HCA: HIGHER HEALTHCARE COSTS FOR AMERICA

Full Report

SEIU
Stronger Together

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ABOUT SEIU

More than one million healthcare workers across hospitals, in-home care, and in nursing homes are united in the Service Employees International Union (SEIU), the nation's largest union of healthcare workers. SEIU is an organization of nearly 2 million members united by a belief in the dignity and worth of workers and the services they provide. SEIU is dedicated to improving the lives of workers, families, and communities to create a more just and humane society.

OVERVIEW

HCA Healthcare (hereinafter "HCA"), the nation's largest hospital system, is engaged in practices that maximize profits at the expense of patient care, working conditions, and responsible corporate behavior.

HCA's hospital markups are generally more than twice the national average, and many HCA hospitals have markups as high as 12 or 13 times the cost of care.[1] At the same time, HCA pays tens of thousands of its employees poverty wages,[2] and staffing levels in its hospitals lag the national average by about 30%,[3] despite the fact that higher staffing levels are associated with better patient care.[4] Given this unbridled pursuit of profit over all else, it should be no surprise that HCA's profits are astonishingly strong —they made $3.75 billion in profit just last year[5] despite the pandemic—and since 2010, the company has paid out more than $29 billion to investors in dividends and share repurchases.[6]

Based on the new research contained in this report, these high profits and payments to investors may originate, in part, from apparent fraud: HCA appears to routinely admit patients for inpatient hospital stays regardless of medical need, as illustrated by SEIU analysis of Medicare data and lawsuits filed against HCA. This analysis, described in our report, indicates that HCA's practice of overadmitting patients may have brought in nearly $2 billion in excess Medicare payments since 2008.[7] This possibly illegal, unethical patient care practice pads HCA's pockets by costing taxpayers and consumers billions in reimbursement for unnecessary procedures and services, while also exposing patients to unnecessary risk. These fraud allegations hold particular weight given HCA's history of Medicare fraud. The healthcare giant was the subject of one of the largest Medicare fraud settlements in U.S. history in the early 2000s when the company agreed to pay the U.S. Department of Justice and other enforcement authorities a total of $1.7 billion dollars.[8]

These business practices—all of which preceded the pandemic and may be continuing—are extremely troubling in a moment when we need our nation's hospitals to safely treat large numbers of COVID patients, as well as patients who require lifesaving procedures. In particular, HCA's staggeringly low staffing levels leave nurses and other healthcare workers overworked and shorthanded. As the pandemic has raged on since March 2020, HCA's continued practice of understaffing has only further exacerbated the strain and burden placed on our nation's frontline healthcare workers. HCA's over-admittance practice, moreover, has serious patient care implications. Over-admitting without medical justification may unnecessarily put tens of thousands of HCA hospital patients every year at increased risk of hospital-acquired infections—including exposure to COVID-19. This practice also takes beds away from COVID patients or those with other emergent conditions who urgently need them. Taken together, these practices overburden workers and put patients in harm's way, all while leeching funds from the taxpayer-supported Medicare program.

SEIU frontline workers have long advocated for system-wide changes throughout HCA to improve patient care and job quality, but HCA has repeatedly failed to make any meaningful changes. Due to HCA's alarming corporate practices, the pressing need for intervention from both governmental and non-governmental actors is clear.

HCA's Long, Troubled History of Fraud Allegations

The allegations of improper emergency department admissions at HCA hospitals are not occurring in a vacuum. These activities are just the latest in a series of HCA improprieties that trace back to the company's inception. HCA's numerous fraud investigations and settlements dating back to the late 1990s demonstrate that HCA has a history of engaging in alleged fraud to maximize profits and that federal and state governments and other stakeholders must take steps to increase scrutiny on for-profit healthcare corporations like HCA. Over the past two decades, HCA and its affiliated entities have had at least nine settlements to resolve fraud allegations with the U.S. Department of Justice (DOJ) and other regulatory enforcement authorities.[9]

The settlements, and the alleged fraudulent conduct underlying them, are as follows:

$1.7 Billion Settlement (Early 2000's)

HCA reached one of the largest healthcare fraud settlements in history at $1.7 billion.[10] The multi-phase settlement was a culmination of years-long investigations that began in 1997 and resolved multiple qui tam actions against the company. In addition to the civil charges, HCA and certain of its subsidiaries pleaded guilty to 14 felonies and entered into an eight-year Corporate Integrity Agreement (CIA) that would expire in 2009.[11] The allegations involved elaborate up-coding schemes, false billing and overcharging schemes, kickback schemes, billing for medically unnecessary procedures and services, and cost report fraud, among others.

Corporate Integrity Agreement Term (2000-2009)

Despite the 8-year CIA that was originally signed in December 2000, HCA appeared to continue to engage in fraudulent activity leading up to the signing of the CIA as well as during its term, as evidenced by subsequent DOJ settlements involving alleged billing fraud via delaying patient transfers (settlement in 2004, conduct occurred 1998-2000),[12] kickback schemes (settlement in 2012, conduct occurred 2007-2011),[13] and billing for medically unnecessary procedures and services (2 settlements in 2015, conduct occurred 2007-2014 & 2003-2010).[14]

Post-Corporate Integrity Agreement (2009-Beyond)

Just a few years after the termination of HCA's 8-year CIA in 2009, HCA continued to engage in alleged fraudulent activities, as evidenced by subsequent DOJ settlements involving: Two false billing/overcharging schemes in 2013[15]; billing for medically unnecessary procedures and services in 2015,[16] and kickback schemes in 2017.[17]

Given HCA's track record and the timeline of DOJ settlements, we are worried that the company has seemingly only changed its behavior when it was forced to do so by legal regulatory enforcement agreements such as CIAs.

MEDICARE DATA REVEALS POTENTIALLY UNNECESSARY HCA ADMISSIONS

HCA has a lengthy history of allegedly defrauding the Medicare system, and Medicare claims data continue to tell a larger story about HCA's practices. Research indicates that **HCA has engaged in potentially illegal, unethical patient care practices that pad the corporation's pockets while costing taxpayers and consumers millions in unnecessary services resulting from emergency department ("ED") admissions.**

Our research examined inpatient admission rates for Medicare fee-for-service ("FFS") beneficiaries through the emergency department ("ED admission rates") at HCA hospitals.[18] We found that the average ED admission rate among HCA hospitals has been substantially above the national average rate in recent years. After rigorous exploration of this data, we have not found any reasons that we believe could justify this difference. We are thus concerned that this is the result of HCA corporate efforts to boost their profits by increasing their admission volumes without respect to medical need. By our calculations, this widespread practice could be leading to tens of thousands of Medicare patients being admitted unnecessarily as inpatients every year, with an estimated **overpayment to HCA of $1.8B by the Medicare program since Federal Fiscal Year ("FFY") 2008.**

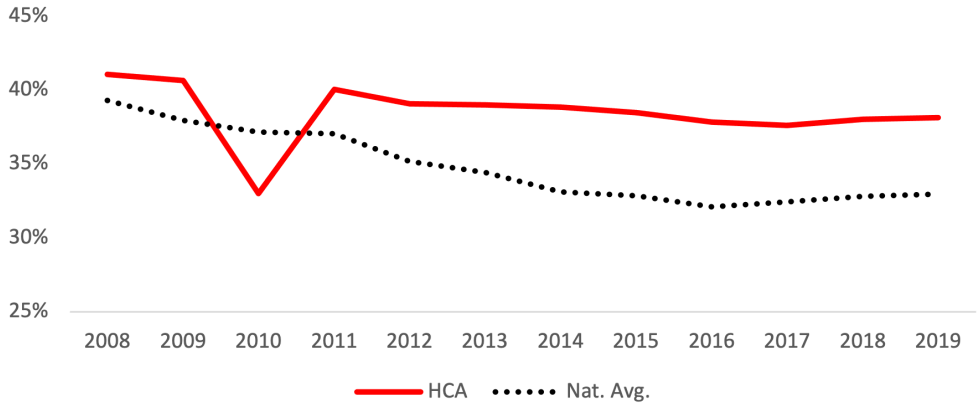
To Admit or Not to Admit

When a patient seeks care in an emergency department, a medical decision will ultimately need to be made for them by their treating physicians: should they receive treatment within the ED and then be discharged from the hospital, or should they be admitted as inpatients to the hospital for stays that may last for days? The decision should be based upon the level of care that the patient actually needs, given their medical conditions. If a patient's condition is acute enough to warrant a multi-day stay with the continual monitoring and treatment that can only be provided by a hospital with the necessary equipment and professional staff, then they should be admitted as an inpatient.

On the other hand, if the patient's care would ***not*** require that level of intensity and duration of care, then they should be treated in the ED and then discharged. Inpatient care is not necessary or even appropriate for all conditions, and patients should not be admitted as inpatients without medical necessity. In fact, inpatient services must be medically necessary as a condition for Medicare reimbursing claims for them.[19]

We notice unusual patterns when we examine ED admission rates at HCA hospitals.[20] While the national average ED admission rate has dropped significantly since about 2008, the average ED admission rate among HCA hospitals nationally has held relatively steady and has surpassed the national average by more than 5 percentage points in each of the last six years of our analysis, as shown in Figure 1.

Figure 1. HCA Avg. ED Admit Rates Medicare FFS



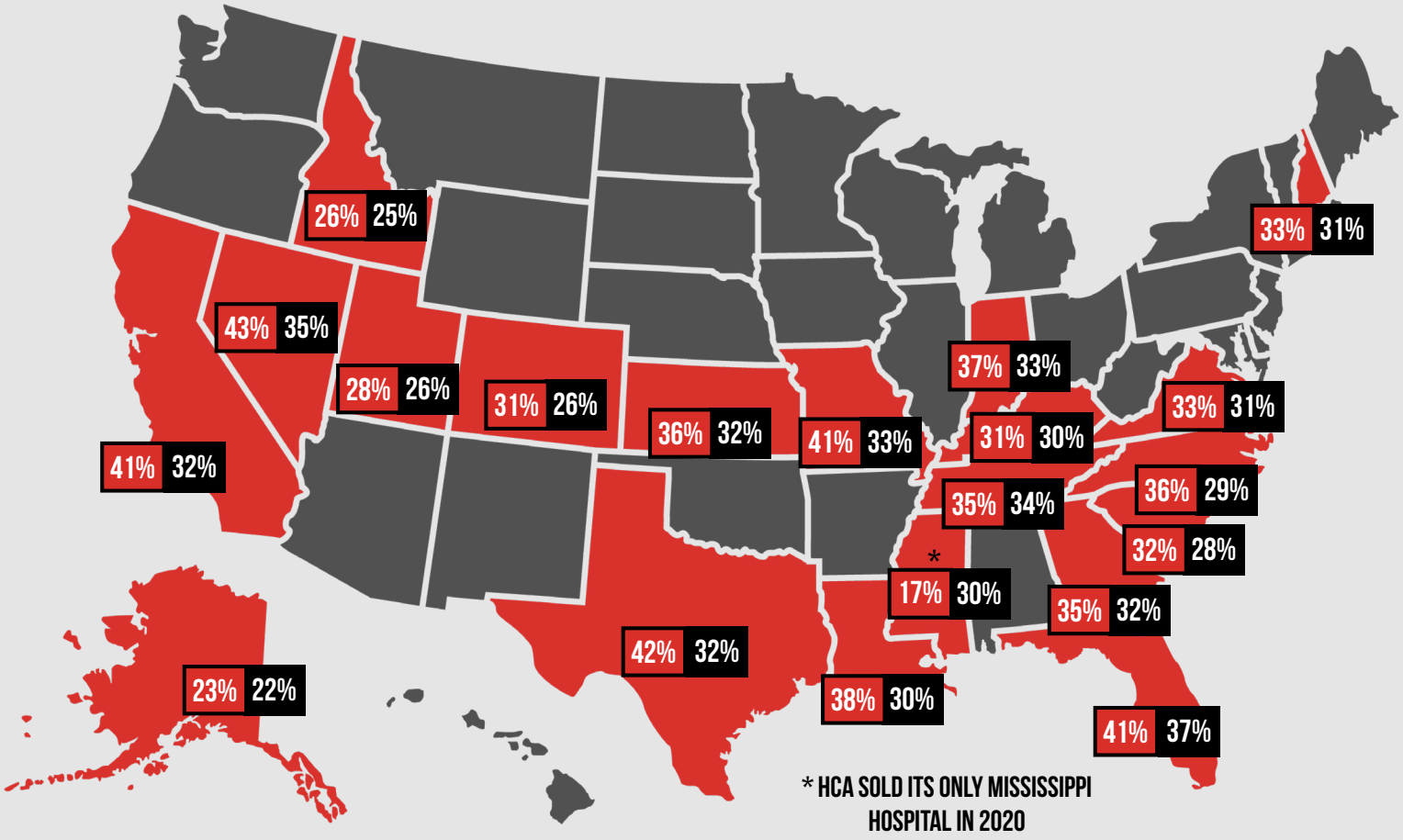
When we examine ED admission rates in Medicare claims data, we look at all claims for visitors to a hospital's ED, and we identify the proportion of these ED encounter claims that resulted in inpatient admissions. A hospital might have a higher-than-average ED admission rate if it routinely saw a more acute patient population in its ED than the national norm. For example, their ED visitors could have had a much higher share of patients experiencing heart attacks, strokes, severe pneumonia, and similar high acuity conditions than other hospital EDs had.

However, higher-than-average ED admission rates may also be a red flag for potential Medicare overpayments. An inpatient admission can bring in thousands of extra dollars in reimbursement as compared to outpatient treatment in the ED,[21] which creates an incentive for unscrupulous hospitals to admit patients to inpatient status. It is alarming to see a hospital system as large as HCA so out of accord with national trends as we do in Figure 1, so we analyzed HCA's claims data further to identify underlying reasons.

HCA is the largest hospital system in the country, with more than 140 hospitals in FFY 2019 based on our analysis.[22] We have identified HCA hospitals in 20 U.S. states for that year. It seems unlikely that HCA's deviance from national norms could be explained by HCA hospitals seeing a more acute patient population in their EDs on average, given HCA's geographic reach and the sheer number of hospitals over which its patient population would be averaged.

Despite extensive presence across the country, HCA commonly exceeds both national and regional average ED admission rates. In FFY 2019, HCA's average ED admission rates in every state except for one surpassed their respective state averages. The one exception was Mississippi, notable because HCA sold off its only Mississippi hospital to another system in the very next year,[23] raising questions about whether the hospital was less important for the system's future due to its lower-than-desired admissions volume.

In 2019, HCA's Medicare emergency department admission rates exceeded state averages in 19 of the 20 states in which they operated.



HCA AVG. | NON-HCA AVG.

The "Non-HCA" average for each state is the average ED admit rate among all hospitals that are not part of HCA in that state for the year 2019. This distinction was selected because in some states (like Florida), HCA is such a large portion of the state that they drag the state average significantly toward them.

ANALYZING HCA'S HIGH NUMBERS OF ED ADMISSIONS

We further analyzed the data to see if characteristics of HCA's patient pool could explain their higher-than-average admission rates. However, through multiple efforts, we found only more reason to be concerned about their behavior.

