operating in all other Relevant Markets. Under these provisions, HCA coerces health plans to include all of HCA's GAC and Outpatient Services in the Outlying Region in the plans, as well as HCA's Outpatient Services in the Asheville Region. HCA significantly disadvantages health plans that do not commit to include in the health plan's top tier and promote all of the GAC and Outpatient Services provided by HCA facilities in the Relevant Geographic Markets.

123. These "all or nothing" contractual provisions constitute unlawful tying under the antitrust laws. Tying occurs when an entity that has market power in one market (the "tying market") leverages that market power in order to gain, maintain, or enhance monopoly power in another market or markets (the "tied market(s)"). Under such tying arrangements, the defendant will sell one service or set of services (the "tying service(s)") only under the condition that the purchaser buys a second service or set of services (the "tied service(s)"). Where the defendant has monopoly power in the tying market, and where the tie allows the defendant to gain, maintain, or enhance monopoly power in the tied market, such tying arrangements are considered anticompetitive and unlawful under the antitrust laws.

124. When a hospital system is the only entity in a given region to offer a product or service that health plans must include in their networks to be viable, that hospital system can refuse to sell services to health plans, or sell only with a significant price penalty, unless those health plans also agree to purchase other services from the hospital system, including services that the health plan would otherwise purchase from a different hospital system or set of providers for lower prices. Either orally during negotiations or in the contracts themselves, a hospital system can give the health plan what effectively is an "all-or-nothing" choice: Include everything the hospital system wants to sell at the price the hospital system dictates or pay much higher penalty prices or even get nothing at all. That is what HCA has done here.

125. In this case, the "tying market" is the GAC Market in the Asheville Region, enabled by HCA's (and prior to that, Mission's) monopoly power through Mission-Asheville Hospital. The "tied markets" include the Outpatient Market in the Asheville Region and both the GAC Market and Outpatient Market in the Outlying Region, or in the alternative, in each of the five counties that comprise the Outlying Region. As a result of the Scheme, HCA has monopoly power in all these markets, measured either by its dominant market shares and/or by its supracompetitive prices, which are inflated by Defendants' Scheme.

126. Mission began forcing health insurance plans to accept "all or nothing" contractual provisions as early as 2017. For example, in 2017 during Mission's negotiations with Blue Cross, Mission asked for exorbitant price increases for GAC and Outpatient Services, and further insisted on the inclusion of services from HCA covering both inpatient and outpatient care in all Relevant Geographic Markets in the Blue Cross contract. When Blue Cross did not agree to Mission's "all or nothing" demand for all these services, Mission took itself out of the Blue Cross network for GAC and Outpatient Services in the Relevant Markets, including the "must have" Mission

Hospital-Asheville. Mission's actions meant that the 260,000 people in Western North Carolina insured by Blue Cross could not seek care at Mission facilities unless they paid much higher "out of network" prices out of their own pockets.

127. While hospital systems and insurers regularly negotiate over rates and terms, a hospital system taking an insurer out of network—especially where the hospital system has such monopoly power—is considered "go[ing] nuclear." With respect to the 2017 negotiation between Mission and Blue Cross, Mission's imposition of the "nuclear" option disrupted the administration of health care in the entire region, requiring tens of thousands of Blue Cross members to switch doctors, forgo medical care, or drive long distances to receive care at a non-Mission facility. Mission remained out of network for Blue Cross for two months, until Blue Cross capitulated, accepting both a rate increase and inclusion of the entirety of the Mission system in all Relevant Markets in network. Given that Blue Cross is likely the most significant health plan in North Carolina and in the Relevant Markets, HCA's ability to bully Blue Cross into accepting its "all or nothing" (and other anticompetitive terms as part of the Scheme) leaves little room for doubt that HCA was also able to compel the other health plans comprising the Class to accept the same restrictive provisions.

2. HCA's Anti-Steering and Anti-Tiering Provisions.

128. HCA has also abused its monopoly power in the GAC Market in the Asheville Region to impose so-called anti-steering provisions on health plans operating in all Relevant Geographic Markets. Anti-steering provisions prohibit health plans from encouraging their members (through financial incentives or otherwise) to use other, less expensive and/or higher quality providers of GAC or Outpatient Services that compete or could compete with HCA's facilities. These contractual provisions discourage rivals from using price as a means of

competition (because rivals cannot effectively use price to attract customers), and thus they lead to less competition, and higher market-wide prices. These anti-steering provisions are anticompetitive and constitute unlawful exclusive dealing.

129. To try to reduce costs and induce competition among health care providers, health plans can incentivize their plan subscribers to patronize lower-cost facilities by including language in insurance plan documents encouraging subscribers to choose one facility rather than another or by conditioning the selection of a higher-cost facility on a higher copay or deductible from the subscriber.

130. Because the individual choosing the health care service provider is not paying the full cost, and the payer—here, the health plan—is not choosing services at or before the point of care, steering is a critical means of ensuring competition for health care services and, thus, reducing health care prices, particularly in consolidated markets. Where steering is not barred, health care providers are incentivized to use price or quality as a means of encouraging plans to steer business their way. As such, plans' use of steering can foster healthy competition between providers and encourage the growth of new providers that have a means of breaking into a market and gaining sales if they can lower price and/or improve quality.

131. Hospital systems' attempts to impose anti-steering provisions, like those Mission and HCA have coerced health plans in Western North Carolina to accept as part of the Scheme, are anticompetitive because they block the ability of health plans to incentivize less expensive and higher quality options and thereby stymie competition and lead to higher prices and lower quality, especially as here, when employed in conjunction with other anticompetitive contractual provisions. In November 2018, the Assistant Attorney General in charge of the Antitrust Division of the DOJ chastised another North Carolina hospital system's "use of anticompetitive steering

restrictions in its contracts with major health insurers," restrictions which "prevented health insurers from promoting innovative health plans and more cost-effective health care providers. . . [and which] inhibited competition among health care providers to provide higher quality, lower-cost services."[17] Likewise, Senator Chuck Grassley, then chairman of the Senate Judiciary Committee said the anti-steering practices of HCA and several other systems were, "restrictive contracts deliberately designed to prevent consumers' access to quality, lower cost care."[18]

132. Tiering provisions allow health plans to sort providers into tiers based on their price and, often, quality relative to other similar providers who treat comparable patients. Health plans that have tiering provisions give preferred rankings to providers with higher quality and lower prices. Health plans use tiering to incentivize members to use providers in the higher tiers and are an important means by which the plans help reduce prices for their members.

133. At all times relevant to this Complaint, Defendants have limited health plans' ability to use steering or tiering language, as a condition of those plans' obtaining access to Defendants' "must have" Mission Hospital-Asheville. Such limitations include, at a minimum, limits on insurers' ability even to provide information about less expensive providers that compete with HCA.

134. Investigative reporting has shown that HCA has a history of using anti-steering, anti-tiering, or similarly restrictive contractual language in their contracts with health plans in other states and regions.

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[17] https://www.justice.gov/opa/speech/assistant-attorney-general-makan-delrahim-remarks-american-bar-association-antitrust.

[18] Cited in https://www.law360.com/articles/1091446/grassley-seeks-ftc-probe-of-hospital-insurer-contracts.

3. HCA's Gag Clauses and Lack of Transparency.

135. Defendants abused their monopoly power in the Relevant Markets to obscure their price increases and anticompetitive contracts from regulators and the public through use of gag clauses that prevent insurers from revealing their agreements' terms. Gag clause language is anticompetitive because it prevents competitors, insurers, and consumers from understanding in a transparent manner the pricing and other terms and arrangements being used by hospital systems, which in turn inhibits the ability of employers to control health care costs.

136. Moreover, HCA has continued to refuse to release the prices it charges for its GAC and Outpatient Services in a fully transparent manner despite a recent change in federal law requiring it to do so. Effective January 1, 2021, a new federal regulation required the public disclosure of certain aspects of HCA's negotiated price terms in agreements with private insurance companies. *See* 45 C.F.R. § 180.50. HCA has however failed to fully disclose this information in a timely, complete, and understandable manner, in violation of federal law.

137. By violating this price disclosure regulation, and by including gag clauses in HCA/Mission's provider agreements with insurers, Defendants have kept community members, regulators, and the general public from learning of the artificially inflated prices that are being charged.

138. This rule was first created by the Trump Administration over the opposition of HCA's lobbying and then proactively continued by the Biden Administration—signaling growing bipartisan consensus that the lack of price transparency with regard to hospital services leads to higher prices for consumers and employers.

B. Defendants' Scheme Has Foreclosed Substantial Competition in Each of the Relevant Markets

139. As a direct and proximate result of Defendants' Scheme, Defendants have foreclosed a substantial share of competition in each of the Relevant Markets.

140. By prohibiting health plans from "mixing and matching" different sets of providers, Defendants' all-or-nothing tying requirement anticompetitively and artificially impairs the ability of actual or potential rival providers of the tied products and/or services to compete with HCA's products and/or services. Likewise, Defendants' tying impairs the ability of health plans to assemble networks of the highest quality, lowest cost providers to offer to employers.

141. Moreover, Defendants' anti-steering and anti-tiering provisions anticompetitively and artificially drive business away from less expensive and/or higher quality providers of GAC and Outpatient Services in all Relevant Geographic Markets, impairing the ability of actual or potential rival providers to compete or to use price or quality as a means of gaining patients and market share.

142. Similarly, Defendants' gag clauses that prevent the dissemination of price information—essential to any well-functioning competitive market—impair the ability of rival providers both to attract business and for health plans to assemble the highest quality, lowest cost menu of in-network providers.

143. Defendants have used their dominance in inpatient GAC at Mission Hospital-Asheville to gain, maintain, and enhance monopoly power through their Scheme in GAC and Outpatient Services in all Relevant Geographic Markets. For example, through the Scheme, Defendants have shielded their smaller, regional hospitals, including Angel Medical Center and Highlands-Cashiers Hospital (Macon County), Blue Ridge Regional Hospital (Mitchell County), and Transylvania Regional Hospital (Transylvania County) from competition. In short, through

their Scheme, Defendants have substantially foreclosed competition from rival hospitals in each of the Relevant Markets, keeping Defendants' rivals' market shares at levels that are too low to constrain Defendants' ability to raise prices above competitive levels.

144. For example, HCA has an 85.3% market share in zip code 28712 in Brevard, NC, the top inpatient zip code for HCA's Transylvania Regional Hospital in Brevard, Transylvania County.[19] In contrast, Pardee UNC Hospital only holds 10.4% market share, despite being about half the driving distance from Brevard and substantially lower cost than Mission Hospital-Asheville. Due to its unlawful Scheme, HCA prevents health plans from steering patients to rival facilities and blocks the ability of rivals to gain share by cutting price and/or increasing quality. As a result, HCA's hospital maintains a far greater market share in Transylvania County than the Pardee UNC Hospital.

145. Similarly, HCA has a 92.4% market share in zip code 28741 in Highlands, NC, the top inpatient zip code for HCA's Highlands-Cashiers Hospital in Highlands, NC, located in Macon County.[20] Northeast Georgia Medical Center only holds 7.6% market share, despite being closer driving distance from Highlands and substantially lower cost than Mission Hospital-Asheville. HCA has used its Scheme to maintain and entrench its monopoly power in GAC Services in Macon County through its Scheme.

146. Moreover, because of Defendants' unlawful conduct, Outpatient Services facilities have closed or relocated to more competitive markets and would-be competitors for Outpatient

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[19] This aggregate HCA market share comes from HCA's Transylvania Regional Hospital's 44.8% market share in the zip code and HCA's Mission Hospital-Asheville's 40.5% market share in the same zip code.

[20] This aggregate HCA market share comes from HCA's Highland-Cashiers Hospital's 43.8% market share in the zip code and HCA's Mission Hospital-Asheville's 48.7% market share in the same zip code.

Services have declined to operate in Buncombe and Madison Counties, which has decreased the quantity of Outpatient Services and increased prices paid by insurers for Outpatient Services.

IX. THE ANTICOMETITVE EFFECT OF DEFENDANTS' SCHEME: ARTIFICIALLY INFLATED PRICES, REDUCED OUTPUT, DECLINING QUALITY

147. Defendants' Scheme has caused supracompetitive prices, artificially reduced output, and reduced quality of health care by, among other things:

- protecting Defendants' monopoly power and enabling Defendants in each Relevant Market to raise prices, reduce output, and reduce quality of GAC Services and Outpatient Services substantially beyond what would be tolerated in a competitive market, to the detriment of consumer welfare;

- restricting the ability of health plans to use reasonable cost control methods, or otherwise induce competition between providers, including through the introduction of innovative insurance products that are designed to achieve lower prices and improved quality for GAC Services and Outpatient Services; and

- reducing the ability of health plans to incentivize consumers to use more cost-effective and higher quality providers of GAC Services and Outpatient Services in the Relevant Markets.

A. Defendants Have Used the Scheme to Inflate Prices Above Competitive Levels in Each of the Relevant Markets

148. As alleged above, Defendants' Scheme has allowed them to harm competition and, thus, to raise prices above the competitive level in each of the Relevant Markets, including in the GAC Market in the Asheville Region.

149. One indication that Defendants' Scheme has artificially and anticompetitively inflated prices is that HCA/Mission prices for routine "plausibly undifferentiated" or standardized GAC and Outpatient Services have increased at a faster rate than the prices for those services statewide over the past five years.

150. A recent RAND analysis of nationwide hospital pricing data, which compared the prices negotiated between hospitals and health plans to the fee schedule set by Medicare, shows

how HCA has been able to raise prices continually well above the typical prices for routine services and procedures in the Relevant Markets.

151. Medicare prices act as a relative baseline (given the federal government's regulatory and buying power). RAND's most recent analysis reports price data at the hospital systemwide level, averaged over the 2018-2020 period, without revealing the prices charged for specific procedures. According to RAND data, Mission Hospital-Asheville, where Defendants have monopoly power, charged commercial insurers 305% above the Medicare price, on average, for GAC Services, versus the North Carolina average of 211% above Medicare. For Outpatient Services, Mission Hospital-Asheville prices are 343% above Medicare prices, on average, versus 331% for the North Carolina average. The substantially higher prices for GAC and Outpatient Services at Mission Hospital-Asheville compared to those charged by hospitals elsewhere in North Carolina are due in large part to the Scheme alleged herein.

152. HCA itself stated in recent regulatory filings in Florida that, in a county with a hospital system with monopoly power, insurers have "limited ability" to "negotiate market-driven rates for hospital services" and that, "[a] large and growing body of literature suggests that health care providers with significant market power can (and do) negotiate higher-than-competitive payment rates."[21]

153. The pricing data for specific standardized medical procedures from a large private, commercial database of health price and claims information (the "Commercial Database") are consistent with the systemwide RAND results, and further demonstrate that the alleged anticompetitive conduct has caused artificially inflated prices. The examples below are

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[21] *See* HCA Certificate of Need Application.

representative of artificial price inflation on a broad array of medical procedures caused by Defendants' Scheme.

154. For example, based on a study involving the Commercial Database, Mission/HCA's average price to health plans for C-sections without complications at the Mission Hospital-Asheville ($10,076 in 2020) was more than double the statewide average ($4,373 in 2020). Further, prices for this procedure over the 2017-2020 period grew faster at Mission Hospital-Asheville than in the rest of the state (17.3 percent vs. 14.4 percent).

155. Similar patterns exist for the prices of other procedures for which data are available. While the average price for cardiovascular stress tests declined statewide between 2017 and 2020 by 10 percent, it increased by 29 percent at Mission Hospital-Asheville during this period. Moreover, the average allowed price for this procedure at HCA was roughly double that of the average allowed price in the rest of North Carolina in 2020.

156. For a shoulder arthroscopy, the price increase at the Mission-Asheville Hospital over the 2017-2020 period was 75 versus 19 percent statewide. In 2020, the Mission-Asheville price for this procedure was $2,419—nearly three times the statewide average of $897.

157. Even low-cost but high-volume procedures like a lipid panel have seen significant price increases since 2017. Mission's average allowed amount for lipid panels increased by approximately 31 percent, while the average price in the rest of the state *declined* by 19 percent.

B. HCA's Scheme Has Led to Artificially Inflated Prices in the Outlying Region

158. HCA's Scheme has enabled it to inflate prices in the Outlying Region substantially above competitive levels—for example, prices at Mission Hospital-McDowell, located about 45 minutes driving time to the east of Asheville, are substantially above competitive levels due to the Scheme.

159. A rival hospital, Carolinas HealthCare System Blue Ridge Morganton, is located fewer than 30 minutes away to the east of Mission Hospital-McDowell. Mission Hospital-McDowell and Carolinas HealthCare System Blue Ridge Morganton are potential competitors.

160. Price data available in the Commercial Database for Mission Hospital-McDowell reflect that for a variety of procedures where there is a significant volume of those procedures for each year, such as, e.g., CT scans, Mission Hospital-McDowell is not only consistently one of the most expensive in the State, but it charges more than three times the average cost for such routine procedures. Mission Hospital-McDowell could not maintain such price disparities unless it had monopoly power through the Scheme.

161. For example, available price data reflect that the average allowed amount for a CT scan of the abdomen and pelvis is about $2,000 at Mission Hospital-McDowell, whereas the average in the State is just under $500. This divergence in price cannot be explained by a quality difference because CT scans are standard commodified procedures. Instead, the price differences are due to Defendants' Scheme.

162. When the COPA was in effect, Mission Hospital-McDowell pricing was well below the State average with respect to prices for Outpatient Services. Today, Mission Hospital-McDowell charges approximately 50% above the State average for Outpatient Services—corresponding with the period in which HCA/Mission were free to couple their anticompetitive contracting practices with unregulated price increases. Using an overall analysis of Outpatient Services pricing, from 2017 to 2020, Mission Hospital-McDowell's overall prices for Outpatient Services increased substantially relative to other providers in North Carolina and are now in the top 3% of prices of providers of Outpatient Services in North Carolina.

163. Mission Hospital-McDowell is not only significantly more expensive than the State average for Outpatient Services, it is also significantly more costly than its only potentially significant competitor, Carolinas HealthCare System Blue Ridge Morganton, which is less than a 30-minute drive away. Health plans do not consider either hospital to be of significantly higher quality than the other, particularly for "plausibly undifferentiated procedures" such as a CT scan.

C. Defendants' Unlawful Scheme Has Reduced Output and Quality of Care

164. In addition to using its unlawful conduct to increase prices above competitive levels, Defendants' Scheme has reduced output and quality in each of the Relevant Markets.

165. As a result of the Scheme, there are fewer doctors and less of the needed health care services than there would have been absent the Scheme. HCA's bolstered monopoly power is reflected in, among other things, its failure to adhere to various quality commitments included in its APA with Mission.

166. Under Section 7.13(j) of the APA, Defendants had asserted they had "no present intent to discontinue any of the community activities, programs or services provided" prior to the buyout. Less than a year later, in October 2019, however, HCA closed outpatient rehabilitation clinics in Candler and Asheville. In 2020, it closed primary care practices in Candler and Biltmore Park and ended chemotherapy services at Mission Medical Oncology locations in Brevard, Franklin, Marion, and Spruce Pine.

167. Section 7.13(a) and Schedule 7.13of the Amended APA require HCA to provide until January 2029 numerous defined services at Mission Hospital-Asheville. However, contrary to its obligations under the APA, HCA has reduced budgets and staffing, making it more difficult for medical staff to provide the same quality of service as before.

168. Section 7.13(b) and Schedule 7.13(b) of the APA required HCA to provide until January 2029 numerous services at its five smaller regional hospitals. However, contrary to its obligations under the APA, HCA has cut budgets, staffing and quality there too.

169. HCA's reductions in services are the product of its deliberate effort to reduce or drive out medical personnel. As of March 2021, at least 79 doctors had left or planned to leave the system since HCA's takeover. Other doctors describe new employment contracts with HCA in which the compensation equations remove quality of care metrics and focus almost entirely on the number of patients seen and amount billed. A significant number of patients have lost their preferred family doctors either due to doctors leaving the system or from HCA's clinic restructurings and closures.

170. Similarly, nurses working at HCA have described their units as "inhumanely understaffed," with conditions so bad that even travel nurses hired to fill in gaps were leaving before their contracts expired. Patients and families describe situations where, for example, their nurse admitted that "she cries every single night because she knows she is not giving appropriate, competent patient care."

171. HCA's cutbacks in service, driven by its exploitation of the additional monopoly power it has gained through the Scheme, have been criticized by regulators. Among other things, the North Carolina Attorney General stated in February 2020 that the Defendants' "decision to focus on emergent care appears inconsistent with the Asset Purchase Agreement" and that the Defendants' website incorrectly claimed its charity care policy covered "non-elective" services. The Attorney General's office also said it had received a "surge" of complaints, including "harrowing" complaints about quality of care and staffing cuts.

172. If Defendants were operating in a competitive market for all of their services in the Relevant Markets, they would not have been able to take these anticompetitive actions. However, due to the Scheme alleged herein, health plans and patients have no choice but to endure the rising prices and worsening quality of service.

173. In a March 16, 2022 letter from North Carolina's Assistant Attorney General Llogan Walters to Greg Lowe, president of HCA Healthcare's North Carolina division, the North Carolina Department of Justice highlighted earlier complaints about primary care and OB/GYN physicians leaving Mission facilities, reduced nursing and administrative staff in emergency departments, a reduction in core services, and higher prices.[22]

174. Since then, the North Carolina Department of Justice has received additional complaints that Mission's Transylvania County Regional Hospital (which HCA acquired as part of the 2019 Mission transaction) had no mammogram technician and was offering no mammogram services at all; that Mission hospital mental health facilities are inadequately staffed; that ENT cancer treatment practices have left Mission Health; and that because of understaffing, HCA's health facilities were unclean and that patients are experiencing long wait times. The letter noted that while HCA justified these outcomes because of pandemic-related labor shortages, other medical establishments elsewhere in the State facing the same labor market conditions, did not have the same high numbers of complaints.

175. Other officials, such as the Mayor of Asheville and Buncombe County officials, have also publicly expressed "deep concerns" about HCA's dramatic cuts and the pressure put on doctors and nurses. Doctors, nurses, and patients have also called the situation created by HCA's

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[22] https://www.scribd.com/document/567469487/NC-DOJ-Letter-to-HCA-16-March-2022.

cost cutting "dangerous," and have noted that HCA's policies force doctors and nurses to see more patients to maximize profit at the expense of patient care.

176. On February 10, 2020, the Chairman of the Buncombe County Commissioners Brownie Newman, Asheville Mayor Esther Manheimer, and most of the delegation of Buncombe County's elected officials in the North Carolina statehouse lambasted these conditions, finding that "numerous, aggressive staff cuts over the past year, put[] patient safety at risk" and that "HCA has aggressively pursued contract renegotiations with multiple physician practices, resulting in unfortunate outcomes."

177. Due to the Scheme, leading national agencies that assess quality of care factors such as safety, accidents, injuries, infections, and readmissions lowered their ratings for the Defendants' hospital system. The Leapfrog Group, an independent agency, downgraded Mission Hospital-Asheville to a "B" from an "A." According to Leapfrog, the hospital fell short in various measures, including infections, high-risk baby deliveries, some cancer treatment procedures, and the patient experience regarding elective surgeries.

178. The Mission Hospital-Asheville hospital now ranks 88 out of 89 hospitals in North Carolina for unnecessary procedures and is in the highest 2% of all hospitals nationwide for billing for unnecessary procedures.[23] It has a "Value of Care" rating of "D-minus."

179. The Centers for Medicare & Medicaid Services ("CMS") also downgraded Mission. CMS uses surveys of patients' experiences, including how responsive hospital staff were to their needs and the cleanliness of the hospital environment. In 2020, CMS even threatened to

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[23] https://lownhospitalsindex.org/hospital/memorial-mission-hospital-and-asheville-surgery-center/.

terminate its contract with HCA/Mission over patient safety concerns, a rare and particularly serious step.

180. CMS's most recent ratings graded the Mission-Asheville hospital two out of a possible five stars, compared to four stars at both AdventHealth Hendersonville (formerly Park Ridge Health) and Pardee UNC Health Care in Hendersonville

181. Between August 2018 and January 2019, the Attorney General of North Carolina required Mission and HCA to include certain provisions in the APA to secure his approval. Under these provisions, Defendants promised to uphold certain commitments set forth in the Amended APA.

182. Certain of these commitments have been the subject of multiple public complaints, providing additional evidence of the dramatic reduction in necessary medical care provided by HCA in the Relevant Markets.

183. HCA promised that until January 2029 it would maintain the same level of charity care coverage for poor patients as it had previously. However, contrary to its promises, HCA has (a) reduced coverage for non-emergency services, (b) implemented a threshold such that out-of-pocket expenses must exceed $1,500 to qualify for charity care coverage, and (c) ended pre-approval for charity care coverage such that patients are forced to risk taking on substantial debt or forgo needed care.

184. Due to the Scheme, the Mission Health System now controlled by HCA has rapidly declined, going from one of the most respected hospitals in the nation and a "crown jewel" of North Carolina's health care system to facilities with deteriorating, even dangerous conditions. At the same time, HCA's profits are at an all-time high, driven by the new addition of Mission Hospital-Asheville as the HCA chain's second highest revenue generating hospital out of all 100-

plus in the chain.[24] HCA's revenues from Mission Hospital-Asheville were recently reported to be over $1.2 billion, ahead of all but one of the other 100-plus hospitals in the HCA chain and second only to HCA's Methodist Hospital (Texas) which has over twice as many beds.

185. In a competitive market, insurers contracting with a hospital can discipline such pricing behavior by threatening in their negotiations, *inter alia*, to take the hospital out of network and to purchase services from a competitor and/or to steer patients to less expensive or higher quality alternatives. But because of Defendants' monopoly power and Scheme to maintain and enhance it, insurance plans are forced to pay artificially inflated prices and endure substandard care.

186. Defendants' Scheme has no procompetitive benefits at all, let alone benefits that could outweigh the foregoing substantial anticompetitive effects.

X. DEFENDANTS' SCHEME HAS CAUSED ANTITRUST INJURY AND DAMAGES TO PLAINTIFF AND THE CLASS

187. Defendants' Scheme has caused antitrust injury to Plaintiff and the proposed Class by artificially inflating prices they have paid for GAC and Outpatient Services directly to Defendants in the Relevant Geographic Markets. The alleged unlawful conduct, and Plaintiff's injuries, are continuing through the present.

188. Plaintiff's injuries are of the type that the antitrust laws were intended to prevent and flow from that which makes Defendants' acts unlawful under the antitrust laws.

189. More specifically, Plaintiff's injuries flow from the Scheme, which violates Sections 1 and 2 of the Sherman Act.

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[24] Top 50 HCA Hospitals by Net Patient Revenue, https://www.definitivehc.com/blog/top-hca-hospitals-nationwide (reflecting that Mission Hospital-Asheville has the second-highest revenues of all of the HCA hospitals, at $1,209,452,518).

XI. CLASS ALLEGATIONS

190. Plaintiff brings this action on behalf of itself and as a representative of a Class of similarly situated entities defined as follows:

> All insurers and health plans that paid for GAC Services and/or Outpatient Services in the Asheville Region and/or the Outlying Region directly from one or more Defendants at any time during the period from June 3, 2018 up to the time the alleged ongoing anticompetitive conduct has ceased (the "Class Period"). The Class excludes all federal governmental entities.

191. This class definition is subject to revision or amendment as the matter proceeds.

192. This action is suitable for resolution on a class-wide basis under the requirements of Fed. R. Civ. P. 23.

193. The Class is composed of at least hundreds of members, the joinder of whom in one action is impractical. The Class is ascertainable and identifiable from, inter alia, Defendants' records and documents.

