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# Case Study Analysis: The Asheville Health Care Market

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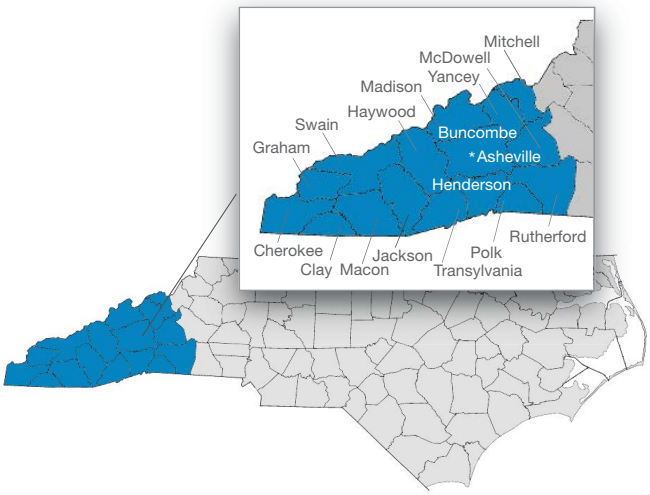
Rising health care prices have increased concerns about hospital and health system consolidation among policymakers, regulators, employers, and other purchasers of health coverage. Although merging hospitals and health systems claim they can achieve greater efficiencies through their consolidation, the economic literature almost universally finds that hospitals that merge have prices above those of surrounding hospitals.[1] And increases in hospital prices have been a key factor driving the growth of commercial health insurance costs over the past decade.[2]

As prices have risen, employers have shifted an ever greater share of the costs to employees. Over the past ten years, the average worker contribution for family coverage has increased faster than the average employer contribution (65 percent vs. 51 percent). Indeed, employee contributions have risen almost 300 percent since 1999.[3] Further, the increased negotiating clout of a concentrated provider sector influences payers' ability to maximize value-improving practices, such as alternative payment models, quality improvement, and transparency efforts.

In a series of six market-level, qualitative case studies, we assess the impact of recent provider consolidations, the ability of market participants (and, where relevant, regulators) to respond to those consolidations, and effective strategies for constraining cost growth while maintaining clinical quality. Our case studies focus on the commercial insurance market, though we recognize that providers and insurers are often operating in multiple markets, including Medicare Advantage, Medicaid managed care, and the Affordable Care Act (ACA) marketplaces. We do not attempt to quantify the effect of provider consolidation in these markets, such as through provider rate or premium changes.

This case study focuses on the Asheville, North Carolina, health care market. For findings from the other studied health care markets (Detroit, Syracuse, Northern Virginia, and Indianapolis), visit https://chir.georgetown.edu/projects-pubs/coverage-affordability/.




## Background, History, and Methodology

This study defines the Asheville, North Carolina, region to include primarily Buncombe and Henderson Counties, home to Asheville and Hendersonville, respectively, and 14 surrounding counties. These include nine counties west of Asheville (Madison, Haywood, Transylvania, Jackson, Swain, Graham, Macon, Clay, and Cherokee) and five counties directly east (Yancey, Mitchell, McDowell, Rutherford, and Polk). While Asheville is just 50 miles away from the westernmost county of Cherokee, the region is mountainous and has small, winding roads. The drive from Cherokee to Asheville can take well over an hour.

Historically, Asheville was home to two large non-profit hospitals, Mission Hospital and St. Joseph's Hospital. In 1993, North Carolina enacted a Certificate of Public Advantage (COPA) law, which allows a state, rather than the Federal Trade Commission, to oversee antitrust issues regarding consolidation among providers. Under the COPA, Mission Hospital and St. Joseph's Hospital were allowed to merge in 1998 under a new Mission Health (Mission) brand. Although the COPA imposed certain restrictions on Mission, including limits on profit margins and its ability to employ physicians, it was able to acquire five smaller rural community hospitals in the region in subsequent years. In 2015, after lobbying by Mission, the state repealed the COPA.[4]