HCA actual admission rates are well above expected rates

Our most compelling look occurred by examining how hospitals' *actual* ED admission rates compared to their *expected* rates based on national trends in admission behavior. In our expected model, we accounted for factors that could have an impact on a hospital's admission rate, including principal diagnosis, patient age, patient sex, and whether a hospital is in a rural or an urban area. We then examine whether and to what degree a hospital's total number of ED admissions is above or below the ED admission total that our model would expect them to have, given their patient pool. This analysis could offer some justification for why a hospital's admission rate may be so much higher than average, particularly if that hospital's ED patients were more acute on average than was the case for others.

This is not what we see with HCA. Commonly, HCA's hospitals show actual ED admission totals that are well above what we would expect them to have – with many exceeding their expected ED admit totals by more than 20% in FFY 2019.[24] When hospitals are ranked by the percent by which they are above or below their expected ED admit rates, many HCA hospitals have ranked among the worst offenders nationally; our analysis shows that more than 60 HCA hospitals have ranked above the 80th national percentile on this metric each year since at least 2015.

Figure 2 shows a systemic pattern throughout HCA. As a system, HCA has exceeded its expected ED admission rates by about 10% since FFY 2014. Considering that HCA had at least 130 hospitals in our analysis in each of these years, that is a stunning level of average deviance among its network of hospitals.

The overpayment resulting from HCA's potentially unnecessary ED admissions is staggering. According to our analysis, the aberrant patterns of admission rates at HCA hospitals may be leading to tens of thousands of Medicare patients being admitted unnecessarily as inpatients every year. A 2006 study found that, on average, Medicare paid about $5,000 more in reimbursement for an inpatient admission than it did for a corresponding outpatient discharge.[25] Multiplying that figure by the roughly 370,000 potentially excess ED admissions at HCA hospitals from **FFY 2008 through 2019, we estimate that HCA may**

Figure 2. HCA Avg. - Percent Above Expected ED Admissions Medicare FFS

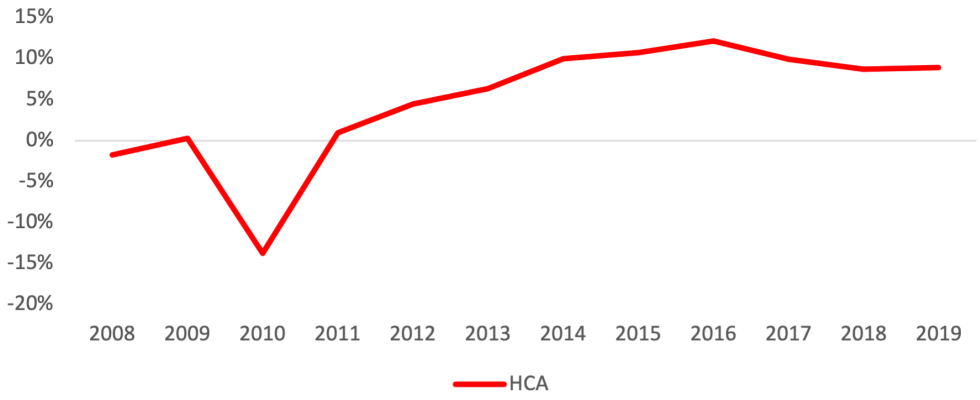
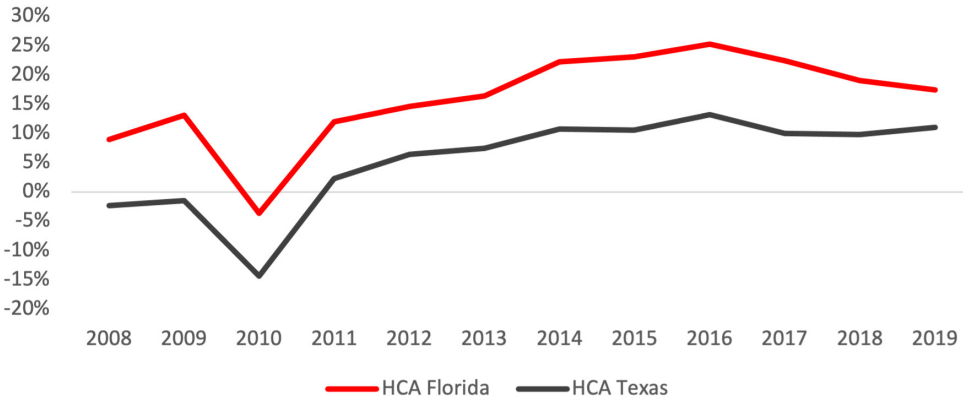


Figure 3. HCA Avgs - Florida and Texas Percent Above Expected ED Admissions Medicare FFS



have been overpaid by the Medicare program by more than $1.8B over this time. It is important to note that this is a conservative estimate of the financial impact for HCA. **Our estimate accounts only for Medicare fee-for-service claims,** due to availability of data. If this problem exists for patients covered by Medicare, **it seems likely that it could exist for patients covered by other payers as well, especially among the private coverage plans that generally bring in much more lucrative reimbursements for hospitals.**

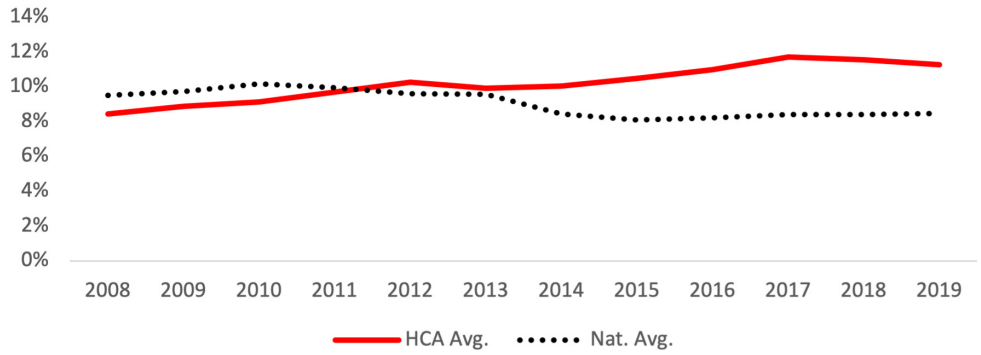
HCA's Florida and Texas markets account for about half of HCA's hospitals,[26] and the system's average in each of these states is well above expected for most of this period, as shown in Figure 3. However, we find this issue in numerous other states as well. HCA hospitals in states from California to Kansas, Missouri, Nevada, and beyond show similar patterns. With a pattern that extends so strongly across different geographies, it raises serious questions about whether corporate influence is leading to these common results.

HCA short stay admission rates have increased and surpass the national average

We further examined short stay rates among HCA's ED admissions. Short stay inpatient admissions – particularly those lasting only one day – have been a frequent target for industry analyses of unnecessary admissions for decades.[27] If a patient's condition is not acute enough to warrant inpatient admission, then that patient would likely not need to stay in the hospital very long if they were actually admitted. A high rate of one-day stays would be therefore considered a red flag for unnecessary admissions occurring at that hospital.

Figure 4 shows that the national average for one-day stay rate among ED admissions has dropped in recent years.[28] However, HCA bucks this trend here as well – in fact, the system's average one-day rate has increased over this period, and it surpassed the national average by about 3 percentage points in FFY 2019.

Figure 4. HCA Avg. One Day Stay Rate Among ED Admits Medicare FFS



As with admission rates, HCA's deviance is spread throughout a significant part of its system. HCA's system one-day rate within almost all of its states surpassed the state average in 2019. Almost half of HCA's hospitals in that year rank above the 80th national percentile on this metric. HCA's performance on this metric offers more reason to be concerned that the system's high ED admission rates are not due to its hospitals seeing a more acute patient population, but instead could be occurring due to a corporate desire to increase admissions without regard to medical necessity.

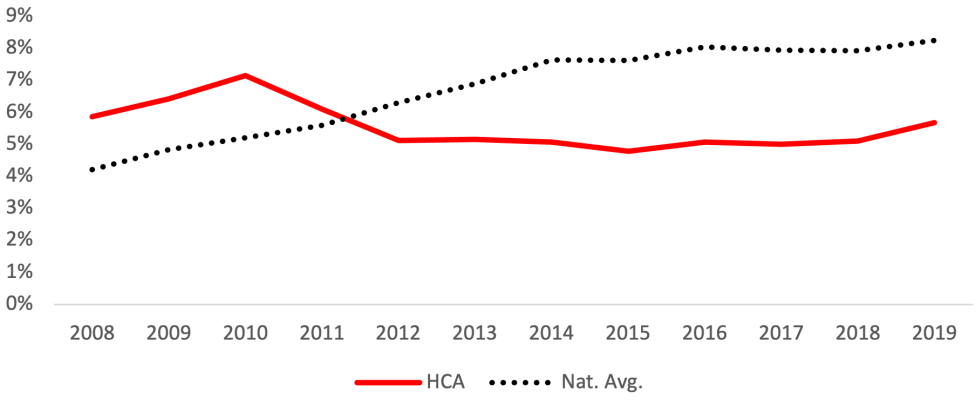
HCA appears to shift outpatient discharges to more lucrative inpatient admissions

We also examined Medicare claims of ED visitors who were not admitted as inpatients, but instead were treated in the outpatient setting of the ED and discharged. If the average patient visitor at an HCA hospital ED were more acutely ill than the norm among non-HCA hospital patients, then we may not only see higher inpatient admission rates at that hospital, but also higher than average levels of acuity among its patients who are not admitted as well. On the other hand, if their hospitals show high ED admission rates but lower-than-average levels of acuity in their ED outpatient claims, then it could be the case that HCA is simply shifting higher-acuity outpatient cases to the inpatient setting and securing the higher reimbursements that accompany them. Two metrics are especially helpful to explore regarding ED patients– observation service rates, and rates of "Level 5" evaluation and management ("E/M") code assignments. HCA's performance on each of these metrics raises more questions about the admission behavior at its hospitals.

Observation services are intended for ED patients whose conditions are acute enough to warrant possible eventual inpatient admission, but for whom more time is needed to monitor their vital statistics, response to treatments, and so forth before such a determination could be made.[29] If observation services are performed for a patient, hospitals can be reimbursed by Medicare per hour for how long they provide these services.[30] Nonetheless, and despite the higher intensity of care provided by observation services, they are still services provided within the outpatient setting, a level of intensity below that of an inpatient setting.

Over the same period of time that the national average for ED admission rate has decreased, the national average for outpatient observation service rate among ED visits has increased; it nearly doubled to about 8% in 2019.[31] However, HCA's outpatient observation service rate has been remarkably consistent, hovering between 5-6% for most of the period. Fewer than 20 hospitals in the HCA system have an outpatient observation service rate above either the national average or their respective state average in 2019, and merely five HCA hospitals rank above the 80th national percentile in 2019 on this metric.

Figure 5. HCA Avg. Observation Rate of ED Visits Medicare FFS



This all stands in stark contrast to the above average rates and high rankings we see for HCA's inpatient admission rates and one-day stay rates. Because observation services can bring in greater reimbursement to a hospital, it would be strange to see a system forgo submitting claims for reimbursement if they truly had a more acute ED patient population. **Our concern is that the systemic pattern at HCA may be occurring instead because corporate executives are pushing for more observation**

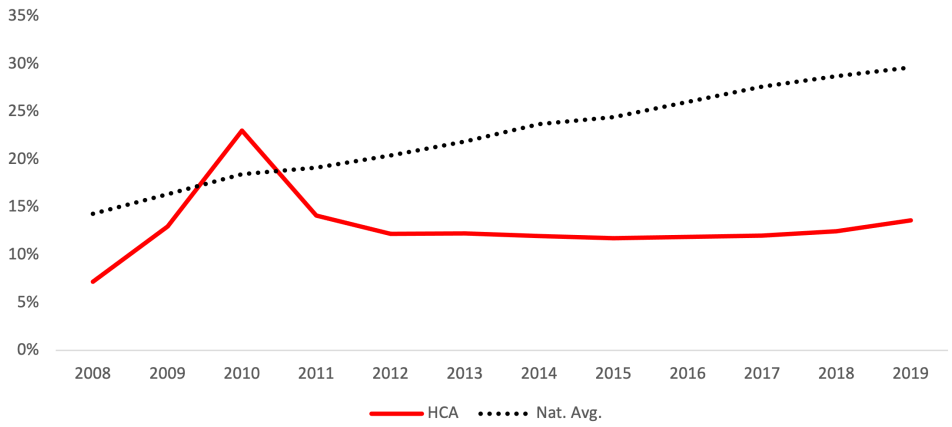
patients to be converted into inpatient admissions. In other words, HCA hospitals may be unnecessarily admitting patients into inpatient care whom non-HCA hospitals otherwise would have treated in outpatient settings and discharged.

We see a similar picture when we explore HCA's assignment of "Level 5" E/M codes. E/M code assignments in the ED have frequently received blame for high patient bills and for "surprise" billing.[32] E/M codes are billing codes that attempt to account for how much work was needed to evaluate and manage the patient's condition. There are five levels of code assignment in the ED; the more complex and/or severe the patient's condition, the higher the code assignment and accompanying reimbursement, with "Level 5" being the highest in both.[33] Because this fee can be quite pricey and be charged on top of charges for actual procedures like MRIs, CT scans, and the like, it represents a significant potential impact on total reimbursement for a hospital. If a hospital has an especially severe or complex patient population in its ED, then it could make sense to see that hospital having a higher than average "Level 5" E/M rate.

The national average for "Level 5" rate among ED outpatient claims has more than doubled since 2008, from about 14% that year to about 30% in 2019.[34] At HCA, however, the system average rate of "Level 5" claims among its ED outpatient claims is *less than half* of the national average in 2019. In fact, throughout almost all of this period, HCA's system average has been below the 2008 national average.

This is a remarkable deviation from national norms, and it is an almost unbelievable outcome for a hospital system with HCA's size and with its higher-than-average admission rates. It seems **likely that HCA hospitals are moving patients who could qualify for an outpatient "Level 5" E/M assignment to inpatient status at a much higher rate than non-HCA hospitals**, thereby shifting their higher-acuity outpatient discharges into lower-acuity inpatient admissions.

Figure 6. HCA Avg. "Level 5" E/M Rates of Medicare ED Outpatient Claims Medicare FFS



The scope of unusual patterns found in this analysis warrants further investigation of HCA's practices for potential improprieties. However, our concerns are not limited to what we have seen in our analysis of HCA claims data. HCA's own corporate statements and operational results lead us to believe that our data findings are the result of an intentional corporate profit-making strategy.