194. Questions of law and fact common to the Class exist as to all members of the Class and predominate over any questions affecting only individual members of the Class. These common issues include, but are not limited to:

a. Whether Defendants have monopoly power demonstrated either through direct or indirect evidence;

b. The definition of the relevant services and geographic markets;

c. Whether Defendants engaged in anticompetitive conduct by willfully or otherwise unlawfully maintaining or enhancing their monopoly power or attempting to do so through the Scheme alleged herein;

d. Whether Defendants' abuse of their monopoly power has substantially foreclosed competition in the Relevant Markets;

e. Whether Defendants' Scheme, or any part thereof, is an unlawful restraint of trade;

f. Whether the Scheme has artificially inflated prices, reduced output, and/or reduced quality in any or all of the Relevant Markets;

g. Whether Plaintiff and the proposed Class have suffered injury caused by the alleged anticompetitive conduct; and

h. Whether and to what extent Plaintiff and the proposed Class members are entitled to an award of compensatory damages and/or injunctive, declaratory, or equitable relief.

195. Plaintiff's claims are typical of the claims of the other Class members. Plaintiff and the other Class members have been injured by the same wrongful practices. Plaintiff's claims arise from the same practices and course of conduct that give rise to the other Class members' claims and are based on the same legal theories.

196. Plaintiff will fully and adequately assert and protect the interests of the other Class members. Plaintiff has retained class counsel who are experienced and qualified in prosecuting class action cases. Neither Plaintiff nor its attorneys have any interests conflicting with Class members' interests.

197. This class action is appropriate for certification because questions of law and/or fact common to the members of the Class predominate over questions affecting only individual members, and a class action is superior to other available methods for the fair and efficient adjudication of this controversy, since individual joinder of all members of the Class is impracticable. Should individuals be required to bring separate actions, courts would be confronted with a multiplicity of lawsuits burdening the court system while also creating the risk of inconsistent rulings and contradictory judgments. This class action presents fewer management difficulties while providing unitary adjudication, economies of scale and comprehensive supervision by a single court.

198. The prosecution of the claims of the Class in part for injunctive relief, declaratory, or equitable relief, is appropriate because Defendants have acted, or refused to act, on grounds generally applicable to the Class, thereby making appropriate final injunctive relief, or corresponding declaratory relief, for the Class as a whole.

XII. CLAIMS FOR RELIEF

COUNT ONE

UNLAWFUL MONOPOLIZATION IN VIOLATION OF SECTION 2 OF THE SHERMAN ANTITRUST ACT

199. The above-alleged paragraphs 1 through 198 are incorporated by reference.

200. Defendants have monopolized, and continue to monopolize, the Relevant Services and Geographic Markets alleged herein in violation of Section 2 of the Sherman Act.

201. At all relevant times, including the last four years, Defendants possessed monopoly power in each of the Relevant Markets. Defendants' monopoly power was durable rather than fleeting and included the ability to raise prices profitability above those that would be charged in a competitive market.

202. Defendants unlawfully maintained and/or enhanced the monopoly power through the Scheme alleged herein.

203. Through the Scheme, Defendants were able to charge supracompetitive prices and reduce output in the Relevant Markets.

204. The Scheme caused injury to Plaintiff and the proposed Class by causing them to pay supracompetitive prices. Plaintiff and the proposed Class seek to recover for these injuries.

COUNT TWO

RESTRAINT OF TRADE IN VIOLATION OF SECTION 1 OF THE SHERMAN ANTITRUST ACT

205. The above-alleged paragraphs 1 through 204 are incorporated by reference.

206. Through the Scheme alleged herein, Defendants have entered into agreements that unlawfully restrained trade in each of the Relevant Markets, in violation of Section 1 of the Sherman Act.

207. Through the Scheme, Defendants were able to charge supracompetitive prices and reduce output in the Relevant Markets.

208. The Scheme caused injury to Plaintiff and the proposed Class by causing them to pay supracompetitive prices. Plaintiff and the proposed Class seek to recover for these injuries.

JURY DEMAND

Plaintiff demands a trial by jury for all claims so justiciable.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays that this Court enter judgment on its behalf and that of the proposed Class and adjudge and decree as follows:

A. certifying the proposed Class, designating the named Plaintiff as class representative and the undersigned counsel as class counsel, and allowing the Plaintiff and the Class to have trial by jury;

B. finding that Defendants have monopolized, and continue to monopolize, the Relevant Markets alleged herein in violation of Section 2 of the Sherman Act, and that Plaintiff and the members of the Class have been damaged and injured in their business and property as a result of this violation;

C. finding that Defendants have unlawfully restrained trade in the Relevant Markets alleged herein in violation of Section 1 of the Sherman Act and that Plaintiff and the members of the Class have been damaged and injured in their business and property as a result of this violation;

D. ordering that Plaintiff and members of the proposed Class recover threefold the damages determined to have been sustained by them as a result of Defendants' misconduct complained of herein, and that judgment be entered against Defendants for the amount so determined;

E. awarding reasonable attorneys' fees, costs, expenses, prejudgment and post-judgment interest, to the extent allowable by law;

F. awarding equitable, injunctive, and declaratory relief, including but not limited to declaring Defendants' misconduct unlawful and enjoining Defendants, their officers, directors, agents, employees, and successors, and all other persons acting or claiming to act on their behalf, directly or indirectly, from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts competition in the manner as alleged hereinabove; and

G. awarding such other and further relief as the Court may deem just and proper.

Dated: June 3, 2022.

/s/ Robert N. Hunter, Jr.
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*Applications for admission *pro hac vice* forthcoming

Attachment 3

Citizen Times

NEWS

Plaintiffs in HCA/Mission antitrust lawsuit double down on anti-steering accusations

Andrew Jones
Asheville Citizen Times

Published 5:00 a.m. ET July 27, 2022 | **Updated 8:02 a.m. ET July 27, 2022**

ASHEVILLE - Attorneys in an antitrust lawsuit alleging monopoly practice by HCA Healthcare-owned Mission Hospital in Western North Carolina are at loggerheads about competition or lack thereof in the case's latest filings.

Nearly one year after the antitrust lawsuit was filed, lawyers are still hashing out differences about monopolies, competition and markets in Davis et. al v. HCA Healthcare et al., a case originally filed Aug. 10, 2021, which is pending a decision from Special Superior Court Judge for Complex Business Case Mark Davis.

The original 87-page complaint — filed in Buncombe County Superior Court — charges HCA Healthcare with using a monopoly on the local health care industry to charge rates much higher than the state average while quality declines, among numerous other allegations.

Related: NC Attorney General Stein says state should 'deny Mission' hospital expansion application

After the case's first business court hearing April 27, Judge Davis asked attorneys to dive deeper into specifics behind plaintiffs' arguments regarding the Centers for Medicare & Medicaid Services data they chose to rely on in the original complaint; the breadth of their allegations about HCA's market power over inpatient and outpatient services in the five non-Asheville markets; and how they could satisfy "pleading requirements" when alleging anticompetitive behavior.

Both parties responded July 25 in roughly 25-page documents.

Attorneys for the plaintiffs — who are six Asheville area residents — were not immediately available for comment.

More about the first WNC antitrust lawsuit against HCA:

Judge in Mission/HCA antitrust lawsuit orders more info from both sides as decision looms

HCA, Mission hit with 2nd WNC antitrust suit in a year, this one from a Transylvania city
NC Treasurer files interest in HCA anti-trust suit; plaintiffs reiterate concerns

In the responses, they further defended numerous allegations about how HCA, through Mission, created a lack of local health care competition, thereby driving up prices and causing "harm" to health care consumers.

Monopoly and antitrust law are two subjects central to those arguments.

What is anti-steering? Is Mission doing it?

"Antitrust law prohibits dominant firms from imposing unreasonable restrictions that limit consumer choice — even if they do so by imposing restrictions indirectly (i.e., on insurers instead of on patients) and even if the restraints do not altogether eliminate rivals," attorneys for the plaintiffs state in a portion of their response addressing anti-steering.

"By hiding prices from consumers or preventing intermediaries from giving incentive discounts, these restraints impose a competitive harm."

"Anti-steering" is a significant idea inside the case. Mission has been blamed for "leveraging (its) market power to force health insurance companies to accept contractual provisions that prohibit the insurers from steering customers to more affordable providers," as North Carolina Attorney General Josh Stein summarized the issues in an amicus brief filed in the case.

More: As HCA-Mission lawsuit awaits judge's call, officials say company was no-show during deal

"HCA/Mission's anti-tiering/steering clauses not only harm insurers' and patients' ability to achieve cost-savings; they also impair HCA/Mission's hospital rivals' incentives to use lower prices or improve quality to gain customers," attorneys for the plaintiffs wrote in the July 25 response.

"If insurers cannot direct patients to these competing providers, those providers have less incentive to lower prices. Harming incentives to compete would be sufficient, by itself, to violate the antitrust laws."

Not so, HCA attorneys claimed in their response.

They called the alleged anti-competitive actions "purported" in their own response, and blamed plaintiffs for making "bald, conclusory assertions."

Related: Mission health care workers demand safer working conditions, join national nurses action

HCA's response said there were "no allegations that Mission's alleged anti-steering and anti-tiering provisions reduce the number of providers or health plans available to patients and employers in any alleged relevant market."

HCA is still asking the judge to dismiss the original complaint.

Outside of dismissal, they also asked a judge to tell the plaintiff's side to, effectively, get better facts on the matters at hand.

"To the extent Plaintiffs are given an opportunity to re-plead any individual count, they should be directed to allege sufficient facts on the elements of monopoly power, anticompetitive conduct, harm to competition, and injury to Plaintiffs flowing from such harm," HCA's response concluded.

More: 'Stupid and dangerous': Forum scrutinizes 3 hospitals' competition for more Buncombe beds

These and a wealth of other issues are under scrutiny in the complaint and the responses. Davis is expected to file an opinion on the case in the coming months, though there is no definitive timeline.

According to previous Citizen Times reporting, the for-profit HCA Healthcare purchased the Mission Hospital system in 2019 for $1.5 billion, and the lawsuit says it now holds a monopoly market share — 70% or more — in seven counties: Yancey (90.9%), Madison (90%), Buncombe (86.6%), Mitchell (85.4%), Transylvania (78.7%), McDowell (76.4%) and Macon (74.7%).

Attorney General Josh Stein in his official capacity and Treasurer Dale Folwell as an individual both have filed friend-of-the-court briefs supporting the plaintiffs and decrying the lack of transparency in pricing and the merger process used during the purchase.

Another suit brought by the city of Brevard was filed June 3 in the U.S. Western District Court of North Carolina.

Besides facing two antitrust lawsuits in 2022, HCA/Mission also faces potential competition in the form of a certificate of need. Mission and two other hospital systems — AdventHealth and Novant Health — want to expand hospital services by 67 beds in Buncombe County, and each has submitted certificates of need to do so.

More: Want to support Mission, Novant, or AdventHealth expansion? You have until Aug. 1

That means Mission may not be the only hospital in Buncombe in the coming years, a decision that will ultimately be made by officials with the N.C. Department of Health and Human Services' Division of Health Service Regulation.

On July 25, Stein, in a letter to the NCDHHS, recommended it deny Mission's application.

The state will hold a public hearing on the certificate of need process Aug. 12.

Andrew Jones is Buncombe County government and health care reporter for the Asheville Citizen Times, part of the USA TODAY Network. Reach him at @arjonesreports on Facebook and Twitter, 828-226-6203 or arjones@citizentimes.com. Please help support this type of journalism with a subscription to the Citizen Times.

Citizen Times

NEWS

NC Attorney General Stein says state should 'deny Mission' hospital expansion application

Andrew Jones
Asheville Citizen Times

Published 12:39 p.m. ET July 25, 2022 | **Updated 10:00 a.m. ET July 26, 2022**

Update: This story has been updated with a comment from Mission Hospital.

ASHEVILLE - North Carolina Attorney General Josh Stein is asking the state Department Health and Human Services deny HCA Healthcare-owned Mission Hospital's application to expand in Buncombe County.

Stein's request came in a letter dated July 25, in which he said Mission had "almost no competition" for acute care in Buncombe County.

The for-profit Mission is competing with two other nonprofit hospital systems, AdventHealth and Novant Health, for a certificate of need to build 67 new beds in the county.

More: 'Stupid and dangerous': Forum scrutinizes 3 hospitals' competition for more Buncombe beds

"Mission has almost no competition for acute care in Buncombe County," Stein said in the letter. "The lack of competition is the result of Mission's unique history. Mission effectively operated as a legislatively authorized monopoly for over twenty years, and no new hospitals have opened even after Mission's arrangement with the State ended in 2016."

He said the lack of competition "harms residents of Western North Carolina" because it increases costs and reduces quality of local health care services.

"I don't care which of the other two hospitals that applied get it, I just want more competition for health care in Western North Carolina," Stein reiterated in an interview with local media July 25.

"While we are not aligned with the opinion expressed in the AG Office's letter, we are confident the NC Department of Health and Human Services will evaluate our application based on the state's

most recent Medical Facilities Plan, which detailed the need for 67 additional acute care beds," said Mission spokesperson Nancy Lindell.

"We are proud of our high-quality care and the significant investments we have made to expand access to healthcare, none of which were opposed by the AG's office."

The three hospital systems submitted their CONs mid-June and a public comment period opened July 1. That period will last through July 31 and be followed by a public hearing on Aug. 12, the first held by the Division of Health Service Regulation since March 2020.

Currently, anyone can write a letter of support for one of the three hospitals and email it to DHSR.CON.Comments@dhhs.nc.gov and julie.faenza@dhhs.nc.gov.

More: Want to support Mission, Novant, or AdventHealth expansion? You have 3 options and 40 days

In the CON documents — which comprise roughly 3,000 pages — Mission, AdventHealth and Novant each argue their case to bring 67 new acute care beds to Buncombe County, a need identified by the 2022 State Medical Facilities Plan that would also serve Graham, Madison and Yancey counties.

Those documents contain hundreds of letters of support. Some letters supporting AdventHealth and Novant echo Stein's stance on competition.

Related: Judge in Mission/HCA antitrust lawsuit orders more info from both sides as decision looms

"The continued lack of competition has predictably led to increased health care costs in western North Carolina," Stein said in the letter. "One lawsuit brought by individual health care consumers in western North Carolina alleges that premiums in western North Carolina are more than 50% higher than in the State's metropolitan areas ... The Attorney General, meanwhile, has received numerous complaints about the cost and quality of Mission's care."

The DHSR is expected to make a decision on the CONs in the coming months, though there is no solid timeline in place.

Andrew Jones is Buncombe County government and health care reporter for the Asheville Citizen Times, part of the USA TODAY Network. Reach him at @arjonesreports on Facebook and Twitter, 828-226-6203 or arjones@citizentimes.com. Please help support this type of journalism with a subscription to the Citizen Times.

Citizen Times

LOCAL

'We have no doctor here': Rural residents voice concerns at HCA compliance meeting

Brian Gordon
Asheville Citizen Times

Published 8:50 p.m. ET Jan. 29, 2020 | **Updated 7:26 a.m. ET Jan. 30, 2020**

This week in the village of Cashiers, Western North Carolinians got their opportunity to meet the people monitoring HCA's compliance with the Mission Health purchasing agreement. Those in the audience had plenty to say.

Around 40 people filled a room in the Cashiers/Glenville Recreation Center to speak to representatives of Gibbins Advisors, the state-appointed independent monitor tasked with ensuring HCA Heathcare adheres to the Asset Purchase Agreement it signed before acquiring Mission Health for $1.5 billion in February 2019.

Related:

- New York-based consultant, Gibbins Advisors, to oversee HCA Healthcare in Mission deal
- From 2018: WNC residents want more protections for rural hospitals in Mission-HCA deal

At the Jan. 28 meeting, Cashiers-area residents voiced concerns over changes they've seen to services at Highlands-Cashiers Hospital since HCA took over. Several mentioned the area's clinic lacking a full-time doctor. Others said they sensed lower overall staffing levels negatively impacting quality of care.

Cashiers residents raise staffing concerns

Ellen Haug, who attended the meeting, says the area's previous doctor retired in September, and now the clinic's only physician travels north from Atlanta a few days every other week.

"We have no doctor here," Haug told the Citizen Times the day after she expressed her frustrations to Gibbins representatives at the meeting. "The hospital here is understaffed."

She said some local residents travel more than an hour east from Cashiers, in Jackson County, to Asheville and Hendersonville for doctor visits.

Cashiers resident Pam Kerr says she travels 90 minutes to Greenville, South Carolina, to see a doctor.

Kerr and Haug helped start the Cashiers Health Forum to address the local physician situation. Last summer, the women circulated a petition to call to attention what they felts were unsatisfactory conditions.

Hospital's CEO responds

During the community meeting, Thomas Neal, CEO of Highlands-Cashiers Hospital, told the audience a full-time physician would start in the area in May.

In a statement to the Citizen Times on Jan. 29, Neal said: "I was happy to attend last night and look forward to further engagement with my community to understand their concerns. We listened and we heard and we are committed to the Highlands and Cashiers community and to delivering superior, patient-centered care."

Kerr says three more months without a full-time local doctor is a source of frustration for many in the area. She says many friends would be attending the Jan. 29 meeting conducted by Gibbins in the nearby town of Highlands.

"They're raring to go. Everybody is pretty unhappy, angry," Kerr told the Citizen Times over the phone while she was in Greenville to see a doctor. "HCA definitely broke our trust."

Related:

- Answer Man: In Mission-HCA deal what becomes of St. Joseph's?
- 6 months after Mission Health-HCA deal, NC attorney general says 'We feel good about it'

Feedback and frustrations

The 147-page purchase agreement protects several health care services, including charity care and rural hospitals.

Yet many of the complaints Cashiers-area residents brought up at the meeting fall outside the agreement, which North Carolina Attorney General Josh Stein appointed Gibbins to independently monitor.

Gibbins founder Ron Winters, who attended the Cashiers meeting, said his firm is open to communicating residents' opinions to HCA management, even if the topics do not pertain to the purchase agreement.

"The region is very passionate and engaged on the issue," Winters said in a statement to the Citizen Times. "That's important and helpful to us. We want to understand the communities. We will review specific feedback and even if matters raised are outside of our scope, we will share the information with HCA."

The Cashiers meeting was the first of seven public events his firm will hold across Western North Carolina through mid-February. (See below for schedule.) Gibbins has also launched a website for the community to provide feedback at IndependentMonitorMHS.com.

The website lists 15 commitments HCA made in the purchase agreement, including "keeping material facilities open for at least 10 years," and maintaining its uninsured and charity care policy for at least a decade.

Neal said the hospital is receptive to learning from any feedback the community offers.

While her frustrations mount, Haug holds some hope her community's feedback will bring changes.

"These are issues relative to our health care within the community, or I should call it our lack of health care within the community," she said. "I think that if HCA is made aware of it, then perhaps we can expect more performance from them."

Upcoming HCA compliance meeting schedule

Macon County, Angel Medical Center: 11:30 a.m.-1 p.m. Jan. 30, Robert C. Carpenter Room, Macon County Community Facilities Building, 1288 Georgia Road, Franklin.

Buncombe County, Mission Hospital: 5:30-7 p.m. Feb. 10, Blue Ridge Room, Mountain Area Health Education Center, 121 Hendersonville Road, Asheville.

Transylvania County, Transylvania Regional Hospital: 5:30-7 p.m. Feb. 11, Unitarian Universalists of Transylvania County (UUTC), 24 Varsity St., Brevard.

McDowell County, Mission Hospital McDowell: 11:30 a.m.-1 p.m. Feb. 12, Marion Community Building, 191 N. Main St., Marion.

Mitchell County, Blue Ridge Regional Hospital: 5:30-7 p.m. Feb. 13, Auditorium, Burnsville Town Center, 6 S. Main St., Burnsville.

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Citizen Times

LOCAL

HCA-Mission's independent monitor got an earful. What happens now?

Brian Gordon
The Citizen-Times

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In recent weeks, the firm hired to ensure HCA Healthcare met the terms of its purchase of Mission Hospital met with Western North Carolinians.

From Cashiers to Marion, residents spoke up. They asked questions. A few highlighted improvements they've seen under HCA. The overwhelming majority, however, described negative and troubling health care experiences since HCA took over in February 2019.

Patients discussed uncomfortable delays during hospital stays. Others bemoaned inconsistent billing practices and charity care policies. One Mission-employed nurse wept while lamenting her hospital's staffing ratios.

The public broached a litany of other issues, from translator service changes to wheelchair clinic cuts to physician disenfranchisement to a lack of rural doctors.

"Certain themes were consistent across meetings while some were unique to a specific facility," Ron Winters, founder of Gibbins Advisors, told The Citizen Times.

After seven meetings, questions linger for those invested in the region's largest health care system: Who holds HCA accountable? What role, if any, does the attorney general play? And ultimately, what comes next?

What is the monitor's role?

While Winters welcomed all public input, the community meetings in January and early February were ostensibly focused on the Asset Purchasing Agreement.

Before HCA bought Mission, HCA promised to uphold 15 commitments outlined in the agreement. Some of the guarantees include maintaining charity care, rural hospitals and

building a new behavioral health hospital. Each commitment can be read here.

In October, state Attorney General Josh Stein approved Gibbins Advisors to monitor the $1.5 billion hospital sale. The appointment of a monitor was another condition of the transaction.

"As I mentioned in each meeting, I recognize that community members may be frustrated that the scope of our work is not to resolve the individual issues they spoke about," Winters said. "That said, it was important to hear directly from the communities because it provided context and insight around key issues."

Most of the issues raised at the public meetings — around staffing levels, wait times, early discharges, and service cuts — fall outside the agreement. Still, Winters said his firm logged all feedback, both from the meetings and online, and will share this information with the "seller group" on a monthly basis.

Ultimately, the seller group is responsible for making sure HCA complies with the 15 commitments spelled out in the purchasing agreement.

Who is the seller?

It's not a simple answer. The seller is a holding corporation, a temporary entity, called ANC Healthcare (ANC stands for Asheville North Carolina). At some point in mid-2020, the seller will becomeDogwood Health Trust.

"At some point" remains the most specific timetable as financial remnants from the former nonprofit entity Mission Health must be settled before Dogwood Health takes over.

A third of Dogwood Health Trust's board of directors previously served on the Mission Health board of directors. Dogwood's leadership vows to protect the 15 commitments, be it through dialogue or litigation.

"We remain optimistic that HCA will fulfill those commitments to provide much needed health care throughout the region," reads a statement provided to the Citizen Times by Dogwood Health Trust spokeswoman Erica Allison. "If discussions with HCA regarding compliance concerns were to result in an outcome that is unacceptable to the Seller Representative, it can take legal action against HCA."

The Dogwood statement admits the organization's "scope is limited to enforcing compliance as defined in the APA."

Related coverage:

'We have no doctor here': Rural residents voice concerns at HCA compliance meeting
'Critically understaffed': Asheville crowd vents frustrations with Mission Health and HCA

The role of hospital advisory boards

Near the end of April, HCA will deliver its own purchase agreement compliance report to six advisory boards representing the region's six Mission hospitals.

In addition to receiving HCA's report, the advisory boards consent to any modifications HCA may wish to make to the purchase agreement. Winters said his firm is unaware of any HCA considerations to alter its 15 commitments.

On each local advisory board sit four HCA appointees and four appointees selected by hospital boards at the time of the HCA-Mission sale.

What can Attorney General Josh Stein do?

If Stein finds the seller — ANC now or Dogwood later — fails to properly enforce compliance, his department can step in on behalf of the public to demand HCA make changes to meet the purchasing agreement.

"Attorney General Stein is committed to ensuring that HCA complies with the agreement he negotiated," wrote Laura Brewer, NC Department of Justice communication director in an email to the Citizen Times.

"If people are seeing anything that concerns them, please urge them to contact our office at 1-877-5-NOSCAM or www.ncdoj.gov/complaint," Brewer said. "Our office will look into these complaints and take action if appropriate."

Issues outside HCA's 15 commitments

Most of the client complaints Karen Sanders hears do not apply to the HCA-Mission purchasing agreement.

Sanders, of South Asheville, is an independent patient and registered nurse advocate who helps people traverse America's bureaucratic, often befuddling health care systems. Her current caseload of patients across Western North Carolina sits at 60. Within the past year,

Sanders said the number of complaints she's received from patients at Mission hospitals have "escalated 100%."

"I'm extremely concerned about the poor quality of care we're hearing about at the hospital," said Sanders, who cited delays in patient care as the most common new issue she hears.

As a result of the seven public meetings, Sanders said she would like to see greater oversight of Mission hospitals.

Mission Health representatives say they've been listening to the worries of Sanders and others.

"We recognize that this past year has been a time of enormous transition for our organization, and that we have sometimes created confusion by not communicating about changes in a clear and timely way," said Mission Health spokeswoman Nancy Lindell. "We have been making progress addressing staffing needs, funding new technological investments and investing in our clinical services. There is more work to be done."

Who oversees hospitals?

A combination of state, federal and private agencies regulate and accredit hospitals.

The Joint Commission is a nonprofit that grants the accreditation health care organizations like Mission Health need to receive third-party payments like Medicaid and Medicare. Without this accreditation, a hospital would likely face bankruptcy.

The Joint Commission assesses compliance with its standards through extensive hospital visits, called surveys. Surveys typically take place every three years, though more frequent surprise visits occur. According to the website QualityCheck, the Joint Commission last conducted a full hospital survey of Asheville's Mission Hospital in April 2018. The Joint Commission conducted several more recent department specific surveys. All six Mission hospitals remain accredited by the Joint Commission.

At the federal level, the Centers for Medicare and Medicaid Services, called CMS, sets hospital regulations.

At the state level, the NC Division of Health Service Regulation lists its own codes.

Sanders encouraged Western North Carolina residents reach out to these agencies to voice any hospital concerns that arise.

Have feedback to give? Here are seven ways to make your voice heard.

Brian Gordon is the education and social issues reporter for The Asheville Citizen Times. He can be reached at bgordon@citizentimes.com, at 828-232-5851, or on Twitter at @briansamuel92.

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It will also move non-chemotherapy infusion services onto the hospital campuses at Blue Ridge Regional Hospital, Mission Hospital McDowell and Transylvania Regional Hospital. Non-chemotherapy infusion services in Franklin will continue in the same building at 834 Depot Street, as a service of Angel Medical Center.

Patients opt for independent centers

Sadler said Mission Health did not make the decision to relocate services lightly.

She said many patients have chosen to stay with Messino Cancer Centers since a group of physicians separated from Mission earlier this year to open it.

Tena Messer, vice president of operations for Messino Cancer Centers, said the physicians split from HCA in January 2020 because they "wanted to continue to be able to provide the quality of service that (they) had done for years in the community and felt that being able to establish (their) practices independently would be the best way to do that."

"Plus with the support behind us from the American Oncology Network, we knew we would have additional support with oral pharmacy services, care management services and so it was just a better option for providing quality care for our patients," she added.

More: 'These conditions have got to change': Mission Hospital nurses double down in call for more staff amid pandemic

More: After long wait, Mission nurses' union election day and details set

Sadler said Mission respects patients' decision to stay with the Messino physicians but that the "additional care options have created less of a need for similar services at some of (Mission Health's) facilities."

Mission Health will be contacting each patient impacted by this change by phone and mail and will assist them with "transitioning their care and records within Mission Health or to any local provider of their choice," according to Sadler.

