Mission Hospital's Financial Performance Under HCA

A Preliminary Report

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This preliminary report is one part of a larger study, funded by the Arnold Foundation,[1] examining what lessons can be learned from the events leading up to, and following, HCA Healthcare's 2019 purchase of the Mission Health system based in Asheville, North Carolina (NC). Findings from this portion of the research are being released as a "working draft" in order to give interested parties a preliminary look at the initial analyses. Comments directed to the author (Prof. Mark Hall)[2] are welcome. Following revision, a final full report will be issued later this year.

Acknowledgements: Colleagues at Wake Forest University who contributed to this work are Doug Easterling, Ph.D., Joe Singleton, J.D., and Laura McDuffee, M.P.A.

[1] https://www.arnoldventures.org/
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BACKGROUND AND SUMMARY

HCA Healthcare (formerly Hospital Corporation of America) is the country's largest investor-owned, for-profit hospital chain. In 2019, it purchased the Asheville-based Mission Health system. As a result, Mission's flagship facility became the fifth largest for-profit hospital in the country. Prior to HCA's purchase, Mission had been operated as a nonprofit "charitable" organization ever since its founding in 1885.

When a for-profit owner acquires a nonprofit hospital, we naturally expect profits to increase. Nonprofit hospitals also seek to earn profits – which are referred to as surplus or margin – in order to fund improvements and maintain general financial health. However, an appropriate phrasing for their approach to financial returns is "not-*for*-profit," meaning that profiting is not their primary goal. The same obviously cannot be said for an avowedly *for*-profit, investor-owned company. Thus, we look to see whether in fact Mission Hospital has become more profitable following HCA's acquisition.

Standard financial reports reveal that indeed it has. Mission's profits dipped in 2019 -- the initial transition year under HCA -- and then Mission incurred substantial losses during the first year (2020) of the COVID-19 pandemic. Since then, however, its financial performance has rebounded impressively, with profits over $100 million a year – which is several times greater than prior to HCA's acquisition.

To understand better what accounts for this striking improvement in profitability, this report examines financial data on Mission Hospital compared with a set of eleven similar (or "peer") hospitals in NC and bordering states. In summary, this analysis finds that:

- Prior to HCA's acquisition, Mission's patient-care ("operating") profit margin was relatively steady at 2-to-4 percent of revenues -- similar to the average among peer hospitals. Following HCA's acquisition, after an initial transition year (2019) and the disruption from COVID (2020), Mission's profits rebounded quite handsomely, jumping to the top of the range among peer comparison hospitals, and is several times higher than prior to the acquisition.

- Although HCA increased Mission's list-price markups (over costs) to the top of the peer hospital range, that increase was not the primary driver of substantially improved profits, because most patients do not pay list prices. Instead, HCA sharply reduced Mission's patient-care costs, dropping those to the bottom of the peer hospital range.

- That drop in costs was driven substantially by HCA's reduction in patient-care staffing. Mission's staffing ratios plummeted from above the peer average to the bottom of the peer hospital range, by cutting the staffing rate from 6.0 full-time equivalent ("FTE") staff per occupied bed in 2018 to 3.7 in 2021. Over the same time, average staffing at other NC hospitals remained steady at 5.1 FTEs per patient.

- Contrary to the expectations of many Mission Board members prior to the sale, a reduction of purchasing costs and general administrative expenses does not appear to be the primary driver of Mission's improved profitability under HCA.

METHODS

Comprehensive financial data from hospital "cost reports" filed with the federal government are the primary data source for this analysis.[3] This source and the financial metrics analyzed (profit margins, pricing, patient-care costs, and staffing) are essentially the same as those Mission used in seeking the Attorney General's approval of HCA's purchase. As Mission Hospital told the NC Attorney General in 2018, "these data represent the only truly uniform and best available basis for comparison of cost performance across the entire industry."[4]

To better isolate the effects of the HCA acquisition from other larger forces in the health care industry, this report compares changes in Mission Hospital's financial performance with how a set of 11 peer hospitals have performed over the same time span. The comparison hospitals, listed below, are the same ones that NC used to evaluate Mission Hospital's performance when it was subject to antitrust review, under the Certification of Public Advantage discussed in [a forthcoming section]. These are hospitals that both NC regulators and Mission agreed are valid comparisons, based on the hospitals' sizes, scopes of service, and market and geographic locations.