FRAUD AS A BUSINESS PRACTICE

We believe our data analysis shows a pattern at HCA hospitals of prioritizing profit-making in emergency departments. Several documents and records raise concerns that such conduct is the result of encouragement/coercion by corporate executives of the medical decision-makers at its hospitals. The patterns revealed in our data analysis are spread across markets, and the common factor between hospitals seems to be they are part of HCA, rather than unique aspects about the patient populations they treat. A deeper dive reveals even more compelling reasons suggesting HCA is following a corporate strategy that results in these data findings. It also reveals that this **strategy appears to maximize profits at the expense of patient care, working conditions, and responsible corporate behavior.**

Corporate Executives Reveal Emergency Department Profit-Making Strategy

Over the past decade, HCA executives have repeatedly emphasized to investors the strategic business importance of the hospital system's emergency departments. Executives have routinely referenced the proportion of its inpatient admissions that comes from the ED, which unsurprisingly, is ever increasing. In late 2011, Richard Bracken – HCA's then-Chairman and CEO – was telling investors that the ED was the source of "about 60%" of HCA's admissions.[35] By late 2017, William Rutherford – HCA's CFO and EVP – was noting that 70% of the system's inpatient admissions started in the ED.[36]

The reasons why HCA leaders would focus so much attention on their EDs in their strategic growth planning are clear. In comments to investors several years ago about how HCA worked to achieve this growth, Sam Hazen – HCA's then-President of Operations (and current CEO) – highlighted four specific corporate strategies that worked to either bring more patients into the ED, or move patients through the ED more quickly and efficiently.[37]

These four strategies were:

HCA's ED Strategy	HCA's Explanation
Strategy #1: Improving Operations	"One is clearly improving our operations in how we take care of our patients when they enter the emergency room. And I think we have done an incredible job at dropping our time to see a patient from maybe 45 to 50 minutes to somewhere around 22 minutes on average across the Company. And that is clearly enhancing the service levels and the satisfaction that we are seeing in the emergency room."
Strategy #2: Adding Program Capability	"…[W]e are adding a lot of program capability. And by program capability […] we have added a number of trauma programs where it adds a level of sophistication to our emergency room, creates a better destination point for EMS services and so forth. And on top of that trauma development we have developed sophisticated stroke capabilities in a number of our emergency rooms, as well as cardiac capability. And I think, again, the combination of those program developments are adding volume as well."
Strategy #3: Adding Capacity	"…We have clearly added capacity in our emergency rooms where we have had compression. We monitor our utilization per bed on a routine basis, and where we start to see capacity constraint we had capital here either on our campus or in some cases off our campus in locations that need emergency capabilities."
Strategy #4: Marketing	"…I think we have marketed our emergency rooms in a way that showcases the performance and the capabilities. And the combination of those four things I think are really driving the activity in our markets."

The four strategic efforts that HCA executives have outlined are relevant to our analysis of apparent Medicare fraud via ED admissions because they either help to bring more patients into the ED (marketing, trauma designation, added ED bed capacity) or help move patients through the ED more quickly and efficiently (reduced wait times).

Emergency Department Profit Strategy #1: Improving Operations

For operational improvement, it appears HCA has focused on tracking performance in their EDs on a number of metrics, and then worked to improve performance on these metrics within their hospitals. On the latter point, executives have discussed the importance of "alignment" existing between their hospitals and the physician groups they contract with on achieving these performance improvement plans. [38]

HCA executives talk extensively about their "Clinical Excellence" program, which is based on utilization of the hospital system's clinical data warehouse. Measuring this data and its alignment to goal or performance metrics requires tracking both significant amounts of data around processes and outcomes, as well as frequent analysis of this data. According to executives, their analysis of metric performance within the system regularly revealed variation in how cases were dealt with by different physicians and at different hospitals. One of the goals of the Clinical Excellence program was to eliminate this variation.[39]

However, a lawsuit filed by a physician who worked at an HCA hospital alleges that HCA's practices of attempting to achieve "alignment" **created an environment that pitted physicians against each other and threatened physicians with termination if they did not toe the company line.**[40]

What HCA Says	What HCA Means
"[T]he first concern we really had is, while we understand that a lot of the variation in healthcare is driven by physicians choices, and unfortunately a lot of the choices aren't necessarily based on science, but based on practice history or maybe not so much keeping up with the new and the interest in medical practice and care. The concern was that it could be off-putting, because it could be either antagonistic or challenging. And we found that data worth was the key element that allowed us to engage in a way that leverages some key characteristics that we found about physicians, truth seekers, problem solvers, and in fact, competitive of course. So, you can tell him how you are doing against the peers and that will raise the game." *Ravi Chari, MD, then-VP of Clinical Excellence for HCA, HCA at Wells Fargo Healthcare Conference – June 18, 2014*	In *United States of America et al ex rel. Ruiz v. Hospital Corporation of America et al*, a former HCA hospitalist alleged that HCA attempts to exert control over its physicians and interfere with their medical judgement for financial gain, without regard for patients' actual clinical needs. He alleged that HCA adopted many troubling policies and practices to exert their control, including: • Sending regular monitoring reports to physicians with details about inpatient admissions and observation cases, compared to peers within their HCA Division; • Creating and fostering competition among hospitalists to reduce observation cases, while increasing inpatient admissions; • Directing, monitoring, and pressuring hospitalists to up inpatient referrals to HCA's employed specialists; • Threatening to terminate/terminating hospitalists who did not meet these and other objectives.

Emergency Department Profit Strategy #2: Adding Program Capability

Following operational improvement, Hazen listed adding "program capability" as a key part of HCA's emergency department strategy, with a specific mention of trauma services. HCA's trauma focus has received a great deal of media attention in the past, with regular focus on their attempts to start new trauma centers against opposition from other peers in their areas. Notably, a trauma director from one of their competitors once said of an HCA attempt to start a new trauma center: "The motivation isn't better care. It's about making money."[41] Given the reporting has focused on HCA's very high charges for trauma care – with fees that were commonly tens of thousands of dollars higher than their peers[42] – it may not be difficult to understand this trauma director's perspective.

Whether the program capabilities being added are for those specifically mentioned by Hazen in 2012 – trauma, stroke, and cardiac – or for any other, it is clear from his comments that these efforts are intended to bring in increased volume for HCA hospitals. Indeed, later remarks made by Hazen suggest that these efforts were also intended to keep its patients inside the HCA system as much as possible,[43] perhaps in spite of the clinical needs of its patients.

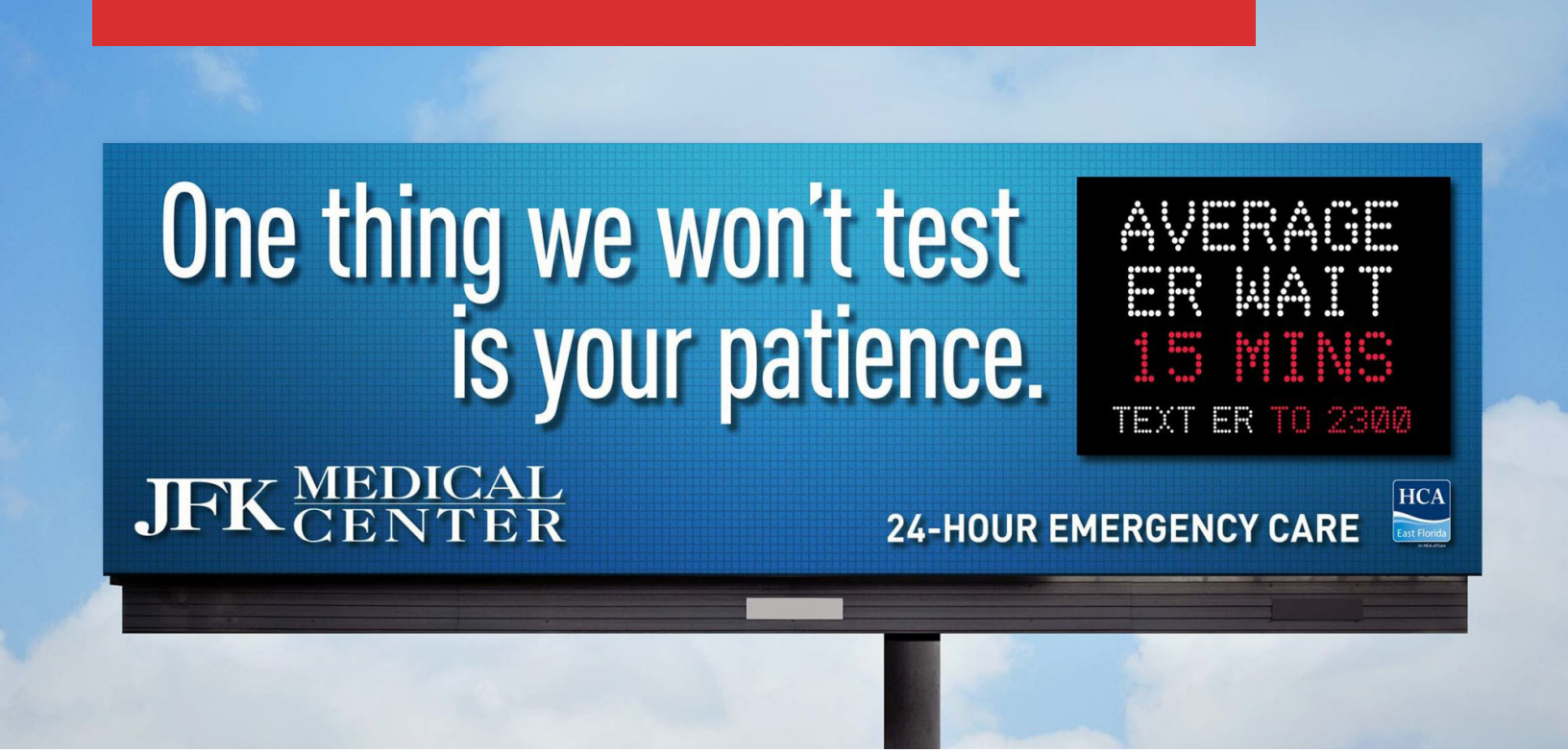
What HCA Says	What HCA Means
"[O]ur goal is to keep the patient internalized within the HCA system if it makes sense for the patient and makes sense for the physician. And in order to do that, we have to have this comprehensive, deep capability with our service line offering, and that has driven our acuity over the past few years. We believe that strategy has a lot of headroom." (emphasis added) *Sam Hazen, then-COO for HCA, HCA at Morgan Stanley Global Healthcare Conference – September 14, 2016*	*O'Burke et al v. Hendersonville Hospital Corporation et al* alleges that a patient at HCA's TriStar Hendersonville Hospital repeatedly asked to be transferred to Vanderbilt University Medical Center (the premier hospital in Middle Tennessee; not affiliated with HCA) due to worsening symptoms. Hospital officials allegedly claimed Vanderbilt did not have bed space, even though Vanderbilt had no records of a transfer request from HCA. After 48 hours, the HCA doctor told the plaintiff's family that there was nothing more they could do, and death was likely. The plaintiff in fact alleges that his family had been warned by a nurse that *"physicians at TriStar Hendersonville would resist efforts to transfer him out of TriStar Hendersonville."*

Emergency Department Profit Strategy #3: Adding Capacity

The third part of HCA's ED strategy that Hazen shared in 2012 was about adding capacity in their emergency departments. This has been a repeated refrain by executives over the years, as they have often cited their high occupancy levels of both inpatient beds and ED beds to explain why they were investing in increasing their number of licensed beds. In March 2012, HCA executives reported an occupancy rate of "about 65%".[44] By 2016, they reported that the system was running at 70% inpatient occupancy and 90% ED utilization,[45] and this level of occupancy was reported for multiple years thereafter.[46] This occupancy growth occurring despite continually adding beds to the system was later noted by Hazen – this time as CEO.[47]

Despite high occupancy trends coupled with ED capacity additions, HCA has been accused of failing to add staff commensurate with these expansions. As a result, staff have reported being overworked and asked to perform tasks for which they are not trained or qualified, creating concerns that patients' clinical needs are not adequately being met.

What HCA Says	What HCA Means
"In the face of all of these new beds that we've added over the years, our occupancy levels continue to go up. And so that's really encouraging that our planning and the execution underneath it is occurring at the levels that we had hoped." *Sam Hazen, CEO for HCA, HCA Q4 2019 Earnings Call – January 28, 2020*	A wrongful termination case filed by a former HCA hospital ED Medical Director *Brovont v. KS-I Med. Servs., P.A.* (Mo. App. 2020) alleged that the skeletal staffing in his HCA hospital ED was "financially motivated." So much so, that after the hospital underwent a $120M expansion project that added 105 hospital beds, no additional ED physicians were added. This meant that ED physicians were required to provide coverage in three units, or physically be in three places at once -- the main ED, the pediatric ED, or in other parts of the 343-bed hospital responding to "Code Blues" (urgent distress calls). As a result, the main ED (which was a level II trauma center), was often left unstaffed by a physician to respond to emergencies.



HCA hospitals advertise live via billboards and on hospital websites the average time patients would need to wait to see a provider.

Source: https://www.mdgadvertising.com/marketing-insights/saving-an-er-billboard-campaign-

Emergency Department Profit Strategy #4: Marketing

The fourth part of HCA's ED strategy was the marketing of their emergency departments in such a way that "showcases the performance and the capabilities." One of the most common ways that HCA hospitals have done this is to advertise the average time that a patient visiting their EDs was waiting before seeing a provider. As early as 2010, it has been reported that potential visitors of HCA hospitals would be able to find out average waiting times by visiting the hospital's website, by texting a number provided by the hospital, or by looking at electronic billboards that the hospital had put up in the area.[48] The "average waiting time" posted in any of these locations would be updated continually based on information coming in from the hospital's emergency department. A continually updating and reporting process such as this likely requires aggressive efforts in data tracking, which would again indicate how important metric performance tracking is for HCA executives in their overall ED strategy.

It is troubling that such extensive tracking for marketing purposes would take place as HCA's clinical staff was dealing with the high occupancy levels that executives commonly reported. Combined with the pressure that hospitals had from corporate to bring down their average ED wait times even further, it becomes easy to be concerned about the level of support that HCA clinicians were receiving and the quality of care that patients would be able to receive.

That level of concern would intensify during an active health crisis that puts its own limits on hospital capacity, and the COVID-19 pandemic provides just such a case. But even as hospitals were dealing with strained capacities on this front in 2020, HCA was still focusing on communications campaigns,[49] without adequately addressing staffing issues or patient safety.

What HCA Says	What HCA Means
"We have a very aggressive campaign, both operationally from a patient safety standpoint as well as a communication standpoint, with our patients on demonstrating to them the safe environment that they deserve when they come to one of our facilities." *Sam Hazen, CEO for HCA, HCA Q2 2020 Earnings Call – July 22, 2020*	HCA's aggressive communications campaign may mislead patients into visiting their EDs, which may lack the capacity to meet their clinical needs. An ED nurse in the whistleblower suit *United States ex rel. Lazard v. HCA* alleges, among other things, that the ED at her HCA hospital is often "woefully understaffed" and "overwhelmed" because HCA routinely admits more patients than it has the capacity to treat. Despite HCA's claims of "patient safety," the nurse alleges, among other things, that: • "Admitted" patients are often boarded in the ED for long stretches of time or placed on gurneys in hallways; • HCA required nurses to provide care outside of their competency and scope of practice; • Instead of admitting higher acuity patients to inpatient rooms (due to lack of space), the hospital pulled on-call nurses from the ICU, medical surge, and telemetry units to chart the patients still located in the ED. • As such, ED nursing staff have been unable to meet patient needs.