According to Messer, Messino — which has locations in Brevard, Franklin, Marion, Spruce Pine and Sylva — provides all of the infusion services Mission will be relocating to Asheville, but does not provide transfusions. For those, residents will still need to go to the nearest hospital.

"Our facilities take care of all the chemotherapy and immunotherapy services in the region and are available to do that," she said.

'Chipping away' of services

Asked if she thinks Mission's move is a loss for these rural towns, Messer said that's always a question when there is a transition of medical services.

"But I feel confident that our facilities are able to provide those services and we are available to do that in those communities," she said. ... "Our physicians have been dedicated to those regions for many years. ... We look forward to continue working in the community."

Scott isn't sure yet how this change will affect Franklin residents, but he said that, even with the Messino centers, he has some concerns.

"It appears that it's a little bit of a chipping away of all the services that we've always enjoyed out here with Angel Community Hospital and then it became Angel Medical Center and now ... it's becoming sort of a triage area to send folks on over to Asheville," he said. "And that's a 60-mile drive."

Highlands Mayor Pat Taylor shares his worries.

"We're still seeing that we're losing access and it seems like we're moving toward more and more of a centralized system where all hospital and health care roads lead to Asheville," he said.

Scott and Taylor aren't the first to bemoan changes to rural health care under HCA. In January, Cashiers-area residents said their clinic lacked a full-time doctor and that they sensed lower staffing levels negatively impacting quality of care.

More: HCA-Mission's independent monitor got an earful. What happens now?

Though Messino will provide much of the care Mission is relocating, Taylor said he hates to see "any cutback in services" in these communities.

Scott said he wants to see more health care options, not fewer.

"Rural health care is in a crisis," he said. "And I feel it every day as I get older. And I feel for our people. I feel for our young couples. ... Our local physicians, I know that they're feeling the change from a community service-type hospital to a for-profit hospital. This is not boding well for any area, not just rural areas."

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Citizen Times

NEWS

AG Stein received 290 complaints about HCA/Mission in Asheville; A mom tells her story

Clarissa Donnelly-DeRoven
Asheville Citizen Times

Published 5:02 a.m. ET Sept. 20, 2021

Tiffany Grzankowski was worried about her 4-year-old daughter Phoenix, who has Down syndrome, autism, a pacemaker and is nonverbal. Over a week in August, the child had been having serious gastrointestinal problems. So on Aug. 20, Grzankowski took her daughter to the doctor, Blue Sky Pediatrics.

"I wanted a referral to a GI specialist, is what I was asking. And they noticed that she had a double ear infection and decided to go ahead and run some labs, mainly checking for celiac," Grzankowski said.

Around 7 p.m., Phoenix's pediatrician, who asked their name be withheld for fear of professional retaliation, called and told Grzankowksi that Phoenix's liver enzymes were extremely high, while her neutrophil levels, a type of white blood cells that help the body fight infections, were low. The doctor, who has since left Blue Sky Pediatrics, declined to be interviewed for this story.

Related: Every person who died of COVID-19 at Mission Hospital was unvaccinated, chief doc says

More: Mission chief doctor walks back statement about only unvaccinated people dying of COVID-19

As more labs came in, the doctor said they had to get off the phone to read them, then called Grzankowski back about two hours later.

"At 9, they told us to get her to Mission, like as soon as we could," Grzankowski said.

She was under the impression that Phoenix would be admitted to the hospital, and perhaps even transferred to Levine Children's Hospital in Charlotte for more specialized care.

But once they arrived at Mission, confusion ensued, according to Grzankowski. Nancy Lindell, Mission Hospital's spokesperson, declined to comment on the specifics of the case, citing HIPAA, a medical privacy law.

Grzankowski said no one seemed to know who they were, or why they were there, even though she thought her doctor had called ahead. Eventually, Mission doctors took another blood test and did an ultrasound of Phoenix's liver.

"They had came in the room and said that the labs looked better than in the morning, and that she could go home and that they weren't doing anything," Phoenix's mother said.

Phoenix's discharge papers confirm that the family came to the hospital because of abnormal lab results, and that doctors prescribed no medications during the visit.

They left the hospital and drove back to their home in Arden. Grzankowski leafed through Phoenix's discharge papers, trying to make sense of them. Her liver enzymes were slightly lower, but definitely higher than they should be. She also saw that doctors noted an enlarged lymph node in Phoenix's liver.

As she panned over the lab results, Grzankowski saw that next to the line "Hepatitis A Antibody, igG," the result read "positive." She took this to mean that her daughter had Hepatitis A.

A few hours later, she got a phone call from a doctor at Mission confirming her suspicions – Phoenix had hepatitis A.

Grzankowski said she was advised that Phoenix could fight the infection on her own, but if she got any worse, to take her back to Mission.

Phoenix did get worse. The next day, she woke up from her nap, still seeming lethargic. Then she started gagging and puking foam, according to her mother. They rushed her back to the hospital, where Grzankowski said, again, doctors didn't give her daughter treatment.

"We got her back to the hospital and told them that we were told to have them call the pediatrician and that most likely they were going to set up transport to Levine's. So the hospital gave her some food and just left the room. Like they didn't even do anything at all. And they came back and said, 'Well, she's eating. We're not calling the doctor. She doesn't

need anything. This is all normal with hepatitis,'" Grzankowski remembered, "'Just go home.'"

By Monday, Grzankowski was furious. Her daughter was not getting better, and she didn't understand how she'd gotten hepatitis A in the first place. Phoenix was fully vaccinated against the virus.

Hepatitis A is a liver infection. It lives in the blood and fecal matter of those who are infected, and is spread when someone ingests particles of the virus, often through contaminated food. Symptoms can include yellowing of the skin or eyes, lethargy, diarrhea, lack of appetite, nausea and vomiting.

"Monday morning, I decided to call the health department myself because I wasn't waiting for anyone at that point. And the lady called me back and said Phoenix doesn't have hepatitis. She's like, 'I don't know who ordered the labs and who was reading the labs, but they tested her to see if she was *vaccinated* for hepatitis A,'" Grzankowski said.

Other news: Mission Hospital COVID-19 cases: Ten patients die in 'past 48 hours'

COVID vaccines: Pardee, MAHEC require staff vaccination; Mission continues to 'encourage' vaccines

"I have all this paperwork in front of me that clearly says she has hepatitis A, what to do for hepatitis A, that came from Mission. And it wasn't just one doctor that did this. This was like three different doctors that had looked at these labs, told us this, plus all the nurses that came into the room."

She was distraught. "That's a huge mix-up. Because this whole weekend, I have a nonverbal child that has a pacemaker, and she can't advocate for herself. She can't tell us what's wrong. I can't communicate with her. And she was suffering in pain -- because you couldn't even touch the girl's belly without her crying. And they did nothing. They didn't do fluids, no nausea meds for the vomiting. And everyone kept telling me, 'Oh, look, this is normal for hepatitis,' and it's not hepatitis this whole time.'"

One of many who allege poor treatment

Grzankowski filed a complaint about her experience with HCA, which owns Mission Hospital, and the Joint Commission, a nonprofit health care accreditation organization. Complaints like Grzankowski's have been rising since HCA took over Mission two years ago.

On Aug. 10, six WNC residents filed a class action lawsuit against the hospital, alleging that since the '90s, Mission has had monopoly power in the region, and that it's used that status to charge exorbitant prices while the quality of care provided has declined.

The office of N.C. Attorney General Josh Stein, who approved HCA's $1.5 billion purchase of the hospital in 2019, receives and reviews many of these formal complaints. The AG's office sends those complaints to the Department of Health and Human Services, which then determines the appropriate organization to investigate the complaint.

"The number of complaints made to the Division of Health Service Regulation (DHSR) about HCA/Mission Hospital since 2019 is confidential. In addition, DHSR cannot comment on complaints nor pending investigations," said Charles Epstein, DHHS's legal communications spokesperson.

Stein's office, though, shared the number of complaints it has received about Mission since the HCA take over -- 290 – and provided the Citizen Times with copies of all 82 complaints submitted in 2021.

More: HCA/Mission hit with anti-trust lawsuit, accused of exorbitant prices, declining quality

Related: AG Stein says he 'will not hesitate to act' if abuses in lawsuit against Mission are true

The complaints come from a range of stakeholders: patients who say they received shoddy care, family members of those who say they've had their health problems neglected by the hospital, and rural residents concerned about closures of regional clinics.

Many of the complaints, too, come from current and former Mission employees. One person, who submitted their complaint anonymously and self-identified as a Mission health care worker, said, "I do not feel safe in my practice and I do not feel safe for my patients."

The complaint alleges that some patients "are having to sit in their own excrement for hours because our floor is expecting 1 CNA to look after 44 patients."

A Franklin woman expressed dismay at the declining number of mental health professionals at the Angel Medical facility near her house since HCA took over.

"I now have no one to see without driving over a mountain into the next county," she wrote. "This seems to me like a clear violation of the agreement negotiated thru (sic) your office to

protect medical services in Western NC, a place that is riddled with drug use and in dire need of psychological counseling."

More: 'Put patients first': Mission nurses picket over contract; union negotiates with HCA

As part of the HCA takeover, Stein's office required the hospital add an independent monitor to keep tabs on its compliance with 15 commitments the multibillion-dollar company made to the community.

"We address every issue the Attorney General's office brings to our attention promptly — both with them and with the patient," Lindell, the HCA spokesperson, said. "Our patient care is our first priority. We strongly encourage everyone to contact us directly any time there is a concern so we can address it with them immediately and personally."

Lindell said anyone who has a concern can call the hospital's "patient experience number at 828-213-1210," or email contactmission@hcahealthcare.com.

Epstein Barr

Over the next two weeks, Grzankowski struggled to get an accurate diagnosis for her non-verbal, sick child. Eventually she learned her daughter had Epstein Barr virus, which can cause infectious mononucleosis, more commonly referred to as mono.

Phoenix's GI issues were likely something else.

"Her stomach issues have gone on for a long time. With Down syndrome you have low muscle tone, so things like delayed gastric emptying (and) gastroparesis are common, as well as issues with constipation," Grzankowski said.

More: Mission Hospital's COVID-19 count climbs, not far off record mark from January

It's also possible Phoenix could have Ehlers Danlos Syndrome, a genetic disorder that Grzankowski has, which impacts connective tissue.

"I have the hypermobility type, which for me causes dislocations, subluxations and I've broken over 40 bones. It causes a ton of different comorbidities like gastroparesis, postural orthostatic tachycardia syndrome, autoimmune diseases, mast cell activation and it's considered one of the top painful conditions," she said.

Grzankowski believes that having spent most of her life with a rare, debilitating medical condition could be a blessing for her daughter, and her ability to access care.

"I think having major health problems my entire life has set me up to be the best advocate for Phoenix. We will get answers and clarity, I just have to keep being her voice. I just feel bad for families that are unable to advocate for themselves," she said.

Though her stomach issues haven't exactly been worked out, Phoenix is feeling much better. She even started school.

A meeting with Mission

On Sept. 10, Grzankowski's phone rang. It was a woman named Sarah Crowley, the director of patient safety and quality at Mission.

Crowley said she'd read Grzankowski's complaint and done some investigating.

"They realized there was multiple chances they missed to catch the mistake," Grzankowski said, of the conversation.

More: Mission, other WNC hospitals resist staff vaccine mandates; many others in NC require them

Crowley did not return a request for comment, and Lindell did not make her available for comment.

Crowley invited Grzankowski to meet with a handful of the hospital's leaders to discuss her case.

On Sept. 15, Grzankowski said she met virtually with four people: Dr. Matthew Gentry, the assistant medical director of Mission's ER; Chris Shelton, the North Carolina division risk management director for Mission/HCA; Kendall Stacey, the director of infection prevention at HCA; and Crowley.

Grzankowski said the meeting went well. It seemed that everyone took her story seriously and said they were reviewing her case to determine where mistakes were made and how they can change policy and procedure to ensure this doesn't happen to any other families moving forward.

"My biggest thing was really I just wanted them to hear me and hear from a patient/caregiver what a simple mistake could cause us. The main thing I wanted was for them to just own the mistake and put new procedures in place so this doesn't happen again, which is exactly what they are doing."

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June 12, 2022

Attorney General's Office Had 'Great Concerns' Mission-HCA Deal Was Rigged 'From the Beginning'

2018 Memo Says "Deck Had Been Stacked" by Then-CEO

BY PETER H. LEWIS AND SALLY KESTIN (MARCH 15, 2022)

Carolinas HealthCare System

Then-CEO Ronald A. Paulus of Mission Health

The North Carolina attorney general's office had "great concerns about how HCA was selected" as the purchaser of the Mission Health System, including that "the deck had bee stacked in its favor from the beginning" by then-CEO Ronald A. Paulus and his advisor Ph D. Green, according to a 2018 internal document obtained by *Asheville Watchdog*.

More: Mission nurses ratify contract; deal includes 7% wage increase in 1st year

As Grzankowski struggled to get care from Mission at the end of August, she wrote in an email that she would avoid going back to Mission at all costs. She considered moving to Charlotte, to be closer to Levine Children's Hospital, because she knew Phoenix would likely have many more hospital visits as she grows up.

Her perspective has since changed.

After the meeting she said: "I hope going forward when my daughter needs to go back to Mission we will have a better experience. I really highlighted on the call that it's not a matter of if we ever have to return to Mission, it is a matter of when, because between the two of us, I know we will have to go to Mission in the future."

"Our community needs to be able to trust that when we go to the hospital we will get the level of care we deserve and the only way that will happen is if people start talking about mistakes that have happened," she said, "because let's be honest, if WNC lost Mission Hospital or could no longer trust the hospital, many people would be in a very bad situation."

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"[W]ith no outside advice other than Phil Green," whom the investigators wrote had an undisclosed "prior business relationship with HCA," Mission Health's board of directors decided not to issue requests for competitive bids or to hold an auction before agreeing to sell Asheville's flagship hospital system to HCA Healthcare for $1.5 billion, according to the document, prepared in advance of a meeting between Department of Justice lawyers and HCA representatives on Oct. 30, 2018.

Instead, as Paulus "coached HCA behind the scenes on how to best present its case to the Mission Board," the board invited only one other healthcare company — identified in other documents as Novant Health of Winston-Salem — to present a formal offer.

"In the end," the document stated, "an outside observer could conclude that HCA rose to the top among a limited number of bidders because the deck had been stacked in its favor from the beginning by Dr. Paulus and Mr. Green."

The attorney general's office was so concerned about potential conflicts of interest by Paulus and Green that it requested the Mission board revote on the transaction, the attorney general's deputy chief of staff, Laura Brewer, wrote to *Asheville Watchdog* this week. After considering the information, the Mission board voted again, unanimously, to approve it.

Paulus did not respond to *Asheville Watchdog's* requests for comment. Green declined an interview request but noted that the attorney general, after an extensive review, did not object to the sale.

Only HCA, Novant, and Atrium Considered

The Oct. 30 document, written by Special Deputy Attorney General Jennifer T. Harrod, who led the North Carolina Department of Justice investigation, was among more than 6,000 records released Feb. 25 by the office of Attorney General Josh Stein in partial response to public records requests filed by *Asheville Watchdog* over the past two years.

The documents contain details not previously made public about the sale of the 133-year-old nonprofit hospital system, including that, other than HCA and Novant, Carolinas HealthCare System (now Atrium Health) was the only other healthcare company that the Mission board seriously considered. But Carolinas was rejected quickly and not even invited to make a presentation to the board, the records show.

The documents confirm and expand on *Asheville Watchdog's* previous reporting on the role played by Paulus and Green. They show Green negotiated proposed term sheets — nonbinding proposals — for both a $1.5 billion sale of substantially all of Mission's assets

HCA and for a $650 million joint venture with HCA that would have preserved some local control. HCA provided Paulus with a written affiliation proposal on Aug. 12, 2017, six weeks before the Mission board authorized Paulus to engage in calls and meetings with potential affiliation partners.

Overall, the newly released documents raise serious questions about the role of Paulus, Mission's president and CEO; his longtime personal friend and advisor Green; and the 18-member Mission board of directors, which investigators said seems to have accepted HCA's arguments about cost-savings and improved quality of care "uncritically."

Paulus's emails examined

Under state law, the attorney general has the right to review any transaction in which a nonprofit corporation sells substantially all of its assets. The investigation of the proposed Mission deal began in May 2018.

By October 2018, Harrod and other lawyers in the attorney general's office had examined thousands of documents related to Mission's decision to sell, including Paulus's and Green's email exchanges with HCA and other potential partners, and minutes of Mission board meetings.

On the afternoon of Oct. 30, 2018, Harrod, at least two other lawyers with the North Carolina Department of Justice, and four representatives of HCA met at the attorney general's office in Raleigh. No one from Mission attended, the records show.

"We see that HCA's purchase of Mission brings something new and dynamic to the region," Harrod wrote in an opening statement. She said the Department of Justice investigators had met the previous week with the chairman and vice-chairman of Mission's board, who talked "about how much HCA's efficiency, commitment to patient care, and sophisticated data analytics impressed them."

"At the same time," she continued, "we have great concerns about how HCA was selected to be the entity that purchased Mission."

"Here are the facts as we currently understand them," Harrod wrote:

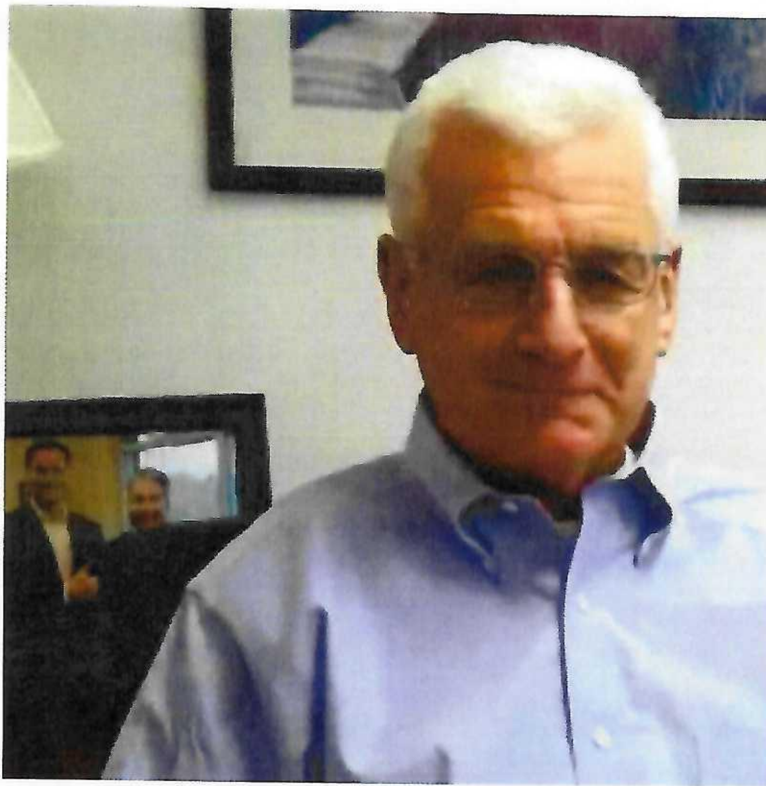
- Paulus and Green "steered the process by which other bidders were identified. Mission decided, with no outside advice other than Phil Green, not to put out a request for bids or hold an auction."

- Green had "a prior business relationship with HCA" that "was never disclosed to the Mission board."
- When Mission's board members visited HCA headquarters, "Dr. Paulus and Mr. Green both thought it was critically important for Mr. Green to attend that meeting to ensure its success."
- "Dr. Paulus coached HCA behind the scenes on how to best present its case to the Mission Board. On two occasions, he pointedly told HCA that Mission's peers were and would favorably consider being acquired by HCA."
- Paulus discussed his continued role with potential buyers. One wanted him to be chief information officer. "Later, that partner was dropped from consideration on grounds that appear pretextual to us ... Reading his email exchanges with HCA, an outside observer could conclude that he was working hard to demonstrate his value to HCA," the memo states. (Just days after the Mission sale closed, Paulus announced he was joining HCA as a strategic advisor. Tax records show Paulus received more than $4 million for his final four months at Mission. The terms of his employment agreement with Mission and his consulting job with HCA remain unknown. A spokeswoman for HCA's North Carolina Division said Paulus is no longer a strategic advisor to HCA.)
- "Neither the board nor its advisors seems to have given any thought to the fact that certain transaction partners offered Dr. Paulus greater scope for advancement versus others or versus no transaction at all," Harrod wrote.
- "In our opinion, Dr. Paulus's conduct violated the Mission conflict of interest policy, which requires an officer or board member with even a potential conflict to not merely recuse himself from voting on the matter, but also from advocating for an outcome. Dr. Paulus offered to recuse himself, but was advised that it was unnecessary. The rationale was that since all of the potential partners wanted Dr. Paulus to continue in some capacity, therefore he had no conflict of interest."

"Just have to trust HCA"

Harrod had already expressed concerns to Mission that the terms outlined in the Letter of Intent (LOI) negotiated by Paulus and Green did not go far enough in protecting the public's interests.

"Given Mission Health's strong operating and financial position, we believe Mission should be well positioned to negotiate for strong terms to protect public health interests, as has been done in other similar transactions," she wrote to Mission officials on Aug. 8, 2018.



Philip D. Green, Mission's strategic advisor

Instead, on Aug. 30, 2018, HCA and Mission signed an official contract, called the asset purchase agreement (APA), on terms the attorney general's office believed favored HCA.

"Dr. Paulus and Mr. Green were principal negotiators of the APA," Harrod wrote in her memo in advance of the Oct. 30, 2018 meeting. "It appears to us comparing the terms of the LOI to the terms of the APA, HCA improved its position considerably."

"One of the major inducements for Mission to enter the LOI with HCA was the promise that hospitals and services would be maintained," Harrod wrote. "We and others advised Mission prior to signing the APA, that such commitments needed to be specific and measurable in order to be enforceable."

"The emails we have seen demonstrate that Dr. Paulus ultimately buckled in the face of resistance from HCA and decided that Mission would just have to trust HCA," she wrote.

Harrod wrote, "Even now, the board believes that HCA has committed to maintaining the current level of services ... even though the APA says no such thing." For example, the agreement allowed HCA to eliminate some services and close facilities if they became "commercially unreasonable," documents show.

Harrod also wrote that "Mission agreed to let HCA use its existing charity care policy, eve
though it appears to us that for most patients, they would be much better off under Missi

policy." Weeks earlier, lawyers for both HCA and Mission had written to Harrod that HCA's charity care policies were "more generous in most respects" than Mission's policies.

HCA's $188 Million Settlement

In January 2017, six months before beginning discussions with Paulus and Green, HCA agreed to pay $188 million to settle litigation over its failure to abide by the terms of its purchase of nonprofit Health Midwest hospitals in the Kansas City area, a transaction similar to its later deal with Mission Health.

In a letter Sept. 10, 2018, Harrod asked Mission senior vice president Donald R. Esposito to "[d]etail the assurances Mission has received that HCA will honor its contractual obligations, in light of its failures to do so in connection with its acquisition of Health Midwest."

In her document for the Oct. 30, 2018 meeting, Harrod stated: "Despite the experiences of the health care foundation in Missouri, Mission agreed to dispute resolution terms that overwhelmingly favor HCA."

"These are examples, not an exclusive list," Harrod concluded.

"The best possible deal"

The attorney general's investigation intensified over the next two months and included ensuring that Mission's board knew about Green's prior business relationship with HCA.

"We requested that the board be fully informed of this relationship and then take another vote on the deal," Brewer, the deputy chief of staff, told *Asheville Watchdog* this week. "We also ensured that Mr. Green would not receive any compensation dependent on closing of the transaction, including any 'bonus' or 'success fee,' and that neither he nor his company would otherwise benefit from the transaction."

The Mission board held special sessions Dec. 13 and Dec. 20, 2018, and Jan. 8, 2019, to discuss final details of the pending deal, including the findings of Harrod's investigation.

In the end, Mission Board chairman John R. Ball wrote, in a letter to Stein after the Jan. 8 meeting, that the board considered the attorney general's concerns and "concluded that Mission's management team and its outside advisors were committed at all times to securing for Mission the best possible transaction with potential merger partners, ultimately leading to the transaction with HCA."

"No member of Mission's management or its advisors took any action, or failed to take any action, that was detrimental to Mission's interests," Ball wrote.

The Mission board, Ball wrote, "believes it has been, and remains fully informed with respect to all these issues," and was "steadfast" in its goal to close the sale to HCA. The board's re-vote was once again unanimous.

Ball could not be reached for comment.

Letter of Non-Objection

In an August 2021 interview with *Asheville Watchdog*, Stein said state law limited his authority to halt the sale despite the information uncovered by his investigation. Because of the law's restrictions, Stein said, he sought specific enforceable agreements, a number of concessions from HCA, and 15 additional conditions to be added to a revised asset purchase agreement.

NC Attorney General Josh Stein

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Stein's conditions included the hiring of an independent monitor to oversee HCA's compliance with the agreement; enforceable commitments to maintain current levels of service at all six hospitals in the Mission system, not for the five years Paulus and Green negotiated in some cases, but for 10 years; and requiring HCA to adopt what he viewed as Mission's more generous charity care obligations.

Stein also got HCA and Mission to agree that the attorney general could enforce the terms of the contract.

On Jan. 16, 2019, Mission and HCA agreed to the attorney general's changes and signed an "amended and restated" asset purchase agreement. Harrod then informed them that the attorney general would not object to the sale.

Green: "Concerns were baseless"

Green declined to speak with *Asheville Watchdog* but emailed a statement. "The Attorney General, after reviewing thousands of pages of documents and conducting an inquiry into ensuring a fair process and the absence of any conflict of interest, concluded that any concerns were baseless and wrote a Non-Objection letter," he wrote.

The letter of non-objection, written by Harrod, actually said the Attorney General's investigation had identified "potential concerns." But, it said, "Mission Health has represented to the Attorney General that ... no one on Mission's board and no one responsible for advising Mission's board will receive any direct or indirect benefit as a result of the sale of the operating assets of the Mission Nonprofit Entities to HCA."

Green is still listed as an independent advisor for large healthcare mergers and acquisitions and has a consulting company based in Arlington, Virginia. Paulus is still a principal of RAPMD Strategic Advisors, based in Asheville.

Update From Stein's Office

Harrod, who led the investigation into the Mission-HCA sale, is no longer with the Attorney General's office. She declined to comment for this story.

In a statement to *Asheville Watchdog* last week, Brewer, Stein's deputy chief of staff, wrote, "Under North Carolina law (unlike in many other states), the Attorney General's authority in these kinds of deals is quite limited" to ensuring a fair purchase price and "that the charitable mission of the non-profit is being carried forward."

"North Carolina law does not give our Office the general authority to police health care transactions based on how they would impact patients, quality of care, rural access, and other issues," Brewer wrote. "Even though the Attorney General's legal authority over this type of transaction is quite limited, we succeeded in negotiating a number of significant improvements to the agreement."

"Paying More and Getting Less Care"

HCA officially took control of the Mission system on Feb. 1, 2019.

Novant, the lone other bidder that Mission's board rejected in favor of HCA's $1.5 billion offer, went on to sign a $5 billion deal, including $2 billion in cash, to acquire a smaller and less profitable hospital in Wilmington.

The Attorney General's office denied *Asheville Watchdog*'s request for a comparison of Novant's and HCA's offers for Mission, citing state statutes that exempt confidential business information from public records requests.

Ashton W. Miller, Novant's manager of public relations, declined to comment.

