LESSONS LEARNED FROM HCA'S PURCHASE OF MISSION HOSPITAL IN ASHEVILLE, NORTH CAROLINA

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This study examines 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). The research is funded by a grant from the Arnold Foundation. Colleagues at Wake Forest University who contributed are Doug Easterling, Ph.D., Joe Singleton, J.D., and Laura McDuffee, M.P.A.

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 some "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, Wake Forest University, and The Source on Healthcare Price & Competition have had 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.

Introduction, Background, and Executive Summary

INTRODUCTION

This study examines 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). HCA (formerly, Hospital Corporation of America) is the country's largest investor-owned, for-profit hospital chain. Prior to this purchase, the Mission Health system operated for well over a century as a nonprofit "charitable" organization. It was recognized as one of the nation's premier community-focused non-academic hospitals.

Despite Mission being in sound financial shape, its board decided that it's longer-term prospects as an unaffiliated community system were challenging. Rather than waiting for financial conditions to deteriorate, the board decided to sell the hospital while it was strong, netting an impressive $1.5 billion, which was used to create a very large community foundation. As discussed in Part 1, the board selected HCA believing that it was the best candidate to maintain Mission's financial and clinical strengths while also carrying on a substantial component of its charitable aims.

HCA's ownership and operation of the Mission Hospital system has proven, however, to be much more controversial and contentious than anyone imagined. Concerns related to Mission's quality of care, scope of services, patient access to services, corporate profits, inadequate staffing, excessive physician turnover, and questionable charitable care policies have produced an avalanche of negative publicity, both locally and nationally, as well as several high-profile lawsuits and a major federal enforcement action.

This research study undertakes a thorough and robust examination of the underlying bases for these pervasive critical reactions. The goal of this study is not to pass judgment on these controversies. Instead, this project aims to identify and provide clarity on what others can learn from what led to Mission's decision to sell to HCA and how HCA has subsequently managed Mission. These lessons can inform communities facing similar health policy concerns about how best to evaluate their options. These lessons can also inform lawmakers and public policy officials seeking to improve the functioning of hospital markets through review of proposed transactions or improved oversight of hospitals with considerable market power.

BACKGROUND

Mission Hospital began in 1885 when four women sold flowers on the streets of downtown Asheville to fulfill their vision of a medical facility for the sick and indigent.[1] The women's dream quickly blossomed: on October 6, 1885, "The Little Flower Mission" began in a five-room house, which cared for people regardless of their ability to pay.

From those humble roots grew what became known as Mission Health, which is now the dominant hospital system in western North Carolina (WNC). Centered on the 815-bed Mission Hospital in Asheville (which is by

[1] https://www.missionhealth.org/about-us/our-history

far the region's largest city), the system also includes five very small general hospitals (25-to- 30 beds) in mostly rural surrounding counties.[2]

A century ago, Asheville's economy was driven by manufacturing, but tourism is now the area's primary economic engine. Today, Asheville is known for outdoor recreation, high quality restaurants, microbreweries, and performing and visual arts. It attracts both retirees and hipsters. It also has a significant homeless population. The broader region has characteristics that typify rural Appalachia, including significant poverty and various dimensions of poor health.

This study focuses mainly on the flagship medical campus, Mission Hospital, which accounts for almost 90 percent of hospital services for residents of Buncombe and Madison counties and about half of hospital care in the neighboring 15 counties. Although four other hospitals serve this broader geographic area, Mission is the only tertiary referral facility[3] and Level II trauma center in the entire region. As such, it provides a broad range of high-level specialized or intensive services that are not otherwise available in western North Carolina.

A decade ago, a series of events began to unfold which eventually led to Mission's Board of Trustees selling the system to HCA Healthcare, the world's largest for-profit hospital conglomerate of almost 200 hospitals. Prior to this sale, reputable ranking agencies and health policy analysts regarded Mission as one of the very best hospitals in the county.[4] Under HCA, however, Mission has experienced what one national reporter called "a stunning fall from grace,"[5] evidenced by a barrage of criticism on multiple fronts. It seems, as one media watcher wrote, that "Mission Hospital news is always bad news since HCA took over."[6] A previous chief of one of Mission's clinical services agrees, writing (to a state agency) that "[w]hat was once the jewel of [western NC] has become a pariah in the national media." Appendix A provides 34 examples from national publications and media outlets and an exceptionally long listing of 142 negative articles about Mission, from local and regional media.

This breadth and depth of negative press tells only part of the Mission/HCA story. Since the acquisition, HCA has completed various substantial capital investments the hospital had previously planned or undertaken to expand and improve Mission's treatment facilities. HCA also committed to keeping the system's five rural hospitals open for a decade unless doing so becomes "commercially unreasonable." Moreover, HCA brought an impressive level of prowess to Mission's management, which likely helped Mission cope more effectively with COVID-19's unprecedented challenges. And, converting Mission from nonprofit to for-profit status added substantially to the area's tax rolls. Relatedly, and most notably, the $1.5 billion proceeds from the HCA sale were used to create an exceptionally large philanthropy (called Dogwood Health Trust), which is

[2] These hospitals are in the NC towns of Marion, Highlands, Brevard, Franklin, and Spruce Pine. The Mission system also includes Asheville facilities for behavioral health, rehabilitation, skilled nursing, and outpatient surgery.
[3] Although hospital-level distinctions are imprecise, Mission claims at least some extent of "quaternary" care, which is the highest level.
[4] https://www.beckershospitalreview.com/rankings-and-ratings/truven-names-15-top-health-systems-for-2017.html https://businessnc.com/north-carolinas-2018-best-hospitals/ https://www.commonwealthfund.org/publications/fund-reports/2004/jul/hospital-quality-ingredients-success-case-study-mission
[5] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia
[6] https://www.dailykos.com/stories/2024/1/13/2217259/-DKos-Asheville-Open-Thread-Mission-Hospital-news-is-always-bad-news-since-HCA-took-over

devoted to improving population health in western NC. Nevertheless, an avalanche of discontent has buried these positive aspects of the sale to HCA.

As Appendix A reflects, the overriding sentiment about Mission's sale to HCA is profoundly negative, expressed variously as regret, sadness, anger, heartbreak, or infuriation. This relentless torrent of deeply felt negative sentiment is truly unparalleled. One year after the 2019 sale, seven state and local government leaders wrote an extraordinary open letter[7] expressing:

> "... deep concern regarding the state of Mission Hospital Systems since the purchase by [HCA], … [based on reports that] have been pouring in from distressed patients, practitioners and HCA employees …. HCA has chosen to make its money by reducing charity care, eliminating medical and unit administrative staff to the detriment of patient care and safety, and sacrificing entire physician practice groups with long-standing contractual relationships by demanding significant reductions in pay. That wasn't the deal we were told about and it wasn't the deal we made as a community."

Similar concerns have led several area municipalities or government agencies to sue HCA Mission for damages resulting from alleged overpricing and for costs incurred in how HCA has managed its emergency room.[8] The state's Attorney General has also sued based on documented inadequacies in cancer care and emergency care.[9]

Equally astounding is a public letter signed in late 2023 by more than 100 area physicians, including seven former board members and nine former clinical chiefs at Mission, which constitutes essentially an "open revolt" against HCA by a significant portion of Asheville's medical community.[10] Additional portions of this remarkable missive are quoted elsewhere in this study, but the core sentiment is that:

> "Many of the for-profit-driven changes that HCA has wrought, despite advocacy and protests from multiple sectors, have gutted the heart and soul of our community healthcare system, … [which has been] a backbone of this community for decades. ... [W]e have seen little to no interest on their part in working with physicians or community leaders across multiple sectors to address quality-related problems ...."

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[7] https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/

[8] https://www.bpr.org/2022-07-29/acity-of-asheville-and-buncombe-county-file-lawsuit-against-hca-healthcare
https://www.citizen-times.com/story/news/2022/07/28/buncombe-asheville-filed-class-action-lawsuit-against-hca-healthcare-mission-health/10171852002/
https://wlos.com/news/local/brevard-hca-mission-health-hospital-scheme-transylvania-regional-lawsuit-western-north-carolina-buncombe-macon-madison-mcdowell-mitchell-yancey

[9] https://ncdoj.gov/attorney-general-josh-stein-sues-hca-healthcare/

[10] https://avlwatchdog.org/50-doctors-including-a-former-board-member-publicly-decry-hcas-management-of-mission-hospital-system/
https://www.northcarolinahealthnews.org/2023/10/22/50-doctors-including-a-former-board-member-publicly-decry-hcas-management-of-mission-hospital-system
See also https://www.citizen-times.com/story/opinion/2024/07/28/opinion-reclaim-healthcare-wnc-hopes-to-move-mission-to-new-ownership/74510873007/

Public distress has been so deep and wide that over 60 area clergy and religious leaders felt "compelled to speak out" in a public letter[11] to say:

> "HCA must bear responsibility for creating the conditions that have led to dangerous situations that are only now becoming public. ... Our community deserves to have accessible, quality, patient-centered healthcare. At present HCA is not providing such care in a reliable way. HCA is not meeting the commitments that they made to this entire region when they purchased Mission Health."

And, in the summer of 2024 a group of community and medical leaders announced a coalition effort to push for replacing HCA with a non-profit owner.[12]

In short, the entire community, on multiple levels, is up in arms about what has happened to its hospital. As summarized by one well-credentialed reporter:[13]

> [F]ive years of HCA management has resulted in documented chronic understaffing; hundreds of physician and nurse departures; higher healthcare prices; plunging employee morale that led to the formation of a nurses' labor union; multiple lawsuits against HCA-Mission by local citizens, the cities of Asheville and Brevard, Buncombe County, and the state's attorney general; heartbreaking stories by patients and family members of substandard care — all culminating with the determination in December [2023] by state inspectors that patients seeking care at the once-proud Mission Hospital were in "immediate jeopardy" of serious injury, harm, impairment, or death.

This research project undertakes a thorough and robust examination of the underlying bases for these pervasive critical reactions – not to pass final judgment on these controversies, but in order to identify and provide clarity on what others can learn from what transpired in Asheville NC.

METHODS

This research is based on extensive document review, analysis of financial data, literature review (including media reports),[14] and interviews with 50 "key informants." These interview sources are North Carolina professionals, mostly from Asheville and surrounding counties, well placed to have insightful knowledge about the questions studied. Eighteen are clinicians, seventeen were at some point in management or on the board at Mission Hospital, seven are government officials (former or current), eight have worked as clinicians or administrators primarily serving low-income uninsured patients in the area, and eight work with health care public policy issues in various other ways. (Some interview sources fall into two of these categories.)

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[11] https://www.citizen-times.com/story/opinion/2024/02/04/hca-healthcare-immediate-jeopardy-incidents-harm-nc-health-care/72428692007/

[12] https://reclaimhealthcarewnc.org/who-we-are
https://www.citizen-times.com/story/opinion/2024/07/28/opinion-reclaim-healthcare-wnc-hopes-to-move-mission-to-new-ownership/74510873007/

[13] https://avlwatchdog.org/former-mission-board-member-we-had-hoped-that-hca-would-be-a-better-corporate-citizen/. For a similar account by a different publication, see:
https://www.citizen-times.com/story/news/local/2022/12/27/hca-mission-health-had-year-of-lawsuits-staff-patient-complaints/69754830007/

[14] For readability, this study cites publicly available information mainly just by website URL links.

Potential interview sources were identified in a variety of ways including their affiliations with key institutions,[15] and respondent-driven referrals. Efforts were made to include well-placed sources who were both favorable and unfavorable, as well as those in a position to evaluate competing perspectives. Unavoidably, this is somewhat of a "convenience sample" because a dozen or so who were approached did not respond or agree to participate. However, recruitment of informed sources continued until reasonable "saturation" was reached, meaning that substantial new information was no longer emerging. Documentary and interview information was analyzed using qualitative methods that are standard for this type of research. "Triangulation" is one such method, by which information from one type of source (interview, documentary, or data) is cross-checked with information from other types to determine whether either confirmation or inconsistency exists.

In addition, preliminary drafts of each of this study's major parts were distributed among key informants and the community at large (via media coverage) to solicit input and feedback.[16] That process revealed no substantial errors or misinterpretations. The final version of this study's findings, analysis, and recommendations are presented in the following seven parts:

Part 1: Mission Hospital's Decision to Sell to HCA

Part 2: Mission Hospital's Financial Performance Under HCA

Part 3: Changes in Patient Care Following HCA's Purchase of Mission Hospital

Part 4: Mission Hospital's Quality Ratings Following HCA's Acquisition

Part 5: Mission Hospital Charity Care Following HCA's Acquisition

Part 6: Positive or Mitigating Aspects of HCA's Acquisition

Part 7: Public Policy and Legal Regulatory Recommendations

[15] To avoid any possible appearance of bias, no sources were identified through the nurse's union or its representatives.
[16] https://hlp.law.wfu.edu/reports-and-issue-briefs/ It is notable, however, that HCA Mission has not responded substantively to any specifics in these preliminary reports.

EXECUTIVE SUMMARY

1. The Decision to Sell to HCA

Key elements of Mission's decision to sell to HCA have been covered extensively by others. pulls together that body of work and adds additional insights from interviews with former board members and informed sources.

In sum, despite the hospital's strong financial condition at the time, Mission's leaders believed that, over time, Mission would struggle to maintain its quality and scope of services as a stand-alone system. A substantial driver of this belief was financial fallout from Mission's failed negotiation with Blue Cross in 2017 to increase payment rates. Because Mission's leaders had already been exploring a potential sale, its board was able to approve a sale to HCA within just a few months after the failed Blue Cross negotiations.

A key event that paved the way for the HCA sale was the NC legislature's decision in 2015 (effective in 2016) to terminate the financial oversight that had been in place for two decades as a condition for allowing Mission Hospital to merge in 1995 with its former Asheville competitor, St. Joseph's. No convincing reason can be found for why NC, having conferred monopoly power, then permitted Mission to become an unregulated monopoly 20 years later. It does appear, however, that state officials and involved community members at the time failed to foresee that lifting regulatory oversight might lead to the hospital's sale to a large, out-of-state profit-driven owner.

Mission's selection of HCA rather than an in-state nonprofit system that offered similar terms has been extensively critiqued, based on concerns that Mission's board was not fully informed or that its CEO had a conflict of interest. Key leaders involved at the time, however, explain that HCA was selected because it appeared better able to achieve operating cost efficiencies without compromising quality or service. Another major draw was that HCA's purchase price would be used to create a large foundation that would broadly address regional health problems. It does not appear, however, that the board anticipated HCA would pursue cost savings by making aggressive cuts in patient care staffing.

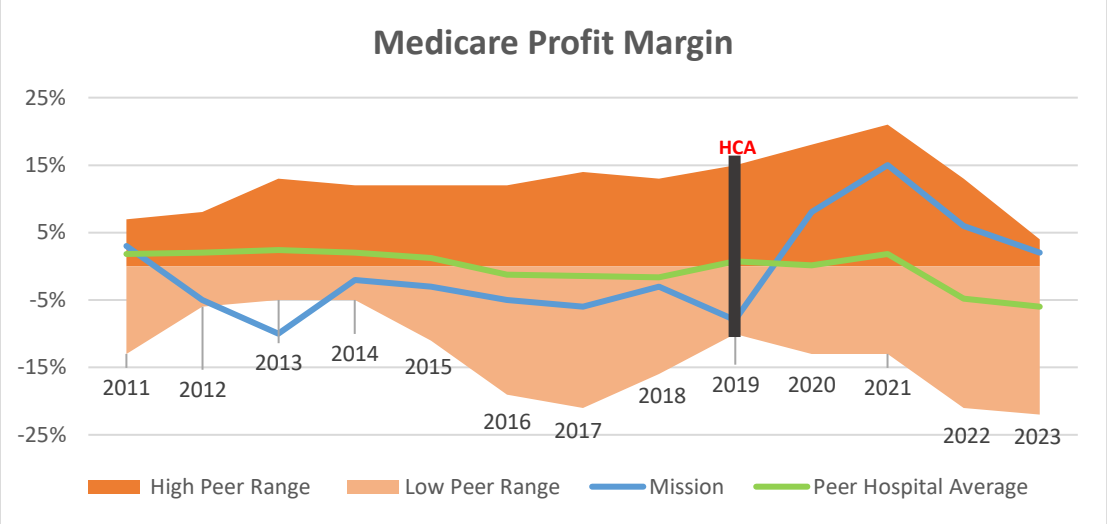
2. Financial Performance Under HCA

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, Part 2 explores whether Mission Hospital has in fact 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, to over $100 million a year – which is several times greater than prior to HCA's acquisition.

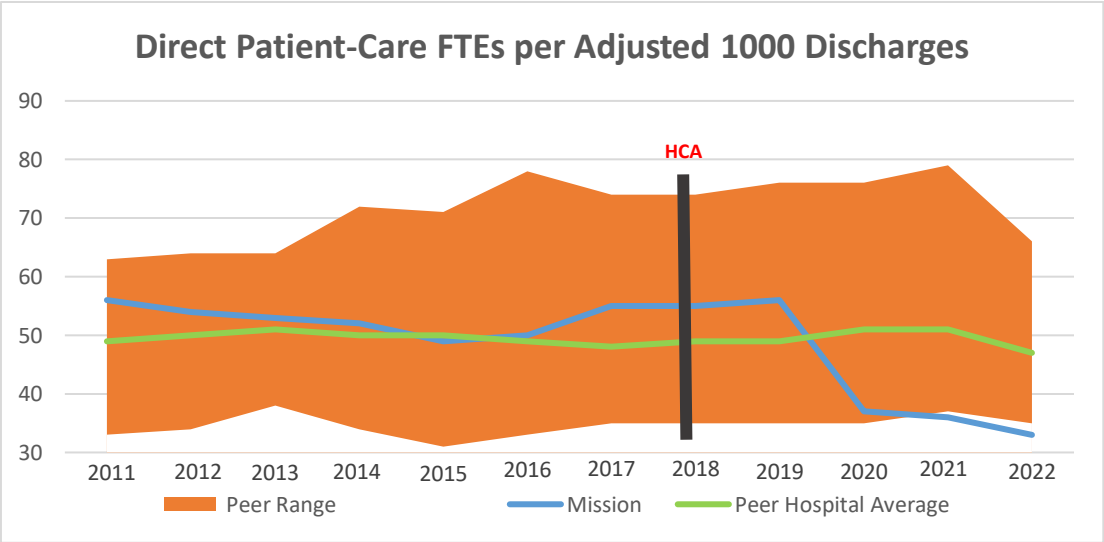
To understand what accounts for this substantial improvement in profitability, Part 2 examines financial data on Mission Hospital compared with a set of eleven similar (or "peer") hospitals in NC and bordering states. In summary:

- Prior to HCA's acquisition, Mission's patient-care ("operating") profit margin was relatively steady at 2-4% of revenues -- similar to the peer comparison average. 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 hospitals, which is several times higher than prior to the acquisition. To illustrate, this Figure shows a sharp increase in profitability for Mission's Medicare patients, compared with a fairly steady break-even level for similar hospitals in the area.



- Although HCA increased its 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, Mission sharply decreased its 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. As the following figure shows, Mission's staffing ratios plummeted from above its peer average to the bottom of the peer hospital range following HCA's acquisition.



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

3. Changes In Patient Care

The effects of HCA's strategy (discussed in Part 2) to increase profits by sharply reducing patient-care labor costs can be summed up by focusing first on physicians, then on nurses and other patient-care staffing, and finally on the emergency room.

1. Physician Departures. Prior to HCA's purchase of Mission Hospital, Asheville's medical community was known for its excellence. In significant part, this was due to the hospital supporting many components of the community. Mission Hospital formed and grew an esteemed group of hospitalists physicians, supported several large primary care practice groups, and either employed, contracted with, or managed a broad range of key specialists.

When HCA purchased Mission, it assumed a different relationship with local physicians. It closed its large primary care clinics outright, and renegotiated employment, contract, and management terms in a fashion that appeared to disfavor a range of less-remunerative medical specialties. Many of these specialists took their practices elsewhere, some largely for financial reasons, but others did so because they felt that patient care was severely degrading under HCA.

HCA was able to replace many of these departures with temporary "traveling" physicians or with more junior hires. However, some key specialties were, and still are, either seriously understaffed or effectively vacant. Examples include otolaryngology (ear, nose, and throat, or ENT), urology, rheumatology, orthopedics, and neurology. Most notably, essentially all of Mission's medical oncologists left, and its marquee cancer center is now practically deserted.

Active and previous clinicians say the net result has been utterly demoralizing, both for those who left and for some who remain. According to a range of observers, what was once an exemplary medical community with robust specialties is now struggling to adequately cover the basics of what is expected from a tertiary care hospital.

2. Nurse and other Patient Care Staffing. HCA's primary cost-saving strategy has been to trim patient-care staff. In addition to nurses, this includes a full range of staff that provide supervision, draw blood, assist nurses, perform tests, clean rooms, transport patients, sterilize instruments, provide meals, handle clerical tasks, watch troubled patients, provide counseling, ensure safety, and more. By all reports, staffing cuts have been steep. In many areas, knowledgeable sources said that nurse staffing has dropped by half and nursing assistants and supervision cut even more, making it all the more difficult to stretch nursing assignments so thinly.

These conditions caused a large number of the most experienced nurses to leave. The nurses who remained formed the only nursing union in the state. Many replacements are inexperienced or only temporary staff, which clinicians believe substantially increases the difficulty of coordination and communication. These

conditions have also made it much more difficult to recruit and retain replacements, because, under HCA, Mission has developed a distinctively negative reputation as a place of work.

Staffing shortages have meant that HCA Mission regularly is unable to keep all of its beds in operation. Shortages have also caused a host of patient-care problems such as cancelled surgeries, difficulties scheduling appointments, and extended delays in obtaining laboratory results, according to various accounts from area clinicians. Most notably, the patient experience at Mission has plummeted. Due to a lack of attentiveness from short-handed staff, patients routinely are not bathed, assisted with toileting, or attended to promptly when suffering – according to reports from patients, clinicians, and other Mission staff. Physicians also report a substantial increase in the number of "near miss" patient-safety events related to turnover and staffing shortages.

3. Emergency Room Debacle. A combination of management decisions by HCA have caused serious patient-safety problems in its emergency room (ER). Despite a 50 percent increase in the ER's capacity, it is seriously overcrowded due to Mission utilizing a good portion of the ER to "board" patients who are waiting on a hospital room to become available. As the previous section notes, this back-up is due in part to staffing shortages. Also contributing to the ER debacle are what appears to be profit maximizing strategies about how to allocate available beds and where to concentrate the burden of understaffing. For instance, HCA Mission now apparently requires *all* medical patients that area physicians admit to the hospital first be screened and evaluated through the ER and then held in the ER boarding area, even if they are not experiencing an emergency.

Due to ER crowding, many, and perhaps most, emergency patients have been treated in hallways, the ambulance bay, or the waiting room. The shortage of available staff to screen, treat and monitor these patients has also led to a number of well-documented patient harms and even death.

Staffing shortages and hospital management have also forced ambulance medical technicians to remain with transported patients for extended time periods because EMTs must wait for hospital staff to accept and receive a patient before Mission assumes responsibility for patients, some of whom are experiencing serious emergencies. Tying up emergency transport services in this manner led to two counties suspending normal transport service for a period of time.

Other serious ER deficiencies also led to the attorney general suing Mission for breaching HCA's purchase agreement. And, most consequentially, following an intensive government investigation, regulators cited Mission with nine instances of placing ER patients in "immediate jeopardy."

On each of these fronts, various informed sources explained that HCA Mission has been able to sacrifice exemplary medical quality for reduced costs because of its market position. As the only hospital in the area's most populous county, and the only tertiary hospital in the entire region, many informed sources report that patients and physicians have little or no choice but to use the hospital if they want to remain in the region.

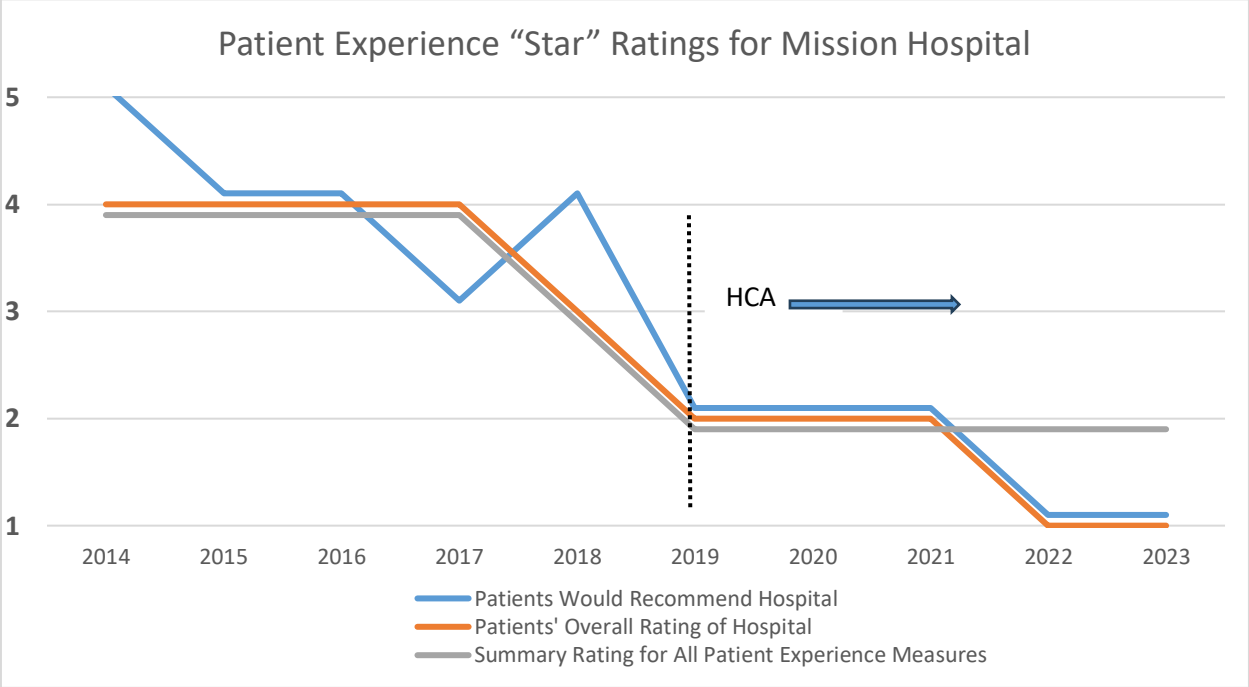
4. Looking Ahead. As described above, HCA did not respond to repeated, insistent efforts by clinicians to address patient-safety issues throughout the hospital. However, signs of possible improvement have emerged very recently, in response to a serious threat of Mission being suspended from the Medicare and Medicaid programs, and the NC Attorney General's lawsuit for HCA's breach of the hospital purchase

agreement.[17] It remains to be seen how meaningful, and lasting, these improvements will be,[18] in light of the fact that the basic market conditions and corporate priorities that gave rise to these issues remain essentially the same.

4. Quality Ratings Under HCA

Prior to HCA's acquisition, Mission Hospital was regarded as one of the highest quality hospitals in the country. Following HCA's acquisition of Mission hospital, however, numerous complaints have been made and serious concerns raised about diminishing quality of care – resulting mainly from the reductions and turnover in staffing discussed in Part 3.

Curiously, however, HCA Mission has not seen a sharp decline in its overall ratings for quality of care from various reputable rating agencies such as *US News and World Report,* the Centers for Medicare and Medicaid Services, the Leapfrog Group, and Healthgrades. Some measures have dipped, and others have remained steady, but only one measure – patients' experience -- has dropped substantially.



[17] The Independent Monitor charged with overseeing compliance of this agreement also has found "potential noncompliance." It is noteworthy that, although HCA Mission did not challenge the state and federal governments' findings that it had place patients in "immediate jeopardy," it has denied the core of the Attorney General's allegations and insisted that it remains in compliance with the purchase agreement, suggesting that many elements of degradation this study surveys are acceptable. Also, now that the regulators have accepted Mission's "plan of correction," placing the hospital back in good standing with Medicare and Medicaid, HCA Mission may feel that it is no longer under as much pressure to make substantial improvements.

[18] Expressing some skepticism, see, e.g.: https://www.medpagetoday.com/special-reports/features/108924 https://www.medpagetoday.com/special-reports/features/108924 https://www.northcarolinahealthnews.org/2024/03/22/staffing-issues-hca-mission-hospital-nurses-say-its-not-happening/

Part 4 provides a detailed account of how and why Mission's quality rankings do not appear to track widespread perceptions that its quality has declined following HCA's acquisition. In summary:

- Hospital quality can be assessed in various ways. Some measures show good or high quality at Mission, while others show very poor quality.
- Measured by patient experience, the figure above shows that HCA Mission now rates near the very bottom, both in North Carolina and nationally.
- Mission's ratings are stronger under objective measures of safety and outcomes. Nevertheless, those measure are not at the same level of excellence Mission showed prior to HCA's acquisition.
- There are some indications that data integrity and hospital reporting practices may have skewed some of HCA Mission's ratings upwards.
- Under HCA, Mission appears to address quality and safety issues somewhat selectively, rather than striving for excellence across the board. This selective focus is consistent with HCA's status as a for-profit organization with an shareholder obligation to maximize profit.
- According to informed sources, HCA's approach to quality and patient experience is also influenced by the fact that its market strength leaves patients and physicians with limited options if they are dissatisfied.
- On the whole, the decline in quality under HCA left several observers with a feeling of resignation that, over time, "things will probably stabilize and we'll be left with a perfectly mediocre hospital," but never one that is again "great" or "nationally ranked."

5. Changes in Charity Care

When a for-profit company acquires a nonprofit hospital, a major concern is always what becomes of the nonprofit's commitment to charity care. Thus, one of the core conditions of the Mission Asset Purchase Agreement (APA) was that HCA would maintain a charity care policy generally equivalent to what Mission had in place, or to what other large nonprofit hospitals have. Part 5 examines whether this has happened.

HCA claimed, and Mission agreed, that HCA's standard charity care policy was actually somewhat more generous than what Mission had at the time. Therefore, when HCA let Mission decide whether to keep its current charity care policy or switch to HCA's, Mission's Board, after analysis, opted for HCA's policy.

In practice, however, genuine charity care has diminished in systematic and extensive ways following the sale to HCA, with unfortunate effects on access to health care in western North Carolina. This has occurred as a result of a number of factors, including:

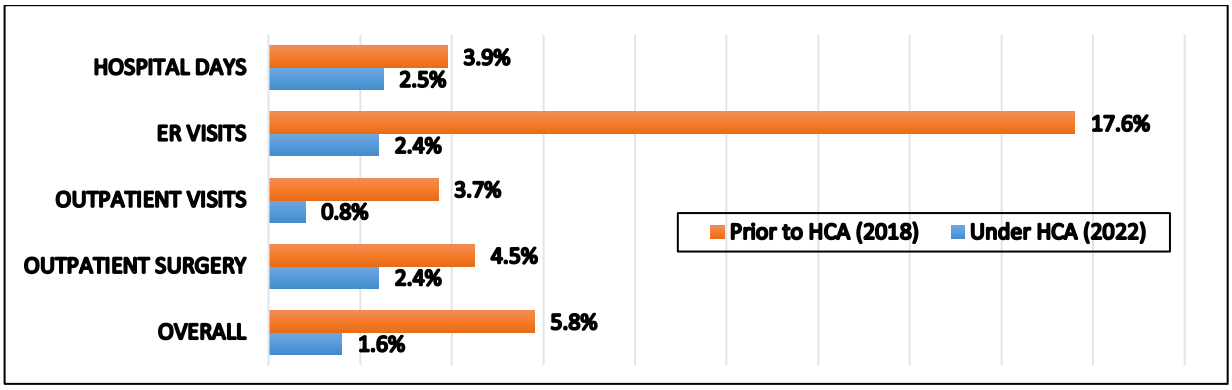
1) Non-obvious limitations that make the charity care policy less generous than what was promoted;
2) More cumbersome procedures for approving charity care; and
3) Financial policies requiring prepayment that disproportionately affect low-income patients.

More specifically,

1. HCA's policy does not apply to all medically necessary care, but instead only to treatment with such urgency that it cannot be postponed.
2. HCA typically applies its policy only after eligible patients receive treatment, and HCA usually requires eligible patients to pay a substantial deposit prior to treatment.
3. Various administrative barriers make it exceedingly difficult for qualified patients to obtain, and maintain, a determination of eligibility on an ongoing basis, and the same barriers appear to greatly hamper receiving charity care on an isolated, episodic basis.

As a result, the following Figure shows that the proportion of patients that Mission Hospital reports as being treated on a charitable basis dropped substantially, and low-income patients who are uninsured no longer reliably receive care regardless of their ability to pay.

Percent of Service Units Classified as Charitable



Reports to the contrary appear to be based on HCA having shifted more of its uncompensated care into the charity care bucket rather than being accounted for as standard discounts or bad debt. Despite that accounting change, there has been a sharp drop in the number of low-income patients HCA Mission treats as true charity cases, that is, regardless of their ability to pay and without an intent to collect substantial payment.

6. Positive or Mitigating Aspects

By setting out to learn lessons from the sale, this study focuses primarily on the problematic aspects. However, Part 6 looks to see what advantages derived from HCA's acquisition, or whether there are factors that mitigate the principal concerns, to determine whether there are any bases on which to conclude that the picture that HCA's harshest critics paint, or that this study has shown, is as troubling as it is made out to be.

The most visible benefit from HCA's purchase is that the proceeds went to creating a major new charitable foundation (Dogwood Health Trust), which is now valued at close to $2 billion. Because it aims for long-term improvements in fairly diffused "social determinants of health," it is difficult to assess what concrete improvements will ultimately emerge from its ambitious goals.

Also quite visible is HCA's investment in building or expanding several significant facilities in the Mission Health system. For the most part, however, these improvements are ones that likely would have happened even if there had been no sale. Less visible, but still notable, is the commitment HCA made to keep open all five of the smaller community hospitals in Mission Health's system. By definition, however, that commitment is time-limited, and it is purely speculative whether the purchase agreement will result in more support for these hospitals than would have occurred in its absence.

A key advantage that Mission's board anticipated when selecting HCA is the depth of resources and expertise that comes with being part of the world's largest hospital chain. That advantage rose to the fore during the COVID-19 pandemic, and subsequently when hurricane Helene devastated the region in September 2024. During both crises, HCA Mission appeared able to access critical supplies and equipment more quickly or effectively than some or many other hospitals. During more routine times, however, clinicians have made a range of complaints about shortages of some critical supplies that they had not experienced prior to HCA's management. According to some accounts, HCA uses it superior data analytics and supply-chain management more to reduce costs than to ensure superior performance.

In sum, it is difficult to point to any concrete lasting improvements that HCA has brought to Mission Hospital. It is telling that, even under the most favorable viewpoints, there is no credible voice openly claiming that Asheville and western North Carolina are actually better off now with HCA at the helm of Mission.

Nevertheless, several leaders genuinely feel that the decision made was the right one at the time, based on what was known at the time. Several informed sources have also said that HCA's criticism often relates to the same kinds of problems that other hospitals also face. However, the level of sustained outcry has been truly extraordinary – well beyond anything Mission experienced prior to HCA's purchase, and beyond what has been reported for most other HCA hospitals.

Several key sources think that negative reactions to HCA have been so much stronger here than elsewhere because of Mission's regional prominence and highly esteemed status at the time of HCA's acquisition. That could explain why HCA applying the same "playbook" to Mission that it has developed for less elite or more struggling hospitals has engendered such backlash. Also of note, other HCA hospitals usually face more local competition than does Mission, and are sometimes run jointly with a charitable organization. Both of those factors remove constraining forces that could curtail the most aggressive cost-cutting.

Finally, it does not appear that HCA's business strategy has been developed with an aim to keep the best performing hospitals operating at the highest quality levels. Instead, in the view of many observers, HCA aims for maximizing its profits while maintaining *acceptable* quality -- meaning quality at a level that avoids legal/regulatory problems and does not lose too much business.

7. Public Policy and Legal Regulatory Recommendations

This study's extensive review of the tumult resulting from Mission Hospital's sale to HCA exposes significant legal gaps that precluded robust protective measures – gaps that exist both in North Carolina and other states. Part 7 draws from the lessons learned here to assist other states considering legal enactments to prevent these deleterious effects. Additionally, Part 7 informs private actors, such as hospital boards or union negotiators, who might consider adopting contractual provisions that seek to avoid adverse consequences from changes in hospital management.

In most states, the state's attorney general has the principal legal authority to decide whether a hospital may change ownership or control. That authority is usually limited, however. Primarily, attorneys general address requirements of antitrust law and nonprofit law. Antitrust law typically is not implicated if a hospital's new owner does not already have significant presence in the hospital's local market or surrounding areas. Nonprofit law is usually satisfied if the sales price is adequate, the proceeds are devoted to a related charitable purpose, and the governing board conducted its deliberations appropriately.

Here, the NC Attorney General had concerns about the board's deliberations and so required HCA to strengthen the commitments it made in its purchase agreement. In circumstances where a state's the attorney general lacks the same basis to push for protective commitments, such commitments might instead be imposed through a state's "certificate of need" review process, building on scattered precedents from a handful of states that attach commitments to regulatory approvals of changes in hospital ownership. Doing that, however, requires giving more thought to how to effectively monitor and enforce various types of commitment that might be needed to protect the public's interest.

HCA's purchase commitments, for instance, did not include any assurances about maintaining staffing levels or the quality of care. Subsequent events suggest that other hospital boards and regulators should consider whether to include quality or staffing commitments. It is difficult, however, to identify and agree on suitable metrics for staffing and quality, and thus such commitments are rare (although not unheard of) in similar or analogous contexts.

In addition to specifying more demanding protective measures, regulators might consider measures that could bring more competitive pressure on hospitals to maintain quality – especially quality as experienced by patients and clinicians. For Mission Hospital, achieving effective competition is difficult because its regional market is unlikely to have room for another tertiary care hospital. However, the lapse in regulatory oversight that allowed Mission to become an unregulated monopoly could be corrected.

A more broad-based legal measure often suggested is to repeal the "certificate of need" (CON) regulations that require hospitals to satisfy regulators that additional hospital capacity is needed before entering a market or expanding. Critics note that this regulatory hurdle creates a substantial barrier to market entry by new hospital competitors. Public policy views differ, however, on whether unconstrained market entry would be beneficial as a general matter in all hospital markets. Therefore, a modified approach that merits consideration is whether CON regulation can be done in a manner that better promotes rather than hinders competition.

Principally, when a need arises for additional hospital capacity, if there are competing applicants, regulators could favor newer or smaller applicants who would increase competition rather than expanding entrenched incumbents. Going further, CON regulators might consider recognizing need for more capacity not just as a tie-breaker between contesting applicants, but as the *primary* basis on which to recognize need for additional hospital facilities in a non-competitive market.

These various measures aim to engage more effectively the existing regulatory structures that are focused on somewhat different concerns (charitable mission or excess hospital capacity) so that they might better address any deleterious effects from a change in hospital ownership. A more direct approach might be more effective, namely, to craft a tailor-made mechanism for reviewing proposed ownership changes under a broad standard of protecting the public's interest. A number of states (including NC) currently require broad-

based public interest review for health insurers (such as Blue Cross) that seek to convert from nonprofit to for-profit status. A handful of states also require this fairly unconstrained public interest review of proposed hospital acquisitions.

Building on these models and insights from the related oversight mechanisms surveyed above, legislation proposed in NC would permit the Attorney General to challenge any substantial change in hospital ownership of control seen as adversely affecting the cost, availability, accessibility, or quality of services, or that otherwise is not in the public's interest. In addition, the Attorney General could either unwind or alter any change in hospital control within 10 years if events following such a transaction provide a strong case that doing so would be beneficial to the public.

This proposal is certain to face substantial opposition and so is unlikely to move forward without significant changes. However, as proposed it is a thoughtful demonstration of what would be needed to address the gaps in regulatory oversight that have allowed the HCA Mission saga in western NC to unfold as it has.

Part 1: Mission Hospital's Decision to Sell to HCA

I. PRECIPITATING EVENTS

A. Mission's Merger with St. Joseph's

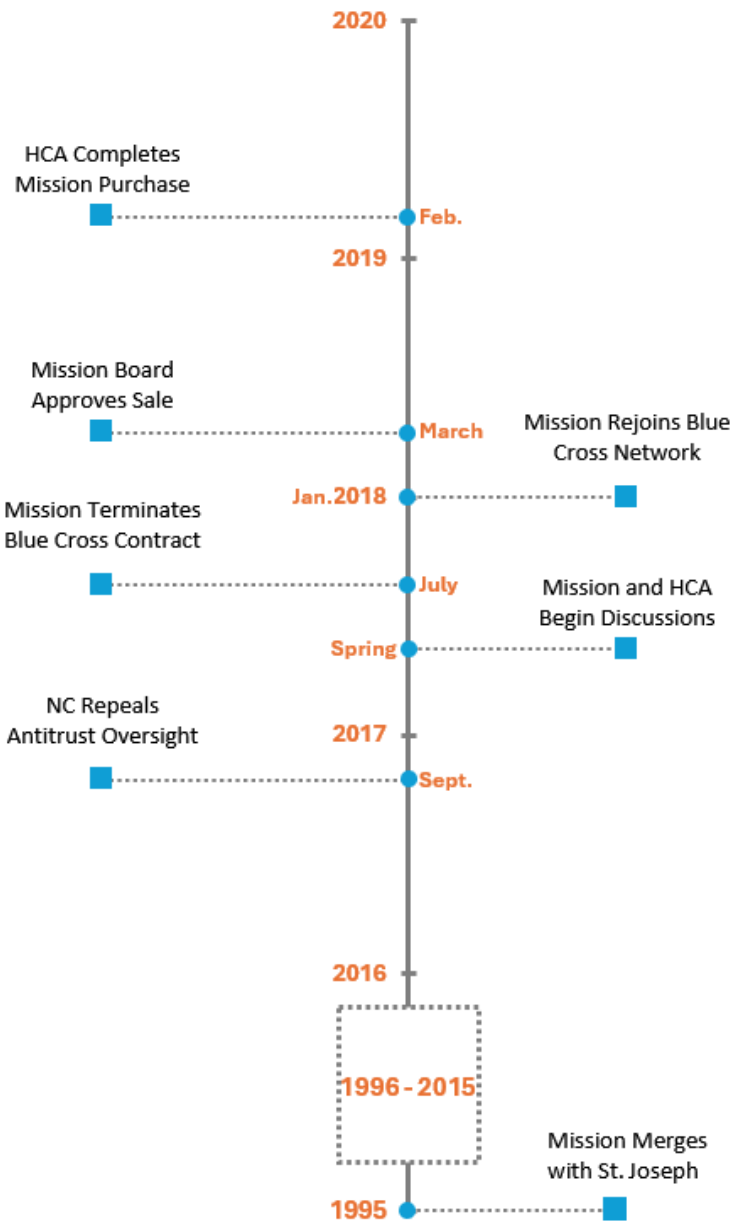
The key event that brought Mission Hospital to market prominence was its state-sanctioned merger with St. Joseph's Hospital in 1995. Mission and St. Joseph's were effectively the only two hospitals serving Asheville. Previously, these two competing facilities were located on the same street, but various factors led them to conclude that merging would be a net benefit to both systems and the community at large.[19] As the smaller of the two, St. Joe's (as it was known) was struggling financially. Administrators at both hospitals felt that the need to compete for the loyalty of local physicians gave physicians too much sway over hospital management. At the same time, local business leaders were concerned that the emergence of managed care contracting by health insurers would make it more difficult for them to select a health plan that satisfied all of their workers, particularly if either hospital was excluded from a managed care network.

Before the 1990s, federal or state antitrust law would often block an attempted consolidation of the only two hospitals in a market to avoid the creation of a health care monopoly. But in 1992, a U.S. Supreme Court decision[20] paved the way for a state to immunize health care activity from federal antitrust scrutiny by adopting a regulatory regime that came to be known as a "certificate of public advantage," or COPA for short.[21] Soon after the Supreme Court's 1992 ruling, 19 states, including North Carolina, enacted COPA laws

[19] https://www.urban.org/sites/default/files/publication/42226/2000111-Certificates-of-Public-Advantage.pdf
[20] FTC v. Ticor Title Ins. Co., 504 U.S. 621 (1992). See also Patrick v. Burget, 486 U.S. 94, 100 (1988).
[21] https://lawecommons.luc.edu/lclr/vol8/iss3/14/

that allowed a state's secretary of health and attorney general to approve hospital mergers, subject to regulatory oversight.[22]

Figure 1: Timeline of Key Events Leading up to HCA's Purchase



North Carolina's 1993 COPA law laid the groundwork for the 1995 merger between Mission Health and St. Joe's. Under the terms of the state's antitrust oversight, Mission/St. Joseph could merge only if the enterprise adhered indefinitely to a set of market and operational constraints. Mission was to keep its costs and profits in line with general medical inflation and similar regional hospitals and to limit the number of physicians it

[22] https://www.urban.org/sites/default/files/publication/42226/2000111-Certificates-of-Public-Advantage.pdf

could employ or have under contract. This antitrust oversight also prescribed the composition of the hospital's board, and it required reasonable behavior in negotiating with managed care insurers.

Mission is the only NC hospital to have received a COPA. The state's antitrust oversight of Mission. continued for two decades, until the state legislature in 2015 repealed the governing statute, effective October 2016.[23] In essence, then, the state, having initially allowed Mission Hospital to become a carefully regulated monopoly, decided two decades later to permit it to continue indefinitely as an *unregulated* monopoly.

A mere two years after lifting state antitrust oversight, HCA purchased Mission Hospital, thus putting what one observer called a "prepackaged monopoly" into the unregulated hands of the world's largest for-profit hospital corporation. As one esteemed health policy analyst recaps, North Carolina "created a monopoly but then abandoned the regulation that governed the monopoly, and now the monopoly is free to exert its market power."[24]

Certainly, on the surface of things it appears puzzling, if not dumbfounding, that thoughtful public policy or community-focused enterprise management would produce this result. Accordingly, how this decision making came about is a key focus of this first portion of the research study. We begin with the state's decision to terminate its antitrust oversight. We then examine the ensuing decision to sell the hospital system to HCA.

B. Terminating "COPA" Antitrust Oversight

Given the critical role that the cessation of NC's antitrust oversight played in Mission's subsequent sale to HCA, this section devotes substantial attention to the various reasons for the state to approve Mission become essentially an unregulated monopoly. Extensive interviews with both state officials and Mission leaders and administrators fail to uncover any convincing reason. Interviews also reveal a lack of clear understanding of the driving rationale for regulation or the potential consequences of its repeal. It continues to be unclear, though, whether Mission's leadership contemplated the hospital's sale at the time they sought regulatory relief.

Legislators' Reasons

Legislative leaders chiefly responsible for the state's repeal of its "certificate of public advantage" (COPA) law did not respond to requests for research interviews. Thus, the thinking that drove this decision to terminate antitrust oversight of a state-created monopoly remains somewhat inscrutable. Several notable points emerge, however, based on observations. First, the decision was not politically controversial: it received broad bipartisan support. Second, there is no indication the decision received significant deliberation or debate, either publicly or within the legislature.[25] Several legislators were interviewed who voted for, but did not lead, the repeal. Almost a decade after the repeal, they could not recall clearly what the rationale was from that time. Some had difficulty distinguishing COPA from a different but similar-sounding regulatory process known as "certificate of need" or CON regulation. For anyone not expert in the field, this failure to differentiate specialized regulatory regimes is understandable, especially considering that the two topics

[23] Originally, this repeal was slated to take effect January 2018, but for reasons that remain uncovered, the repeal date was accelerated by 15 months.

[24] https://www.modernhealthcare.com/article/20180407/NEWS/180409936/hca-may-see-fellow-market-leader-in-mission-health

[25] https://www.citizen-times.com/story/news/2015/09/29/nc-dissolves-anti-monopoly-rules-mission-health/73042066/

were addressed jointly at the time by legislative study committees and by proposed legislation, in which the CON issues took the top billing.[26]

When reminded of COPA's distinct purpose, the only rationale for repeal that interviewees could conjure was a vague sense that, over the two decades since the Mission/St. Joe's merger, "times had changed" in such a way that it was felt that antitrust oversight had "outlived its useful life."[27]

One key change in the times was the emergence of managed care health insurance, which imposed more competitive discipline on health care markets. As for serving its purpose, Mission could point to the fact that it consistently had been a well-performing institution that met or exceeded all of the regulatory requirements and that, as discussed in Part 4 , Mission stood out as one of the most well-regarded hospitals in the country both for high quality and good value.

A sense (whether right or wrong) that a compelling reason for antitrust oversight no longer existed does not answer, however, why it was important, or even advisable, to eliminate this oversight. It was this oversight, after all, that, along with pressure from insurers, led to such good performance results. Several sources suggested that raw political lobbying was probably at play. Or perhaps the driver was a more principled instinct that, absent an obvious need for regulation, less regulation is preferred, even if the regulation is not especially burdensome. As one academic analyst summarized,

"... Mission Health's motivation to alter, weaken, or repeal the COPA [law] to escape the constraints of state supervision over its unfettered market power outweighed the state's commitment to maintain ongoing oversight. ... [N]othing changed to eliminate the need for oversight of Mission Health's monopoly, except the state's political commitment to it.[28]

Hospital's Reasons

In theory, it is possible that antitrust oversight was at least somewhat burdensome. Based on extensive review, however, there are few or no indications of such burdens. Both regulators and hospital leadership during the COPA period said oversight was not especially burdensome, either for the state or for Mission Hospital. Both "sides" agreed that the regulatory process was a cooperative one that set achievable goals and made reasonable adjustments as needs arose.[29] As summarized by a prior extensive study:[30]

> The Mission COPA has operated with low administrative or transactional costs, considerable flexibility to reconcile competing statutory objectives and reasonable speed of decision-making. The oversight agencies seem to have proceeded by ... emphasizing private negotiation with the regulated providers ... rather than through administrative decision [or] judicial challenges .... The state agencies have

[26] https://www.ncleg.gov/Documents/146/
https://webservices.ncleg.gov/ViewDocSiteFile/43458
[27] https://www.citizen-times.com/story/elections/2015/06/19/ron-paulus-mission-health-certificate-of-public-advantage/28975401/
https://www.citizen-times.com/story/news/2015/09/29/nc-dissolves-anti-monopoly-rules-mission-health/73042066/
[28] https://www.milbank.org/wp-content/uploads/2019/01/MMF-North-Carolina-COPA-Repeal-Issue-Brief-FINAL.pdf
[29] https://mountainx.com/files/copareport.pdf
https://www.urban.org/sites/default/files/publication/42226/2000111-Certificates-of-Public-Advantage.pdf
[30] https://www.urban.org/sites/default/files/publication/42226/2000111-Certificates-of-Public-Advantage.pdf

> repeatedly found that Mission was in compliance with the cost and [profit] margin caps, offering suggestive and indirect indications of good value for insurers and patients.

Mission's CEO at the time thought (in the words of one industry reporter) that the caps on profits and costs "were never a concern because [Mission] wasn't close to hitting them."[31] In a 2011 statement, Mission actually extolled the many benefits of antitrust oversight as follows: "The results of the COPA – high quality care delivered at low cost – have been touted by national leaders as a constructive and effective way to achieve community benefit . . . ." A respected health economist hired by Mission in 2011 to respond to criticisms of its regulatory status described the merits of state oversight as follows:[32]

"In the case of the Mission COPA, there are three key elements that drive its reasonably strong success as a proxy for competitive forces: (1) good benchmarking based on reasonably comparable hospital systems, (2) regular updating by continued checking against competitive benchmark systems, and (3) assessing the general performance of the markets in which [Mission Health] operates. Benchmarking against comparable hospital systems allows the regulator to ensure that the COPA [antitrust oversight] is continuing to hold [Mission] to competitive standards without restricting its ability to stay up to date with competitive trends. . . .

The State actively monitors and adjusts the COPA's Cost and Margin Caps ... to take account of new situations or to avoid unnecessary distortions. ... [I]t is fortunate that the State has monitored and updated the Mission COPA with large and small amendments over its 15 years of oversight. ... The evidence I have reviewed clearly indicates that [Mission Health's] performance under the COPA has been a good approximation of competitive outcomes with no evidence of the regulatory distortions [postulated by critics]."

A senior Mission administrator described the oversight period as allowing the hospital "to do what [it] wanted" but at the same time "protect the community from someone abusing the monopoly power we had." A former board member from the business community who, initially, was opposed to the kind of government intrusion COPA oversight represented, changed his view based on experience. He came to realize that, considering market realities, it "makes sense to be regulated" and that antitrust oversight was "the right thing to do."

Regarding the possibility that COPA oversight might at some point become unnecessary, a former senior administrator at Mission commented that the thought never occurred to him because "we were given a monopoly," and "I didn't think it would ever be without strings attached." He expected that state oversight could and would be modified from time to time to address significant concerns (as it was), but that some version would remain in place because "we needed something to hold our successors' feet to the fire, as ours were being" held. In sum, this former Mission executive said "it's beyond me" why the state would terminate COPA. Its terms "weren't onerous to keep up with," and, "by 2015, there was probably *more* of a need for it than" when he was at Mission based on market developments.

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[31] https://www.modernhealthcare.com/article/20180407/NEWS/180409936/hca-may-see-fellow-market-leader-in-mission-health

[32] Thomas McCarthy, Economist's Report on the Mission Health Certificate of Public Advantage, (NERA Economic Consulting, 2011). See also https://webservices.ncleg.gov/ViewDocSiteFile/43426

Several other former Mission leaders echoed that COPA compliance was not onerous, and that "by and large, [it] worked pretty well." This was true to such an extent that some initially skeptical board members came to embrace antitrust oversight. Several skeptics explained that state oversight helped management focus on increasing value for the community by maintaining or improving quality while restraining costs. One very experienced board leader from that time said that they "never found [oversight] to be a hindrance, in all of [their] years." Instead, antitrust oversight "made us focus on costs, ... [so] we took a harder look at them than other [nonprofit] hospital boards I've been on." Another former board leader noted that the oversight did not hamper strategic initiatives such as purchasing smaller regional hospitals. Because the oversight was felt to work well with little or no obstruction, several Mission leaders simply could not remember what, if any, reasons were being articulated for its repeal.

Obstructing Hospital Initiatives

Mission's antitrust oversight was seen as somewhat controversial in only two respects. First, rival hospitals in the area felt the COPA regime gave Mission Hospital an unfair advantage in the market. Second, Mission felt that COPA restrictions on the hospital employing or contracting with physicians hindered its ability to form highly integrated delivery structures, such as "accountable care organizations," that were increasingly becoming more favored by modern market conditions and public policy.[33] These concerns led to an in-depth legislative study and public policy debate in 2011,[34] which resulted in a moderate, state-sanctioned increase in the number of physicians Mission could employ or have under contract.

Based on this adjustment, well-informed subjects were hard pressed to identify any compelling reasons to repeal antitrust oversight altogether, beyond very general deregulatory sentiments. The only substantive reason for repealing antitrust oversight given at the time was the utterly vague assessment that, "[o]ver time, the additional flexibility and reduced costs ... will create important opportunities for Mission Health to adapt and respond to rapidly changing market conditions, and support the quality and availability of healthcare throughout the region."[35]

At first blush, eliminating the COPA regime might have been seen, paradoxically, as a way to appease the continuing criticism from Mission's rivals, that it had having a favored market position.[36] But simple reflection reveals that argument is hardly compelling since Mission surely would have been seen as more threatening *without*, rather than *with*, regulatory oversight.

Looking back, some interview sources thought that even the loosened restrictions on physician affiliations might have been too tight, so wanting to loosen them more might have been "a nudge" for repeal, but no

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[33] Mission's CEO at the time said that "physician employment [by Mission] is directly tied to ... ensuring that high quality, highly coordinated care is able to meet the region's population health needs for the decades to come." https://www.citizen-times.com/story/elections/2015/06/19/ron-paulus-mission-health-certificate-of-public-advantage/28975401/ Ironically, as discussed in Part 3, the subsequent sale to HCA quickly unwound many or most of Mission's previous efforts to more tightly integrate the hospital with area physicians.

[34] https://mountainx.com/files/copareport.pdf
https://www.urban.org/sites/default/files/publication/42226/2000111-Certificates-of-Public-Advantage.pdf

[35] https://www.citizen-times.com/story/news/2015/09/29/nc-dissolves-anti-monopoly-rules-mission-health/73042066/

[36] https://www.carolinajournal.com/opinion/scrapping-the-certificate-of-public-advantage/
https://www.blueridgenow.com/story/news/2011/10/21/house-committee-hears-heated-discussions-on-missions-copa-agreement/28282440007/

specifics were cited.[37] Almost none of this study's interview subjects thought that the oversight limits were hampering Mission to any extent, much less a substantial extent. Also, the revised limits on physician contracting were generally consistent with the strictures of existing antitrust law.

On balance, more than one source felt that Mission's management was not entirely candid about the true reasons for seeking repeal. Several referred to Mission's CEO as, in hindsight, "dissembling," "disingenuous," and "like the Music Man, coming to town to sell us [on these ideas] and then mov[ing] on."