HCA's Relationship With Troubled Physician Group EmCare Raises Serious Questions About Its Practices

As noted earlier, HCA executives have emphasized the importance of alignment between their hospitals and their contracted physician groups as they pursued their strategic goals in their emergency departments. One critical path that HCA appears to have followed in this area is through its joint venture ("JV") agreement with EmCare, one of the largest emergency physician management companies in the country.[50] Our research suggests that EmCare may staff departments in upwards of 90 HCA hospitals.[51]

Because inpatient hospital admissions require physician orders in order to be reimbursed by Medicare,[52] any corporate schemes to increase admissions through the ED will require participation by physicians at the hospital. One way to secure this participation could be to incentivize it through hiring, promotions, raises, and other benefits, or to punish non-compliance with the scheme through firing, demotions, and other punishments. Many ED physicians and hospitalist physicians at hospitals around the country work for medical groups that contract with hospitals to provide services, however, and thus these physicians are not directly employed by the hospitals. In such situations, hospitals will need to develop very strong relationships with their contracted physician groups in order to push for the behavior they want among their physicians.

HCA's JV with EmCare appears to show the strong relationship that could make this possible. Given what we know of HCA's corporate emergency department focus and given the public concerns that have been raised about EmCare's ED practices, HCA's relationship with this group raises further questions about their goals for their EDs.

EmCare/Envision Under Federal Corporate Integrity Agreement Due to Alleged Fraud

HCA entered into its JV with EmCare in 2011, and the JV began providing services to HCA hospitals in the first quarter of 2012.[53] It is around this time that government investigations into EmCare's practices were first announced. Community Health Systems, Inc. ("CHS") and Health Management Associates, Inc. ("HMA"), two of HCA's for profit health system peers, first disclosed that they were under federal investigation related to their ED practices during 2011.[54] EmCare had signed national contracting agreements with both systems in 2008.[55] By early 2013, EmCare had been subpoenaed by the federal government for materials related to their association with both companies.[56] It seems unlikely that a company with HCA's experience would not have caught onto these issues as part of its due diligence process while developing its JV agreement with EmCare.

As a result of the federal investigation into EmCare's practices at HMA hospitals, Envision Healthcare – EmCare's corporate parent – agreed in 2017 to a $29.8M settlement with the DOJ and to enter into a five-year Corporate Integrity Agreement ("CIA") with the Office of Inspector General of the U.S. Department of Health and Human Services ("OIG").[57] Envision is still bound by this oversight agreement today, and our understanding is that it extends to all of its locations where the company provides physician services – not just those that were at previous HMA hospitals. Thus, this oversight should extend into its joint venture with HCA, thereby bringing greater potential for exposure to the issues at HCA.

EmCare's Questionable Billing Practices

EmCare has developed its own reputation for questionable billing practices. In 2017, researchers at Yale looked at nearly 9 million ED visits from a national insurer between 2011 and 2015.[58] The researchers determined that after hospitals in their data set were taken over by EmCare, average ED physician payments increased by 117% and out-of-network billing rates increased more than 81 percentage points at hospitals that previously had low out-of-network rates.[59] Hospital admissions rates and physician billing for the highest intensity type of ED visits also increased.[60]

Around the same time, there were several class action lawsuits filed against EmCare/Envision related to billing practices like balance billing and surprise billing. In one of the complaints, the plaintiff alleges that Envision violated Florida law by balance billing patients for emergency medical services.[61] In another suit, the plaintiff filed a class action suit to represent individuals in California who received surprise bills for emergency services staffed by Envision.[62]

The Profit-making Potential of HCA's Joint Venture with EmCare/Envision

Despite the public critique and scrutiny that EmCare/Envision has brought into this relationship, it seems that HCA believes the potential benefits of this association outweigh the potential risks. Given what little has been reported about the JV, it may not be difficult to see why. Though details of the JV agreement are not available, *Modern Healthcare* reported that the JV established a 50-50 profit sharing model between HCA and EmCare once its margins reach about a 13% threshold.[63] HCA thus has an incentive to encourage – or coerce – its EmCare physicians to perform more profitable services at HCA hospitals, because HCA may get to take part of the profits that the physicians bring in from their billing. Admitting larger numbers of patients further extends HCA's ability to produce profitable physician services, if EmCare staffs the hospitalist physicians or other hospital departments that provide billable services for inpatients. Our research suggests that EmCare does so at numerous HCA hospitals.

Concerns with HCA's JV with EmCare extend beyond its reported profit-sharing arrangement, as EmCare's likely dependence upon the JV's continued business puts HCA in an even stronger position to demand behavior of its physicians. According to financial reporting for Envision, HCA accounted for 20% of their total revenues in 2017,[64] which was the final year before Envision was taken private by KKR.[65] In 2017, Envision reported $7.8 billion in revenue[66] and thus HCA facilities contributed approximately $1.5 billion in revenue to Envision. With such a large share of its business tied up with one company, Envision likely has a strong need for the partnership to continue. HCA is in a stronger position to put leverage on EmCare regarding how much its physicians answer to HCA. In other words, if HCA wants a higher number of admissions or more tests performed or reductions in staffing, EmCare may feel it needs to abide by the requests in order to maintain the contracts. Given the allegations within multiple lawsuits mentioned later in this report – especially the *Ruiz*,[67] *Brovont*,[68] *and Espinoza-Cruz*[69] cases – it seems likely that this pressure is felt by EmCare, or at least that EmCare and HCA are in accord on these matters.

A Cascade of Lawsuits Suggests That HCA Pressure on Emergency Department and Staff Is Widespread

The repeated comments by HCA executives about their plans for their emergency departments lead us to believe that they are putting pressure on their hospitals to fill their beds and rooms with patients quickly. How might this pressure be felt by those who are most directly in line to experience it? We turn to lawsuits, where clinical staff have leveled a number of accusations against HCA or EmCare. The patterns suggest the pressure is widespread across HCA's hospital network and has serious repercussions for patients, workers, and taxpayers alike.

Ruiz v. Hospital Corporation of America: Allegations that HCA Over-Admits Patients without Medical Justification to Boost Profits

The primary lawsuit of interest is one that specifically alleges precisely what this report is arguing: that HCA hospitals routinely admit patients from the emergency department in the absence of medical necessity in order to increase revenue. This lawsuit, *United States of America et al ex rel. Ruiz v. Hospital Corporation of America et al*, was brought by Dr. Camilo Ruiz ("Dr. Ruiz," "the relator"), a hospitalist who worked at HCA's Aventura Hospital and Medical Center in Florida. The relator alleges that HCA and 41 of its hospitals across the country[70] engaged in a systematic practice of maximizing revenues by pressuring hospitalists and other primary care physicians to increase the number of inpatient admissions at their hospitals, regardless of whether these admissions were medically necessary. Though it does not list EmCare as a defendant, the lawsuit also claims that EmCare participated in this pressure of Aventura's hospitalists after it took over the hospitalist group at this hospital in 2012.[71] These practices, like the alleged practices in *Hospital Internists of Austin, P.A. et al v. Quantum Plus, LLC et al* (see below), suggest HCA attempts to exert control over its physicians and interfere with their medical judgement for financial gain, without regard for patients' actual clinical needs.

According to *Ruiz*, Aventura and other HCA hospitals were able to achieve this control through regular monitoring of data concerning their hospitalist physicians' inpatient admissions and outpatient observation cases. Dr. Ruiz and other physicians would receive "report cards" every month that compared their individual performance on these metrics to the average performance among other physicians throughout the HCA East Florida Division (to which Aventura belonged).[72] Key metrics included physicians' average length of stay for their inpatient cases and for their observation cases, their average costs for their inpatient cases, and their average charges for their observation cases.[73]

Allegedly, physicians who were admitting lower percentages of patients than their peers in the same hospital received "red warnings" on their report cards,[74] and physicians with any red warnings would "receive reprimands from Aventura's administration and threats of termination."[75] Indeed, the relator claims that since EmCare took over the hospitalist group at Aventura in 2012, the group has terminated physicians who did not comply with Aventura's demands in this regard – including Dr. Ruiz himself.[76] These regular reports thus served to encourage physicians to compete with each other to bring their individual rates more in line with what their hospital administrators were expecting of them, lest they be penalized with loss of privileges or even termination.[77]

Dr. Ruiz claims that the hospital placed special emphasis on the observation-related metrics. He had received multiple red warnings himself for his performance on these metrics, as his average observation charges and his average observation length-of-stay were longer than the Division averages.[78] He alleges that he had attended multiple meetings where he and other physicians were pressured to move more of their observation cases to the inpatient admission setting.[79] At one such meeting, he alleges that Aventura's CEO told physicians that there would be a "day of reckoning" for those who did not follow these instructions.[80]

After examining data for Aventura and other hospitals in the HCA system, Ruiz concludes that this pressure worked. With Aventura more directly, Dr. Ruiz was able to see in reports across the years that Aventura's numbers of observation cases, average observation length of stay, and average charges for observation cases fell sharply, even to the point that they fell well below the HCA East Florida Division's averages, while the hospital's inpatient admissions "dramatically increased" over the same period of time.[81]

Beyond Aventura, the complaint supplies its own analysis of hospital data, relying on both national Medicare claims data and Florida claims data to examine these hospitals' performance across years and as compared to non-HCA hospitals.[82] Much like what we have learned in our own data analysis, *Ruiz* found that in Aventura and many other HCA hospitals, inpatient admission rates through the ED had increased and were well above the averages among their non-HCA peers.[83] This was noticeable especially when focusing on eight common diagnoses groups that Dr. Ruiz alleged HCA had monitored, such as nonspecific chest pain / atherosclerosis, dizziness or vertigo, and malaise and fatigue.[84]

The relator alleges that HCA's tactics greatly escalated inpatient admissions of Medicare patients usually treated on an outpatient basis, at a cost to Medicare of roughly $1.3 billion in overpayments from 2013 to 2016.[85]

The *Ruiz* lawsuit was voluntarily withdrawn by the relator in 2020[86] after the U.S. Department of Justice declined to join the case in 2019.[87] It should be stressed that this was during the tenure of William Barr as Attorney General. Mr. Barr is on record as believing that the whistleblower sections of the False Claims Act are unconstitutional,[88] and it should be no surprise that under his leadership the Department of Justice might have ignored cases that under other leadership it might have supported by joining. It should also be stressed that this lawsuit's allegations are wholly unrebutted, and the suit itself could be refiled.

In addition to the *Ruiz* lawsuit, which squarely corroborates the core argument of this report, other known lawsuits involving HCA contain allegations of other corporate practices that show similar intents and effects. We provide more detail on these lawsuits below.

HCA's Alleged "Cult of Coercion" in Silencing Staff for Raising ED Understaffing and Safety Concerns

ED physicians allegedly described the hospital environment as "a weird cult of coercion" where "if you didn't toe the party line" they may "get rid of the whole lot of us." - Brovont v. KS-I Med. Servs., P.A.

ED physicians at HCA hospitals have filed lawsuits alleging HCA retaliated against them for raising concerns about policies and practices that compromise patient safety, particularly around profit-motivated staffing decisions in the ED.

Dr. Raymond Brovont – a former ED Director at HCA's Overland Park Regional Medical Center in Kansas – won a $26M judgement[89] in 2021 in a wrongful termination case (*Brovont v. KS-I Med. Servs., P.A.)*[90] Brovont alleged that hospital policies dictated that a single ED physician was to respond to "Code Blues," or urgent patient distress calls, within the entire hospital while also covering an 18-hour shift in the main ED (which was a level II trauma center).[91] Things allegedly worsened after the hospital underwent a $120M expansion project. Even though the expansion doubled the size of the hospital, tripled the size of the ED, and added a new separate pediatric ED, the hospital maintained the same cross coverage and understaffing policies.[92] This meant that ED physicians were required to physically be in three places at once -- the main ED, the pediatric ED, or in other parts of the 343-bed hospital responding to "Code Blues." As a result, the main ED was often left unstaffed by a physician to respond to emergencies. Brovont alleged he was fired and then blacklisted after he and other ED physicians repeatedly raised concerns to both the hospital administration and EmCare.[93] They were told that HCA and EmCare's "staffing decisions for the emergency department were financially motivated."[94] After Brovont's termination, the remaining physicians felt like they worked within "a weird cult of coercion" where if you did not go along with it you would be terminated.[95]

This alleged "cult of coercion" for silencing physicians who raise concerns is not limited to just Overland Park Regional Medical Center in Kansas. In fact, a similar case was filed by another ED physician at HCA's Brandon Regional Medical Center near Tampa, Florida. In *Espinoza-Cruz vs Florida EM-I Medical Services PA*,[96] Dr. Wanda Espinoza-Cruz alleges she was fired from EmCare because she raised concerns about few ED doctors being available to treat the patients' emergent conditions. The nursing supervisor was allegedly told "there was a change in protocol as a response to concerns about profitability…It's expensive to call in a doctor."[97] The hospital's CEO allegedly said "he knew there was a problem, but that he had talked to corporate and that the emergency room staffing model was untouchable because of HCA's relationship with (staffing company) EmCare."[98]

Nurse Alleges HCA's ED Is "Woefully Understaffed" and "Overwhelmed" Due to Over-Admitting, Bills for Services Not Provided

In one lawsuit, a nurse described the ED at her hospital as often "woefully understaffed" and "overwhelmed" because HCA routinely admits more patients than it has the capacity to treat. Then, HCA allegedly fraudulently bills for inpatient services. - United States ex rel. Lazard v. HCA

The skeletal staffing and cross coverage policy claims alleged in the *Brovont* case are echoed by an ED nurse from HCA's Regional Medical Center in San Jose, California. In her case, *United States ex rel. Lazard v. HCA*,[99] the nurse further alleges that HCA routinely admits more patients than it can treat. As a result, 1) "Admitted" ED patients are often boarded in the ED for long stretches of time or placed on gurneys in hallways[100]; 2) Nurses are required to "fraudulently" chart the patients to make them look like they had been moved to inpatient rooms to seek higher billing reimbursements[101]; and 3) Nurses were required to provide care "they have not been trained to provide and for which they are not qualified to provide",[102] thus, they're unable to properly meet patients' clinical needs. Perhaps even more striking, the suit alleges that the hospital responded to concerns expressed by ED physicians about these excess and fraudulent admissions by having "hospital administrators… accepting patients in place of the emergency room physicians."[103]

Lawsuits Claim HCA Co-Opts Patients' Continuum of Care, Infringes upon Physician Medical Judgement

Among the striking allegations in the *Lazard* case were hospital administrators co-opting the admissions process by accepting patients in place of emergency room physicians, thus interfering with physicians' medical judgement, as well as asking staff to perform tasks outside of their competency and scope of practice.