In the statement she prepared for the Oct. 30, 2018 meeting with HCA representatives, Harrod wrote: "We understand that HCA plans to do further acquisitions in North Carolina. This may not be the last time we are across the table from each other."

Last week, when *Asheville Watchdog* asked what lessons were learned from the Mission sale, Attorney General Stein responded:

"Too often, when one hospital swallows up another, patients end up paying more and getting worse care. North Carolinians need better safeguards to review transactions to put the patients' interest first. I'm working with partners in the legislature now to determine how our laws can better protect patients in these health care transactions."

Asheville Watchdog is a nonprofit news team producing stories that matter to Asheville and Buncombe County. Peter H. Lewis is a former senior writer and editor at The New York Times. Email plewis@avlwatchog.org. Sally Kestin is a Pulitzer Prize-winning investigative reporter. Email skestin@avlwatchdog.org.

Asheville Watchdog gratefully acknowledges the assistance of the Duke University School of Law's First Amendment Clinic, with special thanks to Danielle Siegel, Alexandria Murphy, Ben Rossi, and Dillon Farnetti.

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Attachment 4

CAROLINA Public Press

COUNTIES

Mountain maternity wards closing, WNC women's lives on the line

by Catherine Pearson and Frank Taylor · September 25, 2017

Margie Mason of Spruce Pine, who is pregnant with her third child, says she is sad about the maternity unit closures. Mike Belleme / HuffPost

Blue Ridge Regional Hospital in Spruce Pine will no longer have a labor-and-delivery unit after Sept. 30. Mike Belleme / HuffPost

On a frosty January evening, **Nancy Kerr** felt the first twinges of contractions.

Snow was piling up outside her house in the mountains of rural Spruce Pine, in Mitchell County, but the contractions were mild, and she was a week shy of her due date, so she assumed it was simply false labor. Kerr called her doctor, drank a glass of water and tried to relax.

At 11:30 p.m., Kerr's water broke and she was suddenly thrust into active labor. Her husband raced around the house, throwing everything the couple needed for the hospital into his dirty work truck, and they began the six-mile descent to the hospital on winding roads covered in 5 inches of snow.

Kerr did her best to breathe through the contractions that crashed down upon her, trying not to fixate on the two occasions they'd spun off the very same roads in similar whiteout conditions.

Because of the snowstorm, Kerr's regular physician did not arrive at the hospital in time to help her deliver. Instead, she gave birth under the guidance of the labor-and-delivery nurses who coached her through pushing — being mindful of the fact that the baby's heart rate was dropping — while an emergency room doctor caught the newborn. Less than an hour after they arrived at the hospital, Kerr held a healthy baby girl in her arms.

If the drive had been even a few minutes longer, she is certain she would have delivered her daughter on the side of a snowy, low-visibility road.

And if Kerr were giving birth this winter, the trip to the hospital would be significantly longer. The Spruce Pine labor-and-delivery unit will close at the end of September, the latest in a string of maternity ward closures that leave expectant mothers in the mountains of Western North Carolina without access to maternal care within reasonable distances of their homes.

"It was such a reassuring experience to be able to deliver in our local hospital, and receive great care and be able to be close to home," she said. "I don't know what would have happened to me or our daughter had we had to drive [elsewhere]."

Mission Health, a nonprofit hospital network headquartered in Asheville, has operated many longstanding small hospitals throughout the 19-county region — most notably in rural, low-population areas like Spruce Pine and Marion, which are north of the city, and Brevard, Franklin and Highlands to the south.

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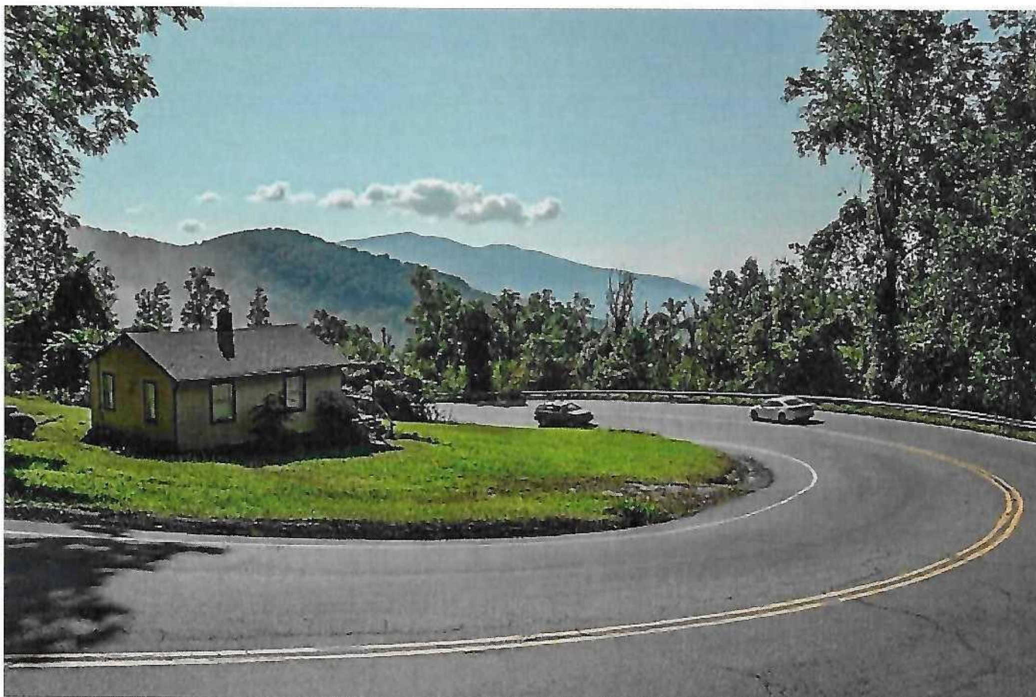
Until two years ago, each of these communities had a labor-and-delivery center nearby. But in 2015, Mission began to close them. First, it was a unit at the Transylvania Regional Hospital in Brevard, servicing nearly 33,000 residents. Then in July 2017, Mission shuttered labor and delivery at Angel Medical Center in Franklin, affecting about 40,000 people in Macon County and surrounding counties. At the end of September, Blue Ridge Regional Hospital of Spruce Pine will also lose its labor-and-delivery unit, affecting the 33,000 people in Mitchell and Yancey counties who rely on that hospital.

At that point, Mission will provide birthing services only at its locations in Asheville and Marion. That means women in rural counties will have to drive at least 20 miles to give birth and — if they want to be able to see the same providers in the delivery room they saw throughout their pregnancies — to get prenatal care.

The roads through the mountains during labor pose a major concern, even without snow. The peaks in this region are the highest in the eastern United States. Except for a few major highways, such as Interstate 40, most roads weren't built by blasting through or tunneling under these hills. They wind around them, often with precipitous drops on one side.



Some expectant mothers in Western North Carolina will face drives of an hour or longer along winding roads, like this one between Spruce Pine and Marion, to reach the nearest hospital offering childbirth services. Mike Belleme / HuffPost

It is an issue facing rural communities nationwide: From 2004 to 2014, 9 percent of all rural counties lost access to hospital obstetric services, and more than half of all rural counties in this country are now without a single local hospital where women can get prenatal care and deliver babies.

It is logistically challenging and expensive to staff a unit that must be ready for women day and night, and it is difficult to make enough money when there simply aren't enough women coming in. Nationally, more than half of births are funded by Medicaid, which pays doctors back at a much lower rate than private health insurance plans. In rural areas, that percentage tends to be even higher. Malpractice insurance also plays a role. Family physicians, who often deliver babies in rural areas, face higher malpractice premiums if they offer obstetric services, while hospitals may face low-volume penalties.

"Hospitals that have the fewest births have to pay the highest premiums, because the risk level is higher when something happens less frequently," said **Katy Kozhimannil**, a professor of health policy and management at the University of Minnesota, whose research focuses on the challenges in rural obstetric health care access. "This is all from conversations with folks ... it's not something we've looked at in research, but it is something that comes up in conversation with clinicians, and with hospitals."

All of which means that delivering babies is a money loser for small hospitals already struggling to stay afloat.

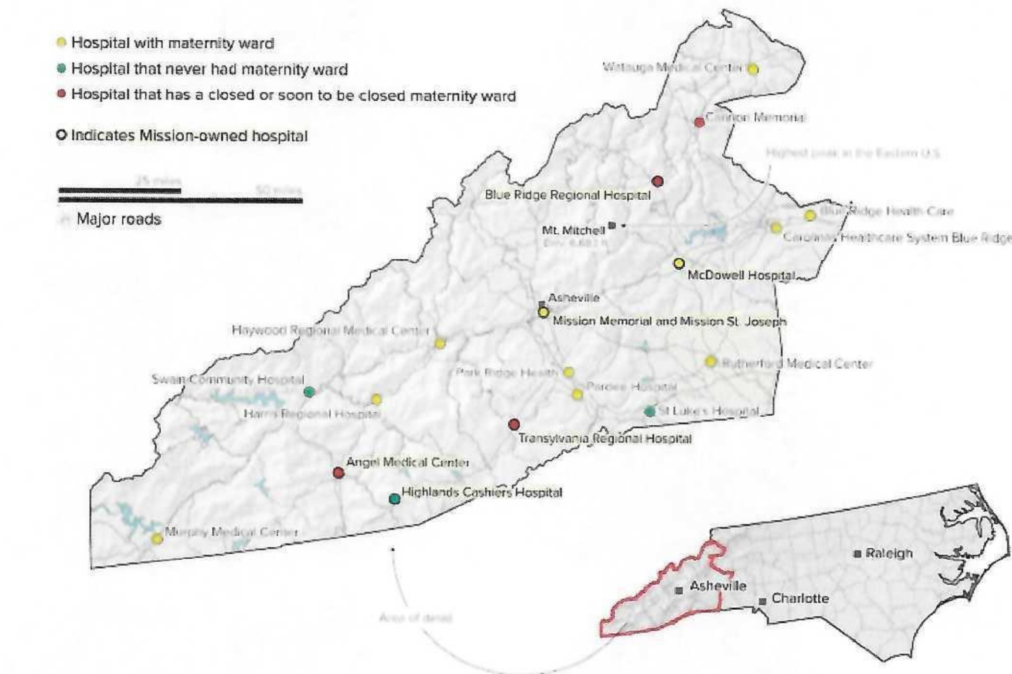
Aside from the substantial inconvenience of significant travel to medical providers, these closures have rural residents concerned that they'll be put in dangerous situations, including giving birth on the side of the road, at home or with lesser-qualified emergency providers.

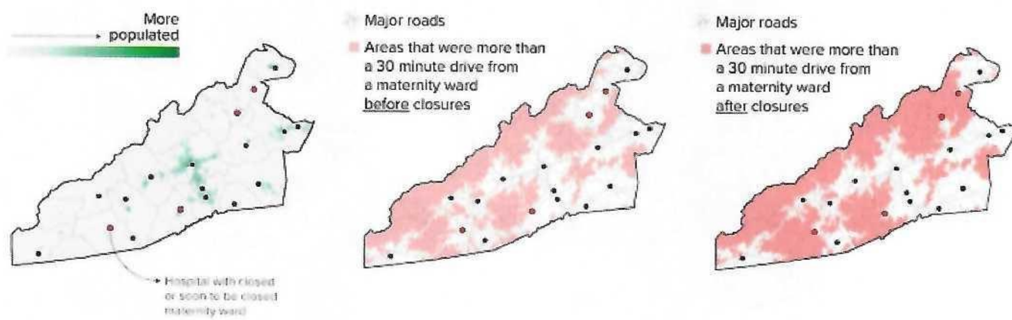
"We cannot ignore the fact that when a health care system or a hospital decides that it's no longer worth the risk to keep the obstetric unit open, that risk does not go away," Kozhimannil said. "It migrates from the hospital to the homes of the people living in that community."

The stakes for expectant mothers are high. The United States has the worst rate of maternal deaths in the developed world, and that rate is rising. **Women living in rural areas tend to fare worse** for reasons that aren't yet entirely understood, though underlying health problems and limited access to high-quality prenatal care are thought to play a crucial role.

Dwindling Access To Maternity Wards In Mountainous Western North Carolina

Mission Health, which operates six hospitals in the nineteen-county region, will have closed three maternity wards by the end of September 2017. The area's geography makes it difficult for residents in remote areas to get to far away hospitals.





Note: Hospitals serving specific populations such as the VA hospital in Asheville and the Cherokee Indian Hospital in Swain County are not shown here (neither have maternity wards).
Sources: Hospitals, Center for International Earth Science Information Network, Mapzen isochrone service, Census Bureau

Alissa Scheller/HuffPost

The battle to keep maternity wards open

For its part, Mission blames the cuts on low demand and financial losses at these locations. Deciding to close these labor-and-delivery services was "incredibly difficult," Mission Health spokeswoman **Rowena Buffett Timms** told Carolina Public Press. But she said it stemmed from the company's "responsibility to ensure that we have the region's best interests in mind."

For Mission, the decision came down to financial sustainability and the ability to continue providing other forms of care amid what Timms described as "the abject chaos in health care policy in our nation."

Nationally, it's not just labor and delivery that is being slashed; entire hospitals are disappearing. States in the South and those that did not chose to expand Medicaid under the Affordable Care Act **have been particularly hard hit**. In addition to the challenges that have long plagued rural hospitals — difficulty recruiting and retaining staff, deteriorating facilities — they have been hit by Obamacare-era cuts to a program that reimbursed hospitals for bad debt without any of the financial boost the health care overhaul offered states that expanded Medicaid.

At Angel Medical Center in Franklin, Timms said the company was unable to continue sustaining losses of up to $2 million annually on the labor-and-delivery program as it prepared to invest in a badly needed $43 million new hospital. The company estimates that not including a labor-and-delivery center in the new facility will cut $7 million in cost.

"We have shared previously that there has been no growth in newborn deliveries in the region and there is no growth forecast," Timms said of Angel.

Timms described Spruce Pine as having the third-lowest volume of births of any facility in the state, so low that she claims it was difficult for the staff to "maintain proficiency."

Not only were these counties more sparsely populated, but mothers "voted with their feet," according to Timms, by traveling to Asheville to give birth. About 60 percent of Yancey County women and 40 percent in Mitchell County went to Mission's facilities in the larger city despite drive times of close to an hour. **Dr. Dorothy DeGuzman**, a family physician with a specialty in high-risk obstetrics who has admitting privileges at Blue Ridge Regional Hospital in Spruce Pine, says she sees that in her own patients. Some simply feel more comfortable delivering at a larger hospital with a neonatal intensive-care unit.

"There are women who drive to Asheville when they don't have to necessarily, and there also are women who are too high-risk for us," she said. "For example, someone who had complicated twins should go to Asheville. Someone who comes in in pre-term labor, they go to Asheville. We deliver babies at 35 weeks and up. We do transfer when it's clinically appropriate."

This has also factored into a decision to include a maternity unit in the plans for an upgraded Mission facility in Marion, slated to open in 2018. Timms described this consolidation as "the only responsible decision."

And the activity of other hospitals in the region contradicts this rationale — while national trends reflect Mission's reasoning, other local companies are increasing their investment in maternity care. Eight small community hospitals — in Murphy, Hendersonville, Sylva, Clyde, Morganton, Rutherfordton, Columbus and Boone — operate labor-and-delivery services, and none has cut back on birthing services during the time Mission Health has been making cutbacks. In fact, several describe increasing demand for their maternity units and a philosophy in which labor-and-delivery services are integral to their work.

"The care we provide at The Baby Place at Park Ridge Health is completely in line with our mission," according to **Beth Cassidy**, director of the birthing facility in Hendersonville, about 25 miles south of Asheville.

"For the community to know that they have an option to receive high-quality, compassionate care for mother and baby provides a peace of mind and confidence for each family member."

Steve Heatherly, CEO at Harris Regional Hospital in Sylva, expressed a similar sentiment, describing birthing services as "a vital need."

DeGuzman questioned whether the company leadership comprehends Mission's mission.

"No one makes money delivering babies," DeGuzman said. "I, as a physician, lose money when I am delivering a baby versus me seeing patients in the office. So no one makes money off it. You do it for the community. You do it because it's

your passion."

With fewer delivery options, pregnant women scramble

Margie Mason gave birth to her first child in Asheville, an hour from her home in Spruce Pine, and described the experience as impersonal. For example, when it was time to go home, the doctor on call forgot about her, she said, forcing her to wait 10 hours while the hospital tried to contact him.

"I was so frustrated because I felt like no one knew me personally," Mason said. "It felt like the nurses would just forget about me during the day."

When she was expecting her second child, friends recommended Blue Ridge, five minutes from her home on good roads.

"It was an amazing, absolutely amazing experience," she said. "I love how small it is. The nurses were so attuned — 'Oh, your baby's sleeping? We'll come back in an hour to see if he's awake and get all the readings we need to.' It was incredible."

Now 28 weeks into her third pregnancy, Mason is once again facing a delivery at a distant facility with a doctor who will be new to her.

Her doctor, DeGuzman, is moving away before she will deliver because the facility where she has admitting privileges is closing. DeGuzman moved to the area six years ago with the specific aim of delivering babies and providing high-quality prenatal care in a rural setting. Mason says her doctor is so devastated by the closure of labor and delivery at Blue Ridge Hospital that she is moving to California at the end of October.

"Dorothy is the most amazing doctor that I've ever seen," Mason said. "She literally just cried on me when she told me that she's leaving, because of how passionate she is about labor and delivery."

Mason is now working with DeGuzman to determine her best option. She will either travel to a freestanding birth center in Asheville, which is more than an hour's drive, or to the next-closest Mission-owned hospital in Marion, 30 minutes away, to put herself in the care of whatever doctor is on call. Though both options accept her Medicaid, both have drawbacks, and Mason is stumped about what she should do.

"I think about it all the time," she said. "All the time."

"I've been sarcastically saying that I'm going to camp out in a gift shop in a hospital for a while now," she added. "I've even looked at home births just because logistically I could be delivering in the car. So do I just commit to having a home birth? (Blue Ridge Hospital) is still so close, but they've been very clear on, 'If you do deliver here, we're bringing your baby to Asheville after in an ambulance.' So that's why I've leaned away from a home birth, because I don't want to be in that situation if there's an emergency."

Sarah Ruth Owens is a doula, trained to assist women during labor and delivery, who lives in northern Georgia, across the state line from Angel Hospital. She has heard from two clients who decided to have home births after the facility stopped offering maternity services last summer.

One is a woman Owens had talked out of a home birth in the first place, pointing to the midwifery model in place at Angel that would allow her to try for the "natural" birth she desired.

The other woman asked Owens if she would help oversee a risky "unassisted" (meaning unsupervised) delivery at home. Owens declined, explaining it was unsafe, and was able to find a midwife 2½ hours away who would attend the birth. It's still risky, though perhaps not as bad as going it alone.

Owens said Mission's decision to cut its facility at Angel has "put women like me in a really tough spot."

"That's two women in a very small community," she said. "You're not talking about thousands of women who deliver here; you're talking about hundreds."

There is not much solid national data looking at what happens to women in rural settings when local obstetric services disappear, though one study in France found it led to an increase in home birth, which is already more common in rural areas. Kozhimannil, the Minnesota professor, is at work on a study looking at the risk for women who don't get adequate prenatal care.

"The further people have to travel, the fewer visits they tend to come to," she said. Up to 70 percent of rural hospitals that cut labor and delivery continue to offer some form of prenatal and general gynecologic care — as Mission has in its facilities — but that does not necessarily offer much comfort to expectant mothers who do not want to see one provider for nine months only to be met by a stranger during one of the biggest moments of their lives.

"A lot of people in the community want to access prenatal services where they are going to deliver their baby."

Women's health experts are worried

Staff at the closed facilities have plenty to say about the mixed messages they received from Mission and their frustrations on behalf of their patients.

DeGuzman has been working in the Spruce Pine area for six years. She worries about what women will do without the local hospital as a delivery option. She also bristles at Mission's suggestion that staff proficiency was a problem, saying the hospital was unable to provide her and her fellow providers with any evidence that their patient outcomes were in any way diminished.

Now the patients' risk will only be greater.

"Women will be delivering in cars or at home," she said. "Some will get hardly any prenatal care."

DeGuzman said medical staff is working out plans with patients they already have. "We're basing it on where they live," she said. Some patients at Spruce Pine lived farther away, including near Burnsville in Yancey County, which has no hospital. "If they're in Burnsville, we tell them to go to Asheville; if they're in Spruce Pine, we tell them to go to Marion. Some are going (farther north) to Boone. We're taking it on a case-by-case basis."

The planning has not reassured everyone. "They're so worried," DeGuzman said. "They're so stressed, and you know especially the ones due — and I have several — that are due, like, the month after it closes."

She is also concerned that some patients are planning home births, which she sees as very risky when they are more than an hour from a hospital that could do an emergency cesarean section.

For DeGuzman, however, this change signals an end to her work here.

"I'm leaving Oct. 27, because I didn't want to stop delivering babies," she said. "That's my passion. ... About three or four months into it, when it became pretty clear (Mission CEO) **Ron Paulus** was going to do this, I applied for a job in California."

Roberta Bowles has been a nurse at Angel Medical Center in Franklin for more than 20 years. She says she is devastated about the closure of the labor-and-delivery unit, both for her staff and her patients. Mike Belleme / HuffPost

Roberta Bowles was the nurse manager at Angel labor-and-delivery before it closed in July. The decision took her by surprise. She has worked for the hospital off and on since 1994 and said she has no sympathy for Mission.

"It was the best-kept secret in the whole world," Bowles said. "When they were making that decision, they did not pull in the obstetric providers. They just really snuck up on everybody."

She was ordered to call a meeting of staff but not told why. When she persisted and finally learned the bad news, she was devastated. "I had to keep a straight face and not cry for my staff. I was totally blindsided. Totally."

The meeting was worse. "People were stunned," Bowles said. "People were crying, because you knew by July 14 you didn't have a job anymore. I had hired a girl from Virginia who had been here just a year. Another nurse moved from Sylva over here; they had just bought a new house and moved in the week before, and now there's no job for her. She's still not employed. It was life-changing for many, if not all of us."

Though Mission reassured her staff they could apply for jobs internally, Bowles said that it is her understanding that only one of her nurses has a job with the company, while 14 of the 26 women on her staff are still unemployed. Many are young mothers themselves and are simply unable to juggle childcare, long shifts and several-hour drives to a new job.

Bowles' concerns aren't just for her staff, however. They are for the mothers she runs into at Walmart or at the grocery store who ask her what they should do. Some, she fears, will have home births far away from any hospital with lay midwives. It's a situation she saw much more of when she first moved to the area in the mid 1990s and saw many "compromised moms and babies" come to the hospital after home deliveries gone wrong.

"That scares us as providers," she said. "It's like, 'Oh, no, here we go again.'"

Other expectant mothers have told her they don't have much of a plan beyond going to Angel's emergency room when they go into labor, a prospect that makes Bowles uneasy. Before her last day, she led a two-hour class for the emergency room nurses and EMS staff on the basics of precipitous delivery, high-risk conditions and the signs that a birth is taking a turn for the worse. It did not make her feel any more confident about what will happen to women who show up at the emergency room in labor.

"A two-hour class does not make you an OB nurse," she said. "I'm just scared for patients. They're scared, too, when I talk to them."

On Sept. 20, with the Blue Ridge labor-and-delivery unit set to close in 10 days, **Dr. Brie Folkner** was present when a patient arrived in severe distress. Folkner sent an email to Paulus the next day:

> *Hey Ron,*
>
> *I just witnessed Dr. Murphy perform an emergency c-section on a (patient) who came in ruptured with meconium and didn't know she was pregnant. No prenatal care, no idea of gestational age and she had had four previous c-sections. I was called to attend the newborn as the physician on newborn call.*

She called Mission's neonatal intensive care team just before the delivery to alert them of the situation, but they did not arrive until 30 minutes after the baby was born. Then it was another hour's wait for an ambulance to come and drive the pair to Asheville. The mother and baby survived, but Folkner is horrified about what may happen if a similar situation arises after Blue Ridge closes its doors to expectant mothers.

"What's the plan?" she asked. "I refuse to watch people die."

Editor's note: This story was produced through a collaboration between **Carolina Public Press** *and* **HuffPost**.

CORRECTION: *An earlier version of this article indicated Cannon Memorial Hospital never had a labor and delivery unit. Cannon Memorial's unit ceased operation in 2015, and the graphic has been corrected.*

Pingback:
Rural Maternity Wards Are Closing, And Women's Lives Are On The Line | Insurance Flavor

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Attachment 5

Filed Jun 23, 2022 1:25 PM Office of Administrative Hearings

STATE OF NORTH CAROLINA
COUNTY OF BUNCOMBE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

FLETCHER HOSPITAL, INC. d/b/a
ADVENTHEALTH HENDERSONVILLE,

Petitioner,

v.

22 DHR ______

NORTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE
REGULATION HEALTHCARE PLANNING
AND CERTIFICATE OF NEED SECTION,

Respondent.

PETITIONER FLETCHER HOSPITAL, INC. d/b/a ADVENTHEALTH HENDERSONVILLE'S PETITION FOR CONTESTED CASE HEARING

Petitioner Fletcher Hospital, Inc. d/b/a AdventHealth Hendersonville ("AdventHealth Hendersonville" or "Petitioner"), hereby files this petition for a contested case hearing pursuant to N.C. Gen. Stat. § 131E-188 and 150B-23 and to 26 N.C.A.C. 3.0103, challenging the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Healthcare Planning and Certificate of Need Section's (the "CON Section" or "Agency") May 24, 2022 decision to conditionally approve the Certificate of Need ("CON") application filed by MH Mission Hospital, LLLP ("Mission" or the "Applicant") to develop a freestanding emergency department ("FSED") in **Arden**, Buncombe County, North Carolina and identified by Project ID B-12191-22 (the "Mission Application" or the "Arden Application"). A copy of the Mission Application with its associated exhibits is attached hereto as **Exhibit 1**. A copy of the Conditional Approval of the

Mission Application and the Required State Agency Findings related to the Agency's review of the Mission Application (collectively, the "CON Decision") are attached hereto as **Exhibit 2**.

In support of this petition, Petitioner states the following:

1. Petitioner Fletcher Hospital, Inc. d/b/a AdventHealth Hendersonville is an acute care hospital located at 100 Hospital Drive, Hendersonville, Henderson County, North Carolina, 28792. AdventHealth Hendersonville is licensed by the Acute and Home Care Licensure and Certification Section. AdventHealth Hendersonville has 62 licensed acute care beds and 41 psychiatry beds, and offers a spectrum of acute care services, including emergency medical care through its emergency department.

2. Respondent CON Section is an agency of the State of North Carolina authorized and required to review CON applications under the Article 9 of Chapter 131E of the North Carolina General Statutes (N.C. Gen. Stat. § 131E-175 *et seq*., the "CON law").

3. Mission proposed in the Mission Application to develop a new freestanding emergency department to be located at 2512 Hendersonville Road, Arden, Buncombe County, North Carolina 28704 and licensed under Mission Hospital. The FSED, when built, will be located less than one mile from the Henderson County line and 4.5 miles from AdventHealth Hendersonville.

4. Mission's total project capital expenditure is $13,320,500. (*See e.g.*, Mission Application, Application Fee Sheet, Form F 1.1, Projected Capital Cost) This amount exceeds the statutory threshold of $4,000,000, and therefore the proposed project would constitute a "New Institutional Health Service" under N.C. Gen. Stat. § 131E-176(16)(b).

