UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

v.

CHARLESTON AREA MEDICAL CENTER, INC.,

Defendant.

Civil Action No. 2:06-0091

Filed:

COMPLAINT

The United States of America, by its attorneys and acting under the direction of the Attorney General of the United States, brings this civil antitrust action to obtain equitable relief against Defendant Charleston Area Medical Center, Inc. (CAMC). The United States alleges as follows:

I. INTRODUCTION

1. CAMC operates the largest cardiac-surgery program in West Virginia, the sixth largest such program in the United States, through facilities located in the city of Charleston, Kanawha County, West Virginia. At all times relevant to the matters alleged in this complaint, HCA Inc. (HCA) owned and operated Raleigh General Hospital (Raleigh General), located in the city of Beckley, Raleigh County, West Virginia. Raleigh General is located about 55 miles south of CAMC's cardiac-surgery facilities.

2. In an April 17, 2002 memorandum of understanding (the CAMC-HCA MOU), CAMC persuaded HCA to agree not to develop a competing cardiac-surgery program at Raleigh General. The CAMC-HCA MOU unreasonably restrained competition to the detriment of consumers by effectively ensuring that one of the most significant potential competitors in southern West Virginia would not compete with CAMC to provide cardiac-surgery services. The United States, through this suit, asks this court to enjoin the defendant from enforcing the anticompetitive provisions of the CAMC-HCA MOU and taking other actions that would restrain competition and injure consumers in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

II. DEFENDANT

3. Charleston Area Medical Center, Inc. (CAMC) is a nonprofit corporation, organized and existing under the laws of the State of West Virginia, with its headquarters in Charleston, Kanawha County, West Virginia. CAMC owns and operates a 913-bed, tertiary, regional referral, teaching medical center located in Charleston, West Virginia. CAMC transacts business and offers health-care services to patients located in the Southern District of West Virginia.

III. JURISDICTION AND VENUE

4. The United States brings this action to prevent and restrain Defendant from continuing to violate Section 1 of the Sherman Act, 15 U.S.C. § 1. The Court has subject-matter jurisdiction over this action pursuant to 15 U.S.C. § 4 and 28 U.S.C. §§ 1331, 1337, and 1345.

5. Defendant transacts business and has committed the unlawful act at issue in West Virginia. Consequently, this Court has jurisdiction over Defendants, and venue is proper in this District pursuant to 28 U.S.C. § 1391(c) and 15 U.S.C. § 22.

IV. EFFECTS ON INTERSTATE COMMERCE

6. CAMC provides health-care services to individuals who reside outside of West Virginia. In addition, it contracts with managed-care and health-insurance providers located outside West Virginia to be included in their networks. These individuals and businesses remit substantial payments to CAMC. CAMC is engaged in, and its activities substantially affect, interstate commerce.

V. WEST VIRGINIA'S CERTIFICATE-OF-NEED STANDARDS

7. The State of West Virginia requires that a hospital obtain a certificate of need ("CON") from the West Virginia Health Care Authority before a hospital may provide cardiac-surgery services. The West Virginia Health Care Authority was formerly known as the West Virginia Health Care Cost Review Authority (collectively, "WVHCA").

8. On February 22, 2002, West Virginia revised the state standards for qualifying for a cardiac-surgery CON. These new standards (the "February 2002 standards") made it easier for hospitals to qualify for a cardiac-surgery CON by lowering the minimum number of medical procedures that a hospital needed to demonstrate that it had performed or would perform.

9. The February 2002 standards were structured in a way such that the WVHCA would most likely approve only one location for a cardiac-surgery program in a "Southern West Virginia region" defined to consist of six counties: McDowell, Mercer, Monroe, Raleigh,

Summers, and Wyoming Counties. In February 2002, no hospital from this region competed against CAMC in offering cardiac-surgery services.

10. Under the February 2002 standards, the likely location of a new cardiac-surgery program in the Southern West Virginia region was one of Raleigh General, Princeton Community Hospital Association, Inc. ("Princeton Community Hospital"), or Bluefield Regional Medical Center, Inc. ("BRMC"). Princeton Community Hospital is located in Princeton, Mercer County, West Virginia, about 95 miles south of CAMC. BRMC is located in Bluefield, Mercer County, West Virginia about 105 miles south of CAMC.