Similar allegations appear in litigation brought by the physician group practice Hospital Internists of Austin P.A. (HIA) against TeamHealth, the physician staffing company contracted by HCA to provide physician services in its hospitals in Austin, Texas.[104] There, HIA was hired by TeamHealth to provide ED physician services and hospitalist services in the hospitals. HIA alleged that HCA and TeamHealth required HIA's hospitalist physicians to treat patients whose medical needs were outside those physicians' specific training and proficiency, including emergency patients.[105] In some cases, this resulted from a policy (called "OneCall") of accepting all transfer patients from nearby hospitals, even if the needed specialist was not available.[106] HIA also alleged that their physicians were pressured to provide diagnoses that they judged were improper, and that this "pressure necessarily infringed on HIA physician's medical judgment."[107] Yet, conforming to that pressure was, in effect, a condition of employment, HIA claimed. HIA alleged, moreover, that their physicians were pressured to quickly discharge patients, where "a St. David's data/administrative employee would routinely email to [TeamHealth subsidiary] Quantum a list of patients that he had determined were ready for discharge."[108]

HCA not only attempts to co-opt a patient's hospital care through infringing upon physicians' medical judgement, but also through keeping patients in the HCA system despite the implications for patient care and outcomes. In *O'Burke et al v. Hendersonville Hospital Corporation et al*,[109] a patient at one of HCA's hospitals in Nashville (TriStar Hendersonville) repeatedly asked for but was denied transfer to Vanderbilt University Medical Center (the premier hospital in Middle Tennessee; not affiliated with HCA) for a higher level of care.[110] After 48 hours of worsening symptoms, a TriStar Hendersonville doctor told the plaintiff's family that "there was nothing more they could do, and death was likely." [111] The plaintiff alleges that his family had been warned by a nurse that "physicians at TriStar Hendersonville would resist efforts to transfer him out of TriStar Hendersonville."[112]

Through all of these lawsuits, we find multiple overlapping themes:

- Retaliating against and silencing emergency department physicians or other staff for reporting safety, understaffing, or compliance issues — *Brovont*, *Espinoza-Cruz*
- Understaffing in the ED — *Brovont*, *Lazard*
- Over-admitting from the ED — *Ruiz*, *Lazard*
- Excessively admitting patients to different settings of care without medical necessity to maximize profits — *Lazard*, *HIA*
- Falsely billing for patients as inpatient, while fraudulently billing for patients who are merely boarded in their EDs or kept in hallways — *Lazard*
- Interfering with physicians' medical judgement or patient's medical needs for financial gain — *Ruiz*, *Lazard*, *HIA*, *O'Burke*

These lawsuits support the core argument of this report — that HCA has been engaged in a concerted program to admit patients from the ED not for medical necessity but to increase revenue.

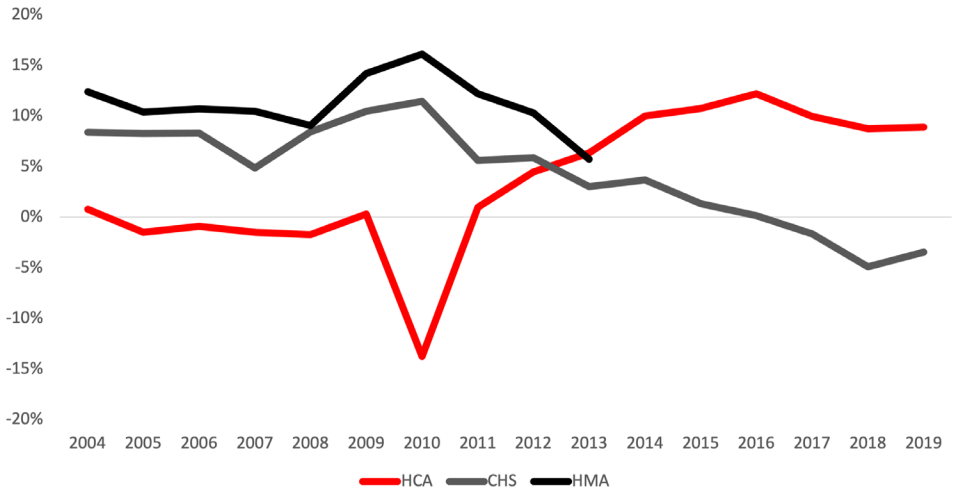
HCA Appears to Ignore Punishment of HCA's Peers over Similar Practices

The case against HCA regarding their alarming ED admission practices is strong, and the level of potential overpayment that we see for them – $1.8B since FFY 2008 just from Medicare fee-for-service alone – is much higher than any other system we have analyzed. We have seen similar unnecessary ED admission issues with other systems in the past, albeit in lower total overpayment terms. About a decade ago, two of HCA's publicly-traded peers – Community Health Systems, Inc. ("CHS") and Health Management Associates, Inc. ("HMA") – each showed a very similar pattern to the one we see for HCA, and each system was punished for their behavior following lengthy government investigations. The fact that HCA is nonetheless showing these patterns now makes us especially worried about what we are seeing with the system, and about what this might say about HCA's concern for public accountability. With the strong similarity in patterns between these systems, we believe that comparison of the cases will help understand the risk faced by HCA now.

The chart below looks at one of the metrics we examined earlier in this paper – system average percent above expected ED admissions among Medicare claims – and it compares the relative performance on this metric between HCA, CHS, and HMA.[113] Because the issues at CHS and HMA were publicized in the past, we have extended the period focused upon in this chart back further in time. As the chart shows, both CHS and HMA were well above expected as systems for much of the mid-2000s, while HCA's deviance did not appear to begin until years later. In fact, HCA's deviance seems to begin around 2011, which is around the same time that CHS's and HMA's were beginning to wane.

2011 is not an arbitrary year with respect to these other systems. This is the year when both CHS and HMA announced that they were under federal investigation for their ED admission practices.[114] It is not surprising then that the average performance for each system on the metric shown in Figure 7 begins to drop off beginning in this year. After all, the systems' leaders now knew their behavior was being watched, and they had reason to be concerned that punishment would be possible.

Figure 7.
Percent Above (Below) Expected ED Admissions for HCA, CHS, and HMA Medicare FFS



As we have seen with HCA, the data patterns found at these systems occurred in the midst of strong efforts by corporate leaders to focus on their hospitals' EDs. Indeed, CHS and HMA executives regularly informed investors of the importance of their EDs to their overall strategic planning. The system's leaders emphasized their efforts to market their EDs and to expand the capacities of their EDs, and they regularly talked about how they were tracking performance in their EDs and attempting to improve their results[115] – all topics that we have seen emphasized by HCA executives as well.

One topic of focus among these other systems is particularly noteworthy in comparison to what we see with HCA. Prior to the announcement of the federal investigation into their ED practices, CHS executives often emphasized their ED admission rates to investors, as the quote below shows:

We get about 55 to 60% of our admissions through the ER. When we came to the company, about 12 years ago, the admission rate out of the ER was 10 to 11%. Now it's 15%. Actually, the Triad hospitals had an admit rate, which was lower than the CHS, and we've improved that admit rate so far.

Larry Cash, then-CFO and EVP of CHS
CHS at Robert W. Baird & Co., Inc. Health Care Conference – September 10, 2009[116]

Interestingly, CHS's share of its admissions coming from their EDs *at a time when they were so far out of line with national norms* was "55 to 60%;" well below the 60-70% share that HCA has regularly noted in recent years.[117] Further, when an HCA executive has talked about the system's average ED admission rates recently, he said that it had traditionally been about 17-18%, but during the COVID-19 pandemic it had risen to about 20%.[118] It seems worrisome that HCA's ED admission results have gone above and beyond those of a peer who had eventually been investigated – and punished – for them.

Like HCA, CHS and HMA also faced lawsuits from internal whistleblowers who were concerned about their respective system's ED practices. In 2011, CHS announced that they had become aware of a False Claims Act ("FCA") qui tam suit filed against them by a former case management worker at one of their Indiana hospitals, with the worker alleging that the hospital was billing Medicare for inpatient admissions that were not medically necessary.[119] More lawsuits filed by internal whistleblowers would eventually be revealed after CHS reached a settlement with the federal government to resolve the allegations against it.[120] In 2013, a number of whistleblower lawsuits against HMA were unsealed as the federal government elected to intervene in them, with several of these suits alleging fraudulent admissions through the ED.[121] Whistleblowers among these lawsuits included ED physicians, hospital executives, and corporate compliance officers.

The similarity in patterns that we find here offers reason to believe that the ultimate fallout for the earlier systems might provide a guide to what HCA may experience in the future. Ultimately, CHS reached a settlement with the federal government in 2014 to resolve investigations into its ED practices, whereby the system agreed to pay back nearly $100M and to abide by a five-year Corporate Integrity Agreement ("CIA") with the federal government.[122] In the intervening years, CHS has divested dozens of its hospitals following years of poor financial results.[123] CHS has closed some hospitals during this time, with representatives occasionally saying that closures were occurring after declining admissions following events such as "[c]hanges in admission guidelines."[124]

HMA's experience has been even worse. In 2012, HMA's ED practices became the subject of an investigatory piece by *60 Minutes*.[125] The company experienced significant shareholder revolt afterwards. By 2014 the system's board of directors had been replaced[126] and the system was sold to CHS.[127] As with CHS, a settlement was eventually reached with the federal government to resolve allegations against HMA, and that settlement – occurring in 2018, and ultimately agreed to by CHS – had its new owner agree to pay back about $260M to the federal government. CHS then had to amend its already existing CIA to extend further into the future.[128] As with CHS legacy hospitals, many former HMA hospitals have since been sold off or closed.[129]

Given how similar the pre-investigation cases at CHS and HMA are to HCA's current situation, we feel confident that the impacts experienced by these earlier companies provide a glimpse at the risks that HCA faces. HCA taking their aberrant paths *after* its peers were subject to such strong responses by federal regulators and shareholders is quite concerning. One would have hoped that federal investigations and settlements with companies would act as deterrents to other companies who might consider performing the same behavior. But with HCA, it appears that this has not deterred them.

PROFITS, NOT PATIENTS

As alarming as HCA's apparently fraudulent ED admission practices are, they are part of an even larger issue with HCA's profit-seeking focus and the impact it has on U.S. health care.

HCA: A Profit-Driven System with a History of Diverting Healthcare Dollars to Investors

One of HCA's founders, Thomas Frist, MD, said that he and his co-founders were inspired by "seeing what Holiday Inns 10 years before had done in changing basically the travel industry."[130] HCA did change the hospital industry. Prior to HCA's creation, the hospital industry had long been dominated by nonprofits.[131] Now, HCA is the largest health system in the U.S.[132] and one of the wealthiest health systems in the world,[133] with a market capitalization of $78.1 billion as of November 1, 2021.[134] In fact, HCA's financials are so strong that it makes more revenue and twice as much profits as the three other largest publicly traded acute care hospital systems combined. (See figures below.)

Figure 8. Publicly Traded Acute Care Hospital Systems 2020 Revenues

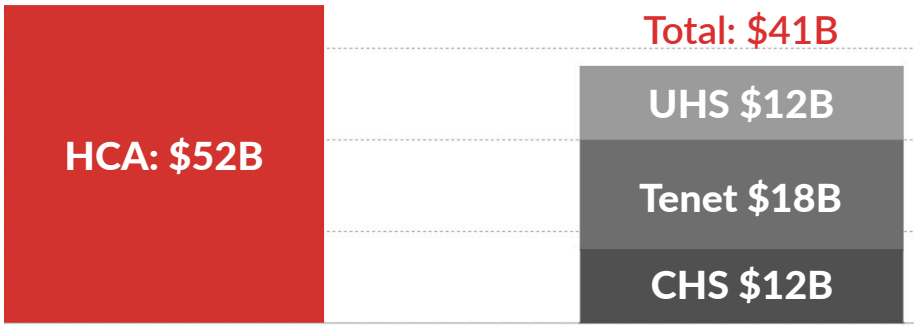
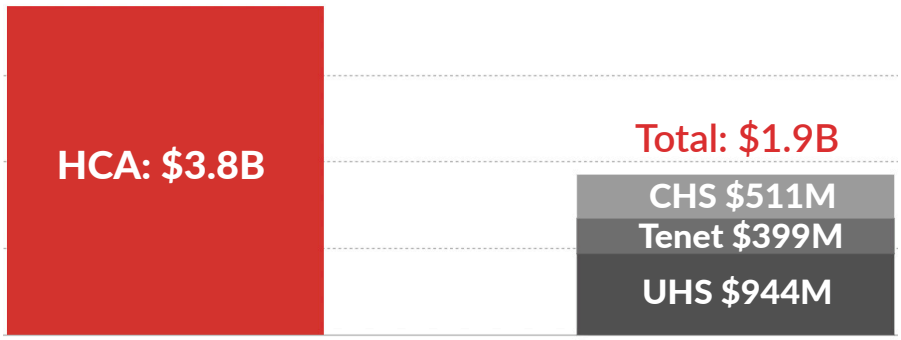


Figure 9. Publicly Traded Acute Care Hospital Systems 2020 Net Income



Source: Capital IQ

Reliance On Government Funding

HCA was founded just years after the creation of two new government health insurance programs, Medicare and Medicaid, flooding the hospital industry with new revenue.[135] More than 40% of HCA's revenue comes from these taxpayer-funded programs.[136] (See Figure 10 below.) In 2020, HCA received more than $22 billion in revenues from Medicare and Medicaid combined.[137]

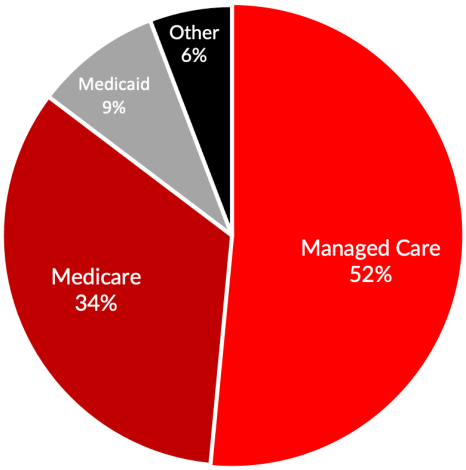


Figure 10. Tax payer funded government programs funded 43% of HCA's revenues in 2020. Medicare and Medicaid Revenues totaled $22 billion.

A Track Record Of Making Investors Rich

Piling on debt to pad the pockets of private equity and the Frist Family

HCA announced in 2006 that it would be taken private in a record-breaking $33 billion leveraged buyout ("LBO") by a consortium of private investors: Bain Capital, KKR, Merrill Lynch and the Frist Family.[138] The bulk of the financing for this deal was in the form of debt, which would then be piled on top of HCA's existing debt. After the transaction closed, HCA would have $28.4 billion in total debt, up from $11.3 billion in the prior quarter[139] and HCA's interest expense payments would more than double, jumping up to over $2 billion a year in 2007.[140]

After HCA's initial public offering ("IPO") in 2011, it was estimated that the Frist family and other investors were expected to more than triple their 2006 LBO investments.[141] According to analysis performed by *Fortune*, Bain Capital took in $1.2 billion from an initial equity investment of only $64 million.[142]

Over $29 billion paid out to investors in the form of dividends and share buybacks

Even before the IPO, private investors were able to start extracting value from HCA's business. In January 2010, HCA paid $1.75 billion in dividends to its backers. Then in May 2010, the company issued another $500 million in dividends. Finally, in November 2010, HCA announced plans to issue another $2 billion, bringing the company's total dividends payment for the year to $4.25 billion—all to Bain, KKR, Merrill Lynch and the Frist Family.[143]

HCA has continued to pay out billions to investors in the form of dividends and share repurchases. From HCA's IPO in March 2011 till September 30, 2021, HCA has paid over $4.8 billion in dividends and over $20.0 billion in share repurchases, or over $24 billion to investors.[144]

Soaring Stock Prices

HCA exited its LBO with an IPO in March 2011,[145] approximately a year after the Affordable Care Act was signed into law.[146] HCA's $3.79 billion IPO was the largest private equity backed IPO at the time and investors jumped at the chance to buy HCA, "shrugging off the hospital operator's high debt levels," which averaged nearly $27 billion in 2010.[147] Investors weren't as concerned due to HCA's strong profits and stable cash flows.[148] In fact, HCA could have paid down a larger chunk of its debt had it not paid over $4 billion in dividends to its private investors right before the IPO.[149]

Investors who bought HCA at the time of the IPO and held on until now would have made a pretty penny. As shown in Figure 11 below, HCA's stock has outperformed both the S&P 500 and the other publicly traded for profit hospitals. In fact, despite the pandemic, HCA's stock prices are around the highest they have ever been.