Table 1: Comparison Hospital Characteristics, 2022

Hospital Name	Ownership	Bed Size	Operating Expense	Patient Severity Index
FORSYTH MEMORIAL (Winston-Salem NC)	Non-Profit	906	$1.5 billion	1.960
CAPE FEAR (Fayetteville NC)	Governmental	627	$1 billion	1.765
PITT COUNTY (Greenville NC)	Non-Profit	1,013	$1.4 billion	2.242
WAKEMED – Raleigh (NC)	Non-Profit	609	$1.2 billion	2.030
MOSES CONE (Greensboro NC)	Non-Profit	779	$1.3 billion	1.967
MOORE REGIONAL (Pinehurst/So. Pines NC)	Non-Profit	412	$0.7 billion	1.925
NEW HANOVER (Wilmington NC)	Non-Profit	694	$1.5 billion	2.059
SPARTANBURG (SC)	Governmental	665	$1.1 billion	1.896
PRISMA (Palmetto) RICHLAND (Columbia SC)	Non-Profit	600	$0.9 billion	2.519
GREENVILLE MEMORIAL (SC)	Non-Profit	721	$1.3 billion	2.232
CARILION – Roanoke (VA)	Non-Profit	637	$1.6 billion	2.350
AVERAGE	**Non-Profit**	**697**	**$1.2 billion**	**2.086**
HCA MISSION (Asheville)	For-Profit	733	$1.2 billion	2.124

[3] These are data that Mission and other hospitals report to the Medicare program, in an annual "cost report" that covers essentially all hospital operations, not just Medicare patients. https://tool.nashp.org/ These data are widely used not only by the government, but also by academic researchers and hospitals themselves, to analyze financial performance.

[4] In somewhat fuller context, Mission's Sept. 20, 2018 letter to the Attorney General explained:

> What is particularly important about the analysis [in the submitted] report is that the source of this comparison is verified Medicare cost reports. The data included in filed Medicare cost reports is strictly defined, mandated and monitored, by the [federal government] and significant penalties may result from false representations. While imperfect, these data represent the only truly uniform and best available basis for comparison of cost performance across the entire industry.

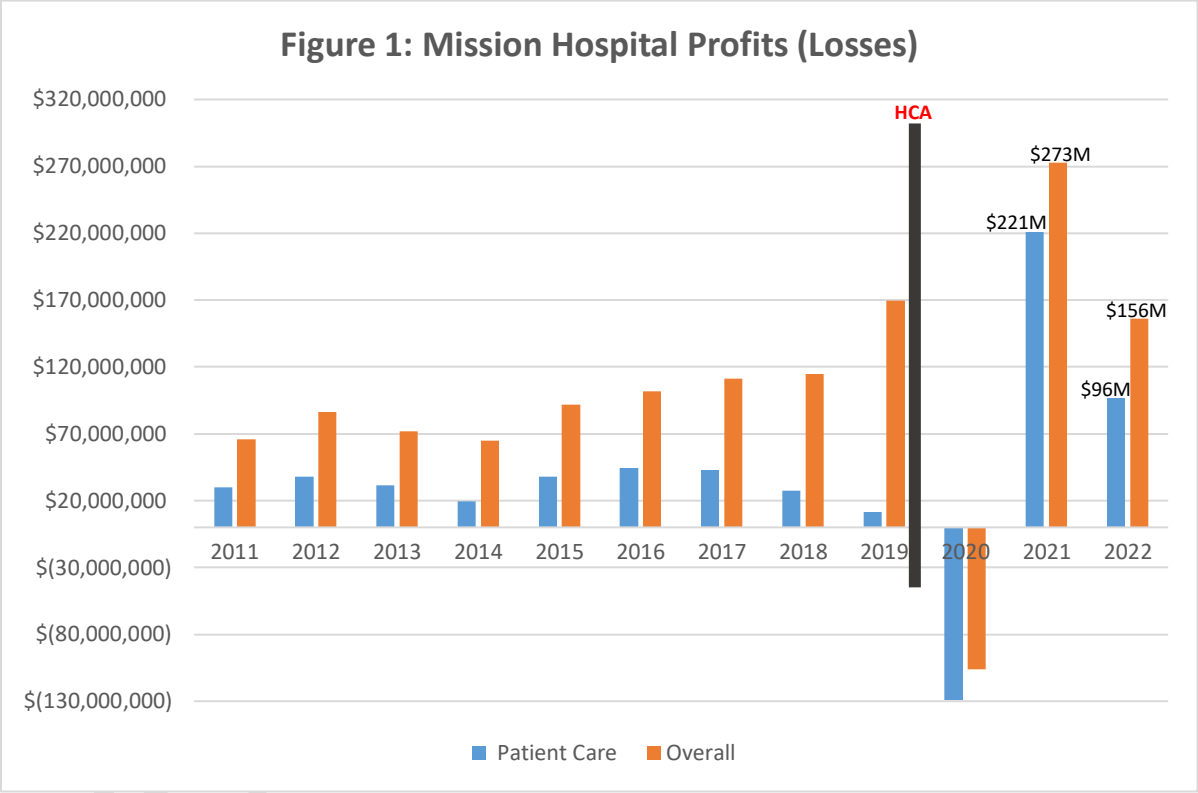
The following factors should be considered in reviewing these financial metrics:[5]

- For most of the hospitals studied (including Mission), the fiscal (financial accounting) year begins in the prior October.
- HCA acquired Mission starting Feb. 2019, and so one third of that fiscal year was prior to HCA.
- The COVID-19 pandemic substantially affected hospitals in 2020 (starting in late March). 2021 was a recovery year, and by 2022, COVID's impact on hospital finances had largely abated.