Genuine Reasons

The more genuine reason for repealing antitrust oversight – a reason given by several key sources and one that has the greatest resonance with subsequent events – is that transformative changes were more achievable without state oversight. Several sources noted that oversight kept Mission's management focused on meeting the COPA benchmarks, which required steady trimming of costs without harming service quality. Although this was well-achieved, in the words of one leader, "fatigue builds up" from having to trim costs "year in and year out" to meet ongoing COPA benchmarks. Although market forces also put steady pressure on costs, COPA's caps on profit margins were felt to limit Mission's ability to undertake more ambitious and transformative changes. A few sources also speculated that COPA's requirements for board membership, which built in some "checks and balances," hampered board composition changes that would have been preferred by the board's leadership or senior management in order to facilitate Mission's pursuit of strategic objectives.[38]

Perhaps the best way to gauge what motivated Mission to push for termination of antitrust oversight is to observe the steps Mission in fact took following repeal that would have been prevented or deterred by oversight. Mission did not substantially accelerate affiliation with physicians. It already employed several hundred, and contracted with many hundreds more.[39] Also, repealing antitrust oversight did not free up Mission to increase its profit margin. To the contrary, its operating profit margin remained essentially the same over the three years following repeal. Over that same period, however, Mission's operating costs per patient did increase 30 percent (from $10,871 to $14,217 per adjusted discharge, between 2016 and 2019).[40]

The most immediate action of significant magnitude following COPA repeal was Mission's decision, discussed below, not to renew its contract with Blue Cross. Blue Cross is and was, by far, the largest commercial insurer. At the same time as this cancellation, Mission sought to launch its own health insurance company, which would compete with Blue Cross. COPA oversight would have either prevented, or hampered, both of these moves.[41] Because these events happened so quickly following oversight repeal, there is good reason to believe these were part of the core motivators for Mission to seek an end to antitrust oversight.

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[37] Of note, a number of key specialty or primary care areas were not subject to these limits on physician contracting.

[38] For instance, members of the medical or business communities represented on the board may have resisted certain approaches to affiliating with physicians or to negotiating with insurers. The COPA required state permission prior to any significant changes in board size or composition.

[39] https://web.archive.org/web/20140217154403/http://www.missionmd.org/physicians-practices https://web.archive.org/web/20161028052350/http://www.missionhealthpartners.org/

[40] These data are from the same source discussed in Part 2.

[41] https://www.milbank.org/wp-content/uploads/2019/01/MMF-North-Carolina-COPA-Repeal-Issue-Brief-FINAL.pdf . The oversight forbade "unreasonably terminat[ing]" any health plan contracts, and it required "negotiat[ing] in good faith with all health plans," including "contract[ing] with all health plans . . . offer[ing] commercially-reasonable terms"

More debatable, however, is whether the ability to sell Mission was, consciously, a core motivator. The COPA required state approval for any ownership change, and so removing that regulatory hurdle would be advantageous if the possibility of sale or merger were contemplated. Certainly, if any of Mission's leadership had contemplated selling to a for-profit firm, then repeal (or at least substantial amendment) of COPA would have been required, since the conditions for approving Mission's merger with St. Joseph's required, without exception, that Mission retain its non-profit status.

Whether, or to what extent, these factors drove Mission's efforts to seek COPA repeal remains speculative. Several well-informed sources thought that senior management's interest in pursuing the hospital's sale did not become serious until about a year following repeal, at which point the interest arose primarily because of the failed contract negotiations with Blue Cross as discussed more below. These sources also noted that Mission's management had been seeking COPA repeal for several years prior to any of these events.[42] According to a key source, Mission's CEO "began to pursue COPA repeal almost from the beginning" of his tenure in 2009.

Others, however, speculated that the possibility of more freely pursuing different hospital ownership or partnership was on senior management's mind at the time of repeal. Key support for that speculation comes from the fact that Mission's CEO was exploring a possible sale to HCA as early as April 2017[43] – just seven months after COPA was repealed, and well before the failed Blue Cross negotiation that others thought was the primary impetus for selling the hospital system.[44] On the other hand, Mission leaders at the time said that they received several expressions of interest from other hospital systems over the several preceding years, and so it was not abnormal to consider those.

Regardless of whether Mission's management envisioned an eventual hospital sale, there was wide agreement from sources that repealing antitrust oversight was essential to HCA's subsequent acquisition. It is highly doubtful state authorities would have permitted HCA's acquisition under COPA.[45] In addition to various health policy considerations, a core purpose of the COPA regime was to keep a financially struggling hospital under local control through a local merger rather than leaving no option but to sell to an out-of-state chain. But, regardless of what the state might have decided, key observers convincingly said that HCA would have been much less interested in purchasing Mission subject to antitrust oversight.[46] The obvious reason is that Mission is much more valuable to HCA as an unregulated monopoly than one that is subject to restrictions on profits.

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that required Mission to assume some financial risk. The state also forbade Mission from contracting with any health plan it owned or operated on more favorable terms than the health plan offered to other providers if doing so would give Mission an unfair competitive advantage.

[42] E.g., https://carolinapublicpress.org/8643/lawmakers-delay-decision-on-missions-operating-agreement/

[43] https://avlwatchdog.org/mission-accomplished-former-ceo-ron-paulus-and-hca-discussed-takeover-options-before-board-okd-search/

[44] Also noteworthy is that, originally, COPA repeal was not scheduled to take effect until 2018, but the effective date was moved up for reasons not yet determined. A plausible explanation for this change was to permit an accelerated timeline to pursue the hospital's sale.

[45] Doing so would have required an amendment to COPA's terms, which required Mission to remain nonprofit.

[46] One health policy expert, for instance, has written that "Mission Health would have been a less desirable acquisition target, particularly by a for-profit buyer, had it continued to be subject to state supervision under the COPA over its costs, margins, health plan contracting, and physician employment." https://www.milbank.org/wp-content/uploads/2019/01/MMF-North-Carolina-COPA-Repeal-Issue-Brief-FINAL.pdf

Whether or not the sale to HCA was foresee*able*, it does not appear to have been demonstrably fore*seen* – at least by a number of state legislators and Mission board members. Several of each said that, had they anticipated such a move, they would never have supported COPA repeal. Nevertheless, the reality is that legislators repealed the COPA laws, which allowed HCA's purchase of Mission. We turn, then, to two remaining questions: why did Mission's board decide to sell the hospital, and why to HCA?

C. Fallout with Blue Cross

The public events leading to HCA's purchase began with Mission's fall 2017 showdown with Blue Cross, which various informed sources characterized as a "self-inflicted" "fiasco" or a "botched" job that caused "pandemonium." Free of state antitrust oversight, Mission was more able to play hardball in its 2017 negotiations with Blue Cross over renewal of its three-year managed care contract. Because Mission's negotiating tactics did not succeed, it lost network status with the area's primary commercial insurer, before ultimately agreeing (after 10 weeks) to Blue Cross's initial terms. That temporary break caused a financial setback. More significant, though, was that this blow, as many interview sources explained, is what ultimately convinced Mission's Board of Trustees that it needed to sell the hospital, which it quickly did – since, by itself, the hospital demonstrably lacked the ability to negotiate more favorable terms with Blue Cross.

We will never know if Mission could have salvaged better terms from Blue Cross than it ended up with. Accounts of the negotiating breakdown differ (both published,[47] and via confidential interviews), but they share these common features. Blue Cross had decided to implement a "value-based" payment system that rewarded hospitals based on controlling costs and improving quality. Mission's senior management also strongly believed in the value-based concept, but wanted to be the leader rather than follower. To do so, Mission felt it needed a cumulative double-digit increase in Blue Cross rates over the next three years (i.e., at least 4% a year). Blue Cross, on the other hand, sought to freeze value-based reimbursement rates, at least for one year, and then structure rate increases based primarily on the hospital's performance on quality and cost metrics.

Additional details are not well documented. There are some indications that Mission would have agreed to four percent annual increases and that Blue Cross might have agreed to two percent. But, there are other assertions that, at least initially, Blue Cross offered no increase in base rates for three years, whereas Mission asked for as much as six or seven percent increases year after year. There is possibly some truth in both accounts at different points in the negotiation; nevertheless, no details are available about the specific terms of Blue Cross's value-based payment measures, or whether Mission would be advantaged or disadvantaged given its status as a very high-performing hospital (as discussed in Part 4).[48]

The fatal break in the negotiations came in July 2017 when Mission, facing a contractual deadline, announced its intention to terminate its Blue Cross participation in three months. At that point, Blue Cross cut off all

[47] https://chirblog.org/wp-content/uploads/2020/02/GtownCHIR_ProviderConsolidation_Asheville_Jul2019.pdf
https://www.citizen-times.com/story/news/local/2017/07/30/blue-cross-nc-mission-hospital-split-would-affect-thousands-wnc/514214001/
https://mountainx.com/blogwire/mission-health-board-members-release-op-ed-about-bcbsnc-contract/
https://www.citizen-times.com/story/opinion/2017/08/14/blue-cross-ncs-perspective-surprised-disappointed/104582580/

[48] According to one source connected with Mission, Blue Cross' "unrealistic" metrics would have required "almost a zero error rate" to earn significant increases, but another source disputed this characterization.

negotiations, as Mission had reason to know it might,[49] which made the break unavoidable (unless Mission entirely capitulated, which it eventually did). For 10 weeks, both Mission and Blue Cross struggled with the great bulk of commercially insured patients in the area suddenly being out of network, both for the hospital system and for its very large network of contracted physicians.[50]

Mission had hoped that many local businesses would switch from Blue Cross to the new insurance company that Mission had created. But that failed to happen.[51] Mission, additionally, was frustrated that the general community was not more vocally supportive of the hospital's efforts to improve its financial position.[52] In the end, Mission was forced to capitulate entirely. Beginning January, it agreed to Blue Cross's original terms,[53] which also the very same point in time when Mission's board decided to pursue either partnering with or selling the hospital to a larger system.

II. THE DECISION TO SELL TO HCA

The other highly visible change following the state's repeal of Mission Hospital's antitrust oversight is, of course, its sale to HCA. Although not consummated until January 2019, serious pursuit of this possibility was under way by mid-2017 (and most likely earlier)[54] – at the same time that Mission embraced its aggressive negotiating stance with Blue Cross. The deliberation process accelerated during the ten-week break with Blue Cross in late 2017, and culminated in spring 2018 with the board's decision to sell Mission to HCA. Although controversy has abated over the fallout with Blue Cross, controversy still rages over both Mission's decision to sell and the choice of HCA as its purchaser.

A. Concerns about Financial Sustainability

Mission's board unanimously decided to give up the hospital's independence and local control because it became convinced that, over the long term, it could not independently afford to maintain its high quality and scope of service. The board reached this decision despite Mission's strong financial condition at the time. Over the three-to-four years prior the sale, Mission's net assets (or so-called book value) had increased almost 20 percent and its operating profits had remained a fairly steady and respectable 3 ½ to 4 ½ percent.[55] As a somewhat more forward looking metric, a hospital's bond rating is a widely used financial outlook for those who are evaluating whether to lend substantial sums. The year prior to the board's decision to sell, leading

[49] https://www.citizen-times.com/story/news/local/2017/10/11/mission-ceo-email-senior-employees-blue-cross-unethical-bullying-foe/750504001/
Blue Cross has consistently refused to negotiate with hospitals in advance of an announced contract termination, knowing that if it did so for one hospital, soon most would employ that tactic. Also, informed sources reported that Blue Cross notified Mission specifically that it would adhere to this position. As one source subsequently commented, "there is yet to be a hospital that [took this negotiating approach with Blue Cross] and improved their position." https://chirblog.org/wp-content/uploads/2020/02/GtownCHIR_ProviderConsolidation_Asheville_Jul2019.pdf
[50] https://chirblog.org/wp-content/uploads/2020/02/GtownCHIR_ProviderConsolidation_Asheville_Jul2019.pdf
[51] https://www.citizen-times.com/story/news/local/2017/07/30/blue-cross-nc-mission-hospital-split-would-affect-thousands-wnc/514214001/
https://smokymountainnews.com/archives/item/20467-mission-offers-its-own-health-care-plan
[52] https://smokymountainnews.com/archives/item/21144-mission-tightlipped-about-negotiations-with-bcbs
[53] https://chirblog.org/wp-content/uploads/2020/02/GtownCHIR_ProviderConsolidation_Asheville_Jul2019.pdf
[54] https://avlwatchdog.org/mission-accomplished-former-ceo-ron-paulus-and-hca-discussed-takeover-options-before-board-okd-search/
[55] https://www.northcarolinahealthnews.org/2020/12/13/nonprofit-mission-made-lots-of-profits-especially-for-bosses/

rating agencies gave Mission strong, AA ratings with a "stable" outlook[56] (meaning they expected this strength to continue in the medium term).

Taking a longer view, however, Mission's board reached a different conclusion, apparently based in large part on the failed Blue Cross negotiation, a "fiasco" that several informed observers thought was the "straw that broke the camel's back" of Mission's hope of remaining independent.[57] The timeline of events (shown in Figure 1 above) has led some to question whether the failed negotiation with Blue Cross was indeed the primary driver of the decision to sell, considering that Mission's leadership was exploring the hospital's sale, and in particular its sale to HCA, at the same time that Mission initiated its aggressive negotiating stance with Blue Cross, prior to that strategy's failure. Perhaps Mission's leadership was pursuing a two-pronged approach in order to be able to pivot quickly in case the Blue Cross strategy failed.[58] In any event, the financial reasons to sell gained strength after the failed negotiations.[59]

This failure is key because Blue Cross is the primary route to offsetting lower reimbursement rates received from government programs, whose payments are non-negotiable. Mission, like most other hospitals, relies on the profit it makes from commercially insured patients to offset any losses from Medicare or Medicaid,[60] and to cover the costs of treating uninsured patients. Due to age and income demographics in western North Carolina, only about a quarter of Mission's revenues come from commercial insurers, and Blue Cross is overwhelmingly the largest insurer. Therefore, Mission's inability to get Blue Cross to budge convinced the board that this "payor mix" was not financially sustainable in the long run. A consultant's report gave this fuller summary:

"The Board identified significant challenges facing Mission, including an unfavorable payer mix heavily weighted towards Medicare and Medicaid on which Mission earns a negative margin, an aging population causing a further shift from commercial insurance to Medicare, modest rate increases from commercial payers, North Carolina's decision not to expand Medicaid resulting in a larger population of uninsured patients, ... and continually reducing operating expenses without compromising the quality of clinical care. The Board unanimously agreed that continuing as an independent system was not viable, as continuous cost-

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[56] https://www.moodys.com/credit-ratings/Mission-Health-System-NC-credit-rating-802830019/reports
https://www.fitchratings.com/research/us-public-finance/fitch-rates-mission-health-system-inc-nc-series-2016-2017-bonds-aa-outlook-stable-10-08-2016
Confirming that these are strong ratings, see
https://www.beckershospitalreview.com/finance/20-health-systems-with-strong-finances.html
https://www.beckershospitalreview.com/finance/63-health-systems-with-strong-finances.html

[57] Of note, however, is that Moodys reaffirmed its strong rating once Mission rejoined Blue Cross. https://www.moodys.com/research/Moodys-affirms-Mission-Health-Systems-NC-Aa3-and-Aa3VMIG-1-Rating-Action--PR_904308169 . Also, noteworthy is that the board reached its decision without input from Mission's CFO, who retired at the end of 2017 and was not involved in either the Blue Cross negotiations or the financial analyses leading to the board's January 2018 decision.

[58] On the other hand, several subjects speculated that at least some leaders intended to pursue the hospital's sale regardless of the outcome of Blue Cross negotiations. Their theory is that, if negotiations succeeded, Mission would have even more value, but if it failed, then sale became more inevitable.

[59] See note 58, however.

[60] Hospitals do not necessarily lose money on these programs. Some break even and some make modest profits. Prior to the HCA sale, Mission typically reported relatively small losses from Medicare, but somewhat larger profits from Medicaid, such that, on balance, it made rather than lost money from these two programs. https://tool.nashp.org/

cutting would ultimately undermine clinical programs, leading to diminished quality, access, and affordability, and very possibly some hospital closures."

Based on these considerations, Mission's leaders thought that the system would financially struggle to stay afloat without major changes, perhaps necessitating the closure of some of its services or rural hospitals. But some voiced more dire concerns that, over time, Mission as a whole may not survive at all, under the assumption that major insurers would continue to resist increasing payment rates.[61]

Joining or partnering with a larger hospital system offered Mission a potential lifeline for two reasons. First, a larger system could have more negotiating clout with Blue Cross than Mission had on its own.[62] Second, a larger system could bring economies of scale, which offered the prospect of trimming hospital costs through purchasing discounts and "home office" administrative efficiencies.

B. The Envisioned Path to Financial Sustainability

Based on various considerations,[63] Mission's board invited proposals from HCA and Novant Health, a North Carolina-based system. Both offered similar or equivalent price terms,[64] but the Board unanimously selected HCA. Full reasons for favoring HCA have not been given,[65] but one that stands out from public statements is HCA's ability, based on its sheer size, to reduce costs through purchasing discounts and administrative cost savings.[66] In a formal letter to the Attorney General's office,[67] Mission's attorney said that the board was especially impressed by "a set of projections prepared by HCA ... demonstrat[ing] what HCA believed it could achieve in expected cost savings, particularly from corporate office synergies." In addition, Mission said it was impressed with HCA's "ability to procure supplies at more favorable prices than Mission, due entirely to is sheer size and volume of purchases."

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[61] https://www.citizen-times.com/story/news/local/2018/04/21/boyle-column-former-mission-ceo-bob-burgin-offers-views-proposed-sale-hca/535732002/
https://www.citizen-times.com/story/news/local/2018/03/31/boyle-column-mission-may-surprised-hca-deal-and-newfound-devotion-stock-market/474299002/

[62] On the other hand, it would be difficult to improve on the market clout that Mission already had (and still has) as the dominant hospital system in its market. Although a larger system that also has market power in other locations could, in theory, attempt to leverage that in the Asheville area, doing so could well run afoul of antitrust laws. https://sourceonhealthcare.org/market-consolidation/cross-market-systems/.

[63] Other potential "suitors" were thought to either lack sufficient financial strength or to be at too great a risk of being denied regulatory permission based on antitrust considerations.

[64] https://web.archive.org/web/20220802234818/https://avlwatchdog.org/wp-content/uploads/2022/08/Charles-Ayscue-CON-APPL-Novant-Hlth.pdf
In addition to the purchase price, HCA also committed to completing a range of capital improvement projects that were already planned or under way.

[65] Some knowledgeable sources commented that HCA's presentation to the board was much more polished -- "like a Broadway show" rather than a "high school musical" in the words of one participant. Outside critics, however, attribute this to their impression that Mission's management gave HCA special "coaching" prior to the presentation. A key executive at the time, however, has written that "more favorable options [were] available to Mission at the time that HCA was chosen as the buyer." https://avlwatchdog.org/mission-sale-wasnt-good-for-hca-either-a-former-top-exec-argues-for-a-return-to-local-control-nonprofit-status/

[66] https://www.northcarolinahealthnews.org/2018/07/25/missions-leaders-chose-to-dance-with-hca/

[67] https://www.scribd.com/document/563249268/HCA-008156-Inquiry-on-HCA-Health-Midwest-deal

Other Mission leaders echoed these sentiments. The board's chair wrote the public at large that: [68]

"The reason [for choosing HCA] is simple: HCA has significant economies of scale and concomitant expertise unavailable to Mission Health that will result in very significant cost savings and care enhancements. ... HCA buys volumes of products, equipment and services at prices far below what Mission alone (or any similar system) ever could. While its clinical staffing is very similar to Mission's, it has significant, demonstrated efficiencies in finance, information technology and other "back-office" functions."

Of note, however, is that explanations from Mission's leadership never give any hint that HCA might substantially cut patient-care staffing or compromise quality. Suggesting to the contrary, the passage just quoted assures that HCA's "clinical staffing is very similar to Mission's." Also, Mission's webpage of FAQs at the time stated that "we do not anticipate significant changes [in staffing] beyond what we typically experience or that otherwise would be required."[69]

Based on these assurances, several sources in the community now say they feel "lied to," both in the fact that the hospital was "not really failing," and in the assertion that significant staffing cuts would not happen. The resulting widespread anger from having been given these false impressions is on vivid display in an extraordinary open letter that seven state and local government leaders wrote one year after the sale:[70]

"During the negotiations and public discussions leading up to the sale, Mission officials were repeatedly asked, "If Mission is losing money, how will HCA make money by purchasing Mission?" The only answer we ever received was that HCA would make money through more efficient purchasing power and staff reductions in redundant back office, administrative positions. It is clear now that this was a lie. Instead, HCA has chosen to make its money by reducing charity care, eliminating medical and unit administrative staff to the detriment of patient care and safety, and sacrificing entire physician practice groups with long-standing contractual relationships by demanding significant reductions in pay. That wasn't the deal we were told about and it wasn't the deal we made as a community."

C. Maintaining a Charitable Mission

An obvious compromise in choosing HCA for its sheer size and administrative prowess is that HCA is avowedly organized and operated for profit; thus, it does not inherently have the commitment to community benefit and social welfare expected of a charitable institution. One can be skeptical of whether non-profit hospitals in the modern era are truly charitable, but differences in institutional mission and operational tenor nevertheless can be expected. And, certainly, to most observers, including ones with health care savvy, it came as an astounding surprise that a hospital explicitly named for its charitable "mission" would sell to the world's largest for-profit health care corporation.[71]

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[68] https://www.citizen-times.com/story/opinion/2018/07/13/mission-health-hca-board-made-right-decision-hca-merger/780893002/

[69] https://www.northcarolinahealthnews.org/2018/07/25/missions-leaders-chose-to-dance-with-hca/
https://web.archive.org/web/20180331010545/https://missionhealthforward.org/faqs
https://web.archive.org/web/20180409082221/https://missionhealthforward.org/faqs/

[70] https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/

[71] https://www.citizen-times.com/story/news/local/2018/04/21/boyle-column-former-mission-ceo-bob-burgin-offers-views-proposed-sale-hca/535732002/

Various features of the deal aim to address this concern, however. First, as discussed in Part 5, under HCA, Mission adopted a charity care policy that the board believed was as good, or better, than what the system previously had.[72] Based on this, Mission expected that "[j]oining HCA Healthcare would not change how Mission approaches patient care or treatment of the uninsured in any way."

Second, the Attorney General required HCA to make various assurances about maintaining core services throughout the region for at least 10 years.[73] Most impressively, though, is that the $1.5 billion purchase price was used to create what, for a time, was the country's largest per capita community foundation, devoted to improving health throughout western North Carolina.[74] There is good reason to believe (as discussed in then Endnote below) that Mission's CEO at the time was especially interested in this foundation's creation, with the thought that he might lead it. Also, several long-time hospital board members were initially appointed to the foundation's board.

Using the proceeds of a nonprofit hospital sale to create an independent charitable foundation typically occurs only when a for-profit entity makes the purchase. If another nonprofit makes the purchase, that is more often done simply through a merger of assets, whereby one nonprofit absorbs the other. Thus, a distinct advantage of selling to a for-profit is to "unlock" the value stored in the nonprofit so that those assets can be devoted to similar charitable purposes.

A sale to a for-profit entity is not the only means, however, to achieve that goal. Sometimes an acquiring nonprofit pays a purchase price just like a for-profit acquirer. In fact, that is precisely what transpired in Wilmington, NC two years after HCA's acquisition of Mission. There, Novant – the rejected suitor for Mission – purchased the county's hospital for $2 billion.[75] To address community concerns about giving up local control, county officials required that over half of this purchase price be placed in an independent foundation very similar to the one created by HCA's purchase.[76]

D. Concerns about a Tainted Deliberative Process

Thus, it appears at least possible that Mission's board might have struck a similar deal with an in-state nonprofit rather than an out-of-state for-profit. That possibility calls for more careful investigation into why the board nevertheless unanimously preferred HCA. Presumably, the board believed that, on the whole, HCA would do a better job running Mission Hospital than Novant. Because the deliberative process is not public, it is impossible to know the exact basis on which the board may have reached this conclusion. Some well-placed sources, however, relate that Novant's presentation to the board was distinctly inferior.

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https://www.citizen-times.com/story/opinion/2018/03/24/editorial-who-profit-missions-impending-merger/451201002/

[72] https://web.archive.org/web/20180331010545/https://missionhealthforward.org/faqs

[73] https://www.searchwnc.org/overview-transaction. Another example is Kaiser Permanente's 2017 purchase of Group Health Cooperative (in Puget Sound), which created a community foundation with $1.8 billion in assets. https://inatai.org/about/ https://dogwoodhealthtrust.org/wp-content/uploads/2023/12/DHT-HCACompliance1123-3.pdf

[74] https://dogwoodhealthtrust.org/

[75] https://www.northcarolinahealthnews.org/2020/11/27/mission-sale-good-for-wnc-or-just-hca/ https://www.northcarolinahealthnews.org/2020/07/14/novant-unc-win-bid-for-new-hanover-regional/

[76] Due to that county's smaller geographic footprint, this resulted in a substantially larger per capita foundation than the one created by HCA's purchase of Mission.

Assessing that possibility is necessarily speculative, but there is a credible indication why it might have occurred. Extensive investigative journalism has revealed a range of evidence that, from the outset, Mission's senior management treated HCA more favorably than other contenders.[77] This version of events is not presented with the intent of claiming any legal improprieties. Instead, it is meant to convey a plausible account of how Mission's board received information that would lead it to conclude that HCA was the better choice.

When Mission's leadership began to explore the possibility of a sale in 2017, and throughout the process, it devoted significant attention to HCA, using a consultant who had prior and concurrent business dealings both with HCA and with Mission's CEO. Concerns about these and other potential conflicts of interest[78] caused the Attorney General's office to investigate. Based on information obtained, the staff attorney in charge composed an internal document (in October 2018) summarizing that the Attorney General's office had "great concerns about how HCA was selected to be the entity that purchased Mission … [and] about how the negotiations [unfolded]."[79] The document then recited the following "facts as we currently understand them":

> 1. Phil Green, a longtime friend and associate of [Mission CEO] Dr. Paulus's, also has a prior business relationship with HCA. … Mr. Green's prior relationship with HCA was never disclosed to the Mission board ….
>
> 2. Over the next few months, Mr. Green and Dr. Paulus steered the process by which other bidders were identified. … Mission's board formed a Strategic Planning Committee. Although Dr. Paulus was not a member of that committee, he participated in it as if he were. …
>
> 3. A regional system was initially included in the bidding. We have learned that that potential partner wanted Dr. Paulus's role to be Chief [Innovation] 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 … Dr. Paulus coached HCA behind the scenes on how to best present its case to the Mission Board.
>
> 4. … 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 [professional] advancement [following the sale] versus others or versus no transaction at all. … 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. …
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> 5. HCA stated that it could make the system profitable by virtue of its low supply chain pricing and back-office efficiencies. The Board seems to have accepted that proposition uncritically.

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[77] https://tribpapers.com/archive/2021/11/community/asheville-watchdog-investigating-hca-mission-hospital/30545/ https://avlwatchdog.org/attorney-generals-office-had-great-concerns-mission-hca-deal-was-rigged-from-the-beginning/ https://avlwatchdog.org/mission-accomplished-former-ceo-ron-paulus-and-hca-discussed-takeover-options-before-board-okd-search/ https://www.northcarolinahealthnews.org/2020/11/26/a-done-deal-how-mission-health-wooed-hca/ https://avlwatchdog.org/year-in-review-rigged-from-the-beginning/

[78] See Appendix B.

[79] https://avlwatchdog.org/attorney-generals-office-had-great-concerns-mission-hca-deal-was-rigged-from-the-beginning/

> 6. In the end, 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. …

Several of these concerns and perceived facts have been contested; therefore, it is not settled that this document is 100 percent accurate, nor do we know for sure if there are any additional facts relevant to the integrity of this process.[80] Nevertheless, it is clear that the hospital's CEO was a key leader of the process. Also, several well-placed sources felt that the board did not confer sufficiently with outside expert guidance independent from management, as is often strongly advised and done in these situations.[81] The Endnote below provides additional discussion of Mission's CEO.

Also significant is the timeline shown in Figure 1 above that led to the board's decision. Recall that the board decided to sell the hospital in early 2018, which was in the immediate wake of the "botched" Blue Cross negotiation. The financial strains this caused likely created a sense of urgency in reaching a decision. Once senior management and board membership had decided on a sale, Mission's leadership added another layer of urgency to quickly sell Mission rather than wait to see whether the hospital could weather the climate at the time. According to participants in the deliberations, the prevailing sentiment was that Mission "had to strike while iron was hot," since the "handwriting was on the wall" and it was unsure "how long a runway" the hospital had before it went "in the gutter."

Few board members were available to interview (owing in part to nondisclosure agreements), but among those who were, only two expressed any regret over the decision that was made. For one, that regret was less about the wrong decision being made than about it being made with too great a sense of urgency and maybe even undue "panic," considering Mission's underlying financial strength.[82] Indeed, deliberations with the full board proceeded rapidly, which left little time for doubts or division to emerge. Also, some key figures who turned out to be strongly opposed to the decision felt they were kept "in the dark" until the decision was announced,[83] and others who were skeptical were said to be "picked off one by one" prior to full board deliberations.

Several informed observers noted that, following the 2016 repeal of state antitrust oversight, the board composition changed in a manner that brought in new members, some of whom, despite being well-placed in the community, had little or no experience with hospital management or health care finance and thus were more "naïve" or less prepared to ask the right kinds of detailed questions than board members who came "up through the ranks." Therefore, as one participant explained, by the time skeptics in management or in

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[80] For instance, one possible reason Mission's leadership may have focused on HCA first was to obtain an initial offer that it could use to better leverage competing bids from others, and, indeed, it appears (as mentioned above) that the only other competing bid the board considered essentially matched HCA's offer.

[81] One former Mission administrator commented that failure to do so is "highly unusual," as have two other experts who spoke with reporters about the situation.
https://avlwatchdog.org/mission-accomplished-former-ceo-ron-paulus-and-hca-discussed-takeover-options-before-board-okd-search/
https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/.
See also Jill R. Horwitz, State Oversight of Hospital Conversions: Preserving Trust or Protecting Health? (2002), https://www.hks.harvard.edu/centers/cpl/publications/state-oversight-hospital-conversions-preserving-trust-or-protecting-health

[82] Another insider noted that it would have been wise to see how the new Blue Cross contract actually played out, considering that Blue Cross reportedly no longer insists on the similar contract terms.

[83] One such figure was the hospital's chief financial officer.

communication with the board were notified, "it was too late," and the "die was already cast" because the choice of HCA was presented "as a predetermined" decision. An industry consultant familiar with the parties involved also agreed that Mission's senior leaders "orchestrated" the board's choice of HCA.[84]

In any event, once an initial decision of this magnitude is made, there is natural reluctance to reconsider or retract. When the Attorney General required the board to deliberate again after presenting his concerns about the process leading to its decision, the board unanimously reaffirmed its decision.

This apparent unanimity cloaks some unsettledness that interviews revealed. Informed observers noted that, although no board members involved are openly expressing regret,[85] none are vocally expressing wholehearted support for the decision, and at least one has said things "obviously have not" turned out as hoped.[86] Privately, one board member interviewed said they "absolutely regret the decision" and some sources close to other board members said that several have also expressed "deep" or "severe" regrets and "are very unhappy with the outcome." Some other board members, however, believe the decision was the right one at the time based on the information available, but that Mission found itself in "a bad place at the wrong time." Two key leaders at the time note that there is a tendency to compare current conditions with the "way things used to be," without failing to appreciate that conditions could not remain the same and that similar changes would have happened regardless of who was in charge.

It should not be surprising that a decision as complex and consequential as this would leave behind a cloudy and fractured picture of exactly what motivated it and what various alternatives might have produced. Nevertheless, what happened, happened. Having set this stage as best as is now possible, this investigation turns to a set of issues that hopefully can be addressed more clearly: what exactly has transpired following HCA's acquisition of Mission.

[84] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/
[85] https://avlwatchdog.org/opinion-heres-why-asheville-watchdog-reporters-knocked-on-the-doors-of-mission-board-members/
[86] https://avlwatchdog.org/former-mission-board-member-we-had-hoped-that-hca-would-be-a-better-corporate-citizen/

ENDNOTE: MISSION HEALTH'S CEO DURING THE LEAD-UP TO HCA's PURCHASE

The story of Mission Hospital's sale to HCA cannot be told without specific attention to the CEO at the time, Ron Paulus, M.D. Just about every interview of relevance mentioned him in some fashion, and some gave him considerable focus in describing what unfolded.

Dr. Paulus appears to leave indelible impressions on many who meet him. Described in various ways, he is said to be highly charismatic, sometimes perhaps approaching messianic. Mission's board chose Dr. Paulus as CEO in 2010, in part to repair frayed relationships with the local medical community. Equipped with training both as an MD and an MBA (from Wharton), Dr. Paulus came from a nonprofit physician-led integrated-delivery health system (Geisinger).[87] During his tenure at Mission, he devoted a great deal of effort and energy to establishing similarly strong connections with area physicians, with the goal of fostering more performance-based payment methods and population-focused health promotion.[88] His leadership helped Mission Health achieve repeated recognition as the best hospital in the state and one of the very best hospital systems in the country.[89]

Dr. Paulus' devotion to the principles of integrated finance and delivery of health care[90] poses somewhat of a puzzle for why he would have favored joining HCA rather than another health care system. As discussed in Part 3, HCA does not follow an integrated-delivery business strategy centered on performance-based payment. Indeed, with Mission, HCA quickly dismantled, or allowed to crumble, much of the hospital-physician integration that Dr. Paulus so painstakingly built. It is possible that Mission felt its other suitors would not have behaved much differently, but that seems unlikely. Therefore, it merits some consideration what other attributes of HCA would, in Dr. Paulus' mind, offset this sacrifice.

Some have postulated venal motives, pointing to Dr. Paulus' employment by HCA following the acquisition, and the substantial "golden parachute" that he reportedly received with the sale.[91] He worked for HCA for less than two years, however, which is not unusual following a change in ownership, in order to assist with the transition. Also, it is not unusual to pay the CEO a bonus at the end of a successful leadership. It remains unsettled, however, whether or not HCA's purchase produced a substantially larger severance payout than might have occurred if Mission had partnered with another nonprofit organization.[92]

In any event, another possible reason to favor HCA that would be consistent with laudable principles is the creation of a large independent foundation, focused on improving social determinants of health. Although (as noted [above]) the same might have resulted from a nonprofit purchaser, Dr. Paulus might have thought

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[87] https://www.commonwealthfund.org/publications/journal-article/2008/sep/continuous-innovation-health-care-implications-geisinger

[88] https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/

[89] See Part 4 of this study.

[90] https://www.researchgate.net/scientific-contributions/Ronald-A-Paulus-35309583

[91] See https://avlwatchdog.org/a-done-deal-how-mission-health-wooed-hca/
https://avlwatchdog.org/attorney-generals-office-had-great-concerns-mission-hca-deal-was-rigged-from-the-beginning/
https://avlwatchdog.org/mission-accomplished-former-ceo-ron-paulus-and-hca-discussed-takeover-options-before-board-okd-search/

[92] Although the specifics are not available, sources suggest that severance terms might have differed if the transaction were structured as a partnership or merger of assets rather than as an outright sale.

that such foundations often are smaller and less ambitious and remain more closely tied to the hospital's objectives.

A third explanation offered by several who knew Dr. Paulus well is that he primarily wanted to see Mission put in the best financial hands possible, and HCA made a convincing case for its ability to make the deepest cost cuts. Under this account, Dr. Paulus had tired of the incessant cost trimming required first by COPA oversight and then by the inability to negotiate substantial payment increases from Blue Cross. If he was not going to be able to generate enough surplus to make more transformational changes to how Mission operates, then he was not interested in continuing as CEO, according to this account. Some also thought that perhaps he felt bitter about the lack of support from community or business leaders during the Blue Cross showdown. Rather than simply leaving, an attractive exist strategy (according to this view) was selling the hospital for a handsome sum to a purchaser with the wherewithal to execute Mission's capital improvement plans, fund an ambitious foundation of eye-popping proportions, and accomplish painful but necessary belt-tightening while maintaining quality of care and service to the community.

It may have appeared that HCA fit that bill better than others. The following Parts examine whether or not this wishful thinking worked out as well as hoped.

Part 2: Mission Hospital's Financial Performance Under HCA

INTRODUCTION

As a result of HCA's purchase, Mission's flagship facility became the fifth largest for-profit hospital in the country. 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 Part examines financial data on Mission Hospital compared with a set of eleven similar (or "peer") hospitals in NC. Comprehensive financial data from hospital "cost reports" filed with the federal government are the primary data source for the analysis in this Part.[93] 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."[94]

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[93] 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.

[94] 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

To isolate the effects of the HCA acquisition from other larger forces in the health care industry, this Part 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 Part 1. 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

The following factors should be considered in reviewing these financial metrics:[95]

- 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

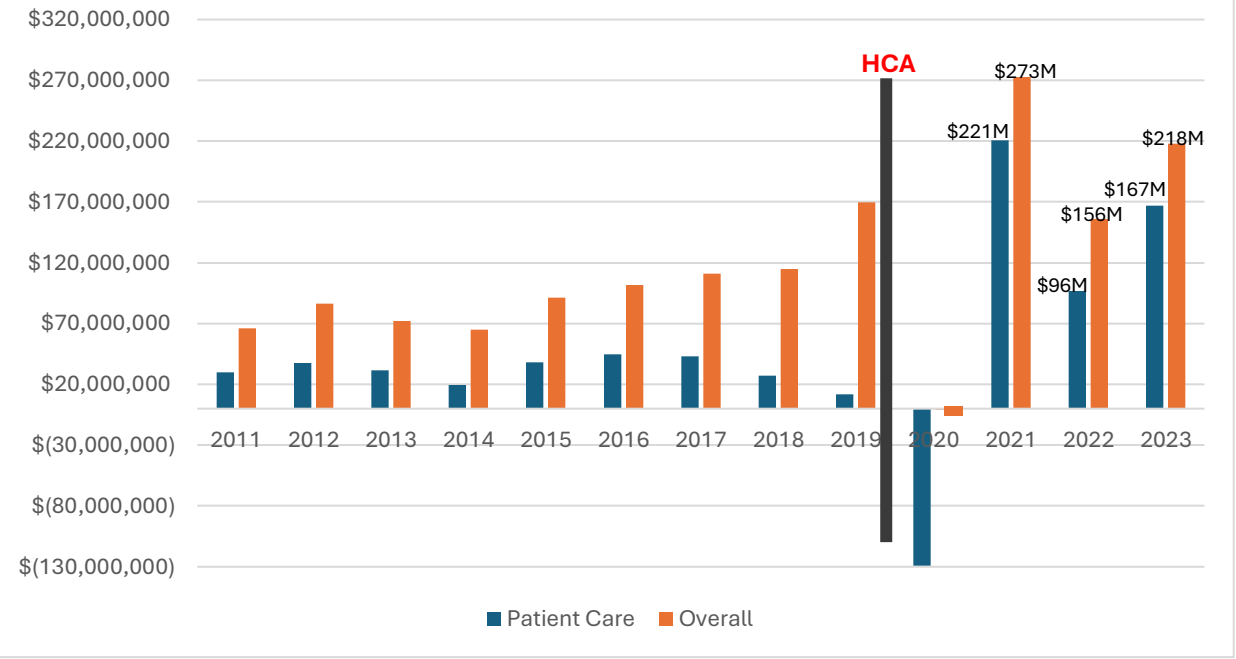
1. Profits

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.

representations. While imperfect, these data represent the only truly uniform and best available basis for comparison of cost performance across the entire industry.

[95] 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).

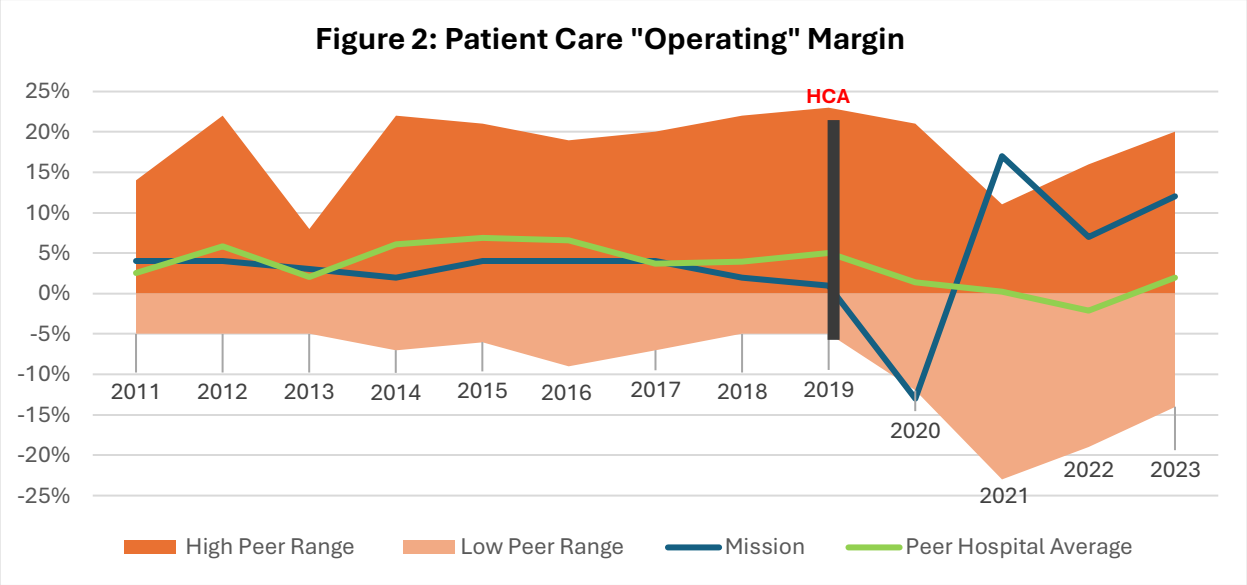
Figure 1: Mission Hospital Profits (Losses)

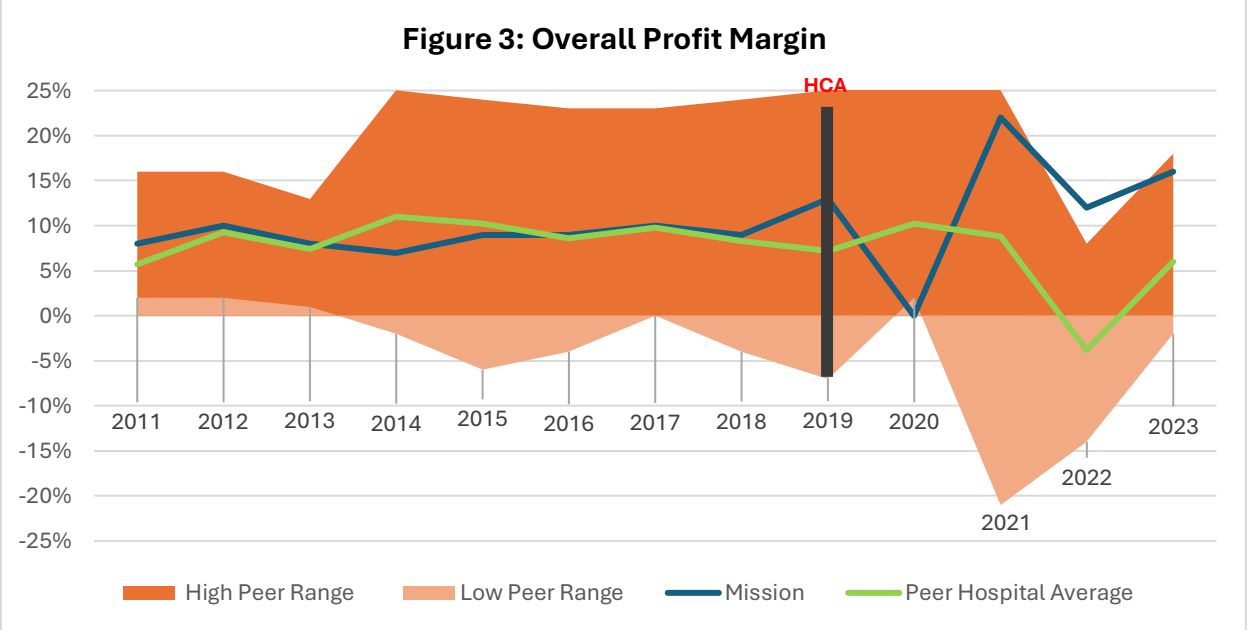


In the most recent year for which comparable data is available (2023), Figure 1 shows that Mission's patient-care profits were $167 million, which was *six times* its profits the year before HCA's purchase, or more than 4 times its $38 million profit average over the four years prior to HCA's purchase. 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 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 four years, Mission's two profit metrics fluctuated significantly, 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.

After 2021, HCA Mission's trajectory has tracked more closely the changes in the peer hospital average, but Mission continues to have substantially higher profitability than average (Fig. 2). Its patient-care profit margin was 12 percent in 2023, compared with a 2 percent average among peer hospitals. Only one other hospital (Greenville SC at 20%) had higher profitability.

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

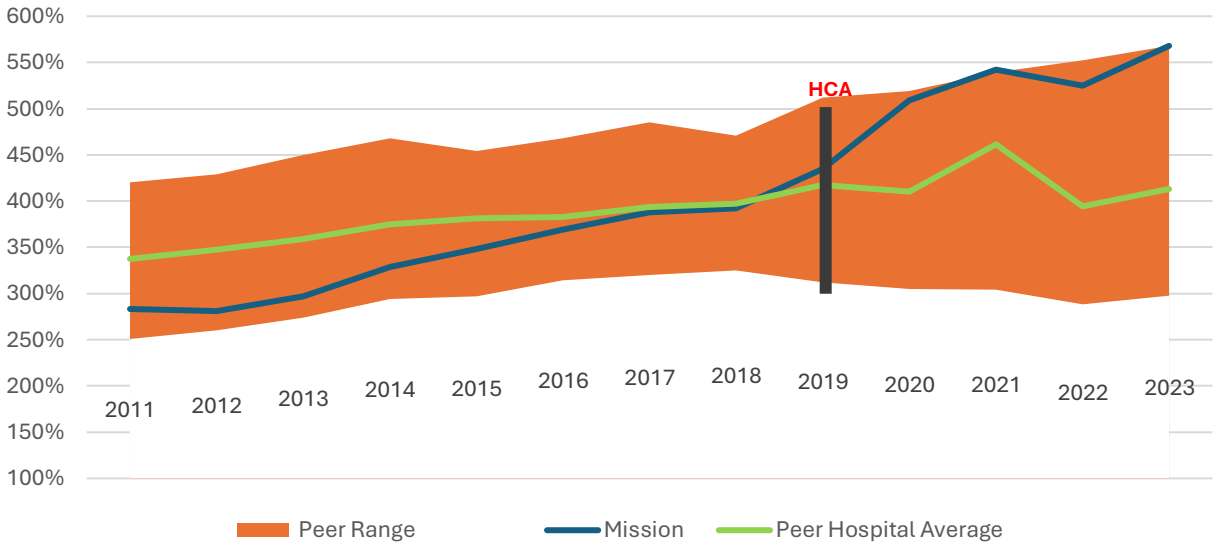
There are two basic ways to improve a profit margin: increase prices or decrease expenses.[96] It is difficult for HCA Mission to increase effective prices, for two reasons. First, the substantial majority of its patients are covered by Medicare or Medicaid, under which the government essentially sets 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 Part 1, 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 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 400% *of* costs (or 300% *over* costs), ranging from about 350 percent to 550 percent *of* costs (or 250% to 450%+ *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.

[96] 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.

Figure 4: List Prices as Percent of Costs



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 29 percentage points a year (or 26 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) [97]:

> 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 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 beyond. These increases do indicate, however, the degree to

[97] 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/

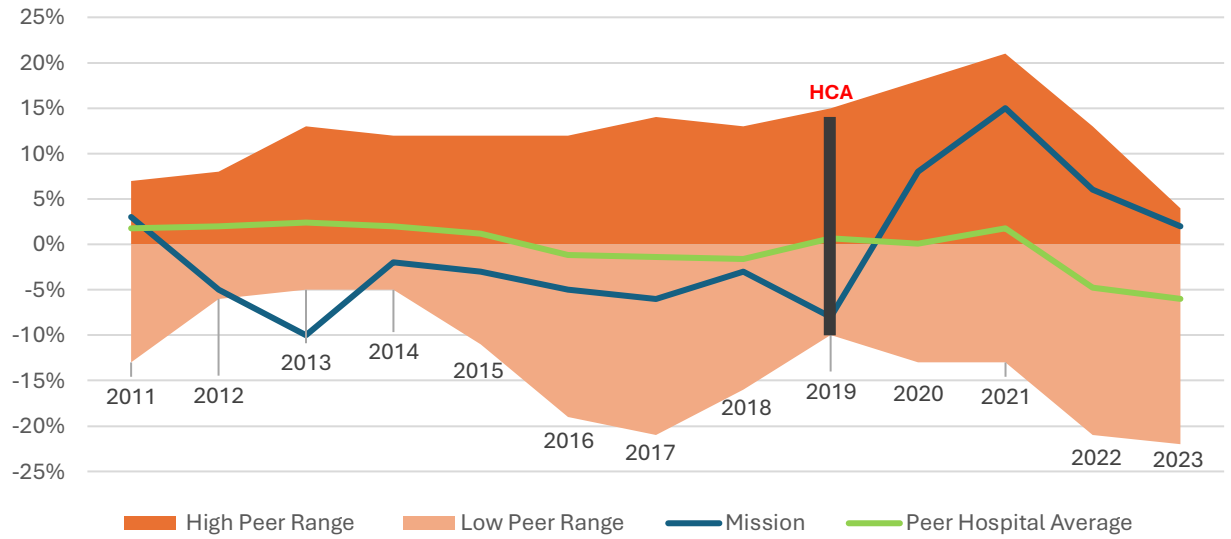
which a profit-oriented owner is inclined to use every leverage to increase profits. Despite that inclination, Mission's top-of-range markup is actually at a more moderate level (568% of costs) than what is typical at most other HCA hospitals, where markups average about 10-fold (1,000%).[98]

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. That remarkable increase pushed Mission from below the peer hospital average to near the top of the peer range. Although its Medicare profitability has dropped since then (to 2% in 2023), the same has happened at peer hospitals, such that the most recent peer average was a -6 percent loss from Medicare.

Figure 5: Medicare Profit Margin



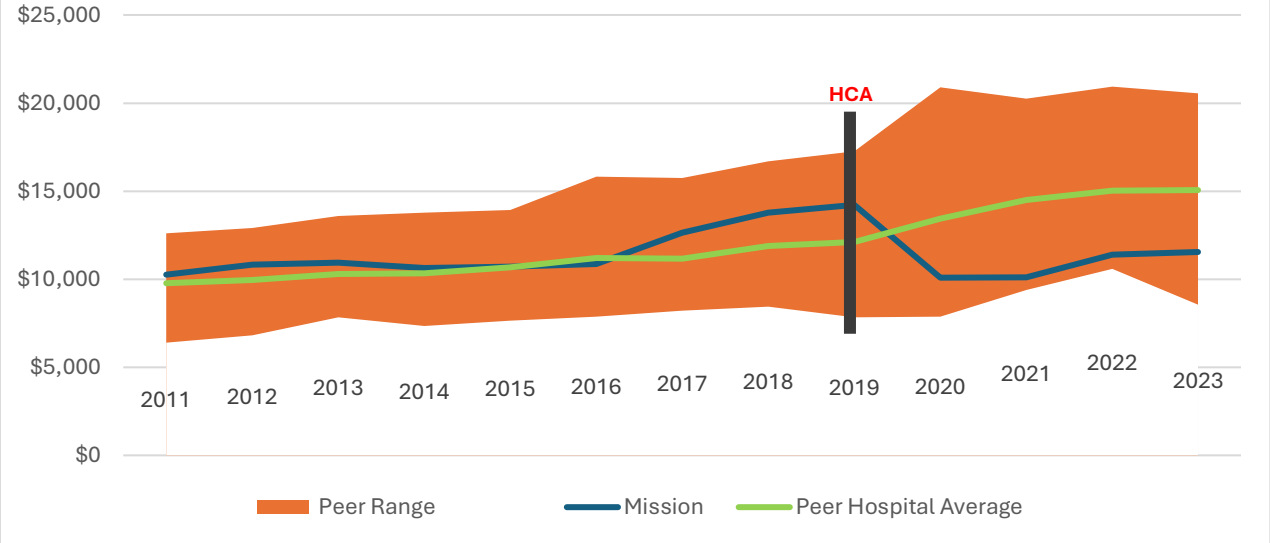
Confirming that cost control has been the key to profitability, Figure 6 shows Mission's average patient-care costs per patient over time.[99] For the first half of this span, Mission was very near its peer average, a requirement set by the state's antitrust review. When state review was terminated in 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 2023. That drop moved Mission

[98] 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

[99] 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.

from 17 percent above the peer average to near the bottom of the peer range, at 25 percent below the peer average.

Figure 6: Hospital Costs per Adjusted Discharge

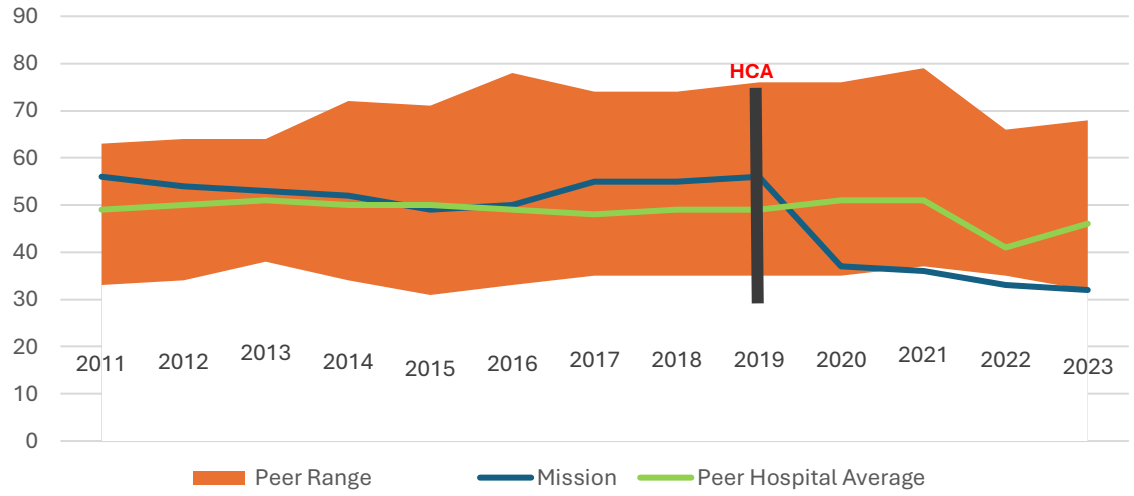


Also significant is that the only other two hospitals near Mission's low level (Cape Fear and Moore County) have a patient population whose average case severity (measured by the case mix index shown in Table 1) is noticeably lower than Mission's (-17% and -9% less severe, respectively). In contrast, 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.

Figure 7: Direct Patient-Care FTE per Adjusted 1000 Discharges



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.[100] 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.

Additional confirmation comes from an analysis done by an NBC reporting team, which analyzed similar data through 2021 to conclude that "the number of full-time employees at Mission Hospital has declined by 37%

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

since HCA took the system."[101] In-depth research from Bloomberg News provides further confirmation. Based on data for all HCA hospitals nationally, these investigative journalists reported that, during the COVID-19 pandemic, while other hospitals (both for-profit and nonprofit) were increasing patient care staffing, HCA hospitals reduced their staffing.[102] Over the same period, HCA showed increased profits, whereas profits dropped on average at both for-profit and nonprofit hospitals nationally.

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 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**	

[101] www.nbcnews.com/health/health-news/workers-us-hospital-giant-hca-say-puts-profits-patient-care-rcna64122

[102] www.bloomberg.com/news/features/2024-11-22/what-happens-when-us-hospitals-binge-on-nurse-practitioners

*Source: Mission Hospital CON Application for 67 Acute Care Beds, June 15, 2022
Note: For Table 3, some categories overlap, such that the calculated total of $1.06 billion exceeds the stated total by 5%.

A team of NBC reporters drew the same conclusion. Based on federal government data, they reported that "positions [HCA] said had been transferred to corporate headquarters — information technology, human resources, marketing and finance — would likely total less than 5% of its full-time employees, according to average hospital employment figures published by the Bureau of Labor Statistics."[103]

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.[104] 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.

[103] www.nbcnews.com/health/health-news/workers-us-hospital-giant-hca-say-puts-profits-patient-care-rcna64122
[104] It is possible, however, that some labor expense was included in the latter.

Part 3: Changes in Patient Care Following HCA's Purchase of Mission Hospital

INTRODUCTION

When a large, investor-owned company acquires a hospital that enjoys essentially unregulated monopoly status, operational changes can be expected that increase profits. Many would expect prices to increase. Part 2 of this study shows that has occurred to some extent, but, to a much greater extent, Mission's profits have shot up primarily due to steep cuts in costs. On reflection, this makes sense because hospitals have much more direct and immediate control over their costs than over the prices paid by government programs and large managed care insurers.