In 2018, Mission was acquired by HCA Healthcare (HCA), a for-profit hospital system based in Nashville, Tennessee.[5] Acquisition by a for-profit system would not have been possible under the COPA. Prior to approving the merger (effective in early 2019), the North Carolina Attorney General placed stipulations on HCA to maintain provider services and facilities in the rural counties of western North Carolina for ten years. The agreement also required Mission to contribute $1.5 billion in proceeds from the sale to a new philanthropic foundation, called the Dogwood Health Trust, to focus on community health in the Asheville region.[6]

Mission, now owned by HCA, is the only major hospital system in the Asheville market, with its flagship hospital and a children's hospital in Asheville, three smaller hospitals to the east in Transylvania and Macon Counties, and two hospitals to the west in Mitchell and McDowell Counties. The region is also home to smaller community hospitals affiliated with provider systems based in central and eastern North Carolina: University of North Carolina Health Care's Pardee Hospital (Pardee) in Hendersonville; Adventist's Advent Hospital (Advent), also in Hendersonville; and two Duke LifePoint facilities, one in Jackson County and one in Swain County. Mission holds 49.5 percent of the market share in the expanded 17-county region and a 90 percent market share in Buncombe County alone.[7]

Mission also owns or affiliates with over 1,600 physicians and specialists in the region. Beyond physician groups, Mission affiliates with Mountain Area Health Education Center (MAHEC), an Asheville-based provider training and education program.[8]

Due to a large retired and low-income population, 75 percent of the payer mix in the Asheville market is Medicare, Medicaid, or self-pay (i.e., uninsured), with commercial insurance making up just 25 percent of revenue for providers.[9] For commercial insurance, BlueCross BlueShield of North Carolina (BCBSNC) is the dominant insurer both in Asheville and statewide, and for 2019 was the sole insurer offering coverage on the ACA-compliant individual market. The company announced in March 2019 a partnership with Cambia Health Solutions, a BlueCross BlueShield company based in the northwestern United States.[10] Healthy State, a health insurer owned by Mission, and UnitedHealthcare play a limited role in the region. However, both companies are more competitive in the Medicare Advantage market than in the commercial markets.

Just prior to the merger with HCA, Mission and BCBSNC had a months-long dispute over reimbursement. After Mission's requests for increased reimbursement were rejected by BCBSNC, the Mission board of directors voted to terminate their contract with BCBSNC.[11] As a result, Mission became an out-of-network provider for BCBSNC enrollees for two months until the dispute was resolved.[12] This contentious negotiation resulted in public backlash, negative media coverage, and financial challenges for both sides: BCBSNC faced criticism from customers who lost access to the dominant delivery system in the region, while Mission faced the administrative burden of working directly with patients to receive out-of-network reimbursements. Neighboring hospitals (Pardee, Advent, and the LifePoint facilities) took advantage of the unexpected new stream of patients. Ultimately, Mission agreed to a lower-than-hoped-for reimbursement increase, and rejoined the BCBSNC network.

The Mission system is the largest employer west of Charlotte, NC. Beyond Mission, key employers include state and local governments and the tourism industry, most notably the Biltmore Company, a hospitality company owned by the Vanderbilt family.

To assess the varying ways in which insurers respond to provider consolidation, we conducted an environmental scan, a literature review, and interviews with ten national experts and regulators. Additionally, we interviewed nineteen Asheville-area providers, insurers, purchasers, and expert observers. The latter interviews occurred between March 8, 2019, and April 15, 2019.

## Descriptive Analysis: Market Sectors

### 1. Hospitals and Physicians

Mission's seven facilities dominate the western North Carolina market. Stakeholders describe the other hospitals in the region as "nibbling" at Mission's market share, but unable to make much headway for several reasons. First, the other hospitals are located outside the population center of Buncombe County, making it less

likely that Asheville residents will travel there (although many were forced to do so, during the brief period after Mission terminated its contract with BCBSNC). Second, LifePoint, Pardee, and Advent Health are described by many observers as "community" hospitals that cannot provide the same level of service as Mission. For "tertiary or quaternary services, level 1 and level 2 trauma centers, and comprehensive cancer treatment," the common perception is that patients in western North Carolina have only Mission as their care option. However, a local provider noted that the three hospitals that compete with Mission in the region are beginning to "step up their game." "I'm hearing from recruiters that they are ramping up, hiring surgeons, ortho[pedic doctors], [and] heart surgeons, " she said. Third, Mission is widely acknowledged for its reputation for high quality, even among its detractors. "It's not really a question," said one observer about the clinical quality at Mission, noting they set "high standards" and consistently receive high ratings from independent assessments, such as the Medicare "Hospital Compare" rating system.[13]