VI. CAMC PERSUADES HCA NOT TO COMPETE

A. CAMC acted to prevent Raleigh General from developing a competing cardiac-surgery program.

11. After the February 2002 standards were issued, CAMC recognized that the WVHCA would likely approve a new cardiac-surgery program to be located either in Raleigh County at Raleigh General or in Mercer County at BRMC or Princeton Community Hospital.

12. CAMC wanted the new cardiac-surgery program to be located in Mercer County because a program in nearby Raleigh County would compete with and take revenue away from CAMC to a much greater extent than a program in more distant Mercer County. CAMC's cardiac program was its most profitable program, contributing about $20 million in net profits per year, and the counties south of Charleston accounted for a large percentage of CAMC's cardiac-surgery business. In an April 2002 strategic plan, CAMC estimated that a cardiac-surgery program in Raleigh County would lower CAMC's net profits from $7 million to $12 million more per year than would a similar program in Mercer County. The same strategic

plan estimated that a cardiac-surgery program in Raleigh County would draw 935 to 1780 patient procedures per year away from CAMC. Due to this potential loss in patients and profits, a 2001 CAMC strategic plan concluded that CAMC should "fight aggressively" to prevent a cardiac-surgery program in Raleigh County.

13. Preventing a competing cardiac-surgery program at Raleigh General was one of CAMC's key objectives. A June 7, 2001 presentation entitled "Cardiovascular Network Project Executive Steering Group Meeting #1" said that a possible CAMC market strategy for the Beckley area was to "[f]ocus efforts on obtaining [an] open-heart CON for Bluefield/Princeton, and averting [a] CON for Raleigh General Hospital." A June 22, 2001 document entitled "Open Heart Strategy Meeting" said that one of CAMC's goals was to "[p]revent open heart programs as our first priority; delay (except for Mercer County); maintain; then have the configuration we want for open heart services. If Parkersburg becomes inevitable, support Bluefield; absolutely not Beckley." (emphasis in original). Similarly, an August 2001 document entitled "Cardiovascular Network Project Draft Report" said that a possible market strategy for the "Close-in South" area was to "fight [a] Beckley CON. . . [and] support [a] Princeton/Bluefield CON as a blocking strategy."

14. If Raleigh General did obtain a cardiac-surgery CON, CAMC planned to compete more aggressively for cardiac-surgery patients in the Raleigh County area. One CAMC document says that CAMC planned to respond with "aggressive strategies" to compete with a Raleigh General cardiac-surgery program including placing CAMC cardiologists in Beckley. A CAMC executive has said that if Raleigh General "were granted a certificate of need, we would be down there -- it's only an hour away -- we would be down there advertising and facilitating

and probably even putting physicians down there to ensure that those patients came to Charleston instead of going to Raleigh General." CAMC did not plan to take similar measures in response to a new cardiac-surgery program in Mercer County.

15. In February 2002, CAMC initiated talks with HCA about a possible agreement relating to cardiac-surgery services in West Virginia. CAMC pursued an agreement with HCA to ensure that HCA would not develop a cardiac-surgery program at Raleigh General.

16. During these talks, HCA told CAMC that it desired CAMC's help to develop a cardiac-surgery program at HCA's St. Joseph's Hospital in Parkersburg, West Virginia and a therapeutic cardiac-catheterization program at HCA's St. Francis Hospital in Charleston, West Virginia.

17. HCA's desire to obtain CAMC's support for the St. Joseph's and St. Francis programs presented CAMC with a strategic opportunity. CAMC realized that its support for the HCA St. Joseph's and St. Francis programs would make it significantly more likely that HCA would be able to attain the necessary CONs for those programs from the WVHCA. In negotiating the MOU, CAMC was able to induce HCA to agree not to develop a cardiac-surgery program at Raleigh General by making that non-competition agreement a condition for its support of HCA's St. Joseph's and St. Francis programs.