This Part builds on the preceding financial impacts analysis by examining how HCA's cost-cutting has affected patient care at Mission, focusing first on physicians, then nurses and other patient-care staffing, and finally the emergency room.[105]

[105] The discussion draws from documents filed by the Attorney General in his lawsuit against HCA Mission, which can be found in the "Combined Exhibits" folder here: https://ncdoj.sharefile.com/share/view/s9a1f854765ac4354aa6a549013687ae8/fo6b686e-516a-4e8f-9355-8475fecb8cbd

I: PHYSICIAN DEPARTURES FOLLOWING HCA'S ACQUISITION

Mission's Esteemed Medical Community

Well before HCA purchased Mission in 2019, the hospital had reached state-wide and national prominence for its excellent quality of care.[106] This success was due in large part to the breadth and depth of Mission's medical staff. As one observer noted recently, Mission had "a reputation for quality that once drew esteemed doctors from across the country."[107] Mission's former CEO explained to fellow hospital executives in 2010 that the close working relationship between the hospital and its first-rate medical staff "attracted me to Mission Health" and was "one reason why the region [had] ranked as among the nation's best for providing high quality, low cost care."[108]

Long-time members of Asheville's medical community have described the "really, really remarkable depth of specialists" who came to the area because of the hospital's marked reputation for quality, the depth of medical expertise, and the strength of connections within the medical professional community. One physician, for instance, who reflected on Mission's rise to prominence over the past fifty years, wrote that:

> We saw brilliant young doctors come. The cardiologists were as fine as any at the Mayo Clinic. Superb pathology and anesthesiology, ancillary internal medicine practices arrived. The quality and quantity, the variety of sub-specialties just blossomed. The most complicated diseases, which had been referred to university centers, now were beginning to be competently treated right here, right now. Early on there was no hand surgeon, no pediatric surgeon [but then they arrived]. Quickly, the beauty and meaning, this fine gem of Asheville, became known at academic medical centers. Specialists came for Asheville's beauty, peaceful forests and mountains. Asheville became a medical gem.[109]

Another medical professional who practiced in Asheville for 40 years, recently ruminated that, during the pre-HCA Mission era:

> Physicians from the most prestigious programs in the country wanted to come here…. We were building a medical community defined by trust, collegiality and excellence…. We were all committed to providing the best care possible. Our relationships supported that end. For members of the community, working at Mission or St. Joe's was something to aspire to, a place

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[106] See Part 4.

[107] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/

[108] https://www.beckershospitalreview.com/hospital-executive-moves/hospital-industry-leader-to-know-dr-ronald-paulus-of-mission-health-system.html

[109] https://www.citizen-times.com/story/opinion/2024/06/23/asheville-mission-hospital-was-medical-gem-before-hca-took-over/74122574007/

Also reflecting on this past, see: https://www.citizen-times.com/story/opinion/2024/06/30/memorial-mission-hospital-lost-asheville-trust-with-mergers/74137618007/

> to have a career, a place to belong, to feel proud of. There was a sense of ownership for them as well.[110]

Mission's quality of care also garnered highly favorable attention from national research organizations and health policy experts. Twenty years ago, one research group specifically chose to study Mission Hospital because of its exemplary quality. The researchers reported that:[111]

> Because of its attractive location in the mountains, the local lifestyle, and the institution's good reputation, the health system has succeeded in attracting highly qualified physicians from top schools and other top-ranked institutions. Ninety-three percent of its physicians are board certified. Also, Mission's family practice residency enjoys the top match of any family practice residency in the country—a strong statement about the quality of the institution and its physicians. …. Mission's location in the mountains of North Carolina also seems to contribute to high quality, by creating a sequestered community of physicians who take a long-term view of the institution and its needs.

Physician Departures under HCA

Considering the long-standing strength and relative cohesiveness of Asheville's medical community, it is troubling that, relatively soon after HCA's purchase, a large number of established and well-regarded physicians severed their ties with the hospital. Yet, Mission's CEO at the time of the sale assured a community group that, under HCA, Mission would have "the exact same people and exact same doctors and exact same nurses providing all the care."[112] Even the hospital's FAQs webpage discussing the proposed sale reassured that, "We don't expect any changes for private practice primary care physicians."[113] Clearly, things have not played out as expected, which signals that all is not well with Mission Hospital under HCA.

Exact, or even approximate, counts of departing physicians are not obtainable (in part because HCA Mission will not provide them). It is clear, however, that, due to various forms of unhappiness with HCA, doctors have left Mission in droves. Well over one hundred—and by some estimates several hundred—doctors have either left Mission or have shifted some or most of their medical practice elsewhere. According to one count, 223 doctors fell entirely off the hospital's medical staff between August 2019 and February 2022.[114] A former senior administrator at Mission said that, prior to HCA's purchase, the hospital actively managed 750

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[110] https://www.citizen-times.com/story/opinion/2024/05/26/opinion-physician-says-hca-mission-purchase-is-like-hostile-takeover/73775402007/ Another physician reflected that Asheville's "reputation as a beautiful mountain town with a superior medical center fueled a migration of physicians from the best universities." https://www.citizen-times.com/story/opinion/2024/08/11/opinion-asheville-played-role-in-advanced-modern-rheumatology-care/74685451007/

[111] https://www.commonwealthfund.org/publications/fund-reports/2004/jul/hospital-quality-ingredients-success-case-study-mission

[112] https://www.citizen-times.com/story/news/local/2018/12/30/if-mission-health-sold-hca-what-happens-quality-care/2390200002/

[113] https://web.archive.org/web/20180724134555/https://missionhealthforward.org/faqs/

[114] https://www.northcarolinahealthnews.org/2022/03/26/how-many-doctors-have-left-mission-hca-wont-say/. This count would include doctors who retired or left the area for reasons unrelated to HCA, but it excludes doctors who retain only a reduced or residual status on the medical staff.

physicians, but that number has dropped by two-thirds.[115] As summarized by the respected former head of Mission's hospitalist group:[116]

> There were a host of unforced errors that resulted in the emergency department staff being put under stresses that caused them to leave, that caused [most hospitalists] to leave, that caused most of our psychiatrists to leave, that imploded our hospice and palliative care service, that caused all of our otolaryngologists to resign from the medical staff, that put stress on the cardiology group, and the pulmonary and critical care group ….

There are additional indications that, after several years under HCA, Mission continues to have significant physician departures. According to one active physician, "40 percent of the doctors and nurse practitioners and PAs left [Mission's] ER in 2023."[117] Another said that 18 emergency room physicians left over the space of a few months in 2023. In 2024, the number of staff neurologists at Mission dropped from seven to, at one point, only two, due largely to resignations caused by "burnout, 'nausea and fury.'"[118]

Key observers[119] have characterized this overall "slew of departures" "en masse" as a "massive flight" or "painful dismantling" in which physicians "fled Mission in droves" and "entire practices vaporized." They say this has amounted to a "HUGE, HUGE turnover" or "upheaval" constituting an "implosion" or "mass exodus" that "decimated," "dismantled," and "unwound" major parts of a "painstakingly assembled" medical community. And they exclaimed how "terrible," "horrible," and "distressing" it has been to witness the decline of what had become one of best medical communities in the country, one that (as a former board chair said) "we worked so damned hard" to build.

The breadth and depth of discontent that arose in the area's medical community following HCA's purchase is powerfully expressed in an extraordinary open letter in late 2023 that has now been signed by more than 250

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[115] Essentially confirming this, Mission recently said it operates fewer than 200 physician practices. https://www.beckersasc.com/leadership/its-been-devastating-where-a-physician-landed-after-hca-shuttered-practices.html

[116] https://avlwatchdog.org/i-was-beginning-to-feel-like-i-was-on-a-sinking-ship-says-former-mission-hospitalist/

[117] https://avlwatchdog.org/this-is-a-four-level-problem-dr-clay-ballantines-full-statement-at-ashevilles-watchdogs-hca-mission-community-event/

[118] https://www.northcarolinahealthnews.org/2024/08/23/more-than-half-of-missions-remaining-staff-neurologists-say-they-are-resigning-citing-burnout-nausea-and-fury/

[119] See, e.g.: https://www.medpagetoday.com/special-reports/exclusives/91263
https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/
https://avlwatchdog.org/missions-urology-services-loses-physicians-asheville-urological-associates-gives-up-privileges-there/
https://avlwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say/
https://avlwatchdog.org/how-many-doctors-does-mission-hospital-have-they-wont-say/
https://www.transylvaniatimes.com/news/hca-sees-exodus-of-local-mds-transylvania-county-nc/article_caa88f2d-c3e8-52db-b207-b50b50590b24.html
https://www.medpagetoday.com/special-reports/exclusives/91263
https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/

area physicians,[120] including seven former board members and nine former clinical chiefs at Mission.[121] Additional portions of this remarkable missive are quoted below, but the core sentiment of this "open revolt"[122] is that: "Many of the for-profit-driven changes that HCA has wrought, despite advocacy and protests from multiple sectors, have gutted the heart and soul of our community healthcare system, … [which has been] a backbone of this community for decades."[123]

As discussed in the next two sections, physicians have been motivated to disassociate from HCA Mission for two sets of reasons: economic and medical professionalism.

Economic Reasons

Economics is the primary basis for discontent among many former Mission physicians. Prior to HCA, Mission, recognizing the importance of a strong physician network, grew its stable of closely affiliated physicians by paying them well. When HCA took over, however, well-informed sources explained that HCA's business model does not prioritize integrated care and population health—goals that were pursued by Mission's previous leadership.[124] Instead, HCA has a "different mindset" that values strong connections with only certain types of physicians, based entirely on a particular medical practice area's profitability to a hospital that is focused on high-reimbursement acute care services. One source commented that most other hospitals "want to control all the buckets" of medical practice, but HCA "only wants the buckets with [good profit] margins."

A physician who previously served on Mission's board underscored that HCA "cherry-picked" which services and programs to keep open based on profitability. By way of example, the physician stated that HCA closed the wheelchair seating clinic and the elder-care service that previously complimented Mission's rehabilitation unit because those services lacked profitability. Another community physician noted that HCA closed Mission's bariatric weight loss clinic despite continuing its bariatric surgical program because only surgery makes money.

In neurology, HCA reportedly attaches greater value to the surgical branch of the specialty than the medical branch, because much of the latter is done on an outpatient (non-hospital) basis. Neurosurgery is said to receive better treatment from HCA because that branch of the specialty is much more lucrative.[125] Several sources noted that neurology is an "extreme case" of HCA "running off" much-needed medical specialists that Mission had "painstakingly" recruited to the area in the past. According to one insider, most of the sizeable Mission-supported neurology group felt they had no choice but to cut ties and relocate when HCA insisted on "egregious" changes to their compensation. As a result, this has left "a gaping hole for Alzheimer's,

[120] https://avlwatchdog.org/they-must-leave-coalition-launches-campaign-to-push-hca-to-relinquish-mission/
[121] https://www.northcarolinahealthnews.org/2023/10/22/50-doctors-including-a-former-board-member-publicly-decry-hcas-management-of-mission-hospital-system
https://www.medpagetoday.com/special-reports/features/107516
[122] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/
[123] https://drive.google.com/file/d/1l2GEDz95cRhlFe2D1gDY5XrPMZDxjEMN/view
[124] See, e.g., https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/
[125] Nevertheless, there is some indication their ranks also have diminished at Mission, but not nearly to the same extent as medical neurologists. https://avlwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say/

Parkinson's, stroke care [and dementia care] in our aging population,"[126] as one physician said, which makes it much more difficult than before to arrange care for patients suffering from major impairments, according to several sources.

Several sources also pointed to the community's loss of several prominent cardiologists, even though cardiac surgery remains relatively strong. Others noted that this differential treatment is consistent with HCA's observed "playbook" nationally,[127] which focuses on "higher acuity" "interventional" or "procedure-oriented" practice areas that are more "money-making" than more routine medical care. Accordingly, in a range of medical practice areas, HCA was said to offer physicians a "take-it-or-leave-it" change in contract terms that drove many of them away.[128] The resulting loss of physicians has meant, according to one community leader, that the ability to get a doctor's appointment "changed dramatically," "like night and day," after HCA purchased Mission.

Multiple sources said that HCA could afford to drop support for primary care doctors and community-based specialists because Mission is the only tertiary-care hospital in western NC, and the larger Mission system offers the only accessible hospitals in a significant portion of the region. Thus, as some sources have flatly posed, "where else are [these patients] going to go?" Even if Mission is at risk of losing patients who need less-complex hospital care, these patients are often less profitable. Ultimately, Mission can afford to focus on more profitable, complex medical care, all while "leaving the scraps for others."

Even for essential hospital physicians, HCA has recognized that certain market conditions allow it to substantially reduce their pay, increase work demands, or both.[129] A former financial adviser to Mission's board said that HCA now regards these core physicians as "cogs in a machine" that it can readily and repeatedly replace. For instance, internal medicine physicians who work as full-time "hospitalists" are considered the "backbone" of the hospital. Prior to HCA, Mission systematically built up a large core of more than 50 hospitalists, most of whom had practiced there for many years. Following HCA's purchase, almost "every single one" left – most by moving their practice elsewhere (although some by retiring or by changing their area of practice). When asked about the situation, one of the last hospitalists to leave Mission said "you're going to make me cry" having to think about it. This physician and several others described that, soon after HCA's purchase, members of this large and well-respected group "started peeling off," leaving fewer and fewer until none were left. As one physician emphasized, they were simply "GONE," which another stressed was "very sad."

Some hospitalists left because, as discussed below, they found that practice conditions under HCA became intolerable. Others left mainly because, "within a hot minute," HCA worsened their work and compensation terms by turning this practice area over to a national physician staffing firm (Team Health) that substantially

[126] https://avlwatchdog.org/this-is-a-four-level-problem-dr-clay-ballantines-full-statement-at-ashevilles-watchdogs-hca-mission-community-event/
[127] https://www.pressreader.com/usa/modern-healthcare/20181008/281762745204037
https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/
[128] https://www.carolinacoastonline.com/regional/article_003a1ff8-4167-11ef-a880-0b4d180c2e81.html
[129] https://avlwatchdog.org/i-was-beginning-to-feel-like-i-was-on-a-sinking-ship-says-former-mission-hospitalist/

cut their pay[130] and increased their workload. Full details were not available, but one physician described having to now care for roughly 30 patients a day, a level they said is "absurd."

In other practice areas, HCA outright terminated its physician support altogether, for financial reasons. Most visibly, HCA either greatly reduced or virtually eliminated support for family medicine and other common primary care practitioners. An experienced physician explained that "jettisoning" primary care is consistent with HCA's "pattern [elsewhere, which] is to shut down [support for] primary care wherever they're going and just assume other people are going to pick it up. They don't want it. It's not a big enough profit for them."[131] Another former Mission said "there was an attitude primary care was no longer really important."[132]

As one long-time member of the local medical community recounts, HCA's withdrawal of support affected a broad swath of important services beyond just physician care:[133]

> [Under HCA] access to the outpatient rehabilitation clinics [was] greatly curtailed, essentially gone. The incontinence and bladder function clinic, GONE. The lymphedema clinic, GONE. The vertigo and balance clinic, GONE. The senior driving assessment program, GONE, … for these patients who've … had strokes, major orthopedic issues, and they're trying to rebuild their lives and get a grip on what's happened to them. The psychological services in the [rehab] facility, GONE. … They tried to get rid of the amputee clinic that takes care of the wounded appendages and make sure they have the right prosthetics and they tried to get rid of … an integrated outpatient program to keep people able to live at home or keep them out of nursing homes and out of the hospital.

For main-line primary care clinics, physician interviewees said that HCA's local chief executive initially assured them (in one physician's words), that "oh no, [HCA dropping support] will never happen. We have no intention of doing that." Yet, a few months later and reportedly with very little notice, HCA entirely "shuttered" two substantial primary care clinics, causing many thousands of patients to have to scramble to find new doctors.[134] As another physician lamented, "that's how they work:" at first, "flatly denying" any intent to pull support, but then suddenly rescinding that assurance by forcing a key clinic to close within one month.

Informed observers explained that HCA does not invest in primary care for business reasons. One reason, suggested by a local primary care physician, is that effective primary care actually hurts a hospital's business by keeping people healthy, explaining that: "Our job was set up by the previous hospital administration to

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[130] Specifics were not provided, but in general, prior to HCA Mission was said to pay its hospitalists based on the services they provided, whereas under HCA hospitalists reportedly are now paid based primarily on time or salary, with only a small portion based on services.

[131] https://carolinapublicpress.org/47175/hca-takeover-reframing-primary-care-in-western-nc-could-threaten-regional-hospitals/

[132] https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/

[133] https://avlwatchdog.org/this-is-a-four-level-problem-dr-clay-ballantines-full-statement-at-ashevilles-watchdogs-hca-mission-community-event/

[134] https://wlos.com/news/local/clinics-closed-dozens-of-doctors-leave-mission-health-since-hca-takeover https://carolinapublicpress.org/47175/hca-takeover-reframing-primary-care-in-western-nc-could-threaten-regional-hospitals/

keep folks out of the hospital and to keep costs down, and we did a really good job at it. We kept people healthy and we kept them out of the hospital."[135] A second business reason is that HCA realized, according to multiple physicians, that they "don't need a feeder network" when "they have a monopoly" on key hospital services. Physicians commented that, even without HCA's support, "where else will patients go" for hospital care? There is "nowhere else to send them," since "there just aren't that many [hospital] options for going elsewhere."

Quality of Care Concerns

Other established physicians have disengaged from Mission Hospital – either partly or entirely – based primarily on concerns about their ability to deliver quality care.[136] An orthopedic surgeon left his successful practice at Mission because"[p]art of the attraction of working at Mission was to be surrounded by high quality, very well-trained physician colleagues," but now, "[m]any of these people are leaving as they aren't willing to compromise patient care in Asheville."[137] A former clinical leader who HCA itself recruited ended up leaving because, he said, "I became completely demoralized by HCA's lack of willingness to try and improve [care] so we could effectively treat patients."[138] He also noted that, although he was able to recruit some replacements for previous physicians who left, "unfortunately their tenure at Mission was short due to the culture and work environment within the hospital …." One of those departing recruits explained that "I left because I couldn't in good faith take care of patients somewhere that I didn't think was safe."[139]

The highly respected head of Mission's large hospitalist group also left after struggling through several years of frustration under HCA because serious quality problems were "not something that I was ever able to adequately get remediated." [140] Despite being very committed to remaining with the department that he built and led for two decades, this former Army doctor said it "came to a point for me that I just felt I couldn't deliver the care that I wanted to deliver," due to "there [being] just so much turnover and so much turmoil."[141] Also, he noted (in a sworn statement) that this "is the reason why many" of his physician colleagues who pre-departed him left. "They simply could not practice medicine under those circumstances."[142]

In August 2024, three of Mission's five staff neurologists resigned over frustration with ongoing failures to improve their working conditions by filling staff vacancies.[143] According to one departing physician, "the demands on each individual neurologist were incredible, and it was rare that we could conclude one emergency without being interrupted by another emergency."

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[135] https://www.beckersasc.com/leadership/its-been-devastating-where-a-physician-landed-after-hca-shuttered-practices.html
[136] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/
https://avlwatchdog.org/i-was-beginning-to-feel-like-i-was-on-a-sinking-ship-says-former-mission-hospitalist/
[137] https://www.citizen-times.com/story/news/2021/05/14/mission-hospital-departures-concerns-doctors-leave-hca-healthcare-more-work-less-pay/5042082001/
[138] Note 105, Exhibit 2.
[139] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/
[140] Note 105, Exhibit 8.
[141] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/
[142] Note 105, Exhibit 8.
[143] https://www.northcarolinahealthnews.org/2024/08/23/more-than-half-of-missions-remaining-staff-neurologists-say-they-are-resigning-citing-burnout-nausea-and-fury/

Collapse of Cancer Care

Cancer care is the most visible example of physicians reducing or severing ties with HCA Mission based in large part on concerns about the quality of care. The head of the cancer service and his entire oncology staff, who HCA recruited to build the cancer services at Mission, left over the space of just a couple of years[144] "due in large part to the maladaptive management style of hospital administrators and their fundamental lack of understanding of cancer services."[145] As a result of these departures, a leading industry news source described the SECU Cancer Center that was once a gem of Mission's medical campus as, essentially, a "ghost town."[146] The head of oncology that HCA Mission recruited wrote (in a sworn affidavit) that issues causing this collapse included:

> 1. … inadequate [staff] support to successfully operate an outpatient oncology practice.[147] …
> 2. Support services needed for a comprehensive cancer program were largely eliminated (palliative care, nutrition services, and community engagement related to cancer screening, transportation, and education).
> 3. At times, due to staffing issues, administrative assistants were asked to complete work ordinarily done by a registered nurse. …

This edited list of concerns focuses on outpatient care. Addressing hospital care, this same clinical leader said (in his sworn affidavit):[148]

> Our group also had concerns regarding patient safety and the administration of intensive chemotherapy regimens on the inpatient oncology unit due to inadequate, transient, and undertrained staff. The [hospital] lacked adequate [physician] coverage at night to address the urgent needs of complex oncology patients and there were limited hours during which oncology drugs could be prepared due to pharmacy staffing. Chemotherapy, particularly regimens for leukemia and lymphoma, are intensive regimens [requiring] round-the-clock monitoring. Because of short nursing staffing - particularly at night - I deemed that the inpatient oncology unit was unable to provide the monitoring to deliver leukemia care. As a result, the providers in our practice decided not to provide leukemia induction therapy at Mission.

The decision by HCA Mission's oncologists to cease leukemia treatment due to safety issues left leukemia treatment in the hands of a different medical oncology group in the community. However, in due course, that

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[144] https://www.citizen-times.com/story/opinion/2023/12/17/hca-mission-hospital-has-no-medical-oncologists-on-staff/71894784007/

[145] Note 105, Exhibit 2.

[146] https://www.oncologynewscentral.com/article/cancer-center-a-ghost-town-after-acquisition

[147] The doctor elaborates: "As example, this practice was to be staffed by two registered nurses, but for long periods there was only a single nurse and at one point the clinic had no nursing support for several months. [Also, there was] [i]nsufficient and inadequately trained administrative support staff to complete paperwork, answer phone calls, and to get patients properly scheduled for procedures and clinic appointments."

[148] Note 105, Exhibit 2.

community practice also decided to send their leukemia patients elsewhere. According to the group's leader, who also heads the state's oncology association:

> In September 2023, Messino Cancer Center determined it could no longer provide chemotherapy treatment to complex hematology patients at Mission Hospital. That decision … was based on concerns about understaffing of the inpatient oncology unit, issues with the supply of chemotherapy drugs (including an inadequate number of chemotherapy-trained pharmacists to mix the drugs), and delays in receiving laboratory results.[149] ... We were finding more and more cases of missed care and errors. ... We were catching them, but it was one of those things where it was just a matter of time before something was going to slip through the cracks and someone was going to get hurt.[150]

In sum, unresolved concerns about patient safety under HCA now mean that the very sick leukemia patients with the area's primary oncology group must now travel to hospitals outside of western NC to receive essential chemotherapy infusions.

HCA Mission's Response

HCA Mission claims this turmoil and its significance are overstated. It points, for instance, to the fact that, in response to the critical letter from physicians noted above, 82 clinicians currently on the staff wrote a letter in support saying that "there are many of us who do not feel that their [colleagues' critical] voice represents us as a whole."[151] HCA Mission also notes that it has been able to fill many or most of the vacancies created by various physician departures, and it claims that, on the whole, "we have about as many providers on our medical staff today as we did prior to the [HCA] acquisition."[152] These responses fail to adequately address core concerns for several reasons.

Regarding the competing letters from area physicians, it is very possible that many more area physicians agree with the critical view, but, for obvious financial and professional reasons, they are reluctant to speak out publicly.[153] Regardless, even granting that views in the current medical community are somewhat divided, it should be a clear red flag that a few hundred well-respected physicians in the community openly say there are serious problems at HCA Mission. Not all canaries need to choke before realizing that the mine shaft isn't safe.

Moreover, it is misleading and disingenuous simply to point to Mission having retained roughly the same number of physicians on its medical staff. This fails to adequately address reported problems for at least three reasons. First, as noted above, many, and perhaps most, replacement physicians have substantially less

[149] Note 105, Exhibit 10.
[150] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/
[151] https://mountainx.com/blogwire/mission-health-physicians-letter-to-independent-monitor/
[152] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/
[153] The October 2023 physician's letter, for instance, stated that "many physicians believe they cannot express their concerns publicly for fear of retribution from HCA. That fear and the overall sense of intimidation is widespread." https://www.northcarolinahealthnews.org/2023/10/22/50-doctors-including-a-former-board-member-publicly-decry-hcas-management-of-mission-hospital-system. Several physicians interviewed for this study also expressed a strong need for confidentiality out of concern for potential professional consequences.

experience or commitment to remain in the community. Second, a simple count of total names on the hospital's medical staff roster obscures whether there are concentrated pockets of key medical specialties that are too thinly populated. Third, simple medical staff membership does not convey how much of a physician's actual practice time occurs at a hospital. It is important to understand that hospital-physician affiliation takes two basic forms: full-time employment/contracting or simple medical staff membership.[154]

Full-time employment or contracting is typical for doctors who work exclusively in the hospital. Simple medical staff membership is the more conventional arrangement in which community-based physicians have hospital "admitting privileges," meaning that they have permission to treat their patients there. This critical distinction can be obscured by the fact that "staff" can describe either arrangement. When staff refers simply to being allowed to admit patients, counting the number of physicians on the medical staff says little about the extent to which these physicians are actually available to treat hospital patients or consult as specialists with other physicians.

Again, cancer care is a prime example. In 2010, the State Employees Credit Union (SECU) Foundation donated a substantial sum to open a cancer center with the goal of providing comprehensive, coordinated cancer care – both outpatient and hospital-based.[155] At the time of HCA's acquisition, it appears that the community's principal oncology group[156] was under contract negotiations with Mission to staff and run this cancer center. Failing to reach satisfactory terms, that group left to practice independently in the community. Although those physicians remained on the medical staff, HCA Mission had to recruit a different, highly credentialed physician to build a Mission-based oncology group from scratch. Over the space of just a couple of years, that group's leader, and all of its members, left, "due to unresolved practice issues at Mission Hospital"[157] as described above.

As noted above,[158] these departures left Mission's marquee Cancer Center almost deserted. One outraged cancer patient summed things up by stating that, in her experience, "[t]here is absolutely no denying the degradation in [cancer center] services. … The amount of gas-lighting and lying [to the contrary] is astounding." [159] As she describes Mission's Cancer Center:

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[154] Adding further complexity, a variety of partial-service contracting arrangements exist, such as the hospital managing a physician's office practice, or an independent community physician agreeing to "take call" as a consulting doctor for hospital patients.

[155] As HCA describes the goal, a "comprehensive cancer program ... [is] committed to caring for patients throughout Western North Carolina [w]ith a robust team of oncology services in a range of specialties (breast, colorectal, hepatobiliary, gynecological, infusion, interventional, medical, orthopedic sarcoma, pediatric, plastics, radiation, surgical, urological and more), along with nurse navigators, pathologists, radiologists and reconstructive physicians, this highly skilled team offers care from diagnosis through survivorship." https://wlos.com/news/local/mission-health-cancer-center-claims-false-rumors-social-media-medical-oncology-practice-confusion-ask-13-answers
See also https://www.citizen-times.com/story/news/2020/11/03/mission-cancer-care-get-boost-partnership-sarah-cannon-officials-say/6126554002/

[156] It is now known as the Messino Cancer group, for its revered leader who subsequently retired.

[157] Note 105, Exhibit 2.

[158] Note 146

[159] https://avlwatchdog.org/hca-lawyers-blast-ags-investigative-demand-as-legally-improper/

> They shut the cafe down, so there are only vending machines now. Our pharmacy is gone, and every single oncologist. That is just THIS year [2023]. In 2019, we had outpatient triage in the cancer center with a thriving oncology practice and all pods open in infusions. All the offices were full. There was coffee available on every floor, a full-service cancer institute with RNs to offer massage, healing touch and aromatherapy to cancer patients. We never ran out of food. Now, if you develop blood cancer, you have to drive to Charlotte for treatment because HCA will not maintain safe staffing levels.

Although HCA Mission still has a "cancer center" building, it would appear to be a "center" in name only, since it lacks many or most of the complement of multidisciplinary physicians and technicians needed to provide what HCA Mission's CEO described as a "one-stop-shop" coordinated cancer service under one roof.[160] The head of the state's oncology association explains that:[161]

> To provide chemotherapy treatment to inpatients, you need medical oncologists, oncology trained nurses, chemotherapy trained pharmacists, consistent and timely access to chemotherapy drugs and laboratory testing, nutrition services, and round-the-clock physician and/or nurse practitioner support for patients. … Under HCA's leadership, some of these necessities have not been available at Mission Health.

HCA Mission's former head of oncology confirmed the same: "Cancer care is a 'team sport' that requires oncologists, registered nurses, pharmacists and support staff that work together to create and effective and safe treatment plan."[162] Counting nominal members of the medical staff falls far short of meeting these self-professed standards.[163]

Effects on Patient Care

Beyond oncology, numerous sources pointed to a range of other important specialties where it is difficult, or "almost impossible," to get adequate "coverage" or consultation at Mission when needed. This list of "completely gutted" or thinly populated specialties includes otolaryngology (ear, nose, throat, or ENT), urology, rheumatology, orthopedics, and neurology.[164] Mission covers some of these specialties to a limited but diminished extent, but for some, there have been, and continue to be, times when certain specialties have simply not been available at all. Summarizing these views, one local physician emphasized that, not too long after HCA took over the specialists "I used to be able to call" for consultation or referral were "just

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[160] https://ashvegas.com/mission-health-under-hca-leadership-looks-to-growth-hiring/
[161] Note 105, Exhibit 10.
[162] Note 105, Exhibit 2.
[163] See Note 155.
[164] Note 105, Exhibit 8.
https://avlwatchdog.org/this-is-a-four-level-problem-dr-clay-ballantines-full-statement-at-ashevilles-watchdogs-hca-mission-community-event/
https://avlwatchdog.org/missions-urology-services-loses-physicians-asheville-urological-associates-gives-up-privileges-there/
https://avlwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say/
https://www.northcarolinahealthnews.org/2024/08/23/more-than-half-of-missions-remaining-staff-neurologists-say-they-are-resigning-citing-burnout-nausea-and-fury/

GONE."[165] Several physicians related that, prior to HCA's acquisition, they "never had an issue" with coverage or consultation in most of these areas, but now, problems are chronic.

As a result, one Mission physician summarized that, although the hospital claims to provide "tertiary" care, it "isn't REALLY a tertiary hospital." Instead, it is "tertiary light," due to the "spotty coverage" in various key areas that is more like in smaller community hospitals. This physician and other colleagues explained that these shortages require them to send critically ill or injured patients elsewhere or convince more generalist physicians to take on difficult cases outside of their zone of experience and comfort.

Several medical professionals mentioned hand surgery as a key example, pointing to the fact that the unavailability of a qualified surgeon to repair mangled fingers required either air lifting accident patients to another part of the state or prevailing on a less-experienced colleague to do the best they could in an emergency.

Telemedicine is another fallback HCA Mission sometimes has to resort to for gaps specialist coverage. When the majority of its neurologists resigned, the hospital suspended any neurology coverage overnight, requiring that after-hours critical care be handled remotely by a "contracted telemedicine company."[166]

Many physician departures did not create permanent vacancies because HCA Mission eventually filled these vacant positions. Even so, physicians explained that widespread turnover does real harm. The first harm is simply the "huge brain drain" of highly skilled and experienced physicians from the area, many of whom are replaced with very junior practitioners "fresh out of residency." In other situations, HCA Mission relies heavily on temporary "traveling" physicians. Several sources commented that having to rely on less experienced physicians "can be scary" or "dangerous." One local physician summarized that "we've gone from providing amazing care to mediocre care."[167]

A former board chair at Mission explained that the "rotating door" of new and departing physicians makes caring for patients more difficult because "you don't know who is on the other end of phone" during a specialist consult. They also lamented that this "constant turnover" caused a "loss of trust" and the debasement of "social and institutional capital." A primary care physician noted that, back when they knew the hospitalists, their personal connection facilitated a "warm hand-off" in which they each understood what to expect of the other, but now that "good communication" is greatly diminished with community physicians following Mission's "100 percent turnover" in hospitalists under HCA.

A former leader of Mission's hospitalist group commented that "when very important people ... were leaving, the administration's perspective was, 'Well, so what? We'll just have to replace them with somebody else.' There was no sense of loss when people were leaving, and it began to help me understand that they didn't really value those relationships as much as previous administrations had."[168] This physician, felt that

[165] Listen also to https://youtu.be/Tn74RQpaRws?t=453

[166] https://avlwatchdog.org/mission-sees-exodus-of-staff-neurologists-they-cite-burnout-high-patient-volume-lack-of-hires/

[167] https://www.northcarolinahealthnews.org/2022/03/26/how-many-doctors-have-left-mission-hca-wont-say/

[168] https://wlos.com/news/local/former-mission-health-doctor-describes-slow-speed-train-crash-led-state-attorney-general-lawsuit-asheville

"[d]estroying the institutional memory of the hospital makes it harder to practice medicine effectively ...." [169] A departing neurologist agreed, saying "HCA considered everyone replaceable, [with no value placed on] the institutional knowledge that left with them."[170]

Physicians said that the general degradation in some specialties has made it more difficult for HCA Mission to recruit "the best and brightest," as Mission had been able to in the past, because promising early-career prospects are sensing that the area is losing what it needs to support "a more elite practice." One local physician complained angrily that HCA's "bad press is f***ing killing us in recruitment," pointing to the fact discussed in the Introduction that media stories "are 10:1 negative" about HCA, which potential recruits "are reading online." As a result, whereas it used to be easy for groups to recruit physicians who have the credentials to "go anywhere," now trying to do so is like "swimming upstream."

The second serious consequence of turnover, even among credentialed clinicians, is the disruption this causes to patients. One report recounted that HCA's closure of its principal primary care clinics, with only a month's notice, caused thousands of patients to have scramble to find new sources of care.[171] Some of these departing physicians opened "concierge" or "boutique" practices with restricted slots and higher costs. Thus, many displaced patients had to shift to low-income community health centers, which reported being "flooded" with a "wave of patients."

Treatment disruption is an even more pressing concern for patients with serious chronic conditions, such as cancer. As an oncologist explained:

> Any time there's a serious health issue, whether it's cancer or heart issue or whatever, changing teams is one of the riskiest times for the patients, because that's been where there's the highest likelihood of errors happening.[172]

This is illustrated well by the experience one Asheville cancer patient described:[173]

> *When you found that the person that you've entrusted to get you through one of the most difficult times of your life is leaving because of hospital ineptitude, it is infuriating, it is scary, it's panicky, ... it's going to be very difficult to catch a new physician up on two years' worth of stuff, problems, hospitalizations, different things.*

See also Appendix B, item 2.

[169] https://avlwatchdog.org/i-was-beginning-to-feel-like-i-was-on-a-sinking-ship-says-former-mission-hospitalist/
[170] https://www.northcarolinahealthnews.org/2024/08/23/more-than-half-of-missions-remaining-staff-neurologists-say-they-are-resigning-citing-burnout-nausea-and-fury/
[171] https://carolinapublicpress.org/47175/hca-takeover-reframing-primary-care-in-western-nc-could-threaten-regional-hospitals/
[172] https://avlwatchdog.org/attorney-generals-office-very-concerned-about-changes-at-mission-cancer-center/ .
[173] https://avlwatchdog.org/attorney-generals-office-very-concerned-about-changes-at-mission-cancer-center/

Effects on Professional Morale and Esprit de Corps

Finally, an overriding insight conveyed in the October 2023 physician's letter quoted above is the long-lasting harm this disruption inflicts on professional morale and working relationships in the medical community. Looking back over the decades, these physicians wrote that:[174]

> [O]ur healthcare system has been a backbone of this community for decades. As contentious as it was, the 1998 merger of Mission and St. Joseph's was accomplished in good faith, with unified purpose, and with meaningful physician involvement. We were committed to honoring shared values. Collaborative relationships, despite disagreements, were maintained for the greater good. ... [T]here was no wavering in the support for the highest quality medical care possible for all residents of western North Carolina. It was what this community and our physician staff stood for. We were proud of our system and, despite its imperfections, we could defend it and advocate in meaningful ways for sustained, continued improvement. ... Relationships mattered, collegiality mattered, respect mattered. The culture built by thousands across all the hospital services mattered. It was a given that the value of a personal touch during a hospital stay or procedure mattered.

These physicians said, however, that what has happened under HCA is "the gutting of what has mattered, [and] the loss of the heart and soul of our healthcare system. . . . We did not anticipate how devastating this transition would be to our community, nor the marked impact it would have on the foundational issue of quality care in our region."

These physicians said that "we have seen little to no interest on [HCA's] part in working with physicians or community leaders across multiple sectors to address quality-related problems." Similarly, HCA's former oncology leader commented:[175]

> Through my daily interactions with clinic leadership and hospital administrators, it became clear to me and the other providers in the practice that they were not genuinely interested in physician input particularly if input did not align with their plans. Decisions were repeatedly made with inadequate input from stakeholders and without perceived understanding of the potential clinical ramifications of their decisions.

He explained that, when he was still with HCA Mission, his and colleagues' concerns "were repeated[ly] dismissed" and that, in general, the hospital administration "was seemingly incapable of addressing physician concerns …. Physicians were routinely left out of any of the decision-making processes. Although physicians were given titles of medical director, service line leaders, and committee chairs, they were frankly powerless and often ignored/sidelined in the decision-making process." A former administrator with a physician organization also noted that HCA removed or drove away most or virtually all the physicians who previously were in leadership roles at Mission.

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[174] https://drive.google.com/file/d/1l2GEDz95cRhlFe2D1gDY5XrPMZDxjEMN/view
[175] Note 105, Exhibit 2.

Echoing these widely shared views, a long-time family physician in the community wrote that, prior to HCA:[176]

> Physicians were in leadership roles across the board, working with hospital leadership to prepare for what was around the next corner.... For members of the community, working at Mission or St. Joe's was something to aspire to, a place to have a career, a place to belong, to feel proud of. There was a sense of ownership for them as well. ... Mission defined who we were as a community. It was where we shared a sense of meaning, where we had history, a voice, and where we could all strive to be the best we could be.

But now, that has all changed:

> There's a deep sense of loss so many of us feel since HCA has taken over. Their corporate-driven changes are not only antithetical to our way of being, they dismantled what we'd worked so hard for. They've erased our institutional memory. ... HCA brought with them a culture that has undermined trust, alienated many and harmed the collaboration and collegiality that's defined who we've been. Their manner has been marked by a lack of respect for the ethic and shared purpose that defined our health care community.

Summing up this profound and widespread sense of demoralization, a former chief of staff at Mission became so dejected by the way that HCA "destroyed the medical community that was Mission," that he left the state, saying that "I truly felt like it was a moral injury to be working for them."[177] A community member speaking at a public forum expressed the loss perhaps best of all, based on their observation as a patient:

> It seems that it's a death by a thousand cuts. It's not anything you can point at and say, "Oh, they knocked that building down," or "Oh, they fired those people." It's more seeing people resigning, seeing the morale just dipping [lower and lower]. That is the lifeblood of this hospital system. You can have great facilities, and you have great machines, you have great people working for you, but if … the morale of the people that are working for [you] is terrible, it's not a healthy system.

[176] https://www.citizen-times.com/story/opinion/2024/05/26/opinion-physician-says-hca-mission-purchase-is-like-hostile-takeover/73775402007/

[177] https://avlwatchdog.org/former-mission-chief-of-staff-i-truly-felt-like-it-was-a-moral-injury-to-work-for-hospital/ He concluded: "I was proud to be part of Mission Health for nearly nine years but could not bear the thought of working under HCA for the remainder of my career."

II: NURSING AND OTHER PATIENT CARE STAFFING UNDER HCA

Prior to HCA's purchase of Mission Hospital, a factor that helped attract a strong medical community to the Asheville area was that the hospital was well-staffed with experienced nurses and patient care service personnel. The superior working conditions for nurses resulted in Mission receiving the American Nurses Association's highest recognition[178] (called "Magnet" status).[179] Prior to that, a leading health policy research institute chose Mission to profile as one of the best hospitals in the country, in part because Mission's managers:

> … clearly regard the quality of the nursing staff as one reason for the institution's high quality and low costs. . . . In a time when most hospitals are struggling with nursing shortages, Mission boasts a high registered nurse (RN) skill mix. ... The health system also enjoys a low nurse turnover rate of 12 percent, a low vacancy rate of 5 percent, and an average of 2.9 RNs per patient. Nurses appear to be respected and valued at Mission. They have a strong voice at the service line level and at the administrative level, where four of the vice presidents are nurses, and always attend physicians' meetings.[180]

This exemplary past stands in sharp contrast to what quickly transpired under HCA. A year after HCA's purchase, nurses' discontent with their deteriorating working conditions (described below) prompted a drive to unionize. Despite the fact that organized labor has very little private-sector presence in Western NC, this drive quickly succeeded, making Mission the only hospital in the state to have a nurse's union.[181] As one experienced observer commented, "When they've run it into the ground hard enough to make nurses UNIONIZE in *North Carolina*, you know it's bad." An additional sign that staff morale quickly plummeted under HCA is what many have called an "exodus" or "mass exodus" of long-time members and leaders of the nursing staff, soon after HCA's purchase.[182]

There are two core drivers of these nurses' discontent: reductions in nurse staffing and in supportive patient-care staff. Reducing nurse staffing levels obviously increases workload because each nurse must care for a greater number of patients. And the workload per patient becomes substantially more difficult with reduced

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[178] Mission received this recognition in 2020, the year after HCA's purchase, but several key sources explained that the groundwork for this achievement was laid well before the purchase. As HCA Mission acknowledges, the "Hospital's journey to Magnet recognition began in September of 2015." https://www.missionhealth.org/locations/mission-hospital/about-us/nurses

[179] https://health.ucdavis.edu/nurse/magnet/faq.html

[180] https://www.commonwealthfund.org/publications/fund-reports/2004/jul/hospital-quality-ingredients-success-case-study-mission

[181] https://www.northcarolinahealthnews.org/2020/09/20/asheville-hca-nurses-union-vote-unprecedented-in-nc/
https://www.carolinajournal.com/nurses-action-in-asheville-another-sign-unions-are-flexing-muscles/

[182] https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/
https://avlwatchdog.org/conditions-at-ashevilles-mission-hospital-pose-immediate-jeopardy-to-patients-health-and-safety-state-investigators-report/
https://www.bpr.org/bpr-news/2024-02-16/patient-deaths-at-mission-report-details-failures-cms-accepts-hospitals-plan-for-correction
https://mountainx.com/news/patients-staff-challenge-quality-of-care-at-mission-hospital-under-hca-management/

support personnel across multiple assistive functions, such as patient hygiene, food service, room cleaning, patient transport, interpretive services, and various clerical positions.

Drivers of Discontent

Many indications from multiple kinds of sources show that reductions in both nurse staffing and supportive patient-care staff have occurred, and continue to occur, to a troubling (and sometimes very troubling) extent. As one staff physician commented, "the speed with which the staffing and resources at Mission were gutted after the acquisition was breathtaking, and left little room for doubt about HCA's priorities."[183]

Beyond nurses' discontent, these staffing cuts have led to a sustained and widespread "cascade of complaints from patients, … doctors, and other health care professionals,"[184] as well as the community at large. One previous hospital leader said that, prior to the purchase, there were many discussions of combining Mission's existing strengths with HCA's managerial efficiency, to achieve the "best of both." However, that did not occur because, "when HCA's teams came in, they said 'this is the way it's going to be.'" For instance, clerical staff were not needed "if nurses and doctors can do the necessary paperwork." As a result, nurses "were just working like dogs." Seeing that happen, this former leader recounted, "all of a sudden, I knew there were going to be problems."

Indeed, a year after HCA's purchase, a half dozen local municipal and government officials wrote:

> There have been numerous, aggressive staff cuts over the past year, putting patient safety at risk. Certified Nurse Assistants and unit secretaries have been cut dramatically or eliminated altogether, putting new pressure on nurses. Patient to nursing staff ratios have also increased and some departments have seen an exodus of nurses, further stressing the remaining nurses. Anecdotal accounts abound from Mission physicians and nurses on how these cutbacks have affected patient care.[185]

One knowledgeable patient who spoke at a public meeting said:

> It seems that it's a death by a thousand cuts. It's not anything you can point at and say, "Oh, they knocked that building down," or "Oh, they fired those people." It's more seeing people resigning, seeing the morale just dipping slower and slower, and steeper and steeper curve. That is the lifeblood of this hospital system. You can have great facilities, and you have great machines, you have great people working for you, but if it's all about the profit, the profit margin, and the bottom line, and the morale of the people that are working for is terrible, it's not a healthy system.

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[183] https://avlwatchdog.org/mission-sees-exodus-of-staff-neurologists-they-cite-burnout-high-patient-volume-lack-of-hires/

[184] https://www.citizen-times.com/story/news/local/2021/05/31/quality-care-concerns-rise-mission-hospital-staffing-decline/5249489001/

[185] https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/

Various other sources interviewed for this study or quoted in credible reports over the past several years[186] confirm this assessment. According to one investigative report, "all of the [many current and former] health care professionals contacted ... cited staffing levels as the critical issue for quality of care at Mission." [187] Others refer, for instance, to being "shocked and horrified" when Mission's patient-care staff suffered "massive" and "debilitating" cuts from "HCA [coming] in with a hatchet" to "slash," "gut," and "decimate" staffing, both for nursing and for a broad range of supportive patient care services. A long-time Mission nurse stated at a public meeting that "[e]very single department in that hospital designed to help the patient is critically and unethically, inhumanely understaffed."[188] One public official interviewed said that, from an outside perspective, this all appeared to be "a complete collapse."

HCA Mission does not release detailed data about nurse or other staffing levels.[189] Therefore, it is difficult to quantify the extent of any staffing issues with precision.[190] However, a number of reliable indicators exist that, under HCA, Mission's staffing, both for nurses and for other patient care functions, has declined substantially, to levels lower, or perhaps much lower, than industry norms. These may not be perfect indicators, but HCA is in the best position to correct their imprecision if the general impression they give is inaccurate. We start with nurse staffing, and then turn to staffing conditions more generally.

Reduced Nurse Staffing

One indication that HCA Mission has very lean nurse staffing is from the competing applications that different hospitals filed with the state to Asheville's need for 67 more beds. Two other hospital chains (Advent and Novant) each proposed to build a new facility to meet this need. HCA, however, proposed to expand Mission hospital to meet the need.[191] These competing applications reveal how HCA's staffing model compares with these other reputable hospitals. As shown in Table 1, Mission's proposed nursing staff for the same number of additional patient beds was 60 percent lower than one competitor and 70 percent less than the other.[192]

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[186] Cited throughout this Part.

[187] https://www.citizen-times.com/story/news/local/2021/05/31/quality-care-concerns-rise-mission-hospital-staffing-decline/5249489001/

[188] https://avlwatchdog.org/pandemic-put-pause-on-missions-troubles/

[189] Instead, there is some indication the hospital may be taking steps to avoid the release of such information, in that Mission declined for the first time to respond to a survey administered by one of the leading hospital rating agencies (Leapfrog) the year (2023) that it first started to request specific numerical data about nurse staffing. Previously, Mission had self-reported a perfect staffing score of 100 based on self-assessed qualitative measures. See Part 4 .

[190] Doing so would require counts of "full-time equivalents" (FTEs) per job category, in order to account for those who work part-time, and to identify areas where staff changes may be more pronounced in size or effects.

[191] As discussed in Part 7, the state ultimately awarded the "certificate of need" to Advent, despite its new-hospital proposal entailing higher costs – in part in order to invite more competition.

[192] Mission argued that this much leaner staffing made it a superior choice to the other two hospitals. Page 44 of of: https://info.ncdhhs.gov/dhsr/coneed/comments/2022/june/Buncombe-Acute-Care-Beds-Project-ID-B-12233-22-AdventHealth-Asheville-Comments-by-Mission-Hospit.pdf

Table 1: Projected Nursing Staff FTE's and Illness Severity for 67 Proposed Hospital Beds

	Mission	Advent	Novant
Nursing FTE	75.5	188	260
Acuity Index	2.0	1.7	1.2

Making this contrast even starker is the difference in "acuity level" between Mission and the other two hospitals. The adequacy of nurse staffing depends on how sick patients are. Thus, on average, 2 or 3 times more nurses are needed per patient in an intensive care unit (ICU) than in a normal medical unit. Mission's proposal allocated 22 of the 67 beds to intensive care, which require a good deal more nursing staff than a normal unit, but the other hospitals proposed no ICU beds. Yet, HCA projected that, on average, its patients in these 67 beds would require substantially more medical care than what the other two hospitals projected while simultaneously estimating that it would need significantly less nursing staff than the other two hospitals proposals that lacked ICU beds.

Consistent with that representation, there are multiple indications that Mission employs much leaner nurse staffing than what is standard in the industry, but that this was not the case before HCA's purchase.[193] One long-time Mission nurse told the U.S. Federal Trade Commission that:

> Before the sale to HCA, my unit . . . [had] a one-nurse-to-three patient ratio with a nursing supervisor having the ability to support our unit. Now, we have . . . a one-to-five ratio in the best of conditions. Unfortunately, the reality is often more like a one-to-seven ratio.[194]

A distinguished reporter[195] who investigated this issue described one hospital unit at Mission that "used to have one nurse for every three patients," but "[m]ost days now, . . . there is one for every six."[196] (items 19-32) provides similar, confirming accounts from several additional nurses who have worked at HCA Mission.

A physician currently working at Mission said that nurse staffing ratios are "thin across all levels of care," from critical care to "stepdown" to "ward level." Confirming what others reported, this physician said they have seen staffing in the ICU as low as one nurse for every four patients, whereas a 1-to-2 ratio is fairly standard in the industry. Another current Mission physician complained with great emphasis that nurse staffing is *"ridiculous, ridiculous,"* the ratios "stink," giving as an example a 1-to-6 nursing ratio in the "step-down" unit (which cares for patients whose needs fall between general wards and the ICU).
Several sources also noted that, unlike in other hospitals, HCA requires supervising "charge nurses" to take direct responsibility for a number of patients, even though their primary role is to oversee and assist the front-

[193] https://www.bpr.org/news/2021-12-16/have-staff-shortages-at-mission-meant-less-care-for-patients
https://avlwatchdog.org/quality-of-care-concerns-rise-at-mission-hospital/
Note 105, Exhibits 6, 11, 13.
[194] https://www.ftc.gov/system/files/ftc_gov/pdf/FTC-DOJ-Listening-Forum-%20Health-Care-Transcript.pdf
[195] Formerly she was a correspondent for the *Financial Times of London* and an editor for National Public Radio's *All Things Considered*.
[196] https://avlwatchdog.org/mission-nurses-overburdened-patients-suffer/

line nursing staff. For instance, one current physician described charge nurses that are responsible for overseeing nurses caring for 30-40 patients also having direct care responsibility for 6 patients. In a sworn affidavit, an experienced nurse explained that this practice "is never the standard of care" and "should not" happen, since the charge nurse needs to be free to respond to emergencies or issues more junior nurses are struggling to handle.[197]

Some of these examples may seem extreme, but according to multiple sources (including those in Appendix B), they are not rare. Instead, as one nurse reported, "[m]y unit is pretty much always short-staffed."[198] Another experienced nurse explained that "[w]e weren't concerned about staffing at all before HCA took over. ... There, of course, were times when a floor was understaffed for a shift here and there, but [now] this is an ongoing, daily event."[199] Again, (pp. 8-17) provides multiple other confirming specifics from numerous nurses and several physicians who have worked at HCA Mission.

Less Experienced Replacements

Compounding concerns about reduced nursing staff is that, due to the "mass exodus" of experienced nurses mentioned above, the remaining positions increasingly have been filled with either temporary or inexperienced nurses. According to one traveling nurse who worked at HCA Mission, '"90% of dayshift [nurses] on my unit were [temporary] travelers, including the manager." Another source reported that "roughly half of the hospital's nurses are now [temporary] travelers, and in some units, almost all are."[200] This is confirmed by reports from several other Mission nurses quoted in Appendix B (items 55-58). As a result, an experienced nurse said that "there's almost no continuity of care."[201] Troublingly, high turnover is also seen among former nursing leaders at the hospital. Within two years of HCA's purchase, "[s]ix of the 11 directors of nursing, who oversee three to five nursing units each, [had] resigned," according to one credible source.[202]

Several active physicians said that relying on temporary "traveling" nurses, as HCA does considerably, makes patient care more difficult because they are not familiar with the hospital's systems. A surgeon who left Mission in 2021 because of various aspects of HCA's "culture"[203] explained that "[c]onsistently excellent patient care flows from people working together over time versus [the] revolving door model" that arose under HCA. Several others wrote that, as a result of the churn in staff, nurses "may start a shift without having access to the [medical] charting system,"[204] and physicians' "orders get lost." A long-term Mission nurse agreed that "travel nurses have limited orientation, so they are not sure who to call, how to operate the phone and computers systems effectively, or the flow and institutional behavior of the hospital, which in tum

[197] Note 105, Exhibit 6.
[198] https://avlwatchdog.org/mission-patients-endangered-by-emergency-department-transfer-procedures-nurses-say/
[199] https://wlos.com/news/local/dozens-rally-outside-mission-hospital-concerned-about-unsafe-working-conditions-nurses-unite-in-protest-against-hcas-handling-of-mission-hospital-staffing-issues
[200] https://avlwatchdog.org/mission-nurses-overburdened-patients-suffer/
[201] Ibid.
[202] https://www.citizen-times.com/story/news/local/2021/05/31/quality-care-concerns-rise-mission-hospital-staffing-decline/5249489001/
[203] He said that, for a variety of reasons discussed later in this Part, he "could not bear the thought of working under HCA for the remainder of my career" https://www.citizen-times.com/story/news/2021/05/14/mission-hospital-departures-concerns-doctors-leave-hca-healthcare-more-work-less-pay/5042082001/
[204] https://downloads.regulations.gov/FTC-2024-0022-1423/attachment_2.pdf

negatively affects patient care."[205] Traveling nurses themselves report that it is difficult to quickly transition into HCA Mission's intense work environment. For instance, several quoted in Appendix B (items 52-54) expressed difficulty in contacting the appropriate physician for a patient.

Sources also stressed that real challenges arise from *permanent* nursing replacement hires, because many of HCA's new recruits are much less experienced than the career nurses who left Mission. A letter from a half dozen prominent area physicians to state inspectors emphasized that:

> In addition to not having enough staff, particularly nurses, another problem is staffing nurses with insufficient experience. … For example, pre-HCA, Mission required nurses in the ER to have several years of experience in other parts of the hospital before working in the ER. By contrast, under HCA, nurses in the [new nurse training] program can be placed in the ER as their first placement after graduation from nursing school.[206]

In a sworn affidavit, one experienced Mission nurse wrote of seeing "newly graduated nurses who have just finished orientation staff[ing the oncology unit] at patient-to-nurse ratios of 6 to 1," which is extremely high.[207] Another explained:

> It is not safe to have all new nurses. Seasoned nurses provide a safety net by preventing new nurses from making mistakes in their provision of care. New nurses without this guidance are like doctors who have not gone through residency.[208]

New nurses at HCA Mission have written that they felt thrown into unsafe situations that their training and limited experiences did not prepare them to handle.[209] Similar concerns have been reported at other HCA hospitals.[210]

Several physicians at Mission stressed that working with less experienced and entirely new nursing staff makes their work much more difficult. One said that, prior to "losing [most] of our seasoned nurses," the nursing staff had very good "clinical competency" and decisionmaking judgment, so I could "trust them to let me know when a patient needs immediate attention." But this is no longer the case. Newer nurses, many of whom are younger and "overworked," "don't necessarily know what they are doing. Another hospital physician said they have seen a lot more "safety incidents" for their patients than ever before, "probably one every shift." One reason for this "flood of near misses" is the absence of a more "senior nurse" to step in to help alleviate the recurring "pandemonium." (pp.18-20) documents similar concerns with specific illustrations.[211]

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[205] Note 105, Exhibit 13.
[206] https://avlwatchdog.org/doctors-advocates-blast-missions-plan-to-correct-immediate-jeopardy-call-for-hospital-to-increase-staff/
[207] Note 105, Exhibit 11.
[208] Note 105, Exhibit 13.
[209] See Appendix B, items 23, 57, 99-103.
[210] https://www.bloomberg.com/news/features/2024-11-22/what-happens-when-us-hospitals-binge-on-nurse-practitioners
[211] Ibid.

Other Staffing Reductions

Cries of frustration or outrage have also been heard due to substantial cutbacks in other patient-care functions and support staff that cover the breadth of care and services at Mission Hospital. According to one public official, this amounts to "all the people that make the hospital work, and who let nurses be nurses." Various sources decry the cuts to: front-line clerical staff, nursing assistants, interpreters, housekeeping, patient transport, dietary services, phlebotomists, surgical instrument sterilization, speech and physical therapy, the hospital morgue and mortuary services, hospital chaplains, hospice grievance counselors, discharge planning, security guards, and various support functions for specialized clinical services such as chemotherapy transfusions. A letter to the Federal Trade Commission from a group of area medical professionals, elected officials, and others[212] summarized that:

> Signs of understaffing are everywhere. ... Patients do not receive regular hygiene services. Security guards are expected to transport corpses from the rooms where they died to the morgue, because morgue staff has been cut. There are not enough chaplains. Patients do not receive adequate supervision on behavioral health units, creating unsafe conditions. Units have been stripped of unit clerks and secretaries, leaving nurses to try to take up the slack. There are not enough nurses to provide basic care to patients, so patients are assigned to charge nurses, who should be coordinating and overseeing the overall work of the unit or floor.

Numerous clinical professionals address these and other examples in Appendix B (pp. 11-17, 22-24).