Several respondents suggested that Mission's prices trend higher than those of competing hospitals in the region. "Competition is eroding in the Asheville market," said one employer representative, "and it is driving costs up." However, others noted that Mission's prices are competitive compared to those of large hospital systems in other regions in the state. Mission's efforts to increase its prices in 2017 led to the well-publicized dispute with BCBSNC; observers suggest that HCA's deeper pockets could give Mission a greater ability to withstand a future contract battle, perhaps leading to price increases down the road.

Critics of Mission argue that, even before its takeover by HCA, it did not "feel like a non-profit," using its size and clout to buy up physician practices, push physicians to join its Medicare accountable care organization (ACO), and exercise greater control over health care delivery in the region. For example, several years ago Mission took the unusual step of establishing its own federally qualified health center (FQHC) in Asheville, even though an existing FQHC was already adequately serving the community. "It's very odd to have two competing FQHCs in town," said one provider, who attributed Mission's decision to create its own to its desire to have more control over the delivery of primary care services. Several observers also had concerns about Mission's recent cost-cutting moves, particularly its decision to eliminate OB/GYN and other unprofitable service lines at its more rural facilities.[14]

Stakeholders estimate that between 50 and 60 percent of the region's physician groups are part of the Mission system. Mission controls "most of the larger specialty practices," said one observer, including the sole cardiology practice in Asheville, as well as most of the pulmonologists. Primary care physicians tend to be more independent, although many also have been acquired by Mission. Additionally, the area is home to a 1,600-physician clinically integrated network called Mission Health Partners (MHP). Although technically independent from Mission, observers noted they "practice under the umbrella" of the Mission system and constitute the physician arm of Mission's Medicare ACO. Observers also noted that physicians had been "under a lot of pressure to team up with the Mission system," although others flagged that physicians that did so had certain advantages, including stronger negotiating clout with payers, lower malpractice insurance costs, and administrative support for back-office functions and information technology.

Respondents noted that recruiting and retaining physicians—both specialists and primary care doctors—can be a challenge for the area. The majority of patients in the region are insured through relatively low-paying government programs (Medicare or Medicaid) or are uninsured. As a result, many physicians do not view the payer mix as advantageous. In addition, outside of Buncombe County, many communities are rural, mountainous, and lack high-quality school systems and other amenities attractive to young professionals.

### 2. Insurers

While Mission is the dominant hospital system in the Asheville region, BCBSNC is unquestionably the dominant commercial payer. "Blue Cross is a near monopoly," said one provider. "While our payer mix is mostly Medicare, Medicaid, and no-pay, the rest is [Blue Cross Blue Shield]." Patients insured via employer group coverage constitute a relatively small share of most providers' panels, but they are a critical source of revenue due to the more generous reimbursement paid by

commercial payers. Indeed, one observer estimated that between 60 and 70 percent of provider revenue in the region is derived from BCBSNC alone.

BCBSNC is the only insurer offering individual market products in the region, but there are a few other payers competing for employer business. Mission created its own health plan, Healthy State. It largely competes for Medicare Advantage business, but it has tried to break into the market for administrative services only (ASO) contracts with self-funded employer plans. However, observers did not think Healthy State had been able to dent BCBSNC's dominance in the employer space. "They didn't show up on the radar," said one observer. Other payers, such as United, Cigna, and Aetna, have some employer business, but their market share is very small. Due to generous commissions, local insurance brokers "make all their money from BCBSNC," said one respondent. This makes it more difficult for competing carriers to convince them to market their products.