Source: Capital IQ

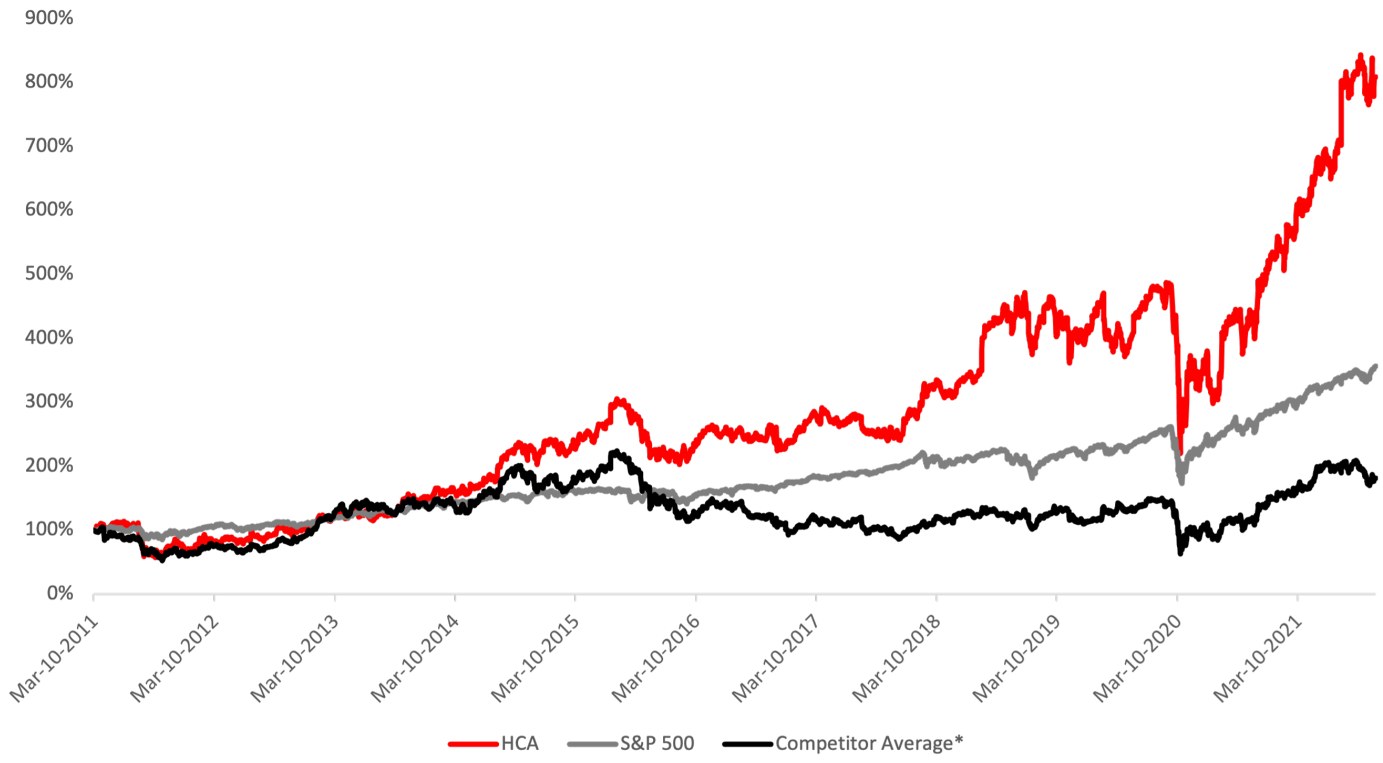


Figure 11. HCA'S STOCK PERFORMANCE FROM IPO TO PRESENT

** Competitor Average based on stock performance from the following companies: Community Health Systems, Tenet Healthcare and Universal Health Services*

Profit Driven Approach

HCA has always stood out for its ability for its strong revenue growth and high profits. Without its strong financials, HCA would have never been able to withstand the heavy debt load from the LBO or pay out over $29 billion to investors in the form of dividends and share repurchases.[150]

As mentioned earlier, it has more revenues and profits than its publicly traded competitors combined. Figures 12 and 13 below show HCA's steady and strong revenue and profit growth over time.

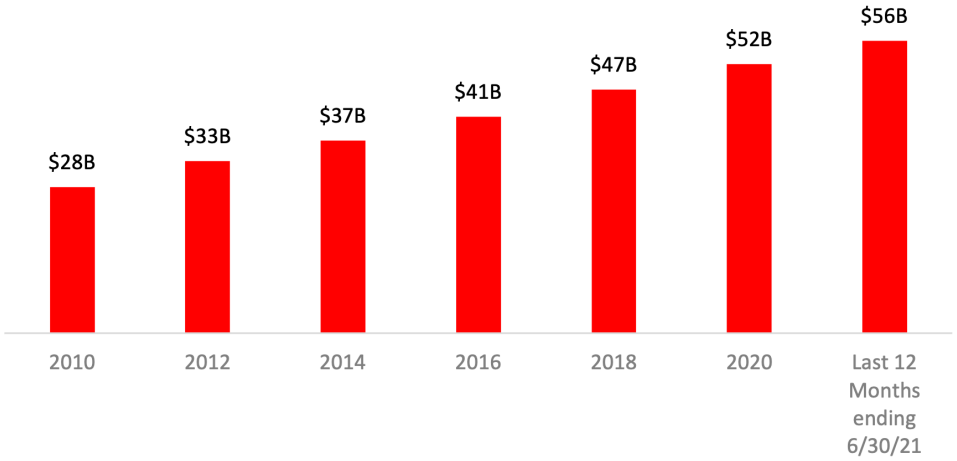


Figure 12: HCA'S REVENUE

Source: Capital IQ

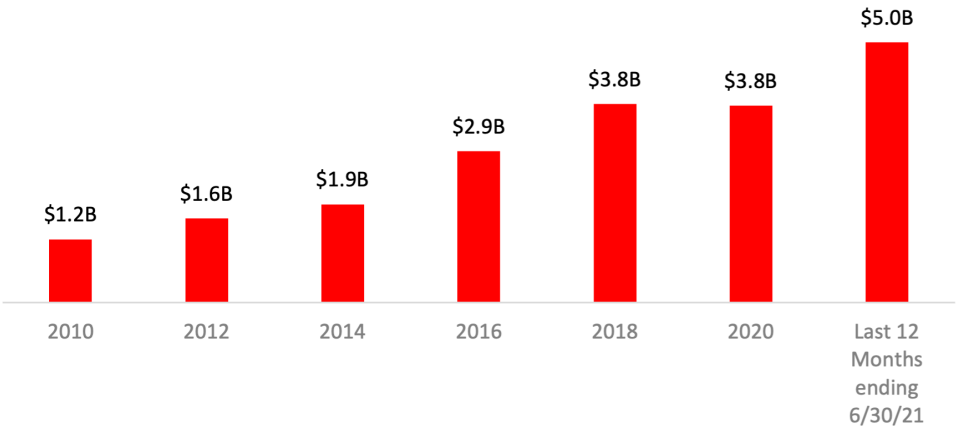


Figure 13: HCA'S PROFITS (NET INCOME)

Source: Capital IQ

Over the past 50 plus years, HCA has grown to over 2,000 sites of care and 35 million patient encounters a year,[151] becoming an industry leader based on size alone. HCA also stands out for its huge profits and soaring stock prices. Given its size, history, and track record, HCA has become a health system whose actions set the tone for the rest of the industry. This is highly problematic given the strong likelihood that the company has been engaging in fraudulent behavior to significantly boost its top and bottom lines – potentially driving other companies to do the same.

Additionally, this behavior is costly to taxpayers who fund a significant portion of hospital revenues through government funded programs. As shown earlier in this report, Medicare and Medicaid paid for 43% of HCA's revenue in 2020. In the end, the only ones benefiting from HCA's profit driven approach are its investors. Through dividends and share repurchases, since 2010 HCA has diverted over $29 billion to the pockets of rich investors like Bain, KKR, Merrill Lynch and the Frist family.

Chronic Understaffing at HCA Undermines Patient Care

HCA's profit-driven approach appears to extend to their hospital staffing decisions as well. Our analysis of cost report data from the Centers for Medicare and Medicaid Services ("CMS") shows that there is a pattern of lower-than-average staffing ratios at HCA's facilities nationwide. In 2019, HCA had about 30% fewer full-time equivalent ("FTE") staff per adjusted occupied bed ("FTE rate", or "staffing rate") than the national average for acute care and critical access hospitals.[152]

This pattern of having significantly fewer staff per adjusted occupied bed is found across the HCA system. In 2019, HCA's weighted average FTE rate was lower than the state average in nearly every state where HCA operates, except for Mississippi[153] – and as noted earlier in this report, HCA sold its only Mississippi hospital in 2020.

Staffing rates have also gone down at recent HCA acquisitions. HCA bought two hospitals in Georgia between 2017 and 2018 — Memorial Satilla Health in Waycross and Memorial Health University Medical Center in Savannah.[154] Our analysis shows that FTE rates in both of those hospitals dropped after HCA took over, with Memorial Satilla showing a 30% decrease the year it was acquired.[155] Staffing level decreases have also been raised as one of the major reasons for concern after HCA acquired North Carolina's Mission Health system in 2019.[156]

The common lower-than-average staffing ratios that we find at HCA hospitals stand in marked contrast to their higher-than-average ED admission rates. Were HCA to argue that its admission rates were the result of treating a patient population with higher average acuity than national norms, then it would seem a dangerous decision to meet that higher acuity population with a *lower* staffing presence than is commonly found elsewhere. The same would be true if HCA said of its higher admission rates that the system was just acting out of an abundance of caution and favoring admission in borderline cases. If so, why would HCA not staff to a level that suggests it is ***providing*** an abundance of caution?

Staffing-Related Care Deficiencies

The pattern of low staffing and over-admitting at HCA hospitals is accompanied by a number of disturbing care failures that have impacted patients, as evidenced by news reports, as well as our review of CMS inspection reports for HCA-owned facilities. Examples include:

- **Threatened termination from the Medicare and Medicaid programs by CMS**, reportedly for leadership failures and noncompliant staffing ratios.(HCA's Good Samaritan Hospital, San Jose, California)[157]

- **Patient deaths** from not having enough staff to 1) change batteries on blood oxygen measuring machines (HCA Hospitals, Denver, Colorado),[158] or 2) perform timely cardiac assessments on ED patients (HCA Northside Hospital, Saint Petersburg, Florida).[159]

- **Patients boarded in the ED for "prolonged periods"**

    - An HCA Hospital in California reportedly had patients boarded in the ED (some on gurneys) for "prolonged periods of time" and were thus not getting the level of care they needed. The ED had between 83 and 132 patients receiving treatment at different times on the two days of the CMS inspection, despite the ED having only 35 beds. (HCA Riverside Community Hospital, Riverside, California)[160]

    - A patient, who had an incomplete miscarriage, spent seven hours on a gurney in the ED still attached to her deceased fetus/umbilical cord because the OB physician was unavailable due to being in surgery. (HCA Houston Healthcare West, Houston, Texas)[161]

- **A possible stroke patient waiting 14 hours for an MRI** because the NSICU nurse was "not available" and needed to perform other patient care tasks. (HCA's Medical City Plano, Plano, Texas)[162]

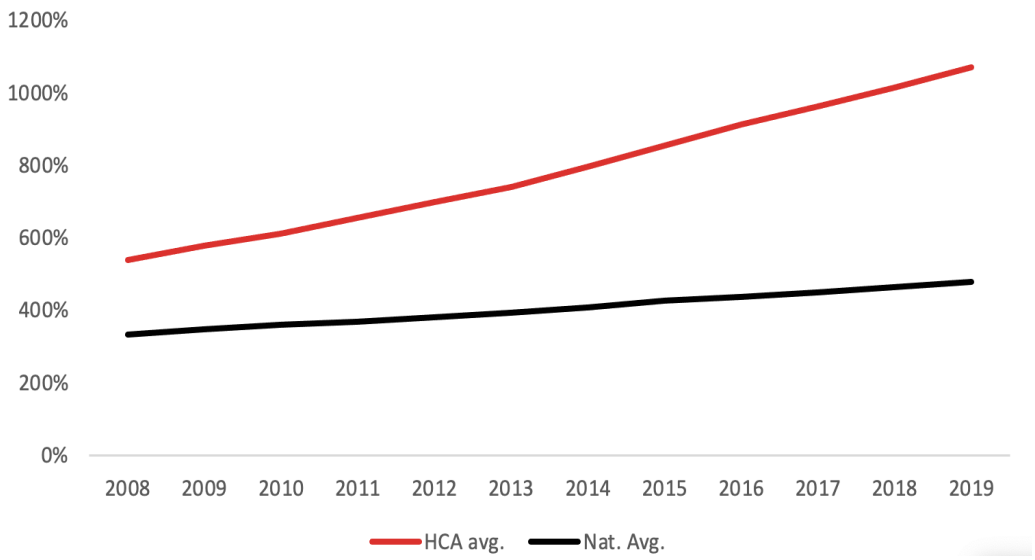
- **Failures in controlling infection, maintaining sanitary ED exam rooms.** The hospital's ED manager stated that nurses were responsible for cleaning between patients, with 100-120 patients treated each day. The director of environmental care (EVS) stated one EVS staff is assigned to clean bedside tables, floors and monitors, but not "anything with wheels." (HCA Houston Healthcare Clear Lake, Houston, Texas)[163]

HCA's Aggressive Charging Practices Stand Out Among Peers

HCA's profit-seeking focus appears to extend into how its hospitals charge for their services. Our analysis of Medicare Cost Reports reveals that HCA hospitals commonly report charges that are well in excess of the costs they report for the service they provide. We measure this by looking at a simple metric called the charge-to-cost ratio. According to our analysis, the average charge-to-cost ratio among HCA hospitals in 2019 was 1072% – more than double the national average ratio that year.[164] In fact, if HCA's average ratio was the charge-to-cost ratio for a single hospital that year, then that hospital would rank among the highest 5% of all hospitals nationally in 2019. In other words, HCA's average charge practices make this system an extreme national outlier.