HCA's willingness to stretch support staff so thinly is reflected in the same comparison noted above between Mission and two competing hospitals' applications to staff 67 additional beds in the Asheville area. HCA Mission argued that much leaner staffing was a reason to favor its proposal to add those beds to its existing campus rather than allowing one of the competing proposals to build a new hospital. Specifically, HCA Mission said that adding 67 more beds would require no increase in medical technology or support staff, compared with the substantial number of such employees (169 and 202) the other hospitals said they would need for that same increase in service.[213]

Hampered Recruitment

Reduced staffing at Mission appears to have created a feedback amplification loop. The stress caused by reduced staffing has convinced more people to leave and makes it more difficult to fill vacant positions, further adding to the strain. One hospice nurse summarized that HCA's management has "essentially created a vicious cycle of downward spiraling care, demoralized staff, and patient and family dissatisfaction."[214]

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[212] Others include religious leaders, patient advocates, and Western North Carolina residents. https://downloads.regulations.gov/FTC-2024-0022-1423/attachment_2.pdf

[213] p. 48 of https://info.ncdhhs.gov/dhsr/coneed/comments/2022/june/Buncombe-Acute-Care-Beds-Project-ID-B-12230-22-Novant-Health-Asheville-Comments-by-Mission-Hospi.pdf

[214] https://avlwatchdog.org/quality-of-care-concerns-rise-at-mission-hospital/

Table 2: Selected Comments about HCA Mission Hospital from Experienced Traveling Nurses[215]

"Just save your time and don't go to [Mission] .... I tried to give it a chance. … Long story short, just stay away. It's a dumpster fire from the top down. The place and people are awful and it's NOT worth the pay. I will never go back. They treat their travelers terribly and then have the audacity to wonder why they can't keep anyone there!"
"I've worked in 9 hospitals and this one made me question being a nurse. Unsafe, dirty, and all around terrible! … I'm tough and can handle a lot but this place is scary and dangerous for patients and your license."
"My recruiter swears against the facility. She actively avoids placing me there (me and my recruiter are from Charlotte NC for reference)."
"I didn't know about [Mission] but my recruiter said he wasn't comfortable submitting nurses there …"
"As a recruiter I always discuss Asheville with my travelers before we even submit. It will be very fast paced, will be high ratios, and heavy floating. I am happy to discuss hospitals that would be a good fit for you that would have safe ratios and a great experience!"
"I have ONLY ever heard really bad things about that place. I wouldn't go there. My recruiter flat out told me they are a shit show."
"I really want to go to Asheville but I have heard horror stories about the hospital. A shame because it sounds like an amazing town."
"Was just contacted by a recruiter [for an HCA Mission position] and I said … nope! Your reputation is too bad within the traveler's community …"
"[E]veryone [on this traveling nurse website] warns of how awful it is at Mission. It's enough people [who say this] that I'll never take an assignment there."
"This has been no secret in the [traveling nurse] world. Lots of people have wanted to [take a travel position in] Asheville, but DON'T because the hospital has a serious rep."
"Avoid Mission at all costs. Everything everyone has said is true. Only unionized because of bad management."
"[I've] been working in NC and have talked to plenty of other travelers who've worked there. Every single one has said it's awful."
"I think between [this website] and Facebook this hospital has thousands of horrific reviews from [people] who have worked there. My friend just quit a contract early after working there due to how badly they treated her and even the staff nurses."
"[HCA Mission] is by far the most negatively reviewed hospital on this [traveling nurse web] page."
"From what I've heard in this [traveling nurse] group among several posts is to AVOID Mission!!!! I haven't read one single positive about it. I have heard that Asheville is lovely! But not enough to make working at Mission worth it."
"NC native here, I've never taken a contract in Asheville but I have ONLY ever heard bad things about working there. Every experienced traveler I have met has cautioned me away."
"There are nothing but horrible reviews by [other] travelers. Most people I've met quit there on week one from how unsafe it is."
"This is easily the most hated hospital on any travel[ing nurse web] page."
"I was staff there. We had many travelers leave mid contract when the [wage] rates were sky high if that tells you anything."

[215] These are from the sources noted in Appendix B. As explained there, because our focus is on problematic aspects, these do not represent more positive views that can be found about HCA Mission Hospital.

HCA Mission has insisted that it works diligently to fill vacant positions. Still, there are ongoing reports of hundreds of unfilled positions.[216] As a result, Mission continues to rely on temporary contract workers substantially more than it did prior to HCA. But even those slots can be difficult to fill when these substitutes either hear about, or experience, the more stressful working conditions at Mission. Several sources noted that multiple internet sites warn potential workers about coming to Mission, [217] and that those who do arrive often leave before their contract expires because they find working conditions to be so much worse than expected, or than experienced elsewhere.[218] HCA Mission's reputation is bad enough that several independent recruiters for traveling nurse positions will not serve Mission or will warn against working there. Table 2 collects sample statements found on several websites used by traveling nurses which confirm Mission's worsening reputation. As one Mission nurse summed up, this "opens your eyes to how dire the situations and conditions are at the hospital."[219]

Mission rightly observes that other hospitals encounter recruitment problems, and that staffing problems worsened during and following the COVID pandemic.[220] However, at Mission, the problems appear to predate COVID[221] and have continued at substantially the same rate after COVID.[222] Mission's staffing problems arose, and continue, across a wide range of personnel beyond those--such as nursing--that were most directly affected by COVID. There are additional indications that, post-COVID, Mission's staffing woes have continued to a greater degree than at most other hospitals.[223] As the Attorney General's office wrote to Mission in March 2022, "health care systems across the state face the same issues without resulting in the same high number of complaints" received from Mission's patients.

Moreover, concerns about staffing do not relate primarily to *unfilled* positions. Instead, most appear to relate to HCA management decisions to substantially reduce staffing labor expenses across a broad range of positions. Labor is, by far, the largest controllable expense category for hospitals. Accordingly, HCA has a well-documented track record of keeping or cutting labor expense to what it considers an acceptable minimum.

Multiple sources refer to substantially leaner staffing as a, or *the*, key element of HCA's "playbook" when it assumes ownership or management of a hospital.[224] A national publication (*Barron's*) studied changes in

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[216] https://avlwatchdog.org/hca-owned-missions-failures-in-care-coincided-with-hundreds-of-empty-nurse-positions-data-show/

[217] https://avlwatchdog.org/mission-nurses-overburdened-patients-suffer/

[218] https://www.citizen-times.com/story/news/local/2021/05/31/quality-care-concerns-rise-mission-hospital-staffing-decline/5249489001/
https://avlwatchdog.org/overworked-nurses-say-patient-care-suffers/

[219] https://avlwatchdog.org/mission-nurses-overburdened-patients-suffer/

[220] https://businessnc.com/short-story-too-few-full-time-nurses-cause-severe-problems-at-n-c-hospitals/

[221] According to several sources, they began shortly after the Feb. 2019 sale. For example, one employee commented: "it was like the ball dropped and we started seeing staffing cuts, . . . we saw our nurse-patient ratios change." https://missouriindependent.com/2023/09/07/some-states-back-hospital-mergers-despite-record-of-service-cuts-price-hikes/ . The NC Attorney General wrote HCA Mission in Feb. 2020, just as the pandemic was starting, to say that he has received "a surge in complaints about quality of care," some of which were "harrowing to read." https://ncdoj.gov/wp-content/uploads/2020/02/Stein-Letter-to-HCA-_02252020.pdf

[222] https://avlwatchdog.org/overworked-nurses-say-patient-care-suffers/

[223] https://avlwatchdog.org/pandemic-put-pause-on-missions-troubles/

[224] https://www.citizen-times.com/story/news/2021/05/14/mission-hospital-departures-concerns-doctors-leave-hca-healthcare-more-work-less-pay/5042082001/

staffing at other hospitals HCA purchased in recent years, reporting "steep staffing declines soon after HCA bought them."[225] The study noted that this pattern "contrasts with statewide trends over the same period, where staffing remained relatively flat or increased" at other hospitals in these states.[226] An NBC reporting team interviewed 17 HCA employees in five states who said that "the company understaffs its hospitals as a practice, helping to keep profits high …."[227]

Impact on Timely Patient Care

These cutbacks affect patient care in pervasive ways -- some striking, and some more mundane. For instance, staffing cutbacks or turnover are blamed for errors and backlogs in routine preparation of sterilized surgical instruments, causing surgeons to delay or abruptly cancel procedures. A nurse wrote that the hospital "[r]outinely runs out of sterile surgical instruments, and numerous patients have had surgeries canceled or rescheduled,"[228] and a national reporter recounted that one Mission surgeon had "half his surgeries called off [one day] because there weren't enough clean instruments."[229] Even Mission's chief of staff during HCA's first two years complained that "I just don't really even trust that I'm getting sterile instruments up here to operate," so he had to consider cancelling surgeries to avoid "put[ting] my patients at risk."[230]

Due to staffing cutbacks, even simple, everyday matters such as scheduling an appointment or ordering a test are said to be infuriatingly difficult under HCA. Some doctors complained that they regularly find it difficult to reach other physicians on the phone because they are put on hold for extended periods and then repeatedly transferred to the wrong place. One doctor who spoke at a public forum said:[231]

> Lack of staff has led to empty schedules because nobody was there to make the calls to get the patients in to see the doctors, so the doctors are sitting there with an empty schedule.... That lack of staff also means that [at] the main office, there are hundreds of [patient] phone calls weekly that go unanswered.
>
> The inpatient radiology, the CT scans, X-rays or MRIs, other imaging studies can have long delays, even for stat orders [that are needed right away]. I ordered a stat CT on a lady who had internal bleeding. Twenty-four hours later, I was still calling people in radiology, going "Get her down there." They just can't do it. They don't have the staff down there. The machines are sitting down there, but Mission has cut the staff.
>
> In the outpatient world where I'm working all the time, the labs and X-rays and consults that we have tried to get for patients and been able to get as quick as a snap in the past now require multiple attempts. We send these orders over and over again and we keep hearing back from radiology, from the lab, from the consultants we're trying to send it to, "Oh, it got lost." Which really means, "Oh we don't have any staff to take care of these requests as they come in." We spend hours

[225] https://www.barrons.com/articles/hca-stock-hospital-staffing-36ffa43b
[226] These findings confirm what the current study reports in Part 2.
[227] https://www.nbcnews.com/health/health-news/workers-us-hospital-giant-hca-say-puts-profits-patient-care-rcna64122
[228] https://drive.google.com/file/d/17fwqww6QYqWIZH7lbI28TAMEhMmfRndC/view
[229] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/
[230] https://avlwatchdog.org/former-mission-chief-of-staff-i-truly-felt-like-it-was-a-moral-injury-to-work-for-hospital/
[231] https://avlwatchdog.org/this-is-a-four-level-problem-dr-clay-ballantines-full-statement-at-ashevilles-watchdogs-hca-mission-community-event/

> of our day every day just advocating for patients trying to get things set up. At one point they were kicking mammograms down the road three months at a time, even [follow-up] diagnostic ones where women had problems [detected] …. They say, "Oh, … we just can't do that today. Three months. Here's your next appointment."

Echoing these concerns, the group of medical professionals and others referenced above who wrote to the Federal Trade Commission said that:[232]

> Laboratory services are now provided by contractors, resulting in long delays. One doctor described the difficulty in getting laboratory samples analyzed on a "stat," or immediate basis. "Stat lab is essentially a joke," he said, adding that it had recently taken eight days for the lab to return results for a patient who was battling an infection in the intensive care unit. Without those results, the patient's doctor did not know which antibiotic to prescribe. Similarly, delays are common in obtaining imaging studies such as CT scans, X-rays or MRIs. A doctor told of waiting more than 24 hours to get a CT scan of a patient who had internal bleeding.

In a sworn affidavit, a leading cancer physician in the area said that he too has "experienced delays in processing laboratory results. Laboratory tests that should be completed in two or three days were instead taking five or six days" due to "HCA reducing the laboratory staff since the acquisition."[233] State inspectors who interviewed hospital staff in late 2023 about an emergency patient who died apparently from delayed diagnosis and treatment relayed the following account from an emergency room nurse:[234]

> My concern is we have had trouble getting in contact with the phlebotomist [for urgent blood draws]. That morning they were not logged into to their [portable] device. I called the general lab number, and no one answered. I then contacted my house supervisor, and he told me "we don't have another option right now [for getting the urgent blood sample].

The state inspector further reported that their interview "revealed not being able to reach a phlebotomist during [the] night shift had happened before. [This nurse] had called multiple times to reach the lab phlebotomist to draw [urgent] blood orders without reaching someone."

Appendix B (items 52-67) quotes multiple different professional sources providing a range of other and confirming examples of staffing under HCA compromising the safety, quality and efficiency of patient care and supportive services. Included are several accounts of a nearly fatal suicide attempt by an unmonitored psychiatric patient (items 65-67).

[232] https://downloads.regulations.gov/FTC-2024-0022-1423/attachment_2.pdf]
[233] Note 105, Exhibit 10.
[234] https://drive.google.com/file/d/1oz_V4371DkaqET7123l57BOpjYCCWKtr/view

Patients' Experience

While the effects of staffing cutbacks are felt "across the board" (in one physician's words), the effects are especially concentrated and visible in nurses' ability to care for patients. Various HCA critics consistently remark on the diligence and "heroic" dedication of those who continue to work at Mission, despite the escalating demands they face due to being stretched so thin. This appears especially true for nurses. As noted at the outset, cutbacks in nurse staffing, in which patient loads roughly doubled, were coupled with cutbacks in support staff such as nursing assistants, front-line clerical support, and various patient care supportive services, which further compounded nurses' feeling that they are not able to "do their jobs" the way they should.

Speaking to a reporter, a leading cancer physician said he was "horrified" that, on several occasions, he has found his hospital patients in "excruciating pain" because nurses were too overburdened to administer medications on time.[235] A former administrator with a physician organization relayed that one of their members was at "wits end" and "very angry" when we arrived at the hospital to find several of his "patients lying in their own shit." (pp. 11-17) gathers additional examples from medical professionals, along with others reported by individual patients or family members.

A national publication reported several Mission nurses recounting "that they often ended up delivering food and emptying trash bins after HCA outsourced the hospital's food service and janitorial functions."[236] A respected reporter described nurses having to assist with transporting dead patients to the morgue "because the unit that normally handles this work, the Office of Decedent Affairs, has been cut back by HCA."[237] An emergency room nurse explained (in a sworn statement) [238] that, because HCA stopped staffing assistants in the ER:

> A substantial portion of [ER] nurses' time is spent performing [personal care] tasks …. For instance, I often must spend time changing patients' clothing after they have soiled themselves, which impedes my ability to attend to the many other patients also under my care who are very sick. Other times, patients will sit in their feces or urine for hours.

Physicians and other hospital personnel regularly have to help pick up the slack.[239] A former leader of the hospitalist physician group recalled[240] that:

> Because of [the] lack of other staff and ancillary staff members, … there are times where a patient's family member will come out and ask me, "My family member really needs to go to the bathroom, like, I need help in here." And they're asking the physicians because there's literally no one else around to help. The nurse is busy. There are no float nurses to help. There

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[235] https://avlwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say/
[236] https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/
[237] https://avlwatchdog.org/quality-of-care-concerns-rise-at-mission-hospital/
[238] Note 105, Exhibit 12.
[239] For instance, a hospital chaplain said that, before she resigned, she and colleagues often had to help clean patients' rooms. https://avlwatchdog.org/former-mission-chaplain-the-moral-injury-that-is-happening-there-daily-is-staggering/
[240] https://avlwatchdog.org/in-unusual-email-mission-leaders-inform-medical-staff-that-they-are-expected-to-care-for-desperately-ill-patients-in-emergency-room/

> are no techs to help. There's none of the typical additional staff that would be in an emergency department who could say, "Oh, I'll come do that." … And so I do find myself, when I can, helping a patient to the commode or helping them on a bedpan with a family member because there's just not staff there to do it.

During an extensive investigation in late 2023, state inspectors reviewed a sample of patient records to determine how regularly patients were offered routine bathing or linen changes. Although this sample was limited, it confirms a multitude of reports from patients and professionals, such as those collected in Appendix B (pp.3-4, 11-17). State inspectors reported that basic linen or bathing services were not offered during hospital stays lasting one, two, and even three weeks.[241] A nursing assistant interviewed by government inspectors said she is often assigned to cover an entire hospital unit of 36 rooms by herself. Similar accounts from many others are documented in Appendix B (pp. 8-17).

It is no surprise, then, that reduced staffing is regarded as the primary driver of the plummet in patient experience ratings under HCA, discussed in Part 4 . One well-respected journalist reported[242] that:

> On one unit at Mission Hospital, with several dozen beds, nurses are assigned six or seven patients each — double their normal workload — and provided a single [nursing assistant], where protocols call for four. "Patients are lying in their own feces for up to an hour," [a nurse] said, "and they are not getting their meds for hours."

This reporter recounted that, following the article just quoted, "I heard from many other patients who told of similar or worse experiences at Mission — long waits for care, patients stashed on gurneys in hallways, pain medicines administered late or not at all, patients waiting hours for assistance to get to the bathroom, and on and on."[243] The reporter was able to review patient-care alerts that Mission nurses had filed with their supervisors. Based on these:

> One nurse on a surgical floor at Mission Hospital reported "patients lying in stool for an unknown amount of time," pain medications and insulin being administered late, and "irate family members." A nurse caring for the sickest patients on a surgical floor at Mission documented "delayed and missed medications due to RNs having 7-8 patients … Inadequate staffing led to patient fall."[244]

The state's Attorney General also reports receiving a large number of disturbing complaints, both from patients and from HCA Mission's clinical staff. One Mission nurse wrote about patients "having to sit in their own excrement for hours because our floor is expecting one [nursing assistant] to look after 44 patients."[245] The "surge in complaints about quality of care" received by the Attorney General during HCA's first year of

[241] https://drive.google.com/file/d/1oz_V4371DkaqET7123l57BOpjYCCWKtr/view
[242] https://avlwatchdog.org/quality-of-care-concerns-rise-at-mission-hospital/
[243] https://avlwatchdog.org/overworked-nurses-say-patient-care-suffers/
[244] https://avlwatchdog.org/mission-nurses-overburdened-patients-suffer/
[245] https://www.citizen-times.com/story/news/2021/09/20/hundreds-complain-nc-attorney-general-ashevilles-hca-mission/8370318002/

ownership prompted him to write the hospital an official letter requesting more information about staffing, noting that these complaints "frequently raise concerns about the impact of staffing cuts, especially for nurses" that are "harrowing to read."[246] So too are the similar reports from patients and professionals gathered in Appendix B (pp. pp.3-4, 11-17, 18-20).

Diminished Patient Safety and Quality of Care

Stretching staff "razor thin" (in the words of one physician)[247] affects not only staff morale and patients' experiences; this also has demonstrable impacts on patient safety and the quality of care. As summarized in a letter to the Federal Trade Commission written by area medical professionals and other stakeholders:[248]

> Patient safety is constantly compromised by inadequate staffing. Examples: Sitters must observe multiple patients at one time; people who monitor telemetry on gravely ill patients are overloaded and no longer located on site; no environmental services staff work the night shift in the emergency department, so rooms are not cleaned or sanitized appropriately (in many instances, nurses and even chaplains are left to try to remove blood and other bodily fluids). Short staffing in the sterile processing department means sterile equipment is not always available for the surgeons.

A national journalist who reviewed an extensive report from state inspectors summarized[249] that:

> It's nearly 60 pages describe[ing] a catastrophic state of dysfunction at Mission's flagship Asheville hospital. They contain stunning allegations of patients being treated in waiting areas within full view of other patients, nurses emptying trash bins and delivering food, and patients found dead in emergency room beds hours after they died.

Confirming the severity of disarray, a sworn affidavit from a long-time nurse at Mission stated that the "number of [written] complaints related to events involving harm or death to patients" received by the nurses' committee charged with monitoring patient safety "have increased dramatically since HCA following." [250] The patient-safety committee member noted that "[t]his was not a concern of consequence prior to the purchase" and that the committee now "has reported events that rarely occurred under the old Mission management that now happen frequently under HCA." For instance, "since HCA purchased Mission there have been more patient falls, more mistakes, and more hospital-acquired conditions, such as central line bloodstream infections, catheter-associated urinary tract infections, and hospital acquired pressure injuries."[251]

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[246] https://assets.documentcloud.org/documents/6786656/Stein-Letter-to-HCA-02252020.txt https://ncdoj.gov/wp-content/uploads/2020/02/Stein-Letter-to-HCA-_02252020.pdf

[247] https://www.citizen-times.com/story/news/2021/05/14/mission-hospital-departures-concerns-doctors-leave-hca-healthcare-more-work-less-pay/5042082001/

[248] https://downloads.regulations.gov/FTC-2024-0022-1423/attachment_2.pdf

[249] https://www.statnews.com/2023/12/14/hca-mission-health-lawsuit/

[250] Note 105, Exhibit 13.

[251] Ibid.

Another nurse who serves on this patient-safety committee said "almost every day" the group receives complaints from multiple units in the hospital about short-staffing endangering patient safety. A non-Mission, but highly experienced hospital nurse reviewed the patient-safety committee's reports at the request of a journalist and exclaimed "she was shocked at what she read."[252]

A year after HCA's purchase of Mission, a collection of area civic leaders wrote that "[a]necdotal accounts abound from Mission physicians and nurses on how these cutbacks have affected patient care."[253] A former Mission physician wrote to state regulators that "I have heard from countless nurses about the degradation of quality of patient care. Understaffing has literally led to dangerous situations for patients." Two physicians reported alarm at finding patients with surgical wounds lying in excrement and then scrambling to clean them up to avoid an increased risk of a serious septic infection.

Summing up the general state of affairs, one doctor described that staffing shortages created a daily feeling of having to "juggle eggs" in order to avoid serious patient injury. The physician opined that HCA's staffing practices result in "throwing more at you all the time," forcing you to "have to catch them before just before they hit the floor." This physician continued that, "so far I have been able to do that, but, at some point …. , " leaving his thought unfinished. Another physician described having had a "flood of near misses" from almost daily incidents compromising their patients' safety.. A prominent cancer physician made the difficult decision for his group to entirely cease treating complex blood cancer patients at Mission because "[w]e were finding more and more cases of missed care and errors. … We were catching them, but it was one of those things where it was just a matter of time before something was going to slip through the cracks and someone was going to get hurt."[254]

Appendix B (pp. 18-20) documents similar concerns with specific illustrations.

III: DYSFUNCTIONAL ASPECTS OF HCA MISSION'S EMERGENCY ROOM

Mission's emergency room (ER) became the most visible manifestation of the range of problems [the first two parts of this report] surveys. A combination of all elements – reduced staffing, physician and nursing departures, difficulties recruiting and retaining new clinical staff – combined to create serious and sustained problems with patient care in the ER. These problems have been of a magnitude that can fairly be called an outright debacle. Major deficiencies of patient care in Mission's ER under HCA have resulted in:

- Widespread public outcry at public forums, on social media, and elsewhere.[255]
- Emergency medical service agencies limiting their ambulance transports to Mission.
- Intensive state and federal inspections leading to multiple government findings of "immediate jeopardy," which threatened to entirely disqualify the hospital from the Medicare and Medicaid programs.

[252] https://avlwatchdog.org/overworked-nurses-say-patient-care-suffers/
[253] https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/
[254] https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/
[255] This is documented in Appendix B and in sources cited throughout this Part.

- A major legal challenge from the state's attorney general accusing HCA of violating the terms of their purchase agreement, by "providing woefully inadequate emergency and trauma services."[256]
- A determination by the "independent monitor" charged with enforcing HCA's purchase agreement that deficiencies in Mission's ER put it in "potential noncompliance" with the agreement.

At the core of this debacle is intense overcrowding of Mission's ER. Ironically, that level of extreme overcrowding emerged under HCA despite the fact that, within HCA's first year of ownership, Mission completed major[257] construction of a new tower that expanded its ER by almost 50 percent and replaced 200 in-patient rooms, touting various improvements to enhance efficiency.[258] Despite these improvements, the ER debacle ensued for a combination of these reasons, discussed below:

- HCA Mission has not been able to consistently staff many of the replacement patient rooms it brought on line.
- For rooms that are staffed, HCA's substantially leaner staffing model causes delays in how quickly rooms are cleared, cleaned, and made ready for the next patients.
- These bottlenecks have caused HCA to "board" a greater number of newly admitted patients in the ER for longer periods of time while they await transfer to a patient room.
- All of this causes backup in the ER, which is exacerbated by HCA's new policy that virtually all hospital patients other than scheduled surgeries must go through the ER first before being placed in a patient room, even if they do not have an emergency condition.[259]
- These management policies result in many ER rooms being occupied by "boarded" patients who aren't currently in an actual emergency.
- This extensive boarding requires that many (and sometimes most) true emergency patients be cared for either in hallways, the ambulance bay, or the ER waiting room.

Summing up this array of interconnected management decisions and consequences, the highly respected former head of Mission's largest physician group explained (in a sworn affidavit) how this state of affairs came about under HCA:[260]

> "… [T]he existing nursing staff continued to atrophy and go [elsewhere] where the pay scales are better. HCA would continue to [increase the] empty beds within the hospital which would aggravate the backup problems in the ER department with patients that were either

[256] https://ncdoj.sharefile.com/share/view/s9a1f854765ac4354aa6a549013687ae8/fo6b686e-516a-4e8f-9355-8475fecb8cbd

[257] https://avlwatchdog.org/new-independent-monitor-finds-hca-in-potential-non-compliance-with-mission-asset-purchase-agreement/

[258] https://www.hdrinc.com/portfolio/mission-hospital-north-tower
https://www.citizen-times.com/picture-gallery/news/local/2019/09/23/photos-tour-mission-hospitals-new-north-tower/2421307001/

[259] Note 105, Exhibit 13. See also https://avlwatchdog.org/this-is-a-four-level-problem-dr-clay-ballantines-full-statement-at-ashevilles-watchdogs-hca-mission-community-event/

[260] Note 105, Exhibit 8.

> overflowing into these [ER boarding] pods or being flowed back into the waiting room to wait for a bed to become available. ...
>
> It turned into a real 'goat rodeo' of empty beds in the hospital, inadequate nursing staff, the ER department getting overwhelmed, patients being boarded in the ER who were unable to get adequate care, and patients backing up into the waiting room."

Extensive ER "Boarding"[261]

Increased patient boarding leading to a more crowded ER is not a problem unique to HCA or Mission.[262] HCA notes that many hospitals nationally experience these problems to some extent. But, by all accounts, these problems arose at Mission only after HCA's purchase, due to the combined elements of its different management approach. Notably, the severity of these problems at HCA Mission appears to be much greater than what is typical at hospitals elsewhere.[263] A highly respected physician leader related that on a typical day when he worked at HCA Mission "only 25 or 30 of [Mission's 97 ER] beds would be staffed" for emergency patients. "The remaining 70 to 75 beds were either unoccupied or used as overflow beds for patients awaiting a bed on an inpatient floor in the hospital for patients to come to the floor."[264] Other physicians quoted below relay that, due to devoting most of its ER beds to boarding, HCA Mission is forced to treat not just some, but most of its emergency patients in the ER hallways or waiting room.

Unfortunately, HCA has not provided useful data, nor is detailed data publicly available, regarding Mission's current ER boarding practices.[265] According to an industry source, however, summary data indicate that the national average time for a patient to remain in the ER while waiting for a hospital room to become available—"boarding time"—was 3 hours in 2022, up from 2 hours in 2020.[266] Based on more comprehensive data, the average boarding time nationally was 101 minutes in 2019, with fewer than 1 percent of hospitals reporting more than six hours.[267] In the two years prior to HCA's 2019 purchase, Mission reported an average boarding time of two and a half hours.[268]

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[261] ER "boarding" refers to holding patients in the ER while they wait for a hospital room to become available. Such patients can either arrive through the ER or be referred from a community physician or another hospital. As discussed below, boarding patients are regarded as "admitted" for billing purposes even though they are not yet in a regular hospital room.

[262] See, e.g.: https://www.citizen-times.com/story/news/local/2015/03/28/mission-er-saving-lives-losing-millions/70548612/
https://www.wect.com/2022/08/24/report-feds-details-many-problems-nhrmc-emergency-room-that-put-patients-immediate-jeopardy/

[263] Mission's experience may, however, typify other HCA hospitals. One sophisticated academic analysis found that "HCA hospitals reduce[d] their ED physician staffing by approximately 25% by the second year [following the company's switch to] private equity ownership." https://www.rand.org/pubs/working_papers/WRA2844-1-v2.html

[264] Note 105, Exhibit 8.

[265] For a few years, the federal government collected information about average ER boarding times, but it ceased doing so in 2019, the year HCA purchased Mission. https://www.healthaffairs.org/content/forefront/despite-cms-reporting-policies-emergency-department-boarding-still-big-problem-right

[266] These data are based on a self-selected sample of hospitals that report voluntarily.
https://www.acepnow.com/article/a-sobering-year-for-emergency-departments-and-their-patients

[267] https://www.healthaffairs.org/content/forefront/despite-cms-reporting-policies-emergency-department-boarding-still-big-problem-right

[268] https://data.cms.gov/provider-data/archived-data/hospitals

At least anecdotally, boarding times at Mission are now regularly a great deal longer than these averages. Various sources describe ER patients regularly being boarded for much of the day, and often for several days. An active hospital physician explained that, prior to HCA, emergency patients were almost always either released or moved to an in-patient room within a day. But "now it's the norm" for patients to remain in the ER for more than a day. A former chief of the medical staff said they were personally aware of a few patients who spent four days in the ER. A physician formerly on the board described regularly holding patients two to three days waiting for a hospital bed. A county EMS director also wrote (in a sworn affidavit) of patients "sometimes stuck in the emergency department for days,"[269] as did an experienced nurse.[270]

HCA Mission partly blames its crowded ER on legal challenges brought by its competitors, which have held up the state's approval for Mission to build two new "free-standing" emergency facilities in the community. Those facilities, however, would not address the extensive patient boarding that is at the core of Mission's ER problems because, as the hospital explained in its "certificate of need" application to the state, "a very low percentage of [patients who come to free-standing ERs] typically require admission to inpatient care (2% to 4%)."

Also, multiple sources stress that extensive and extended boarding is not due primarily to Mission's hospital beds all being filled. Instead, they stress that, typically Mission has empty beds; it's just that it doesn't have enough nurses to staff all of the beds (even at its much leaner staffing ratios), or that its depleted cleaning staff is behind in preparing rooms for patients. As one Mission physician emphasized, "the irony is that Mission just built a MASSIVE new hospital wing, but they don't have the staffing they need for these brand new beds."

According to a physician formerly on the board, the hospital will say that it has no beds available, "but, really, it's that it has no nurses available to staff the beds." Another physician verified that "Mission's inability to maintain nursing staff leads to lots of empty beds up in the hospital."[271] The experienced nurse quoted above agreed that "prolonged stays in the [ER] ... are not due to a lack of actual beds. Mission has empty beds, they do not have nursing staff."[272] A county EMS director's affidavit states that ER overcrowding is due to "not enough staffed beds on patient floors at Mission Hospital, and because of this there are open beds that are left empty." [273] He also relays that EMS staff in Mission's home county "has reported that some lower acuity beds have been closed due to a lack of staff." A respected former leader of the hospital's largest physician group described the situation most extensively, as follows:[274]

> Although Mission has approximately 800 inpatient beds, often times we effectively only had 600 or 650 beds [when I worked there prior to 2024] because we did not have the nursing staff to be able to staff the balance of the beds that we had. So, at a time when we would be

[269] Note 105, Exhibit 17.
[270] https://drive.google.com/file/d/17fwqww6QYqWIZH7lbI28TAMEhMmfRndC/view
[271] https://avlwatchdog.org/this-is-a-four-level-problem-dr-clay-ballantines-full-statement-at-ashevilles-watchdogs-hca-mission-community-event/
[272] Note 270.
[273] Note 105, Exhibit 15.
[274] Note 105, Exhibit 8.

> boarding, my [hospitalist] practice alone may be boarding 40 to 60 patients in the ED, we might have 100 empty beds up on the floor that were simply unoccupied because we did not have nurses that could staff those beds for us. ... [B]efore HCA acquired Mission, I do not remember any time where a similarly substantial number of beds in the hospital remained unstaffed.

As noted above, ER boarding at Mission is exacerbated by HCA's new policy that virtually all hospital patients other than scheduled surgeries must go through the ER first before being placed in a patient room.[275] In other words, physicians may no longer directly admit their patients for medical care. A clear explanation for this unusual policy has yet to emerge. This footnote[276] provides several speculative reasons, some of which are purely financial rather than medical. Among financial reasons, one that ER experts point to is that scheduled surgical patients often are much more profitable for a hospital than are medical patients; therefore, a hospital focused on "the financial benefits of ED boarding" has a reason to "hold[] admitted patients in the ED [in order to] to bring in and dedicate [more] beds to elective admissions."[277] This explanation is consistent with what others observe to be HCA's "playbook" (discussed above) of focusing hospital management strategies on maximizing revenue from elective surgeries.[278]

Regardless of the reason(s), it is clear that requiring non-emergency medical patients to be processed through the ER prior to admission has had a marked impact on patient flow in its ER. As shown in Figure 1, the percentage of Mission's emergency patients that are admitted to the hospital has increased by almost 50 percent following HCA's acquisition.[279]

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[275] See Note 259.

[276] One possibility is that since most community physicians no longer practice in the hospital, going through the ER (even when there is no actual emergency) could be seen as a sensible way to assign a hospital-based physician. A second possibility is that requiring all admitted medical patients to be screened and evaluated through the ER, even though they have already been seen by the doctor that referred them, generates more billing for the hospital. A third possibility is that, if other patients are already waiting for a room via ER boarding, it is more fair to require all medical patients to be boarded so that they receive their room in turn, or according to which patients' needs are most urgent at the moment. Fourth, it may be more efficient to run a battery of necessary tests on a newly received patient in the ER than in a regular hospital unit. Finally, collecting referred patients in the ER for "boarding" avoids the possibility that a referring physician might send them elsewhere if a bed is not readily available. Pointing to this last explanation, one physician at an outlying hospital wrote (in a source from Appendix B):

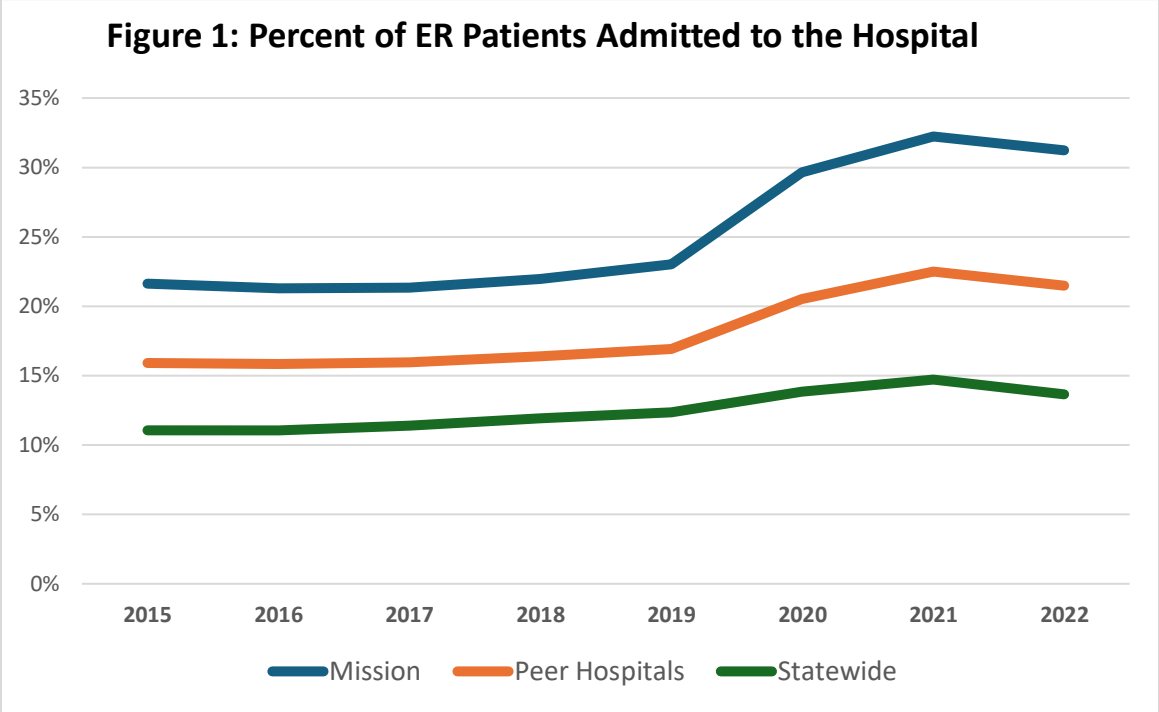
> "I can attest … [that] prior to HCA, Mission would [sometimes not have the capacity to accept] certain [referrals], so we would have to hold patients in our ER until there was an available bed at Mission. In many cases, we would find other facilities to take our patients because it isn't appropriate to hold patients in our ER waiting, in some cases, days for a bed at Mission. [Under HCA], Mission started accepting 90%+ of our transfers as ER to ER, just to keep us (and probably other outlying hospitals too) from transferring our patients elsewhere. Now, Mission ER staff get slammed holding direct admits, on top of all their normal patient volume."

Also of note, research has shown that HCA hospitals tend to admit as in-patients a higher proportion of their ER patients than do hospitals generally. https://pubmed.ncbi.nlm.nih.gov/37875259/

[277] https://www.healthaffairs.org/content/forefront/despite-cms-reporting-policies-emergency-department-boarding-still-big-problem-right. See also https://www.ena.org/press-room/articles/detail/2023/04/25/ena-joins-letter-to-white-house-urging-solutions-to-boarding-crisis

[278] See text at note 127.

[279] These data are collected by the state and available at: https://www.shepscenter.unc.edu/?s=NC+Emergency+Room+Discharge+Data



Much of that increase coincided with COVID-19, but it has not diminished much following the pandemic, and the increase has been substantially greater at HCA Mission than at peer hospitals in the state.[280] In 2022, Mission admitted almost 50 percent more of its ER patients to the hospital than did peer NC hospitals. It is implausible that this wide of a disparity is due to a major difference in the severity of these patients' conditions. Instead, from all indications, it is much more likely that this increase reflects a large number of patients now being processed through Mission's ER that, previously, had been directly admitted. Unavoidably, this increased flow of admitted patients through the ER exacerbates the crowding conditions caused by the number of patients Mission boards prior to admission.

Financial Considerations

Before proceeding further into the details, one might ask why HCA would choose to manage its ER in this fashion – one that might appear more akin to an intake kennel for hospital admissions than a true ER. Economically, boarding patients prior to room assignment does not obviously disadvantage HCA because boarded patients are regarded as "admitted" for billing purposes even though they are not yet in a regular hospital room.

In fact, using the ER to board admitted patients might be *more* profitable, considering that (as discussed below) the nurse staffing ratio in most of these ER holding pods is even leaner than the already-reduced staffing levels in the hospital's regular medical units. A highly respected former physician leader at Mission wrote (in a sworn affidavit) that, in most of the ER, "at best the nurse-to-patient ratio in the pods would be

[280] The peer hospitals chosen for comparison are the same seven NC hospitals that Mission and state regulators agreed were appropriate for benchmarking Mission's performance when it was subject to antitrust oversight prior to 2016. See Part 2.

12 patients to one nurse."[281] Staffing in some other areas of the ER is even lower, as discussed more below. In addition to leaner staffing, ER boarding offers the potential financial advantage, noted above,[282] that it facilitates prioritizing available hospital beds for more profitable patients (often, those with scheduled surgeries).

Obviously, an over-crowded ER has negative consequences, but a key aspect (noted by several informed sources) that prevents a troubled ER from hurting HCA Mission's finances is simply the fact that, for many people in the region, there simply is no other place to go. Mission is the only Level II trauma facility in western NC. Other ERs in the region serve only less severe injuries and ailments, and they are farther away from the largest population center (Asheville). In contrast with scheduled medical care, patients needing urgent attention do not have the option of considering whether to travel outside the region. Moreover, because the primary emergency service in the area is county-based, ambulances normally will transport only to Mission. Thus, poor service has little impact on Mission's ER business.

Underscoring how trapped patients sometimes feel in Mission's ER, two sources related that they considered calling 911 *from the ER* because they became so desperate from the lack of response from ER staff.[283] A community physician recounted that a colleague called a taxi to take him to an ER in a different county after waiting at Mission's ER for such an extended time.

A physician expert on hospital ERs explained that a poorly run ER is not likely to significantly hurt a hospital by driving away physicians. Although most of Mission's established ER doctors left due to HCA's approach to management and ER staffing continues to experience much turmoil, HCA has been able to quickly replace departures through a national physician staffing agency (Team Health). This expert explained that an easy-to-replace approach to medical staffing gives hospital management much more leeway to run the ER however it sees fit, since these contract physicians, who often are assigned only temporarily, typically do not have influential leadership positions at the hospital, and their contract terms make them vulnerable to quick transfer elsewhere. According to one former insider, this set of factors permits HCA Mission to regard its core hospital-based physicians as essentially "cogs in a machine."

Finally, a somewhat cynical, but still possible, explanation for a hospital to tolerate a level of ER dysfunction is that prominent hospital assessment measures do not focus as directly on the ER as they do on inpatient care. For instance, the national rating agency that gives Mission the highest marks (Healthgrades) excludes data on ER patients.[284] Accordingly, it stands to reason that it would not be illogical for a hospital facing staffing challenges to divert more of its available resources away from the ER, or if it were to concentrate as much as possible of its under-staffed patient load in the ER. However, whether that explanation factors into HCA's management approach is speculative.

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[281] Note 105, Exhibit 8.
[282] Text at Note 276.
[283] https://www.citizen-times.com/story/life/2020/02/20/nancy-williams-asheville-mission-hospital-er-may-call-911-help/4760392002/; Appendix B, item 95.
[284] https://avlwatchdog.org/mission-hospitals-leapfrog-healthgrade-scores-and-rankings-dont-tell-the-whole-story-draft-report-says/
https://carolinapublicpress.org/63283/hca-mission-hospital-asheville-cms-jeopardy-rankings-dubious/

HCA Mission's Responsiveness

In any event, this ER debacle did not occur due to HCA Mission's lack of awareness or inadvertent neglect. Instead, several key clinicians said they repeatedly raised these various problems with hospital leaders and recommended improvements. A current ER physician at Mission wrote that "I made a patient safety report about the incident [of an unmonitored withdrawal patient who had a seizure and suffered a head injury in the waiting room,] and no one ever contacted me for additional information. ... When I have brought up concerns about safety in the waiting room, I have been ignored." Likewise, the respected leader of Mission's largest physician group, who recently left the hospital due to unresolved patient safety concerns in the ER, wrote (in a sworn affidavit) that:[285]

> I brought [my] concerns formally to the chief medical officer who concurred with me that [sending a patient back to the waiting room after the doctor ordered prompt treatment] was an issue but did not take steps to prevent [unsafe conditions] from happening. ... It was not something that I was ever able to adequately get remediated .... There was nothing I could do to convince HCA administration that they needed to review the hospital's ... policy and to better address the needs of the nurses. Despite these issues being brought to the administration's attention, HCA was completely blind to any input from the nursing staff, and to the medical staff which had provided similar feedback.

County EMS directors also became exasperated over HCA Mission's repeated failures to remedy serious problems. One wrote (in an official letter to the hospital) that "Time and time again we have been promised that [conditions] would improve . . . . Sadly, things continue to get worse without any visible action from HCA."[286] Reportedly, conditions finally improved somewhat in the first part of 2024. But, as noted below,[287] it appears these improvements are likely in response to the EMS directors suspending normal ambulance service at Mission, combined with an array of serious legal problems the hospital was facing, more so than from the hospital's own standards of safety and quality.

Treating Patients in the Waiting Room

Perhaps the most remarkable indication of how extreme conditions became in Mission's ER is its decision sometime in 2022 to begin treating patients in the ER waiting room on a regular basis. HCA Mission began this systematic practice by creating what it terms an Intake Patient [or patient] Assessment (IPA) area.[288] A current ER physician at Mission wrote that HCA Mission has "moved the vast majority of providers to the waiting room to see patients. We now see 72% of all [emergency] patients through the waiting room." Another physician who left recently gave the following--even more startling--account:

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[285] Note 105, Exhibit 8.

[286] https://www.citizen-times.com/story/news/local/2023/11/02/mcdowell-ems-says-hca-fails-to-correct-emergency-department-issues/71419332007/

[287] Text at notes 309, 18.

[288] Another source says that IPA stands for "internal processing area." https://avlwatchdog.org/as-state-inspects-mission-for-cms-hospital-makes-changes-to-emergency-department.

> Currently at Mission ER, roughly 50% of the MD shifts and 80% of the PA/NP shifts are in ... the waiting room. You are literally seated in and seeing patients in the waiting room for the entirety of the shift. ... The waiting room will often reach 60+ patients. Seeing patients in a waiting room environment makes it impossible to obtain an appropriate history and exam. Patients are hesitant to be honest with their history (especially related to drug/alcohol/sexual history) since they are being evaluated in a public setting. Patients are fully dressed during exams, again in a public setting. ... Even patients with critical illness can be in the waiting room for hours. ... Patients will spend hours in the waiting room with critical conditions (e.g. [heart attack], PE [pulmonary embolism], AFib RVR [very rapid heart arrhythmia], anaphylaxis [severe allergic reaction]).

The first physician quoted emphasized that "[i]f we try to say a patient in the waiting room needs a room acutely (for [a life-threatening condition) we are often ignored."

An experienced nurse confirmed regularly "running IVs and life support medication in the waiting room."[289]

Another wrote (in a sworn affidavit) that "I have seen patients with life-threatening illnesses left unattended in hallway beds for days without being hooked to a monitor."[290] Even more worrisome is how poorly staffed this waiting room area is, considering how serious these patients' conditions can be. This same nurse stated that, sometimes there are only two nurses working in this large holding area, such that the "patient-to-nurse ratio can get as bad as 30 to 1." Under those conditions, "patients do not have an assigned nurse [and so] there is no one responsible for directly monitoring" them. State inspectors who interviewed Mission clinicians reported this account from one nurse practitioner:[291]

> One hundred percent, patients [placed in waiting room] are not safe, orders are not completed, and staffing is a concern. There is one nurse with a line out the door, I can put orders in, but it is not going to get done because of the volume of patients and minimal staff.

Shifting much of emergency treatment out of patient rooms and into the waiting room and hallways has created a chaotic scene vividly described by many who experience it (either as patients or as staff). According to medical professionals, one staff member said it is regularly "like a zoo," and "people were screaming, yelling, and crying."[292] A physician leader in the community said their ER colleagues describe it "like a combat zone." A former chief of the medical staff agreed it's "a horrible mess." A retired distinguished physician described having an "awful experience" based on the "horrendous" conditions. (pp. 25-28) collects similar accounts from patients.

Patients also provide deeply disturbing accounts. One mother wrote that when she brought her son in for a broken foot:

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[289] https://drive.google.com/file/d/17fwqww6QYqWIZH7lbI28TAMEhMmfRndC/view
[290] Note 105, Exhibit 6.
[291] https://drive.google.com/file/d/1oz_V4371DkaqET7123l57BOpjYCCWKtr/view
[292] Note 105, Exhibit 4.

> What I witnessed during those hours was horrifying. All the waiting room chairs and floor were filled with people crying out in pain, receiving IVs, …. Paramedics brought in people on gurneys and had to fit them into the waiting area.[293]

Another patient said it "was like being in the Twilight zone," and a third that it "was like being in a horror movie. I can't even describe it all. People were lined along the walls screaming and moaning with no one tending to them."[294] Perhaps most vividly of all, a distinguished reporter gave this account from his personal experience:[295]

> There were people throwing up in the hallways. There were meth addicts tweaking out on the floors. It was really a Hieronymus Bosch kind of painting.[296] And, ... in the article that I wrote [about this] on Halloween [I said] it was like Halloween in the emergency room.

Long Delays in Accepting Ambulance Patients

Another highly visible consequence of ER dysfunction under HCA is the decision by several area EMS directors in late 2023 (during the holiday season) to restrict ambulance transports to Mission. These fairly startling decisions were made because ER understaffing was causing far too great a delay in the hospital accepting responsibility for ambulance patients. When an ambulance arrives, it cannot leave until hospital staff assume responsibility for the transported patient. Normally, that happens fairly quickly, especially when the patient needs immediate attention, so that the ambulance can promptly return to servicing the community elsewhere.

Under HCA, however, ER understaffing has caused the hospital to delay taking ambulance patient handoffs for extended periods of time.[297] During these "wall times," EMS personnel are forced to continue attending to their patients on their ambulance gurneys parked against a wall in the ambulance bay, even if the patient needs urgent medical attention. One county EMS director recounted several patients with wall times of 2 hours each that had arrived as "code red" 911 emergencies.[298]

Prior to HCA's purchase, a paramedic for one area EMS service reported that the average turnaround "wall time" at Mission was 24 minutes, with only one percent of transports experiencing more than an hour delay. By 2023, however, the average wall time for this EMS service had risen by one-third, to over 32 minutes, with

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[293] https://avlwatchdog.org/conditions-at-ashevilles-mission-hospital-pose-immediate-jeopardy-to-patients-health-and-safety-state-investigators-report/

[294] These are from sources cited in Appendix B.

[295] https://www.podavl.com/theoverlook/ev2og7ibkkkfxvuyeh3d2wd0rv02vb

[296] See, e.g.: https://www.ranker.com/list/scary-hieronymus-bosch-paintings/lea-rose-emery
https://www.artspace.com/magazine/interviews_features/lists/the-10-worst-ways-to-die-in-a-hieronymous-bosch-painting-53872

[297] https://www.citizen-times.com/story/news/local/2023/07/25/mission-hospital-ambulance-patients-wait-hours-for-care/70401738007/
https://www.citizen-times.com/story/news/local/2023/11/13/buncombe-may-change-mission-emergency-dept-patient-handoff-policy/71530048007/
https://www.citizen-times.com/story/news/local/2023/11/02/mcdowell-ems-says-hca-fails-to-correct-emergency-department-issues/71419332007/

[298] Note 105, Exhibit 15.

a 7-fold increase in the percent of transports experiencing more than an hour delay.[299] This experienced paramedic wrote (in a sworn affidavit) that extended delay "has become a common occurrence at Mission Hospital, but one that we do not experience at any other hospital. ... [T]he Emergency Department at Mission Hospital is much worse under HCA than it was prior to the purchase in 2019. Additionally, the awful conditions at Mission Hospital are not typical of other tertiary hospitals in similar areas."[300]

The contrast is even more extreme for transports from the hospital's home county (Buncombe). According to its EMS data, only 4 transports in this sizeable county had more than an hour delay in the year prior to HCA's purchase, but, by 2023, the annualized rate was over 400 transports with more than an hour delay in the hospital taking responsibility for a patient arriving by ambulance[301] – which is a 100-fold (or 10,000%) increase.

Area EMS services reported these extended wall times even when they are transporting a patient from another, outlying Mission hospital from which the Asheville hospital has verbally accepted a transfer request and so has had advance notice of one-and-a-half to two hours.[302] As one EMS director paints the picture, when bringing a "code red" patient to Mission from a rural hospital "we're responding lights and sirens, moving that patient as quickly as possible only to wait on the wall at Mission" even though the hospital had ample advance notice.[303] Painting a less flashy picture, directors of two area EMS departments wrote that hospital staff shortages prompted their ambulance drives to help clean beds and rooms and assist with moving patients in order to facilitate the ERs ability to accept responsibility for newly transported patients.[304]

Area EMS directors express deep frustration over Mission's continuing failure to correct this situation. According to one, "time and time again we have been promised that wait times would improve . . . . Sadly, things continue to get worse without any visible action from HCA."[305] Of more than passing note, two EMS directors wrote that hospital staff shortages prompted their ambulance drives to help clean beds and rooms and assist with moving patients in order to facilitate the ERs ability to accept responsibility for newly transported patients.[306] The hospital's home county (Buncombe) and one other became so exasperated that, toward the end of 2023 (during the holiday season), one county suspended non-emergency transports and the other instituted a policy of simply leaving patients at the ER even if hospital staff say they are not yet ready

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[299] Note 105, Exhibit 9.
[300] Ibid.
[301] https://www.citizen-times.com/story/news/local/2023/11/13/buncombe-may-change-mission-emergency-dept-patient-handoff-policy/71530048007/ The 2023 yearly number is estimated based on 309 such cases in the first 8 months of the year.
[302] https://www.citizen-times.com/story/news/local/2023/07/25/mission-hospital-ambulance-patients-wait-hours-for-care/70401738007/
[303] https://wlos.com/news/local/mcdowell-county-emergency-services-voices-concerns-over-wait-times-at-mission-hospital
[304] https://www.citizen-times.com/story/news/local/2023/11/02/mcdowell-ems-says-hca-fails-to-correct-emergency-department-issues/71419332007
https://www.citizen-times.com/story/news/local/2023/11/13/buncombe-may-change-mission-emergency-dept-patient-handoff-policy/71530048007/
[305] https://www.citizen-times.com/story/news/local/2023/11/02/mcdowell-ems-says-hca-fails-to-correct-emergency-department-issues/71419332007/
[306] Note 304.

to accept them.[307] Mission's home county even sued the hospital to recoup expenses incurred over several years from these extraordinary delays.[308]

In early 2024, Mission finally took steps to improve this long-standing situation, and so these counties reinstated normal transport service.[309] But it took extreme measures to bring about this improvement. In addition to the counties' suspension of normal service, Mission Hospital had been sued by the attorney general for "providing woefully inadequate emergency and trauma services," and was under intensive investigation by state and federal regulators who threatened to suspend or terminate the hospital's participation in Medicare and Medicaid.

Prohibiting "Warm Hand-offs" Between Hospital Units

A less obvious consequence of understaffing in Mission's ER is how it handles patient transfers from the ER to inpatient units. Prior to HCA's purchase, ER nurses at Mission would speak with a "floor" nurse receiving a patient before sending a patient up to the unit, so that the unit would know the patient's condition and what was needed. These "warm handoffs" were viewed as especially important for more acutely ill patients requiring immediate care.

HCA, however, adopted a policy essentially prohibiting warm handoffs between the ER and hospital units other than the ICU. Instead, floor staff were expected to review the patient's medical record and ER staff were told they may only *fax* rather than *call* with a report.[310] According to one physician at Mission, prior to HCA they had a "brilliant" system for patient hand-offs from the ER – one that "everyone liked" as a good way "to handle a stressful situation" of moving an unstable patient. However, "HCA scuttled it right off the bat."

An explanation has not been given for HCA's unusual and seemingly counterproductive policy, but three possible reasons come to mind. The first is that its ER staff now have more pressing things to attend to than patient-care conversations with colleagues in other units. The second might be simply that, often, it may be difficult to reach the right person on the relevant hospital units. As discussed in the previous section,[311] HCA has eliminated most of the "secretarial" positions in the hospital units and has substantially reduced nursing assistants, resulting in phones simply not being answered many times. Although other communication routes may exist, a number of nurses at HCA Mission have noted how difficult it can be to reach physicians when they need them.[312] Relatedly, supervising "charge" nurses are now being assigned many more of their own patients to care for directly, which restricts their capacity to manage a unit.

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[307] https://www.citizen-times.com/story/news/local/2023/11/02/mcdowell-ems-says-hca-fails-to-correct-emergency-department-issues/71419332007/
https://www.citizen-times.com/story/news/local/2023/11/13/buncombe-may-change-mission-emergency-dept-patient-handoff-policy/71530048007/
https://www.citizen-times.com/story/news/local/2023/12/19/buncombe-ems-implements-mission-handoff-policy-for-ambulance-patients/71964670007/

[308] https://carolinapublicpress.org/63740/buncombe-proposal-join-nc-ag-stein-lawsuit-hca-mission/

[309] https://www.citizen-times.com/story/news/local/2024/01/24/mission-hospital-er-improvements-lead-to-shorter-ambulance-wait-times/72327813007/

[310] https://avlwatchdog.org/mission-patients-endangered-by-emergency-department-transfer-procedures-nurses-say/

[311] Text at notes 184-188 and 212-212.

[312] See Appendix B, items 52-54.

A third possible reason for HCA's policy is that ER staff who know about a patient's condition often may be unavailable to relay relevant information when a room opens up. This is a likelihood due to the duration and frequency that admitted patients are boarded in the ER while awaiting a staffed inpatient room to become available. Thus, a "cold" record made earlier, at the time an admission decision is reached, may be the only feasible means for a handoff report, when the handoff occurs several or many hours (or, sometimes, days) later.

Underscoring this third possible explanation for barring warm handoffs, Mission nurses assigned to the ER's boarding area state that they usually have very little, and sometimes no, information about the patients they are boarding. It is unclear why this occurs, but possibly it is because these boarding nurses are often temporary "travelers" who are "floated" from their normal assignments in regular hospital units. According to one such nurse:[313]

> I've been floated to the ED hold area and it was a nightmare to say the least. Very unsafe practices as patients are put in your room without anybody saying anything. They also don't give [nurses] any report or hook the pt up to the monitor. … Without [a] report it's hard to figure out why [patients] are on the drips they are on as you scramble to dig through the charts.

Another traveler wrote that, at Mission:

> Your job is really and truly just to babysit these patients until they get a room. … Help is minimal. … As soon as your people get a room, someone "cleans" the room very swiftly and sticks another patient in there, with no information given to you - you just have to keep up with it. … [H]onestly, that ER hold area is a real purgatory for patients - I have witnessed a lot of unsafe shit because these patients are just shuffled around with no word to anyone about what's going on, and I've often walked into a room where I've got minimal time to figure out WTF is wrong with my patient - I'm not an ER nurse so I'm used to at least having SOME info to go off of.