The majority of commercial plans in the region have relatively open-access, preferred provider networks. "HMOs haven't really taken off" here, said one expert, noting further that BCBSNC is known for its "very large network." Although not an explicit change to its network, BCBSNC has announced its intention to shift participating hospital providers to risk-sharing reimbursement arrangements in which the provider must agree to lower compensation if it does not meet certain targets for savings and clinical quality.[15]

### 3. Employers

There are few large employers in the Asheville region, and many in the tourism or service industry typically do not offer generous health benefits to employees. As the largest employer, Mission covers an estimated 18,000 lives in its employee health plan. "In Asheville, 700 [employees] would be a large number," said one resident. The state government is estimated to be the second-largest employer in the region. Several mid-sized employers have joined forces with an association that operates a self-funded health plan, representing approximately 25,000 employees.

## Key Findings

### The COPA was an unusual factor in the Asheville market.

The existence and subsequent termination of the COPA was generally not cited by respondents as a key factor in how the Asheville market has developed, though its termination was critical to allowing the for-profit HCA to acquire Mission in 2019. As mentioned, the state implemented the COPA in 1993 to allow for the creation of a single dominant health system, Mission Health.[16] For the next 22 years, Mission had to adhere to caps on physician employment (although these caps were expanded over the years), limits on costs and profit margins, as well as deliver annual reports to the state with analyses from external expert accountants paid for by financial assessments on the health system.

In Mission's lobbying efforts to repeal the COPA, respondents recalled arguments that the health system had met or exceeded every requirement set by the state for the past two decades, and faced unfair scrutiny in its efforts to acquire physician practices, hindering its ability to provide needed services and maintain clinical quality. "One of the reasons for getting out of the COPA was that more physicians wanted to be employed," said one observer, "About 50 percent are either employed or under professional services agreement with Mission." However, some respondents suggested that Mission's more aggressive negotiating tactics and eventual contract termination with BCBSNC were a direct result of the COPA repeal.

Repeal of the COPA also undoubtedly played a role in HCA's acquisition of Mission, which was viewed as an attractive acquisition opportunity for an outside health system like HCA. Since HCA did not yet have a presence in North Carolina, its acquisition of Mission did not set off any alarms with federal antitrust officials, yet would still promise them a near-monopoly in the region. This was true even though the state Attorney General imposed some conditions on the acquisition, as noted earlier.

### The 2017 contract dispute between Mission and BCBSNC illustrates power dynamics between two dominant market actors.

Nearly every respondent we interviewed cited the 2017 dispute as a key event, although the motivations are reported differently by involved stakeholders. On October 1, 2017, the BCBSNC contract with Mission expired after an extended negotiation, and Mission left the Blue Cross network. After about two months, a contract was reestablished.

From the insurer side, BCBSNC was unwilling to consider Mission's request for a large rate increase of about 15 percent. It argued that Mission was not being efficiently run, making an increase unjustified. The insurer also adhered to a longstanding company principle that if a provider terminates its contract, the insurer would cease all negotiations, and instead transition its enrollees to other providers for care. Several observers noted that public sentiment was generally supportive of BCBSNC's position in the dispute. After being out-of-network with BCBSNC for a brief period, Mission accepted the last contract offer from BCBSNC—with essentially no increase in rates. The dispute was described by one participant as "useless, senseless, and a waste of time."

Advocates of Mission's position argue that BCBSNC's pricing was "unsustainable," noting that the hospital system was regularly forced to cut services and costs to stay afloat. Mission's goal going into the negotiations was to get a better financial deal, including some assurance that the hospital's performance on clinical quality would not result in rate cuts in future value-based contracts. When the contract terminated, BCBSNC initiated an aggressive media and community relations campaign with "full page ads talking about how Mission doesn't care about you." In addition, Mission's revenue suffered as BCBSNC began reimbursing enrollees directly for services they received at Mission facilities, which were now treated as out-of-network claims. This put the hospital in the awkward situation of pursuing patients to pass along payments for the insurer's share of their bills. Combined, these factors led Mission to concede to the BCBSNC terms.

Throughout the contract dispute, patients were caught in the middle, which left a negative impression in the community. One respondent recalled, "It had a dramatic impact on that community. People called nonstop . . . terrified about their health care." Many believe the outcome of the dispute drove Mission into HCA's arms shortly thereafter; others assert the HCA acquisition was planned long before the negotiations with BCBSNC began.