5. Pursuant to N.C. Gen. Stat. § 131E-175(7), "the general welfare and protection of lives, health, and property of the people of [North Carolina] require that new institutional health services to be offered within this State [are] subject to review and evaluation as to need, cost of

service, accessibility to services, quality of care, feasibility, and other criteria as determined by provisions of this Article or by the North Carolina Department of Health and Human Services pursuant to provisions of this Article prior to such services being offered or developed in order that only appropriate and needed institutional health services are made available in the area to be served."

6. The Agency is required, pursuant to N.C. Gen. Stat. § 131E-183(a) to review each CON application utilizing the criteria outlined in that subsection (each a "Statutory Review Criterion" and, collectively, the "Statutory Review Criteria") and to determine that an application is either consistent with or not in conflict with the criteria set forth therein before a CON for the proposed project may be issued.

7. In assessing the Mission Application, the CON Section erroneously determined that the Mission Application satisfied all applicable Statutory Review Criteria and was therefore approvable by the Agency.

8. As is discussed hereinbelow and as was set forth in the Public Comments on the Mission Application filed by AdventHealth Hendersonville (**Exhibit 3**), Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital ("Pardee", **Exhibit 4**), and Haywood Regional Medical Center ("Haywood Regional", **Exhibit 5**), which are incorporated herein by reference, Mission failed to demonstrate that the proposed project conforms with all of the Statutory Review Criteria set forth in N.C. Gen. Stat. §§ 131E-183(a), including the Statutory Review Criteria set forth at N.C. Gen. Stat. §§ 131E-183(a)(1), (3), (4), (5), (6), (18a), and (20). Among other deficiencies in the Mission Application, Mission failed to demonstrate: the need for the proposed project among the population that the Mission Application proposes to serve; that its proposal is the least costly or most effective alternative; that its need methodology was based upon reasonable assumptions and that the project will be feasible in light of the numerous unsupported

assumptions and errors; that its proposed project would not unnecessarily duplicate existing health services; that the proposed services would enhance competition and have a positive impact on the cost-effectiveness, quality, and access to the services proposed; and that quality care has been provided by the applicant in the past.

9. Further, the Agency's approval of the Mission Application further entrenches Mission as a monopolistic presence offering acute care services in and around Buncombe County, North Carolina. As is discussed herein, Mission is currently the subject of a class-action lawsuit brought pursuant to Article 1, § 34 of the North Carolina Constitution (stating that: "Perpetuities and monopolies are contrary to the genius of a free state and shall not be allowed.") and pursuant to the state's antitrust and consumer protection statute (N.C. Gen. stat. § 75-1 *et seq.*). The complaint alleges that Mission has acted, and that it continues to act, in restraint of trade, and that Mission has unlawfully monopolized the provision of inpatient general acute care services in the region. (*See* **Exhibit 6**)

10. This petition challenges the CON Decision conditionally approving the Mission Application.

11. Pursuant to N.C. Gen. Stat. § 131E-188(a), any "affected person" is entitled to a contested case hearing under the North Carolina Administrative Procedure Act, by filing a petition for such a hearing. Similarly, N.C. Gen. Stat. § 150B-23 and 26 N.C. Admin. Code 3.0103 provide that "any person aggrieved," as defined by N.C. Gen. Stat. § 150B-2(6), may commence a contested case by filing a petition with the Office of Administrative Hearings.

12. Petitioner is an "affected person" under N.C. Gen. Stat. § 131E-188(c) because Petitioner is, among other things, a person "who provides services, similar to the services under review, to individuals residing within the service area and the geographic area to be served by the

proposed project. Petitioner is also a "person aggrieved" within the meaning of N.C. Gen. Stat. § 150B-2(6) because the CON Decision approving the Mission Application directly or indirectly affects Petitioner substantially in its person and property, adversely affects the rights of Petitioner, and substantially prejudices Petitioner for reasons including, but not limited to, all of the comments attached to this Petition, by allowing the duplication of services in the relevant geographic area, including services provided in such area by Petitioner, and by permitting and enabling the further entrenchment of Mission's monopoly over acute care services within and surrounding the proposed service area.

13. As set forth in the Comments filed as exhibits to this Petition, Mission took on its current form pursuant to a Certificate of Public Advantage. That Certificate, for a period of time, made Mission's monopoly compliant with applicable law. That Certificate is no longer in existence, yet Mission's monopoly continues unabated, and its monopoly power is no longer compliant with applicable law. The Mission Application represents an attempt to not only continue, but to expand, this monopoly power.

14. As discussed above, Mission is currently the subject of a lawsuit under the North Carolina Constitution and the North Carolina antitrust statutes alleging that Mission has routinely and repeatedly acted in restraint of trade and that it has unlawfully monopolized the provision of inpatient general acute care services in the region. While Mission certainly deserves the right to defend itself against these allegations, the project proposed in the Mission Application is itself a clear example of the very anticompetitive conduct of which Mission stands accused. Namely, the project is designed to funnel more patients to Mission's acute care facilities in Asheville, in part, by diverting patients away from existing emergency department service providers in the area, in an attempt to further consolidate Mission's control over the market. This is made more clear by

Mission's concurrent submission of a proposal to develop an FSED in Candler, Buncombe County, North Carolina (the "Candler Application"). The Candler Application, identified by project ID number B-012192-22, was approved by the Agency on May 24, 2022, concurrently with the Arden Application, and is the subject of a separate petition for contested case hearing. The projected ED volumes, growth rates, and market shares in the Mission Application, as well as the location of the proposed facilities in Arden and Candler—which are closer in proximity to existing emergency departments and urgent care centers and much further away from the northern portions of the county where a greater need exists for emergency services—make clear that Mission is targeting existing providers to duplicate their services, starve them of resources, and increase the scope and range of the monopoly that it currently holds.

15. Mission's monopoly over acute care services will be further supported by development of the projects proposed in the Arden Application and the Candler Application. Mission's position as a monopolist in this market is illustrated, in part, by the projection that, following the approval and development of the FSEDs proposed by Mission in Arden and Candler, Mission will control 97.8% of the projected Emergency Department market share in portions of the proposed service area by the Project Year 3. (*See* Public Comments of AdventHealth Hendersonville, Exhibit 3, p. 7) For reference, the North Carolina Business Court has noted that "[g]enerally speaking, a 70% to 75% market share is necessary to sustain a monopolization claim." (*See* <u>Sitelink Software, LLC v. Red Nova Labs, Inc</u>., No. 14 CVS 9922 (N.C. Super. June 14, 2016) (citing, <u>Advanced Health-Care Servs., Inc. v. Radford Cmty. Hosp</u>., 910 F.2d 139, 143 (4th Cir. 1990)) Petitioner's rights have also been substantially prejudiced as a matter of law by the Agency's failure to apply the Statutory Review Criteria, the Agency's reliance on the unsupported assumptions and errors in applicant's need methodology, the Agency's approval of a proposed

project that will result in the further entrenchment of Mission's monopoly over acute care services within the proposed service area, and by other Agency error as set forth herein and in the public comments attached hereto, and as may be shown during discovery and at the contested case hearing. Thus, for the reasons set forth herein, the CON Decision approving the Mission Application has deprived Petitioner of property and has otherwise substantially prejudiced Petitioner's rights within the meaning of N.C. Gen. Stat. § 150B-23(a).

16. As Petitioner is an "affected person" under N.C. Gen. Stat. § 131E-188(c), and is also a "person aggrieved" within the meaning of N.C. Gen. Stat. §§ 150B-2(6) and 150B-23, that has had its rights substantially prejudiced by the CON Decision conditionally approving the Mission Application, Petitioner is entitled to a contested case hearing pursuant to N.C. Gen. Stat. § 131E-188(a) and pursuant to the North Carolina Administrative Procedure Act.

17. This Petition is timely filed in accordance with N.C. Gen. Stat. § 131E-188(a) and N.C. Gen. Stat. § 150B-23(f), having been filed within thirty (30) days of the May 24, 2022, CON Decision.

18. Petitioner has otherwise complied with all conditions precedent to the filing of a petition for a contested case hearing. Pursuant to N.C. Gen. Stat. § 131E-188(a1), AdventHealth Hendersonville has deposited a bond in the amount of $50,000—an amount equal to the lesser of $50,000 or five percent (5%) of the cost of the proposed new institutional health service that is the subject of this Petition—with the Clerk of Superior Court of Buncombe County. A copy of the Deposit of Appeal Bond is attached hereto as **Exhibit 7**, and incorporated herein by reference.

19. Based upon the knowledge of Petitioner at the present time, additional facts supporting this petition are set forth herein, including without limitation the exhibits attached hereto. However, after Petitioner has had an opportunity to conduct discovery—by deposition, document

request, interrogatory, or otherwise—a reasonable likelihood exists that Petitioner will become aware of other specific facts and additional relevant issues to be contested in this action, including but not limited to those showing additional substantial prejudice to Petitioner and agency error. Petitioner thus expressly reserves the right in any hearing to rely upon facts, issues, theories, or arguments not raised at this time that may be developed during discovery, at the hearing or otherwise, including but not limited to those showing violations of other Statutory Review Criteria or additional violations of the Statutory Review Criteria enumerated herein.

20. Without waiving the reservation of rights stated above, Petitioner maintains that, in conditionally approving the Mission Application, which did not comply with multiple Statutory Review Criteria, the CON Section has substantially prejudiced the rights of Petitioner, exceeded its authority and jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily and capriciously, and failed to act as required by law or rule in, *inter alia*, the ways set forth below.

21. Specifically, for the reasons set forth herein and those contained in the public comments of AdventHealth, Pardee, and Haywood Regional, attached hereto as Exhibits 3, 4, and 5, respectively, the Mission Application should have been found to be non-conforming with, at least, Statutory Review Criteria (1), (3), (4), (5), (6), (18a) and (20), based on the deficiencies discussed herein, including the aforementioned Exhibits 3, 4, and 5.

A. **Statutory Review Criterion (3) (N.C. Gen Stat. § 131E-183(a)(3)): Identification of the Population to be Served, Demonstration of Need, Access by Underserved.**

i. The North Carolina General Assembly has determined "that the financing of health care, particularly the reimbursement of health services rendered by health service facilities, limits the effect of free market competition and government regulation is therefore necessary to control costs, utilization, and distribution of new health service facilities . . ." (*See* N.C. Gen. Stat.

131E-175(1)) In addition, the legislature has found that "the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services. (Id. at (4)). As result of these and other findings, the CON laws require persons wishing to offer a new institutional health service in North Carolina to first, among other things, demonstrate the need for the proposed project.

ii. Mission failed in its application to reasonably demonstrate the need for the proposed project and services, a free-standing emergency department with 12 exam rooms, one CT scanner, one ultrasound machine, one unit of x-ray equipment, laboratory services, and pharmacy services. (*See* Mission Application, p. 35) Mission's proposed service area and patient origin projections are unreasonable and failed to account for the existence of two existing health facilities, AdventHealth Hendersonville and Pardee, which are located within Mission's proposed service area, which are often closer in proximity to the patients that Mission proposes to serve, and which are not facing capacity constraints. Specifically, the Mission Application failed to demonstrate the need for its proposed project, particularly given that there are two acute care hospitals in Henderson County and one hospital in Haywood County, relatively close to Mission's proposed FSED's in Arden and Candler, respectively, yet there are no acute care hospitals in Madison or Yancey Counties to the North, which comprise a greater percentage of ED referrals to Mission than does Henderson County. (*See* Petitioner's Public Comments, Exhibit 3, p. 7-8) Similarly, although Mission claimed that it receives "high [ED] referral volume from AdventHealth", in fact, AdventHealth's referrals to Mission, expressed as a percentage of its emergency department volume, represented only 1.7% in 2020 and 1.4% in 2021. (*Id.*, p. 9; *Citing,* Mission Application, p. 48) In addition, although Mission claimed it experienced significant growth in ED volume from

2020-2021, the Mission Application failed to demonstrate a trend of historical growth in its own ED services, with a 2017-2021 CAGR of only 0.1%. (See Petitioner's Public Comments, p. 11 (*Citing*, Mission Application, pp. 40 and 54))

iii. Although Mission cited capacity constraints at existing providers as one basis for supporting the need for its proposed project, there are no capacity constraints at the emergency departments of AdventHealth Hendersonville, Pardee, or Haywood Regional. This is reflected by the absence of any growing trend in ED utilization at Mission, indicating that there is no overwhelming evidence of capacity constraints at Mission or other existing ED service providers. Indeed, as Pardee stated in its Public Comments, following the standards of the American College of Emergency Physicians and based on the capacity of existing emergency departments in the proposed service area, the available capacity at Mission Hospital, and the historical utilization of existing health service facilities, the proposed service area currently has a surplus of 10 emergency department exam rooms. This surplus will increase to a surplus of 22 emergency department exam rooms if the 12 exam rooms proposed in the Mission Application are developed. (*See* Pardee's Public Comments, Exhibit 4, p. 5).

iv. The emergency department growth rates projected in the Mission Application are overstated and unsupported. Mission forecasts that utilization at the proposed project will grow by 6.1 percent annually in 2026 and 2027, a growth rate that is substantially higher than the one-year growth experienced by Mission and one that yields a compound annual growth rate ("CAGR") significantly higher than Mission's historical CAGR. (*Id.* at 6-7 (citing Mission Application, p. 54) As Petitioner noted in its Public Comments, "Mission's assumed Henderson County market share increases result in an overall projected CAGR of 8.2% during 2021-2027, which is nearly eight times higher than its actual CAGR during 2017-2019. The only way Mission

can achieve this feat is by taking ED market share from AdventHealth Hendersonville and Pardee Hospital." (Petitioner's Public Comments, p. 17) Yet, as was noted above, neither AdventHealth Hendersonville nor Pardee are experiencing capacity constraints.

v. In addition, the market share growth forecast in the Mission Application was the same market share gain that Mission projected in Project ID# B-12093-21, Mission's nearly identical CON application to develop a FSED in Arden, North Carolina in 2021 (the "Prior Mission FSED Application"). The Agency denied the Prior Mission FSED Application, in part, because Mission did not "provide a reasonable basis for how it determined the incremental market share growth of 0.5% for low acuity patients and 0.1% for high acuity patients [from project year 2 to project year 3], other than stating 'greater incremental market share in ZIP codes that are closer in proximity to the proposed FSED and lower incremental market share in ZIP codes close in proximity to Mission's main ED or close to the other existing hospital EDs.'" (Pardee's Public Comments, p. 8) Given that the Mission Application uses substantially similar market share forecasts as the Prior Mission Application, the Mission Application should have been found non-conforming with Statutory Review Criteria 3 and found unapprovable for the reasons stated by the Agency in its review of the Prior Mission Application.

vi. The Mission Application projects an unreasonably high percentage of high acuity patients, ranging from 13-14 percent, which is substantially higher than the percentage of high acuity patients served by similar HCA FSEDs in Tennessee, data about which were included in the Figure 15 of the Mission Application. (*Id.* at 10; *See also*, Mission Application, p. 58) The projected growth rate is also more than two time higher than Mission's actual ED utilization. (*See* Petitioner's Public Comments, p. 16) Yet Mission provided no data to support these unreasonably high projections of high acuity patients.

vii. As Pardee noted in its Public Comments, in both the Mission Application and the Prior Mission Application, Mission utilized the same service area, incremental market share growth rates, and patient shifts. (Pardee's Public Comments, p. 11) Despite using the same underlying methodology and patient origin, the projected payer mix changed substantially. The most notable increases were in services provided to traditionally underserved groups (Medicare, Medicaid, and charity care) offset by a substantial decrease (over 14%) in services reimbursed by insurance. However, Mission provided no basis or explanation for the projected change in payor mix, and it provided no explanation or support for the validity of the actual payor mix in the Mission Application, undermining and casting further doubt on the credibility of the financial projections contained in the Mission Application.

viii. On the basis of the foregoing issues, as well as other faulty assumptions discussed herein and in the public comments of Petitioner, Pardee, and Haywood Regional, and as otherwise may be shown during discovery and at the contested case hearing, the need methodology and utilization projections provided in the Mission Application were not reasonable and were not supported by credible assumptions or facts. For these reasons, the Mission Application should have been found nonconforming with Statutory Review Criteria (1) and (3).

B. **Statutory Review Criterion (4) (N.C. Gen Stat. § 131E-1 83(a)(4)): Demonstration that Least Costly or Most Effective Alternative has been Proposed.**

i. Mission failed to adequately demonstrate the need for the proposed services under Statutory Review Criterion (3). A proposal that is not needed cannot be the most effective alternative. Consequently, the application is, and should have been found by the Agency, nonconforming to Statutory Review Criterion (4). In addition, Mission failed to demonstrate that developing a new FSED in Arden is the most effective alternative means of increasing access to

Mission's emergency services. As was discussed in Petitioner's Public Comments, Mission claimed that the proposed FSED in Arden is needed to relieve capacity constraints experienced in Mission's main campus ED due to volume, acuity, operational constraints, and bed capacity constraints. (*See* Petitioner's Public Comments, p. 18; Mission Application, p. 44) However, while there are two existing acute care hospitals providing emergency services in Henderson County to the south (Pardee and AdventHealth Hendersonville), and one hospital in Haywood County to the west (Haywood Regional Medical Center), there are no other acute care hospitals in Madison and Yancey Counties to the north and northeast. Further, Mission's historical patient origin for emergency services indicates that Madison County alone comprises a comparatively higher share of Mission's ED visit volume than does Henderson County. (*See* Petitioner's Public Comments, pp. 18-19; *See also*, Mission Application, p. 40) Residents of Madison and Yancey Counties must travel 21 and 37 miles, respectively, to access Mission's existing emergency facilities, while residents of Henderson County have much closer access to two acute care providers and to Mission, to the north. (*See* Petitioner's Public Comments. at 19)

ii. The unnecessary duplication of existing health services and facilities is not, and cannot reasonably be considered, the least costly or the most cost-effective alternative. Rather, such unnecessary duplication results in "costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services." (*See* N.C. Gen. Stat. 131E-175(4))

C. **Statutory Review Criterion (5) (N.C. Gen Stat. § 131E-183(a)(5)): Immediate and Long-Term Financial Feasibility.**

Although the financial feasibility of the proposed FSED is directly impacted by the utilization, Mission's projected utilization was not based on reasonable and adequately supported assumptions.

Because the utilization projected in the Mission Application was unsupported and unreasonable, it follows that the assumptions used by Mission in preparation of the pro forma financial statements were not reliable. Thus, Mission failed to show the immediate and long-term financial feasibility of the proposed project. In addition, because Mission failed to demonstrate the need for its proposed project under Statutory Review Criterion (3), Mission also failed to demonstrate that the financial feasibility of the proposal is based upon reasonable projections of costs and charges. Consequently, the application was and should have been found by the Agency to be not conforming to this criterion, as Mission failed to demonstrate the immediate and long-term financial of the proposed project in the Mission Application.

D. **Statutory Review Criterion (6) (N.C. Gen Stat. § 131E-1 83(a)(6)): Project demonstrates no unnecessary duplication of service capabilities or facilities.**

Mission failed to adequately demonstrate the need for the proposed services pursuant to Statutory Review Criterion (3), and for that reason, and others discussed herein, also failed to adequately demonstrate that its proposal will not result in an unnecessary duplication of existing or approved emergency department services. Indeed, as was noted above, under ACEP standards, there is a surplus of emergency department capacity in the proposed service area. (*See* Pardee's Public Comments, p. 5). As was also discussed above, although there are two acute care hospitals with emergency departments in Henderson County to the south and one acute care hospital with an emergency department in Haywood County to the west, there are no other acute care hospitals or emergency departments in Madison or Yancey County to the north and northeast. Mission's proposed service area includes zip codes in southern Buncombe County and northern Henderson County that are presently served by AdventHealth and Pardee. Yet Mission failed to demonstrate that there are capacity constraints at these existing health service facilities, or at its own main

campus, which experienced a 45 percent increase in emergency department capacity in 2020. (*See* Pardee Comments, p. 13) In addition, the proposed market share gains in the respective zip codes are neither reasonable nor supported and would result in the consolidation of Mission's monopoly over acute care services in the region. The proposed FSED will unnecessarily duplicate emergency services in the service area. Therefore, the application was, and should have been found by the Agency, nonconforming to Criterion (6).

E. **Statutory Review Criterion (18a) (N.C. Gen Stat. § 131E-183(18a)): Positive Competitive Impact, Cost Effectiveness, Quality, and Access.**

Mission failed to demonstrate that its proposed FSED would result in a positive competitive impact on cost-effectiveness, quality, and access because, among other reasons, Mission failed to show: (i) the need for the project among the population to be served; (ii) that the proposal would not unnecessarily duplicate existing and approved health services; and (iii) that the financial projections were based on reasonable assumptions. In addition, and as was previously described, Mission is currently the subject of a class action lawsuit alleging that Mission has acted in restraint of trade and that it has unlawfully monopolized the provision of inpatient general acute care services in the region. (*See* **Exhibit 6**) The actions alleged in the complaint in that lawsuit, and Mission's status as a monopolist in the region, have a direct negative impact on competition, cost-effectiveness, quality, and access. The CON Applications submitted by Mission to develop FSEDs in Arden and in Candler, close to three existing acute care service providers and to Mission's own ED, and further away from relatively underserved Yancy and Madison Counties where Mission faces no market competition, strongly suggest that Mission is targeting existing providers to duplicate their services, starve them of resources, and increase the scope and range of the monopoly that it currently holds. Rather than fostering a positive competitive impact, the FSED proposed in the Arden

Application, as well as the FSED proposed in Candler, would further entrench Mission's monopoly over acute care services in the region. As is discussed below, the outpouring of complaints from the community following Mission's conversion to a for-profit business and, in particular, following HCA's acquisition of Mission, make clear that the perpetuation of Mission's monopoly has been detrimental to the community. Based on the foregoing, the Mission Application was, and should have been found by the Agency, nonconforming with Statutory Review Criterion (18a).

F. **Statutory Review Criterion (20) (N.C. Gen Stat. § 13lE-l 83(20)): Demonstration that Quality Care has been Provided in the Past.**

As was noted in Petitioner's Public Comments, the N.C. Department of Labor's Occupational Safety and Health Division performed three inspections in October and November 2021 at Mission Hospital which resulted in nearly $30,000 of civil penalties. Mission Hospital staff have also been vocal regarding their safety concerns. In June and September 2021 and February 2022, the labor union representing registered nurses at Mission Hospital staged protests to call attention what it called "patient safety and unsafe working conditions" at Mission Hospital. Among other complaints, the National Nurses Organizing Committee of National Nurses United asserted that Mission Hospital scheduled symptomatic, COVID-positive nurses to work at the hospital, and failed to provide nurses with adequate masks, gowns, gloves, and other personal protective equipment. Staff safety is equally as important as patient safety. (*See* Petitioner's Public Comments, pp. 22) In addition, the following examples of public complaints related to Mission, published in the local media, were noted by Petitioner in its Public Comments:

- https://mountainx.com/news/from-asheville-watchdog-profits-are-up-at-hca-ratings-are-down-at-mission/21 (05/01/21)

- https://avlwatchdog.org/attorney-generals-office-had-great-concerns-mission-hca-deal-was-rigged-from-the-beginning/ (03/15/22)
- https://my40.tv/news/local/lawsuit-against-mission-health-could-have-an-impact-nationwide-says-law-professor (09/15/21)
- https://www.facingsouth.org/2021/09/lawsuit-targets-hcas-hospital-monopoly-western-north-carolina (09/01/21)
- https://wlos.com/news/local/group-of-nc-residents-file-antitrust-lawsuit-against-hca-healthcare (08/10/21)
- https://www.citizen-times.com/story/news/2021/09/20/hundreds-complain-nc-attorney-general-ashevilles-hca-mission/8370318002 (6-9-21)
- https://www.beckershospitalreview.com/finance/north-carolina-ag-gets-116-complaints-about-mission-health.html (06/09/21)
- https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed (06/08/21)
- https://www.bpr.org/news/2021-05-21/quality-of-care-concerns-rise-at-mission-hospital (05-21-21)
- https://www.northcarolinahealthnews.org/2020/02/13/elected-officials-blast-hca-for-first-years-performance-at-mission/ (02/13/20)
- https://carolinapublicpress.org/29762/irate-crowd-voices-frustrations-with-medical-services-in-cashiers/ (01/29/20)
- https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/ (02/12/20)

The egregious deficiencies cited at Mission immediately preceding the submission of the Mission Application, as well as the sustained outpouring of public concern and complaints regarding the quality of Mission's services, by patients, providers, employees, and community members and leaders, render the application non-conforming to Criterion (20).

22. For the reasons set forth in the preceding paragraphs, and those contained in the Public Comments attached hereto, the Mission Application should have been found non-conforming with, at least, Statutory Review Criteria (1), (3), (4), (5), (6), (18a) and (20).

23. A CON application that fails to show consistency with, or that it is not in conflict with, the applicable Statutory Review Criteria is not approvable by the Agency. Therefore, because the Mission Application did not comply with one or more Statutory Review Criteria, the Mission Application was not approvable by the CON Section and should not have been approved.

24. In approving the Mission Application, the Agency exceeded its authority and jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily and capriciously and failed to act as required by law or rule. The Agency's failure to review the Mission Application in accordance with the CON law will result in the further entrenchment of Mission's monopoly over acute care and emergency services in the region, to the detriment of other service providers and patients, and has and will substantially prejudice Petitioner's rights. Petitioner is an "affected person" under N.C. Gen. Stat. § 131E-188(c) and a "person aggrieved" within the meaning of N.C. Gen. Stat. §§ 150B-2(6) and 150B-23 and its rights have been substantially prejudiced by the CON Decision conditionally approving the Mission Application, which was not approvable by the Agency and which further erodes market competition in the service area by consolidating the monopoly that Mission has over acute care services in the service area, and in such other ways as may be shown during discovery and during the contested case hearing of this matter. Petitioner is

entitled to a contested case hearing pursuant to N.C. Gen. Stat. § 131E-188(a) and the North Carolina Administrative Procedure Act.

WHEREFORE, Petitioner hereby respectfully requests:

1. That Petitioner be granted a contested case hearing on the CON Section's decision to approve the Mission Application, and that such hearing be recorded and transcribed by an official court reporter;

2. That the Administrative Law Judge enter a final decision that the Mission Application failed to conform with all applicable Statutory Review Criteria and that the Agency erred in conditionally approving the Mission Application;

3. That the Administrative Law Judge enter a final decision that the CON Section's decision on the Mission Application be reversed and that Mission not be allowed to develop the FSED pursuant to its application;

4. For such other and further relief to Petitioner as may be deemed just and proper.

This the 23rd day of June 2022.

WYRICK ROBBINS YATES & PONTON LLP

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CERTIFICATE OF SERVICE

The undersigned counsel hereby certifies that a copy of the foregoing PETITIONER FLETCHER HOSPITAL, INC. d/b/a ADVENTHEALTH HENDERSONVILLE'S PETITION FOR CONTESTED CASE HEARING was served via U.S. Certified Mail on the following:

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NC Department of Health and Human Services
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Micheala Mitchell, Chief
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Healthcare Planning and Certificate of Need Section
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This the 23rd day of June 2022.

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STATE OF NORTH CAROLINA
COUNTY OF BUNCOMBE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS

FLETCHER HOSPITAL, INC. d/b/a ADVENTHEALTH HENDERSONVILLE,

Petitioner,

v.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF HEALTH SERVICE REGULATION HEALTHCARE PLANNING AND CERTIFICATE OF NEED SECTION,

Respondent.