The 2019 results continue to demonstrate a pattern for HCA that has stretched on for many years. Figure 14 shows the HCA average charge-to-cost ratio across years compared to the national average. As is easily seen, HCA's average rates are well out of line above national norms every year during this period, and indeed the system's average has been more than double the national average during the last several years.

Figure 14: HCA Avg. Charge-to-Cost Ratios



HCA's hospital geography cannot explain this level of deviance. In fact, in 2019, HCA's average charge-to-cost ratio in every state in which it had hospitals was higher than the respective state average ratio that year.[165] Often, the HCA state average was roughly double the state average that year. With these practices so consistently spread throughout the system, it would appear that aggressive charging is occurring due to corporate strategy.

Other reports have focused on HCA's high charges as well, especially its trauma care service line.

- A November 2020 report from National Nurses United noted that of the 100 hospitals with the highest charge-to-cost ratios in 2018, 53 of them were part of HCA.[166]

- Johns Hopkins University researchers examined the markups at the 100 highest-revenue hospitals in the US and found that HCA's Chippenham Hospital had the highest rate among them, with this Virginia hospital charging nearly 13 times its costs. The five highest-ranked hospitals in the group – and seven of the 10 highest – were part of HCA.[167]

- A 2014 analysis by the Tampa Bay Times found that the average trauma bill at HCA's Florida hospitals was $40,000 higher than the average found from other trauma centers in the state.[168]

- More recently, Kaiser Health News analysis showed that HCA's average trauma activation fee far exceeded the "non-HCA" average in all of HCA's states with trauma centers in 2020, with HCA having rates that were more than double their peers in most of its states.[169]

Studies have found that hospitals' charges impact reimbursement, thus making it clear that aggressive charging can increase what people could expect to pay, either through higher individual patient bills or through higher premiums to cover what their insurers are paying.

- One such study of large insurers found that "23% of hospitals' inpatient cases have prices set as a share of hospitals' charges."[170] In other words, the amount paid for inpatient care by many subscribers was a direct function of how much a hospital charged, showing that high charges clearly matter.

- Another study found that increases in a hospital's charge-to-cost ratio are associated with increases in patient revenue per adjusted discharge.[171] That study also reported that uninsured patients are often billed at full charges, unless they are specifically covered by their hospital's charity care policy. This points to a special problem in our healthcare system with aggressive charging practices – the people who may feel the worst effects of this are likely the people who have the least support available to them to pay these charges.

None of the matters reported in this paper should be examined in a vacuum. HCA's high charges are of course a concern to patients and taxpayers alike, given the fact that they are likely contributing to higher costs of care for all in this country. But it becomes especially worrisome when the system's high charges are looked at in the context of the unnecessary utilization, understaffing, and shareholder return issues already reported here. Unnecessary admission concerns then become amplified by potential premium cost paid for services that may never have needed to be performed. The services – necessary or not – that HCA patients are paying such a high cost for are further being shortchanged by understaffing the care that is being provided. And the extra money paid out due to all of this seems to be largely exiting the healthcare system as HCA's corporate leaders focus so much attention on distributing profits to investors, perhaps to the detriment of further investments into care delivery.

The COVID-19 Pandemic Worsens HCA Issues: Care Access and Infection Control

One of the biggest possible implications of HCA's unnecessary admissions issues is its potential impact on dealing with the COVID-19 pandemic. Unnecessary admissions are a problem for reasons beyond the overpayments they may cause.

Filling inpatient beds with patients whose care could be appropriately provided at home results in potentially taking those beds away – at least on a timely basis – from patients whose conditions are more acute and who may need that level of care. This potential problem could become most severe when a hospital is operating at or near its capacity. Given the frequent references by HCA executives to their system's very high occupancy levels,[172] this could have been an issue at HCA even before this pandemic began. The problems that unnecessary admissions could cause become even clearer in the context of the COVID-19 pandemic. U.S. hospitals have been exposed to multiple surges of patients that have wiped out bed capacities in both the ED and inpatient settings, and staff at hospitals around the country have been repeatedly stretched thin. If, amidst all such pressure on bed and worker capacity, hospitals are still trying to find ways to admit patients who do not have emergent conditions, then this increases the risk that inpatient beds will not be available to those who truly need them.

Unnecessary admissions also increase the risk of spread of infectious disease. Hospital-acquired conditions are a topic that has received a great deal of focus in examinations of quality of care over the years, and many of these conditions are infections that are easier to be exposed to in a healthcare setting. COVID-19's transmissibility has further heightened the need for infection control in healthcare settings. COVID-19's spread and impact on many infected people necessitate that hospitals do everything they can to limit its further spread to workers and non-infected patients within their walls. At a minimum, that should mean that hospitals are only admitting the people who absolutely need to be admitted.

HCA's Pandemic Response: Business as Usual

Although these risks are well known, we are concerned that HCA does not appear to be taking these risks as seriously as they should. Given HCA's position in states that had been among those hit hardest by recent surges[173] – especially Florida and Texas, the two states with the largest HCA presence[174] – the system's leaders should be well aware that the pandemic is far from over, and that is not yet time to go back to normal operating strategic planning inside their hospitals. However, HCA has provided multiple reasons for being concerned about the system's early and continued responses to the pandemic along these lines.

We are concerned about a perceived reluctance by HCA to suspend elective procedures in the face of COVID. As early as April 2020 – only a month after the World Health Organization declared COVID to be a global pandemic[175] – HCA's CEO Sam Hazen was telling investors about their plans to "reboot" suspended operations like elective procedures across all their markets by June.[176] Even recently, as hospitals across the country were dealing with the Delta-fueled surge, HCA hospitals appeared to be resisting suspensions of elective procedures. In August 2021, as some Florida HCA hospitals opened outdoor tents to address increased utilization of their EDs, their leaders continued to stress that they had the capacity to continue to safely treat their patient loads, even as other non-HCA hospitals in the area paused their own elective surgeries.[177]

HCA's Pandemic Response: Failure to Protect Patients and Workers

Unfortunately, we have reasons to be concerned about HCA's efforts to safely care for their patients or to contain the spread of COVID-19 within their facilities as well. In July 2020, nurses at multiple Florida HCA hospitals reported that the hospital was not regularly testing them for COVID-19 and that they were being told to come to work even when they were symptomatic.[178] Still others reported that HCA hospitals were not notifying them when co-workers who they had been in close contact with had tested positive themselves.[179] Throughout the pandemic, there have been numerous complaints of HCA hospitals failing to provide their workers with the Personal Protective Equipment ("PPE") they need in order to perform their jobs safely – including complaints raised more than a year after the pandemic began. A critical care registered nurse at HCA's Research Medical Center in Missouri testified before Congress in March 2021 that nurses on her unit were, at that point, "still caring for COVID-19 patients without adequate protection."[180] In Denver, nurses at HCA's hospitals complained of regular understaffing at their facilities, allegedly leading to increased pressure sores and infections, as well as to at least one death of a COVID-19 patient at North Suburban Medical Center.[181] Amid all of these complaints, some HCA caregivers have reported being terminated or suspended for raising issues either internally or externally,[182] and this may have deterred other workers from speaking out themselves.

As mentioned earlier, none of the concerns we have with HCA's practices should be considered only on their own, and that is especially true for their pandemic response. If the gains reported in their recent earnings had been occurring because HCA had been encouraging its hospitals to focus on normal operational goals – perhaps including the aggressive focus on ED practices that we have detailed in this paper – then the effects could have been devastating. If capacity were being artificially limited by patients being admitted whose condition did not necessitate admission, then what impact could that have on the availability of beds for the growing number of serious COVID-19 cases, let alone for patients with other emergent conditions? If their EDs and inpatient units were being understaffed, overcrowded, and without workers with sufficient PPE or regular testing, then what could stop the spread of COVID-19 from patients or workers to each other?

> ***"If borne out, I think this would be a significant case for DOJ and/or for private insurers who sought private actions against HCA. The risk here is legitimate."***
>
> Michael Sheehan,
> *White Collar & Regulatory Enforcement and Health Care Lawyer at Crowell & Moring LLP, as quoted in March of 2021 in Modern Healthcare regarding allegations of HCA's excessive ED admissions practices*[183]

RECOMMENDATIONS

The circumstances are clear: HCA's repeated history of Medicare fraud has yielded mammoth profits that could incentivize further reliance on the practice as an organizational standard. The decades-long practice will not end without governmental and regulatory intervention.

Multiple legislative and regulatory oversight bodies maintain the proper jurisdiction to take action into HCA's potentially egregious and widespread ED admissions practices. As the largest union of healthcare workers in the US, caring for millions of patients each year, we urge the following actions by different stakeholders:

- Congress, through relevant committees and subcommittees, should convene an investigation, especially because more than 40% of HCA's revenue is obtained from the Medicare and Medicaid programs, which Congress oversees and funds;
- The Department of Health and Human Services (HHS) should launch an investigation into HCA and its practices;
- Investors should demand information from the company regarding its compliance protocols;
- Because company practices and procedures are likely not limited to specific payors (such as traditional Medicare), all payors other than Medicare should review claims data and scrutinize reimbursement contracts to determine whether significant numbers of patients might have been admitted unnecessarily;
- For the same reason, self-insured employers in HCA's markets should launch similar reviews;
- State regulators and policymakers should investigate HCA's specific practices and operations in their states.

The opportunity to secure meaningful reform of HCA's systemic over admissions of Medicare patients cannot be overstated. As the nation's largest for-profit hospital corporation, HCA Healthcare is the industry leader — setting standards for care that are echoed by smaller chains across the country. Meaningful reform of HCA's decade-long emergency department admissions policies would disrupt an unethical business model for an industry giant — and improve patient safety for the millions of Americans who enter HCA medical facilities every year.

ENDNOTES

1 Based upon SEIU analysis of Medicare Cost Reports.

2 SEIU analysis of local union contracts.

3 Based upon SEIU analysis of Medicare Cost Reports.

4 Kane, Shamliyan, Mueller, Duval, and Wilt, "Nurse Staffing and Quality of Patient Care," Research Prepared for the U.S. Agency for Healthcare Research and Quality, 2007, p. v.

5 HCA 2020 10K, p. 71, (See: Net Income attributable to HCA Healthcare, Inc.) Accessible at https://www.sec.gov/ix?doc=/Archives/edgar/data/860730/000119312521048994/d37951d10k.htm

6 Based on an analysis of HCA's filings, press releases, investor presentations and an article by Pitchbook. Analysis can be provided.

7 Based upon SEIU analysis of claims data from the Medicare Inpatient and Outpatient Standard Analytic Files.

8 Press Release. June 26, 2003. "Largest Health Care Fraud Case in U.S. History Settled: HCA Investigation Nets Record Total of $1.7 Billion." U.S. Department of Justice. Accessed at https://www.justice.gov/archive/opa/pr/2003/June/03_civ_386.htm.

9 1) $1.7B, multi-phase settlement in 2000 & 2003, respectively:
https://www.justice.gov/archive/opa/pr/2000/December/696civcrm.htm
https://www.justice.gov/archive/opa/pr/2002/December/02_civ_731.htm
2) $30K settlement in 2004:
https://www.justice.gov/sites/default/files/civil/legacy/2014/04/18/HCA%20Inc.%202004.pdf
3) $16.5M settlement in 2012:
https://www.justice.gov/archive/usao/tne/news/2012/September/091912A%20HCA%20Settlement.html
4) $7.15M settlement in 2013: https://www.justice.gov/usao-wdny/pr/fifty-five-hospitals-pay-us-more-34-million-resolve-false-claims-act-allegations
5) $1.02M settlement in 2013: https://www.justice.gov/usao-sdga/pr/doctors-hospital-augusta-and-radiation-oncology-practice-pay-more-1-million-resolve
6) $2M settlement in 2015: https://www.justice.gov/usao-sc/pr/hca-settles-allegations-billing-unnecessary-lab-tests-and-double-billing-fetal-testing-0
7) $2.4M settlement in 2015: https://www.justice.gov/usao-mdfl/pr/us-attorney-s-office-collects-more-136-million-us-taxpayers-fiscal-year-2015, https://www.justice.gov/usao-mdfl/pr/united-states-settles-false-claims-act-allegations-against-multiple-jacksonville
8) $15.8M settlement in 2015: https://www.justice.gov/opa/pr/nearly-500-hospitals-pay-united-states-more-250-million-resolve-false-claims-act-allegations; https://www.justice.gov/opa/file/789656/download p5-6
9) $8.6M settlement in 2017: https://www.justice.gov/usao-sdtx/pr/four-area-hospitals-pay-millions-resolve-ambulance-swapping-allegations

10 Press Release. June 26, 2003. "Largest Health Care Fraud Case in U.S. History Settled; HCA Investigation Nets Record Total of $1.7 Billion." U.S. Department of Justice. Accessible at https://www.justice.gov/archive/opa/pr/2003/June/03_civ_386.htm

11 Press Release. December 14, 2000. "HCA - The Health Care Company & Subsidiaries to Pay $840 Million in Criminal Fines and Civil Damages and Penalties; Largest Government Fraud Settlement in U.S. History." U.S. Department of Justice. Accessible at https://www.justice.gov/archive/opa/pr/2000/December/696civcrm.htm.

12 Civil and Administrative Settlement Agreement between United States, HCA Inc., and MileStone Healthcare, Inc. September 2004. Accessible at https://www.justice.gov/sites/default/files/civil/legacy/2014/04/18/HCA%20Inc.%202004.pdf.

13 Press Release. September 19, 2012. "HCA Inc To Pay $16.5 Million To Resolve Federal & State Health Care Fraud Investigation." U.S. Department of Justice. Accessible at https://www.justice.gov/archive/usao/tne/news/2012/September/091912A%20HCA%20Settlement.html.

14 See: Press Release. November 17, 2015. "HCA Settles Allegations of Billing for Unnecessary Lab Tests and Double Billing for Fetal Testing for $2,000,000." U.S. Department of Justice. Accessible at https://www.justice.gov/usao-sc/pr/hca-settles-allegations-billing-unnecessary-lab-tests-and-double-billing-fetal-testing-0. See also: Press Release. October 30, 2015. "Nearly 500 Hospitals Pay United States More Than $250 Million to Resolve False Claims Act Allegations Related to Implantation of Cardiac Devices." U.S. Department of Justice. Accessible at https://www.justice.gov/opa/pr/nearly-500-hospitals-pay-united-states-more-250-million-resolve-false-claims-act-allegations (List of impacted hospitals is accessible at https://www.justice.gov/opa/file/789656/download).

15 See: Press Release. July 2, 2013. "Fifty-five Hospitals to Pay U.S. More than $34 Million to Resolve False Claims Act Allegations Related to Kyphoplasty." U.S. Department of Justice. Accessible at https://www.justice.gov/usao-wdny/pr/fifty-five-hospitals-pay-us-more-34-million-resolve-false-claims-act-allegations. See also: Press Release. July 8, 2013. "Doctors Hospital Of Augusta And Radiation Oncology Practice Pay More Than $1 Million To Resolve False Claims Act Litigation." U.S. Department of Justice. Accessible at https://www.justice.gov/usao-sdga/pr/doctors-hospital-augusta-and-radiation-oncology-practice-pay-more-1-million-resolve.