FINDINGS

1. Profits

Hospital profits or losses can be measured in two ways: overall (including investment returns) and based on patient-care operations. Figure 1 shows both measures over time.



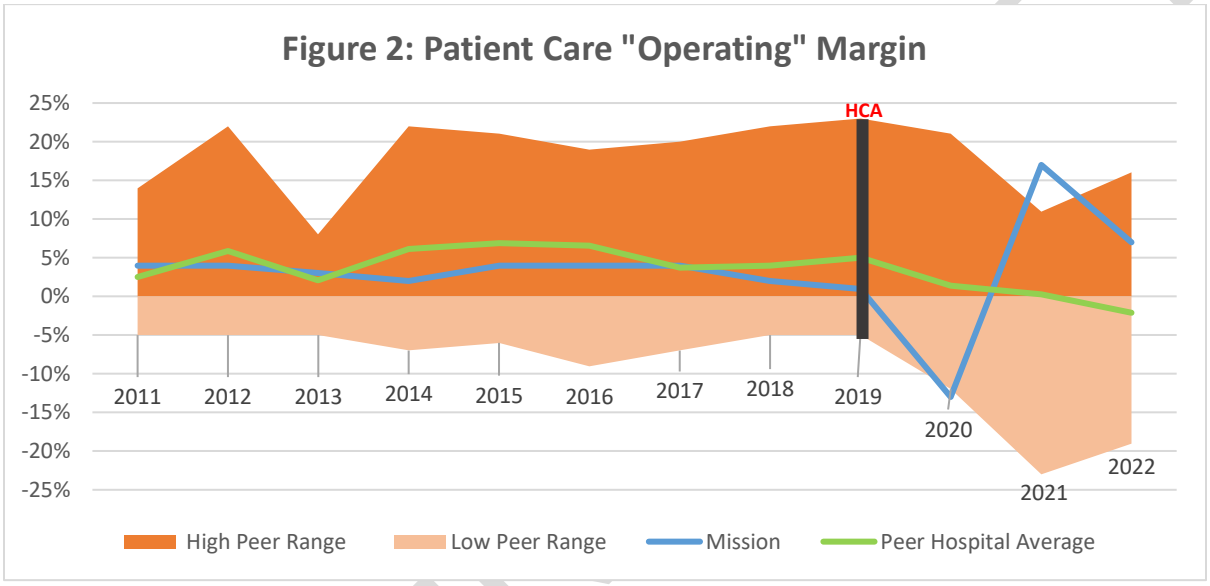
In the most recent year for which comparable data is available (2022), Figure 1 shows that Mission's patient-care profits were almost $100 million, which was about 3.5 times its profits the year before HCA's purchase, or about 2.5 times its $38 million profit average over the four years prior to HCA's purchase. During its initial transition year (2019), HCA had reduced patient-care profits (possibly due in part to the fact that 1/3 of that fiscal year was prior to the acquisition). In 2020, it incurred a substantial loss due to the height of the COVID-19 pandemic. By 2021, however, Mission's financial performance had rebounded impressively, to $221 million profits from patient care, which was *eight times* its profits the year prior to purchase (2018), and almost six times its four-year pre-purchase average. Even more impressively, HCA

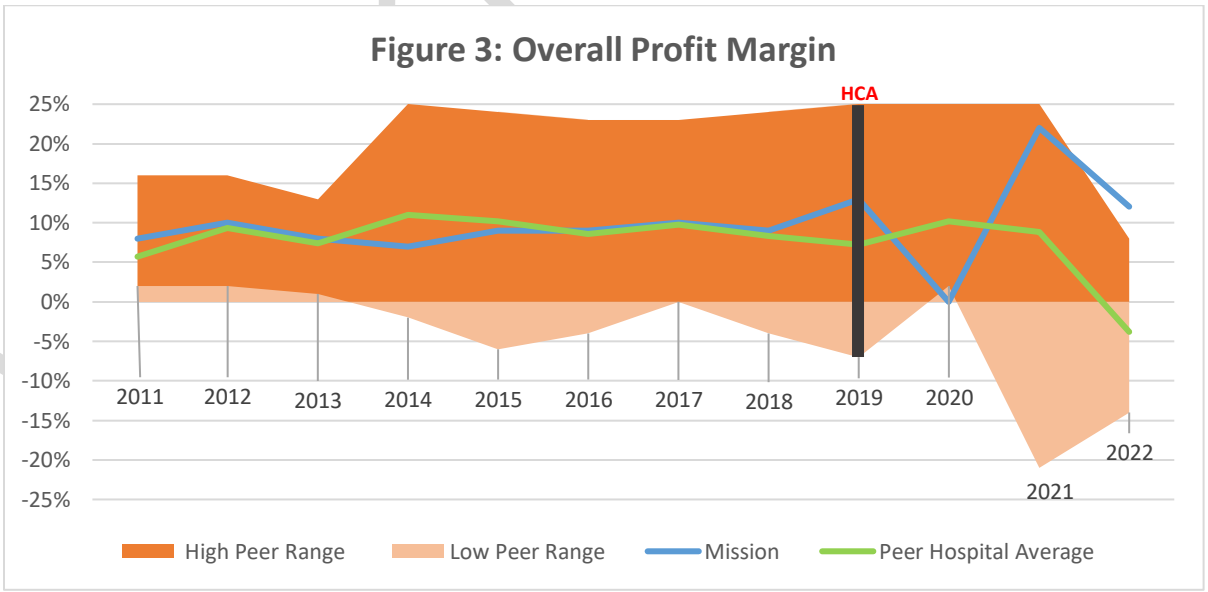
[5] Also, for clarification: the averages among peer hospitals used to compare Mission's performance are calculated excluding Mission, and they are unweighted averages (that is, giving each hospital equal weight).