22 DHR ______

PETITIONER FLETCHER HOSPITAL, INC. d/b/a ADVENTHEALTH HENDERSONVILLE'S PETITION FOR CONTESTED CASE HEARING

Petitioner Fletcher Hospital, Inc. d/b/a AdventHealth Hendersonville ("AdventHealth Hendersonville" or "Petitioner"), hereby files this petition for a contested case hearing pursuant to N.C. Gen. Stat. § 131E-188 and 150B-23 and to 26 N.C.A.C. 3.0103, challenging the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Healthcare Planning and Certificate of Need Section's (the "CON Section" or "Agency") May 24, 2022 decision to conditionally approve the Certificate of Need ("CON") application filed by MH Mission Hospital, LLLP ("Mission" or the "Applicant") to develop a freestanding emergency department ("FSED") in **Candler**, Buncombe County, North Carolina and identified by Project ID B-12192-22 (the "Mission Application" or the "Candler Application"). A copy of the Mission Application with its associated exhibits is attached hereto as **Exhibit 1**. A copy of the Conditional Approval of the

Mission Application and the Required State Agency Findings related to the Agency's review of the Mission Application (collectively, the "CON Decision") are attached hereto as **Exhibit 2**.

In support of this petition, Petitioner states the following:

1. Petitioner Fletcher Hospital, Inc. d/b/a AdventHealth Hendersonville is an acute care hospital located at 100 Hospital Drive, Hendersonville, Henderson County, North Carolina, 28792. AdventHealth Hendersonville is licensed by the Acute and Home Care Licensure and Certification Section. AdventHealth Hendersonville has 62 licensed acute care beds and 41 psychiatry beds, and offers a spectrum of acute care services, including emergency medical care through its emergency department.

2. Respondent CON Section is an agency of the State of North Carolina authorized and required to review CON applications under the Article 9 of Chapter 131E of the North Carolina General Statutes (N.C. Gen. Stat. § 131E-175 *et seq.*, the "CON law").

3. Mission proposed in the Mission Application to develop a new freestanding emergency department to be located at the intersection of Smokey Park Highway and Brookside Circle, Candler, Buncombe County, North Carolina 28715 and licensed under Mission Hospital.

4. Mission's total project capital expenditure is $14,749,500. (*See e.g.*, Mission Application, Application Fee Sheet, Form F 1.1, Projected Capital Cost) This amount exceeds the statutory threshold of $4,000,000, and therefore the proposed project would constitute a "New Institutional Health Service" under N.C. Gen. Stat. § 131E-176(16)(b).

5. Pursuant to N.C. Gen. Stat. § 131E-175(7), "the general welfare and protection of lives, health, and property of the people of [North Carolina] require that new institutional health services to be offered within this State [are] subject to review and evaluation as to need, cost of service, accessibility to services, quality of care, feasibility, and other criteria as determined by

provisions of this Article or by the North Carolina Department of Health and Human Services pursuant to provisions of this Article prior to such services being offered or developed in order that only appropriate and needed institutional health services are made available in the area to be served."

6. The Agency is required, pursuant to N.C. Gen. Stat. § 131E-183(a) to review each CON application utilizing the criteria outlined in that subsection (each a "Statutory Review Criterion" and, collectively, the "Statutory Review Criteria") and to determine that an application is either consistent with or not in conflict with the criteria set forth therein before a CON for the proposed project may be issued.

7. In assessing the Mission Application, the CON Section erroneously determined that the Mission Application satisfied all applicable Statutory Review Criteria and was therefore approvable by the Agency.

8. As is discussed hereinbelow and as was set forth in the Public Comments on the Mission Application filed by AdventHealth Hendersonville (**Exhibit 3**), Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital ("Pardee", **Exhibit 4**), and Haywood Regional Medical Center ("Haywood Regional", **Exhibit 5**), which are incorporated herein by reference, Mission failed to demonstrate that the proposed project conforms with all of the Statutory Review Criteria set forth in N.C. Gen. Stat. §§ 131E-183(a), including the Statutory Review Criteria set forth at N.C. Gen. Stat. §§ 131E-183(a)(1), (3), (4), (5), (6), (18a), and (20). Among other deficiencies in the Mission Application, Mission failed to demonstrate: the need for the proposed project among the population that the Mission Application proposes to serve; that its proposal is the least costly or most effective alternative; that its need methodology was based upon reasonable assumptions and that the project will be feasible in light of the numerous unsupported assumptions and errors; that its proposed project would not unnecessarily duplicate existing health

services; that the proposed services would enhance competition and have a positive impact on the cost-effectiveness, quality, and access to the services proposed; and that quality care has been provided by the applicant in the past.

9. Further, the Agency's approval of the Mission Application further entrenches Mission as a monopolistic presence offering acute care services in and around Buncombe County, North Carolina. As is discussed herein, Mission is currently the subject of a class-action lawsuit brought pursuant to Article 1, § 34 of the North Carolina Constitution (stating that: "Perpetuities and monopolies are contrary to the genius of a free state and shall not be allowed.") and pursuant to the state's antitrust and consumer protection statute (N.C. Gen. stat. § 75-1 *et seq*.). The complaint alleges that Mission has acted, and that it continues to act, in restraint of trade, and that Mission has unlawfully monopolized the provision of inpatient general acute care services in the region. (*See* **Exhibit 6**)

10. This petition challenges the CON Decision conditionally approving the Mission Application.

11. Pursuant to N.C. Gen. Stat. § 131E-188(a), any "affected person" is entitled to a contested case hearing under the North Carolina Administrative Procedure Act, by filing a petition for such a hearing. Similarly, N.C. Gen. Stat. § 150B-23 and 26 N.C. Admin. Code 3.0103 provide that "any person aggrieved," as defined by N.C. Gen. Stat. § 150B-2(6), may commence a contested case by filing a petition with the Office of Administrative Hearings.

12. Petitioner is an "affected person" under N.C. Gen. Stat. § 131E-188(c) because Petitioner is, among other things, a person "who provides services, similar to the services under review, to individuals residing within the service area and the geographic area to be served by the proposed project. Petitioner is also a "person aggrieved" within the meaning of N.C. Gen. Stat. §

150B-2(6) because the CON Decision approving the Mission Application directly or indirectly affects Petitioner substantially in its person and property, adversely affects the rights of Petitioner, and substantially prejudices Petitioner for reasons including, but not limited to, all of the comments attached to this Petition, by allowing the duplication of services in the relevant geographic area, including services provided in such area by Petitioner, and by permitting and enabling the further entrenchment of Mission's monopoly over acute care services within and surrounding the proposed service area.

13. As set forth in the Comments filed as exhibits to this Petition, Mission took on its current form pursuant to a Certificate of Public Advantage. That Certificate, for a period of time, made Mission's monopoly compliant with applicable law. That Certificate is no longer in existence, yet Mission's monopoly continues unabated, and its monopoly power is no longer compliant with applicable law. The Mission Application represents an attempt to not only continue, but to expand, this monopoly power.

14. As discussed above, Mission is currently the subject of a lawsuit under the North Carolina Constitution and the North Carolina antitrust statutes alleging that Mission has routinely and repeatedly acted in restraint of trade and that it has unlawfully monopolized the provision of inpatient general acute care services in the region. While Mission certainly deserves the right to defend itself against these allegations, the project proposed in the Mission Application is itself a clear example of the very anticompetitive conduct of which Mission stands accused. Namely, the project is designed to funnel more patients to Mission's acute care facilities in Asheville, in part, by diverting patients away from existing emergency department service providers in the area, in an attempt to further consolidate Mission's control over the market. This is made more clear by Mission's concurrent submission of a proposal to develop an FSED in Arden, Buncombe County,

North Carolina (the "Arden Application"). The Arden Application, identified by project ID number B-012191-22, was approved by the Agency on May 24, 2022, concurrently with the Candler Application, and is the subject of a separate petition for contested case hearing. The projected ED volumes, growth rates, and market shares in the Mission Application, as well as the location of the proposed facilities in Arden and Candler—which are closer in proximity to existing emergency departments and urgent care centers and much further away from the northern portions of the county where a greater need exists for emergency services—make clear that Mission is targeting existing providers to duplicate their services, starve them of resources, and increase the scope and range of the monopoly that it currently holds.

15. Mission's monopoly over acute care services will be further supported by development of the projects proposed in the Mission Application and in the Candler Application. Mission's position as a monopolist in this market is illustrated, in part, by the projection that, following the approval and development of the FSEDs proposed by Mission in Candler and Candler, Mission will control 96.7% of the projected Emergency Department market share in portions of the proposed service area by the Project Year 3. (*See* Public Comments of AdventHealth, Exhibit 3, p. 5) For reference, the North Carolina Business Court has noted that "[g]enerally speaking, a 70% to 75% market share is necessary to sustain a monopolization claim." (*See* Sitelink Software, LLC v. Red Nova Labs, Inc., No. 14 CVS 9922 (N.C. Super. June 14, 2016) (*citing*, Advanced Health-Care Servs., Inc. v. Radford Cmty. Hosp., 910 F.2d 139, 143 (4th Cir. 1990)) Petitioner's rights have also been substantially prejudiced as a matter of law by the Agency's failure to apply the Statutory Review Criteria, the Agency's reliance on the unsupported assumptions and errors in applicant's need methodology, the Agency's approval of a proposed project that will result in the further entrenchment of Mission's monopoly over acute care services within the proposed service area, and

by other Agency error as set forth herein and in the public comments attached hereto, and as may be shown during discovery and at the contested case hearing. Thus, for the reasons set forth herein, the CON Decision approving the Mission Application has deprived Petitioner of property and has otherwise substantially prejudiced Petitioner's rights within the meaning of N.C. Gen. Stat. § 150B-23(a).

16. As Petitioner is an "affected person" under N.C. Gen. Stat. § 131E-188(c), and is also a "person aggrieved" within the meaning of N.C. Gen. Stat. §§ 150B-2(6) and 150B-23, that has had its rights substantially prejudiced by the CON Decision conditionally approving the Mission Application, Petitioner is entitled to a contested case hearing pursuant to N.C. Gen. Stat. § 131E-188(a) and pursuant to the North Carolina Administrative Procedure Act.

17. This Petition is timely filed in accordance with N.C. Gen. Stat. § 131E-188(a) and N.C. Gen. Stat. § 150B-23(f), having been filed within thirty (30) days of the May 24, 2022, CON Decision.

18. Petitioner has otherwise complied with all conditions precedent to the filing of a petition for a contested case hearing. Pursuant to N.C. Gen. Stat. § 131E-188(a1), AdventHealth Hendersonville has deposited a bond in the amount of $50,000—an amount equal to the lesser of $50,000 or five percent (5%) of the cost of the proposed new institutional health service that is the subject of this Petition—with the Clerk of Superior Court of Buncombe County. A copy of Petitioner's Deposit of Appeal Bond, filed with and acknowledged by the Clerk of Superior Court of Buncombe County, is attached hereto as **Exhibit 7** and is incorporated herein by reference.

19. Based upon the knowledge of Petitioner at the present time, additional facts supporting this petition are set forth herein, including without limitation the exhibits attached hereto. However, after Petitioner has had an opportunity to conduct discovery—by deposition, document

request, interrogatory, or otherwise—a reasonable likelihood exists that Petitioner will become aware of other specific facts and additional relevant issues to be contested in this action, including but not limited to those showing additional substantial prejudice to Petitioner and agency error. Petitioner thus expressly reserves the right in any hearing to rely upon facts, issues, theories, or arguments not raised at this time that may be developed during discovery, at the hearing or otherwise, including but not limited to those showing violations of other Statutory Review Criteria or additional violations of the Statutory Review Criteria enumerated herein.

20. Without waiving the reservation of rights stated above, Petitioner maintains that, in conditionally approving the Mission Application, which did not comply with multiple Statutory Review Criteria, the CON Section has substantially prejudiced the rights of Petitioner, exceeded its authority and jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily and capriciously, and failed to act as required by law or rule in, *inter alia*, the ways set forth below.

21. Specifically, for the reasons set forth herein and those contained in the public comments of AdventHealth, Pardee, and Haywood Regional, attached hereto as Exhibits 3, 4, and 5, respectively, the Mission Application should have been found to be non-conforming with, at least, Statutory Review Criteria (1), (3), (4), (5), (6), (18a) and (20), based on the deficiencies discussed herein, including the aforementioned Exhibits 3, 4, and 5. .

A. **Statutory Review Criterion (3) (N.C. Gen Stat. § 131E-183(a)(3)): Identification of the Population to be Served, Demonstration of Need, Access by Underserved.**

i. The North Carolina General Assembly has determined "that the financing of health care, particularly the reimbursement of health services rendered by health service facilities, limits the effect of free market competition and government regulation is therefore necessary to control costs, utilization, and distribution of new health service facilities . . ." (*See* N.C. Gen. Stat.

131E-175(1)) In addition, the legislature has found that "the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services. (Id. at (4)). As result of these and other findings, the CON laws require persons wishing to offer a new institutional health service in North Carolina to first, among other things, demonstrate the need for the proposed project.

ii. Mission failed in its application to reasonably demonstrate the need for the proposed project and services, a free-standing emergency department with 12 exam rooms, one CT scanner, one ultrasound machine, one unit of x-ray equipment, laboratory services, and pharmacy services. (*See* Mission Application, p. 35) Mission's proposed service area and patient origin projections are unreasonable and failed to account for the existence of the existing emergency department service providers in and adjacent to the proposed service area, which are often closer in proximity to the patients that Mission proposes to serve, and which are not facing capacity constraints. Specifically, the Mission Application failed to demonstrate the need for its proposed project, particularly given that there are two acute care hospitals in Henderson County and one hospital in Haywood County, relatively close to Mission's proposed FSED's in Arden and Candler, respectively, yet there are no acute care hospitals in Madison or Yancey Counties to the North, which comprise a greater percentage of ED referrals to Mission than does Henderson or Haywood County. (*See* Petitioner's Public Comments, Exhibit 3, p. 5-6) Similarly, although Mission claimed that it receives "high [ED] referral volume from AdventHealth", in fact, AdventHealth's referrals to Mission, expressed as a percentage of its emergency department volume, represented only 1.7% in 2020 and 1.4% in 2021. (*Id.*, p. 7; *Citing*, Mission Application, p. 50) In addition, although Mission claimed it experienced significant growth in ED volume from 2020-2021, the Mission Application

failed to demonstrate a trend of historical growth in its own ED services, with a 2017-2021 CAGR of only 0.1%. (See Petitioner's Public Comments, p. 9 (*citing* figures from the Mission Application, pp. 39 and 55))

iii. Although Mission cited capacity constraints at existing providers as one basis for supporting the need for its proposed project, there are no capacity constraints at the emergency departments of AdventHealth Hendersonville, Pardee, or Haywood Regional. This is reflected by the absence of any growing trend in ED utilization at Mission, indicating that there is no overwhelming evidence of capacity constraints at Mission or other existing ED service providers. Indeed, as Pardee stated in its Public Comments, following the standards of the American College of Emergency Physicians and based on the capacity of existing emergency departments in the proposed service area, the available capacity at Mission Hospital, and the historical utilization of existing health service facilities, the proposed service area currently has a surplus of 10 emergency department exam rooms. This surplus will increase to a surplus of 22 emergency department exam rooms if the 12 exam rooms proposed in the Mission Application are developed. (*See* Pardee's Public Comments, Exhibit 4, p. 5).

iv. The emergency department growth rates projected in the Mission Application are overstated and unsupported. Mission forecasts that utilization at the proposed project will grow by 6.1 percent annually in 2026 and 2027, a growth rate that is substantially higher than the one-year growth experienced by Mission and one that yields a compound annual growth rate ("CAGR") significantly higher than Mission's historical CAGR. (*Id.* at 6-7 (citing Mission Application, p. 54) As Petitioner noted in its Public Comments, "[the Mission Application] page 57 states Mission experienced 11.9 percent growth in ED volume in the service area zip codes. On [Mission Application] page 64, Mission projected ED service area market in 2021 by applying its

11.9 percent growth to 2020 market volume. This projected growth is more than eight times the ED service area 2017-2019 CAGR of 1.4 percent . . ." (See Petitioner's Public Comments, p. 12)

v. The Mission Application provided no analysis or assumptions underlying its determinations of market share gains in the Candler Application beyond asserting "due to the presence of the proposed [FSED] and the increased access it will provide.". This is the same methodology Mission used in Project ID# B-12093-21, a nearly identical CON application to develop a FSED in Arden, North Carolina in 2021 (the "Prior Mission FSED Application"). The Agency denied the Prior Mission FSED Application, in part, because Mission did not "provide a reasonable basis for how it determined the incremental market share growth of 0.5% for low acuity patients and 0.1% for high acuity patients, other than stating 'greater incremental market share in ZIP codes that are closer in proximity to the proposed FSED and lower incremental market share in ZIP codes close in proximity to Mission's main ED or close to the other existing hospital EDs.'" (Pardee's Public Comments, p. 7) Given that the Mission Application uses substantially similar market share forecasts as the Prior Mission Application, the Mission Application should have been found non-conforming with Statutory Review Criteria 3 and found unapprovable for the reasons stated by the Agency in its review of the Prior Mission Application.

vi. On the basis of the foregoing issues, as well as other faulty assumptions discussed herein and in the public comments of Petitioner, Pardee, and Haywood Regional, and as otherwise may be shown during discovery and at the contested case hearing, the need methodology and utilization projections provided in the Mission Application were not reasonable and were not supported by credible assumptions or facts. For these reasons, the Mission Application should have been found nonconforming with Statutory Review Criteria (1) and (3).

B. **Statutory Review Criterion (4) (N.C. Gen Stat. § 131E-1 83(a)(4)): Demonstration that Least Costly or Most Effective Alternative has been Proposed.**

i. Mission failed to adequately demonstrate the need for the proposed services under Statutory Review Criterion (3). A proposal that is not needed cannot be the most effective alternative. Consequently, the application is, and should have been found by the Agency, nonconforming to Statutory Review Criterion (4). In addition, Mission failed to demonstrate that developing a new FSED in Candler is the most effective alternative means of increasing access to Mission's emergency services. As was discussed in Petitioner's Public Comments, Mission claimed that the proposed FSED in Candler is needed to relieve capacity constraints experienced in Mission's main campus ED due to volume, acuity, operational constraints, and bed capacity constraints. (*See* Petitioner's Public Comments, p. 16; Mission Application, p. 43) However, while there are two existing acute care hospitals providing emergency services in Henderson County to the south (Pardee and AdventHealth Hendersonville), and one hospital in Haywood County to the west (Haywood Regional Medical Center), there are no other acute care hospitals in Madison and Yancey Counties to the north and northeast. Further, Mission's historical patient origin for emergency services indicates that Madison County alone comprises a comparatively higher share of Mission's ED visit volume than does Henderson or Haywood Counties. (*See* Petitioner's Public Comments, pp. 16-17) Residents of Madison and Yancey Counties must travel 21 and 37 miles, respectively, to access Mission's existing emergency facilities, while the proposed facility in Candler is only 9.4 miles from Mission's main campus. (*See* Petitioner's Public Comments, p.17)

ii. The unnecessary duplication of existing health services and facilities is not, and cannot reasonably be considered, the least costly or the most cost-effective alternative. Rather, such unnecessary duplication results in "costly duplication and underuse of facilities, with the

availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services." (*See* N.C. Gen. Stat. 131E-175(4))

C. **Statutory Review Criterion (5) (N.C. Gen Stat. § 131E-183(a)(5)): Immediate and Long-Term Financial Feasibility.**

Although the financial feasibility of the proposed FSED is directly impacted by the utilization, Mission's projected utilization was not based on reasonable and adequately supported assumptions. Because the utilization projected in the Mission Application was unsupported and unreasonable, it follows that the assumptions used by Mission in preparation of the pro forma financial statements were not reliable. Thus, Mission failed to show the immediate and long-term financial feasibility of the proposed project. In addition, because Mission failed to demonstrate the need for its proposed project under Statutory Review Criterion (3), Mission also failed to demonstrate that the financial feasibility of the proposal is based upon reasonable projections of costs and charges. Consequently, the application was and should have been found by the Agency to be not conforming to this criterion, as Mission failed to demonstrate the immediate and long-term financial of the proposed project in the Mission Application.

D. **Statutory Review Criterion (6) (N.C. Gen Stat. § 13lE-l 83(a)(6)): Project demonstrates no unnecessary duplication of service capabilities or facilities.**

Mission failed to adequately demonstrate the need for the proposed services pursuant to Statutory Review Criterion (3), and for that reason, and others discussed herein, also failed to adequately demonstrate that its proposal will not result in an unnecessary duplication of existing or approved emergency department services. Indeed, as was noted above, under ACEP standards, there is a surplus of emergency department capacity in the proposed service area. (*See* Pardee's Public Comments, p. 5). As was also discussed above, although there are two acute care hospitals with

emergency departments in Henderson County to the south and one acute care hospital with an emergency department in Haywood County to the west, there are no other acute care hospitals or emergency departments in Madison or Yancey County to the north and northeast. Yet Mission failed to demonstrate that there are capacity constraints at these existing health service facilities, or at its own main campus, which experienced a 45 percent increase in emergency department capacity in 2020. Thus, "from 2019 to 2020, Mission's visits per emergency department room dropped from 1,606 to 1,012." (*See* Pardee Comments, pp. 12-13) In addition, the proposed market share gains projected in the Mission Application are neither reasonable nor supported and would result in the consolidation of Mission's monopoly over acute care services in the region. The proposed FSED will unnecessarily duplicate emergency services in the service area. Therefore, the application was, and should have been found by the Agency, nonconforming to Criterion (6).

E. **Statutory Review Criterion (18a) (N.C. Gen Stat. § 131E-1 83(18a)): Positive Competitive Impact, Cost Effectiveness, Quality, and Access.**

Mission failed to demonstrate that its proposed FSED would result in a positive competitive impact on cost-effectiveness, quality, and access because, among other reasons, Mission failed to show: (i) the need for the project among the population to be served; (ii) that the proposal would not unnecessarily duplicate existing and approved health services; and (iii) that the financial projections were based on reasonable assumptions. In addition, and as was previously described, Mission is currently the subject of a class action lawsuit alleging that Mission has acted in restraint of trade and that it has unlawfully monopolized the provision of inpatient general acute care services in the region. (*See* **Exhibit 6**) The actions alleged in the complaint in that lawsuit, and Mission's status as a monopolist in the region, have a direct negative impact on competition, cost-effectiveness, quality, and access. The CON Applications submitted by Mission to develop FSEDs in Arden and Candler,

close to three existing acute care service providers and to Mission's own ED, and further away from relatively underserved Yancy and Madison Counties where Mission faces no market competition, strongly suggest that Mission is targeting existing providers to duplicate their services, starve them of resources, and increase the scope and range of the monopoly that it currently holds. Rather than fostering a positive competitive impact, the Mission's proposed FSED, as well as the FSED in Arden, would further entrench Mission's monopoly over acute care services in the region. As is discussed below, the outpouring of complaints from the community following Mission's conversion to a for-profit business and, in particular, following HCA's acquisition of Mission, make clear that the perpetuation of Mission's monopoly has been detrimental to the community. Based on the foregoing, the Mission Application was, and should have been found by the Agency, nonconforming with Statutory Review Criterion (18a).

F. **Statutory Review Criterion (20) (N.C. Gen Stat. § 13lE-l 83(20)): Demonstration that Quality Care has been Provided in the Past.**

As was noted in Petitioner's Public Comments, the N.C. Department of Labor's Occupational Safety and Health Division performed three inspections in October and November 2021 at Mission Hospital which resulted in nearly $30,000 of civil penalties. Mission Hospital staff have also been vocal regarding their safety concerns. In June and September 2021 and February 2022, the labor union representing registered nurses at Mission Hospital staged protests to call attention what it called "patient safety and unsafe working conditions" at Mission Hospital. Among other complaints, the National Nurses Organizing Committee of National Nurses United asserted that Mission Hospital scheduled symptomatic, COVID-positive nurses to work at the hospital, and failed to provide nurses with adequate masks, gowns, gloves, and other personal protective equipment. Staff safety is equally as important as patient safety. *See* Petitioner's Public Comments at p. 19) In

addition, the following examples of public complaints related to Mission, published in the local media, were noted by Petitioner in its Public Comments:

- https://mountainx.com/news/from-asheville-watchdog-profits-are-up-at-hca-ratings-are-down-at-mission/21 (05/01/21)
- https://avlwatchdog.org/attorney-generals-office-had-great-concerns-mission-hca-deal-was-rigged-from-the-beginning/ (03/15/22)
- https://my40.tv/news/local/lawsuit-against-mission-health-could-have-an-impact-nationwide-says-law-professor (09/15/21)
- https://www.facingsouth.org/2021/09/lawsuit-targets-hcas-hospital-monopoly-western-north-carolina (09/01/21)
- https://wlos.com/news/local/group-of-nc-residents-file-antitrust-lawsuit-against-hca-healthcare (08/10/21)
- https://www.citizen-times.com/story/news/2021/09/20/hundreds-complain-nc-attorney-general-ashevilles-hca-mission/8370318002 (6-9-21)
- https://www.beckershospitalreview.com/finance/north-carolina-ag-gets-116-complaints-about-mission-health.html (06/09/21)
- https://wlos.com/news/local/josh-stein-hca-a-concerning-number-attorney-general-describes-recent-mission-health-complaints-filed (06/08/21)
- https://www.bpr.org/news/2021-05-21/quality-of-care-concerns-rise-at-mission-hospital (05-21-21)
- https://www.northcarolinahealthnews.org/2020/02/13/elected-officials-blast-hca-for-first-years-performance-at-mission/ (02/13/20)

- https://carolinapublicpress.org/29762/irate-crowd-voices-frustrations-with-medical-services-in-cashiers/ (01/29/20)
- https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/ (02/12/20)

The egregious deficiencies cited at Mission immediately preceding the submission of the Mission Application, as well as the sustained outpouring of public concern and complaints regarding the quality of Mission's services, by patients, providers, employees, and community members and leaders, render the application non-conforming to Criterion (20).

22. For the reasons set forth in the preceding paragraphs and those contained in the Public Comments attached hereto, the Mission Application should have been found non-conforming with, at least, Statutory Review Criteria (1), (3), (4), (5), (6), (18a) and (20).

23. A CON application that fails to show consistency with, or that it is not in conflict with, the applicable Statutory Review Criteria is not approvable by the Agency. Therefore, because the Mission Application did not comply with one or more Statutory Review Criteria, the Mission Application was not approvable by the CON Section and should not have been approved.

24. In approving the Mission Application, the Agency exceeded its authority and jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily and capriciously and failed to act as required by law or rule. The Agency's failure to review the Mission Application in accordance with the CON law will result in the further entrenchment of Mission's monopoly over acute care and emergency services in the region, to the detriment of other service providers and patients, and has and will substantially prejudice Petitioner's rights. Petitioner is an "affected person" under N.C. Gen. Stat. § 131E-188(c) and a "person aggrieved" within the meaning of N.C. Gen. Stat. §§ 150B-2(6) and 150B-23 and its rights have been substantially prejudiced by the CON

Decision conditionally approving the Mission Application, which was not approvable by the Agency and which further erodes market competition in the service area by consolidating the monopoly that Mission has over acute care services in the service area, and in such other ways as may be shown during discovery and during the contested case hearing of this matter. Petitioner is entitled to a contested case hearing pursuant to N.C. Gen. Stat. § 131E-188(a) and the North Carolina Administrative Procedure Act.