18. During the MOU negotiations, CAMC also rejected proposed language that would have reduced the time period during which Raleigh General could not develop a cardiac-surgery program.

19. CAMC's and HCA's talks resulted in the CAMC-HCA MOU, section 3 of which prevented HCA from developing a cardiac-surgery program at Raleigh General by committing

HCA to develop a single cardiac-surgery program in the Southern West Virginia region at either Princeton Community Hospital or BRMC for a period of three years. In exchange for HCA's agreement not to compete in Raleigh County, CAMC agreed to provide valuable support for HCA's efforts to provide cardiac-surgery services at HCA's St. Joseph's Hospital in Parkersburg and therapeutic cardiac-catheterization services at HCA's St. Francis Hospital in Charleston. CAMC did not need HCA's agreement not to compete in Raleigh County in order to agree to support HCA's programs at St. Joseph's and St. Francis.

20. CAMC wanted a program at Bluefield rather than Raleigh General because, as one CAMC executive stated, "Raleigh General would pull more patients from Charleston Area Medical Center than a program in Bluefield." Another CAMC executive testified that the basic reason why CAMC obtained HCA's agreement not to apply for a CON at Raleigh General was because of the threat to CAMC of losing open-heart surgery patients coming from southern West Virginia.

B. Raleigh General has been a significant potential competitor in cardiac-surgery services

21. As discussed below, until Raleigh General signed the CAMC-HCA MOU, Raleigh General had been a significant potential competitor to CAMC in the market for cardiac-surgery services. Raleigh General has maintained a consistent and active interest in pursuing, and taken steps to secure, a cardiac-surgery program.

22. Hospitals often provide diagnostic cardiac-catheterization services as a precursor to providing cardiac-surgery services. Raleigh General received a CON to provide diagnostic

cardiac-catheterization services in January 1987 and has provided those services at all times relevant to the anticompetitive conduct alleged in this Complaint.

23. Raleigh General sought to offer cardiac-surgery services as early as July 1992, when it applied for a cardiac-surgery CON with the WVHCA. The WVHCA denied that application in July 1995 because Raleigh General was unable to show that it would perform the minimum number of procedures required by the then-existing state standards for granting cardiac-surgery CONs.

24. In 1999, representatives from Raleigh General continued their pursuit of a cardiac-surgery program by exploring the possibility of a joint venture with Princeton Community Hospital to provide cardiac-surgery services.

25. Raleigh General and Princeton Community Hospital engaged a consultant to determine whether Raleigh General or Princeton Community Hospital was a better location for a cardiac-surgery program. In a January 2000 report, the consultant concluded that "[b]ased upon the market, geographical location, physician support and referral patterns and clinical infrastructure and culture, Raleigh General Hospital is the recommended location for the cardiovascular surgical program." The two hospitals were ultimately unable to finalize a strategy for jointly pursuing a cardiac-surgery CON.

26. In the period leading up to the February 2002 changes to the state cardiac-surgery standards, Raleigh General remained interested in pursuing a cardiac-surgery program and actively lobbied state officials to change the standards in such a way as to enable it to qualify for a cardiac-surgery CON.

27. After the February 2002 standards were revised to make it easier to obtain a cardiac-surgery CON, Raleigh General did not apply for a cardiac-surgery CON – despite its earlier active pursuit of such a CON – but instead entered into the CAMC-HCA MOU, which precluded Raleigh General from applying for a CON for three years.

28. In January 2003, BRMC and Princeton Community Hospital entered into two agreements that allocated cardiac surgery and cancer programs between themselves in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. Also in January 2003, BRMC applied for a cardiac-surgery CON with CAMC and Princeton Community Hospital as joint applicants. The WVHCA approved BRMC's application in August 2003. Despite receiving a CON to offer cardiac-surgery services, BRMC has yet to begin offering cardiac-surgery services.