Mission projected as part of a "certificate of need" application to the state (p. 176) that, by 2026, its profits for medical services (excluding behavioral health) will increase an additional 75 percent from their 2021 level.

2. Profit Margins

To better understand this financial performance, we now compare Mission with the peer hospitals in Table 1 (above). Since the size of these hospitals varies, we look to profit *margins* (i.e., the percent of revenues retrained as profit) rather than profit *totals*. Also, because investment returns vary for reasons unrelated to hospital operations, we focus primarily on "operating" (or patient-care) profits and costs.





Figures 2 and 3 show that, prior to HCA's acquisition, Mission's profits, by either measure, were relatively steady and were similar to the average for the 11 peer comparison hospitals, ranging from 2-to-4 percent for patient care, and 7-to-10 overall. In 2019, the first year under HCA, Mission's patient-care margin dipped to almost zero, below the peer hospital average, but its overall profit margin stepped up to almost double the peer average (Fig. 3), indicating that HCA had an especially good investment year. In the following three years, Mission's two profit metrics fluctuated a great deal, but they moved essentially in lock step, indicating that variations were driven substantially by patient-care profits/losses.

The COVID-19 pandemic obviously affected Mission's profits, and COVID effects can also be seen for the peer comparison hospitals in 2020 and 2021. However, there are noticeable differences in how COVID affected these hospitals' financial performance. In 2020, COVID's first year, the peer average for patient-care (operating) profits dropped some, but not nearly as much as for HCA (Fig. 2). In 2021, financial performance continued to decline at peer hospitals, whereas HCA's financial performance rebounded quite handsomely (Fig. 2). HCA Mission went from a loss level at the bottom of the peer range in 2020, to a very large patient-care profit margin of 17 percent in 2021. Mission's profit margin exceeded any other peer comparison hospital in 2021 and was much higher than the peer average, which was essentially zero.

By 2022, other hospitals on average still had not recovered to their pre-COVID performance, incurring an average patient-care loss of 2%, whereas HCA retained nearly its top-ranking profit level (Fig. 2). Its patient-care profit margin was 7 percent in 2022, exceed by only two other hospitals (Greenville SC at 16% and Moore County (Pinehurst NC) at 9%).

In sum, despite the instability caused by the COVID-19 pandemic, over HCA's first four years of ownership, Mission went from the lower end of patient-care profitability to the top of the range among these peer hospitals.

Importantly, financial projections that HCA Mission filed with the state in 2021 (as part of its "certificate of need" application for a 67-bed expansion) show that it expects to continue increasing its profitability. In that filing (pp. 176-178), it projected that its patient-care profit margin from medical services (excluding behavioral health) will increase by another 50 percent by 2026. We next seek to understand how HCA has accomplished, and most likely intends to continue, this impressive improvement.