WHEREFORE, Petitioner hereby respectfully requests:

1. That Petitioner be granted a contested case hearing on the CON Section's decision to approve the Mission Application, and that such hearing be recorded and transcribed by an official court reporter;

2. That the Administrative Law Judge enter a final decision that the Mission Application failed to conform with all applicable Statutory Review Criteria and that the Agency erred in conditionally approving the Mission Application;

3. That the Administrative Law Judge enter a final decision that the CON Section's decision on the Mission Application be reversed and that Mission not be allowed to develop the FSED pursuant to its application;

4. For such other and further relief to Petitioner as may be deemed just and proper.

This the 23rd day of June 2022.

WYRICK ROBBINS YATES & PONTON LLP

By: /s/ Frank S. Kirschbaum

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Counsel for Petitioner Fletcher Hospital, Inc. D/B/A AdventHealth Hendersonville

CERTIFICATE OF SERVICE

The undersigned counsel hereby certifies that a copy of the foregoing PETITIONER FLETCHER HOSPITAL, INC. d/b/a ADVENTHEALTH HENDERSONVILLE'S PETITION FOR CONTESTED CASE HEARING was served via U.S. Certified Mail on the following:

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NC Department of Health and Human Services
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Adams Building – Room 154
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Raleigh, North Carolina 27699-2001

Micheala Mitchell, Chief
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Division of Healthcare Service Regulation
Healthcare Planning and Certificate of Need Section
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This the 23rd day of June 2022.

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Filed Jun 23, 2022 3:56 PM Office of Administrative Hearings

STATE OF NORTH CAROLINA BUNCOMBE COUNTY	IN THE OFFICE OF ADMINISTRATIVE HEARINGS 22 DHR ______
HENDERSON COUNTY HOSPITAL CORPORATION d/b/a PARDEE HOSPITAL, **Petitioner,** v. **NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, HEALTHCARE PLANNING AND CERTIFICATE OF NEED SECTION,** **Respondent.**	**PETITION FOR CONTESTED CASE HEARING**

Pursuant to N.C. Gen. Stat. § 131E-188 and 26 N.C.A.C. 3.0103, Petitioner Henderson County Hospital Corporation d/b/a Pardee Hospital ("Pardee") hereby files this petition for contested case hearing to challenge the May 24, 2022 decision of the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Healthcare Planning and Certificate of Need Section ("CON Section" or "the Agency") to approve the certificate of need application filed by MH Mission Hospital LLLP ("Mission") proposing to develop a new satellite freestanding emergency department under Mission Hospital's license in Arden in Buncombe County, close to the Henderson County line ("Agency Decision"). In support of its petition, Pardee states the following:

1. Petitioner Henderson County Hospital Corporation is a North Carolina non-profit corporation with a principal place of business at 800 North Justice Street, Hendersonville, North Carolina 28791.

2. Respondent Agency is the operating section within the Division of Health Service Regulation that administers the Certificate of Need Act ("CON Act"), N.C. Gen. Stat. Chapter 131E, Article 9.

3. On or around February 15, 2022, Mission filed a CON application to establish a new satellite freestanding emergency department ("FSED") under Mission Hospital's license in Arden in Buncombe County, close to the Henderson County line ("FSED Arden Application"). The application was assigned Project ID # B-12191-22 and FID # 220170.

4. Pardee submitted written comments opposing Mission's FSED Arden Application. A copy of Pardee's written comments is attached as Exhibit A and incorporated herein by reference.

5. AdventHealth Hendersonville ("AdventHealth") submitted written comments opposing Mission's FSED Arden Application. A copy of AdventHealth's written comments is attached as Exhibit B.

6. Haywood Regional Medical Center submitted written comments opposing Mission's FSED Arden Application. A copy of Haywood Regional Medical Center's written comments is attached as Exhibit C.

7. On May 24, 2022, the Agency issued a decision approving Mission's FSED Arden Application. A copy of the Agency decision letter is attached as Exhibit D.

8. On May 24, 2022, the CON Section also issued its Agency Findings concerning its decision to approve Mission's FSED Arden Application. A copy of the Agency Findings is attached as Exhibit E.

9. This petition is timely filed in accordance with N.C. Gen. Stat. § 131E-188 and the North Carolina Rules of Civil Procedure because it was filed within thirty (30) days of the Agency Decision, which was dated May 24, 2022.

10. Pursuant to N.C. Gen. Stat. § 131E-188(a1), Pardee deposited a cash bond in the amount of $50,000.00 with the Clerk of Superior Court of Buncombe County prior to filing the petition.

11. "Person" is defined in the CON Act as "[a]n individual; a trust or estate; a partnership; a corporation, including associations, joint stock companies, and insurance companies; the State; or a political subdivision or agency or instrumentality of the State." Pardee is a corporation and, therefore, is a person under the CON Act.

12. Pardee is an affected person pursuant to N.C. Gen. Stat. § 131E-188 and is entitled to file this petition and to have a contested case hearing because it is a person who currently provides emergency services, similar to the services proposed by Mission, to individuals residing within the service area and the geographic area proposed to be served by Mission, and it is a person who, prior to receipt by the Agency of Mission's application, provided written notice to the Agency of an intention to continue to provide similar emergency services in the future to individuals residing within the service area and the geographic area to be served by Mission.

13. Mission's CON application proposed to establish a new freestanding emergency department in Arden, in southern Buncombe County close to the Henderson County line. As noted on page 4 of the Agency Findings, Mission described the geographic area that it proposed to serve in Section C.3, page 41 in its CON application. The Agency Findings on Page 4 state that Mission included in its application the following table for its projected patient origin:

County or ZIP Code Area	Third Full FY of Operation following Project Completion CY2027	
	Patients	% of Total
28704-Buncombe	2,338	22.5%
28730-Buncombe	902	8.7%
28732-Henderson	1,310	12.6%
28759-Henderson	292	2.8%
28791-Henderson	363	3.5%
28803-Buncombe	2,327	22.3%
28806-Buncombe	1,569	15.1%
28792-Henderson	487	4.7%
28742-Henderson	45	0.4%
All Other Immigration	781	7.5%
Total	10,414	100.0%

Source: Table on page 41 of the FSED Arden Application.

14. As noted on page 14 of the Agency Findings, Mission represented in its FSED Arden application that Pardee is a provider of emergency department services to residents in the geographic service area proposed by Mission. The Agency Findings note:

> In Section G.1, page 95, the applicant identifies three providers of emergency services in the proposed service area: Margaret R. Pardee Memorial Hospital, AdventHealth Hendersonville and Mission Hospital.

See p. 14, Agency Findings attached as Exhibit E.

15. Pardee has an emergency department located in Henderson County approximately 11 miles away from the site proposed by Mission for its Arden FSED. Pardee provides emergency services to residents of Henderson and Buncombe Counties and to residents in all of the zip codes identified by Mission as the geographic area it proposed to serve. Recent data shows that Pardee has provided emergency services to residents of all of the zip codes identified by Mission as follows:

Zip Code	**County**	**Number of Pardee ED Patients in CY[1] 2020**
Mission's Proposed Primary Service Area		
28704	Buncombe	Over 350
28730	Henderson	Over 50
28732	Henderson	Over 550
28759	Henderson	Over 625
28791	Henderson	Over 2700
28803	Buncombe	Over 150
Mission's Proposed Secondary Service Area		
28806	Buncombe	Over 175
28792	Henderson	Over 7700
28742	Henderson	Over 400

16. As noted in Pardee's written comments concerning Mission's FSED Arden Application that Pardee submitted to the Agency (*see* Exhibit A), Mission's FSED Arden Application proposes the same geographic area to be served as Mission proposed in its 2021 application to establish a FSED in Arden. Pardee's written comments that it submitted concerning Mission's 2021 FSED Arden application also documented how Pardee provides emergency department services to individuals residing in the geographic service area that Mission proposed in its application to serve. A copy is attached as Exhibit F.

17. Pardee's 2022 license renewal application, which was available to the Agency during its review of Mission's 2022 FSED Arden application, also documents that Pardee provides emergency services to residents of Buncombe and Henderson Counties. Excerpts of the licensure renewal application are attached as Exhibit G. According to Pardee's 2022 hospital licensure

[1] Calendar year.

renewal application, which reported data for October 1, 2020 through September 30, 2021, Pardee had 24,867 emergency department visits and provided emergency department services to 19,456 residents of Henderson County. Pardee also provided services to 1,441 residents of Buncombe County. Mission proposed in its FSED Application to serve residents of Henderson and Buncombe Counties.

18. Mission represented in its FSED Arden Application that it will increase its market share of emergency patients that originate from Henderson and Buncombe Counties in the zip codes or geographic area that it proposes to serve. *See* Page 6, Agency Findings attached as Exhibit E. Market share measures the percentage of patients each provider in the area serves with the total for all providers equaling 100%. Any increase in market share for one provider means a decrease in market share for other providers. Mission projecting that it will increase its market share of emergency patients that originate from Henderson and Buncombe Counties in the zip codes or geographic area that it proposes to serve means that Mission believes that Pardee, one of the existing providers of emergency services to patients in these counties, will experience a decrease in market share.

19. One of the reasons Mission represents in its application for proposing a FSED in Arden is to shift low acuity ED patients to the FSED. Some low acuity ED patients can be served more cost effectively in an urgent care center. Patients often do not know whether to seek care at an emergency department or an urgent care center.

20. Pardee has an urgent care center on the Mission Pardee Health Campus that straddles the Buncombe/Henderson County line where Mission and Pardee provide complementary outpatient services. Mission's application proposes to locate its FSED in Arden, approximately 1.1 miles from Pardee's urgent care center and the Mission Pardee Joint Campus.

In fiscal year 2020, Pardee's urgent care center patient origin included over 3500 patients originating from the Buncombe County and over 16,000 patients originating from the Henderson County zip codes listed by Mission as within the geographic area it proposed to serve.

21. The Certificate of Need Act establishes a clear legal right for Pardee as an affected person to be entitled to a contested case hearing in N.C. Gen. Stat.§ 131E-188(a)(emphasis added) when it states:

> After a decision of the Department to issue, deny or withdraw a certificate of need or exemption or to issue a certificate of need pursuant to a settlement agreement with an applicant to the extent permitted by law, **any affected person**, as defined in subsection (c) of this section, **shall be entitled to a contested case hearing** under Article 3 of Chapter 150B of the General Statutes. ...

22. The express language of N.C. Gen. Stat.§ 131E-188(a) also evidences the legislature's intent to assure that affected persons have the right to a full contested case hearing and not just the right to file a contested case. N.C. Gen. Stat.§ 131E-188(a) provides that an affected person "shall be entitled to a contested case hearing" and not just "shall be entitled to file a contested case." The legislature's choice of words must be considered to be intentional and mandatory.

23. The language of N.C. Gen. Stat.§ 131E-188(a) is clear and unambiguous. It contains no qualifiers or preconditions to be satisfied. N.C. Gen. Stat. § 131E-188 (a) does not state "shall be entitled to a contested case hearing" **if** additional conditions in N.C. Gen. Stat.§ 150B-23(a) are satisfied or **if** any further requirements are met. Instead, N.C. Gen. Stat.§ 131E-188(a) unequivocally states that **any affected person shall be entitled to a contested case hearing** under Article 3 of Chapter 150B of the General Statutes, meaning that a full evidentiary contested case hearing at the Office of Administrative Hearings ("OAH"), and nothing less, must be assured.

24. "Hearing" is not defined in the CON Act or the APA. The common meaning of "hearing" is a proceeding at which evidence is presented and arguments are made.

25. Allowing an affected person to file a contested case but denying the affected person the right to a "contested case hearing" violates an affected person's legal right to a contested case hearing established by N.C. Gen. Stat.§ 131E-188. This legal right established by the legislature cannot be deprived by grafting on to N.C. Gen. Stat.§ 131E-188 other requirements to show some elusive substantial prejudice or some harm when the CON Act by its express terms does not require such a showing and an affected person under the CON Act has no right to recover damages or right to any relief other than to set aside or modify the agency action challenged in the contested case petition.

26. *Hospice of Greensboro, Inc. v. N.C. Department of Human Resources, Division of Facility Services*, 185 N.C. App. 1, 647 S.E. 2d 651 (2007), held that substantial prejudice existed when the CON Section erred as a matter of law by determining that certain actions by a provider were exempt from CON review and by failing to require the filing of a CON application and an application review process in which affected persons had the opportunity to submit applications and/or comment. The *Hospice of Greensboro* court found that agency error alone established substantial prejudice and entitled the petitioner to relief.

27. The *Hospice of Greensboro* court did not require a further showing of harm, projection of monetary or other damages, or identification of any legal right other than the rights established in the CON Act. Any trial or appellate court decisions to the contrary seek to legislate policy and fail to uphold the CON Act as enacted by the legislature.

28. N.C. Gen. Stat.§ 150B-23(a) mandates that "[t]he parties in a contested case shall be given an opportunity for a hearing without undue delay." Pardee is entitled to such a hearing.

29. Mission also submitted a CON application in 2021 proposing a FSED in Arden at the exact same location as proposed in its 2022 FSED Application. The application was assigned Project ID # B-12093-21. Pardee commented on and opposed approval of Mission's 2021 Arden FSED Application. *See* Exhibit F.

30. The Agency disapproved Mission's 2021 Arden FSED Application and found the 2021 Application non-conforming with statutory criteria N.C.G.S. 131E-183 (a) (3), (3a), (4), (5), (6), and (18a). The Agency Findings on Mission's 2021 Arden FSED Application are attached as Exhibit H. The Agency Findings on Mission's 2021 FSED Application determined that there was not a need for the proposed FSED in Arden and that Mission did not adequately demonstrate that its proposal would not result in unnecessary duplication of existing or approved services in the service area because Mission did not adequately demonstrate that its proposed FSED was needed in the service area. Exhibit H, pp. 3-13; 19-20.

31. Mission's 2022 Arden FSED Application did not materially differ from Mission's 2021 Arden FSED Application with regard to purported demonstration of need and lack of unnecessary duplication. The circumstances in the geographic area that Mission proposed to serve relevant to need and unnecessary duplication also did not change between the time of Mission's submission of its 2021 and 2022 Arden FSED Applications. The Agency's Findings on Mission's 2022 Arden FSED Application do not expressly address any material distinction between Mission's 2021 and 2022 Arden FSED Applications with regard to need and unnecessary duplication.

32. By its decision, the Agency exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily and capriciously, and failed to act as required by law or rule and substantially prejudiced Pardee's rights by:

(a) Erroneously finding that the FSED Arden Application conformed or conditionally conformed with the following statutory and regulatory review criteria: N.C. Gen. Stat. §§ 131E-183(a) (1), (3), (4), (5), (6), and (18a);

(b) Erroneously approving Mission's FSED Arden Application;

(c) Erroneously approving the FSED Arden Application and erroneously finding that it conformed or conditionally conformed with the applicable statutory and regulatory review criteria for the reasons summarized in the written comments submitted by Pardee, AdventHealth, and Haywood Regional Medical Center. *See* Exhibits A, B, and C;

(d) Erroneously approving Mission's FSED Arden Application and erroneously finding that it conformed or conditionally conformed with the applicable statutory and regulatory review criteria when it had the same service area, incremental market share growth rates, and patient shifts as Mission's 2021 FSED Arden application that the Agency found nonconforming with the applicable statutory and regulatory review criteria and denied;

(e) Erroneously finding that the FSED Arden Application conformed with N.C. Gen. Stat. § 131E-183(a)(1) and (3) by:

(i) erroneously determining that Mission demonstrated the reasonableness of the defined service area, which extends beyond a 25-minute drive time from the proposed location;

(ii) erroneously determining that Mission demonstrated the reasonableness of the defined service area when a number of patients in the defined service area are closer to existing emergency departments than Mission's proposed location in Arden;

(iii) erroneously determining that Mission had demonstrated the need for the proposed project when there are two existing emergency departments in Mission's proposed service area, Pardee and AdventHealth, and there is available emergency room capacity in the service area;

(iv) erroneously determining that Mission had demonstrated the need for the proposed project when its emergency department growth rates are overstated and unsupported;

(v) erroneously determining that Mission had demonstrated the need for the proposed project when its incremental market share growth is unsupported and is not different from the incremental market share growth projected in Mission's disapproved 2021 FSED application;

(vi) erroneously determining that Mission had demonstrated the need for the proposed project when its patient shifts are unsupported and are the same as the patient shift methodology, explanation, and percentages as Mission's disapproved 2021 FSED application;

(vii) erroneously determining that Mission had demonstrated the need for the proposed project when its projections by acuity are unsupported;

(viii) erroneously determining that Mission had demonstrated the need for the proposed project and the extent to which all residents of the area, including underserved groups, are likely to have access to the services proposed when its payor mix is unsupported; and

(ix) otherwise failing to recognize that Mission did not adequately demonstrate the need the population it proposed to serve has for the proposed emergency services in Arden;

(f) Erroneously finding that the FSED Arden Application conformed with N.C. Gen. Stat. § 131E-183(a)(4) by failing to appropriately analyze and find that Mission failed to adequately demonstrate that its project constituted the most effective or least costly alternative;

(g) Erroneously finding that the FSED Arden Application conformed with N.C. Gen. Stat. § 131E-183(a)(5) by:

(i) failing to determine that Mission's financial and operational projections were unreasonable because they were based upon unreasonable and unsupported utilization assumptions and projections;

(ii) failing to determine that Mission did not demonstrate that its project would be financially feasible based on its flawed utilization projections; and

(iii) otherwise failing to appropriately analyze the reasonableness of the costs and charges provided in the FSED Arden Application;

(h) Erroneously finding that the FSED Arden Application conformed with N.C. Gen. Stat. § 131E-183(a)(6) by:

(i) relying upon the erroneous findings on other criteria, including but not limited to incorrectly relying upon unfounded conformity with N.C. Gen. Stat. § 131E-183(a)(3); and

(ii) erroneously determining that Mission's proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities;

(i) Erroneously finding that the FSED Arden Application conformed with N.C. Gen. Stat. § 131E-183(a)(18a) by:

(i) failing to determine that Mission's Application would not enhance competition and therefore would not have a favorable impact on cost-effectiveness, quality, and access to the services proposed; and

(ii) otherwise failing to appropriately analyze whether the FSED Arden Application conformed with N.C. Gen. Stat. § 131E-183(a)(18a);

(j) Approving Mission's 2022 Arden FSED Application after disapproving Mission's 2021 Arden FSED Application when the applications were not materially different with regard to failure to demonstrate need and lack of unnecessary duplication.

(k) Otherwise exceeding its authority and jurisdiction, acting erroneously, failing to use proper procedure, acting arbitrarily and capriciously, and failing to act as required by law or rule in determining the FSED Arden Application conforming with all relevant review criteria and approving the FSED Arden Application, which actions substantially prejudiced Pardee.

33. Pardee is also substantially prejudiced by the Agency approving Mission's 2022 FSED Application despite the lack of need for the proposal and presence of unnecessary duplication of Pardee's and other existing emergency department services for patients in the geographic area that Mission proposed to serve.

34. Pardee's petition is based upon facts known and information available to it at this time. Because Pardee has not yet been able to engage in discovery, there may be other facts and issues of which it is not presently aware but which may support its contentions. Pardee expressly reserves the right to rely on facts, grounds and theories that are not yet known to it and that may become evident during discovery and litigation of this case.

WHEREFORE, Pardee respectfully requests a contested case hearing on the Agency's decision to approve Mission's FSED Arden Application, that the Office of Administrative Hearings appoint an administrative law judge without delay, and that the administrative law judge enter a final decision directing that:

1. The Agency decision be set aside and the Application disapproved; and
2. Such other and further relief be awarded as is deemed appropriate.

This the 23rd day of June, 2022.

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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing Petition for a Contested Case Hearing has been served as follows upon the following persons at the addresses shown:

Lisa G. Corbett Department of Health and Human Services Office of Legal Affairs Adams Building – Room 154 2001 Mail Service Center Raleigh, NC 27699-2001	By Certified Mail
Derek L. Hunter (dhunter@ncdoj.gov) Assistant Attorney General NC Department of Justice, Health Service Section 114 Edenton Street Raleigh, NC 27603	Courtesy copy via e-mail
Kimberly Randolph (krandolph@ncdoj.gov) Assistant Attorney General N.C. Department of Justice P.O. Box 629 Raleigh, NC 27602	Courtesy copy via e-mail

This the 23rd day of June, 2022.

Maureen Demarest Murray
Attorney for Petitioners

Attachment 6

Facility Data

A. **Reporting Period.** All responses should pertain to the period **October 1, 2020 to September 30, 2021.**

B. **General Information.** (Please fill in any blanks and make changes where necessary.)

For B and C, submit one record for the licensed hospital. **DO NOT SUBMIT SEPARATE RECORDS FOR EACH CAMPUS.**

1. Admissions to Licensed Acute Care Beds: **include only admissions to beds in category D-1 (a – q) on page 6; exclude responses in categories D-2 – D-8 on page 6; exclude normal newborn bassinets; exclude swing bed admissions.**	41,492	
2. Discharges from Licensed Acute Care Beds: **include only discharges from beds in category D-1 (a – q) on page 6; exclude responses in categories D-2 – D-8 on page 6; exclude normal newborn bassinets; exclude swing bed admissions.**		
3. Average Daily Census: **include only admissions to beds in category D-1 (a – q) on page 6; exclude responses in categories D-2-D-8 on page 6; exclude normal newborn bassinets; and exclude swing bed admissions.**	615	
4. Was there a permanent change in the total number of licensed beds during the reporting period?	Yes	No ✓
If 'Yes', what was the number of licensed beds at the end of the reporting period?	n/a	
If 'Yes', please state reason(s) (such as additions, alterations, or conversions) which may have affected the change in bed complement:	n/a	
5. Observations: Number of patients in observation status and not admitted as inpatients, excluding Emergency Department patients.	10,314	
6. Number of unlicensed Observation Beds	Ø	

C. Designation and Accreditation

1. Are you a designated trauma center? ✓ Yes ___ No Designated Level # II
2. Are you a critical access hospital (CAH)? ___ Yes ✓ No
3. Are you a long term care hospital (LTCH)? ___ Yes ✓ No
4. Is this facility TJC accredited? ✓ Yes ___ No Expiration Date: 10-23-2024
5. Is this facility DNV accredited? ___ Yes ✓ No Expiration Date: ___
6. Is this facility AOA accredited? ___ Yes ✓ No Expiration Date: ___
7. Are you a Medicare deemed provider? ✓ Yes ___ No

Attachment 7

A Voice for Nurses. A Vision for Healthcare.

OAKLAND
155 Grand Avenue
Oakland CA 94612
phone: 800-504-7859
fax: 510-663-1625

TAMPA
1406 North 19th Street
Tampa FL 33605
phone: 813-223-5312
fax: 813-223-5679

July 10, 2020

Mr. Chad Patrick
Chief Executive Officer
Mission Hospital
509 Biltmore Ave.
Asheville, NC 28801

Nurses at Mission are organizing to ensure that the Western North Carolina Community receives the highest standard of patient care possible. However, currently conditions at the hospital are such that patient care is suffering. Furthermore, the Covid-19 pandemic has exacerbated all existing issues and we are on the verge of a local healthcare crisis if steps to alleviate the situation are not immediately taken. Nurses demand that HCA and Mission Executives:

- Hire more full-time and part-time RNs, fully utilize PRNs and hire more support staff
- Utilize Registry/ Travelers to fill staffing holes while positions are open
- Offer Extra Shift Bonuses and other incentives every time a unit is short
- Staff by acuity, not just by grid numbers and ensure that NUS's do not take patients
- Clearly post staffing grids on each unit and make daily assignment sheets accessible to RNs
- Stop disciplining RNs for discussing patient care issues and divert money from union busting into staffing

The RNs of Mission

National Nurses United

(/)

PRESS RELEASE

Mission Hospital nurses to rally for recruiment, retention, and patient safety in Asheville

National Nurses Organizing Committee/National Nurses United May 31, 2022

RNs at HCA's Mission Hospital will rally on June 2 to demand immediate action from management

Registered nurses at HCA Healthcare's Mission Hospital in Asheville, N.C., will hold a rally on June 2 to demand that hospital management take immediate action toward recruiting and retaining staff nurses, National Nurses Organizing Committee/National Nurses United (NNOC/NNU) announced today. Mission RNs say dangerous conditions in their hospital necessitate immediate action to protect patient care and safety.

Mission Hospital is forcing nurses to work while there is a deficit of more than 400 RNs hospital-wide. As a result, one intensive care unit nurse routinely has three patients, instead of one or two, a gravely unsafe RN-to-patient ratio. Nurses across the hospital are working in excess of 13 hours a day with no meal or rest breaks. These high RN-to-patient ratios and long hours with no breaks endanger patient care and safety.

"It is unconscionable for HCA to impose these unsafe conditions on our patients, and we won't stand for it," said Amy Waters, RN, who works in Mission's pediatric intensive care unit. "We will do what it takes to hold HCA accountable."

Who: RNs at HCA's Mission Hospital

What: Rally for Recruitment and Retention

When: Thursday, June 2, 8 a.m. to 9 a.m.

Where: Corner of Biltmore Drive and Hospital Drive

Nurses are demanding Mission Hospital stop creating unsafe conditions for patients. When nurses have too many patients to care for, patients do not get optimal care. Mission RNs say management must immediately implement safe RN-to-patient ratios and cease all efforts to undermine RNs' scope of practice.

National Nurses Organizing Committee is a national union and professional organization for registered nurses, advance practice nurses, and RN organizations who want to pursue a more powerful agenda of advocacy, promoting the interests of patients, direct care nurses, and RN professional practice. NNOC is affiliated with National Nurses United, the largest and fastest-growing union and professional association of registered nurses in the United States with more than 175,000 members nationwide.

(https://www.nationalnursesunited.org/covid-19)

Covid-19

Resources and updates for nurses during the Coronavirus Pandemic. Click to learn more about the virus, PPE, and your rights as health care workers.

Learn more (https://www.nationalnursesunited.org/covid-19)

HOSPITALS

How many doctors have left Mission? HCA won't say

Watchdog counts 223 departures since takeover in 2019

by **Asheville Watchdog**
March 26, 2022

How Many Doctors Have Left Mission? HCA Won't Say

By Barbara Durr and Sally Kestin, for Asheville Watchdog

Two prominent physician groups quit the Mission Health system in the first two weeks of the year, the latest in an exodus from the hospital since its sale three years ago to for-profit HCA Healthcare.

The seven doctors at Asheville Ear, Nose & Throat "decided to no longer provide medical or surgical care at Mission Hospital or Asheville Surgery Center," as of Jan. 1, they wrote **in a letter** to their patients.

Also on Jan. 1, the 10 surgeons at Carolina Spine & Neurosurgery Center parted ways with Mission and joined UNC Health's Margaret R. Pardee Memorial Hospital in Hendersonville. They retain privileges to practice at Mission.

HCA declined repeated requests for the number of doctors who have left the Mission system since it took over in February 2019 and refuses to say how many doctors are on staff today, other than that the number is "relatively the same."

But *Asheville Watchdog* identified 223 doctors who appear to be no longer practicing there; their names were on the Mission **Find a Doctor website** as of August 2019 but had been removed as of February 2022.

Another 57 doctors still on the website are no longer listed as employed or affiliated with Mission.

Asheville Mayor Esther Manheimer, who was among a group of elected officials signing a **scathing public letter** in February 2020 over concerns about patient care and staffing at Mission, said of *Asheville Watchdog*'s analysis,"It seems unavoidable

that Asheville, Buncombe County and Western North Carolina will see a deterioration in healthcare as a result of Mission-HCA hemorrhaging doctors."