29. The United States challenged the BRMC and Princeton Community Hospital agreements in United States v. Bluefield Regional Medical Center, Inc., Civil Action No. 1:05-0234 (S.D.W.V.) (Chief Judge Faber). The Final Judgment in that matter, entered on September 12, 2005, annulled BRMC's and Princeton Community Hospital's market-allocation agreements and enjoined the hospitals from agreeing to allocate any cancer or cardiac-surgery service, market, territory, or customer.

C. Future Anticompetitive Effects

30. The incentives that led CAMC to seek HCA's agreement not to compete at Raleigh General continue to exist today and may motivate CAMC to pursue similar anticompetitive agreements that would restrict or prevent potential or actual competition from area hospitals. CAMC remains the dominant provider of cardiac-surgery services for Kanawha, Raleigh, and other nearby counties and stands to lose significant patient revenue if area hospitals

develop cardiac-surgery programs or expand existing programs. To protect this revenue, CAMC will likely oppose any future efforts of nearby hospitals to develop competing cardiac-surgery programs.

31. In particular, CAMC could again seek an agreement with HCA not to pursue a CON for cardiac surgery at Raleigh General. Raleigh General has retained an active interest in developing cardiac-surgery services in Beckley and continues to believe that Beckley is a better location for a cardiac-surgery center than Mercer County because Beckley is more accessible for the greatest number of patients. In the event that BRMC does not pursue its cardiac-surgery program or the State of West Virginia again amends its CON standards to permit another cardiac-surgery program in southern West Virginia, Raleigh General would again be a significant potential competitor for such a program. Fearing the loss of revenue from such a competing program, CAMC could again seek to prevent HCA from establishing a cardiac-surgery program at Raleigh General.

32. CAMC's use of the CAMC-HCA MOU to eliminate Raleigh General as a potential competitor prevented benefits that would have resulted from a cardiac-surgery program at Raleigh General. Those potential benefits to patients, managed-care plans, and employers include increased price competition resulting in lower prices, improved quality of cardiac-surgery services, the ability to choose Raleigh General as a provider of cardiac-surgery services, and increased innovation in cardiac-surgery services.

VII. VIOLATION ALLEGED

33. The United States incorporates paragraphs 1 through 32.

34. The agreement between CAMC and HCA, embodied in the CAMC-HCA MOU, constituted an agreement not to compete between an existing competitor and the most significant potential competitor after the February 2002 revisions to West Virginia's CON laws. The agreement unreasonably and unlawfully restrained trade and commerce in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

VIII. REQUEST FOR RELIEF

35. The United States requests that:

(a) the Court declare that section 3 of the CAMC-HCA MOU violates Section 1 of the Sherman Act, 15 U.S.C. § 1;

(b) the Court enter an order enjoining the Defendant from

(1) enforcing section 3 of the CAMC-HCA MOU;

(2) entering into, continuing, maintaining, or enforcing any agreement to allocate any cardiac-surgery service, market, territory, or customer; and

(3) entering into, continuing, maintaining, or enforcing any agreement that

(i) prohibits or restricts a health-care facility from obtaining a certificate of need relating to cardiac surgery or

(ii) otherwise prohibits or restricts a health-care facility from taking actions related to providing cardiac surgery;

(c) the United States recover the cost of this action; and

(d) the United States have such other relief as the Court may deem just and proper to redress, and prevent recurrence of, the alleged violation and to dissipate the anticompetitive effects of the Defendant's actions.

Dated: 2/6/2006

FOR THE PLAINTIFF
UNITED STATES OF AMERICA

THOMAS O. BARNETT
Acting Assistant Attorney General

J. BRUCE McDONALD
Deputy Assistant Attorney General

DOROTHY B. FOUNTAIN
Deputy Director of Operations

MARK J. BOTTI
Chief, Litigation I Section

PETER J. MUCCHETTI
MITCHELL H. GLENDE
Attorneys for the United States
Antitrust Division
United States Department of Justice
1401 H Street, N.W., Suite 4000
Washington, D.C. 20530
Telephone: (202) 353-4211
Facsimile: (202) 307-5802

CHARLES T. MILLER
Acting United States Attorney

By: Kelly R. Curry / JBW

KELLY R. CURRY
Assistant United States Attorney