In a battle of behemoths, BCBSNC ultimately had the edge. As told by one observer, the story in the community was that "Mission Health . . . thought it had more market power than it did." Although Mission is, for most Asheville residents, the only provider in the area, they played chicken with the only payer in the area and ultimately swerved. Another bystander questioned whether Mission was smart to take on BCBSNC given the insurer's history: "You don't take on BCBSNC, not unless you are prepared for collateral damage . . . . There [are few] instances in the last 10 years that a hospital went out of network with Blue Cross that ended up the better for it. They may have been able to get back in no worse shape, but there is yet to be a hospital that went out and improved their position." One respondent, however, offered a different take, suggesting that Mission forced BCBSNC to come to the table when it never really had to come to the table for anyone before. "Mission played their hand and ended up exerting a great deal of power." While most observers concluded that BCBSNC had the upper hand in the 2017 dispute, some suggest HCA's acquisition of Mission could change that dynamic.

### BCBSNC uses market clout as strategy in the face of a consolidated market.

BCBSNC has market clout and uses it, as illustrated in its 2017 contract negotiations with Mission. It is striking that the insurer was able to refuse the hospital system's demand for a significant price increase, even though many would argue that Mission is a "must have" hospital system for any payer in western North Carolina. The insurer's market clout is enhanced by its role as third-party administrator (TPA) for many of the region's large self-funded employers, including coverage for state employees.

The 2017 termination fight demonstrated that BCBSNC was willing to use hardball tactics. It cut off negotiations after Mission's contract expired and forcing the hospital to collect insurance payments paid directly to BCBSNC patients. These tactics showed they were willing to let Mission go out of network—to "go nuclear"—a weapon that many insurers in other markets have been unwilling to use.[17] While respondents in this market could point to the leverage that BCBSNC was able to wield, they were not generally in a position to articulate why this was the case in the Asheville region more so than in other markets.

### Mission has used its clout in other ways.

Although Mission arguably failed in the contract battle with BCBSNC, it has seized other opportunities to take advantage of its dominant position in the market by, for instance, controlling where services are provided throughout the region. Observers reported that Mission responded with assertions that these services are less profitable and that the low volume of services performed in these areas raised quality concerns. As one Mission defender put it, "No one can make someone keep something open that is patently unsafe." Others emphasized that the mountainous terrain creates greater challenges for women to get to Asheville for obstetric services. In response, observers reported that Mission cited both financial and quality concerns, asserting both that these services are less profitable and that the low volume of services performed in these areas raised quality concerns. As one observer put it, "No one can make docs want to go live in these places. No one can make someone keep something open that is patently unsafe."

Another provider from an outlying county in the region pointed out how relationships between local providers and the nearby rural Mission hospital have deteriorated in recent years. In the eyes of that respondent, the relationship has "really gone downhill," and the administration "is less responsive to local needs," "more big-corporation," and "less cooperative."

Mission has also used its clout to acquire a number of physician practices, and it affiliated with additional practices through MHP, leaving relatively few independent practices. This vertical integration has given Mission greater bargaining power. For example, one stakeholder noted that Mission was leveraging access to its physicians during the recent roll-out of Medicaid managed care contracts: "MHP is doing all the negotiating for the vast majority of providers in that area in this Medicaid discussion, and relaying the wants of Mission."

### Employers are concerned about costs, but see options as limited.

Employers in the region recognize that they are paying high commercial rates for services at the dominant Mission system, but Mission remains an essential component of their health plan provider networks. Employers also recognize that most of their employees are unwilling or unable to travel much beyond Buncombe County for health care services—and there are a few services for which only Mission is an option. However, employer respondents identified a variety of methods they are adopting to control their health care costs, in some cases finding ways to use providers other than Mission. These include programs to encourage healthy behaviors among employees and designating lower-priced, high-quality hospital systems outside the region as "centers of excellence" for certain elective procedures. Additionally, the state employee health benefits program is considering limiting hospital reimbursement to a fixed percentage of Medicare rates.