Regardless of HCA's reasons for prohibiting warm handoffs, a number of Mission nurses believe this policy creates a serious patient-safety risk. One travel nurse, for instance, wrote that the "ER doesn't call [to] report [when patients are being sent to a room] and I've had a few [patients] come up in bad shape. Getting ahold of a MD is a struggle … so in a pinch you have to go through the chart and figure out who to call and then see who is actually on call." Two other nurses recounted suicidal patients being dropped off with no notice and no attendant.[314] Other nurses report patients being taken to hospital units unable to handle the care required because no one spoke with the nursing unit first. According to one nurse:[315]

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[313] These accounts are from the sources indicated in Appendix B.
[314] Ibid. items 60, 61.
[315] https://avlwatchdog.org/mission-patients-endangered-by-emergency-department-transfer-procedures-nurses-say/

> Every day patients are transferred from the ER with no report and often to areas that are not the appropriate level of care, which then requires the resources of our rapid response nurse to care for these patients until they can be transferred to ICU.

This happens, they say, because the supervising "charge" nurse is often too busy with other patients to "have adequate time to look up incoming patients to ensure they are safe and appropriate to come to our floor. This often results in patients coming to us who are on medications and IV drips that we are not educated or certified to take care of."[316]

Concerned for patient safety, and frustrated that the hospital would not change its policy, Mission's nursing committee charged with monitoring patient safety filed a formal complaint with state regulators, stating: "We have documented numerous incidents where patients were likely harmed or experienced significant and avoidable delays in treatment because of this process."[317] Over a year-and-a-half later, and while the hospital was under intense investigation, HCA Mission reportedly relented by rescinding its ban on warm handoffs.[318] The underlying problem may still exist, however, if the ER staff is simply too busy to have these conversations, or if patients needing a hospital room are being held in the ER too long for the clinicians who know their condition to be still available at the time of transfer.

Patient Injuries and Death

It is obvious that overcrowding and understaffing conditions in Mission's ER create substantial concern for patient safety. Adding to what has been recounted so far, one highly respected former physician leader wrote (in a sworn affidavit) that, due to lean staffing, ER nurses often "simply did not have the bandwidth to provide the care that I was ordering."[319] But, more than just increased risk of patient harm, medical professionals pointed to actual harm occurring. Elaborating on one of those instances mentioned above, an ER physician wrote:

> I have had several bad cases in the waiting room. One in particular was a patient that was seen by another provider, diagnosed with [alcohol] withdrawal, [a withdrawal] protocol was ordered, and the patient was admitted. He did not receive any medications for 9 hours in the waiting room. He then had a withdrawal seizure and fell, striking his head on the ground. I saw the patient after the seizure and head injury.

Most disturbing, of course, are reports of Mission patients dying or suffering serious harm while unattended in ER hallways or understaffed ER "pods" (groups of patient rooms). The physician leader quoted several previous times, for instance, told a court that:[320]

> I had patients who had been admitted to the hospital with active, time-sensitive orders but those orders would not be executed. The patients would be placed in hold areas where there

[316] Ibid.
[317] Ibid.
[318] https://avlwatchdog.org/mission-changes-patient-transfer-process-following-watchdog-report-on-nurses-complaints/
[319] Note 105, Exhibit 8.
[320] Note 105, Exhibit 8.

> was inadequate staffing for the nurses to be able to retrieve medications or blood products from the pharmacy to provide care. ... I had the experience of a patient being brought to the floor who had died in the orange pod, and they did not even recognize that the patient had died during the night.
>
> That subsequently evolved into worsening problems with patients I had admitted from the ED that instead of being sent to a hold area or to the floor were actually returned to the ED's waiting rooms. I had an 18-year-old patient admitted with status asthmaticus who went in respiratory arrest with his mother in the waiting room. I admitted a patient in diabetic ketoacidosis who had orders for intravenous fluids and intravenous insulin who instead was disconnected from their drips and, unbeknownst to me, was returned to the waiting room where they lapsed into a coma. I am aware of numerous examples of patients with decompensated acute medical conditions who were returned to the waiting room.

Tragic results like these, along with other serious mishaps, prompted a number of official complaints to government officials, which then prompted an extensive, multi-week investigation near the end of 2023 by state and federal authorities. That investigation resulted in a 384-page report detailing a range of disturbing dysfunctional elements connected with patient deaths or serious injuries, or that exposed patients to substantial risk.[321] As summarized in a letter to the Federal Trade Commission from a group of area medical professionals, elected officials, and others:[322]

> The evidence, gathered by the state Department of Health and Human Services (DHHS), included patients who died parked in hallways, spent agonizing hours waiting to be triaged or receive diagnostic procedures or treatment that had been ordered, were not adequately monitored even when their condition was extremely perilous, or were held for extended periods in the overcrowded Emergency Department because there was insufficient staff to care for them in other areas of the hospital.

News reports summarize this investigative report in greater detail, including four cases where ER patients died.[323] One summary, for instance, says that the investigation painted "a dismal scene" of[324]:

> [H]ours-long delays in critical tests, patients piled in hallways instead of rooms, families pleading for attention, overworked nurses, and doctors' orders ignored. The 384-page report ... provides an almost microscopic analysis of the serious medical, staffing and management issues that local nurses and patients have been decrying ever since HCA ... took over the Mission Health system in 2019. Beyond the headlines — four patients dead and dozens of others victimized in 2022 and 2023 by delays in care, neglect, long waits for lab work,

[321] https://drive.google.com/file/d/1oz_V4371DkaqET7123l57BOpjYCCWKtr/view
[322] https://downloads.regulations.gov/FTC-2024-0022-1423/attachment_2.pdf
[323] https://avlwatchdog.org/cms-details-fifth-patient-death-at-mission-accepts-hospitals-plan-to-fix-emergency-care-issues/
https://avlwatchdog.org/cms-immediate-jeopardy-report-on-mission-details-deaths-of-patients-significant-delays-in-care/
[324] https://avlwatchdog.org/cms-report-dissects-widespread-failures-at-mission-hospital/

> unapproved and expired medications, and a litany of other failures by HCA and Mission management.

Based on this investigation, the federal government found that, in 11 of 35 cases reviewed, the hospital:[325]

> failed to provide a safe environment for patients presenting to the emergency department (ED) by failing to accept patients on arrival, resulting in a lack of or delays with triage, assessments, monitoring and implementation of orders, including labs and telemetry. ED nursing staff failed to assess, monitor and evaluate patients to identify and respond to changes in patient conditions. The hospital staff failed to ensure qualified staff were available to provide care and treatment for patients who arrived in the ED. The cumulative effects of these practices resulted in an unsafe environment for ED patients.

These findings led the government to cite the hospital with nine instances of placing patients in "immediate jeopardy," which is when noncompliance with federal rules "has placed the health and safety of [patients] at risk for serious injury, serious harm, serious impairment or death."[326] Immediate jeopardy "is the most serious deficiency type, and carries the most serious [government] sanctions."[327] These citations are fairly rare, but not unheard of, at other hospitals. But, finding this many instances in a single round of hospital inspections is exceedingly rare.[328] When this occurs, it is usually at a hospital that is struggling to stay afloat or that soon closes[329] – rather than a hospital of Mission's stature.

CODA: Looking ahead

As described above, HCA did not respond to many of the repeated, insistent efforts by clinicians to address patient-safety issues throughout the hospital. However, signs of possible improvement have emerged very recently, in response to a serious threat of Mission being suspended from the Medicare and Medicaid programs, and the NC Attorney General's lawsuit for HCA's breach of the hospital purchase agreement.[330] It remains to be seen how meaningful, and lasting, these improvements will be,[331] in light of the fact that the basic market conditions and corporate priorities that gave rise to these issues remain much the same.

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[325] https://dogwoodhealthtrust.org/wp-content/uploads/2024/07/IM-Annual-Report-Compliance-Evaluation-2023_FINAL.pdf
[326] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-09-ALL.pdf
[327] Ibid.
[328] See https://www.beckershospitalreview.com/hospital-physician-relationships/5-hospitals-hit-with-immediate-jeopardy-citations-in-2024.html
[329] See, e.g., https://www.beckershospitalreview.com/legal-regulatory-issues/shuttered-california-hospital-had-history-of-patient-safety-issues.html
[330] The Independent Monitor charged with overseeing compliance of this agreement also has found "potential noncompliance." It is noteworthy that, although HCA Mission did not challenge the state and federal governments' findings that it had place patients in "immediate jeopardy," it has denied the core of the Attorney General's allegations and insisted that it remains in compliance with the purchase agreement, suggesting that many elements of degradation this report surveys are acceptable. Also, now that the regulators have accepted Mission's "plan of correction," which places the hospital back in good standing with Medicare and Medicaid, HCA Mission may feel that it is no longer under as much pressure to make substantial improvements.
[331] Expressing some skepticism, see, e.g.: https://www.medpagetoday.com/special-reports/features/108924 https://www.medpagetoday.com/special-reports/features/108924 https://www.northcarolinahealthnews.org/2024/03/22/staffing-issues-hca-mission-hospital-nurses-say-its-not-happening/

Part 4: Mission Hospital's Quality Ratings Following HCA's Acquisition

INTRODUCTION

Prior to HCA's acquisition, Mission Hospital was regarded as one of the highest quality hospitals in the country. In 2004, the Economic and Social Research Institute chose Mission as one of just four "exemplary hospitals" across the country to study in depth, in order to inform other hospitals about the "best practices" that "contributed to the success" of "high-performing hospitals."[332] These researchers concluded that "Mission [was] an excellent example of how a variety of factors can come together to promote quality of care in a large institution, ... [because] the drive to do whatever it takes to provide the best possible care seems to permeate the organization, from the Board to the executive levels to the bedside." The researchers "heard consistently that both the CEO and chief medical officer at Mission [were] strong champions of quality—not just reacting and responding to problems but taking action to move the institution ahead and keep it strong."

Mission maintained this national and regional excellence over the ensuing decades, up to the point of HCA's acquisition. One indication of regional excellence is the ranking done by the *Business North Carolina* magazine. In each of the seven years prior to HCA's purchase, this respected publication rated Mission the best or second best hospital in the state.[333] Nationally, IBM Watson Health selected Mission and its affiliated hospitals as one of the top 15 hospital systems in the country -- in six of the seven years prior to HCA's acquisition.[334] Mission was the only hospital system in NC to make IBM Watson Health's top-15 list and the only system in the entire country to make this list so frequently.

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[332] https://www.commonwealthfund.org/publications/fund-reports/2004/jul/hospital-quality-ingredients-success-overview-and-lessons

[333] https://businessnc.com/north-carolinas-2018-best-hospitals/. The magazine states that the rankings are based on "25 metrics ... [from] the U.S. Centers for Medicare & Medicaid Services, including patient-satisfaction surveys, infection rates, and readmission and death rates for common conditions and procedures. We also consider criteria from insurer Blue Cross and Blue Shield, U.S. News & World Report and The Leapfrog Group, a Washington, D.C.-based organization that grades hospitals based on patient-safety records."

[334] https://www.readkong.com/page/watson-health-15-top-health-systems-study-2018-3286465. Similar to other such rankings, this one is based on weighted composite measures of mortality, infections, complications, costs, and patient satisfaction. https://www.pinc-ai.com/100-top-hospitals

Following HCA's acquisition, however, numerous complaints have been made and serious concerns raised about diminishing quality of care – principally due to staffing reductions and turnover discussed in Part 3. These documented complaints led to an extended state investigation that resulted in the federal government recently citing HCA Mission with nine instances of placing patients in "immediate jeopardy" – a rare and very serious charge.

Curiously, however, HCA Mission has not seen a sharp decline in its overall ratings for quality of care from various reputable rating agencies such as *US News and World Report,* the Centers for Medicare and Medicaid Services, the Leapfrog Group, and Healthgrades.[335] Some measures have dipped, and others have remained steady, but only one measure has dropped substantially.

This Part provides a detailed account of how and why Mission's quality rankings do not consistently track widespread perceptions that its quality has declined following HCA's acquisition.

PATIENT EXPERIENCE RATINGS UNDER HCA

Following HCA's acquisition, Mission no longer receives these same accolades. While for the most part, Mission continues to receive positive ratings, there nevertheless has been a notable decline in several quality indicators.

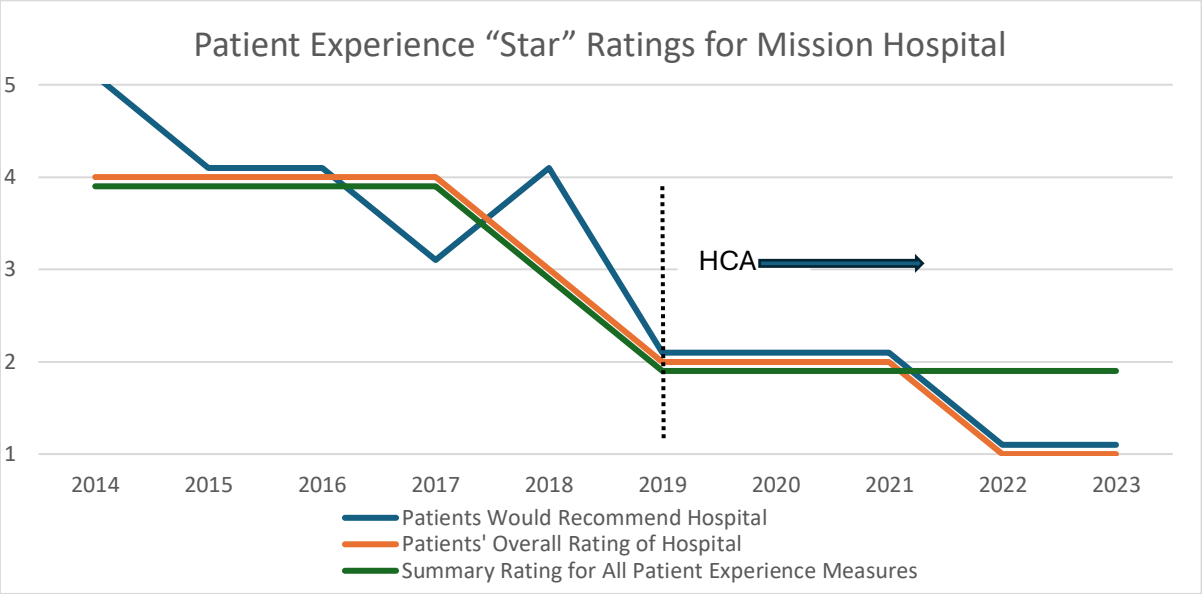
Most strikingly, Mission's patient experience ratings have plummeted under HCA. This is seen, for instance, in *Business North Carolina's* rankings of hospitals statewide based on a systematic federal survey of the percentage of patients who would recommend the hospital to others. In the six years prior to HCA's acquisition, Mission Hospital's state rankings ranged from 3rd to 7th on this recommend-to-others indicator, but during the first year under HCA (2019), Mission's patient-experience ranking suddenly dropped to a statewide tie for 18th-23rd.[336] In more recent years, Mission's patient experience ratings have kept it either at the bottom of or entirely out of the top 25 statewide.

This plummet is based on data collected and reported by the federal government, through the Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) survey, which it administers each year to several hundred randomly selected patients at each hospital.[337] One of the HCAHPS survey's key summary measures is simply whether the patient would recommend the hospital to others.[338] The percentage responding no vs. yes is converted to a scale from one star (worst) to five stars (best).[339]

The following Figure shows that, under HCA, patients' rating of Mission has dropping from 4 (our 5) stars, to one star. This one-star rating places Mission in the bottom 4% percent of hospitals nationally on whether its patients would recommend the hospital to others. No other NC hospital with more than 300 beds was rated

[335] https://missionhealth.org/awards/
[336] https://businessnc.com/?s=%22patient+picks%22&post_type=post
[337] https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hcahps-patients-perspectives-care-survey; https://hcahpsonline.org/en/
[338] Verifying the robust strength of this indicator, see https://onlinelibrary.wiley.com/doi/10.1002/hast.1523
[339] Each hospital's score is adjusted to account for characteristics of the patients who respond, so that the star rating reflects how a hospital does compared to hospitals with similar patients nationally. https://hcahpsonline.org/

this low in 2022 or 2023.[340] The following Figure also shows similar declines in two other summary measures of patient experience at Mission.



Similar, but not as extensive, declines can be seen in the star ratings that patients or family members give Mission Hospital on the widely used Yelp and Google review internet platforms. In the six years prior to HCA's purchase, Mission averaged 3.0 stars on both Yelp (40 reviews) and Google (179 reviews). In the five years following HCA's purchase, Mission's average rating dropped to 1.7 stars on Yelp (98 reviews) and 2.2 on Google (521 reviews).[341]

OTHER QUALITY MEASURES

To obtain a more expansive view of hospital performance, rating agencies routinely measure the quality of care in ways other than just patients' experience. A variety of respected sources rate hospitals based in substantial part on objective measures of patient outcomes and hospital processes, such as mortality or infection rates, or taking steps to avoid complications. For several of these key ratings, Mission did not decline initially following HCA's acquisition. Unlike patient surveys, however, these objective measures have an inherent time lag due to the 2-3 years required to collect relevant data, analyze it, and publish it. Once most of the relevant data began to come from the post-acquisition time frame, Mission's ratings based on objective measures declined on several fronts, although not as steeply as for patient experience.

[340] The other NC hospitals with one star in 2022 were Central Carolina in Sanford, Wilson Medical Center, Maria Parham in Henderson, and Halifax Regional in Roanoke Rapids; in 2023 they were joined by University City Hospital in Charlotte.

[341] This count was done in December 2023. The Yelp ratings are based on reviewers it "recommends" (using an algorithm that is sensitive to how reviewers behave elsewhere). Including also the "not recommended" Yelp reviews does not change the pre-HCA average, but doing so increases the post-HCA average to 2.0.

For instance, referring again to overall rankings from *Business North Carolina*, Mission continued to be listed as first in the state in 2019, based on safety and quality data from earlier years. But, by 2022, Mission's overall ranking had slipped to 12th in the state but improved in 2024 to a tie for 6th.[342]

Similarly, on a national level, the data analytics firm IBM Watson and its successor (Premier or PINC) have long ranked Mission among the country's top 15 health systems -- a distinction that Mission had held for six of the seven years prior to HCA's purchase, but not once following HCA's acquisition in 2019.[343] IBM Watson also had consistently ranked Mission Hospital among the top 50 cardiovascular hospitals nationally for at least the five years prior to HCA's acquisition. Under HCA, Mission maintained that distinction through 2021, but has not received it since then.[344] This delayed drop coincides with the 2-3 year time lag between the collection of core data and the announcement of these rankings.[345]

Similar delayed degradation in Mission's national rankings can be seen from other sources, which use similar but somewhat different methodologies. All such ranking methodologies have limitations, but some are stronger than others, and some are notably weaker.[346] Among the strongest is *U.S. News and World Report*. In the five years prior to HCA's acquisition, *US News* ranked Mission from 5th to 7th statewide for overall quality. The first two years under HCA, when most underlying data predated the acquisition, *U.S. News* continued to rank Mission in the top 10 statewide. But since 2021, Mission has fallen out of the top 10 in the state and it currently ranks in a 3-way tie for 9th-11th.[347] While this is a respectable ranking, it is a distinct step down from the very top ranks that Mission occupied prior to HCA.

The federal government maintains another widely referenced rating system, which awards hospitals from one (lowest) to five (highest) stars.[348] In the Spring of 2021, which is the first year relevant data fell primarily under HCA management, the federal government downgraded Mission Hospital from the top 5-star rating, which fewer than 10 percent of hospitals receive nationally, to 4 stars. Four stars is still respectable, but it puts Mission in roughly the top half of rated hospitals in North Carolina, rather than the very top tier.[349]

Some Ratings Remain High

Two exceptions to declining quality ratings are the Leapfrog Group and Healthgrades, both of which continue to give Mission top ratings. Notably, neither of these rating firms includes in their overall ranking metrics any data on patient experiences or satisfaction. Also of note, both of these firms charge hospitals a fee in order

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[342] https://businessnc.com/?s=%22patient+picks%22&post_type=post

[343] Rankings are not provided below the top 15, but the firm reported most recently that Mission is not in the top 100, and in 2022 was not among the top one-fifth of health systems.
https://www.pinc-ai.com/100-top-hospitals/winners/
https://web.archive.org/web/20220707133345/https://www.ibm.com/downloads/cas/GDBBYRWE

[344] https://www.pinc-ai.com/100-top-hospitals/50-top-cardiovascular-hospitals/results/

[345] https://cdn.sanity.io/files/dcd4gsuh/production/85dff22267f5c0ca207ea486309d6bc67bd0283b.pdf. Also of note, this ranking is based in part on performance trends measured as much as 8 years prior to the ranking.

[346] http://catalyst.nejm.org/evaluation-hospital-quality-rating-systems/
https://www.advisory.com/topics/clinical-quality/2019/11/metrics-used-in-hospital-quality-rating-programs
https://www.chicagobooth.edu/review/hospital-ratings-are-deeply-flawed-can-they-be-fixed
https://avlwatchdog.org/ratings-company-says-ashevilles-mission-is-the-best-hospital-in-north-carolina-we-seek-a-second-opinion

[347] https://health.usnews.com/best-hospitals/area/nc

[348] https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating/

[349] https://www.medicare.gov/care-compare/results?searchType=Hospital&page=1&state=NC&sort=highestRated

to publicize their rankings.[350] Accordingly, these two rating firms use "grading curves" that tend to rank hospitals more highly than do other rating firms.[351] That does not necessarily mean their ratings are invalid; however, independent evaluators consider their methods to be less rigorous and reliable than the other ranking firms discussed so far.[352]

Healthgrades

Mission's most notable accolade is from Healthgrades, which continues to rank Mission among the country's top 50 hospitals. For the past several years, Mission has been the only such hospital in NC.[353] On the face of it, this distinction is counter-intuitive,[354] and is inconsistent with the substantial body of data and analysis reviewed so far, especially as discussed in Part 3 and documented in Appendix B. One explanation is the long eight-year "look-back" period that Healthgrades uses to classify and rank hospitals.[355] This expanded window means that Mission's current ranking is still based to some extent on how it performed for several years prior to HCA's acquisition. Another explanation is that Healthgrades does not consider any data relating to care in the emergency room,[356] which, as Part 3 discusses, is the source of a good deal of the criticism that Mission has received under HCA.

Healthgrades' top-50 list is not based on the full set of measures that compose other leading rankings. For instance, Healthgrades' top-50 rating does not include patient experience evaluations, which it lists separately. In that separate listing, Mission is not among the dozen NC hospitals that receive Healthgrades' patient experience award,[357] and Healthgrades notes that Mission is significantly below national averages for patient experience.[358]

Another key feature of Healthgrades' best hospital ranking is that the majority of metrics focus on the performance of surgical procedures, and less so on medical care more generally.[359] Successful surgery depends to a great extent on the surgeon's skill, and so it appears likely that Mission has retained a skilled medical staff for surgical and other interventional procedures. These are also the kinds of hospital services

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[350] The Leapfrog rating is done by a nonprofit group formed primarily by employers. Healthgrades is owned by a private-equity-backed firm.

[351] For instance, in 2023 Healthgrades awarded 864 hospitals for either "excellence" in patient safety or being "outstanding" in patient experience. https://www.beckershospitalreview.com/rankings-and-ratings/healthgrades-recognizes-800-hospitals-for-patient-safety-experience.html. As discussed below, Leapfrog typically gives an A to about a third of hospitals, and over half receive at least a B. In contrast, the federal government's rating system awards 4 or 5 stars to fewer than a quarter of hospitals, with 5 stars going to less than 10 percent. https://www.medicare.gov/care-compare/resources/hospital/overall-star-rating

[352] http://catalyst.nejm.org/evaluation-hospital-quality-rating-systems/

[353] https://www.healthgrades.com/quality/ratings-awards/reports/americas-best-hospitals

[354] Adding a degree of incredulity is that, even when expanding the ranking to the country's top 250, only one other little-known NC hospital (Pardee) has been listed the last several years. https://www.healthgrades.com/quality/americas-best-hospitals/north-carolina?americasBestAwardType=top250

[355] https://www.healthgrades.com/quality/hospital/americas-best-hospitals-for-clinical-excellence-2024-methodology. In addition, data for each of those years reaches back several additional years, such that current rankings are based, at least in part, on data from a decade ago. https://www.advisory.com/content/dam/advisory/en/public/shared/Daily-Briefing/2022/HealthGrades_BestHospitals_2022.pdf

[356] https://carolinapublicpress.org/63283/hca-mission-hospital-asheville-cms-jeopardy-rankings-dubious/

[357] https://www.healthgrades.com/quality/outstanding-patient-experience-award/north-carolina

[358] https://www.healthgrades.com/hospital-directory/north-carolina-nc/mission-hospital-hgstcb797b36340002#overview

[359] https://www.healthgrades.com/quality/healthgrades-americas-best-hospitals-for-clinical-excellence-methodology

that informed sources noted are more profitable and therefore for which HCA typically provides more support.[360]

Contrasting with Healthgrades' procedure-centric metrics are those that focus more on general medical care. Examples include pressure ulcers, catheter-related infections, hospital falls, and various aspects of post-operative care. For this group of preventable safety measures, is one among 11 NC hospitals, and over 400 hospitals nationally, in Healthgrades' award category for "patient safety indicators."[361]

In sum, Healthgrades' ratings indicate that, under HCA, Mission has maintained top performance selectively rather than across the board. Its ratings are exemplary for a range of surgical procedures, but not as outstanding for the broader array of hospital care delivered by nurses, hospitalists, and other clinical staff. As discussed in Part 3, these are also the areas where HCA has sought to economize and so where Mission has experienced greater staffing cutbacks and turnover.[362]

Leapfrog

The Leapfrog Group is another rating agency that continues to give Mission high marks. Leapfrog is a respected nonprofit rating agency formed by employers to evaluate hospitals they select for their health plan networks. Like Healthgrades, however, hospitals pay Leapfrog a fee to use its ratings for promotion purposes. Accordingly, Leapfrog is not known as an especially tough grader. Nationally it awards either an A or B to half of hospitals, with a third receiving A's.[363] North Carolina hospitals do especially well.[364] In the most recent ratings, almost half received A's.[365]

Leapfrog's ratings (which it issues twice a year) have two other notable features. First, as noted above, unlike several other rating agencies Leapfrog does not include patient-reported experience or (dis)satisfaction. Second, Leapfrog relies on both data that regulators routinely collect, and data that hospitals self-report through an annual survey. However, about half of hospitals do not respond to Leapfrog's voluntary survey; for those hospitals, Leapfrog either omits the self-reported measures, or it uses proxy substitutes discussed below.

Prior to HCA's acquisition, Mission usually received A's from Leapfrog, with only occasional B's.[366] In the first two and a half years under HCA, however, Mission averaged B's, and at one point (fall 2019) it dropped to a C. For the next two and a half years, Leapfrog awarded A grades to Mission, but its grades returned to B in 2023.

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[360] This point is discussed more in Part 3.

[361] https://www.healthgrades.com/quality/patient-safety-excellence-award/north-carolina

[362] https://www.hospitalsafetygrade.org/h/mission-hospital

[363] https://www.hospitalsafetygrade.org/media/file/ExplanationofSafetyGrades_Fall2024-1.pdf
https://www.advisory.com/content/dam/advisory/en/public/shared/Daily-Briefing/2020/Cheat-Sheet--Leapfrog-Safety-Grades_Fall2020.pdf

[364] https://www.wral.com/story/north-carolina-ranks-no-1-in-us-for-hospital-safety/20274858/
https://www.northcarolinahealthnews.org/2017/11/03/hospital-safety-ratings-2017/

[365] https://www.hospitalsafetygrade.org/search

[366] https://ncdoj.gov/wp-content/uploads/2020/02/Stein-Letter-to-HCA-_02252020.pdf
https://wlos.com/news/local/leapfrog-group-wnc-hospitals-graded-among-the-best-worst-in-the-state
https://www.healthcarefinancenews.com/news/full-list-these-844-hospitals-earned-fall-2016-leapfrog-ratings

As suggested above, there are three explanations for Leapfrog reporting good performance despite other worrisome indicators. First, due to somewhat lenient grading, an A places Mission merely in the top half of the North Carolina hospitals that Leapfrog evaluates, and a B places it in the top three quarters of NC hospitals. Second, Leapfrog does not include data that reflect patients' views or experiences, which have dropped substantially (as discussed above). Third, Leapfrog, more than other rating agencies, allows hospitals to make strategic decisions to avoid reporting certain data elements that might be unfavorable.[367]

Data Integrity

To illustrate the point just mentioned, until recently Mission consistently responded to Leapfrog's annual self-reporting survey, but Mission did not do so after 2022. As a result, Leapfrog had to resort to its fallback "imputation" method that assigns Mission an average (rather than actual) score for these measures, based on the performance of similar hospitals.[368]

Other hospitals also make such decisions about how to put their best face forward. However, several informed sources pointed out that HCA has perhaps the best data analytic skills and methods in the industry,[369] and so it is especially adept at making these kinds of strategic decisions. A national expert commented that HCA, which "is famously data-driven, ... teaches to the test" in that they "will hit the number necessary to hit the level of quality or efficiency that optimizes their shareholder value. Period."[370] One Mission doctor noted that, "when HCA came in, there were so many emails on metrics."[371] A former Mission administrator riffed that, with all the data HCA has, they "can manage things down to a gnat's butt."

Data analytics are key to helping hospitals address safety and improve quality by spotting problem areas or performance gaps, and HCA undoubtedly has used their prowess in that fashion, to improve quality performance. However, several sources also thought HCA does so selectively, by focusing on quality mainly in ways that do not cost a great deal to make measurable improvements. One former Mission administrator had the derisive view that HCA "won't spend a dime more than they need" to improve quality, as long as Mission stays at "a level that keeps them from getting into trouble." A local physician agreed that HCA is skilled at "being just good enough to stay out of trouble," but will not "spend what it takes go from the 90th to the 95th percentile" in quality, especially when doing so doesn't bring them any more business.

Finally, it merits mention that, when hospitals report data, either to Leapfrog or to other rating agencies, there is at least some potential for skewed or inaccurate reporting. This point is not at all unique to HCA Mission, but several examples can be noted from Mission's data. For instance, Leapfrog's annual survey asks hospitals to self-report on a number of measures relating to leadership, teamwork, and staffing. In 2019, when Mission's Leapfrog grade dropped to a C, it reported a nurse staffing measure that was below average.

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[367] https://www.hospitalsafetygrade.org/HospitalFAQ. Hospitals can purchase a "calculator" that helps them anticipate whether submitting or not submitting self-reported data will be to their advantage.
https://catalyst.nejm.org/doi/full/10.1056/CAT.19.0629
https://premierinc.com/newsroom/blog/hospital-rankings-how-to-stay-on-top-with-pinc-ai-quality-enterprise

[368] Explaining this imputation method, see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5517312/

[369] https://www.pressreader.com/usa/modern-healthcare/20181008/281762745204037

[370] https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/ /

[371] Barbara Durr and Sally Kestin, "How Many Doctors Have Left Mission? HCA Won't Say," Asheville Watchdog, March 23, 2022, https://avlwatchdog.org/how-many-doctors-have-left-mission-hca-wont-say/

The following years, however, when its Leapfrog grade improved, Mission received a perfect score of 100 on this self-reported nurse-staffing measure.

A perfect score may have been technically accurate because Leapfrog's nurse-staffing measure was based primarily on the hospital adopting a recommended list of administrative plans and processes,[372] rather than on actual staffing levels. As discussed Part 3, Mission's actual staffing levels are (to say the least) far from perfect. Thus, this scoring improvement does not reflect enhancements in actual nurse staffing. Based on that critical data limitation, Leapfrog began in 2023 to ask hospitals to report actual nursing hours per patient day.[373] Whether related or merely coincidental, 2023 is also the first year that Mission declined to respond to Leapfrog's survey.

In short, lifting the hood on how key metrics are assessed reveals a variety of ways[374] that hospitals can optimize their quality ratings. Other hospitals engage in similar practices,[375] but as noted above, several observers thought that HCA is particularly astute about maximizing available advantages.

Another example of a possible anomaly comes from data collected by the federal government relating to "timely and effective care,"[376] a measure that various rating agencies use. One of these data points is the percent of patients who leave the emergency room without being seen. Implausibly, Mission reports zero percent.[377] Statewide, the average is four percent, and only two other NC hospitals report zero percent, both of which are part of the HCA Mission system.[378] Prior to HCA's acquisition, Mission typically reported at or close to the statewide average of four percent.[379] Under HCA, however, in 2019 the reported percent of patients leaving Mission's emergency room without being seen suddenly dropped to, and largely remained at, zero.[380]

This abrupt improvement does not align with widespread reports discussed in Part 3 and documented in Appendix B of chronic overcrowding and hugely extended wait times in Mission's emergency room under HCA's management.[381] One possible explanation emerges from interviews with those who currently or

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[372] www.leapfroggroup.org/sites/default/files/Files/2014LeapfrogReport_NursingWorkforceBestPractices_Final.pdf

[373] https://ratings.leapfroggroup.org/sites/default/files/inline-files/2023%20Nursing%20Workforce%20Factsheet.pdf

[374] Yet another possible example is the practice reported at some other HCA hospitals of encouraging patients with little prospect for survival to enroll in hospice, even though doing so does not necessarily alter the care they receive. According to these reports, a motivation for encouraging hospice is that, when under hospice care, a patient's death is not counted against the hospital in its mortality statistics.
https://doctorow.medium.com/americas-largest-hospital-chain-has-an-algorithmic-death-panel-5d6df28e2648
https://hcacarecrisis.org/hospice-transfers/
https://avlwatchdog.org/wrongful-death-suit-filed-against-hca-mission-alleges-catastrophic-medical-error-other-missteps/. One possible indication of this happening at HCA Mission comes from allegations in a malpractice case against Mission filed in 2024. https://www.nbcnews.com/health/health-care/doctors-say-hca-hospitals-push-patients-hospice-care-rcna81599. See also Appendix ___.

[375] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5517312/

[376] https://data.cms.gov/provider-data/dataset/yv7e-xc69

[377] https://www.medicare.gov/care-compare/details/hospital/340002?city=Asheville&state=NC&measure=hospital-timely-and-effective-care. Since measures are reported in whole numbers, this likely signifies less than 0.5.

[378] The other three Mission hospitals report 1 percent.

[379] https://data.cms.gov/provider-data/archived-data/hospitals

[380] In 2021 Mission reported one percent.

[381] https://www.beckershospitalreview.com/legal-regulatory-issues/north-carolina-ag-sues-hca.html

previously worked in Mission's ER, explaining how HCA Mission may be classifying being "seen" in a manner that "games the numbers." As discussed in Part 3, HCA has instituted a screening and triage process that entails doing abbreviated medical exams in the ER waiting room or triage area, but then leaving patients to wait many hours before receiving fuller evaluation and proper treatment. If HCA Mission were to record a cursory triage or screening assessment as being "seen," then this measure would show favorable performance even if a patient were to leave without a proper examination.

Thus, there is a plausible hypothesis that, more than actual substantive enhancements, HCA's management and reporting practices in classifying components of ER patient care explain the sudden, sharp, and unique improvement in this one quality performance measure. Similarly, other management practices could affect how well other data components reflect true quality. Whether this hypothesis is accurate, and the extent to which it accounts for Mission's continuing high performance on various quality measures, is unknown. It is known, however, that, as a general matter, HCA excels at data analysis and process management.

QUALITY RATINGS IN PERSPECTIVE

Even crediting Mission with the full benefit of its favorable ratings under HCA, it is clear that Mission is no longer at the level of excellence it had achieved prior to HCA. Patients' ratings of their hospital experience have plummeted to the lowest level, and Mission no longer regularly scores at the highest levels under the more rigorous and widely respected systems that rate overall quality. Some objective measures of quality and patient safety are still high, however, and others are still respectable.

Despite maintaining respectable ratings, several area physicians noted cause for concern. They said that staffing cutbacks and turnover discussed in Part 3 have made medical mishaps more likely. Even though, in their experience, serious adverse events have mostly been avoided, these sources report that safety incidents are much more common than before -- happening "every single time we admit a patient" according to one doctor and "probably one every shift" according to another. This has amounted in one physician's view to a "flood of near misses" where bad outcomes are avoided only by knowing there is now a need to exercise much greater vigilance to double check aspects of care that previously were not an issue. As another physician described things, under HCA it feels "like juggling eggs, with more being thrown at you all the time, and having to catch them just before they hit the floor. So far [we] have been able to do that, but at some point . . . "

On the whole, the decline in quality under HCA left several observers with a feeling of resignation that, over time, "things will probably stabilize and we'll be left with a perfectly mediocre hospital," but never one that is again "great" or "nationally ranked." Several stressed that, despite plummeting patient ratings and diminished quality metrics, HCA has no real incentive to do better than average, acceptable, or enough to "stay out of trouble," considering that doing better "does not matter" if patients and physicians "have nowhere else to go." Many informed sources thought that this overall culture of passable quality is in sharp contrast with how Mission previously had been characterized, when national experts said that, at Mission,

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https://mountainx.com/news/mission-patients-endangered-by-emergency-department-transfer-procedures-nurses-say/
https://www.citizen-times.com/story/news/local/2023/11/02/mcdowell-ems-says-hca-fails-to-correct-emergency-department-issues/71419332007/
https://www.citizen-times.com/story/news/local/2023/11/13/buncombe-may-change-mission-emergency-dept-patient-handoff-policy/71530048007/

"the drive to do whatever it takes to provide the best possible care seems to permeate the organization, from the Board to the executive levels to the bedside—… not just reacting and responding to problems but taking action to move the institution ahead and keep it strong."[382]

[382] https://www.commonwealthfund.org/publications/fund-reports/2004/jul/hospital-quality-ingredients-success-case-study-mission

Part 5: Mission Hospital Charity Care Following HCA's Acquisition

BACKGROUND AND SUMMARY

When a for-profit company acquires a nonprofit hospital, a major concern is always what becomes of the nonprofit's commitment to charity care. This was certainly the case when it was announced in 2018 that HCA would purchase Mission Health based in Asheville, NC. One of the core conditions of the Asset Purchase Agreement (APA) was that HCA would maintain a charity care policy generally equivalent to what Mission had in place, or to what other large nonprofit hospitals have.[383] Prior to signing that agreement, Mission assured the public (on a FAQs website it maintained about the sale) that "Joining HCA Healthcare would not change how Mission approaches … treatment of the uninsured in any way," and that "Mission's charity care would absolutely continue under HCA."[384]

Moreover, HCA claimed, and Mission agreed,[385] that HCA's standard charity care policy was actually somewhat more generous than what Mission had at the time. Therefore, when HCA let Mission decide whether to keep its current charity care policy or switch to HCA's, Mission's Board, after analysis, opted for

[383] https://searchwnc.files.wordpress.com/2018/09/388077864-mission-health-hca-healthcare-inc-asset-purchase-agreement-aug-30-2018.pdf

[384] https://web.archive.org/web/20180409082221/https://missionhealthforward.org/faqs/
https://web.archive.org/web/20180331010545/https://missionhealthforward.org/faqs

[385] On its FAQs website about the proposed sale, Mission said that HCA "has one of the most generous charity care policies in the industry, even more generous than Mission Health."
https://web.archive.org/web/20180409082221/https://missionhealthforward.org/faqs/
https://web.archive.org/web/20180331010545/https://missionhealthforward.org/faqs/

HCA's policy. Principally, this is because HCA's policy covers households up to four times the poverty level, whereas Mission had covered up to only three times poverty. For instance, in 2024 HCA's policy covers a single person earning up to almost $60,000, compared to less than $45,000 income if Mission had kept its prior policy. For a family of four, the equivalent comparison would be $120,000 rather than $90,000 household income.

In practice, however, this Part finds that genuine charity care has diminished in systematic and extensive ways following the sale to HCA, with unfortunate effects on access to health care in western North Carolina. This has occurred as a result of a number of factors, including:

1) non-obvious limitations that make the charity care policy less generous than what was promoted;

2) more cumbersome procedures for approving charity care; and

3) financial policies requiring prepayment that disproportionately affect low-income patients.

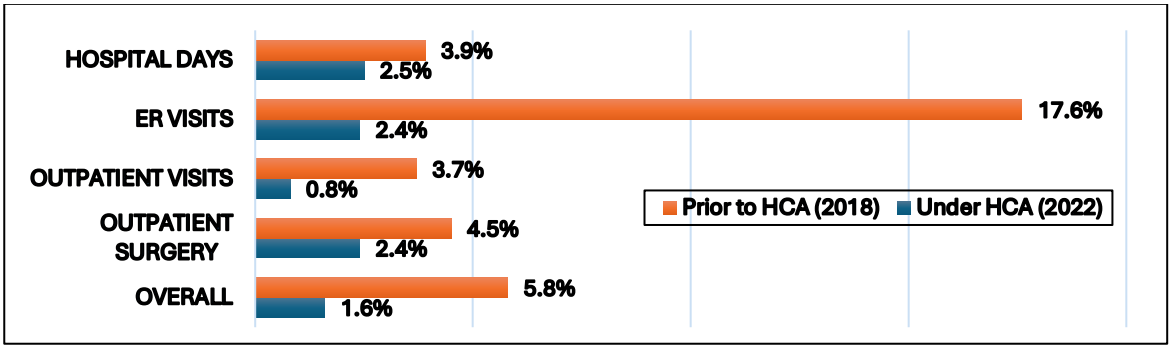
As a result, the proportion of patients that Mission Hospital reports as being treated on a charitable basis dropped substantially, and low-income patients who are uninsured no longer reliably receive care regardless of their ability to pay.

This Part provides a detailed account of how and why Mission Health's charity care has diminished following the sale to HCA despite its previous leaders' contrary expectations.

CHANGES IN REPORTED CHARITY CARE SERVICE

Mission claims that it provides more charity care under HCA than it did previously.[386] That claim is based on financial data examined below, but to verify the claim from another data source, we start by examining data that Mission reports to the state each year on the number of charity patients (measured by various units of service).[387] Snapshots from 2018 (the last year before HCA) and 2022[388] show a substantial, and in some respects precipitous, drop in charity care services.

Figure 1: Percent of Service Units Classified as Charitable



[386] https://6953d107-2bae-4c3d-a042-af970d2bcbe1.usrfiles.com/ugd/6953d1_cc713a9e92634f6fb876b1f9a72b7e90.pdf

[387] https://info.ncdhhs.gov/dhsr/mfp/data/hospital.html.

[388] Mission data appears partially incomplete for several years under HCA, but 2022 data appears to be complete.

The percentage of hospital days Mission reported as charity dropped by a third (from 3.9% to 2.5%), and the percentage of outpatient surgeries done as charity fell by almost half (from 4.5% to 2.4%). Stunningly, the proportion of emergency room visits Mission reported as charity plummeted 86 percent, with a similar drop of almost 80 percent for charitable visits to outpatient clinics. Overall, Mission reported a 72 percent drop from (5.8% to 1.6%) in the proportion of its visits or days that were for charity patients.

HCA Mission does not appear to consider these steep declines as being anomalous. In several applications to the state for "certificate of need" approvals of various services, Mission projects that charity care service will remain at these reduced levels, equivalent to what it has reported in these initial years under HCA ownership.[389]

UNEXPECTED LIMITATIONS IN HCA'S CHARITY CARE POLICY

This unexpected result arises directly from several critical limitations in HCA's charity care policy – both in terms of what it says and how it has been implemented. A readily apparent limitation is that HCA's policy does not promise to cover any bill less than $1,500.[390] Other limitations, however, are not at all readily apparent.

Emergent Care Only

Mission's prior charity care policy applied to all medically recommended services (as do charity care policies at most other hospitals), but HCA's policy applies *only* to "emergent, non-elective" services.[391] The phrase "emergent, non-elective" uses technical terms of art within the hospital industry whose meaning is not at all evident, even to many who work in health care. The key contrast is *not*, as it might appear, between care that is entirely discretionary versus care that is medically necessary. Instead, the contrast is between all medically recommended care versus care whose need is especially urgent. The core idea is that medically necessary care is considered "elective" if it can be scheduled and therefore delayed if need be, whereas "emergent" care must be done right away.

One well-documented explanation of this key distinction[392] (from a leading physician-advised[393] consumer information website) explains:[394]

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[389] For instance, in a 2023 application for a new PET scanner, it projected that, through at least 2027, 0.8% of patients served and 0.7% of revenue generated will be on a charity care basis. This projection is based on Mission's current or recent level of charity care for similar service.

[390] Such bills are covered only at the hospital's discretion, in unspecified "extenuating circumstances." Although Mission's previous policy did not have this particular limitation, it did impose some graduated partial payment obligations. However, as noted below, it did not require these payments prior to receiving treatment.

[391] https://missionhealth.org/financial-services/financial-support/

[392] Similar explanations can be found in other sources cited in this section, and in:
https://www.health.harvard.edu/blog/what-to-do-when-elective-surgery-is-postponed-202110202620
https://amastyleinsider.com/2013/01/23/emergency-emergent-urgent
https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/types-of-surgery
https://en.wikipedia.org/wiki/Elective_surgery

[393] "The website is maintained by 120 health experts, including doctors, trainers, dietitians, specialists, and other professionals, with the content being reviewed and approved by board-certified physicians."
https://en.wikipedia.org/wiki/Verywell

[394] https://www.verywellhealth.com/elective-vs-nonelective-surgery-5409504 (with emphases added).

> "Elective surgery" is the term used for a procedure that can be safely delayed without great risk to a patient's health, such as cataract surgery. A nonelective (or emergency) surgery is a procedure that must be performed immediately for lifesaving or damage-preventing reasons, such as in repairing a brain aneurysm. While both types of surgery are medically important for a person's health, there are key differences between the two. . . . Simply put, what is not an emergency is considered to be elective surgery. This means that the procedure can be scheduled in advance or postponed without compromising the patient's health and safety.
>
> Contrary to popular belief, the term "elective" does *not* mean that the surgery is optional or unimportant; it simply means that the procedure is not quite as time-sensitive as nonelective surgery. In fact, most elective surgeries are considered to be essential and medically necessary, whether it's for a major condition (such as a hip replacement) or a more minor one (such as cataract surgery). Other examples of elective surgeries [include]: Diagnostic surgery, like an endoscopy; Joint replacement; Kidney stone removal; Carpal tunnel release. ... Examples of nonelective surgeries include procedures to treat: Cardiac emergencies, such as heart attacks or cardiac shock; Limb amputation; Brain aneurysm; ... Certain cancers; Abdominal or bowel blockage.
>
> Researchers estimate that about 90% of surgeries performed in the United States are considered to be elective, … [and] that nonelective general surgeries represent about 11% of hospital admissions.

Becker's Hospital Review, a leading industry news service, reports that "some healthcare professionals want the public to know exactly how important an 'elective' procedure can be," explaining that elective "does not describe the acuity of the medical condition or necessity of the procedure. Rather, the use of 'elective' distinguishes those surgeries that are scheduled in advance from emergency surgeries, such as trauma cases."[395] According to one physician *Becker's* interviewed, "Whether it's pain from a chronic hernia or the inability to adequately eat because of biliary disease, these ["elective"] issues can be debilitating." To clarify this understandable confusion, the reporter notes that "physicians are taking to the web to debunk what can be a misnomer, ... [and] can sometimes be deceiving."

In the current study, a professional who works with low-income patients gave as a chilling example someone who had developed an aneurysm that was at risk of rupturing. Had it ruptured, the patient could have suffered severe brain injury or even died, but because they were not in immediate distress, HCA Mission refused charity care.

These term-of-art distinctions are obscured in the Asset Purchase Agreement (APA) that specifies HCA's purchase commitments. The APA requires any changes to Mission's charity care policy "to provide no less access to *necessary medical care* regardless of the ability to pay" than under Mission's previous charity care

[395] https://www.beckershospitalreview.com/hospital-physician-relationships/don-t-let-the-term-elective-fool-you-physicians-urge-the-public.html. The article quotes one academic physician, for instance, who said "'elective' surgery doesn't mean optional, it just means it doesn't have to happen right now at 3 a.m. . . . Most cancer and heart surgeries, for example, are 'elective' in that we can schedule them for Tuesday."

policy – using phrasing that at least suggests – contrary to what HCA's actual policy provides -- that coverage is intended for medically necessary care generally.

Due to the obscurity of these technical meanings, both Mission's board and its managers appear to have been largely, or almost entirely, unaware of the "emergent-only" limitation in HCA's charity care policy. Mission's charity care policy at the time appeared to equate "elective" with "not medically necessary" – a sensible interpretation, but not the one that governs HCA's charity policy. Board members who were interviewed, including some senior members, said that the emergent-only limitation was not given any attention in deliberations and did not come up in discussions. One reason noted for this lack of awareness is the relative lack of experience that many Board members had in the hospital industry, which some former Board members said was a distinctive feature of the 2018 Board that handicapped its deliberations about the hospital's sale.[396]

Despite the confusion that can be anticipated, Mission's charity care policy does not explain these critical distinctions in any way. Initially, Mission did not provide the public any copies of HCA's policy, despite repeated requests.[397] After what one source described as "giving them enough hell," HCA finally posted its policy, but the posting still does not explain what "elective" care means nor does it draw any attention to the crucial difference between medically necessary care generally and care that is especially urgent.[398]

Instead, HCA appears elsewhere to obscure or deflect attention from this key contrast. In responding to the NC Attorney General's inquiry about what exactly HCA's charity care policy does and doesn't cover, Mission's President contrasted a ruptured appendix, which is covered, with "elective procedures, such as cosmetic surgery," which aren't covered.[399] This fails to acknowledge or even allude to the fact that HCA's interpretation of "elective" also excludes a wide swath of medically necessary care that is non-emergent.

The meaning of "elective" hospital care is now apparent, however, due to the COVID-19 pandemic. To protect patients from infection and cope with surges in critical hospital care, most hospitals cancelled or postponed all elective care for several months during the COVID crisis, in order to focus on the most emergent needs. This unprecedented strain on hospitals brought focused attention to how the "elective" vs. "emergent" concepts apply.

Early in the COVID-19 pandemic, the federal government issued guidance that described non-elective services as those needed to "save a life, manage severe disease, or avoid further harms from an underlying condition."[400] In contrast, guidance from the NC Department of Health defined "elective and non-urgent" as any treatment that could safely be postponed for a month.[401] Various medical groups and experts issued additional guidance that provided specific examples of procedures that were, or could be, considered elective. These included: kidney stone removal, cancer biopsy, hernia repair, hysterectomy, cardiac valve

[396] These sources also speculated that Mission's management preferred less experienced Board members because that made them more dependent on management's explanation of relevant factors and considerations.
[397] https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/
[398] https://missionhealth.org/financial-services/financial-support/
[399] https://avlwatchdog.org/wp-content/uploads/2020/05/Mission-charity-care-responses-3.pdf
[400] https://www.cms.gov/files/document/covid-elective-surgery-recommendations.pdf
[401] https://covid19.ncdhhs.gov/covid-19-elective-surgeries-final-0/open

replacement, joint replacement, orthopedic injury repair, back-pain surgery, early stage surgery for various treatable cancers, and possibly even scheduled Cesarean deliveries.[402]

Consequences of Limiting to Emergent-Only

Clearly, then, "elective" does not mean optional or even unimportant. As one hospital system warned, "Elective surgeries are vital to a patient's health and well-being. … Breast cancer surgery like a mastectomy is critical to address, even though it might not qualify as an emergency procedure needing to be done [right away]."[403] A group of international physicians similarly cautioned that "[m]any non-emergent surgeries, such as for cancer care, may face dire consequences if delayed considerably."[404]

These statements of concern address possibly *postponing* elective care until normalcy is restored. Under HCA Mission's application of the concept, however, care that can be postponed for a limited time is, in effect, postponed *indefinitely*. For some patients, that means permanently. For others, it means until a patient's condition worsens to the extent it is an emergency, or something close to one. The obvious concern, of course, is that by the time things get that bad a patient's chance of recovery is quite possibly diminished greatly. With cancer, for instance, stage 1 progresses to stage 2 or 3 – which is still not hopeless, but favorable outcomes become substantially less likely. Similarly, absence of early intervention for treatable cardiac disease or other major organ dysfunction means a patient's condition continues to deteriorate before postpone-able care becomes "emergent."

Yet other medical conditions would likely never qualify as non-elective because they are chronic conditions people conceivably can just live with. Examples might include hernia repair, major joint replacement, serious back pain, debilitating carpal tunnel syndrome, various sports injuries, and the like. If these do not cross the line from postpone-able to emergent, then many people obviously will be left to cope indefinitely with considerable pain or serious physical limitations. These are conditions that prevent people from working and that can cause them to slide into depression or become more susceptible to substance abuse.

These COVID-specified applications of the elective, non-emergent concept do not necessarily describe exactly how HCA has chosen to implement its charity care policy, at least so far. It is possible – and indeed likely – that HCA has chosen, at least sometimes, to be somewhat more generous, perhaps due in part to the scrutiny its management has received. The experience under COVID illustrates, however, how HCA might further restrict its charity care policy in the future.

Moreover, the uncertainty about how exactly Mission will draw the elective/emergent line means that physicians who refer patients for medically necessary charity care no longer have the authority they previously had to determine what services are important enough to merit this request. As explained by several sources, each such referral has to go through what one source called "the HCA chain of command." That uncertainty and delay was said to add greatly to the difficulties, discussed in the next section, in

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[402] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7107008/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9388274/
https://www.adena.org/health-focus-blog/detail/adena-health-focus/2022/11/01/elective-surgeries/
https://www.facs.org/media/wfjhq0jw/guidance_for_triage_of_nonemergent_surgical_procedures.pdf
[403] https://www.osfhealthcare.org/blog/what-is-an-elective-surgery/
[404] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9388274/

determining in a timely manner whether or not a particular patient's specific medical needs are in fact eligible for charity care.

Determining Charity Status only AFTER Receiving Care

In addition to excluding medically necessary care that is not emergent, HCA has imposed several notable administrative barriers to receiving charity care that were not present under Mission's previous policy. Most significantly, HCA does not readily administer its policy in advance of treatment. Instead, typically –and by several accounts almost always – Mission now determines charity care eligibility only *after* a patient has received treatment. Based on several reports, the determination usually is made once a patient receives a bill they cannot pay, at which point it's often the case that Mission has already initiated at least an internal collections process; quite possibly, HCA may determine charity status after sending patient bills to a collection agency. [405]

Classifying care as charitable only after billing a patient is inconsistent with charity's widely accepted meaning, which is to offer care with no intent to charge for it. The American Hospital Association, for instance, states that "charity care is care for which hospitals never expected to be reimbursed,"[406] and they elaborate that:

> Hospitals typically use a process to identify who can and cannot afford to pay, in advance of billing, in order to anticipate whether the patient's care needs to be funded through an alternative source, such as a charity care fund.[407]

Certainly, this is not always done, and other hospitals regularly convert some billed charges to charity status during a financial assistance process. At HCA Mission, however, post-treatment determination appears to be the overwhelming norm rather than an exception or fallback to a general pre-treatment determination practice.

In one sense, determining charity eligibility only after treatment is consistent with HCA's policy restriction to emergent care, because much emergent care arises unexpectedly, without an opportunity to determine financial assistance in advance. But conceivably some emergent care can be anticipated, and thus should be eligible for determination prior to treatment. Nevertheless, based on many reports this rarely happens, likely due in large part to the administrative barriers discussed below.

Requiring Multiple Re-applications

Another barrier to charity care arises from how frequently patients must go through the application process. Unlike Mission's prior practice, HCA does not normally extend eligibility for charity care beyond a single episode of treatment. One patient advocate who dealt with HCA's process explained, for instance, that if an unlucky (or clumsy) person injures their shoulder in a car accident, then falls down some stairs, and then slices themselves with a kitchen knife, they would have to fill out the entire charity care paperwork each time

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[405] In the Independent Monitor's July 2024 report finding that HCA was "in potential non-compliance with" one aspect of its charity care commitment, the Monitor noted that had failed to respond when "specifically asked to confirm that patient billings that qualify for [charity care] are not subject to any collection procedures," suggesting that as least some charity-eligible patients are subject to collection efforts. Page 28 of https://dogwoodhealthtrust.org/wp-content/uploads/2024/07/IM-Annual-Report-Compliance-Evaluation-2023_FINAL.pdf

[406] https://www.aha.org/system/files/content/00-10/10uncompensatedcare.pdf

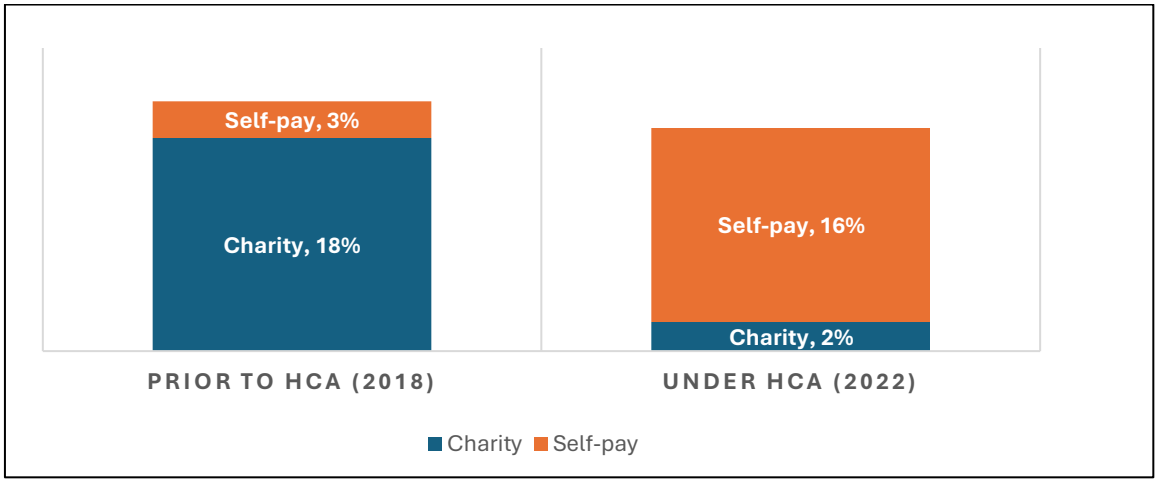
[407] https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost

they sought care, even if this all happened in fairly quick succession, requiring them to "go up the flagpole" of approvals each time.