3. Prices

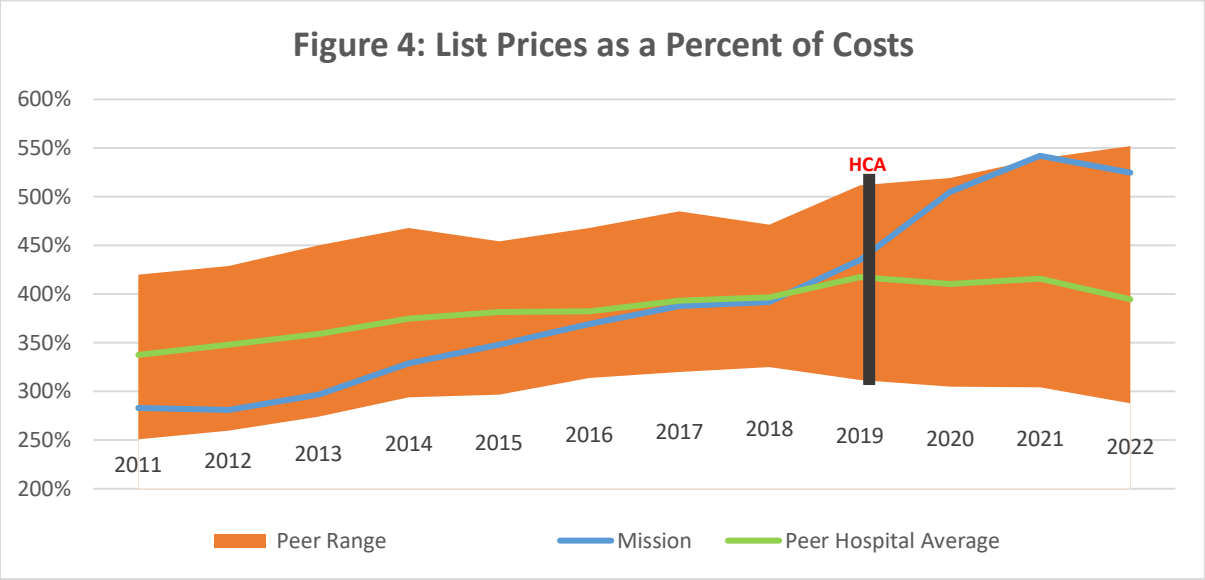
There are two basic ways to improve a profit margin: increase prices or decrease expenses.[6] It is difficult for HCA Mission to increase effective prices, for two reasons. First, the substantial majority of its patients are covered by Medicare or Medicaid, under which the government essentially sets prices. Second, for commercially insured patients, Blue Cross/Blue Shield of NC has a very large share of the private insurance market, which gives it substantial leverage to resist hospital price increases. Indeed, as discussed in [a forthcoming section], it was Mission's failed negotiation with Blue Cross in 2017 that led to the Board's 2018 decision to sell to HCA.

Hospitals can, however, influence prices paid by patients out of pocket, by smaller and some larger health plans, or by non-standard insurers such as auto or accident. Hospitals attempt to do so by increasing their "chargemaster" rates, which are essentially their list prices. A measure of the extent to which they do so

[6] Total profits can also be increased by increasing services, but our focus here is on profit *margin* – income as a percent of revenue – rather than on total profits.

is the "charge-to-cost ratio." That ratio is simply how much, on average, a hospital's list prices exceed its reported costs of service.

Notoriously, almost all hospitals maintain list prices with a markup that is surprisingly or shockingly high. Figure 4 shows that, on average, these comparison hospitals mark up their list prices about 350% *of* costs (or 250% *over* costs), ranging from about 250 percent to more than 500 percent *of* costs (or 150% to 400%+ *over* costs). Very few patients actually pay these full amounts, but for some patients, list prices are the basis for negotiating discounted payments. Some patients, though, are actually billed these exorbitant amounts, which harms their credit rating if they cannot pay and even sends some patients into bankruptcy.



Over the span of time shown in Figure 4, Mission steadily increased its average price markup prior to HCA's acquisition, with an average annual increase of 16 percent points from 2011-2018, compared with a 9-point average increase by peer hospitals. As a result, over those eight years Mission rose from the lower end to the middle of this peer range. Under HCA, however, Mission's annual mark-up increases doubled, averaging 33 percentage points a year (or 30 points disregarding the 2019 transition year). These accelerated price increases propelled HCA to the top of this peer range within just two years, which is especially notable considering that, over this same time, the average for peer comparison hospitals remained essentially level.

Reflecting these increases, the several antitrust suits that have been filed against Mission following HCA's acquisition cite a number of specific examples of HCA increasing prices for particular services to a significantly greater extent than have other NC hospitals. In one antitrust case, for instance, the court summarized (citations omitted) [7]:

> HCA's high market shares have allowed it to raise prices in the Relevant Markets, and, over the past five years Mission's and HCA's prices for routine or standardized [hospital] services have increased at a faster rate than prices for those services statewide. ... Data from a large, private

[7] In Re Mission Health Antitrust Litigation, D. Ct. No.: 1:22-cv-114 (2024, W.D.N.C.), https://law.justia.com/cases/federal/district-courts/north-carolina/ncwdce/1:2022cv00114/108404/67/