16 Press Release. May 8, 2015. "United States Settles False Claims Act Allegations Against Multiple Jacksonville Hospitals And An Ambulance Company For $7.5 Million." U.S. Department of Justice. Accessible at https://www.justice.gov/usao-mdfl/pr/united-states-settles-false-claims-act-allegations-against-multiple-jacksonville.

17 Press Release. October 4, 2017. "Four Area Hospitals to Pay Millions to Resolve Ambulance Swapping Allegations." U.S. Department of Justice. Accessible at https://www.justice.gov/usao-sdtx/pr/four-area-hospitals-pay-millions-resolve-ambulance-swapping-allegations.

18 SEIU analyzed claims data for short-term general acute care hospitals from the annual Medicare Inpatient and Outpatient Standard Analytic Files ("SAF"). Emergency department claims were identified through revenue center codes and Healthcare Common Procedure Coding System ("HCPCS") codes. We calculate a hospital's ED admission rate by dividing the hospital's total number of inpatient admissions that came through the ED by that hospital's total number of ED encounter claims (including outpatient discharges and inpatient admissions). Hospitals with too few claims in a given year were excluded from analysis. Further methodology can be provided.

19 See "Hospital Inpatient Admission Order and Certification." January 30, 2014. Centers for Medicare & Medicaid Services. Accessible at https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/downloads/ip-certification-and-order-01-30-14.pdf.

20 HCA hospitals are identified by SEIU analysis of HCA corporate communications and news clips. Hospitals are only included as part of HCA in our data analysis starting in the Federal Fiscal Year ("FFY") in which they were acquired by HCA.

21 A 2006 report estimated that the average Medicare payment difference between an inpatient hospital admission and a corresponding outpatient discharge with observation services to be about $5,000. For this report, please see: "In Hospital Observation Struggle, Uncertain Outcomes May Justify Inpatient Admissions." *Report on Medicare Compliance*, Volume 15, No. 37. October 23, 2006. P.1.

22 Based upon SEIU analysis of claims data for short-term general acute care hospitals from the annual Medicare Inpatient and Outpatient Standard Analytic Files ("SAF"). The total number of hospitals identified as HCA in our analysis will not match the total number of hospitals that HCA reports for their system for multiple reasons, including 1) some HCA hospitals are not short-term general acute care hospitals; 2) some HCA hospitals report information to Medicare on a consolidated basis, and 3) some current HCA hospitals may not have been part of the system during a particular year being analyzed. Further methodology can be provided.

23 Ayla Ellison. October 2, 2020. "HCA Sells Hospital, Exits Mississippi." Becker's Hospital Review. Accessible at https://www.beckershospitalreview.com/hospital-transactions-and-valuation/hca-sells-hospital-exits-mississippi.html.

24 To calculate hospitals' expected ED admission rates, we first calculate a national average ED admission rate by Federal Fiscal Year for each combination of the following patient- and hospital-based characteristics: patient age, patient sex, patient principal diagnosis, and hospital rural/urban designation. Upon finding these national rates, we then multiply them by the corresponding number of ED encounters at each qualifying hospital within that given characteristic combination group; this provides the hospital's expected number of ED admissions for that group. To determine the overall number of expected ED admissions at a hospital, we aggregate the expected ED admissions totals for all applicable groups for the given FFY. We then calculate a hospital's total number of potentially excess ED admissions by subtracting the "expected" ED admissions total for that hospital from the actual number of inpatient ED admissions reported for that hospital. Further methodology can be provided.

25 See: "In Hospital Observation Struggle, Uncertain Outcomes May Justify Inpatient Admissions." *Report on Medicare Compliance*, Volume 15, No. 37. October 23, 2006. P.1.

26 HCA, SEC Form 10-K for the year ended December 31, 2020. Filed February 19, 2021. P.54. Accessible at https://www.sec.gov/ix?doc=/Archives/edgar/data/860730/000119312521048994/d37951d10k.htm.

27 One-day hospital admissions have been flagged as potentially unnecessary since at least the 1980s. See: "National DRG Validation Study: Short Hospitalizations." Office of Inspector General, U.S. Department of Health and Human Services. May 1989.

28 We calculate a hospital's one-day ED admission rate by dividing the hospital's total number of inpatient admissions that came through the ED with a length of stay of zero days or one day by that hospital's total number of ED admissions.

29 See: Medicare Benefit Policy Manual. Chapter 6:20.6(A) .
Accessible at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf.

30 See: Medicare Benefit Policy Manual. Chapter 6:20.6(B) .
Accessible at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf.

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LIST OF HCA U.S. HOSPITALS[184]

Name	City	State
Alaska Regional Hospital	Anchorage	AK
Good Samaritan Hospital	San Jose	CA
Los Robles Hospital & Medical Center	Thousand Oaks	CA
Regional Medical Center of San Jose	San Jose	CA
Riverside Community Hospital	Riverside	CA
West Hills Hospital & Medical Center	West Hills	CA
North Suburban Medical Center	Thornton	CO
Presbyterian/St. Lukes Medical Center	Denver	CO
Rocky Mountain Hospital for Children	Denver	CO
Rose Medical Center	Denver	CO
Sky Ridge Medical Center	Lone Tree	CO
Spalding Rehabilitation Hospital	Aurora	CO
Swedish Medical Center	Englewood	CO
The Medical Center of Aurora	Aurora	CO
Aventura Hospital and Medical Center	Aventura	FL
Blake Medical Center	Bradenton	FL
Capital Regional Medical Center	Tallahassee	FL
Central Florida Regional Hospital	Sanford	FL
Citrus Memorial Hospital	Inverness	FL
Doctors Hospital of Sarasota	Sarasota	FL
Englewood Community Hospital	Englewood	FL
Fawcett Memorial Hospital	Port Charlotte	FL
Fort Walton Beach Medical Center	Ft Walton Beach	FL
Gulf Coast Regional Medical Center	Panama City	FL
HCA Florida Brandon Hospital	Brandon	FL
HCA Florida Plantation Emergency	Plantation	FL
HCA Florida South Tampa Hospital	Tampa	FL
HCA Florida West Tampa Hospital	Tampa	FL
HCA Florida Woodmont Hospital	Tamarac	FL
Highlands Regional Medical Center	Sebring	FL
JFK Medical Center	Atlantis	FL
JFK Medical Center - North Campus	West Palm Beach	FL
Kendall Regional Medical Center	Miami	FL
Lake City Medical Center	Lake City	FL

Name	City	State
Largo Medical Center	Largo	FL
Lawnwood Regional Medical Center	Fort Pierce	FL
Medical Center of Trinity	Trinity	FL
Memorial Hospital Jacksonville	Jacksonville	FL
Mercy Hospital - Miami	Miami	FL
North Florida Regional Medical Center	Gainesville	FL
Northside Hospital	St. Petersburg	FL
Northwest Medical Center	Margate	FL
Oak Hill Hospital	Brooksville	FL
Ocala Regional Medical Center	Ocala	FL
Orange Park Medical Center	Orange Park	FL
Osceola Regional Medical Center	Kissimmee	FL
Oviedo Medical Center	Oviedo	FL
Palms of Pasadena	St. Petersburg	FL
Palms West Hospital	Loxahatchee	FL
Poinciana Medical Center	Kissimmee	FL
Putnam Community Medical Center	Palatka	FL
Raulerson Hospital	Okeechobee	FL
Regional Medical Center Bayonet Point	Hudson	FL
South Bay Hospital	Sun City Center	FL
St. Lucie Medical Center	St Lucie	FL
St. Petersburg General Hospital	St. Petersburg	FL
Twin Cities Hospital	Niceville	FL
West Florida Hospital	Pensacola	FL
West Marion Community Hospital	Ocala	FL
Westside Regional Medical Center	Plantation	FL
Doctors Hospital of Augusta	Augusta	GA
Fairview Park Hospital	Dublin	GA
Memorial Health Meadows Hospital	Vidalia	GA
Memorial Health University Medical Center	Savannah	GA
Memorial Satilla Health	Waycross	GA
Eastern Idaho Regional Medical Center	Idaho Falls	ID
West Valley Medical Center	Caldwell	ID
Terre Haute Regional Hospital	Terre Haute	IN
Menorah Medical Center	Overland Park	KS

Name	City	State
Overland Park Regional Medical Center	Overland Park	KS
Wesley Childrens Hospital	Wichita	KS
Wesley Medical Center	Wichita	KS
Wesley Woodlawn Hospital & ER	Wichita	KS
Frankfort Regional Medical Center	Frankfort	KY
TriStar Greenview Regional Hospital	Bowling Green	KY
Lakeview Regional Medical Center	Covington	LA
Rapides Regional Medical Center	Alexandria	LA
Tulane Lakeside Hospital	Metairie	LA
Tulane Medical Center	New Orleans	LA
Belton Regional Medical Center	Belton	MO
Centerpoint Medical Center	Independence	MO
Lafayette Regional Health Center	Lexington	MO
Lees Summit Medical Center	Lees Summit	MO
Research Medical Center	Kansas City	MO
Angel Medical Center	Franklin	NC
Blue Ridge Regional Hospital	Spruce Pine	NC
CarePartners Rehabilitation Hospital	Ashville	NC
Highlands-Cashiers Hospital	Highlands	NC
Mission Hospital	Asheville	NC
Mission Hospital McDowell	Marion	NC
Mountain Area Health Education Center	Asheville	NC
Transylvania Regional Hospital	Brevard	NC
Frisbie Memorial Hospital	Rochester	NH
Parkland Medical Center	Derry	NH
Portsmouth Regional Hospital	Portsmouth	NH
MountainView Hospital	Las Vegas	NV
Southern Hills Hospital & Medical Center	Las Vegas	NV
Sunrise Childrens Hospital	Las Vegas	NV
Sunrise Hospital & Medical Center	Las Vegas	NV
Colleton Medical Center	Walterboro	SC
Grand Strand Medical Center	Myrtle Beach	SC
Moncks Corner Medical Center	Moncks Corner	SC
Summerville Medical Center	Summerville	SC
Trident Medical Center	Charleston	SC
Parkridge East Hospital	Chattanooga	TN
Parkridge Medical Center	Chattanooga	TN

Name	City	State
Parkridge Valley Hospital	Chattanooga	TN
Parkridge West Hospital	Jasper	TN
The Childrens Hospital at TriStar Centennial	Nashville	TN
TriStar Ashland City Medical Center	Ashland City	TN
TriStar Centennial Medical Center	Nashville	TN
TriStar Centennial Parthenon Pavilion	Nashville	TN
TriStar Hendersonville Medical Center	Hendersonville	TN
TriStar Horizon Medical Center	Dickson	TN
TriStar Skyline Madison Campus	Madison	TN
TriStar Skyline Medical Center	Nashville	TN
TriStar Southern Hills Medical Center	Nashville	TN
TriStar StoneCrest Medical Center	Smyrna	TN
TriStar Summit Medical Center	Hermitage	TN
Bayview Behavioral Hospital	Corpus Christi	TX
Corpus Christi Medical Center - Bay Area	Corpus Christi	TX
Corpus Christi Medical Center - Doctors Regional	Corpus Christi	TX
Corpus Christi Medical Center - Northwest Regional	Corpus Christi	TX
Corpus Christi Medical Center - The Heart Hospital	Corpus Christi	TX
Del Sol Medical Center	El Paso	TX
HCA Houston Healthcare Clear Lake	Webster	TX
HCA Houston Healthcare Conroe	Conroe	TX
HCA Houston Healthcare Kingwood	Kingwood	TX
HCA Houston Healthcare Mainland	Texas City	TX
HCA Houston Healthcare Medical Center	Houston	TX
HCA Houston Healthcare North Cypress	Cypress	TX
HCA Houston Healthcare Northwest	Houston	TX
HCA Houston Healthcare Pearland	Pearland	TX
HCA Houston Healthcare Southeast	Pasadena	TX
HCA Houston Healthcare Tomball	Tomball	TX
HCA Houston Healthcare West	Houston	TX
Heart Hospital of Austin	Austin	TX
Las Palmas Del Sol Healthcare	El Paso	TX
Medical City Alliance	Fort Worth	TX

Name	City	State
Medical City Arlington	Arlington	TX
Medical City Childrens Hospital	Dallas	TX
Medical City Dallas	Dallas	TX
Medical City Denton	Denton	TX
Medical City Fort Worth	Fort Worth	TX
Medical City Frisco	Frisco	TX
Medical City Green Oaks	Dallas	TX
Medical City Las Colinas	Irving	TX
Medical City Lewisville	Lewisville	TX
Medical City McKinney	McKinney	TX
Medical City North Hills	North Richland Hills	TX
Medical City Plano	Plano	TX
Medical City Weatherford	Weatherford	TX
Methodist Childrens Hospital	San Antonio	TX
Methodist Heart Hospital	San Antonio	TX
Methodist Hospital	San Antonio	TX
Methodist Hospital | Ambulatory Surgery	San Antonio	TX
Methodist Hospital | Metropolitan	San Antonio	TX
Methodist Hospital | Northeast	Live Oak	TX
Methodist Hospital | South	East Jourdanton	TX
Methodist Hospital | Specialty and Transplant	San Antonio	TX
Methodist Hospital | Stone Oak	San Antonio	TX
Methodist Hospital | Texsan	San Antonio	TX
Rio Grande Regional Hospital Main Campus	McAllen	TX
St. Davids Childrens Hospital	Austin	TX
St. Davids Georgetown Hospital	Georgetown	TX
St. Davids Medical Center	Austin	TX
St. Davids North Austin Medical Center	Austin	TX
St. Davids Round Rock Medical Center	Round Rock	TX
St. Davids South Austin Medical Center	Austin	TX
Texas Orthopedic Hospital	Houston	TX
The Womans Hospital of Texas	Houston	TX
Valley Regional Medical Center	Brownsville	TX
Brigham City Community Hospital	Brigham City	UT
Cache Valley Hospital	North Logan	UT

Name	City	State
Lakeview Hospital	Bountiful	UT
Lone Peak Hospital	Draper	UT
Mountain View Hospital - Payson	Payson	UT
Ogden Regional Medical Center	Ogden	UT
St Marks Hospital	Salt Lake City	UT
Timpanogos Regional Hospital	Orem	UT
Chippenham Hospital	Richmond	VA
Dominion Hospital	Falls Church	VA
Henrico Doctors Hospital	Richmond	VA
John Randolph Medical Center	Hopewell	VA
Johnston-Willis Hospital	Richmond	VA
LewisGale Hospital Alleghany	Low Moor	VA
LewisGale Hospital Montgomery	Blacksburg	VA
LewisGale Hospital Pulaski	Pulaski	VA
LewisGale Medical Center	Salem	VA
Parham Doctors Hospital	Richmond	VA
Reston Hospital Center	Reston	VA
Retreat Doctors Hospital	Richmond	VA
Spotsylvania Regional Medical Center	Fredericksburg	VA
StoneSprings Hospital Center	Dulles	VA


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