## Looking Ahead

The impact of HCA's acquisition of Mission is unknown. Because our interviews in this market were conducted within the first three months of the effective date of this deal, respondents could only share their hopes and fears for how Mission—and the broader Asheville health care market—would change. Ultimately, HCA faces the same constraints Mission has faced – a payer mix dominated by government programs and a monopolistic commercial insurer.

Like most hospital mergers, HCA's acquisition of Mission came with conditions. Two will be important to track. One is the role that the Dogwood Trust, the spin-off foundation that is receiving a share of the Mission assets, will play. The Trust has suggested it will focus on social determinants of health. But it's not clear that future investments by the Trust will translate into changes in the care delivery system or a reduction in the overall cost of care.

In addition, the Attorney General demanded a 10-year commitment that HCA will not close rural hospitals or require major cuts to services. These conditions were imposed in part to respond to the community's concerns about Mission's recent elimination of labor and delivery services at some hospitals. However, some observers are concerned that the process for HCA to obtain exceptions to that commitment is too lax, raising anxiety that the for-profit chain will be relatively unfettered in closing unprofitable service lines.

The economic implications of the merger will need time to play out as well. The next round of contract negotiation—still several years away—could be telling. According to one respondent, "I think the hope is that with HCA's deeper pockets, [Mission] can weather the storm a little better in the future, and hopefully get a better negotiation [outcome]." But others doubt HCA will be able to fundamentally change the dynamic. Unlike some other markets studied for this project, HCA does not have a presence elsewhere in North Carolina to leverage in statewide negotiations with BCBSNC. But it does have experience in other markets, and it is committed to creating some efficiencies that lower its costs, potentially allowing it a better response to BCBSNC in negotiations. HCA also has a reputation for being able to make a profit with its Medicare business, which Mission has been unable to do.

Respondents also raised questions about whether Mission will be able to maintain and enhance its reputation as a high-quality provider and as an active participant in delivery system innovations. In the eyes of some respondents, Mission has a better track record with delivery system innovation and accountable care organizations than HCA. That view was not universal, however. At least one respondent suggested that HCA has broad experience with various reimbursement and risk models via their hospitals in other parts of the country. At the same time, BCBSNC is under new leadership that has pledged greater attention to value-based payment models.

Whether Mission can use HCA's deep pockets to push BCBSNC to increase prices will depend in part on BCBSNC's willingness to keep the "go nuclear" option on the table and omit the system from its network. A less contentious path could involve HCA wringing efficiencies out of Mission's cost structure and partnering with BCBSNC on risk-sharing models. To the extent that Mission's current prices are competitive relative to other hospital systems in the state, this latter path might be relatively easy to travel.

The changes in Asheville are only one part of a fluid health insurance and delivery system restructuring across North Carolina. The state recently transitioned to Medicaid managed care. The State Treasurer, an elected officer in North Carolina, continues to advocate for a shift to reference-based pricing—using Medicare rates—for the state employee health plan. And BCBSNC is transitioning its hospital systems to value-based contracts, is experimenting with reference-based pricing in the individual market, and announced a new partnership with a BlueCross BlueShield affiliate on the other side of the country. It is not yet clear what these additional moves might mean for Mission, BCBSNC, and the broader Asheville region, but these changes will undoubtedly be a factor in each player's role and market power going forward.

## Acknowledgments

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## Endnotes

[1] Keith K, Corlette S and Hoppe O. "Case Study Analysis: The Syracuse Heath Care Market." Washington: National Institute for Health Care Reform, November 2018, http://journals.sagepub.com/doi/pdf/10.1177/0003603X0204700407. Accessed June 2018; see also Gaynor M and Town R. "The Impact of Hospital Consolidation – Update." Princeton, NJ: Robert Wood Johnson Foundation, 2012. https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261. Accessed June 2018.

[2] White C, Reschovsky J and Bond A. "Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein in Costs." *Health Affairs*, Vol. 32, (2), January 2014. https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0747. Accessed June 2018.

[3] Claxton G, Rae M, Long M, et al. "Employer Health Benefits Annual Survey, 2018." Menlo Park, CA: Kaiser Family Foundation, 2018. http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018. Accessed October 2018.