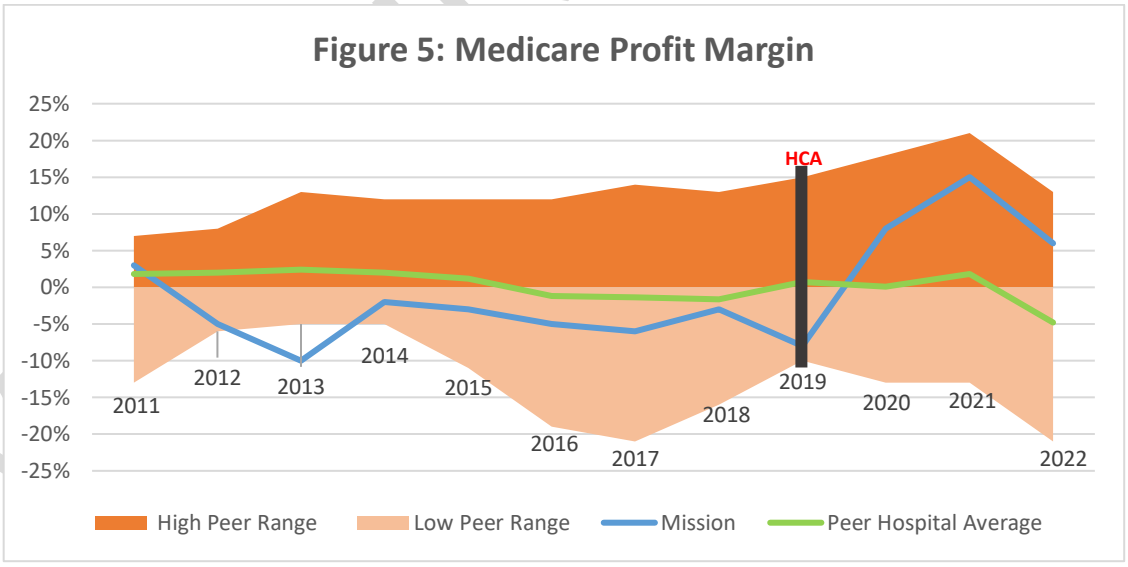
> commercial database of health price and claims information provides examples of HCA's average prices for specific procedures. From 2017 to 2020, ... the price for a shoulder arthroscopy at Mission Hospital-Asheville increased by 75%, while it increased only19% statewide .... For stress tests, the average price declined by 10% statewide, while increasing by 29% at Mission Hospital-Asheville. Similarly, the average price of a lipid panel declined by 19% statewide, while increasing approximately 31% at Mission.

Because so few patients actually pay these full amounts, however, increased list prices do not explain most of Mission's improved profitability in 2021 and 2022. These increases do indicate, however, the degree to which a profit-oriented owner is inclined to use every leverage to increase profits. Despite that inclination, Mission's top-of-range markup in 2022 is actually at a more moderate level (525% of costs) than what is typical at most other HCA hospitals, where markups average about 10-fold (1,000%).[8]

4. Costs

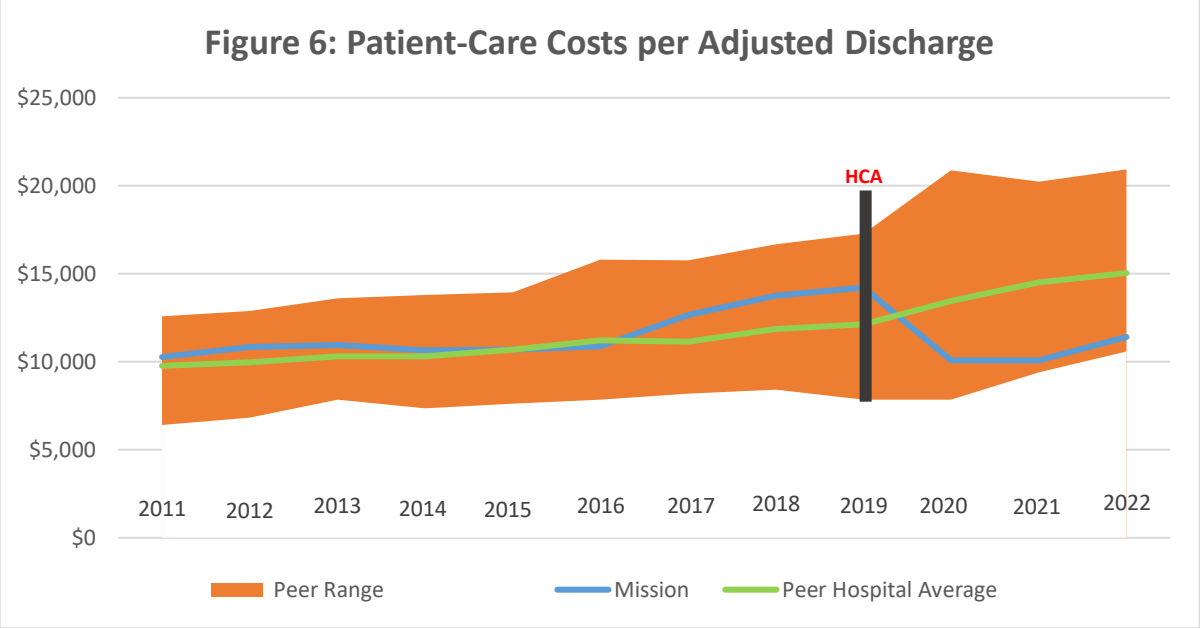
Mission's cost performance under HCA offers a much more compelling explanation than its pricing for how it has achieved top-of-range profits. Mission's financial performance under Medicare is one clear indication that cost control has been key. Because the government sets Medicare prices, cost control is the primary way a hospital can improve its profits under Medicare.