In sharp contrast, Mission's practice, like that of similar hospitals, had been to maintain a patient's charitable eligibility for six or twelve months, once eligibility was established. Doing that allowed low-income uninsured patients to know they could obtain any necessary follow-up care, or address any newly emerging medical needs, without having to undergo frequent, repeated re-applications. HCA's position, however, was said to be that frequent re-application makes sense because a patient's eligibility for Medicaid or subsidized insurance can change from month to month based on various family and financial circumstances.

A telling indication of the change in Mission's pre-approval policy and practice for charitable service is a sharp shift in how Mission classifies the payment status of emergency patients. Based on data Mission reports each year to the state,[408] in 2018, the last full year prior to HCA's purchase, Mission classified 17.6 percent of its emergency patients as covered by charity. Under HCA, that plummeted to only 2.4 percent in 2022.

Figure 2: Charity Status of Emergency Patients Before and After HCA's Acquisition



Mission reported in 2018 that three percent or less of emergency patients were "self-pay" (i.e., non-charitable and without insurance), but under HCA that percentage shot up to 16 percent (for 2022). Likely, the proportion of emergency patients that are low income and uninsured did not change substantially, and certainly not this dramatically. However, prior to HCA, Mission had previously screened many of those patients as eligible for charity care and so continued to recognize them as such when they sought emergency care. That continuity of status did not continue for most patients, however, under HCA.

Frequent re-application would be more palatable if the process were not laborious, but under HCA it reportedly is, as discussed below. Several aspects of Mission's policy facilitated or expedited the application process, such as presuming eligibility based on enrollment in other social service programs, and accepting attestations of income if tax forms or pay stubs were not readily available. In contrast, HCA's practice under its policy was described as, and seen to be,[409] much more exacting in the documentation required. As one patient vented at a public meeting, qualifying for charity care used to be "a piece of cake" but now "it's a

[408] https://info.ncdhhs.gov/dhsr/mfp/data/hospital.html
[409] https://web.archive.org/web/20221121133049/https://missionhealth.org/wp-content/uploads/2022/11/508_Mission-Health-Website-FAA.pdf

terrible, terrible thing [that] now I've got to jump through seven hoops and wonder, Am I going to be lucky or not?" Because of this, the patient said they have basically stopped trying to qualify because "I'd rather die in peace."

Requiring Advance Deposits Regardless of Ability to Pay

Insisting that low-income patients pay a deposit prior to treatment is another HCA Mission policy inconsistent with the concept of charity and normal charity care practice. Prior to HCA's purchase, when Mission was asked whether HCA can "refuse to treat patients who do not pay for treatment upfront," Mission answered (on a FAQs website): "Absolutely not."[410] That has not turned out to be the case, however. Instead, according to multiple reports from professionals with hands-on experience, HCA Mission regularly refuses care to charity-eligible patients who cannot pay a substantial deposit prior to treatment. This is also confirmed by patients' own descriptions of their experience, collected in Appendix B. These multiple sources indicate that, repeatedly, patients eligible for charity care who were scheduled for needed service had their appointments cancelled for failing to pay an advance deposit.

One source, for instance, described a surgeon who noticed that scheduled surgeries were being cancelled without any notice to them. After inquiring, they learned that HCA Mission called patients the day before a surgery, or sometimes just the evening before, to ask for pre-payment, and, if that was not received, HCA Mission cancelled the surgery without any notice to or consultation with the physician. Another clinician likewise said they discovered this practice only after inquiring, which explained why "a ridiculous number" of people were not showing up for scheduled service. A third source explained that cancelling service without notice to the referring clinician could easily result in a patient who needs critical care, such as cancer treatment, not receiving it without the referring clinician having any reason to know.

Some of these examples are not restricted to charity care, but other sources recounted similar experiences with charity patients specifically, noting in the words of one that this was "happening left and right." (See also Appendix B.) They also noted that the HCA personnel asking for a deposit were not inquiring whether the patient was, or might be, eligible for charity status. When clinicians do learn this happens, one reported that it took "frantic calls" and another said they had to "fight back" to get situations straightened out, especially when the treatment was critically needed.

Staff Shortage and Inadequate Training

Compounding these various difficulties is HCA Mission's substantial staffing turnover and cutbacks described in Part 3. By all accounts, these staffing issues have made it much more difficult than before to determine charity care eligibility at Mission. Multiple sources described, in sometimes colorful or salty terms, the frustration felt when they repeatedly were unable to reach HCA staff with knowledge and authority to address charity care issues. One clinician said that it takes "hours of time" just to get approval for a single routine visit or procedure. Other clinicians or patient navigators referred to HCA's "impenetrable systems" and "obtuse" application process that imposed a "huge onus of paperwork." They also bemoaned the absence of any "peer to peer" contact and several noted having to remain on hold for very extended periods of time. Appendix B provides additional accounts.

[410] https://web.archive.org/web/20180409082221/https://missionhealthforward.org/faqs/

Adding to these burdens, following HCA's acquisition Mission Hospital declined, for nearly four years, to make its actual charity care application readily available to the public and the medical community.[411] That refusal caused a great deal of confusion and uncertainty about what was required to receive assistance, even among internal hospital staff.[412] HCA Mission eventually posted the policy only after sustained advocacy pressure.[413]

Finally, exacerbating all of this is the difficulty multiple sources noted in knowing what exactly to say once an HCA person does respond. Although HCA told these sources that it trains its relevant staff on its charity care policy, interview sources said they did "not find this to be true."[414] Their experience was that it took a "constant battle" of communication to address a situation, after which HCA personnel would change and they would have to "start all over again."

The experience of several knowledgeable sources was that HCA's staff usually do not raise the possibility of charity care on their own. Instead, "you have to *know* to ask" and you have to know exactly "the right lingo" to use in in order to make any headway in assisting a patient.[415] As one source summarized, "you have to know the right people, the right wording, and the right contact information" of who to talk to, and so "no normal person would *ever* know how" navigate the process.

Net Effects: Emergency Service Only

This poorly designed approach to arranging charity care has caused a great deal of frustration and even anger, for both the general public[416] and for many in the medical community. Appendix B provides excerpted examples, all of which resonate with accounts heard during interviews for this study. One key informant who previously had gathered pertinent information to better understand the charity care problems under HCA, said that they "didn't get one example of this [new charity care policy] working." Several others, with extensive experience, stressed that this has all been "a huge change" from how charity care worked prior to HCA. Before, they "never had a problem" and could "always get care" when needed, but that now trying to do the same is a "nightmare."

As a result, several professionals said they have "mostly stopped trying" for charity care approval at HCA, unless the service needed is not available elsewhere. Even for potentially eligible patients who have received a bill from Mission, several professionals said they no longer advise patients to apply for charity care because the effort is too frustrating and futile. One clinician tells their patients needing hospital care to just "cross your fingers and wait for Medicaid expansion," but in the meantime, "I'll just manage the symptoms as best

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411 https://www.beckershospitalreview.com/finance/hca-owned-system-yet-to-make-charity-care-application-public-despite-push-from-advocates
https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/

412 One source recounted that an HCA employee told them: "There have been several versions of the policy; people don't know what it is. There's no education. None of us know how to implement it."

413 https://www.beckershospitalreview.com/finance/patient-advocacy-leads-north-carolina-hospital-to-post-charity-care-application-online.html

414 One source recounted that an HCA employee told them: "There have been several versions of the policy; people don't know what it is. There's no education. None of us know how to implement it."

415 For instance, one clinician said that the magic word needed to reconsider an initial refusal was to request an "escalation."

416 https://www.citizen-times.com/story/news/local/2020/05/24/hca-missions-charity-care-letter-stein-has-info-asheville-wnc/3107646001/
https://web.archive.org/web/20230924064347/https:/www.independentmonitormhs.com/community-events-archive

I can." Another says he and colleagues "have resorted to using the ER to get our patients the care they need for things that could have been managed [outside] the ER." Yet another, who said they still have not been able to get one of their patients qualified under HCA, instead sends their patients who need charity care to other institutions.

Other sources noted that diverting charity care to other hospitals is thought to be a common HCA strategy. Elsewhere, HCA hospitals usually are near enough to other hospitals that erecting charity care barriers does not create as much of a problem or draw as much attention. Mission, however, was said to be distinctive because it is "a prepackaged monopoly." In western NC, other hospitals often are too far away or do not offer the necessary service. That is why one source said this change in charity policy has been "so devastating to our community."

At HCA Mission the only workable way to obtain "necessary medical care regardless of the ability to pay" (as specified in the Asset Purchase Agreement and as promised in its 2011 Certificate of Need application) appears to be through the emergency room. Reflecting that reality, multiple sources noted that, to receive charity care, patients effectively have to, as one put it, "wait until the issue flares up enough to go to the emergency room." In the emergency department, all care is presumed, at least initially, to be emergent, and federal law requires at least stabilizing care regardless of the ability to pay. Patients will still be billed for this care, but once they receive a bill they can then apply for charity write-off, which usually is a lengthy and cumbersome process.[417]

This pathway for charity care can meet a limited set of needs – mainly for unexpected medical emergencies – but this narrow pathway does not reasonably accommodate those who need to arrange in advance for care, even for very critical care. Sources explained that, in effect, in such predicaments western North Carolinians are best advised to go unannounced to Mission's emergency room (ER). As discussed in Part 3, however, its ER is often chaotic and massively overcrowded, requiring patients to suffer through delays extending many hours and sometimes days. Due to wanting to avoid that ER experience if at all possible, physicians interviewed said that many people who need charity care simply wait until their condition worsens, to the point that it truly is an emergency.

CONFUSING REPORTS OF FINANCIAL ASSISTANCE AMOUNTS

Considering the significant substantive limitations and administrative hurdles described so far, one would expect HCA to report providing much less charity care than Mission previously did, but that is not consistently the case. On the one hand, the earlier discussion shows (in Figure 1) that there has been a substantial, and in some respects precipitous, drop in charity care services.[418] Equivalent drops are not seen, however, when measured in reported dollar value rather than in numbers of patients. Using data Mission submits each year

[417] The fact that, under HCA, Mission predominantly determines charity status only after billing a patient is reflected by data, noted above, showing that the total percent of emergency patients who are uninsured remains similar prior to and after HCA's acquisition, but Mission now reports a much larger proportion of those uninsured emergency patients as being simply "self-pay" rather than as charity patients.

[418] This sharp drop is also confirmed by a certificate of need application HCA Mission filed with the state in 2019, in which it reported that the proportion of hospital services for charity patients (measured by gross revenues) dropped in half (from 3.1% to 1.4%) between 2018 and 2019.

to the federal government, HCA claims that Mission Hospital now provides substantially more financial assistance than prior to the purchase, amounting to $300 million a year.

That sum vastly overstates the true value, however, because it is based on discounts from list-price charges. Mission, like most hospitals, sets its list-price charges many *multiples* higher than its costs, and many multiples higher than it typically receives in actual payments. In fact, almost no patient actually pays full charges (other than for fairly miniscule bills). Accordingly, the standard practice (endorsed by the American Hospital Association) is to report charity care in terms of hospital *costs* rather than charges that are discounted or written-off.[419]

Measured in terms of costs, though, HCA Mission still appears to be doing well. For the five years prior to the purchase (2014-2018), Mission reported that 3.3% of its total patient care costs counted as charity care. For the first five years following the sale (2019-2023), HCA reported that this figure increased to 4.4%. That report poses a puzzling discrepancy between the drop in *units* of charity care service documented above and the increase in *dollar value* of financial assistance. Understanding that discrepancy requires a more nuanced understanding of what constitutes charity care versus other forms of financial assistance.

Multiple Forms of "Financial Assistance"

Hospitals classify uncollected charges as either charity, bad debt, or general "uncompensated care." Reflecting these differences, Mission has not just *one* financial assistance policy, but *four*.[420] Mission's classic charity care policy, which can write off charges entirely, applies to patients up to twice the poverty level. Its "expanded" charity care policy, which applies to patients up to four times poverty (essentially middle class), charges patients but caps charges for any given episode of care at 3-to-4 percent of household income.[421]

Mission also has a "liability protection" plan, which it does *not* appear to regard as a "charity" policy. Liability protection offers discounts (of unstated size) to people even with insurance if they incur a large bill that insurance does not cover. Mission has not made details of this plan publicly available,[422] but it states that it applies to households up to 10 times the poverty level (which would be upper middle class).

Finally, Mission has an "uninsured discount policy," which applies without regard to income. For people who pay out of pocket (i.e., without using insurance), this policy simply discounts charges by a remarkable 83 percent on average, but only if patients pay in full at the time of treatment (or commit to a monthly payment plan). Essentially, then, this is a prompt pay discount. As such, it is simply a *pricing* policy rather than a financial assistance policy. The eye-catching size of this discount reflects the extent to which HCA routinely marks up list-price charges over amounts it actually expects to collect from most patients.

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[419] https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost

[420] https://missionhealth.org/financial-services/financial-support/

[421] Apparently, patients are required to pay up to that amount for each treatment episode, even if there are several in a row.

[422] In response to the Attorney General's request, Mission provided HCA's liability protection plan for ambulatory surgery centers rather than for its hospital. https://avlwatchdog.org/wp-content/uploads/2020/05/Mission-charity-care-responses-3.pdf. For people with bills over $10,000, that policy offers discounts ranging from 50 percent down to 20 percent for households up to five times poverty.

These multiple layers of possible financial assistance make it difficult to draw apples-to-apples comparisons between pre-HCA Mission versus Mission under HCA. Stated another way, these multiple policies make it more likely that any such comparison is more apples-with-oranges.

An example of this inherent slipperiness is HCA's April 2020 response to the Attorney General's official inquiry about charity care. Prompted by widespread complaints about changes in HCA's charity care policy and practice, the Attorney General asked Mission for "utilization rates for financial assistance policies" before and after HCA's acquisition.[423] HCA Mission responded that, for the 12 months prior to HCA, "Mission Health provided financial assistance to 72,741 patients under the legacy Mission Health charity care policy" (emphasis added).[424] HCA then stated that, in comparison, in the 12 months following its acquisition "HCA provided financial assistance to 92,652 patients under its current financial assistance programs, including the Charity Care Policy, Uninsured Discount Program and the [Liability Protection] Program ...." In other words, HCA expressly (but subtly, without the emphases shown) compared pre-purchase "apples" with post-purchase "oranges."

HCA gave no indication of how much of the purported increase in financial assistance was due to inclusion of the additional, non-charitable programs. Also, although HCA presumably had the relevant data, it did not include in the pre-HCA assistance count any of the patients Mission previously assisted under its similar discount and liability protection programs. In other words, HCA ducked, and appears to have obfuscated, this aspect of the Attorney General's direct request for a clean before-and-after comparison.[425]

Charity Care vs Uncompensated Care

Understanding these distinctions helps to reveal one key way that HCA has been able to show increased charity care: As shown below, HCA has shifted more of the care that is uncompensated to "charity care" status. These exhibits show changes in reported costs of charity care, as well as costs for other forms of uncompensated care, using data Mission submits each year to the federal government.[426]

To maintain consistency in how these data are reported, and to average out some yearly variations, this comparison aggregates the five years prior to HCA's acquisition, and the first five years under HCA.[427]

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[423] https://ncdoj.gov/wp-content/uploads/2020/02/Stein-Letter-to-HCA-_02252020.pdf

[424] https://avlwatchdog.org/wp-content/uploads/2020/05/Mission-charity-care-responses-3.pdf

[425] HCA's response was similarly mismatched for the dollar value of financial assistance. For pre-HCA, Mission reported only *charity care* amounts. But, for post-HCA, it primarily reported *all* of its financial assistance programs combined. It did, however, break out the separate amounts in a footnote, such that it was possible, with some careful study, to make at least a partial apples-to-apples charity comparison (but based only on list-price *charges* rather than on *costs*).

[426] https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports/hospital-2552-2010-form
https://tool.nashp.org/

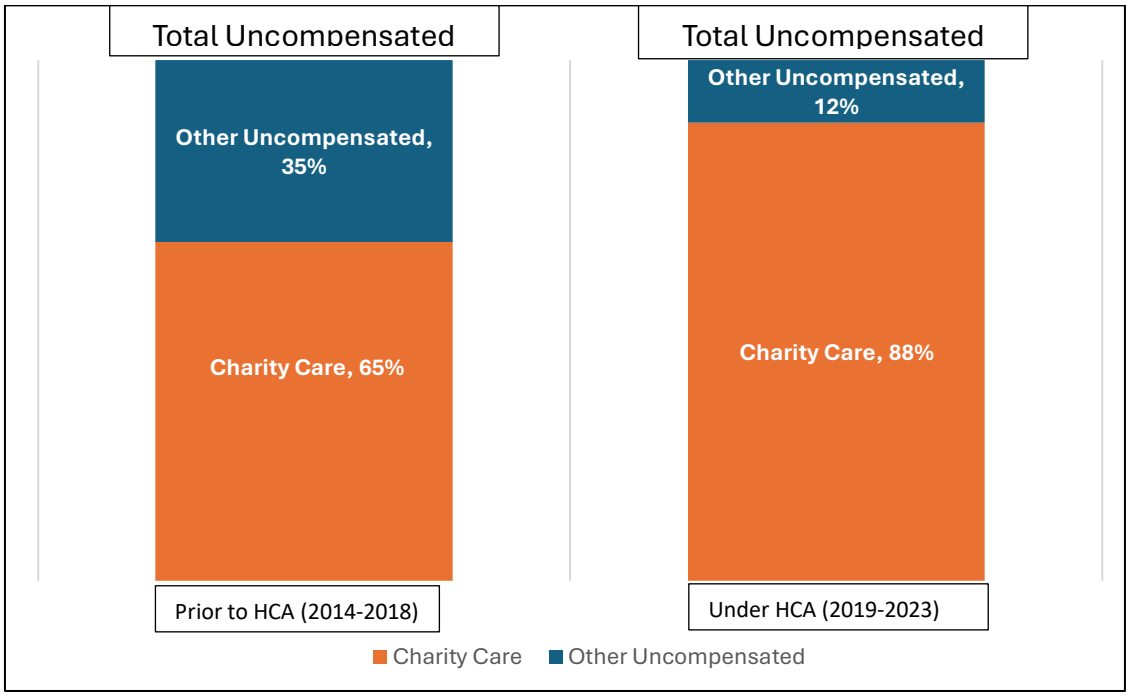
[427] Due to differences in calendar year versus fiscal year reporting, the pre-HCA period is 5.3 years, compared with 3.7 years post-HCA.

TABLE 1. Changes in Costs of Charity Care and Uncompensated Care Following HCA's Acquisition

	Charity as % of Total Care Costs	Uncomp. Care as % of Total Care	Charity as % of Uncomp. Care
Prior to HCA (2014-2018)	3.3%	5.1%	65%
Under HCA (2019-2023)	4.4%	5.0%	88%

Comparing those before-and-after time spans, Mission reported that an identical 5.1 percent of total patient care was uncompensated. A greater proportion of that uncompensated care was charity care under HCA, however, than was the case before HCA took over.[428] Prior to HCA, 35 percent of Mission's uncompensated care was not charitable whereas HCA reports that only 12 percent has been non-charitable.[429]

Figure 3: Reported Uncompensated Care Costs Before and After HCA Acquisition



This sizeable shift in distribution between charitable and non-charitable uncompensated care occurred *immediately* upon HCA's acquisition. Prior to the sale, Mission reported that about half of its uncompensated care was charitable, in both the 4 months pre-sale and in the year prior to that. But, the charitable proportion

[428] A similar pattern can also be seen in the state's service-quantity data, reported above, which show a much greater drop in service to uninsured patients in outpatient clinics than for hospital patients.

[429] Similarly, in its 2022 application to the state for a certificate of need to add 67 hospital beds, HCA Mission projected that it would provide over five times more in charity care than it would write off in bad debt (measured by charges). Stated another way, HCA Mission projected that 85 percent of its total uncompensated care would be in the form of charity care.

Mission reported shot up to almost 90 percent in the immediate 8 months following HCA's acquisition. The shift's size and suddenness indicate this was an accounting change rather than a change in actual composition of patients being served.

This pattern, coupled with problems discussed above in coverage and administration of Mission's financial assistance policies, strongly suggests that Mission has not in fact increased service to low-income patients without adequate insurance. Measured by federal data on financial value, such service appears to be at a similar level under HCA as before. In effect, Mission's revised financial assistance policies have shifted reporting of much uncompensated care from bad debt to reported charity, despite the fact, discussed above, that much of this service may not in fact be offered regardless of a patient's ability to pay.

In contrast, measured by state data (Figure 1), charitable service has dropped noticeably under HCA. It is not at all clear why these two different indicators differ. Possibly, the two different reporting systems have different criteria for classifying charity. It is also possible that some of HCA's reported amounts are not fully accurate.[430] As an example of one or the other of these two possibilities: In a 2019 "certificate of need" application to the state to add 67 more beds, HCA Mission reported that the proportion of hospital services for charity patients (measured by gross revenues) dropped in half (from 3.1% to 1.4%) between 2018 and 2019 – which is only about half the level it reported to the federal government. In any event, it is clear that low-income uninsured patients do not have the same ability under HCA as they did previously to receive non-emergency care regardless of the ability to pay.

SUMMING UP

During deliberations over the hospital's sale, Mission's Board became convinced that HCA's charity care policy is more generous than what Mission then had in place. Mission's executives also assured the public that HCA's purchase would not diminish the hospital's charity care commitment. Neither of these representations turned out to be accurate.

These expectations were based on the appearance that, although HCA's policy does not readily apply to bills less than $1,500, HCA's policy reaches higher incomes than did Mission's previous policy. That appearance, however, masks the reality that, in several ways, HCA constrains the availability of non-emergency care regardless of the ability to pay. These constraints arise from both substantive limitations in HCA's policy and from barriers created by how the policy has been implemented. Primarily:

4. The policy does not apply to all medically necessary care, but instead only to treatment with such urgency that it cannot be postponed.

5. HCA typically applies its policy only after eligible patients receive treatment, and HCA usually requires eligible patients to pay a substantial deposit prior to treatment.

6. Various administrative barriers make it exceedingly difficult for qualified patients to obtain, and maintain, a determination of eligibility on an ongoing basis, and the same barriers appear to greatly hamper receiving charity care on an isolated, episodic basis.

[430] One source who worked closely with a substantial number of low-income uninsured patients noted that, when they asked HCA Mission for data about their provision of charity care, they "found lots of errors."

It is curious, however, that available data does not consistently reflect these realities. Data from the state in fact shows a substantial drop in patients treated on a charity basis. Data that HCA Mission reports to the federal Medicare program, however, shows the opposite – that the value of charity care has increased.

A quite plausible explanation for this discrepancy is that HCA has changed how Mission classifies uncompensated care. Rather than regarding many uncollected bills as bad debt, or regarding discounted prices as normal market pricing decisions, HCA appears to use its generous-sounding financial assistance policy to shift a good portion of these uncollected amounts over to the charitable side of its ledgers.

Regardless of whether, or to what extent, this somewhat speculative impression is accurate, it does appear clear that, with the possible exception of its emergency room,[431] HCA Mission no longer treats a substantial number of low-income patients as true charity cases, that is, regardless of their ability to pay and without an intent to collect substantial payment.

[431] Even in the emergency setting, HCA appears to bill low-income uninsured patients for care without first determining if they might be eligible for charity status.

Part 6: Positive or Mitigating Aspects of HCA's Acquisition

Stepping back to assess the overall picture, it is important to consider some of the positive aspects of Mission Hospital's sale to HCA. By setting out to learn lessons from the sale, this study has focused primarily on the problematic aspects, which the Executive Summary summarizes. Before concluding this case study, however, we look to see what advantages derived from HCA's acquisition, or whether there are factors that mitigate the principal concerns.

Positive Aspects

Creation of a Major Foundation

The most visible benefit from HCA's purchase is that the proceeds went to creating a major new charitable foundation (Dogwood Health Trust) that strives to improve health, social justice, and community welfare in a variety of important ways. Relatedly, now that Mission is no longer tax exempt, it pays roughly $15 million a year in state and local taxes.

The charitable foundation created is now valued at close to $2 billion, and it is providing close to $100 million a year in grants to a wide range of community, civic, and educational institutions.[432] Although the foundation experienced some initial birthing pains,[433] it now appears to have strong leaders who are pursuing an impressive set of goals. These goals aim, however, for long-term improvements in fairly diffused "social determinants of health." Therefore, it is difficult to assess what concrete improvements will ultimately emerge.

New and Improved Facilities

Also quite visible is HCA's investment in building or expanding several significant facilities in the Mission Health system. HCA completed construction of a new patient care building on Mission's main campus, it built a replacement for one of Mission's smaller community hospitals, and it built a new behavioral health hospital in Asheville. However, most of these and other substantial capital investments were ones that either were under way or were planned by Mission prior to its sale. Thus, for the most part, these improvements are ones that likely would have happened in any event (had there been either no sale or a sale to someone else).

Similarly, HCA has kept open all five of the smaller community hospitals in Mission Health's system. Prior to the sale, Mission had reduced services (such as obstetrics or some surgeries) at some of these hospitals; thus, there was concern that HCA might make further reductions or might close one or more of them entirely. The Asset Purchase Agreement negotiated with the Attorney General prevented any reduction or closure of Mission's smaller hospitals for the ten years.

By definition, however, that commitment is time-limited, and it is purely speculative whether the purchase agreement will result in more support for these hospitals than would have occurred in its absence. Also, it

[432] https://report.dogwoodhealthtrust.org/2023-annual-report/
[433] https://mountainx.com/news/dogwood-ceo-chiang-takes-unexplained-leave-of-foundation/
https://www.theassemblync.com/place/a-1-25-billion-bet-new-hanover-endowment/

merits notice that, under HCA, physician staffing reportedly has dropped sharply in at least some of these hospitals.[434]

Deep Pockets and Management Expertise

Another advantage that Mission's board anticipated when selecting HCA as the preferred purchaser is the depth of resources and expertise that comes with being part of the country's largest hospital chain. This advantage rose to the fore during the COVID-19 pandemic, when HCA Mission appeared able to access critical supplies and equipment early in the crisis more quickly or effectively than some or many other hospitals.[435] More recently, when hurricane Helene devastated the region, shutting down the water supply for weeks or months, HCA Mission was able to maintain or restore operations by bringing in 20 tanker trucks of water a day, along with fuel, food, and other essentials.[436]

During more routine times, however, Part 3 documents a range of complaints that clinicians have made about supply shortages for specialized medications and sterilized equipment – shortages they had not experienced prior to HCA's management. According to some accounts, HCA uses it superior data analytics and supply-chain management more to reduce costs than to ensure superior performance.[437] That accusation is similar to the observation in Part 4 that HCA uses its impressive prowess in data analytics to present in the best light the particular quality metrics that rating agencies use rather than mainly to make substantive quality improvements across the board.

Unduly Critical Reactions?

For the reasons discussed, it is difficult to point to any concrete lasting improvements that HCA has brought to Mission Hospital. Nevertheless, a viewpoint several informed sources conveyed is that HCA has received excessive criticism, often relating to the same kinds of problems that other hospitals are also facing. Indeed, the other hospital system (Novant) that the board invited to bid alongside HCA a year later purchased a similarly-sized hospital on the other side of the state (Wilmington NC). Under that new management, the coastal hospital has encountered similar problems as HCA Mission, [438] albeit not to the same extent.

This observation gives some credence to view expressed by a couple of Mission's former leaders, that for an important institution such as Mission, many people tend to base their impressions on the level of performance they feel should be expected rather than a more realistic level that reflects the true difficulties that all hospitals face in current and changing economic, political, and public health spheres. In brief, as one

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[434] https://www.northcarolinahealthnews.org/2024/09/28/buncombe-lawsuit-hca-mission-hospital-rural-wnc-hospitals

[435] https://www.citizen-times.com/story/news/2021/05/08/patients-ppe-and-covid-19-lowe-talks-hca-systems-pandemic-year/4986115001/
https://avlwatchdog.org/pandemic-put-pause-on-missions-troubles/

[436] https://www.nbcnews.com/health/health-news/ashevilles-mission-hospital-workers-describe-dire-conditions-storm-rcna173614
https://wlos.com/news/local/hca-healthcare-north-carolina-boosts-asheville-hurricane-recovery-with-1-million-donation

[437] See, e.g., https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/

[438] https://www.wect.com/2022/09/22/state-treasurer-nurses-hospital-putting-profit-over-patients/
https://www.wect.com/2022/08/24/report-feds-details-many-problems-nhrmc-emergency-room-that-put-patients-immediate-jeopardy/

former leader put it, the tendency is to measure Mission "against what is perfect, but not what is possible" considering various realities.

Also, it bears recognition that prior to HCA's purchase, Mission was not in fact adored uniformly. Instead, some physicians and community members routinely criticized Mission when they thought management was not doing well enough or was doing the wrong thing.[439] A former senior manager said what others acknowledged, that it sometimes felt that Mission was the hospital that many people "loved to hate."

Is Mission Unique?

One way to put these observations in perspective is to observe whether HCA Mission is unique in receiving this outpouring of critical reaction. The Introduction documents that the level of sustained outcry has been truly extraordinary – well beyond anything seen prior to HCA's purchase, and beyond what has been reported for most other HCA hospitals. This begs the question, then: why has HCA encountered so greater adverse reaction here than it or other hospitals receive elsewhere? HCA did not become the largest and most profitable hospital chain in the country (and thus in the world) by being an ineffectual hospital manager. Has it made missteps here that it does not make elsewhere, or is the climate here just that much more hostile to for-profit hospital management than elsewhere? A full analysis of that question exceeds the bounds of this study. However, several useful observations can be made.

Several well-placed sources -- who were either involved in the decision to sell HCA or who have been engaged through the ensuing years -- thought that negative reactions to HCA have been so much stronger here than elsewhere because of Mission's more highly esteemed status at the time of acquisition. These sources observe that HCA's management decisions have simply been a standard execution of the "playbook" or "game plan" it has developed successfully over the years. Often, however, HCA applies that management approach to struggling hospitals where deep cuts are seen as more essential to keeping the hospital afloat.[440] As Part 1 explains, however, Mission was doing well financially when it sold to HCA, and it was operating at a very high quality level by all measures.

HCA's business strategy has not been developed with an aim to keeping the highest performing hospitals at the top. Instead, in the view of many observers, it aims for maximizing its profits while maintaining acceptable quality -- meaning quality at a level that avoids legal/regulatory problems and does not lose too much business.[441] As one national expert explained, HCA, which is "is famously data-driven, ... teaches to the test" in that they "will hit the number necessary to hit the level of quality or efficiency that optimizes their shareholder value. Period."[442] In various ways, this study's findings support that view.

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[439] See, e.g., https://www.citizen-times.com/story/news/local/2015/04/18/rural-hospitals-concerned-mission-hospital-asheville-north-carolina-tactics/25956329/

[440] https://avlwatchdog.org/mission-sale-wasnt-good-for-hca-either-a-former-top-exec-argues-for-a-return-to-local-control-nonprofit-status/
https://www.aol.com/opinion-doubtful-hca-healthcare-fix-101016211.html
https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/

[441] See, e.g., https://www.citizen-times.com/story/opinion/2024/02/25/opinion-hca-healthcare-needs-to-understain-health-care-the-most-important-resource-is-your-employees/72672976007/

[442] https://fortune.com/longform/hca-hospital-chain-mission-health-care-north-carolina/

Mission differs from more typical HCA hospitals in important ways. It is much larger, and more regionally prominent, than most other HCA hospitals. Several informed sources noted that HCA did not have significant experience taking over a hospital of Mission's stature and quality. As a result, they thought that, in essence, HCA "overplayed its hand" in applying to Mission the same levels of lean staffing that appear to have been more or mostly acceptable at other HCA hospitals. These observers (some of whom remain actively engaged) said that this clash between HCA's management style and Mission's culture is fundamentally at the root of the ongoing backlash from both professionals and the general public.

An important feature to recognize is that Mission's board decided to turn the reigns over to HCA entirely, rather than to enter a co-ownership arrangement where community leaders or a charitable institution continued to have a role in the hospital's management. Alongside its purchase offer, HCA also offered terms for shared control and ownership – an arrangement that it sometimes has with other hospitals. The likely reason the board passed on that opportunity is that outright purchase probably brought a much greater purchase price with which to fund the new community foundation (Dogwood Trust). However, this sacrificed a critical means that exists in some other HCA acquisitions to safeguard against deleterious cost cutting. Of note, the HCA hospital chosen for Mission's board to tour prior to their decision was one (St. David's in Austin TX) that HCA runs in partnership with the charitable foundation created by the proceeds from HCA's investment in the hospital. Therefore, its operation may not have typified that of a hospital that HCA solely owns.[443]

Another key observation is that, in Asheville, HCA has been able to apply its management playbook in a market where Mission faces no substantial competition for most of its services. Often, HCA hospitals are in markets with immediate competitors. Some market analysts note the HCA may strategically choose such markets because that frees them to be more selective about focusing on service lines that are more profitable, knowing that one or more other hospitals in the area cover a full range. However, in those markets HCA needs to be concerned about losing too much business to other hospitals if physicians and patients become too disgruntled. In Asheville and its region of the state, HCA does not face those same concerns, or at least not to nearly the same extent as in many other HCA markets.

As a result, it may well be the case that HCA has indeed simply used the same management techniques at Mission as it does elsewhere; however, it have been able to execute the playbook somewhat more aggressively than elsewhere, knowing that disgruntlement will not cause it to lose much business, or at least much of its more profitable business. That possibility, coupled with the fact that HCA appears to aim for, or at least accept, a performance level well below where Mission stood at the time of purchase, provide potentially insightful perspectives on why HCA's operation of Mission has been received much more negatively than is typical for other hospitals confronting similar management challenges.

"If You Had to Do it Over ..."

On balance, there are various bases on which to conclude that the picture that HCA's harshest critics paint, or even that this study's Executive Summary shows, is not as bad as it's made out to be. There are some

[443] That likely possibility is underscored by the fact that the charitable foundation's management control is sufficient to maintain the hospital's charitable tax exemption, despite HCA's equity interest.
https://physiciansnews.com/2006/04/16/joint-ventures-with-tax-exempt-hospitals/

positive aspects to Mission's conversion to a for-profit hospital, and to HCA's substantial resources. Also, the problems that have arisen at Mission are not unique to it or to HCA.

However, taking all of this into consideration, this study's extensive interviews with former leaders at Mission uncovered virtually no one who felt that the sale was the right thing to do, knowing what we know now. Still, several leaders genuinely feel that the decision made was the right one at the time, based on what was known then. This study helps to understand various factors supporting that viewpoint.

This study's goal, however, is not to pass judgment on the decision as it was made. The goal is to learn from what has transpired since then. For each of the points addressed, assessments can vary, as can an overall assessment of the acceptability of HCA's management. What is telling, however, is that even under the most favorable viewpoints, there is no credible voice openly claiming that Asheville and western North Carolina are actually better off now for Mission having been sold to HCA.

Part 7: Public Policy and Legal Regulatory Recommendations

Extensive review of the tumult resulting from Mission Hospital's sale to HCA exposes significant legal gaps that precluded robust protective measures. In this regard, North Carolina does not differ substantially from many other states.[444] Thus, lessons learned here can assist other states considering legal enactments to prevent these deleterious effects. Also, these lessons can inform private actors, such as hospital boards or union negotiators, who might consider adopting contractual provisions that seek to avoid adverse consequences from changes in hospital management.

REGULATORY GAPS

As in most states, NC's Attorney General has the principal legal authority when a hospital's ownership or control changes.[445] That authority is limited in NC, however, as it is in many other states.[446] Primarily, Attorneys General address requirements of antitrust law and nonprofit law. Antitrust law typically is not implicated if a hospital's new owner does not already have significant presence in the hospital's local market or surrounding areas. Acquiring a nonprofit hospital requires scrutiny to ensure that the transaction is faithful to the existing entity's obligations to its community and previous donors. Normally, those obligations are readily satisfied if another nonprofit purchases the hospital. Purchase by a for-profit entity, however, requires special consideration.

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[444] For a survey of all 50 states, see: https://sourceonhealthcare.org/market-consolidation/merger-review/#state-authority-maps.

[445] Hospital sales must also comply with Department of Health and Human Services regulations, but usually those elements are entirely pro forma, such as simply reflecting the hospital's new ownership in licensure materials.

[446] Robert Berenson, et al., Addressing Health Care Market Consolidation and High Prices: The Role of the States (Urban Institute and UC Law SF, Jan. 2020), https://sourceonhealth.wpenginepowered.com/wp-content/uploads/2020/06/addressing_health_care_market_consolidation_and_high_prices_3.pdf; Alexandra D. Montague, et al., State Action to Oversee Consolidation of Health Care Providers (Milbank Mem. Fund, Aug. 2021), https://www.milbank.org/publications/state-action-to-oversee-consolidation-of-health-care-providers.

Nonprofit hospitals are permitted to convert to for-profit status if they meet three key conditions: 1) The sales price is at fair market value; 2) The proceeds are devoted to a related charitable purpose; and 3) The governing board's deliberations leading to its decision were conducted appropriately. If an Attorney General believes one or more of these conditions is not met, they may file suit to block the transaction.

Here, NC's Attorney General (and now governor) Josh Stein evaluated each of these elements carefully before approving HCA's purchase of Mission, and he approved the sale only after adding significant protective conditions (contained in what was referred to as the "Asset Purchase Agreement"). Regarding market value, the Attorney General's independent expert confirmed that the HCA's purchase price of Mission was assessed at fair market value. Moreover, using those proceeds to fund a very large foundation (known as Dogwood Trust), devoted to improving health throughout much of western NC, clearly serves a charitable purpose.

Ratifying the hospital board's deliberation process proved to be more challenging. The Attorney General determined that the board appeared to be overly influenced by the views of the hospital's CEO, and that the CEO and hospital's consultant had potentially serious conflicts of interest (in the form of prior or anticipated business dealings with HCA) that had not been adequately disclosed to the board. Specifics of those elements are addressed in Part 1 of this study. What is key to understand, however, is that such deficiencies are not necessarily fatal to a proposed transaction. Instead, it is often possible to cure them once they are identified, and where that is feasible, existing law typically requires that the board be allowed to do so.[447]

Here, the Attorney General took what could be regarded as fairly aggressive action.[448] First, he required the board to re-negotiate their purchase agreement to substantially strengthen the scope, content, and duration of commitments HCA made regarding a range of issues, including maintaining existing services and facilities; completing planned or initiated improvement projects; and maintaining acceptable financial assistance policies. Second, he required the appointment of an "independent monitor" to help ensure that HCA kept its commitments. Third, he insisted on a special meeting with the board to discuss his concerns about the CEO's apparent influence and conflict of interest, after which the board was required to deliberate and vote again.

Not surprisingly, the board reaffirmed its previous decision to approve the sale, which under standard legal precedents likely cured any overt legal deficiencies in its process. Regarding the strengthened purchase agreement and monitoring process, criticisms have been leveled that they were not strong enough. However, they equal or exceed the strongest examples that can be found from other such transactions,[449] and the Attorney General had reason to believe that insisting on more stringent protections would have been challenged in court; if so, he might not have been able to sustain all of the strengthened protective elements that he had been able to negotiate.

Absence of Quality-of-Care Assurances

The most notable weakness of the re-negotiated purchase agreement is the absence of any assurances about maintaining quality of care. Much of the well-founded criticism HCA has received relates to deep staffing cuts across most hospital functions.[450] In two areas – the emergency room and cancer care – staffing cuts were serious enough to trigger a legal challenge by the Attorney General claiming that HCA had breached its

[447] Restatement of the Law of Charitable Nonprofit Organizations §2.02 Comment *d* (Am. Law Institute, 2021).
[448] See Part 1 of this study for documentation and additional detail.
[449] See note 453 below.
[450] See Part 4 of this study.

commitment to provide those core services. That challenge is still pending, but even if it were to succeed in some manner, it would not address the strong evidence that the quality of both services—and many others at Mission—has substantially diminished, beyond anything the prior board and management (or at least some of its members) might have contemplated during the sale.

This absence of a quality commitment came into focus most sharply in HCA's response to the Attorney General's lawsuit. The lawsuit alleged that the substantial degradation in quality of Mission Hospital's emergency services and the extent of its cancer care violated HCA's agreement to maintain these services. HCA responded, however, that the agreement was "silent as to the quantity or quality of services required,"[451] which seems to indicate fairly explicitly that service of *any* amount or quality would suffice. Appearing to confirm approximately that position, the independent monitor initially charged with enforcing HCA's commitments infuriated members of the public when it took the position that quality of care issues are beyond its purview.[452]

Quality Measures

This experience certainly should caution other hospitals and regulators about what could transpire in broadly similar circumstances elsewhere. However, it is unclear how best to guard against potential degradation in quality. Just as market conditions in many locations do not guard well against high hospital costs, they do not guard well against diminished quality. Pricing and costs can be measured and assessed more objectively than quality; therefore, those elements are more amenable to contractual or regulatory specification.[453] The quality of medical care is notoriously much more difficult to assess and monitor, even at a *minimally* acceptable level. It is even more difficult to do so for *relative* degrees of acceptability or excellence.

Nevertheless, the year following HCA's purchase of Mission, another hospital system (Novant), whose similar bid the Mission board rejected, agreed to specific quality adherence conditions when it bought a similarly sized county-owned hospital in Wilmington, NC (New Hanover Regional). The asset purchase agreement negotiated with the county requires the purchaser to "use reasonable best efforts to position and maintain the [hospital] in the top 10% nationally with respect to each … quality metric [it] adopted …."[454] The agreement specifies that these quality metrics "include measures relating to patient safety, clinical effectiveness, patient-centeredness, timeliness, efficiency and quality as may be implemented from time to time" at the hospital.

This is an impressive commitment. However, terms such as "reasonable best efforts," plus the bounded discretion to choose which metrics to assess, provide a certain degree of wiggle room. The effectiveness of

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[451] https://avlwatchdog.org/hca-mission-respond-to-stein-lawsuit-denying-they-have-broken-commitments-made-at-time-of-sale/

[452] https://wlos.com/news/local/mission-hospital-hca-healthcare-limited-power-independent-monitor-to-effect-change-doctors-patients-seek-accountability-elsewhere-lack-of-quality-healthcare-decline-ron-winters.

[453] Verifying this is an extensive study of 80 conditional approvals of health care provider transactions. Alexandra D. Montague, et al., Considerations for state-imposed conditions on healthcare provider transactions, Frontiers Public Health 11:1220624 (Aug. 2023), https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1220624/full. The following provides more detailed information about particular examples: https://sourceonhealthcare.org/wp-content/uploads/2023/04/Conditional-Approval-Transactions-Complete-List-with-Documents.xlsx

[454] https://ncdoj.gov/wp-content/uploads/2021/01/2020-10-09-New-Hanover-County-and-NHRMC-Transaction-Notice-10.9.2020.pdf

this quality commitment has not been assessed. Anecdotal reports suggest, though, that, at least initially, it has not avoided several of the problems experienced with HCA Mission, such as staff reductions, emergency room crowding, and adverse findings from government inspectors.[455]

Another effort to specify acceptable quality levels is found in the formation of the Ballad Health hospital system in eastern Tennessee and southwestern Virginia. To receive state approval, Ballad agreed to maintain or improve its scores on 17 specified quality measures focused on surgical outcomes and hospital-acquired infections.[456] However, these are only a small set of the 100 quality measures used to monitor the hospital system,[457] and even for this fraction, whether the system meets these quality commitments counts as only 5 percent of the total score used to determine whether the system is in compliance.[458] As a result, it has remained in technical compliance despite failing to meet most of these specific quality commitments.[459]

Staffing Levels

Another approach to quality control could be to specify a minimum level of staffing that is considered acceptable for key components of effective hospital operation. Doing that, however, is also considerably more complex than first meets the eye. For each type of position, staffing can plausibly or legitimately vary according to particular skill levels for that position. Nursing, for instance, recognizes nurse practitioners, charge nurses, RNs, LPNs, and various nursing assistants. Also, for each type, a particular nurse can be more or less trained and experienced in the particular area of medicine involved. Similar, and often more substantial, differentiations obviously exist for clinicians, and to some extent for a host of other patient-care related functions.

Equally confounding is the particular mix of patient conditions being treated. Each of the variables just noted, and others not mentioned, depend a great deal on how many patients need care at any given point, for what conditions, and at what level of severity. After modest reflection, it quickly becomes apparent that specifying just the staffing element of care quality is a daunting task.[460]

Nevertheless, some, and perhaps many, of these aspects of adequate staffing are amenable to some degree of specification, at least in setting minimum levels, and so such efforts should not be rejected out of hand. Also, even if such measures are not imposed by regulators, they might be considered by private parties, such as labor unions, when negotiating contractual assurances of minimum or adequate quality and safety. Regardless of any such success, however, we need to consider whether stronger legal authority is needed to protect the public interest when private negotiations may not be sufficiently rigorous.

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[455] https://www.wect.com/2022/09/22/state-treasurer-nurses-hospital-putting-profit-over-patients/
https://www.wect.com/2022/08/24/report-feds-details-many-problems-nhrmc-emergency-room-that-put-patients-immediate-jeopardy/
https://www.theassemblync.com/business/novant-new-hanover/
https://www.whqr.org/local/2023-08-04/federal-agency-again-rates-novant-nhrmc-two-out-of-five-stars

[456] Exhibit K of: https://www.tn.gov/content/dam/tn/health/documents/copa/2022-07-01-FINAL-EXECUTED-Third-Amended-and-Restated-Terms-of-Certification-Governing-the-COPA.pdf.

[457] Of potential significance, though, is that the state agency retains the discretion to add to the designated compliance list any quality measures for which it determines the system is "underperforming." Ibid.

[458] Note 456 at Exhibits I and J.

[459] https://tennesseelookout.com/2023/09/29/these-appalachia-hospitals-made-big-promises-to-gain-a-monopoly-theyre-failing-to-deliver/

[460] https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01521

FILLING REGULATORY GAPS

Reinstating Monopoly Oversight Regulation

The most direct path to avoiding the problems encountered in western North Carolina would have been to maintain the monopoly oversight that was created when Mission Hospital was allowed to merge with its direct competitor (St. Joseph's) 30 years ago. As this study discusses in Part 1, that "active supervision" worked well by almost all accounts. Yet it was rescinded by NC's legislature shortly before Mission's leaders started to quietly explore the hospital's sale. Had the supervision remained in place, it is highly unlikely the sale would have been consummated. Either HCA would not have wanted to purchase Mission at anywhere close the price it did if Mission had remained subject to monopoly oversight regulation, or the state would have simply denied permission for the hospital's sale out of concern that HCA would abuse the hospital's existing market power.

When the state repealed its monopoly oversight regulation, no one outside of Mission's inner circle contemplated the possibility that the hospital might be sold to a for-profit owner. Instead, the prevailing rationale for repeal appeared to be a vague sense that active supervision was no longer needed due to changes in market conditions, and a sense that the hospital's management would continue to function more or less as it had.

Clearly, based on information amassed in this study, both assumptions have proven to be markedly wrong. Anticipating that reality, the Federal Trade Commission has used Mission Hospital as an example of why repealing this monopoly oversight regulation is bad idea.[461] Taking umbrage, when Tennessee similarly allowed the merger of several competing hospitals in 2018, it included a proviso that key aspects of monopoly regulation "shall survive termination of the [law authorizing the merger] …. and shall last until [regulators] determine[s] that they are no longer necessary to prevent anticompetitive conduct …."[462]

This experience suggests that the situation in western NC might be substantially improved if NC's legislature were to reinstate the "active supervision" that accompanied the original approval of the merger with St. Joseph's that gave birth to modern Mission.[463] Nonprofit hospitals with insufficient competition tend to be more wasteful because they lack either market or investor incentives to increase efficiency. When for-profit hospitals face insufficient competition, however, they are prone to cut expenses in order to enhance profits. As such, excess profits become the primary focus, since limiting profits suppresses the financial incentive to cut quality in a noncompetitive market. If monopoly oversight were reinstated at Mission, it would need to shift its focus from avoiding excess expenditures to ensuring adequate investment in patient care.

Improving the situation in western NC would not, however, address the need to address future situations that arise. The antitrust exemption Mission Hospital received to merge with its direct competitor is no longer available in NC, and this mechanism has been used in only a handful of other states – in large part because

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[461] FTC Policy Perspectives on Certificates of Public Advantage (Staff Policy Paper, Aug. 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf

[462] Section 9.12 of: https://www.tn.gov/content/dam/tn/health/documents/copa/FourthAmendedandRestatedTOCGoverningtheCOPA_FINAL.pdf

[463] Indeed, an argument might be made that such supervision is legally required, in order to avoid violating either federal antitrust law, or NC's constitutional prohibition of state-created monopolies. Those distinct possibilities exceed the scope of this study, however.

health policy analysts rarely agree that overriding normal antitrust rules is the best long-term course for improving hospital market conditions.[464]

Repealing Certificate of Need (CON) Regulation

A more broad-based strategy to improve hospital market conditions that is perennially discussed is to repeal, or substantially scale back, certificate of need regulation (CON). Proponents of this tack hope that freer market entry will impose more competitive discipline on hospital markets that are not serving patients' interest as well as they might. The basic case for this path is that, to date, CON regulation has made it much more difficult for hospitals to enter markets where the existing facilities either have sufficient capacity, or can expand fairly readily to meet increased needs.[465] If CON barriers are removed or greatly lowered, the assumption is that other hospitals would enter markets that are not performing well, or that existing facilities would improve their performance to forestall increased competition.

Opponents of this viewpoint are concerned that, in many hospital markets, competition is not capable of functioning well enough to serve public interest adequately. They note that at least some conditions that gave rise to ineffective competition prior to CON regulation still exist, such that hospital competition tends to fuel a "medical arms race" that produces some degree of inefficient duplication of services and excess capacity, fueling cost and price increases.

Opponents of CON repeal are also concerned that the ability of established hospitals to continue providing a wide range of essential services regardless of their profitability depends on being able to earn good profits on certain services in order to support less profitable ones. When hospital markets are more open to new entrants, these established hospitals are concerned that this implicit "cross-subsidization" will be undermined if new competitors "cherry pick" their more profitable patients and services – perhaps by focusing on particular specialties and neglecting others, or by locating closer to higher-income patients.

Defense of continued CON regulation also comes from the observation that, without some regulatory constraint, there would be nothing (or at least much less) to stop established providers from expanding their market dominance, by using their substantial assets and market positions to move aggressively into new territory or lines of service.[466] Under this view, CON regulation promotes competition to some extent by supporting more orderly market entry by new providers or expansion by smaller-footprint providers. For instance, in 2022 CON regulators in Massachusetts rejected a proposal by the Harvard's prestigious teaching hospitals to expand outpatient services into suburban markets, citing the threatened financial impact on smaller and less expensive competitors.[467]

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[464] See, for instance: https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-policy-paper-warns-about-pitfalls-copa-agreements-patient-care-healthcare-workers

[465] U.S. Departments of Labor, Treasury, and Health and Human Services, Reforming America's Healthcare System Through Choice and Competition (Dec. 2018). https://home.treasury.gov/system/files/136/Reforming_Americas_Healthcare_System_Through_Choice_and_Competition.pdf

[466] See p. 44 of: Congressional Budget Office, Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services (Sept. 2022), https://www.cbo.gov/system/files/2022-09/58222-medical-prices.pdf.

[467] https://fortune.com/2022/05/03/massachusetts-health-care-costs-hospital-expansion/

Various studies over past decades lend at least some support to all of these CON viewpoints, and so experience has not conclusively resolved this debate.[468] Given this is a long-standing debate, it is unlikely that any newly highlighted set of concerns will tip the outcome in a different direction. Therefore, it is worth considering: instead of repealing or scaling back CON regulation, can this regulation be revised to operate in a manner that is less harmful to competition, or that perhaps even promotes competition?

Reforming CON Regulation to Promote Competition

There are several ways that certificate of need regulation might bring new entrants to poorly performing markets in a more controlled manner than simply repealing the CON regime.[469] A more conventional approach would be, when there is a need for more capacity in a market area, CON regulators can favor applicants that are less developed or are new to the market, rather than allow more established providers to expand. Even if expanding existing facilities might be more cost-effective in the shorter run than new entry, enhanced competition could provide superior public benefits over a longer term.

A more unconventional approach would be for CON planners and regulators to recognize that system capacity (such as population-wide "bed need") is no longer the primary consideration for inviting or entertaining applications. Instead, they could also recognize additional need based on the absence of adequate competition. For instance, when Florida repealed a major portion of its CON law (in 2019), for the portion that remained (which governs hospices), it added a requirement that the "formula on which the certificate of need is based shall discourage regional monopolies and promote competition."[470] Also, the agency's rules allow an applicant to petition for a CON, despite any shortage in capacity, by showing that anti-monopoly considerations "outweigh the lack of a numeric need."[471]

A third regulatory option worth considering is more active use of *conditional* certificates of need. Conditional CONs are those awarded subject to continued good behavior, defined in specified ways.[472] As an example, Virginia requires applicants to commit to a specified level of charity care and then makes that commitment a condition of awarding any CON.[473] Other kinds of CON conditions are also fairly conventional,[474] but an entirely untested idea is to require applicants to meet a wider range of more demanding conditions, such as limiting profits or controlling costs – conditions similar to those that originally existed under NC's certificate of public advantage (COPA) law, discussed in Part 1 of this study. Such conditions could be assumed by

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[468] Matthew D. Mitchell, Certificate-of-Need laws in healthcare: A comprehensive review of the literature, So. Econ. J., (May 2024), https://onlinelibrary.wiley.com/doi/10.1002/soej.12698 .

[469] See Robert Berenson, et al., Addressing Health Care Market Consolidation and High Prices: The Role of the States (Urban Institute and UC Law SF, Jan. 2020), https://sourceonhealth.wpenginepowered.com/wp-content/uploads/2020/06/addressing_health_care_market_consolidation_and_high_prices_3.pdf.

[470] Fla. Stat. 408.043.

[471] Fla. Admin. Code 59C-1.0355(3)(b).

[472] Alexandra D Montague, et al., Considerations for state-imposed conditions on healthcare provider transactions, Frontiers Public Health 11:1220624 (Aug. 2023), https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1220624/full.

[473] https://law.lis.virginia.gov/vacode/title32.1/chapter4/section32.1-102.4/ https://www.hilltopinstitute.org/wp-content/uploads/hcbp/hcbp_docs/HCBP_CBL_VA.pdf

[474] For instance, in NC it is standard to include a condition that the applicant will "materially comply with all representations made" in their application.

applicants that are newly awarded a CON, or they could be required for established facilities that seek to expand.

Considering Competition

Each of these ideas has potential worth considering, but each also has inherent limitations or potential pitfalls that remain unexamined. Favoring inclusion of competition considerations, the federal government introduced competitive factors in CON analysis as far back as 1979,[475] and current CON criteria in several states recognize the relevance of competitive effects,[476] at least to some extent. A comprehensive national study has not been done; however, a look at NC's legal landscape is informative. Its CON statute requires applicants to "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."[477] Accordingly, when two similarly-qualified applicants vie for the same identified need, NC courts have affirmed using as regulatory a tie-breaker the fact that one of the applicants enhances competition more than the other.[478]

Recognizing Need Based on Competition

Requiring applicants to discuss competitive impacts and permitting the agency to use those impacts as essentially a tie-breaker, are both positive steps, but they do not go nearly far enough to make CON regulation a strong tool to improve competitive conditions. Primarily, this is because this factor comes into play in NC only if health planners initially determine that current capacity for a particular health service is inadequate. Nothing in the current regulatory structure *requires* recognition of need based primarily on inadequate competition, and it is debatable (although not inconceivable) that doing so would be *permissible* under current practice.

The same is true in other states, with the possible exception of Florida, where the "Legislature made clear [in 2019 amendments] that—to the extent possible in a government-controlled industry—the economic value of competition was to be promoted and regional monopolies discouraged."[479] But even there a court ruled it could not *require* the agency to issue a CON "simply because the record establishes that a regional monopoly exists and that competition would be fostered by entry," because promoting competition is just one of several "statutory criteria [that] have a free-floating value" which the agency has discretion to balance.[480]

When a capacity need is recognized, giving competitive impacts more than just tie-breaker status has only limited effect because new recognitions of need tend to happen only on an incremental basis. Awarding small

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[475] See Oregon Eye Assocs. v. State Health Plan. & Dev. Agency of Oregon, 83 Or. App. 368, 373, 732 P.2d 41, 44 (1987); Clark C. Havighurst, Health Planning for Deregulation: Implementing the 1979 Amendments, 44(1) Law & Contemp. Problems 33 (1981).