[4] Fuse Brown E. "To Oversee or Not to Oversee? Lessons from the Repeal of North Carolina's Certificate of Public Advantage Law." New York: Milbank Memorial Fund, January 2019. https://www.milbank.org/wp-content/uploads/2019/01/MMF-North-Carolina-COPA-Repeal-Issue-Brief-FINAL.pdf. Accessed May 2, 2019.

[5] "HCA Healthcare Completes Purchase of Mission Health." *Business Wire*, February 1, 2019. https://investor.hcahealthcare.com/press-release/hca-healthcare-completes-purchase-mission-health. Accessed May 3, 2019.

[6] Livingston S. "HCA-Mission Health Deal OK'd by N.C. Attorney General." *Modern Healthcare*, January 16, 2019. https://www.modernhealthcare.com/article/20190116/NEWS/190119928/hca-mission-health-deal-ok-d-by-n-c-attorney-general. Accessed May 3, 2019.

[7] Bannow T. "HCA May See Fellow Market Leader in Mission Health." *Modern Healthcare*, April 7, 2018. https://www.modernhealthcare.com/article/20180407/NEWS/180409936/hca-may-see-fellow-market-leader-in-mission-health. Accessed May 2, 2019; see also Mildenberg D. "Millions of Dollars at Stake in Mission Health-Blue Cross Battle." Business North Carolina, July 15, 2017. https://businessnc.com/millions-dollars-stake-mission-health-blue-cross-battle/. Accessed May 3, 2019.

[8] MAHEC. About Us. Retrieved from mahec.net/about-us. Accessed May 2, 2019.

[9] Cheney C. "New Mission Health CFO Targets Growth, Costs, Value, Efficiency." *HealthLeaders*, February 18, 2018. https://www.healthleadersmedia.com/finance/new-mission-health-cfo-targets-growth-costs-value-efficiency. Accessed May 3, 2019.

[10] "Blue Cross NC, Cambia Health Solutions Announce New Strategic Affiliation." *BlueCross BlueShield of North Carolina*, March 12, 2019. http://mediacenter.bcbsnc.com/news/blue-cross-nc-cambia-health-solutions-announce-new-strategic-affiliation. Accessed May 10, 2019.

[11] Henderson J. "It's Official: BCBSNC, Mission Health Part Ways." *Triangle Business Journal*, October 5, 2017. https://www.bizjournals.com/triangle/news/2017/10/05/it-s-official-bcbsnc-mission-health-part-ways.html. Accessed May 3, 2019.

[12] Haefner M. "Mission Health, BCBS End Nearly 6-Month Spat with New Contract: 3 Things to Know." *Becker's Hospital Review*, December 6, 2017. https://www.beckershospitalreview.com/payer-issues/mission-health-bcbs-end-nearly-6-month-spat-with-new-contract-3-things-to-know.html. Accessed May 3, 2019.

[13] Medicare.gov. Hospital Compare. Retrieved from https://www.medicare.gov/hospitalcompare/search.html. Accessed April 29, 2019.

[14] Zatkulak K. "News 13 Investigates: Maternity Ward Shutdown." *News 13 WLOS*, November 13, 2017. https://wlos.com/news/news-13-investigates/news-13-investigates-maternity-ward-shutdown. Accessed May 3, 2019.

[15] Sharp JP, Conway PH and Rajkumar R. "Engineering a Rapid Shift to Value-Based Payment in North Carolina: Goals and Challenges for a Commercial ACO Program." *NEJM Catalyst*, January 23, 2019. https://catalyst.nejm.org/blue-premier-nc-value-based-payment/. Accessed May 9, 2019.

[16] Bovbjerg R and Berenson R. "Certificates of Public Advantage: Can They Address Provider Market Power?" Washington: The Urban Institute, February 2015. https://www.urban.org/sites/default/files/publication/42226/2000111-Certificates-of-Public-Advantage.pdf. Accessed on May 2, 2019.

[17] Hoadley J, Corlette S and Hoppe O. "Case Study Analysis: The Northern Virginia Health Care Market." Detroit: National Institute for Health Care Reform, November 2018. https://georgetown.box.com/s/iattsxktleepvn1t0k4askmxcrdlv43b. Accessed May 10, 2019.