Figure 5 shows that, in fact, Mission's Medicare profitability has skyrocketed under HCA. Prior to HCA, Mission Hospital on average lost 4 percent each year on Medicare patients. Within three years after HCA's acquisition, however, it was making almost a 15 percent profit on Medicare patients, and in 2022 continued to make 6 percent (with a three-year average of 10 percent). That remarkable increase pushed Mission from below the peer hospital average to near the top of the peer range, with only one hospital making more (Cape Fear at 13%).



[8] https://www.statnews.com/2024/04/08/hca-charity-care-reported-to-medicare-1-billion-higher-than-financials/ https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0567

Confirming that cost control has been the key to profitability, Figure 6 shows Mission's average patient-care costs per patient over time.[9] For the first half of this span, Mission was very near its peer average, a requirement set by the state's antitrust review. When state review was terminated in 2016, Mission's patient-care costs began to increase noticeably, until 2019, when, under HCA, patient-care costs dropped sharply and abruptly – by almost 30 percent in 2020 and remaining 20 percent lower in 2022. That drop moved Mission from 17 percent above the peer average to the bottom of the peer range, at 25 percent below the peer average.

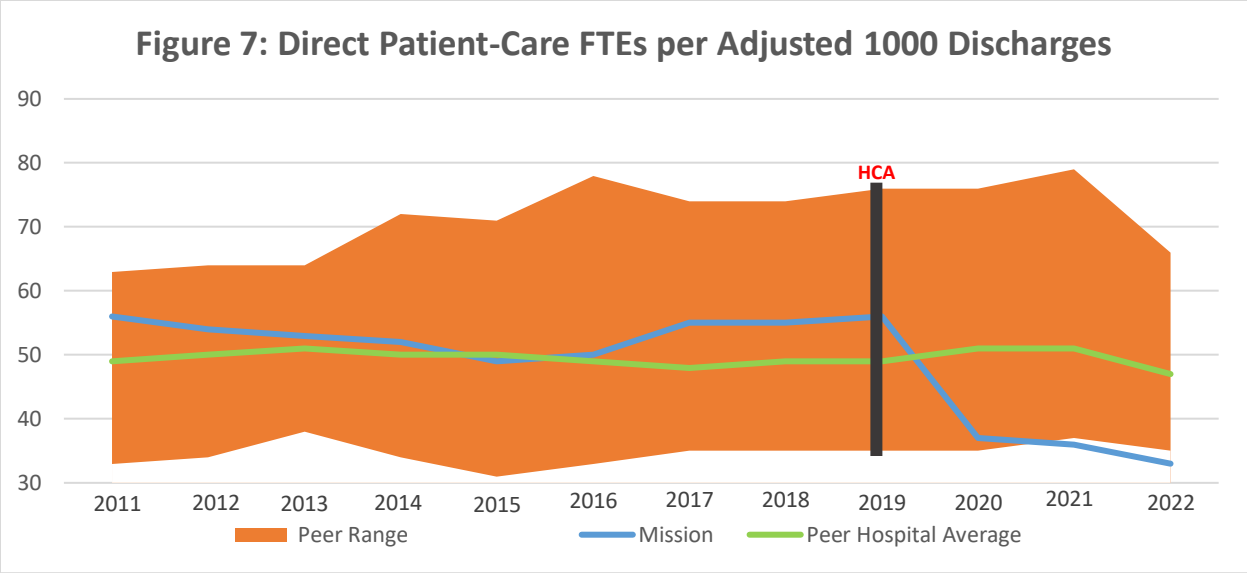


Also significant is that the only other two hospitals near Mission's low level (Cape Fear and Moore County) have a patient population whose average case severity (measured by the case mix index shown in Table 1) is noticeably lower than Mission's (-17% and -9% less severe, respectively). In contrast, the three hospitals with the most comparable patient severity (New Hanover, WakeMed Raleigh, and Pitt County) have operating costs that average about a third higher than Mission's. This is significant because, all else equal, a hospital's operating costs vary by patient severity, but HCA Mission's operating costs are much more in line with lower-severity peer hospitals.

5. Staffing

Next, we explore how these remarkable cost savings were achieved. Figure 7 below indicates that staffing reductions have been a major source of cost savings – especially staffing for direct patient care (as opposed to general management/administration). Here, too, we see the same pattern for patient-care staffing as in Figure 6 (above) for overall patient-care costs. Looking at patient-care FTE (full-time equivalent) staff per patient, Mission began this span higher than the peer comparison average, but then Mission maintained staffing at or near the peer average for four years, before staffing increased noticeably (starting in 2016) once Mission was no longer subject to the state's oversight of its costs.