[476] Mentioning Florida, Georgia, NC, and Virginia, see Robert Berenson, et al., Addressing Health Care Market Consolidation and High Prices: The Role of the States (Urban Institute and UC Law SF, Jan. 2020), https://sourceonhealth.wpenginepowered.com/wp-content/uploads/2020/06/addressing_health_care_market_consolidation_and_high_prices_3.pdf.

[477] N.C. Gen. Stat. § 131E-183(18a).

[478] Total Renal Care of N.C. v. N.C. HHS, 615 S.E.2d 81, 85 (NC Ct. App. 2005) (ruling that "there is nothing … that would preclude [regulators from] identifying the benefits of enhanced competition and consumer choice from among applicants that already qualify for receipt of the certificate").

[479] Compassionate Care Hospice of Gulf Coast, Inc. v. State, 247 So. 3d 99, 100 (Fla. Ct. App. 2018).

[480] Ibid.

toe holds to new market entrants, or incremental increases to small existing facilities, does very little to counter situations where a large established provider has dominant market power.

In Asheville, for instance,[481] NC regulators in 2022 awarded approval for a new 67-bed hospital to a Mission competitor rather than allowing Mission to expand, despite the sizeable difference in capital costs, in part because doing so would introduce more competition.[482] However, that approval permits construction of a hospital only 1/10 the size of Mission, and with only basic service, which will not provide substantial competition for a much broader range of services that only Mission can offer as a major tertiary care regional referral center. More recently, NC recognized the need for an additional 23 beds in the area, but that too would only be a few drops in Mission's dominant bucket.

Conditional CONs

A contrasting approach (noted above) would be to make more forceful use of conditional CONs to require that successful applicants -- whether established or newly entering -- adhere to prescribed practices that benefit patient and community welfare. The type of monopoly oversight discussed in Part 1 of this study established by a "certificate of public advantage" (COPA) program could serve as a model. Under that COPA model, an institution agrees to limit its profits in exchange for being allowed to merge with a competitor. There is no precedent for doing so in exchange for receiving a CON, but, as noted above, CON conditions are currently used in other ways. Thus, in principle, there is no reason legislative authority could not either permit or require specification of more targeted and forceful CON conditions, especially when they mitigate what might otherwise be adverse CON effects on competition.

One uncertainty inherent in this approach, however, is enforcement – especially when conditions are meant to last indefinitely.[483] Ongoing enforcement of CON conditions is relatively untested because of the limited applications of this approach to date.[484] In Virginia, for instance, required commitments for charity care are more-or-less self-executing, by requiring simply that hospitals devote a specified amount either to their own qualifying patients or by donating charitable support to other health care organizations.[485] A conditional cap on profits could operate similarly, by requiring hospitals to rebate excess profits, much like health insurers are required to do by the Affordable Care Act (under its "medical loss ratio" provisions).[486] Any such rebate system or other enforcement mechanism would require careful thought and a degree of trial and error to design well.

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[481] As another example, in a contest over 28 additional hospital beds, a NC court affirmed the CON agency's decision to prefer one applicant over based on improving competition where the winning applicant proposed to expand its tiny 8-bed facility. The other applicant, however, controlled 596 beds in the area. Surgical Care Affiliates v. NC HHS, 766 S.E.2d 699 (NC Ct. App. 2014).

[482] https://info.ncdhhs.gov/dhsr/coneed/decisions/2022/nov/findings/2022%20Buncombe-Graham-Madison-Yancey%20Acute%20Care%20Bed%20Competitive%20Review%20Findings.pdf

[483] Discussing and reviewing enforcement and other difficulties, see Alexandra D Montague, et al., Considerations for state-imposed conditions on healthcare provider transactions, Frontiers Public Health 11:1220624 (Aug. 2023), https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1220624/full

[484] In Connecticut, for instance, which is discussed below, CON conditions can be fairly extensive, but they typically expire after only a few years.

[485] https://www.vhi.org/CharityCare/
https://www.vafreeclinics.org/blog_home.asp?display=20

[486] See https://www.kff.org/private-insurance/issue-brief/medical-loss-ratio-rebates/.

A third possible application of CON regulation is simply to require agency approval before any change in a hospital's ownership. Some states require hospitals that have received CONs, or hospitals in general, to notify the CON agency of a proposed change in ownership.[487] Only a handful, however, contemplate any substantive regulatory review beyond simply confirming that the ownership change does not alter existing conditions relating to service capacity.

Connecticut is one example where CON regulators conduct an extensive review before approving changes in ownership, focused on whether the change will enhance access to affordable services. When approving ownership changes, Connecticut regulators often adopt a set of conditions aimed at achieving promised benefits or avoiding potential detriments, at least in the short run.[488] Recurring examples include: making promised capital investments, maintaining existing financial assistance policies and community benefit programs, and requiring prices to reflect efficiencies achieved and to be justified by general market conditions.[489]

Analysts have noted the potential for other states to confer similar agency authority to review comprehensively the health policy implications of ownership changes.[490] In principle that could be done as part of a CON regulatory program. However, the full range of issues that merit attention, as well as the ability to monitor enforcement of key conditions for extended periods, likely calls for a broader and freshly constructed platform of the type the next section presents.

Broad-based Public Interest Review

Various limitations and uncertainties keep the previous suggestions from offering a fully satisfactory approach to avoiding the rage and depth of concerns that have arisen from HCA's purchase of Mission Hospital. The suggestions above are either limited in scope, or they call on difficult and untested regulatory systems for ongoing monitoring and enforcement. A more ambitious form of health policy oversight that has been in place in NC and other states for several decades offers a potential solution: broad-based public interest review.

A generation ago, concerns similar to those raised here for hospitals also arose for dominant nonprofit health insurers – principally Blue Cross plans across the country (each of which had been a separately-owned business sharing a common trademark). Recognizing the range of strong public interests these health insurers directly affect, a number of state legislatures, including North Carolina, adopted laws requiring that nonprofit health insurers receive approval from state regulators before converting to for-profit status. Regulators (typically over both insurance and health) were given broad authority to determine whether the conversion would be contrary to the public interest.[491]

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[487] Alexandra D. Montague, et al., State Action to Oversee Consolidation of Health Care Providers (Milbank Mem. Fund, Aug. 2021), https://www.milbank.org/publications/state-action-to-oversee-consolidation-of-health-care-providers. For additional detail, see: https://sourceonhealthcare.org/market-consolidation/merger-review/#state-authority-statutes

[488] See note 484.

[489] Examples of these conditional orders can be found here: https://sourceonhealthcare.org/market-consolidation/conditional-approval/

[490] See notes 487 and 489, and sources cited in the following section.

[491] Mark A. Hall & Christopher J. Conover, For-profit conversion of Blue Cross plans: public benefit or public harm?, 27 Annu' Rev' Public Health 443-63 (2006), https://www.annualreviews.org/doi/pdf/10.1146/annurev.publhealth.27.021405.102200; Mark A. Hall & Christopher

This fairly unconstrained consideration of what is or is not in the public interest is a perspective that administrative agencies commonly are authorized or required to take in a wide range of other industries and regulatory settings.[492] In the health insurance context, regulators in some states determined that conversions to for-profit status were permissible, but in others, such as North Carolina, the conversion effort failed because parties were not willing to agree to conditions that the regulators decided were needed to adequately protect the public interest.[493]

Another application of broad public-interest review is starting to emerge in several states for changes in hospital ownership.[494] Much of this recent and current focus addresses concerns arising from hospitals that merge, but these emerging review mechanisms also address other changes in hospital ownership that implicate a range of public policy concerns, such as a local hospital joining a large national chain.

Drawing from these newer models in other states, NC state legislators introduced a bill in 2023 that would address the gaps in state authority identified above.[495] Although this bill initially stalled in committee, it is likely to be revised and reintroduced in a subsequent session, with some degree of bipartisan support. Thus, its original provisions merit some attention.[496]

The proposed NC law would apply to any substantial change in the ownership or control of a hospital. The bill requires notice to the Attorney General prior to any such transaction. The Attorney General is then charged with considering whether the transaction "may have a significant effect on the cost, availability, accessibility,

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J. Conover, The Impact of Blue Cross Conversions on Accessibility, Affordability, and the Public Interest, 81 Milbank Q. 509-42 (2003), https://onlinelibrary.wiley.com/doi/10.1046/j.0887-378X.2003.00293.x .

[492] Jodi L. Short, In Search of the Public Interest, 40 Yale J. Regulation 759-836 (2023), https://www.yalejreg.com/print/in-search-of-the-public-interest/.

[493] https://www.communitycatalyst.org/wp-content/uploads/2022/11/conversion_and_preservation_of_charitable_assets_of_blue_cross_and_blue_shield_plans_mar04.pdf

[494] Discussing leading examples in California, Connecticut, Massachusetts, Oregon, Pennsylvania, and Rhode Island, see Maanas Kona, et al., Understanding Federal and State Levers to Address Provider Consolidation (Georgetown Univ. Center on Health Insurance Reforms, June 2024), https://georgetown.box.com/s/antpaij8sk1n9989n97fkoq7ceambfjo; Robin L. Davison, et al., A Step Forward for Health Care Market Oversight: Oregon Health Authority's Health Care Market Oversight Program (Milbank Mem. Fund, March 2023), https://www.milbank.org/publications/a-step-forward-for-health-care-market-oversight-oregon-health-authoritys-health-care-market-oversight-program; Alexandra D Montague, et al., State Action to Oversee Consolidation of Health Care Providers (Milbank Memorial Fund, Aug. 2021), https://www.milbank.org/publications/state-action-to-oversee-consolidation-of-health-care-providers/; Jaime S. King, et al., Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States (The Source on Healthcare Price and Competition, June 2020), https://sourceonhealth.wpenginepowered.com/wp-content/uploads/2020/06/PreventingAnticompetitiveHealthcareConsolidation.pdf; Sam Hughes and Natasha Murphy, Empowering State Attorneys General To Fight Health Care Consolidation (Am. Progress, Feb. 2023), https://www.americanprogress.org/article/empowering-state-attorneys-general-to-fight-health-care-consolidation/; and Robert Berenson, et al., Addressing Health Care Market Consolidation and High Prices: The Role of the States (Urban Institute and UC Law SF, Jan. 2020), https://sourceonhealth.wpenginepowered.com/wp-content/uploads/2020/06/addressing_health_care_market_consolidation_and_high_prices_3.pdf

[495] The bill is called the Preserving Competition in Health Care Act, SB 16. Senators Burgin, Corbin, and Mayfield are sponsors. https://lrs.sog.unc.edu/bill/preserving-competition-health-care-act-ab

[496] Also discussing this bill, see https://www.nelsonmullins.com/insights/blogs/healthcare_essentials/state-law-updates/if-enacted-north-carolina-house-bill-737-will-transform-the-legal-landscape-for-hospital-transactions https://www.citizen-times.com/story/news/local/2023/01/30/mayfield-stein-backed-bill-would-make-nc-hospital-mergers-more-public/69848936007/

or quality of health care services for any affected community." Factors the Attorney General is required to consider include:

1. whether the affected community will have continued access to affordable health care services;
2. whether the proposed transaction is likely to adversely affect the quality of health care services; and
3. whether the acquiring entity has made a commitment, at least comparable with the existing hospital, to provide (i) health care to individuals who are disadvantaged, uninsured, or underinsured and (ii) other benefits to the affected community to promote improved health care.

For nonprofit or public hospitals, the Attorney General must also consider whether "the governing body ... exercised due diligence in deciding to dispose of the hospital entity's assets, selecting the acquiring entity, and negotiating the terms and conditions of the disposition."

Most comprehensively, the Attorney General would consider for any type of hospital whether the proposed transaction "serves the public interest by promoting the availability and accessibility of safe, essential, and quality health care services and treatment," and whether it is "otherwise in the public interest, including the transaction's ultimate anticipated effect on competition ... among health care providers." If the Attorney General believes a transaction should be stopped, he or she could seek a court injunction based on a finding that "the negative consequences of [a] transaction outweigh any potential benefits."[497] Going further, the Attorney General could either unwind or alter any change in hospital control within 10 years if events following such a transaction provide a strong case that doing so would be beneficial to the public.

If this bill is re-introduced, and if it moves forward in the legislative process, significant elements are almost certain to change. However, as initially proposed, this bill is a thoughtful demonstration of what would be needed to address the gaps in regulatory oversight that have allowed the HCA Mission saga in western NC to unfold as it has.

[497] Of interest, who has the burden to prove this standard would depend on whether or not the hospital being acquired is for-profit. As initially proposed, the bill would be more favorable to for-profits, requiring the Attorney General to prove "by clear and convincing evidence that consummation of the transaction would have significant and deleterious effects on cost, availability, accessibility, and quality of health care." For nonprofit or public hospitals, the presumption shifts such that the hospital would have to prove by clear and convincing evidence that the Attorney General's conclusion of net public disadvantage is wrong. "Clear and convincing" is an elevated standard of proof that gives a substantial degree of deference to the Attorney General's initial assessment.

APPENDIX A

NEGATIVE PRESS ABOUT MISSION HOSPITAL UNDER HCA

National Press

1	Becker's Hospital Review	'Critically understaffed': Lawmakers, patients and staff blast HCA's takeover of Mission Health	2/12/20
2	Becker's Hospital Review	North Carolina AG demands answers from HCA after influx of complaints	2/26/20
3	New York Times	Fired in a Pandemic 'Because We Tried to Start a Union,' Workers Say	4/28/20
4	New York Times	Health Care Unions Find a Voice in the Pandemic	1/28/21
5	MedPage Today	Physicians Flee Hospital Group After HCA Takeover	2/21/21
6	Fortune	America's Largest Hospital Company Is Booming. So Why Is One Community Trying to Run It Out of Town?	3/31/22
7	NBC News	Some workers at U.S. hospital giant HCA say it puts profits above patient care	1/12/23
8	Becker's Hospital Review	Residents have 'lost trust' in HCA's Transylvania Regional Hospital: Report	4/13/23
9	MedPage Today	What's Changed Since HCA's Takeover of Mission Health?	6/20/23
10	STAT News	HCA Doctors Say Its Cost-Cutting is Endangering Appalachian Patients – A Warning for the Whole U.S. Health Care System	11/3/23
11	NBC News	State Attorney General, Doctors And Nurses Criticize HCA Over Patient Care at North Carolina's Mission Hospital	11/13/23
12	Medpage Today	What's Going on at Mission Health?	11/22/23
13	Modern Healthcare	HCA Healthcare Breached Terms of Mission Health Deal: NC AG	12/14/23
14	Becker's Hospital Review	North Carolina AG Sues HCA	12/14/23
15	Medriva	North Carolina Attorney General Sues HCA Healthcare Over Alleged Service Lapses at Mission Health	12/20/23
16	ABC News	At HCA hospitals, the person monitoring your heart may monitor 79 other patients, too	12/21/23
17	Becker's Clinical Leadership	HCA Mission Hospital Hit with Immediate Jeopardy Warning	1/12/24
18	HealthLeaders	Conditions at Asheville's Mission Hospital pose 'immediate jeopardy to patients' health and safety,' state investigators report	1/15/24
19	Kaiser Health News	North Carolina Report Says Asheville Hospital Threatens Patient Health - KFF Health News	1/23/24

20	Becker's Hospital Review	CMS notifies HCA Mission Hospital of immediate jeopardy status	2/6/24
21	STAT News	Medicare threatens to pull funding from HCA's embattled Mission Hospital	2/6/24
22	Fierce Healthcare	HCA's oft-critiqued Mission Hospital receives CMS warning	2/7/24
23	Medriva	Patient Safety Concerns at HCA's Mission Hospital: A Looming Threat to Medicare Funding	2/10/24
24	Becker's Hospital Review	Clinicians, local advocates decry Mission Hospital's immediate jeopardy correction plan	2/22/24
25	Newsweek	Seniors at Risk of Losing Care As Medicare Fights With Hospital	3/5/24
26	Becker's Hospital Review	Steps to correct immediate jeopardy at Mission have 'backslid,' nurses say	3/15/24
27	Health Leaders	In second blow, Feds now cite HCA's Mission Hospital (NC) for violating emergency treatment standards	3/18/24
28	Modern Healthcare	HCA Healthcare faces more Mission Health-related allegations	4/9/24
29	Becker's Hospital Review	Urologists retreat from HCA Mission hospital	5/22/24
30	Becker's Hospital Review	Urologists retreat from HCA Mission hospital	5/22/24
31	Baptist News Global	Faith leaders among those concerned about a North Carolina hospital that went from nonprofit to for-profit	5/23/24
32	MedPage Today	Urologists Flee Mission Health	5/31/24
33	Becker's ASC Review	'It's been devastating': Where a physician landed after HCA shuttered practices	8/9/24
34	Becker's Hospital Review	Following other specialties, neurologists exit HCA Mission	8/23/24

Local and Regional Press

1	Carolina Public Press	Elected Officials Blast HCA for First Year's Performance at Mission	2/11/20
2	Asheville Citizen Times	Patient Care to Staff Safety: Concerns Over HCA's Management of Mission Run Deep	2/11/20
3	Mountain Xpress	Mission Criticized on Staff Shortages, Patient Care	2/12/20
4	Asheville Citizen Times	Attorney General Josh Stein Asks HCA to Answer Concerns About Care, Billing	2/26/20
5	NC Health News	Attorney General Josh Stien to HCA: 'I Want Answers'	2/27/20
6	Asheville Watchdog	Pandemic Put Pause on Mission Troubles	5/13/20
7	Asheville Citizen Times	Patient Criticisms and HCA's Response: What to Know About Mission Charity Care	5/24/20

8	Carolina Public Press	Working for HCA: Asheville Nurses Protest Conditions at Mission Hospital, Win Ruling on Forming Union	8/5/20
9	Asheville Citizen Times	Mission Health to Stop Primary Care Services in Biltmore Park, Candler	9/16/20
10	Carolina Public Press	Asheville Nurses Union Vote Unprecedented in NC	9/17/20
11	Mountain Xpress	Mission Nurses Overwhelmingly Approve Unionization	9/17/20
12	Asheville Watchdog	A Done Deal: How Mission Health Wooed HCA	10/19/20
13	Asheville Watchdog	Mission Sale: Good for WNC, or Just HCA?	10/22/20
14	Asheville Citizen Times	Critically Understaffed': Asheville Crowd Vents Frustrations with Mission Health and HCA	11/13/20
15	Asheville Watchdog	Nonprofit Mission Made Lots of Profits. Especially for Bosses.	12/9/20
16	Carolina Public Press	Irate crowd voices frustrations with medical services in Cashiers	12/29/20
17	ABC 13	Clinics Closed, Dozens of Doctors Leave Mission Health Since HCA Takeover	2/23/21
18	ABC 13	Two Years After Sale to HCA, Care and Cost Concerns Raised with Mission Hospital	2/24/21
19	Asheville Watchdog	Profits Are Up at HCA. Ratings Are Down at Mission.	4/30/21
20	ABC 13	What Changes Have Been Made Since Medicare Threatened to Cut Mission Hospital's Contract?	5/5/21
21	Asheville Citizen Times	Mission Departures: Concerns Mount as Doctors Leave HCA; Physicians Citing More Work, Less Pay	5/16/21
22	Blue Ridge Public Radio	Quality of Care Concerns Rise at Mission Hospital	5/21/21
23	Mountain Xpress	Patients, Staff Challenge Quality of Care at Mission Hospital Under HCA Management	5/28/21
24	ABC 13	A Concerning Number,' Attorney General Describes Recent Mission Health Complaints Filed	6/8/21
25	Carolina Public Press	HCA Takeover Reframing Primary Care in WNC, Could Threaten Regional Hospitals	7/19/21
26	Blue Ridge Public Radio	Suit Claims HCA/Mission Health Using Monopoly to Charge More, Provide Less	8/11/21
27	NC Health News	Local Residents Sue HCA, Alleging Overcharging at Mission Hospital	8/15/21
28	Mountain Xpress	Wellness in Brief: Lawsuit Alleges Mission Health Monopoly	8/27/21
29	ABC 13	Healthcare in WNC Is More Expensive Because of Mission Health	9/16/21
30	Asheville Citizen Times	AG Stein Received 290 Complaints About HCA/Mission in Asheville	9/20/21

31	ABC 13	Mission Hospital Nurses Rally Again, Alleging Short-Staffing Causing Patient Care Concerns	10/21/21
32	Blue Ridge Public Radio	Mission Nurses Rally for Staffing Solutions, Calling Current Staff Levels 'Unsafe'	10/21/21
33	Asheville Watchdog	Pandemic Is Financial Bonanza for HCA	10/25/21
34	ABC 13	Mission Health Responds to Quality of Care Complaints Under HCA	12/14/21
35	Asheville Citizen Times	NC Treasurer Files Interest in HCA Anti-Trust Suit; Plaintiffs Reiterate Concerns	12/15/21
36	Mountain Xpress	Buncombe County Detainee Dies After Being Transported to Mission Hospital	1/26/22
37	NC Health News	Attorney General's Office Had 'Great Concerns' Mission-HCA Deal Was Rigged 'From the Beginning'	3/20/22
38	Asheville Watchdog	How Many Doctors Have Left Mission? HCA Won't Say	3/23/22
39	Blue Ridge Public Radio	Mission Health Fined by NC Department of Labor for Failing to Report an Employee's COVID-19 Death	3/23/22
40	ABC 13	OSHA Cites Mission Hospital Following Complaint From Nurses Union	3/23/22
41	Blue Ridge Public Radio	Mission Nurses Overburdened, Patients Suffer	4/4/22
42	Asheville Watchdog	Angered and Dissatisfied, Some Mission Patients Seek Healthcare Elsewhere	4/15/22
43	Asheville Citizen Times	Mission Nurse on HCA Fallout During Merger Hearing: 'Shocked and Horrified'	4/16/22
44	Asheville Citizen Times	Opinion: How to Remedy Mission, Restore Great Health Care in Our Area? Competition	4/17/22
45	Asheville Citizen Times	AG Stein Hears WNC Leaders on Mision Sale Fallout, Says He's Eying Merger Law Changes	4/28/22
46	ABC 13	Community Leaders, Members Air Mission/HCA Complaints During Roundtable Hosted by AG Stein	4/29/22
47	Mountain Xpress	Asheville Mission Hospital Nurses to Rally for Recruitment, Retention, and Patient Safety	6/1/22
48	Blue Ridge Public Radio	'We Need Action' Brevard Mayor Explains HCA Healthcare Lawsuit	6/8/22
49	Asheville Citizen Times	2 NC Officials Backing Asheville HCA Lawsuit Call New Brevard Case 'Serious,' 'Courageous'	6/14/22
50	Carolina Public Press	Why Small NC Mountain City is Taking on Nation's Largest Hospital System	6/14/22
51	Mountain Xpress	RN Rallies a Common Sight at Mission Hospital	7/5/22

52	Mountain Xpress	Asheville City Council and Buncombe Couty Board of Commissioners File Class Action Lawsuit Against HCA Healthcare, Inc.	7/28/22
53	Asheville Watchdog	Novant Offer for Mission Matched HCA Bid, Former Top Exec Says	8/2/22
54	Asheville Citizen Times	Madison County May Join 3 Other entities in HCA Class-Action Lawsuit, Court Filing Shows	8/5/22
55	Asheville Citizen Times	Mission Lawsuit Merger: Asheville, Buncombe, Brevard Try to Team Up in Class Action Case	8/5/22
56	Mountain Xpress	City, County File Class-Action Lawsuit Against HCA/Mission	8/15/22
57	Mountain Xpress	Nurses at Mission Hospital to Hold Aug. 25 Rally for Patient Safety, Speak Out Against Chronic Short Staffing	8/24/22
58	Asheville Citizen-Times	HCA Mission Health had year of lawsuits, staff, patient complaints	12/27/22
59	Asheville Watchdog	Attorney General's Office 'Very Concerned' About Changes at Mission Cancer Center	5/9/23
60	NC Health News	Doctors' Lawsuit: HCA Healthcare and TeamHealth Overcharged Patients	6/19/23
61	Asheville Citizen Times	Unsealed HCA Healthcare/Mission Lawsuit Reveals 'Humiliating' Job Performance System	6/19/23
62	Asheville Citizen Times	NC Attorney General Issues Warning to HCA for Employing Only 1 General Cancer Doctor	6/22/23
63	Mountain Xpress	North Carolina Attorney General Threatens HCA with Litigation	6/22/23
64	Asheville Citizen Times	NC Attorney General's Office Reprimands Mission Hospital Independent Monitor	6/23/23
65	Mountain Xpress	Mission Cancer Center Struggles to Recruit and Retain Oncologists, HCA Executive Tells AG	6/27/23
66	Asheville Citizen Times	Answer Man: How Many Chaplains Work at Mission Hospital? Are They Cutting Back?	7/3/23
67	Asheville Citizen Times	Mission Hospital Owner HCA Discloses Data Breach at Multiple Hospitals Across WNC	7/11/23
68	Asheville Citizen Times	Patients Arrive at Mission Hospital in Ambulances, Then the Waiting Begins	7/25/23
69	Asheville Citizen Times	HCA Executive Responds to Attorney General Over Claim of Mission Cancer Care Understaffing	8/3/23
70	ABC 13	Mission Health Counted Among 5 NC Hospitals for High Number of Lawsuits Against Patients, Report Shows	8/16/23
71	Mountain Xpress	Mission Patients Endangered by Emergency Department Transfer Procedures, Nurses Say	8/24/23

72	Asheville Citizen Times	HCA Data Breach Class Action Lawsuit May Include 11 Million; Mission Patients Notified	8/29/23
73	Asheville Watchdog	Citing 'System Failures,' Messino to Stop Providing Acute Leukemia Chemotherapy at Mission	9/21/23
74	Mountain Xpress	Messino Cancer Centers To Stop Providing Acute Leukemia Chemotherapy at Mission	9/22/23
75	ABC 13	Concerns Grow Over Loss of More Cancer Services at Asheville's Mission Hospital	9/26/23
76	Asheville Citizen Times	NC Attorney General Reprimands HCA/Mission Health for Providing Inadequate Cancer Services	9/29/23
77	Asheville Watchdog	Mission to Lose Last Remaining Medical Oncologist	10/6/23
78	Asheville Citizen Times	Mission Hospital Ambulance Patient Wait Times Lengthen While Buncombe Mulls Solutions	10/11/23
79	Asheville Citizen Times	NC AG Stein Considers 'Civil Investigative Demand' Against HCA/Mission's Cancer Care	10/12/23
80	Mountain Xpress	State AG Has Been Investigating Mission Hospital, But Some Question If It's Enough	10/13/23
81	Asheville Watchdog	50 Doctors, Including a Former Board Member, Publicly Decry HCA's Management of Mission Hospital System	10/19/23
82	ABC 13	Doctors, Patients Voice Outrage at HCA, Mission Over Lack of Quality Health Care During Public Meeting	10/19/23
83	ABC 13	Limited Power of Mission Hospital's Independent Monitor Has Doctors, Patients Seeking Accountability Elsewhere	10/20/23
84	Asheville Citizen Times	Mission Hospital Patients Staff, Decry Poor Care to HCA Healthcare Independent Monitor	10/23/23
85	Mountain Xpress	HCA's Independent Monitor Faces Tense Public Meeting	10/26/23
86	Asheville Watchdog	Former Mission Chief of Staff: 'I Truly Felt Like It Was a Moral Injury' to Work for Hospital	10/27/23
87	Asheville Watchdog	North Carolina AG Sends Investigative Demand for 41 Sets of Documents From HCA and Mission Hospital	10/27/23
88	Asheville Citizen Times	North Carolina Attorney General Issues Investigative Demand Against Mission Hospital	10/27/23
89	Mountain Xpress	Opinion: Is There Anything We Can Do About Mission and HCA?	10/31/23
90	ABC 45	NC Attorney General Alleges HCA Violated Terms of Mission Purchase Contract	10/31/23
91	Asheville Citizen Times	NC Attorney General: HCA Healthcare Failed to Comply with Mission Purchase Contract	10/31/23

92	Asheville Citizen Times	McDowell EMS Director: Mission CEO Patrick 'Disconnected' From Emergency Department Issues	11/2/23
93	ABC 13	Mission Health Under Scrutiny: Community Voices Concerns, Physicians Send Mixed Messages	11/2/23
94	Asheville Citizen Times	Mission Health Physicians Mount Response to Doctors Critical of Hospital	11/3/23
95	Asheville Watchdog	Messino Cancer Centers Founder: 'HCA Has Sold the People of Western North Carolina a Lemon'	11/10/23
96	Asheville Citizen Times	County to Mission: 'ER Situation Unsafe, Unsustainable;' New Ambulance Wait Time Policy	11/13/23
97	Asheville Watchdog	State Inspectors Visit Mission Hospital Following Nurses' Complaints	11/14/23
98	Asheville Citizen Times	Pending Mission Hospital Bylaws, Policies Threaten to Punish Doctors Who Speak Out	11/15/23
99	Asheville Watchdog	Doctors Practicing at Mission Reject Proposed Bylaws and Policies by a Single Vote	11/16/23
100	Asheville Citizen Times	Mission Hospital Doctors Oppose Silencing Governing Documents In Nail-Biting Vote	11/16/23
101	Asheville Watchdog	As State Inspects Mission for CMS, Hospital Makes Changes to Emergency Department	11/22/23
102	Mountain Xpress	As State Inspects Mission for CMS, Hospital Makes Changes to Emergency Department	11/22/23
103	Asheville Watchdog	Mission Changes Patient Transfer Process Following Watchdog Report on Nurses' Complaints	11/30/23
104	Asheville Citizen Times	Lawsuit: Mission Hospital Negligent Post-Op Care Led to Patient Death	12/7/23
105	Asheville Citizen Times	Court: Mission Hospital Owes Ex-Employee $5k for 'Emotional Distress' But Has Not Paid	12/13/23
106	Mountain Xpress	Mission Hospital Nurses to Hold Rally Today for Patient Safety, Demand HCA Address Unsafe Staffing	12/13/23
107	Mountain Xpress	Attorney General Josh Stein Sues HCA Healthcare	12/14/23
108	Carolina Public Press	HCA Sued by NC Attorney General For Not Providing Promised Care	12/14/23
109	Mountain Xpress	Mission Hospital Nurses Applaud Attorney General Josh Stein for Lawsuit Against HCA	12/14/23
110	Blue Ridge Public Radio	N.C. Attorney General Josh Stein Sues HCA Healthcare Over Alleged Breach of Mission Health Deal	12/14/23
111	Asheville Citizen Times	NC Attorney General Can Now Sue Mission Hospital for Violating Compliance Agreement	12/14/23

112	ABC 13	NC Attorney General Stein Announces Lawsuit Against HCA Healthcare	12/14/23
113	Asheville Citizen Times	NC Attorney General Josh Stein Sues HCA Healthcare and Mission Hospital	12/15/23
114	ABC 13	How the Lawsuit Against HCA Could Impact Health Care in the Mountains	12/18/23
115	ABC 13	McDowell County EMS Extends Its Pause on Non-Emergency Transfers to Mission Hospital	12/20/23
116	Asheville Watchdog	Year in Review: Mission Nurses' Complaints to State Set the Stage for Investigations, Lawsuit	12/26/23
117	Asheville Watchdog	'I Was Beginning to Feel Like I Was on a Sinking Ship,' Says Former Mission Hospitalist	1/2/24
118	Asheville Watchdog	After AG's Lawsuit, Dogwood Opens Applications for HCA Purchase Monitor	1/4/24
119	Asheville Watchdog	Wrongful Death Suit Filed Against HCA, Mission Alleges Catastrophic Medical Error, Other Missteps	1/10/24
120	Asheville Watchdog	Conditions at Asheville's Mission Hospital Pose 'Immediate Jeopardy to Patients' Health and Safety,' State Investigators Report	1/11/24
121	Daily Kos	DKos Asheville Open Thread: Misison Hospital News is Always Bad News Since HCA Took Over	1/13/24
122	Asheville Citizen Times	NC investigators cite 9 'Immediate Jeopardy' incidents at Mission Hospital	1/15/24
123	Asheville Watchdog	Draft report says charity care has declined 'extensively' at Mission after HCA takeover • Asheville Watchdog	1/22/24
124	Asheville Watchdog	'It doesn't have to be this way:' Watchdog event panelists decry HCA, call for improved care at Mission Health	1/24/24
125	Asheville Citizen Times	Opinion: HCA immediate jeopardy incidents could be disaster for WNC health care	2/4/24
126	Blue Ridge Public Radio	Elected officials call on HCA to sell Mission Health System in wake of 'immediate jeopardy' designation	2/6/24
127	Asheville Citizen Times	Federal government declares 'immediate jeopardy' situation at Mission Hospital	2/6/24
128	NC Health News	Feds cite Asheville's Mission Hospital for 'immediate jeopardy,' HCA division president tells staff	2/6/24
129	Asheville Citizen Times	3 patients died at Mission Hospital due to missteps, federal government report reveals	2/15/24
130	ABC 13	Report reveals patient safety issues, including patient death in hallway at Mission Health	2/15/24

131	Asheville Watchdog	The patient was subsequently found unresponsive in a hallway bed': CMS report on Mission Hospital details deaths of patients, significant delays in care	2/15/24
132	Asheville Watchdog	Doctors, advocates blast Mission's plan to correct immediate jeopardy, call for hospital to increase staff • Asheville Watchdog	2/21/24
133	Carolina Public Press	Mission Hospital fixes from HCA have NC advocates skeptical	2/22/24
134	ABC 13	Former Mission Health doctor describes 'slow-speed train crash' that led to state lawsuit	2/23/24
135	Asheville Watchdog	CMS details fifth patient death at Mission	3/1/24
136	Asheville Watchdog	Former Mission chaplain: "The moral injury that is happening there daily is staggering"	3/1/24
137	Asheville Watchdog	Mission Hospital still at risk of losing federal funding	3/8/24
138	Carolina Public Press	What HCA has told feds it's doing to fix staffing issues at Mission Hospital. Why nurses say it's not happening.	3/21/24
139	Asheville Watchdog	She had appendicitis. It took 12 hours, trips to two hospitals, and a needless pregnancy test before emergency surgery at Mission Hospital	4/9/24
140	Carolina Public Press	Web of Mission Health litigation grows. Buncombe seeks to join attorney general's case against HCA.	4/15/24
141	Asheville Watchdog	More than half of Mission's remaining staff neurologists say they are resigning, citing burnout, 'nausea and fury'	8/20/24
142	Tribune Papers	Controversy Surrounds Mission Health's Expansion Amid Concerns Over Care Quality	8/25/24
143	Blue Ridge Public Radio	Buncombe's lawsuit against HCA highlights struggle of patients in rural WNC hospitals	9/19/24
144	Asheville Citizen Times	Once-storied Mission Ethics Committee lost support after HCA Healthcare purchase	10/13/24

APPENDIX B

NARRATIVE ACCOUNTS OF PATIENT CARE AT HCA MISSION FROM PROFESSIONALS AND PATIENTS

This Appendix gathers, from a range of public sources, a wide array of narratives from staff, patients, and professionals that document and illustrate various points in in Parts 3 and 5, providing more depth and perspective. The sources for these excerpts are:

> Community meetings held in January and February of 2020 by the "Independent Monitor," who reports to the Dogwood Health Trust and the Attorney General: https://web.archive.org/web/20230924064347/https://www.independentmonitormhs.com/community-events-archive
>
> Complaints submitted to the Attorney General: https://ncdoj.gov/wp-content/uploads/2023/12/HCA-personal-impact-narratives.pdf
>
> "Mountain Maladies," a 15,000-member Facebook group created as a forum for the public, and Mission Hospital employees, to share perspectives and experiences, and express opinions about, Mission Hospital under HCA: https://www.facebook.com/groups/mountainmaladies
>
> Google reviews.
>
> Two Facebook groups and a "sub-reddit" for traveling nurses to share experiences and views about working in different hospitals:
> https://www.facebook.com/groups/1826228814370841
> https://www.facebook.com/groups/TheGypsyNurseNetwork/
> https://www.reddit.com/r/TravelNursing/
>
> Readers' comments posted in response to various articles about HCA Mission published by the Asheville Watchdog: https://avlwatchdog.org/?s=mission%20hospital

Because these excerpts are selected to address specific points, they do not represent the full range of views that can be found about HCA Mission Hospital. The excerpts here focus on problematic aspects. Other views can be found from these same sources that provide positive perspectives. Nevertheless, negative perspectives predominate in all of these sources, and excerpts were selected that represent experiences shared by others. Idiosyncratic views are not included, nor are experiences related to or during the height of COVID-19.

The excerpts are edited to focus on factual elements of comments, and to minimize expressions of pure opinion. Also, they are edited for readability, and sometimes for grammar and spelling. Excerpts are grouped by broad topics, and separated according to those from patients, and those from professionals and staff who have worked, or are working, at or with the hospital.

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I. Physicians, Staffing and Services

A. From Patients

1. Here is my experience with Mission since the HCA purchase. About 6 weeks ago I experienced a cardiac issue that could lead to a stroke. My primary care physician sent me to the Mission ER. That was an eye opener. After about 6 hours and some miscommunication, I was sent on my way and told to see a cardiologist. The earliest appointment I could get with Asheville Cardiology (read Mission) was [2-3 months later]. I was able to see a cardiologist [in about two weeks] by driving two hours away. ... Relying on Mission/Asheville Cardiology I would still be waiting for another 2 months to begin the diagnosis process … if I was still above ground. Up close and personal proof that HCA is not providing the medical service that Asheville needs.

2. I am type one diabetic and pregnant with my second child. Last year I gave birth in March at Mission [prior to HCA]. I had a great experience and after the birth my endocrinologist team came and checked on me and got my insulin back to pre-pregnancy levels and made sure I had everything I needed to go home healthy. Fast forward to now… I asked them if I would see them again after my birth and they said sadly no. They aren't going to the hospital at all anymore due to issues with HCA. …

That afternoon I went to my OB doctor for my weekly checkup. I mentioned this to him and he said sadly it's true and it is affecting patients. He said of course he could treat me if I go into [diabetic ketoacidosis] or have diabetes related issues during and after delivery (but this isn't his job and certainly not his field of expertise). He also said he has had [labor and delivery] patients recently waiting 2-3 hours for their epidural after the request had been submitted and [nursing staff] didn't even inform the doctor of the long wait. Communication is starting to lack it seems and it makes me sad because I thought I could feel 100% safe giving birth there this time again like last [time before HCA] but now there will be some worry in my mind regarding these issues. Hopefully I have nothing to worry about and won't have any complications that would require my endocrinologist.

3. It took forever to get someone to help me once I was placed on the floor [after] waiting hours in the emergency room. Once admitted, my IV ran out of fluid and for hours the machine was beeping, the nursing staff actually showed me how to cut the machine off because they didn't have enough staff to cover the patient load on the floor. The IV had dislodged and I had blood all over my bed, gown, and the floor. I pushed the call button time and time again only to have zero response from staff. Once someone finally came to my room, I asked multiple times to please change my sheets and gown only to be told they had no clean linens to give me. I spent two days in a soiled bed and gown. I am thankful I am able to ambulate because no staff was available to assist me for anything. The two nurses I encountered on my stay were both travel nurses and they told me they had 45 patients to cover alone on a single shift.

4. [W]hen I landed in the North Tower, I was appalled by the lack of nursing help. The doctors were great. The nurses were overworked. There was no cleaning staff. We did not have time or

access to the cleaning material so that my projectile vomiting from major GI issues stayed on the bathroom floor for three days. This was a surgery ward with people screaming and no help anywhere. I could not believe I was a patient and had to fight for getting transferred to rehab. I'll not go into [other] issues. Enough has been said about that, but the vomit remaining, granted it was my own vomit, but in the bathroom for three days with no cleaning help and no staff was pathetic.

5. My husband was there in February of 2023 and although the nurses were running, they were short staffed and their equipment was constantly breaking down. The food ... was inedible. After a week of him not being bathed I asked the [nursing assistant] when he would be bathed and she told me "they don't do that anymore because they don't have time." The only place I felt OK to leave him for any length of time was when he was in the ICU where there was better staffing. ... And finally, when he was eventually admitted to HCA Care Partners Hospice, we couldn't get the in-home care we were promised and that we sorely needed to keep him comfortable at home. The entire experience was horrifying and I have not even scratched the surface of all that was wrong.

6. I recently stayed overnight with a friend on a post-op floor. That night there were 44 patients being cared for by two nurses and one [nursing assistant]. Vital signs are usually done twice per shift, there are routine meds to pass, post-op patients need assistance getting to the bathroom, charting has to be done, pain meds may need to be administered, etc. That's just the minimum. Staff needs some break time, maybe even a meal break. What about a lonely, scared, depressed patient who just needs some comforting? These staffing levels are just wrong.

7. The [cardiac catheterization] procedure went well … until the little imbecile who was putting the [IV bands] on my wrist. She misses the first one and says oh we have a hematoma and proceeds to add another [IV band]. … So they take me back to my room. And as I had told numerous people the [medicine?] they had me on had given me diarrhea something terrible. I had told them when I ring and say I need to go to the bathroom someone had better be on the way. .... Well this was a little while after I got back to my room and I knew I had better go. So I rang and said what I needed. Well no one showed up for five minutes and I knew I had to go. So I got up and in trying to get to the bathroom I had an accident. So when the guy got there I told him just unhook so I could go finish. So he did. Well I fainted sitting on the john. When I came to with about 5 people standing around my bed one of the male nurses said, these bands are too tight, her hand is turning black. Get that girl who did this up here. Well it got worse, for twelve hours I was in pain in my arm and hand and the feeling was gone in my fingers. …

Now to your housekeeping. I laid in my bed for two mornings and watched with my own eyes [housekeeping do a cursory job]. … I made sure to go back in the bathroom before I was released and the feces was still on the door facing, shower edge and kick board on the bathroom wall. …

I have had two children, a miscarriage, an aorta bypass and 6 [catheterizations] and I will say this is the most traumatic, horrifying experience I have ever had in my life.

8. [I saw] in person in a friend's room [what others have been writing about]. Poop everywhere in the bathroom. If a guest needed to use the restroom, well I wouldn't because it's so vile. [My shoes are] sticking to the floor it's so nasty. You can see the nasty bed table rust/filth dripping off yuck onto/near sutures. I was … at the Humane Society earlier in the week and some of the dog kennels were cleaner. The nursing staff have however been SO KIND—-just stretched too far. We were told that case managers are responsible for multiple floors as of late —often with over a hundred cases. This can't continue.

9. Anyone that has experienced being a patient at HCA/Mission or staying with a patient at Mission knows it's a horror show. One doctor shows up and prescribes xyz and the next day another doctor takes it away and prescribes abc. The next day some new traveling doctor takes everything away to evaluate. Meanwhile, patients can't get help to the bathroom, no food is provided or it's awful slop, no pain meds given.

10. They brought [my husband a box with a cardiac monitor to take home], put it on the bed and said make sure when you go to the device clinic ... that you bring this box with you. Nobody gave us any instructions. We come home, we have the box, he's at home. Two weeks goes by and we had the appointment .... We go in there and the technician says, "Oh, have they been checking it for you?" and we said, "No, we came here because we thought you were supposed to." And she said, "Nobody gave him any instructions?" … I said "No." So, she said, "Well let me go ahead and check this." So, she put on this portable thing and she goes, "Oh my God," … he had four and a half hours of atrial fib, which probably caused his stroke.

So, when I went to the cardiologist, … I said to him, "So, what's happening …?" He said, "Well, I'm really sorry about this." [My husband] was on the neuro floor, and [the] Dr. said they used to have a private group come in that works with these monitors and they would instruct the patient and tell us how it works, but he said the hospital has let that go, and they depend on the nurses to do that. Well a neuro nurse didn't know how to do that. So, then we come home, and … to this day it's still not working. … [When I called] they go, "Oh well, go ahead and call again." And when I did, they said, "Oh, well our phones aren't working. We have a private outside group that will be in touch with you." To this day, I've still not heard from them.

11. Mission HCA in Asheville has announced that as of the beginning of March, the Mission Cancer Center will no longer have a retail pharmacy. This shows a blatant disregard for patient care and continuity of services. It is the only one of its kind in western North Carolina, seeing patients from all over the region. Integrative health, cafe, gift shop, and now the pharmacy, have all been taken away from patients, families, staff, and providers enduring or participating in difficult and EXPENSIVE medical treatment. Mission still doesn't see the need to keep these important services that help those of us being treated on one of the five floors. Our pharmacists here know all us [cancer patients] and can easily message upstairs for anything we need. They catch mistakes, advise us, and even courier our medication to us when we are too sick to come back for a delayed medication. I am deeply sorry for all of the wonderful, dedicated staff members this negatively impacts. This is a tremendous loss for so many who are reliant on this vital service in what Mission HCA still refers to as their cancer institute.

12. I'm greatly concerned about the closing of the ... wheelchair seating clinic [at the rehab facility]. As a person born with cerebral palsy, the wheelchair clinic has been an invaluable, necessary resource for me. The clinic is where I've been properly fitted by a specialized physical therapist for each wheelchair I have used since I was five years old. I'm now 28 years old. Each particular part of my chair, footrest, back, back seats, etc. have been fitted and customized to my individual body alignment in order to provide proper positioning, minimize scoliosis, prevent pressure sores, and maximize my independence as a human being. … With the closing of [the] wheelchair clinic in Asheville, I have to find someone to drive me round trip to Charlotte or Greenville, South Carolina. This is an incredible inconvenience to me and all disabled people who rely on wheelchairs for independence. What is the rationale for this closure? I know we are a really small minority group, but we are part of this community and therefore expect our hospital system to value us as consumers of healthcare.

B. From Professionals and Staff

1. Loss of Physicians

13. [From a Mission nurse]: Talked with a friend today who had gone to Mission ED with amputated fingers from accident. No hand surgeon available or on call that day. No surgeon available to reattach fingers! Told to wait until surgeon available the next day or go to another hospital. Took ambulance ride to Charlotte for immediate surgery. Mission is supposed to be a trauma hospital!

14. [In response to a] post early this morning about the lack of hand surgeons on call at Mission. I have first-hand knowledge of exactly what is going on down there. I want to merely let the community know the facts, of what a pit of despair … Mission has become. Mission hand trauma call [service] … used to have 24/7 coverage until about [a year prior to HCA's purchase]. Since then, a couple providers have retired, and a few have [stopped] participating in call coverage due to the way administration has been running the hospital, frequency of call that the hospital "requires", etc. … There have been [only two] hand surgeons taking call from the community … almost exclusively for the past 2 years. This was not sustainable for them to shoulder the burden of call themselves.

The hospital's answer was to hire locum tenens [temporary traveling] docs to cover the call on a "majority" of days that the two local hand surgeons were unavailable. There were still uncovered days without any hand trauma coverage. Most recently, the administration has been absent from any communication involving problems those surgeons experienced with the hospital, so after the declining cooperation of HCA, and the increased problems regarding to locum coverage, lack of proper hand-offs and follow-up care from [the] out-of-town providers hired to take call, these local surgeons terminated their relationship with Mission.

After numerous attempts to improve the hand call situation to try to help the community, HCA showed no interest in improving the situation, or working with the surgeons who were working hard to hold this hospital together. I have even heard that they emailed one [surgeon] this weekend on Saturday at 3pm, demanding that surgeon take call on the 4th without any prior communication or notice of such need to cover call …. I have heard they have done this multiple

times to multiple providers, and this is why the surgeons don't want to be there. HCA has dug themselves into a big hole, and it will be difficult for them to recruit new hand surgeons into this toxic work environment. The surgeons that have not retired are all still in the [general area], they have just run far far away from Mission.

15. The hospitalists, as have been mentioned, are the backbone [at Mission]. … Well, guess what? Those hospitalists are leaving in droves. Their contracts had been renegotiated. Their salaries have been cut in half, and they've been asked to do more work. Anybody who doesn't have to be here can elect to leave.

… I came here from Stanford University, and when I came here, they were doing procedures here that we weren't even doing at Stanford yet. I was very proud to be a member of this [medical] community. …. Asheville's been a place that has always recruited the best, but now it's just a warm body. They're [starting] a residency of internal medicine residents. Well, guess what? Residents are people that are just out of med school. They need guidance. Who do you think is going to be guiding them when there's nobody available for them to talk with who has more experience? …

What makes people in this [medical] community want to stay here? … It's not just about money. This is a place where every caretaker used to be proud to work and now they're running out of here in droves. The smart ones got out early. The dedicated ones are having to seek psychiatric services because they're being asked to do things that really just aren't ethical…. I feel like what's happened is a travesty.

16. I would like to confirm the recent anonymous post concerning the loss of neonatologists, nurse practitioners, and seasoned nurses in the NICU at Mission. Many other nurses have cut down to part time or prn [as needed]. We also had one of our managers suddenly retire. There are so many days I don't know the nurses, practitioners, or doctor I am working with. Not only are we overrun with travel nurses in the NICU, but we have travel practitioners and travel doctors as well (called "locums"). We no longer have interdisciplinary rounds, where we sit down as a team with the parents and discuss patients. The providers just whiz through the unit to tell you what changes they made and if you have any questions. Protocols that decrease infection rates, chronic lung disease, or improve outcomes are not followed, because there are too many travelers who don't know what they are. It is common to find mistakes in doctors' orders or daily progress notes. The permanent staff are burnt out picking up the slack and trying to watch out for everyone else. …

The environment feels unstable and more and more unsafe, causing distress to those of us who care. NICU nurses are known for their fierce advocacy and protection of their patients. It is morally distressing when we feel unable to do that. I have spent the vast majority of my nursing career as a NICU nurse, but I question how much longer I can go on like this.

17. This is an anonymous message I received from a trusted healthcare provider regarding the decline in staffing in maternity services at Mission in NICU. I hope this opens a conversation about why so many people are walking away. Of all the things we talk about here, the most damning evidence showing HCA's decimation of this community is when our respected physicians and nurses walk away to protect their integrity and their license. Those folks don't just grow on trees. From a provider:

> "There's always a lot to any story and I could say so much about our NICU at Mission, but the big thing for people to know is that in the span of about 12 months, there has been a loss of 4 neonatologists (and 5 neonatal nurse practitioners) …. In addition to these losses there have been countless, very experienced nurses that have chosen to move on (I do not have these numbers). This is common knowledge for anyone working in the NICU but I'm not sure that many outside of our unit understand the implications."

18. [HCA's] answer is to take locum tenens [temporary traveling physicians]. Locum tenens are not people who are invested in their community. They're not here to stay. They don't have the connections. And truthfully, they're just clocking in and clocking out to fill a void. … Is that what you want for your family member? When you have cancer and you're in the middle of a treatment or your family is? To be taken care of [by] somebody who's just coming in the community to step in for a couple of weeks or a month who knows nothing about your care, and unfortunately, they may be one of only a few people that are available for you.

2. Nurse Staffing Ratios

19. [A nurse wrote to provide these examples of] what is currently happening: …:

A charge nurse is there to help other nurses and help navigate and lead the current shift. If a code blue happens or another medical emergency, a charge nurse is an extra hand to jump in and help. A charge nurse cannot fulfill their duties safely as a charge if they have a patient [load] assigned to them.

NTICU (neuro trauma ICU) is supposed to be [a nurse-to-patient ratio of] 1:2, (sometimes 1:1 if certain interventions are being done) and one charge nurse [without patients. What is] currently happening [is] 1:3 [ratio] and charge nurse … has patients.

MSICU (medsurg ICU) is supposed to be 1:2, (sometimes 1:1 if certain interventions are being done) one charge nurse [without patients. What is] currently happening [is] 1:3 [ratio] and charge nurse … has patients.

CICU (cardiac ICU) is supposed to be 1:2, (sometimes 1:1 if certain interventions are being done), one charge nurse [without patients. What is] currently happening [is] 1:3 [ratio] and charge nurse … has patients.

CVICU (cardiovascular ICU) is supposed to be 1:1 [ratio] or even sometimes 2 nurses per one patient or [2:1], one charge nurse [without patients. What is] currently happening [is] patients [who are] are supposed to get 1:1 [are] being doubled or tripled [up] and charge nurse … has patients.

[C]ardiovascular progressive care: [Is] supposed to be 1:3 [ratio], one charge nurse [without patients. What is], currently happening is 1:5 [ratio] and charge [nurse has patients].

RENAL floor- supposed to be 1:4 (ratio), one charge nurse [without patients. What is] currently happening [is] 1:7 [ratio], and charge nurse [has patients].

20. Day Shift: Intermediate care was 1:5, med-surge 1:7 or 1:8. Charge nurses were no resource as they also were assigned heavy pt. loads. [Nursing assistants were] called out [to other units] or were rarely seen. No [clerical staff], no dietary either. Nurses [handed out] and retrieved trays. The nurses did [the jobs of], the [nursing assistants], the secretary and dietary. … Working conditions so trying a Union was formed by their staff in a Right-to-Work State, please let that speak volumes. It's really a shame as I heard they were this amazing hospital before purchased by HCA. Majority of nurses are travelers. Still I met some amazing and talented (with grace under extreme pressure) nurses.

21. [From a] former mission employee. … PCUs [progressive care units, which are 1 step below an ICU] run 1 to 5 [nurse:patient ratio], but have taken as many as 7, including for charge [nurses]. Med surg is 1 to 6 but can run up to 8. Usually no techs or just one tech for whole floor.

22. The nursing staff was promised at the very beginning of this take over that our nurse-to-patient ratios would not change. That remained true for only about 3 months. ... [Then], I noticed that our staffing grid had changed. …. We used to care for no more than 6 patients at a time. In recent days our nurses are caring for as many as 10 patients at a time. This is absolutely unsafe and has led to our nurses and unit staff feeling burnt out and defeated. We are taking on heavier patient loads, have less support staff, and have new tasks regularly being added to our list of things to do. So, as you would probably expect, our nurses … are quitting, and we have fewer and fewer nurses to staff our unit. The Mother-Baby Unit has experienced a loss of over 18 nurses in a span of about 6 months.

23. Go to Asheville to visit. Never work or be hospitalized there. Mission hospital … used to be a wonderful facility about 3 years ago before a sketchy deal happened and it became for-profit HCA. Apparently, a lot of their wonderful staff left at that point. When offered the position I was told that I would get ratios of 1:5 on the oncology floor, breaks, and be working in the newer part of the hospital. However … [it's not] worth the trauma I experienced at all.

The first week they had me up to 6 patients, floated me to a spine unit I was not competent in with no direction, leadership, or support from the staff. Of my assignment on the spine unit, I had 3 [of] 6 patients actively confused jumpers spaced throughout the entire hallway. I met a new grad [on the] night shift[] who had told me they flex her to 7-9 patients overnight. My second week I had worked multiple shifts without any breaks (food/potty/water), another traveler who had started with me was made charge [nurse] with 5-6 patients (we both did not have any charge experience).

I did talk to my manager about this and how I was scared I'd lose my license but … after that meeting, nothing changed. I [gave] my two weeks [notice] the day they assigned me 7 patients on day shift. … We were expected to take care of 7 patients with no [nursing assistant], no charge [nurse], and the 3rd nurse we were expecting never came. We were left on the floor with 2 nurses and 22 patients. … Mission hospital was the absolute worst assignment I ever took. I met some of the best travel nurse buddies there but I wasn't getting paid enough to try to ride that out. Good luck, for the love of God, please don't work there unless you absolutely need to.

24. My daughter formerly worked at HCA-Mission as an RN on a Med-Surg floor. Per the nurses' contract, staffing should be 4 patients per nurse. Actually, it is 5-6 patients per nurse on day shift with night shift having up to 8 patients per nurse. There are to be 2 [nursing assistants] per floor per the contract, which rarely happens. Charge nurses usually do not have a patient load but at HCA they do. Grievances are filed constantly but go unaddressed or disappear like nothing is wrong.

25. I am currently under contract [at Mission] and have literally floated to every single unit in the entire hospital except OR. … The assignments are heavy and hardly have [any nursing assistants. Patient ratios per nurse are]: ICU:3 pts. PCU [a step down from ICU]: 5 pts. Medsurg: 6-8 pts. [Emergency room] holding is an absolute nightmare, you get 6 rooms with around 20 pts throughout the night.

26. Nurses were so pushed to the limit that on [a] 36ish (I can't remember the exact number) bed unit, the ratios were 8-10:1. [Ratios were] 5-6:1 in stepdown [unit] and 8-10:1 in medsurg.

27. The floor ratios here are pretty unsafe. I almost always had good safe ratios in ICU, but SDU [the step-down unit] is usually 1:4 or 1:5 (6 if you're ER hold!) and the problem with that is they allow high acuity patients on SDU. And frankly, a lot of the time they end up with the 1:5 ratio on that. [An unstable diabetic patient needing blood sugar checks every 15 min.] ends up on SDU...which is totally appropriate when ratios are 1:3 or sometimes 1:4 (if all your other patients are stable and not needy) but I have had many SDU assignments where most of my patients are slightly unstable and [needing frequent attention]. Really unsafe if you ask me. …

28. Worked on an Ortho floor, 7:1 ratio pushing 8-9 at times. Often no tech. Floated every other day. Last straw is when they floated me to a trauma unit with no experience even after expressing my discomfort. I quit the next day.

29. Just found out that one of the med surg units will be taking 8 patients per nurse. While our ratios are sometimes not great, this is just so unbelievably unsafe. Staffing [management] does not care at all. … [I'm] a new grad nurse and even though I would owe HCA money if I broke my 2-year contract, I'm tempted to look elsewhere as many other new hires are. We are defeated because at times the patient care is atrocious, [so] we are set up to fail.

30. Just finished [a traveling stint] in Asheville. Area is fantastic, hospital is awful. Can't get ahold of doctors and hardly any staff -- no techs some days and they [definitely] don't follow 1:6 ratio. Some days I had 7 and some nights nurses took up to 8 patients.