> "It seems unavoidable that Asheville, Buncombe County and Western North Carolina will see a deterioration in healthcare as a result of Mission-HCA hemorrhaging doctors."
>
> Asheville mayor Esther Manheimer

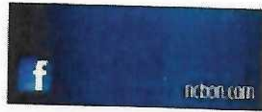
State Sen. Julie Mayfield said,"The loss of these doctors represents collectively hundreds of years of experience, long-standing relationships within and outside the hospital, and consistency of and confidence in care for patients."

"These physicians were a key part of what made Mission a world-class hospital system that prioritized patient care," Mayfield said, "and it is truly unfortunate that HCA chose from the start to prioritize its profit over its people."

Nancy Lindell, director of public and media relations for HCA Healthcare's North Carolina Division, which includes Mission Hospital, said in a statement to *Asheville Watchdog*, "Mission Health is grateful to our team members who provide quality care to our community every day … It is expected that the transition to HCA Healthcare, life events, effects of a global pandemic, and the increasing demand for healthcare services, etc., would lead to both some additions and departures."

HCA refuses to give numbers

The 223 doctors no longer on Mission's Find A Doctor site include 33 family medicine physicians, 25 surgeons, and 15 pediatricians or pediatric specialists. More than 100 doctors moved out of the state or region; others are listed as affiliated with hospitals in Hendersonville, the Charles George VA Medical Center in Asheville, or private practices, according to the **North Carolina Medical Board** and Internet searches.



Lindell said many of the doctors still in the region continue to practice at Mission and "are still part of our medical staff and hospital teams, making the number of physicians on medical staff relatively the same."

Lindell said the Find a Doctor site does not include open positions or doctors in the process of being hired and is not meant as a tool "for tracking the medical staff." Mission has an office dedicated to medical staffing, but Lindell declined to provide even basic information about the number of doctors at Mission before and after HCA took over.

Asheville Watchdog sent Lindell the names of the doctors who are no longer on Find A Doctor or listed as employed or affiliated with Mission. She declined to comment beyond her statement and reiterated, "We continue to have approximately the same number of providers on the medical staff to serve the needs of our community."

Providers include others besides doctors, including nurse practitioners, physician assistants, psychologists and dentists.

Doctors Frustrated

In interviews, doctors who left Mission cited concerns about declining patient care, job burnout, and frustrations with HCA's emphasis on profits. Five of the doctors said some of their patients needing hospitalization were asking to be treated at hospitals other than Mission.

One doctor who remained in the area and spoke to *Asheville Watchdog* on the condition of anonymity because he said he feared retribution from HCA said, "I get asked every day by a patient if I can treat them elsewhere than Mission."

Dr. Martin Palmeri, an oncologist who left Mission in December 2019 to join Messino Cancer Centers, said the hospital system before HCA "was run primarily by doctors and nurses and now it's being run by businessmen."

Dr. Martin Palmeri

"Bedside care is knowing what patients and families are suffering," Palmeri said. "Patient suffering is off their (HCA management's) radar."

He said the hospital needs more doctors in leadership. "We need the right balance between bedside care and corporate benchmarks and revenue," said Palmeri, who was recently elected president of the North Carolina Oncology Association.

Dr. Ben Aiken, a primary care physician employed by Mission until January 2020, said many patients are skeptical "that HCA has their best interests in mind as a for-profit company."

Aiken, who piloted a subscription fee direct primary care practice under Mission's former leadership, said Mission used to employ more primary care doctors even though that specialty is less profitable. HCA shuttered two primary care practices in 2020, in Biltmore Park and Candler, and sold Aiken's pilot program, now called Lantern Health, to him.

Dr. Ben Aiken

"Primary care generally is not an emphasis in HCA," Aiken said.

At least 30 primary care or family medicine doctors and 10 internists have left Mission's employment, *Asheville Watchdog* found in its analysis of the Find A Doctor website.

Aiken said Mission long was able to recruit high-quality physicians to Asheville, considered a desirable place to live and practice. But he said, "The type of physicians that were attracted to Mission may not be attracted to HCA. The business approach is very different."

"Exact same doctors," then-CEO pledged

An emergency room doctor, who spoke on condition of anonymity, said Mission before HCA "could be choosy" about the doctors it brought on staff because so many wanted to work there. "Now they just fill the gaps."

The doctor said that nurses in the emergency room are caring for more patients while management concentrates on meeting minimum standards and "metrics" such as how long a patient waits to be seen.

"When HCA came in, there were so many emails on metrics," he said. "We've gone from providing amazing care to mediocre care."

Aiken said he wants to see a high-quality hospital in Asheville but believes Pardee UNC Health and AdventHealth, both in Hendersonville, are likely to expand if skepticism about Mission continues.

Lindell said Mission patients "continue to receive outstanding care at our hospitals by our clinical teams and board-certified physicians." She said Mission recently passed a state inspection with no deficiencies, and a national accreditation review measuring 1,600 points of care did not produce "a single finding that required corrective action or a repeat visit."

She said hospitals nationwide are struggling to hire and retain doctors, a shortage exacerbated by the pandemic, but that the Mission system in western North Carolina "welcomed almost 60 new physicians to our staff in 2021."

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In May 2018, before the sale of the hospital system, Dr. Ronald A. Paulus, then president and chief executive officer of Mission Health, **told a local business group** that Mission Health under HCA would still have "the exact same people and exact same doctors and exact same nurses" and provide similar or even superior care.

Paulus received a **multimillion-dollar payout** from Mission and joined HCA as a strategic advisor just days after the sale was concluded.

Staffing is key concern

A common complaint among doctors, nurses and patients is that Mission under HCA has skimped on staffing, among the largest costs for hospitals. In 2018, the year before the sale, **Mission Health System reported** more than 12,000 staff. The website **now lists 10,500**. Lindell said some employees formerly included under Mission, such as those working in billing and "our supply chain team," are now counted under different entities.

But doctors and other employees told *Asheville Watchdog* there are fewer people in direct patient care, including certified nursing assistants (CNAs), health unit secretaries and mental health professionals, as well as support positions such as housekeeping, dietary services, and the morgue.

A source of many complaints about care, **patients told *Asheville Watchdog***, is Mission's emergency room.

HCA contracts with TeamHealth, a national physician staffing company owned by the private equity group **Blackstone**, to staff its emergency rooms.

Dr. Mitchell Li, an emergency medical specialist and the founder of **Take Back Medicine**, an organization that raises awareness about the dangers of the corporatization of medicine, told *Asheville Watchdog* that such staffing companies often replace ER physicians with nurse practitioners and physician assistants, a practice he observed first-hand while a resident at a Detroit area hospital staffed by TeamHealth. Li did not work at Mission or HCA.

"HCA and corporate ER staffing groups figure [they] can get away with a minimum of physicians," said Li, who now operates a private, direct primary care practice serving Asheville, Black Mountain and nearby communities.

Asked whether emergency room doctors have been replaced with lesser trained staff such as nurse practitioners, Lindell said, "Most hospitals throughout the nation contract with ER provider groups … We also augment their care with other staff in addition to these ER physicians when further care providers are needed."

Patients in "excruciating pain"

In interviews, doctors said staffing turnover and reductions have affected nurse-to-patient ratios and quality of care at Mission.

Palmeri said he was "horrified" to find on more than one occasion his patients at Mission in "excruciating pain" because nurses responsible for seven to eight patients each could not administer pain medications on time.

Dr. Ken Zamkoff, a retired hematologist in Asheville, said, "When a patient is lying in a bed, it's not just the doctor, it's the whole team that cares for the patient. If you don't have nurses, CNAs, and the whole ancillary staff, you can't do it properly. When you decimate the team, the patient suffers."

Another former Mission doctor, who still has privileges there, said the reduced staffing places a burden on those still practicing at Mission and leads to an "erosion in quality."

Before HCA, he said the staff included many longtime employees who had worked together for years, but "now there's no consistency."

Vote of no confidence

In their letter to patients, the doctors at Asheville Ear, Nose & Throat did not specify a reason for their departure from Mission but said, "All of our doctors will continue to

provide medical and surgical care for our patients at both Pardee Hospital and Park Ridge Hospital (now known as AdventHealth Hendersonville). We also now offer outpatient surgical care at Western Carolina Surgery Center."

The surgeons at Carolina Spine & Neurosurgery Center declined requests for comment. Phil Bridges, spokesman for UNC Health, confirmed that the doctors have affiliated with UNC Pardee, and said current and new patients can expect a seamless transition.

Some doctors have cited pay and management issues in their decisions to depart Mission, including attempts by HCA to cut some physicians' compensation by as much as 25 percent, according to interviews and **published reports**. Lindell said that Mission Health compensates physicians in accordance with fair market rules.

But HCA's approach to healthcare has led many to depart.

Palmeri, the oncologist, said he concluded that HCA's approach to cancer treatment was, in his opinion, "focused on return on investment."

"There's a lot of aspects of oncology that are not that profitable," Palmeri said, such as cancer care in small communities." He said he saw "HCA pulling away from that."

Palmeri said he wanted to ensure access to cancer care throughout the region. His practice, Messino Cancer Centers, has six locations, including Asheville. "I grew up here in Western North Carolina. It was critical for me to do that for our community," he said.

Lindell said that Mission Health recently partnered with the Susan Cannon Cancer Institute of HCA Healthcare, known for its research, to expand its services across Western North Carolina.

The doctor who asked not to be named, and who said patients ask every day about alternatives to Mission, told *Asheville Watchdog* he left after being asked to take a salary cut, and seeing that "the patient experience was declining."

"Concern for the community" at Mission, he said, "turned into care for the shareholder."

A hematologist, who was on the medical staff at Mission and requested anonymity, said that the Mission oncologists last year were increasingly hearing from patients that they were "resistant to going to Mission."

In June, the oncology team, troubled by quality of care and other concerns, took a no confidence vote in HCA management, he told *Asheville Watchdog*. "We brought up the issues again and again," the doctor said, but little changed. Shortly after, he said he concluded that Mission "was more business oriented, not patient oriented," and left.

Asked about the no confidence vote, Lindell said, "We have full confidence in our management team. We regularly gather feedback from physicians, nurses, patients and the community … The feedback raised at these meetings has been addressed."

But two current oncology providers, who asked not to be named, told *Asheville Watchdog* that patient care concerns continue. They said nurse-to-patient ratios remain inadequate to provide needed care for the sickest patients, including providing pain medications on time; there are too few certified nurses for chemo treatments, which forces delays in administering the needed drugs; and there are too few CNAs.

While some patients may be seeking care elsewhere, Lindell said, "We continue to see patients choosing to come to our hospitals."

Doctors have also left HCA-owned hospitals in other states for similar reasons. In Rochester, N.H., for example, 12 of the 14 primary care doctors at Frisbie Memorial left within 15 months after HCA acquired the local nonprofit community hospital in 2020. Some of them cited a lack of support for medical staff and a focus on profits rather than patients.

Top doctor departs

Mission's highest-ranking doctor, Chief Medical Officer Dr. William Hathaway, announced on Jan. 6 that he, too, was leaving to become chief executive at MAHEC, the Mountain Area Health Education Center in Asheville, where he has been chairman of the board.

Hathaway told *Asheville Watchdog* that "my acceptance of the job was purely in relation to the retirement" of MAHEC's CEO, Dr. Jeff Heck, which was announced last summer. Hathaway started as chief medical officer under nonprofit Mission and was the most senior of the previous Mission leaders under HCA.

In an interview with *Asheville Watchdog*, Hathaway acknowledged that his departure created an additional strain on the hospital. At the time, the Mission system was experiencing record COVID-19 cases and admissions, **staffing shortages, a pending lawsuit over alleged price gouging, and an untold number of patient complaints.**

Dr. William Hathaway

But Hathaway, a cardiologist and third-generation physician, said he was excited to start at MAHEC, an organization he described as having a tremendous reputation. "It's all about care for the patients," he said.

HCA profits soar

North Carolina Attorney General Josh Stein reviewed and approved the sale of Mission to HCA, requiring 15 conditions, of which the most significant are restrictions on closing or selling facilities, continuing to provide certain services, and continuing Mission Hospital's charity care policy. Separately, HCA made certain capital expenditure commitments.

Quality of care and staffing levels were not among the 15 stipulations added by Stein.Stein, however, is "extremely concerned about healthcare in western North Carolina," said Laura Brewer, Stein's deputy chief of staff.

"Healthcare facilities must be adequately staffed to ensure patients get the treatment they need," Brewer said. "While the pandemic has exacerbated healthcare shortages all over the nation, reports of acute shortages at HCA are concerning."

She added that the Attorney General will "continue to ask questions about HCA's policies and commitments."

An independent monitor, Gibbins Advisors, is responsible for ensuring HCA lives up to the Mission asset purchase agreement and the additional 15 conditions.

In April, Ronald Winters, a principal at Gibbins Advisors, said in a virtual public forum that Gibbins would examine the issue of physician departures. "To the extent those departures impact services at hospitals, that's certainly something we're going to look at and inquire about," Winters said.

Winters told *Asheville Watchdog* last month that the evaluation is ongoing but declined further comment.

Mission has become a valuable asset in the portfolio of HCA, the largest hospital corporation in the nation. In January, the company reported a near doubling of **profits** during the full pandemic year of 2021, from $3.75 billion in 2020 to $6.96 billion in 2021.

Just months after the consummation of the sale of Mission Health, HCA raised prices across the Mission system by an average of 10 percent. By the end of the first year, net patient revenue increased $548 million compared to the 12-month period before the sale, Greg Lowe, president of the North Carolina Division of HCA Healthcare, wrote in **a letter to Attorney General Stein** on April 30, 2020. The letter was obtained by *Asheville Watchdog* under a public records request.

With annual net patient revenue exceeding $1 billion, Mission Hospital ranked No. 2 among more than 180 HCA hospitals in both 2020 and 2021, according to the consulting firm Definitive Healthcare.

"Healthcare should be the least transactional business in the world," said the doctor who was asked to take a salary cut, but HCA's "approach is very transactional."

He said the upshot at Mission, where he said collegiality and community commitment were once hallmarks, is "the pride is gone. It's just sad."

Peter H. Lewis contributed to this report.

*<u>**Asheville Watchdog**</u> is a nonprofit news team producing stories that matter to Asheville and Buncombe County. Barbara Durr is a former correspondent for The Financial Times of London. Contact her at bdurr@avlwatchdog.org. Sally Kestin is a Pulitzer Prize-winning investigative reporter. Email <u>**skestin@avlwatchdog.org**</u>. Peter H. Lewis is a former senior writer and editor at The New York Times. Email <u>**plewis@avlwatchog.org**</u>.*

Shannon Wilson-Ricw

March 26, 2022 at 12:09

In fall of 2020 I needed some forms filled out for my sons school. He was being seen at Mission Pediatric Neurology. 14 days later I had to go in person and refuse to leave until I had the completed forms. I asked the nurse if they had time to give my son the care he needed due to many issues I had incurred since HCA has taken over. She was honest and answered "no". They had too many patients and not enough staff due to cuts. That day I moved my son to Prisma Health in Spartanburg and have not been happier.

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Citizen Times

NEWS

Mission Hospital departures: Concerns mount as doctors leave HCA Healthcare

Derek Lacey
Asheville Citizen Times

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Dr. Tom Large planned to retire in Asheville, to finish out his career with Mission Hospital as an orthopedic surgeon.

Then the nonprofit Mission sold to for-profit HCA Healthcare in 2019, and that changed. He let his contract expire at the end of March and is now packing up to move his wife and three children to Atlanta and take a position with Emory University.

"We love it here," he said. "My family is happy here, we like the schools here. My wife's family is an hour from here, and I planned on spending the rest of my life here. It's a huge

not only more work and less pay but what he says is a culture that settles for mediocrity and removes physicians from leadership positions.

At Transylvania Regional Hospital, more than a dozen providers leaving has spurred Brevard City Council into action.

In a statement, Large says in his opinion, which he says echoes conversations with many other physicians at Mission Hospital, HCA "consistently demonstrated that all decisions are seemingly strongly driven by profit."

The company, based in Nashville, Tennessee, has systematically removed physicians from positions of leadership and disbanded a committee that advised non-physician administrators on patient care issues, he says.

"Part of the attraction of working at Mission was to be surrounded by high quality, very well-trained physician colleagues," Large said. "Many of these people are leaving as they aren't wiling to compromise patient care in Asheville."

To his knowledge, Large said about 25 physicians from one group of doctors have left the hospital, which now contracts much of its staffing through Team Health, a contracted physician supplier. He says staffing is critically low throughout many areas of the hospital, including housekeeping and patient transporters, and nursing is relying on a huge number of traveling nurses.

"Consistently excellent patient care flows from people working together over time versus this revolving door model," Large said. "I believe they are simply overworking and underpaying most of these positions so they cannot recruit or retain people into permanent position."

He says his patients were routinely waiting 18-24 hours in the emergency department to get admitted to a regular room, not because there weren't beds, but because there weren't nurses to staff the rooms.

Mission Hospital takes care of the most medically unwell and most severely injured patients in the region, Large said, but it's his belief that HCA is using its staffing models from smaller hospitals that take care of less complex patients.

That, he said, is contributing to physician and staff burnout, frustration and unhappiness, and ultimately compromised patient care.

the thought of working under HCA for the remainder of my career."

Money: Profits up at HCA Healthcare, ratings down at Mission Hospital

Related coverage: Is HCA keeping its promises with Mission purchase? Monitors checking accountability

He said physicians at Mission were blindsided by an Asheville Watchdog report showing that Mission didn't even consider joining Duke University Health, UNC Health, Wake Forest Baptist Health, Atrium Health or any other nearby major nonprofit health systems.

And Large, who served two tours in Afghanistan as a deployed orthopedic surgeon, said the work and pay issues are just a small part of his decision.

"For me, it's the cultural issues," he said. "the way they're running the hospital and disempowering physicians and taking our once-great hospital and filling it with mediocrity."

HCA: Doctors still in hospitals; RN shortage

HCA maintains that while doctors may no longer be on their payroll, for the most part they're still on medical staff at its hospitals.

"The majority of physicians who may have chosen not to renew their contracts with Mission - whether it be the cancer center or (Transylvania Regional Hospital) - are still on medical staff at both hospitals," Media Relations Director Nancy Lindell said in an email.

HCA has retained most on medical staff unless they chose to leave the area or retire, she said, and keeps many physicians in leadership roles across many service line committees in the hospital.

She noted the North Carolina Division chief medical officer and Mission Hospital chief Mmedical officer, as well as physicians on the hospital board.

The hospital's 2020 annual report, dated April 30, shows Mission Health has 1,600-plus active and affiliated providers and more than 800 employed providers.

The departures come as Asheville Watchdog reports HCA doubled its earnings in the first three months of the year while ratings drop from the Centers for Medicare and Medicaid

comes to us," Lindell said. "We were disappointed in the report from Leapfrog and CMS and are working diligently to improve."

She said between the Fall 2020 and Spring 2021 Leapfrog score, there was a one- or two-point drop in some metrics regarding communication between staff and patients that caused the downgrade to a "B" grade from the group, and CMS changed its methodology from seven measure groups to five, also changing the weighting of those groups.

"We are using the feedback from both of these scores to implement improvements in these areas at Mission Hospital, and we continue to be very proud of our outstanding clinical outcomes as a regional destination for care," Lindell said.

Brevard City Council has reached out to the North Carolina Attorney General's Office about concerns at Transylvania Regional Hospital. Lindell said there are 425 active and affiliated physicians on medical staff there.

'While some physicians may have changed who formally employs them, the physicians involved in Mission's Cancer program remain involved and active on our medical staff," she said in a statement. "Mission Cancer Center has all of the same physician services that it has always had and has added a rapid anemia and a urology clinic."

Addressing emergency department wait times and staffing, Lindell said contracting with ER provider groups is a practice across most hospitals in the country. Mission Health previously contracted with Carolina Mountain Emergency Medicine and now uses Team Health to staff the ER.

In the ER, patients are evaluated and treated, she said, and if they need to be admitted, are cared for in the ER until an inpatient bed is available.

"Recent staffing constraints, along with a high volume of patients, has the length of time a patient is in an ER bed abnormally high with a year-to-date average of 7.5 hours," Lindell said. "We are working diligently to meet or exceed our goal of 3.5 hours or less. Our ER remains available to serve our community."

She also said the nationwide shortage of RNs across the country is well known, as Mission Health continues to recruit both RNs and RN support positions like health unit coordinators and certified nursing assistants.

Mission's state-certified CNA Training programs at Mission Hospital and Highlands-Cashiers Hospital began classes last fall at full capacity, she added, hoping the programs can help fill RN support positions more quickly.

But staffing levels were also an impetus for nurses at Mission to unionize last year.

Bradley Van Waus, southern regional director for National Nurses United, said contract negotiations continue between HCA and the nurses union at Mission Hospital.

"We are hopeful that we can reach an agreement that will keep patients safe by ensuring that nurses have a voice in ensuring safe and appropriate staffing and ensures the recruitment and retention of experienced nurses," Van Waus said in a statement.

Throughout the bargaining process, he said, nurses have advocated for the community, and they're eager to reach an agreement that addresses both their needs and the community's.

Brevard 'extremely concerned'

"We want our hospital to remain viable," said Brevard City Council member Maureen Copelof. "The community here loves that hospital. They built the hospital."

Copelof, who was appointed liaison for the city with Gibbins Advisors, the independent monitors for the Mission sale, said the end goal is quality health care, which is critical to the community.

She meets with Gibbins and the compliance division from Dogwood Health Trust to talk about any compliance issues.

Copelof said it's hard to get confirmation from HCA on the exact number, but apparently 14 health care providers have parted ways with Transylvania Regional Hospital since the sale.

That doesn't sit well with Brevard City Council, which voted March 15 to send a second letter to North Carolina Attorney General Josh Stein expressing their concerns.

According to the minutes from the council's March 15 meeting, Copelof updated the council about her last meeting with Gibbins, saying she had several questions about why so many

Citizen Times

The council voted unanimously to approve and mail the letter she wrote asking Stein to initiate a study looking at the "impact to rural health care in North Carolina due to the change in the business model of going from non-profit to profit."

The letter is a follow-up to one sent the month before expressing concerns about "the state of medical care in Transylvania County resulting" from the HCA sale.

"We were assured when this sale was pending that our community would continue to receive the same local access to medical services that we had received before the sale," the letter says. "Recent events, however have us extremely concerned about what it happening regarding health care in our rural community."

The first item listed notes the "majority of physicians/health care providers associated with Transylvania Regional Hospital have opted not to continue under contract with HCA."

It verifies 15 providers who recently left HCA, which Copelof clarified is actually 14 after one decided to sign with HCA. The letter lists eight primary care physicians, one of two orthopedic surgeons in the county and "all the general surgeons will have departed when the last one leaves HCA on March 30th."

The primary reason for that, according to Brevard's letter, is a change in compensation from Revenue Value Units to Fair Market Value, "a major change in how rural health care is provided/compensated."

But in a statement, Lindell said, "Our primary care physicians were offered contracts aligned with Fair Market Value as the next step in transitioning them to HCA Healthcare contracts."

Mission Health's previous contracts included non-compete clauses that were waived on a one-time basis so physicians could either accept the new contracts with HCA or choose other local practices, she said, so they could consider their options and remain in the same communities where the hospitals are located.

"While some have chosen to pursue other local options, we are confident that most will continue to care for our community here in Western North Carolina as members of our Mission Health medical staff," Lindell said. "We are actively recruiting to fill any vacancies that we anticipate, and recently signed contracts with several new providers."

unit.

The letter asks if the company is in compliance when a 24/7 service is cut in half, and whether it actually has to go all the way to zero before it triggers a noncompliance.

HCA's primary care locations continue to be available to the community, Lindell said, and that while the employment relationship with some physicians has changed, they continue to be a part of the medical staff and hospital team.

"It's not so much quality of care, but wanting to make sure we have access to all the care locally and that care does not get centralized in Asheville," Copelof said, and gauging the presence of that care in Transylvania is going to require some numbers.

On May 12, Copelof had a follow-up call with Assistant District Attorney Llogan Walters, sharing concerns and talking about how these departures may impact rural health care in Transylvania County and regionally.

Walters said she would get back in touch, Copelof said, after discussions of concerns expressed in the letter and that "we really believe at a state level ... it's important to look at what's happening to rural health care across Western North Carolina."

But they'll only know the impact on the departure of doctors who can still refer patients to TRH, and whether that presents a threat to services by looking at metrics that they currently don't have access to, she said.

Monitors: No commitment on staffing

Noting that the HCA-Mission purchase agreement doesn't specify keeping physician staff numbers at a certain level or specifically mention primary care, Copelof said, "There's the overall indirect impact to health care when these types of shifts and disruptions occur."

Since population locally has remained relatively stable over the past two years, she'd like to compare things like the number of surgeries being performed before and after the sale, the number of acute care cases being referred to Mission and the occupancy of the transitional care unit before and after the sale.

She said she hasn't seen those numbers yet, but will keep asking for them.

commitments, it is important information that informs our compliance evaluation."

HCA/Mission Health is required to provide services as part of the asset purchase agreement, he said, but regulators like the state Department of Health and Human Services assure compliance with clinical and safety standards, including staffing.

"We review information on various topics not specifically covered by the APA all the time, and we consider how those factors may impact the 15 commitments," Winters said.

Copelof said Brevard will continue to work closely with Gibbins, HCA and Dogwood to make sure Transylvania has a high quality hospital with a full range of services.

In February 2020, Stein's office sent a letter to HCA North Carolina Division President Greg Lowe about a number of issues, including "a surge in complaints about quality of care," which "frequently raise concerns about the impact of staffing cuts, especially for nurses," that are "harrowing to read."

The letter then cites the asset purchase agreement when HCA purchased Mission. In it, HCA agreed to those 15 commitments, including one to maintain certain services like "general medicine services" at the Asheville facility.

"Widespread quality of care issues at Mission facilities would raise real questions about whether HCA is providing the services that it guaranteed," the letter says.

Two years since the sale, Gibbons Advisors continues to monitor the company's compliance with those commitments.

In its second annual report to monitors dated April 30, HCA says it has not discontinued any services it's required to continue under the asset purchase agreement, including general medicine, emergency and trauma, and oncology services, as well as specific services at five other hospitals.

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At Transylvania Regional, that includes emergency, surgical, acute medicine services and the transitional care unit, its skilled nursing facility.

In an April 7 public meeting hosted by Gibbins, questions included concerns about staffing at the hospital system, according to the transcript: "Way too many physicians or staff are leaving HCA hospitals. This is not a coincidence. If this is not a breach of contract by eliminating services then I'm not sure what is?"

Winters answers that the asset purchase agreement doesn't deal with nor do commitments include anything about employing physicians.

But, he says, "To the extent that those departures impact services at the hospital, that's certainly something we're going to look at and inquire about."

Later in the transcript, Winters clarifies that HCA is only not in compliance when the services stop and in each case monitors determined that HCA was providing the services, and that there have been no official disputes as of yet, but the two issues he gives as examples are the transitional care unit at Transylvania Regional and physicians leaving the system.

He says HCA hoped to provide the transitional care at a different location within the structure, and felt it was a service still being provided.

"At the end of the day, as a result of what the community said as a result of us bringing it to them, they decided to reopen that space again, and it's operational," Winters said in the transcript.

The monitors have had several conversations over the past six months about physicians leaving, and he says HCA has "spent a lot of time making sure that the surgeons that were leaving are being replaced and we've kept track with that."

Derek Lacey covers health care, growth and development for the Asheville Citizen Times. Reach him at DLacey@gannett.com or 828-417-4842 and find him on Twitter @DerekAVL.