[9] These costs are reported per "adjusted discharge," meaning that outpatient treatment is converted to an equivalent inpatient stay based on hospital-wide averages for the two types of patients.



Following HCA's acquisition, however, Mission's patient-care staffing plummeted in just a single year, from above the peer average to the bottom of the range, and staffing has remained at a level that is 30 percent below the peer group average.

These data show staffing ratios based on the number of patients treated, which does not account for each patient's length of stay. Making that adjustment, however, does not change, but instead confirms the overall picture. Table 2 shows a credible analysis done by the State Employees International Union using the same data source as this report.[10] It calculates an overall "FTE rate" that reflects a yearly average for the number of full-time workers per occupied bed.

Table 2: Staffing FTE Rates per Occupied Bed

	Mission Hosp.	National Average	NC Average
2014	6.3	5.8	5.5
2015	6.2	5.7	5.2
2016	6.2	5.7	5.2
2017	6.0	5.7	5.2
2018	6.0	5.6	5.1
2019	4.7	5.5	5.0
2020	4.7	5.8	5.2
2021	3.7	5.4	5.1

Source: SEIU Analysis of Medicare Cost Reports

As shown, prior to HCA, Mission's overall staffing levels were above state and national averages, but, under HCA, staffing levels immediately dropped by almost a quarter. Then, two years later, staffing dropped further, to a level that is roughly a third less than state and national levels.

Overall, this Section shows that relevant staffing levels can be measured a variety of ways. In the absence of something more definitive, these data that all hospitals report to the federal government are generally

[10] https://www.seanc.org/assets/HCA-NC-CoN-Comment-FINAL.pdf

accepted as the best available measure for hospital staffing levels. The data can be analyzed in various ways – using different metrics and different points of comparison. All available analyses, however, point to a consistent conclusion, that sharply reduced staffing for patient care under HCA explains a large component of the hospital's markedly increased profitability under HCA.

6. Purchasing and Administrative Efficiencies

When Mission's Board decided to sell to HCA, most Board members appeared to believe, based on what they had been told, that expense savings through purchasing power and back-office efficiencies were the primary ways HCA would improve financial performance. Good data are not available to measure those expense elements directly. However, data that HCA Mission submitted to the state in 2022 (as part of its "certificate of need" application to add 67 more beds) suggest that any such cost savings are unlikely to be the dominant or primary driver of the hospital's improved profitability.

HCA's reported data provides only limited insight, but as shown in Table 3, much of its total expenses are concentrated in labor costs, and, as Table 4 shows, the very large majority of labor costs are devoted to patient care rather than administration.

Table 3: Mission Hosp. Categories of Expense

Labor Expenses	$373 million	35%
Prof'l and Management Fees	$76 million	7%
Supplies	$183 million	17%
Pharmacy	$70 million	7%
Central Office	$95 million	9%
Management Fees	$50 million	5%
Maintenance	$25 million	2%
Admin. Misc	$15 million	1%
Depreciation	$106 million	10%
Taxes and Assessments	$43 million	4%

Table 4: Mission Hosp. Categories of Workers

	FTEs	**Percent**
Nursing	1,597	44%
Clinical, various	1,244	35%
Cleaning, Food, Maintenance, Security, Transport, Patient Services	474	13%
Info Services	27	1%
Administration	42	1%
Clerical, Misc	213	6%
Total FTEs	**3,596**	

*Source: Mission Hospital CON Application for 67 Acute Care Beds, June 15, 2022
Note: For Table 3, there appears to be some overlap among categories, with the calculated total of $1.06 billion exceeding the stated total by 5%.

Looking at *non*-labor costs, Table 3 shows that pharmacy and other supplies account for about a quarter of expenses, and various administrative cost categories account for 17 percent of the total.[11] While this breakdown does not precisely reveal purchasing and administrative expense, it indicates that patient-care labor costs are at least on par with general purchasing and administrative costs. Accordingly, contrary to the Board's initial expectations, reductions in purchasing and general administrative costs do not appear to be the primary driver of Mission's substantially increased profitability under HCA.

[11] It is possible, however, that some labor expense was included in the latter.

About the Author and Funder

Mark A. Hall is one of the nation's leading scholars of health law and public policy, with three decades of experience leading social science studies funded by competitive research grants from the federal government and a range of major national foundations and respected "think tanks." An elected member of the prestigious National Academy of Medicine, he regularly publishes in, and conducts peer review for, leading medical and health policy academic journals. Prof. Hall regularly consults with public policy and government officials, including federal and state lawmakers and regulators.

In its efforts to improve health care markets, the funder, Arnold Ventures, supports a certain amount of "impact litigation," as do other public policy groups. Some of that support goes to a public interest law firm that is currently suing HCA Mission on antitrust issues. This research team and Wake Forest University have no connection with that litigation. Also, Arnold Ventures has no control over, or even input into, how this research is conducted or how information gleaned is analyzed or reported. Instead, this is entirely independent academic research, conducted using accepted social science methods.