31. I was staff there. A lot of days were 1:7 and 1 [nursing assistant] for a 44 bed unit so - you're the nurse and [the assistant] for 7.

32. Pros [of HCA Mission]: none. Cons: understaffed. Floated often. Rarely [nursing assistants]. No [clerical staff]. High acuity patients on [the regular] medsurg floors. [Detoxing patients] with high scores, insulin drips, fall risks patients. Can have up to 6 or 7 on night shift. … Unhappy staff. Granted. I was there 3 years ago, so maybe things have changed. But it was my worst assignment in 6 years.

3. General Conditions

33. [Advice from a travel nurse]: Be prepared to clean your own patient rooms and empty trash, draw your own labs, page multiple doctors in order to find the right one, do your own vitals and blood sugars, because every single facet of that hospital is purposely short staffed to maximize profit. 5-6 [progressive care] patients per nurse.

34. I've worked in 9 hospitals and this one made me question being a nurse. Unsafe, dirty, and all around terrible! … I'm tough and can handle a lot but this place is scary and dangerous for patients and your license. 100 [out of] 10, [I] would not recommend!

35. So, here's a few things you can share with [others]:

1) we received notice at 5am this morning that there was ONE phlebotomist in the ENTIRE hospital due to the other 3 calling out sick. All nurses were therefore responsible for drawing their own labs. For the nurses that had 5, 6, 7 patients, this became a very timely task, not to mention if there were an emergency. Obviously, the phlebotomy department is not to blame- who could blame them? They are already extremely short as it is and tasked with meeting demands for the entire hospital far beyond the capacity of the department.

2) Courier services are no longer. When blood was needed for a patient [in another building] the other night, the charge nurse had to leave the floor and take her own private vehicle across the street to retrieve the blood. The tube system was down.....yet again. …

3) A patient had to be transported to Mission [from Mission's long-term acute care facility] for a procedure. The nurse had to accompany the patient (for high level monitoring) in addition to the EMS transport team. The nurse had to leave her other patients in the care of another nurse. After the procedure was completed, it took transport FOUR HOURS to be able to retrieve the patient and nurse to bring them back to [the long-term acute care facility] via ambulance. That means for 4+hours, one nurse assumed the care of her own patients as well as the other patients that nurse had to leave in order to accompany said patient to the procedure. Absolutely unsafe staffing practices for the staff to monitor several more (very ill, ventilated) patients while another nurse had to leave the floor. Absolutely unsafe for the patients who were under the care of one nurse where a safe ratio is far fewer.

36. I work in the behavioral health unit over there in Mission and just in the time that I've worked there, they have cut staff drastically. The first thing they did when they took over is [to get] rid of the [unit secretaries] and they told behavioral health techs you got to do that job too …. [A]s a behavioral health tech I'm not a CNA [nursing assistant]. Now they have behavioral health techs do CNA work and quite frankly it's terrifying that I'm afraid that I'm going to hurt somebody, whether it's in the geri[atrics] department or on my unit because we have medical patients on my [psychiatric] floor. They don't train us, and if we say, "I don't know how to do that," I get yelled at. That is a really scary position. I tell my patients, "I'm not a CNA but I'll help you, can you tell me what I need to do?" That makes them feel *real* confident, [I'm] telling you right now.

And, additionally in my unit, they don't even supply enough stuff for what we have to do. In one week, the entire laundry department quit and there was no one. And now we have to go find our own linens and bring [them] up to the unit. So now we deliver our linens, we do the [secretarial] duties or CNAs [nursing assistant work], and they gave us more patient load and they're short on staff cause everybody's leaving.

I don't know what's going to, what it's going to take to make changes for the positive, because I've [gone] up my chain of command all the way to HR about this and … I was told by my [supervisor] that I shouldn't have done that, that I should have kept it in-house. [But] that's supposed to be reported, so that patients are safe.

Something is really wrong here. It's really wrong. I mean I hope I don't get fired for saying something, but at the same time, the patients I take care of are some of the most vulnerable

population, whether it be because … they're mentally ill, they are suffering with an addiction, they're old.

37. Yes it is very true that close to 9 Phlebotomists left Mission at the same time. There are so few phlebotomists on staff that they are just overwhelmed. In fact just a few weekends ago there were only three phlebotomists for the entire hospital, the fourth was in the ER.
… I think it's important to know that the direction forward appears [to be less and less] phlebotomy and this duty will be pushed to the floors for [nurses to do] timed, [urgent], and stat [blood] collections. I wouldn't put it past them to simply make this a full responsibility of the floor [nurses], only sending a phlebotomist once [two] unsuccessful sticks by two different staff had been attempted.

38. [H]ere are a few staffing issues we have faced since the HCA takeover:
… If a patient has to be transported [from the long-term acute care unit] for a procedure in [interventional radiology], for instance, the nurse must go to monitor the patient on telemetry. Sometimes one of two respiratory therapists [RT] must accompany the patient as well. It has been noted that the patient along with the [therapist] and nurse can be gone as long as 5 hours for a procedure that usually takes less than 1 hour. This leaves the other [therapist] to cover the floor of approximately 28-30 patients and another nurse to then assume care of the patients for the nurse currently off the floor. This leaves 1 nurse with 5 patients- on ventilators, vasoactive drips, telemetry monitoring, etc. . … Medications are then often given late as a result, not to mention other dangers faced by patients due to the temporary decrease in adequate staffing.

39. [From someone working in patient transport]:
The nurses in the ER have been extremely helpful in helping us with moving patients and getting them up to rooms accordingly. Something they shouldn't have to do, but do. Unfortunately like everyone else in the hospital, we are stretched so thin staff-wise we cannot keep up with the rate that [patients] need to be moved. This results in some patients sitting for VERY long periods of time in the [ER]. I've witnessed patients being left sitting in [ER] rooms for prolonged periods of time (sometimes hours) laying in their own mess while they wait for us to get them up to their room.

I will say since the HCA rollover the transport department has been cut in half. We have half the staff and double the job load and we cannot keep up with high demands of the hospital. Like everyone else, we have sacrificed quality patient care for profits and ratios.

40. To Whom This May Concern,
I, [_____], RN, am officially giving my 2-week notice of resignation to the Mother-Baby Unit of Mission Health, [due to dissatisfaction with the terms of the new work contract HCA offered]. I would like to share some background as to why I have made this decision. …

Mission Hospital was once such a beacon for our community [through various volunteer activities.] … My co-workers and I truly felt cared for by the hospital management and the community. We were a community. … I was always so impressed with how clean and nice our hospital was. We were blessed to have the equipment replaced when needed and in a timely manner. The rooms, hallways, nursing stations, and lounge areas were always comfortable and clean. … I was proud to be an employee of Mission Hospital ….

I can't deny that society has been changing, the economy has been changing, politics are changing and therefore healthcare is changing. Mission has not been able to escape this …, but to experience a nonprofit hospital being taken over by an enormous money-making corporation has been devastating. …

HCA started by taking [away] our support staff. Our unit secretaries were removed from the units and .... [our nursing assistants] were either moved to other areas of the hospital, let go or placed in the secretary position so they could now take on both the role of the secretary and nursing assistant. … Our [Mother-Baby] unit requires having a secretary at the desk at all times as their role is a very busy one. Letting patients and visitors in and out of our locked unit, answering phone calls, answering call bells for 34 rooms, making charts for all of our new patients, breaking down charts for all of our discharged patients, retrieving items from our tube system, making sure the right nurse receives the items sent, sending off important lab work to the state, entering information into our computer system, and answering the questions of countless people approaching the front desk as the secretary is the first smiling face you see as you enter our unit.

These are just some of the extremely important tasks our secretaries are responsible for. So unfortunately now, our [nursing assistants] can no longer do the many important and time-consuming tasks they previously helped with on our unit. [They] helped us bathe our tiny newborn patients, draw labs, and helped watch them when a mother or family member was unable to. They helped mothers to the restroom, set up rooms for new patients, stocked the unit with necessary equipment, they wheeled patients out to their cars at the time of discharge, and helped with many other tasks. Not having their vital support has definitely added strain to the workload of our nurses. ...

Not only is the nursing staff suffering. It appears the ancillary staff throughout the hospital are suffering as well. The hospital has never been as filthy and unkempt as it is now. Trash runs over and onto the floors in the patient rooms, nurses' stations, and lounges. Hazardous materials disposal containers have IV fluid bags and tubing pouring out into the medication room floor. Laundry bags pile up and run over onto the floors of our soiled utility rooms. Meal trays are constantly left behind in the patient rooms. Sinks and toilets aren't being kept clean, and, most concerning, leftover items from previous patients are being left in "clean" rooms and baby bassinets. So, why is this? Every time I ask what is going on I receive the same response "We are short staffed. We are doing the best we can." I know this is true and very unfortunate. Yet again, guess who gets to pick up the slack and take out the trays, empty the trash, and reclean the baby bassinets? The already overstretched and overly stressed nursing staff … do it ourselves. …

I am truly sad to be leaving my unit [due to dissatisfaction with a new compensation model]. I know my fellow coworkers and work family are hurting as they work through the most trying times we have ever experienced. … I am praying for all of the staff of Mission Health. I am also praying for the community served by Mission Health. HCA is not who we are.

41. I know patients are getting sicker because we are short-staffed. There's just less staff on the floor to be where we are needed. Being one of two [nursing assistants] on a 44 bed unit (well, the only [one] for the past month) we can't walk people, reposition [patients who require] total care or patients with bed sores, provide requested hygiene, let alone make it to all the bathroom calls and bed alarms when confused patients might jump the rails. It makes me feel helpless seeing patients get sicker and lie in their own feces for upwards of an hour. It also makes me feel guilty whenever I start to lose my patience with a dying patient who has anxiety and OCD and wants me to arrange

her flowers a certain way. Then I feel overwhelmed when trying to balance the stress of not finishing my responsibilities which is every day now. These frustrations are not the patients' burden to bear.

When I spoke to my manager, she asked if the problem was nurses not helping. I responded, "no, the problem is that the nurses can't help!" Our nurses have 6-7 patients [as does] the charge nurse and there is literally no physical way we can be everywhere. I have worked several shifts where nurses have broken down sobbing, stretched beyond their breaking point, asking me, [just a nursing assistant], "what should I do? I can't do this anymore.…

There needs to be change. I'm sure all the other floors are going through the same thing. My question is, who do I talk to? … I will be attending nursing school in the Fall and I understand this might sound naïve of me, but I want to make that change happen myself. Whose boss do I need to become to make this happen? Please tell me because I will work from the bottom up until it is done."

42. I'm a nurse on the neuro floor …. Most nights I come home weary and sad that I haven't taken care of my patients like a nurse should or would. … Doctors on our floor ask us why are we still working on the floor. The [nurse practitioners] help you get people to the toilet, and some have even helped pass out food trays. I mean they know how hard the neuro floor is. Our patients [require] total care. That means sometimes they have to be fed completely. They urinate and have BM's in bed. When we have time and remember, we know they need to be turned every two hours. At shift change when you have 5 or 6 patients, you have to get them all cleaned and it's just you.

Vitals, meals, incontinence and [glucose monitoring] are on you when the [nursing assistants] are floated [to other units]. … I don't have patients for primadonas on my floor and I'm quick to tell them all You have is me today, and oh by the way you're not my sickest patient so please hang on. Sometimes, patients have BM's in their beds but at least they didn't fall, hit their head and have to do a MRI for concussion.

43. There are so many issues and reasons for the long wait times in the ER. Lack of staff is definitely the main issue. Now imagine you're already short staffed, now you have several techs and nurses transporting patients across the hospital to other floors. That could take at LEAST 10 mins to get there. Most of the time even when you get to the room you have to rearrange the room to get your patient in the room AFTER you wait for floor staff to assist you. …. Meanwhile the rooms that were discharged are dirty and [carts] are lined up. Everyone's radio is going off with "we need urine now, discharge now, trauma alert, we need extra hands for a code, can someone take a patient to labor and delivery, we need a tech for a change out, we need a tech for EKG, why hasn't urine been collected. You gave 2 mins to get this patient to the room" from someone SITTING at a desk! We can only do what we can do and we're doing our best but the focus is on time and metrics and not how to better assist the little bit of staff that is left. WE ARE TIRED! WE ARE STRESSED! WE ARE UNDERVALUED! And that goes for nurses, [cleaning staff], techs, physicians, registration, psych clinicians, [respiratory therapists], cafeteria workers, floor nurses, lab, pharmacy, phlebotomy and ALL! We're all getting burnt out.

44. I wanna start by saying we have some amazing nurses, but I want to focus on the [nursing assistants] for a moment. Someone mentioned that [they all go] through several weeks of telemetry training before they can monitor the patients on telemetry. Well did you know that the [ER] techs had [just] two and a half hours to go over [how to monitor heart] rhythms, take a test, and then boom... go monitor? On top of that, they were eventually forced to do telemetry whether they

wanted to or not, with the threat of their pay being cut. The nurses are extremely over worked, but imagine being the only tech with 24 patients, 6 to 8 nurses asking you to do something, transporting patients from the new ER to the old part of the hospital, taking patients to labor & delivery, take visitors back, cleaning rooms, stocking the rooms, doing EKGs, change outs, participating in [dealing with unruly patients], walking things to the lab when the tube stations are down, and any and everything else that comes through the radio or phone. Before moving into the new ER, some techs were forced to go from night shift to day shift because of the lack of techs on day shift. This resulted in techs [quitting], causing both shifts to be short. With that being said, the techs are drowning too.

45. I've been [a physician in] this community since [the mid-1990s]. … I'm currently retired and disabled. I have been a patient here as well as a member of the community, and I have grave concerns over what's happened since HCA has bought our hospital. ...

The trash: Not only does the trash not get taken out, it doesn't get taken out in the ICUs. Patients are having to clean their own rooms or family members are. … Patients have been admitted to rooms where there is urine from other patients on the toilet seat, including trash that hasn't been taken out from a previous patient. We are not in a third world country.

There are patients, because of the ratio of lack of nursing which you continually keep hearing, that are at risk and some have died because there was nobody to take care of them because the nursing staff was taking care of another critical care patient. … Patients are screaming into the hallway, please help, help. They're not in a nursing care facility. They're at a hospital where they're supposed to have assigned nurses, but these nurses are so overworked they can't come to get patients out of their bed to take them to the bathroom. … So, guess what? People don't want to crap or pee on themselves, they attempt to get out of bed, they fall over their oxygen tubing and then they fracture their tibia and fibula. True story.

46. [From an experienced travel nurse]: [Housekeeping] no longer cleans patients' rooms on many of the units unless they are discharged because they are so short staffed. Trash overflowing, the most disgusting floors I've ever seen in a healthcare facility.

47. 6 patients on medsurg is the norm and most units have no [assistants] or only 1 for the whole floor. The whole hospital is short staffed. Labs are taking hours to be drawn past when they're due, pharmacy often takes hours to send up a medication… Hardly anything is stocked in the nutrition room. Like I spend so much time just searching for a spoon or cup. Hardly any snacks for the patients half the time. … A couple days ago I heard they want to start putting patients in beds in the hallways outside of dirty rooms while they wait to be cleaned.

48. I'm here now on [a] PCU [progressive care unit, which is one step below an ICU]]. … I get 5 patients every freaking night. We float at least 1 shift a week and it's usually to the med surg floors where we have you take up to 7 total-care patients. Every unit in the hospital is understaffed. They float the techs every shift so you're pretty much getting your own vitals and doing pt [personal] care on your own. … The doctors don't seem to care about their patients either and are just probably too overloaded to care. The ED sends you patients with no report and half the time don't tell anyone that they've dropped a patient off in a room so its very possible for your patient to be in the room for hours without you knowing. I've stayed as long as I have because of the other fellow travelers but a lot of them aren't renewing so its sad to see them leave. The hospital itself is beautiful and Asheville

is beautiful but I wouldn't send my worst enemy here to get care. I feel like my license is on the line every time I clock in. They put you in dangerous situations and I just really feel bad for the patients. I do the best I can to get through the nights. … I'm never coming back.

49. Hi, I'm Dr. ____. I can't give patients' stories because of a HIPAA violation. I do have one patient story that happened to my own husband. … I've worked in an ER, I've had patients, I've admitted patients through an ER, I know how an ER should work. My husband went to Mission Hospital with a [high] heart rate and didn't receive his medication for an hour, not because of the lack of excellent staff, not because of the lack of excellent nurses, but because those nurses were also being asked to transport people. I was actually told by an administrator once who said we're cutting -- this is true, all these things that you're hearing are true – [we've] cut housekeeping staff, transport staff, respiratory therapy staff, CNA [nursing assistant] staff, food service staff. And then I have patients, I've come to see them, and they haven't had a bath in six days. They'd been in the hospital for six days without a bath. And, of course, the patient would be upset about that. I brought this up once and I was told, "Well, anyone can give a bath," ... "a nurse can give a bath." Okay well, if the nurse is giving a bath, when are they supposed to give the medications?

50. As an RN Patient Advocate, I receive multiple complaints each week about the quality of care at HCA. This past weekend a patient and family member called to report that the room was filthy and trashcans have never been emptied, and the nursing staff were understaffed and were not appropriately medicating a patient with narcotics for exquisite pain. She also stated they only had one Certified Nursing Assistant for the entire 40 bed unit for the last two days. Also, the physical therapist scheduled to work with the patient did not show up one day because they were short staffed, and breakfast comes at 10:00am because there are not enough staff to deliver meals on time.

51. As a Vietnam veteran, I receive all of my medical care at the VA hospital here in Ashville. I recently had a procedure that necessitated an overnight stay at the VA hospital. During that time, I encountered two doctors and four nurses. Each and every one of them said they had transferred to the VA from Mission Hospital. As an old newspaper reporter I had to ask why they'd moved. Almost unanimously they responded, "patient care" and "working conditions", particularly "understaffing."

4. Communication Difficulties

52. Communication between [doctors and nurses] is poor. You will page or text a doctor when they just put a note [in the chart] and orders in on a patient and they will respond that it's not their patient. Trying to find the doctor involves looking at multiple long lists, and they're not always logged into their phones. Some specialties you have to call their office and wait on hold.

53. ER doesn't call [to] report [when patients are being sent to a room] and I've had a few [patients] come up in bad shape. Getting ahold of a MD is a struggle … so in a pinch you have to go through the chart and figure out who to call and then see who is actually on call. Super frustrating place to work but the [geographic] area is absolutely beautiful.

54. it can sometimes be very difficult to figure out who the primary MD is for your patient. literally have had days where I had no idea who to call, because they don't update the attending in [the computer records], and the hospitalist team changes daily. … I will also say that I get a LOT of passing the buck with doctors here. I'm not sure why this is such a big problem here but nobody wants to order [even simple Tylenol as needed] if they can pass it off to another team. … I have never encountered so much of this anywhere else. Literally every day stuff like this happens for me. I had an ortho trauma doc yesterday tell me they felt more comfortable letting the hospitalist manage the pain meds… [That can't be true], you [just] don't feel like getting on the computer and would rather pass it off to someone else. To be fair, I think all the docs here are just as short staffed as nurses are. Literally every department here is short staffed, from food services, to secretaries, to RNs, to docs.

5. Heavy Reliance on Traveling or Less-Experienced Clinical Staff

55. This hospital has A LOT of traveler [nurses], its pretty much all travelers and older RNs who have literally been working at this place for decades. HCA bought the hospital a few years ago. Apparently, this used to be an incredible hospital. …. [T]there are a LOT of CNA [nursing assistant] travelers here lately, and this is not meant to diss them, but the quality really varies quite a lot. Unfortunately most of the traveling CNAs I have worked with here are a bit subpar …. [H]alf the time they haven't a clue how to use [the hospital's computer system] - to be fair they get like one day orientation just like the rest of us, and they get pulled to be sitters quite often (the hospital doesn't seem to hire straight sitters except for maybe the BHU, they just use CNAs to be sitters).

56. It has gotten increasingly more short-staffed since just 3 months ago. It's literally 70-80% travel nurses.

57. I am new to [my current nursing assistant assignment but] worked on a different floor before. … I [now] work[] on [a cardiac unit] for the first time. No training, I know absolutely nothing about heart patients. They gave me 20 patients, … [but] the other [nursing assistant] on the floor had all 40 patients and was also the [clerical worker]. [S]he said that that had become the new normal for [cardiac units] for one [nursing assistant] to take on 40 patients. .... I got off 2 hours late. I had to do things I had never been trained to do and hope I was doing it right.

58. [The clinical staff who remain] are trying so hard. These are good people. They're people that really want to do a good job for Mission. They're working with a lot of people they don't know that come in and out because they're travelers, and it's pretty well known in the nursing community – particularly in the OR nursing community and I am an OR nurse – that most of the hospitals in our country that have to use lots and lots of travelers are a bad place to work. And that's why they have to be travelers.

6. Patient Safety Impacts

59. Mission had to close one of the cardiac units due to short staffing, it was closed most of the time I was there. Transport dropped an ER patient off in the unit, all lights off, not a single employee there and left the patient. The patient was finally able to get ahold of the operator on the phone to find some help. You think that would be a [serious] never event [as defined by regulators], but Mission

was just getting started. They put signs up on the doors that the unit was closed and transport dropped off a SECOND patient, abandoning them to a very clearly closed unit. They dropped off 2 dead patients on one of the medical floors. The last one according to staff was just left on the stretcher in the hallway with a note on their chest that said "needs blood," and nobody noticed at first because they were in the middle of a code. One patient went down [to another floor] for a scan and then got put in a random hallway while waiting for transport and was left there for about 8 hours until family started raising hell asking where the f*** their family member was at.

60. You get [sent] patients from ER with no report most of the time, [and] the ER nurses are lucky if they know what the pt is there for. I walked out of a room and found a suicide patient sitting in [another room], dropped off, no sitter, [ER] didn't tell anyone they brought them.

61. [I'm working at Mission] now and would say 10 [out of] 10, not recommend [for other travel nurses]. … Poor staffing ratios. No help, pts dumped in ICU without reports given, suicide pts dumped in rooms and no one alerting staff and no sitter came with [them]. The list goes on and on! I've been traveling for 3 years and never wanted to quit a contract more!

62. Mission was my worst [nursing assignment] in my seven years of traveling. Ratios are now 1:7/8 sooo short staffed. A patient did commit suicide and it was the charge nurse's patient …. We had a patient arrive from [the ER] dead. [ER] said he was alive. No one was notified he had arrived. No support from upper staff members

63. I am an internal medicine physician who has been on staff at Mission for 19 years. Yesterday, I admitted an 88-year-old woman from her home. She was acutely confused without obvious cause. Among other orders was an order for IV fluids, as she was obviously dehydrated. It took 28 hours for this order to be accomplished. I spoke directly with her overburdened RN regarding this oversight. She informed me that she had called pharmacy three times today to fulfill the order. This is shameful care. I am astounded and horrified!

64. [From a retired physician]: Patients are being put on floors with nurses who have no idea how to care for them. Instead of being in an ICU setting, they're put up on a cardiac ward, their bowels eviscerate, they have a surgical life-threatening emergency, and the nurse doesn't know how to find the surgeon. … People come in with a routine ruptured [appendix] and ended up leaving two months later, 15 surgeries later, losing their bowel, having a colostomy bag, being intubated, trached, and then have a lifetime worth of surgeries that they continue to have because somebody didn't recognize that something had gone wrong. Things go wrong. I'm a surgeon, things happen. That's not the problem. It's recognizing it. We are not in a third world country….

7. A Near-Fatal Suicide Attempt

65. The event surrounding the [near-fatal] suicide [attempt] happened in the late afternoon and the rounder [a behavioral health tech. checking on patients] was 1hr behind. … This particular rounder tries hard to do their job, and I would not say anything bad about the rounder, as this individual is dedicated to their job. The patient that attempted to hang themself is actually not expected to survive, though we are praying the patient recovers.

[This happened in] the largest unit with 23 beds, [which] has a lower staff-to-patient ratio. Management says it is an easier milieu, but [the unit] routinely cares for patients that have a higher acuity level, medical psych, etc. Initially when [the unit] opened there were to be 4 RNs and 4 techs on days, 4 RNs and 3 techs at night. HCA changed that … by taking away an RN and tech from each shift. … Staff has consistently asked for additional staffing. Rounders are routinely having to do extra tasks while rounding, not to mention [the unit] has the largest physical space of all the units, and when rounders have to do extra tasks while they round, it is hard to stay on time with rounds.

After this incident, management decided to give [the unit] an extra rounder so that 2 staff are rounding when patients are awake. After the patients are asleep, it goes back to 1 rounder. That sounds great, right? Staff had been saying that something terrible would have to happen before adequate staffing was supplied. And it would appear to be true, right? But that is not so. Management told staff it was only for the weekend. The state was going to come and inspect our unit. Apparently, they just wanted to make it seem as if they would have corrected the issue.

Also, when the patient hung themself and a code blue was called, the code team couldn't immediately find a ride from [the main hospital] across the street. [The psychiatric] campus does not have a code team physically located there. It was an extended time period before a code team could arrive.

66. The [almost successful] suicide [attempt] at [Mission's psychiatric facility] has left the staff traumatized. Several nurses and BHT's [behavioral health tech's] told management that a second person was needed for keeping account of patient safety and whereabouts on the unit. [That request] was ignored. … [Afterwards, the] BHT who was tracking the patients that day was fired, and there is talk of more action against staff who were working that day. … The staff caring for patients all over Mission Hospital, in every department need relief from being held responsible for the dangerous decisions of management. This relief is needed now.

67. BHT's [Behavioral health technicians] on [my psychiatric unit] have had their job description updated to reflect that they also do what state certified [nursing assistants] on other medical floors and facilities do, such as cleaning patients if they soil themselves, shower patients, turn bed-bound patients to prevent bed sores, etc. …

[The recent] event [where a patient almost committed suicide during a thinly-staffed shift] has not brought about extra staff, but management [now] wants 2 [out of 3] BHTs to round [check on patients] from 715 am to 11pm, with no change to the daily tasks, group [sessions], or patient care (including caring for total-care patients). This effectively leaves 1 BHT to run group [sessions] and visitation, feed, ensure physical needs of patients (including patients [that require total care due to medical condition]) are seen to, and manage the psychological needs (de-escalation of patients that are escalating their problem behaviors), as well as cleaning the unit.

Staff morale is at an all-time low because the unit was operating on a shoestring before, and now it is significantly worse. [Psychiatric] staff work here because we truly feel a calling to care for a part of society that is incredibly vulnerable. We try to do our jobs to the best of our ability, but sadly many of us are looking for other positions due to the lack of safety for patients as well as staff.

8. Morale and Administrative Responsiveness

68. I have been an RN for over 40 years … in various hospitals [including] Mission for 14 years. I am retired basically now. … When I first … started working for Mission, I had just come out of some pretty nice hospitals, but I was very impressed with Mission when I came here. The staff was wonderful. We all really got along well. We cared. We were proud of where we worked, and I was happy that I had moved to a beautiful place like this, like Asheville, and it just happened to have a fabulous hospital and wonderful providers, and I just -- it breaks my heart to see what's happened. I no longer work for Mission, but boy do I hear the stories. I have lots and lots of friends that work for Mission. They are miserable. I'm speaking for them and the patients as well. The staff is miserable. They are.

69. This week has been just the tip of iceberg of how overwhelmed and inundated the ER and, by association, the rest of the hospital can become. It happens all the time but mid to late summer is typically the worst. I don't know why but it is. We warned them. We told them with data. But still they chose to decrease staff and close critical areas. And now they are being reactionary when all they had to do was listen to those who know our [geographic] area better than anyone. But they aren't suffering. They aren't the ones … who are trying to provide the best possible care in what feels like war zone conditions. Staff are suffering. Patients are suffering more. I'm heartsick.

70. [The psychiatric] unit has been unsafe since its opening last March. All staff have reported their concerns of the units' lack of safety for patients and staff. For so long we have begged for more staff only to be given less, and more responsibilities. We always said something tragic would happen and unfortunately it did [when a patient hung themselves and almost died]. It's not one person's fault, it's not the staff on shift fault. It's the management and HCA for not listening to the staff who work the unit day in and day out. … Our hearts ache because we feel as if we let so many of those we care for down. Many of us are looking for different jobs since this [near-suicide] event. … We are tired of working in an environment where our voices and those we care for aren't being listened to.

71. It is heartbreaking [what has happened to Mission Hospital], and the thing is, as several people have said here, I don't know how this can get fixed. How? Because it's Hospital Corporation of America and it is for profit and the first thing they do – they did it in the hospital down in Atlanta [where I worked] and they're doing it here – they get rid of as much staff as possible because that's the quickest way to help your bottom line. … [T]hey can get some of their medical supplies cheaper cause it's a huge corporation, but corporations, once again, they are not people. They're corporations. They don't really... they don't see the individual, whether they be the patient or the person working there. And so, I don't know the answer. I don't know how we can make a corporation accountable. Not really. So that's what scares me.

9. Supply Shortages

72. Add to [everything else that is wrong] the constant lack of supplies. Just this last week [in early 2023] we were out of IV medication tubing and 60 mL feeding syringes. Finding substitutes and work arounds for the lack of supplies is the norm. In the past year we have rewashed disposable bottles and nipples, rewashed feeding extension tubing, and split bottles of sterile water between patients.

I have contacted other NICU nurses I know throughout the US and no one is having the supply chain issues we are.

73. [From a nurse]:
No linen available to make ER beds
No isolation carts, i.e. gowns, supplies for Covid patient care
No critical patient supplies in Omnicell (supply room)
No patient care carts stocked [with] basic, critical supplies for immediate patient care
No beverages/ basic nutrition stocked in nutrition rooms ([due to] short-staffed nutrition department)
No commonplace meds stocked in pyxis (locked medication "dispensary")

10. Delays in Test Results and Scheduling

74. Sad to say my experience as a physician in the community is a very noticeable general decline in quality of care and functioning of the Mission Hospital System since HCA took over. Some care continues to be great, but I have many complaints and fears expressed by my patients and generally the quality of service is lower. This includes very dysfunctional communication from Mission related medical offices, totally unacceptable waits for appointments for specialty care and most alarmingly the hospital refusing to arrange follow up care for new urgent medical conditions before discharging patients. That was always a critical part of good medical care. We cannot settle for a 'Treat them and street them' (get them out of here ASAP) mentality.

75. I work at a pediatric office that serves 12,000 patients in [neighboring] counties. And ... [one of the] things that the providers that I work for are concerned about is … when we don't get records back from [Mission for] abnormal MRIs of the brain for 10 days, that not only puts our children at risk, but that further delays their treatment because there's very few pediatric neurologists that we can refer them to.

76. I work for a primary care provider who is not associated with Mission. I schedule testing, radiology, labs. We have to go through Mission now. They have eliminated the entire scheduling department at [the local community hospital]. They have eliminated the bookkeeping department. They have eliminated everybody. I had a stat radiology that I needed done [right away]. Five days, it took me to schedule it, five days. That is a shame.

77. I'm actually a practice manager of a medical office here in town…. I do agree with a lot of the people here …. There are scheduling issues. … We have patients who visit the ER, follow up with your PCP within five to seven days, we get no reports. We have no idea why they were in the ER. You have no idea what medicines were changed. We have no idea what medicines were given, what they were treated with, nothing. You call for medical records, forget it. 10 to 20 days at [a] minimum that it's going to take you to get those reports. I have spent hours on the phone with Mission … trying to get [the same] access [t]hat we have with [non-Mission hospitals]. … Nobody calls you back. If you do get ahold of somebody, they say "we don't know how to help you. We're just going to transfer you to somebody else."

11. Other Services and Functions

78. HCA is ruining the Solace Hospice facility. The pressure to keep cutting staff and other reasons has resulted in the physician, [nurse practitioner], clinical manager, 3 RNs and 2 [nursing assistants] to resign within the last 2 weeks. Since Mission acquisition and the HCA takeover so many seasoned caring dedicated Hospice team members have resigned yet [our] management has supported every cut and loss to this very valuable community service. All in the name of profit.

79. I'm a retired social worker. I'm also a licensed sign language interpreter, and I'm coming tonight with information that I've gleaned from conversations in the deaf community in western North Carolina about the changes at Mission Hospital in the past year since HCA took over. Primarily the use of video remote interpreting equipment rather than live, onsite interpreters. They use small [tablet] screens. … These are supposed to be on dedicated internet lines but often are not. At least 30 to 40% of the time, the equipment malfunctions, is blurry. The view of the deaf person is blocked so they cannot see the interpreter and participate in their medical treatment. HCA's unwritten policy of primarily using video remote interpreting equipment and their lack of staff training means if staff don't know how to use the equipment, it results in inappropriate, ineffective communication with deaf patients, endangering their lives.

80. I'm the assistant director [or an organization the provides] services for victims and survivors of domestic violence, sexual assault and human trafficking. … [U]ntil the mergers happened, we actually never had an issue with obtaining forensic nurses to provide forensic rape kits and forensic examinations for strangulation victims [at a rural Mission hospital]. Since the merger, I would say that 99% of the time we are responsible for transporting victims who have been violently sexually assaulted, trafficked sexually, or who have been strangled and physically assaulted all the way to Asheville to have an examination, which is unconscionable and inhumane.

In addition to that, if [Mission] does the transport, for example, the amount of time that the victim must wait to receive the medical transport by ambulance, again, is unconscionable. The last rape kit that I did, where I took a victim to Mission, we were there for 13 hours. That is only one of many examples. In addition, prior to the merger, we never had an issue with rape victims being charged for the use of the emergency room. We now are being billed, victims are being billed for the use of the emergency room at Mission. Again, that is unconscionable. … The last victim that I took over received a bill for $1,000s. The only services that she received in the emergency room was to have the rape kit performed. When we try to reach out to, again, resolve these issues, I will go back to what [someone else] said [about] the ability to access [anyone], because it is this entity that's just out there somewhere, to resolve those issues is impossible. When the services were localized, the ability to reach someone to actually resolve if there was a billing issue or billing question was much easier.

81. I feel that with all the lack of professionals, they've also lacked ancillary people like social services. So, mother/baby and pediatrics used to have four social workers. You have people coming in, they have babies that are premature, there's a ton of babies that are coming off of drugs because their parents are heroin or meth addicts. And there's nobody here to transition them to make it out in the community.

82. I have seen all of the posts others have been posting about Security and what is going on with them. Each one has bits and pieces which are all true but I wanted to make one that includes everything already mentioned plus some.

Before HCA took over Mission, we had an AMAZING Security Team. We typically had 12 Officers per shift …. We had hours upon hours of training every year …. We even had "extra" trainings on different types of things yearly such as gang knowledge, crime scene control, etc. … When it was Mission Security we didn't just hire every person who applied, you had to make the cut. You had to be a team player and a hard, dedicated worker who wasn't afraid to get hurt, because you would, period. We also had great insurance, a great retirement plan, and were paid at not only a decent base pay but also great shift differentials.

Now fast forward to HCA taking over… . Mission Security was given the run around when we first learned of the buyout on what was going to happen to our department. We were eventually notified we would be contracted out but that nothing would change. We would even get to keep our pay. WRONG! … From there it all went downhill. We lost our insurance, our retirement, and our shift differentials. ... On top of that we lost our training. Now when you are hired the only training you receive is [crisis prevention]. That is it. Nothing else. … They also now will hire anyone with a pulse. No background, no nothing.

[The new security company] was contracted to provide 12 Officers per shift (4 shifts) but has yet to even fulfill their contract. They didn't have enough people when the contract started (only about 15 stayed from the original Mission Security out of about 40) and they have yet to fill the shifts like they were supposed to. Why? Because the pay sucks, the benefits suck ….

A little over a week ago we were brought into four meetings, one for each squad advising us that HCA was cutting us back. They wanted us to go from 12 Officers a shift to 5! They only wanted 1 Officer at [the psychiatric facility] and 3 at Mission and 1 Supervisor to go between the two campuses and also handle outside calls. We were advised [the contractor] was hopeful they had gotten HCA talked back up to 7 Officers a shift but we have yet to hear. If so this would [still] mean [only] 3 Officers at Mission, [with] 3 at [the psychiatric facility], and 1 Outside. Anyone that works here though knows, that it can take up to 4 people and sometimes even 6 or more to handle a combative patient…

If you aren't familiar with what all "jobs" Security has, here is a short list: perform interior and exterior rounds, assist in behavioral health change outs and take possession of patient property, inventory it, log it in and store it, deal with contraband, return patient property, deal with lost and found, perform room searches, door locks and unlocks, respond to Staff Duress, Panic Alarms, HUGS (Pediatric) Alarms, Code Berts (Behavioral Emergency Response Team), respond to Fire Alarms, Code Blues, escort patients, staff and visitors to multiple locations, monitor cameras, take theft reports, visitor/crowd control especially during shootings, deal with the homeless and suspicious people and vehicles, assist with Shuttle and Valet, deal with irate patients, visitors and sometimes even staff, go hands on with behavioral health patients, people strung out on drugs, people who are intoxicated, people with [traumatic brain injuries], etc. You get the point... Also, now we assist with [decedent affairs] duties of pickup[ing up] the deceased, paperwork, and releasing of them. We also cover three lobbies … at night where we used to make visitor passes (pre-COVID) and now perform screenings. We are told this is going away but who knows. There is no way we will be able to cover [this] with such short staffing anyway.

It's not if but when … medical staff gets hurt [by an unruly patient]. ... We just thought our numbers were high now for people getting hurt, we haven't seen nothing yet. It is about to get bad.

Real bad. Patients even get hurt by other patients and that will continue as well. … I've said all this to say, things were bad, things are bad, but things are about to get real bad. … Stay Safe.

II. Emergency Room

A. From Patients

83. I'm here to tell you about the most unreal, horrific, traumatizing four days of my 74 years of living. On Feb 24 I was taken to Mission (HCA) by ambulance. I had asked if they transported to another hospital and of course was told no because they have contracts with Mission. So I arrived at the ER with heart problems at around 8:00 PM. I was rolled into a hole in the wall and then it began. I was on a gurney and that is where I was left. It was worse than pulling teeth to get any answers. I laid there for 24 hours, my back killing me and no one could give me a reasonable answer. … My daughter finally came in and in less than 20 minutes I was taken to the heart tower. My daughter stayed with me for about 15 minutes, until visiting hours were over. … Just as she sat down in her car her cell phone rang. She … answered and a young lady said "this is Victoria in ER, … could you tell me where your mom is." Needless to say my daughter's response was not nice. But we should have picked up on [the fact that] the nurse [did not seem to know anything about my case] when I got to the room.

84. I drove myself to Mission when I experienced unusual heart symptoms. … and went into the lobby at just before 10:00PM. I announced that I might be having a heart attack and was immediately steered to the screening nurse who gave me an EKG and took my blood pressure which was [high, as were heart enzymes and heart rate]. … After I was screened, I was directed to the crowded [ER] lobby …. [A]n hour after that I was called into the back for a chest X-ray. 5 hours and 35 minutes after I arrived at Mission, I was taken from the lobby into the ER and put in a room. I was hooked up to a monitor by someone who identified themselves as my nurse and who told me that the ER doctor would see me soon. It was now just before 4:00AM.

An hour later the ER nurse, stuck her head in and told me that the doctor was very busy but would get to me, she also told me that they would give me another enzyme blood test at about 6:00AM. Judging by his constant paging, there was only one doctor on duty in the overflowing ER that night. At 5:35AM a man showed up and told me he was moving me. Neither he nor anyone else ever told me why I was being moved. I was moved to [another ER room] and pushed into the room, the monitoring equipment was disconnected and [taken somewhere else] and I was never monitored again. No [blood pressure], no [heart enzymes], both of which had still been high in the ER. …

[By morning] I had yet to see a doctor. At about 8:00 I buzzed my nurse and asked for water and said I had to urinate. 15+ minutes later she brought me a urination bottle but no water. I explained I was very thirsty, not having had anything to drink for more than 13 hours. … At 11:00AM. I again asked for water on the intercom, I was denied it again. I literally pleaded and explained that I was dizzy from dehydration but again I was denied until I had a doctor's permission. I asked when I was going to see a doctor and the nurse told me a hospitalist wouldn't be available until after 4:00PM or even later. …

It's now 11:30AM. I call my primary care doctor and get him on the phone, he tells me to check myself out of Mission and come directly to his office. … Before I can leave, the still unmasked

nurse asks me to remove my jacket so she can take out my IV. I explain that no IV was ever inserted. The nurse says "OMG, that's unbelievable" and still makes me take off my jacket so she can see for herself. I have no IV. At a few minutes after 1:00PM, I leave Mission Hospital. I've been there for a little more than 15 hours and have never seen a doctor or been evaluated. [After further evaluation by his personal physician, this patient arranged to go to Duke the same day, where he immediately received a heart operation.]

85. Over more than 40 years in the medical device industry, I ran the three most prominent ultrasound cardiac imaging companies of their eras, all three are now owned by large international companies (GE, Siemens and Phillips). I've had countless interactions with cardiologists, radiologists and hospitals all over the world. Hospitals in third world countries handle their ER's and standard ER protocols better than Mission did that night in April. Mission violated many standard ER protocols in my case. I was there for over 15 hours and was never evaluated by or even seen by a doctor …. I sat in the outer waiting room for more than five and a half hours while exhibiting significant cardiac symptoms. I never had an IV inserted and I was there for a cardiac issue. I was never given the second enzyme blood test I should have received. I was not properly monitored during my stay and I had no nursing care, no one would have known if I'd had a heart attack. I was just warehoused and left sweating behind a closed door with no nursing or physician services. I was never even given a glass of water in 15 hours, though I begged for one. I believe I only survived because of my own stamina, strong will and because I finally signed myself out of Mission after 15 hours. I should have done so earlier, but I was ill and I kept assuming someone was going to help me. Wrong!

86. My 74-year-old husband was in the Mission Health ER [on a Friday night]. He has had multiple concussions since 1997 and can have seizures from that. ... He was treated massively abusively. He was strapped to a table so tightly in six places it restricted blood flow, and he could hardly move at all. He had no access to any kind of bathroom, and ended up wetting the bed, and was left in the wet bed. The next morning, he managed to get the straps off, and get dressed. I was talking on the phone with a doctor who was to give me an update, and the doctor said he's in holding in the ER, then looked around and said, "He's gone! We'll have to try and find him!" My husband began to walk around Asheville, and being a lifelong athlete, literally walked 30 or 40 miles trying to get to our home. He was finally able to reach me with a borrowed phone, and had had NO food in the ER, so he was hypoglycemic.

87. My husband had a stroke over a year ago and still cannot walk. The past month he can't stand or walk at all [since] he's paralyzed from the waist down and he finally was worse Friday and I called 911 for an ambulance. I arrived at Mission about 45 minutes later to get a pass to go in the back to him and they said he's in the waiting room. I could not believe it when I found him sitting in a chair and he can hardly sit up; he said, "I fell out of the chair here a while ago." They had helped him back up. I went straight to the front desk to ask what was going on they said there are no beds in the back and patients are being brought in from the ambulances to the waiting room. After being in there about an hour I did see them bringing patients in on a stretcher and helping them off to chairs. How is this possible when they are brought in an ambulance. Then it took us 17 hours later [until] he finally got to a room [in the ER].

88. I am not one to go to the emergency room but, recently circumstances came about that landed me there. ... Nobody seemed to know what was going on and the lack of communication is insane. I understand that things happen and I'm aware that you aren't seen as soon as you walk in the door. I'm not being unrealistic. There were people wheeling around their computers, to check patients in and get insurance information as well as to have them sign consent to treat AFTER being there for hours and hours or already receiving some form of care. I witnessed a woman in a wheelchair, with an IV in, slumped over the side of her wheelchair with her head and arm dangling for over an hour. I saw people with decent lacerations having to wait way too long to be triaged. ... Everything I experienced that trip was like being in the Twilight zone. This hospital isn't a pop-up store, it's a hospital that's been operating for a long time, regardless of changing ownership. It was as though it was day 1 of opening and everybody was trying to figure out what their role was.

89. Upon admission we spent some time in the ER, which was like being in a horror movie. I can't even describe it all. People were lined along the walls screaming and moaning with no one tending to them. Our nurse kept apologizing she was not there for my husband, who had suffered a debilitating stroke. He didn't even receive the medication he needed to stop the bleed until many hours after admission.

90. At 2 am, I went to the ER with elevated blood pressure – 210/116. After seeing a nurse behind a curtain in the lobby, I was told to wait in the waiting room for a blood draw to check for heart enzymes to see if I was having a heart attack. An hour and a half later, a nurse came to draw blood. I got the results on [my smartphone through my patient internet portal] – no one came to tell me. I asked when I would see a doctor and was told "change of shift", which was 3 hours away. Around 5 am, I was given a blood pressure pill. At 7:30, a doctor appeared and I asked him if I could go home, and he released me. This level of care is unacceptable. And I was not alone. Others were being sent to wait, unattended and unmonitored in the waiting room.

91. I will no longer go anywhere near Mission Hospital and it used to be so wonderful. I personally have had to sign myself out without receiving treatment because I was left sitting for over 5 hours in the ER and was far too sick to sit any longer. A friend with a potentially fatal, serious, heart disorder, had to do the same and luckily made it to Hendersonville the next day without dying.

92. I was taken by ambulance to Mission Hospital emergency room. I never got into the ER because the paramedics literally couldn't get my gurney in the door. The entrance and hallways were jammed with gurneys...elderly people having trouble breathing, people bleeding, and no one helping them. I was dumped into a folding wheelchair in the triage area. I never saw an RN. I was not physically examined by the doctor who saw me for three minutes and ordered tests.

93. Mission Hospital is a real mess. My 87-year-old dad just spent two weeks there for a broken hip. The staff begged us to call, write and share our horrific experiences from sitting in an ER room with the floor covered in someone's blood to having him languish a week in the hospital after being medically discharged to enter a Rehab. The staff is begging for someone to shine a light on what is happening here.

94. My now deceased husband was in the ER over 12 hours. He had cancer and heart issues. After he was finally stabilized there were no beds for hours to admit him. The floor they finally placed him on (he was moved 3 times) had a whole wing not being used, literally just empty of anything or anyone. Ridiculous.

95. I was, unfortunately, a patient in Mission Hospital system for two months through six emergency room visits, three hospitalizations. I had no complaints about the staff that was providing me with care. I felt so sorry for them. Most of them were in fear of their jobs for complaining about anything, so they didn't. But it showed, I was in the hospital in Mission twice and came to almost the point of calling 911 to get care in a hospital. It is ridiculous.

From Nurses

1. Staffing Ratios

96. I'm working on the ER now and our ratios are consistently 5:1. When I first started and was given the 5 patients I questioned it. They stated that "the 5th patient will always be low acuity." Not at all the case. Oftentimes would have a sepsis work up or cardiac work up needing monitoring. Like this every shift. Last week it was so bad they were asking nurses to take 6 patients. It's so awful. I fear that scenario again.

97. A [travel nurse] friend took on the "it can't be that bad" mentality & didn't even finish his orientation last week. And he's worked many big city & county ER trenches. 1:6 is considered an easy load but 2 of those will be ICU; ED ratios are typically 1:8-10 but easily 1:20+ when you're triage. Inpatient holds for days. Patients "bedded" wherever there's a chair in the hallway. Staff will take traumas (to make sure all the reimbursement boxes are checked) but then dump them on travelers once resus [resuscitation attempt?] end time is charted. Burned out docs & providers with major communication breakdown.

2. Boarding Patients

98. I just [arrived at] work at the ER and … [w]e are holding 39 patients in the ER for admission. HCA doesn't have enough nurses to open the necessary floor beds so these patients end up sitting in the ER for hours and hours and hours.

99. I want to share a warning for anyone considering [a nursing job at] Mission Hospital in Asheville, NC. A traveler [I worked with] … went the first time they were floated to the ED, was left with zero resources. Not one person came when he called and this includes the charge, house supervisor, respiratory, lab, etc. No one came until day shift. On top of that, in the ED there you are not given a [nursing assistant], you have to clean your own rooms, like you are 100% on your own and often even providers takes hours to return calls and messages.

Well, they voiced their complaints and concerns to their hiring manager who took it up the chain. … Because [the hospital] said they corrected the issues and they would have access to help if needed, they accepted being floated to the ED for a second time. This was worse than the first time. This

nurse had a total of 6 patients with [3 on IV medication requiring close monitoring], 4 [patients needing] total care, 4 severely AMS [altered mental state?], 1 [alcohol] withdrawal, 1 [congestive heart failure] exacerbation. They dropped off [one of the patients needing close monitoring], never told them there was a new patient and didn't discover that patient in the room for over an hour while in another room. No [nursing assistant] assignment to that area. Called for assistance several times. Around 0300 the house sup[ervisor finally] came down ….

Well, they attempted to send them to ED to float again and they refused until they had a [nursing assistant] float there too for extra hands and to see when new patients got dropped off. The charge never requested [one] and told the hirer-ups that this nurse and another full out refused, never mentioning they would accept the assignment with help.

Well they were both released from their contracts and blacklisted. …

Apparently from other travelers, this is very common at this facility and it's not unusual to have 4 ICU patients and 2 step-down [patients] at one time in the ED. We have heard the complaints from numerous nurses there and this is the result.

100. [From a travel nurse]: [In the ER boarding area nurses] will be expected to do everything including [drawing blood] and cleaning the rooms. If you don't clean the rooms within 5 minutes of the patient leaving they will start to yell at you, or just dump another patient in the dirty room. The ER doesn't see it as part of their unit, so it is a free-for-all and they will dump anything and everything. Insulin drips, Heparin drips, [blood pressure in the] 220s, brain bleeds, LVADs [heart pumps], critical patients with zero report[ed information about what they need] and sometimes not even an IV. …

[For patients in hallway beds], they have no way to monitor patients on tele[metry], they say they won't put any tele[metry] patients in the hallway and then [they] dump tele[metry] patients every ~ damn ~ time. Also check every patient on oxygen because they like to leave them hooked up to oxygen tanks, which of course run empty fast.

101. [From a travel nurse]: I've been floated to the ED hold area and it was a nightmare to say the least. Very unsafe practices as patients are put in your room without anybody saying anything. They also don't give [nurses] any report or hook the pt up to the monitor. … Without [a] report it's hard to figure out why [patients] are on the drips they are on as you scramble to dig through the charts. Had a pt need to be intubated as I happen to walk by the room and notice they were there and not breathing.

102. [From an experienced travel nurse working at Mission]: If you're not used to an ER environment it will be really stressful - your job is really and truly just to babysit these patients until they get a room. … Help is minimal. … As soon as your people get a room, someone "cleans" the room very swiftly and sticks another patient in there, with no information given to you - you just have to keep up with it. … [H]onestly, that ER hold area is a real purgatory for patients - I have witnessed a lot of unsafe shit because these patients are just shuffled around with no word to anyone about what's going on, and I've often walked into a room where I've got minimal time to figure out WTF is wrong with my patient - I'm not an ER nurse so I'm used to at least having SOME info to go off of. …

I along with four other staffing pool nurses were pulled to work in the ED on Wednesday…. Our job is to take care of patients waiting on beds. Patients are moved around so quickly and these nurses are assigned so many patients throughout their 12 hour shift that we can't provide adequate care for these patients. This is totally unsafe for all involved.

III. Charity Care

A. Prepayment Issues

103. I work [as a physician] at … a federally qualified health center, so we see people who are on a sliding scale, … who have very little money. ... We used to be able to work with Mission. I mean anything, you talk about a hospitalization that was tens of thousands of dollars to do a test that was a few hundred dollars and they would get a discount that would make it affordable, sometimes it would be basically free. I had a patient that very much needed a CT scan recently, and fine, you get a discount, … $1,300 was going to be her portion of this discounted rate, 25% of a CT scan. Now again, anyone who's been in medicine, a normal CT scan was not, I'm sorry, what's the math, $5,000 before [HCA], that was not the normal cost of a CT scan before. And not only that, she was humiliated when she went to get it. "Didn't they tell you that you were going to need to pay this?" So, most people, myself included at times, are not going to be able to pull $1,300 out of their bank account, especially somebody who's needing charity care on a sliding scale. So, this charity care is not happening, and if that was a service they were promising, it's not effectively happening.

104. I'm actually a practice manager of a medical office here in town…. We call for stat CT, stat ultrasounds, [it] takes 10 days if they're uninsured. They're asking patients, "Oh, do you have $5,000 to pay upfront?" No, they don't. We are sending all of our services pretty much to [non-Mission hospitals] for any of those outpatient radiology services just to avoid the hassle.

105. I worked for a primary care clinic in the area. We are a federally qualified health center, which means that we see uninsured folks regardless of their ability to pay …. We were informed that [charity] care would remain accessible through the Mission Health System. So prior to the HCA transition, if we referred a patient to any Mission associated facility and they were under 200% of the federal poverty guideline as well as several other things, they could have their services covered at 100% of costs, which meant if I sent someone to Mission Neurology … for a specialist consult, that could then be applied for the charity care program to have that covered. After HCA, that slowly got it phased out and now our patients are required to pay 20% of the cost of every visit upfront. Now when you serve a population that is uninsured and is earning low to no income, often these can be $100 to $200 for a specialist visit which means we have resorted to using the ER to get our patients the care they need for things that could have been managed [outside] the ER. It could be as simple as we see someone for suspected pneumonia and we want an X Ray but now we can't send them to Mission Imaging, because Mission Imaging is going to ask them for $120 before they even provide the procedure. We have to send them to the ER, which clogs up the ER and prevents people with actual urgent care need from getting the care they need.

My wife and I own a small business. We're homeowners, we're not chronic deadbeats, we simply were priced out of the healthcare market in 2010. So, we had to turn to Mission and the charity care they were providing. Now, they said nothing was going to change and that is not our experience. … I had gone to the doctor, she wanted me to go over to the hospital to have a test. The scheduler called me up and asked me for $200 upfront that I had to pay right then, which I did not have. I explained to her we had been on charity care and she said that was no longer an option. I had to come up with $200. Then she looked and said okay since you don't have insurance, I could cut it down to around $100. Same problem, I don't have $100 [so] I can't do charity care. I had to go around for three months with the people, the caseworkers to help me out. I was told they no longer have charity care to help me with. So now it's been six months, I didn't have that test taken, so I guess I'm out of luck. What am I going to do? If there's something wrong, I [won't] know about it. It seems to be nowhere else for me to turn. … When HCA took it over, everything [about charity care] changed. The caseworkers told me there's no charity care. The people, the scheduler for Mission said that there was no charity care. That's the message they gave me. So, I do not know where to turn to. … The reason they're saying [the CC policy] is better, it used to be I think 200% of the poverty level.

106. Now it's 400%. Well, that is better but it's not if you don't have the hundred dollars or whatever you need to do it, it's nonexistent.

B. Administration Issues

107. [From a low-income primary care clinic]: When you have someone who doesn't have an address or is constantly moving around or people that are unstably housed and being kicked out of where they're being housed, they can often miss the deadline for this paperwork and then they're deferred for six months from reapplying. Which means, if we want a diabetic with early stage kidney disease to see a nephrologist and they get denied for this program, we have to wait six months to send them, at which point they get worse, and maybe they get so worse at that point we have to send them to the ER for further care. So, … I really wish someone would look into this charity care program because it has made primary care very difficult to do for a really vulnerable population.

108. [Before HCA's purchase,] we were fortunate to have [help] from Mission financial assistance. … [W]e were lucky enough to … [have] up to 70% discount on any bill. And if I remember correctly, it was a piece of cake to get it. You had to fill out a few papers, so forth, but it wasn't a big deal. But since HCA's taken [over] as a profit outfit, why would they make it easy for a person to get financial assistance when they can make it hard for them. … [I was] assured that HCA was going to keep financial assistance. Well, they kept it all right. They keep it in their pocket. It doesn't take a rocket scientist to figure out if they make it hard enough, the people aren't going to get it, and they'd make more money. Real simple. I'd rather die in peace. I understand. But I think it's a terrible, terrible thing. … I used to wave a flag for Mission, but now I've got to jump through seven hoops and wonder, "Am I going to be lucky or not?" …. So … my main thing is that from nothing to seven hoops to get financial assistance, it's criminal. It is, pardon my French, damn criminal.

109. I have been involved with the charity care [policy as a patient]. … Five times [in 2019 I] called the office, the numbers. They told me that during the transition, it is no longer the way it used to be where all the bills are under just your name. You have to do each one individual. I was also told that it takes up to six months for them to get the information from [Blue Cross] ... even though I already

got it, the information of what they paid. Then, they would mail it to me. The first three phone calls I had made to them, they had the wrong address. I had it corrected for three times, but that's not why I didn't get it. Finally, they told me they're way behind with all this transition. Just wait six months. Okay. I've been waiting six months. In the meantime, I had to have x-rays and MRIs and a doctor to look over all that. I have $6700 deductible that I am now getting collection people [telling] me that I owe this money, and charity care just wants me to sit around and wait for them to mail me a form. They had to fill out one for each bill when they finally hear from Blue Cross. This all started last year in the spring. I've got not one [form] from them. Not one. I don't call them anymore. I just don't know what to do.

C. General

110. I've worked for Mission Hospitals for eight years at Mission …. I'm a behavioral health specialist. I've always been very proud of the charity care program that Mission provided. It was amazing. People in the ICU going home with no insurance and not having their lives taken away from them for the bills. It covered so many people. Practically I was being covered as a behavioral health person under charity care for many of my patients. When HCA took over, … [t]hey will get a 20% discount on $150 bill if they see me. And these are people who are uninsured … and have no insurance and then they end up … inpatient if they're not getting care. And so, I just want to say that I have seen that change.