DISTRICT COURT FOR THE CITY & COUNTY OF DENVER 1437 Bannock Street Denver, Colorado 80202	DATE FILED: February 26, 2024 4:16 PM FILING ID: 294C0C6E50F53 CASE NUMBER: 2024CV30595
STATE OF COLORADO, *ex rel.* PHILIP J. WEISER, Attorney General, Plaintiff, v. U.S. ANESTHESIA PARTNERS OF COLORADO, INC., Defendants.	▲ **COURT USE ONLY** ▲
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COMPLAINT

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Plaintiff, the Attorney General for the State of Colorado ("Plaintiff" or "Attorney General"), by and through their undersigned counsel, for their Complaint against Defendant, U.S. Anesthesia Partners of Colorado, Inc. (USAP), states as follows.

I. NATURE OF THE ACTION

1. What happens when private equity firms take over the practice of medicine? The incessant drive for returns on investment can stifle competition that normally leads to innovation and efficiencies in health care delivery, the improvement of the quality of care, and the lowering health care costs for everyone.

2. Early concerns about private equity investment in health care included "the need for private equity firms to achieve high returns on investment (often at least 2.5×) on a fast time horizon (approximately 6 years on average) may conflict with the need for investments in quality and safety."[1]

3. Recent studies examining the impact of private equity investment in health care found significant price increases—varying by specialty—with the acquisition of private physician practice groups by private equity.[2] One medical specialty heavily targeted for investment by private equity is anesthesia, particularly anesthesiologists practicing in a hospital inpatient setting supporting patients in surgical procedures.

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[1] Gondi and Song, *Potential Implications of Private Equity Investments in Health Care Delivery*, JAMA. 2019;321(11):1047-1048. doi:10.1001/jama.2019.1077.

[2] Sheffler, et al., *Monetizing Medicine: Private Equity and Competition In Physician Practice* Markets, American Antitrust Institute, July 10, 2023 (noting significant price increases of 3-5% in dermatology, 11% across dermatology, gastroenterology, and ophthalmology, and 13-26% in anesthesiology); *citing* Yu et al., *Physician Management Companies and Neonatology Prices, Utilization, and Clinical Outcomes*, Pediatrics, April 2023; La Forgia et al., *Association of Physician Management Companies and Private Equity Investment with Commercial Health Care Prices Paid to Anesthesia Practitioners*, JAMA Internal Medicine, February 28, 2022; Singh et al., *Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization*, JAMA Health Forum, 2022; Braun et al., *Private Equity In Dermatology: Effect On Price, Utilization, And Spending,* Health Affairs, vol. 40, No. 5, May 2021: La Forgia, *The Impact of Management on Clinical Performance: Evidence from Physician Practice Management Companies*, Management Science, vol. 69, Issue 8, August 2023; Joseph Bruch et al., *Workforce Composition In Private Equity–Acquired Versus Non–Private Equity–Acquired Physician Practices,* Health Affairs, 2023, 121–29, found at https://doi.org/10.1377/hlthaff.2022.00308.

4. In 2012, private equity firm Welsh Carson Anderson & Stowe (WCAS) saw anesthesia as a new market for investment with significant growth potential. To take advantage of that growth potential, WCAS formed U.S. Anesthesia Professionals, Inc. by acquiring the largest anesthesia practice group in Texas.

5. WCAS's strategy was to acquire the most attractive anesthesia practice groups in a given market and leverage those platforms through additional acquisitions in those same markets to expand equity returns before exiting the market.

6. Early on, WCAS identified the Denver-Lakewood-Aurora Metropolitan Statistical Area (Denver MSA) as an attractive area to grow its anesthesia business.

7. From its introduction into Colorado in 2015, USAP has charted a course of action intending to become the dominant surgical anesthesia provider group in Colorado, and particularly in the Denver MSA.

8. The plan was for USAP to acquire other high-quality surgical anesthesia practices and maximize its penetration in the Denver MSA hospital market. It would then leverage its market size and scale to obtain hospital exclusive contracts. Accomplishing all of that would then allow USAP to maintain or increase its reimbursement rates from health plans above its competitors in the Denver MSA and elsewhere in Colorado.

9. USAP also blocked the potential for new lower cost and higher quality competition from its ex-employees by imposing overly onerous non-compete and non-solicitation burdens on those employees.

10. By 2021, USAP had acquired its primary rivals and controlled the two largest hospital systems in Denver. By this time, USAP accounted for more than seventy percent (70%) of health plan reimbursements for surgical anesthesia in the Denver MSA. This dominant position allowed USAP to successfully retain reimbursement rates from those plans at levels between 30% and 40% higher than any other independent surgical anesthesia group in Denver and statewide.

11. USAP's dominance of the hospital inpatient surgical anesthesia market in the Denver MSA resulted in higher costs to hospitals and higher reimbursement rates from commercial and employer-funded health plans.

12. This is action is brought to restore competition for hospital inpatient surgical anesthesia services in the Denver MSA and to reduce the cost of such services to patients and consumers of these services.

II. PARTIES

13. Philip J. Weiser is the duly elected Attorney General of the State of Colorado and is authorized under the Colorado State Antitrust Act of 2023 to bring actions in his own name, and as *parens patriae* on behalf of the citizens of the State

of Colorado, to enjoin violations of this Act, including through divestiture of assets, to seek civil penalties, and to recover his costs and attorney fees. *See* C.R.S. §§ 6-4-112 and 113.

14. Defendant U.S. Anesthesia Partners of Colorado, Inc. is a provider network and a wholly owned subsidiary of U.S. Anesthesia Partners, Inc. USAP was incorporated in Colorado on July 5, 2016, as a successor to Greater Colorado Anesthesia, Inc., which USAP acquired in February 2015.

15. USAP's ultimate parent company is U.S. Anesthesia Partners Holdings, Inc., which is owned by current and former physician-partners associated with USAP in Colorado and other states, as well as by private equity investors, including WCAS.

III. RELEVANT TIMES

16. The conduct that gives rise to the claims for relief contained in this Complaint began in 2015 and continues through the present.

17. This action is timely brought pursuant to C.R.S. § 6-4-119 in that it is brought within four years of the date on which these causes of action were discovered or should have been discovered in the exercise of reasonable diligence. Further, much of the conduct complained of herein is ongoing.

IV. PUBLIC INTEREST

18. Through its unlawful and anticompetitive practices, USAP has impacted, and will continue to impact, the relevant market for hospital inpatient surgical anesthesia services in the Denver MSA. Those impacts are felt on hospitals and their staff, patients, and health plans, to all of their detriment. Therefore, these legal proceedings are in the public interest and are necessary to safeguard competitive health care markets for the benefit of Colorado businesses and consumers.

V. JURISDICTION AND VENUE

19. Pursuant to C.R.S. §§ 6-4-112 and 113, this Court has jurisdiction to enter appropriate orders prior to and following an ultimate determination of liability. The Court also has jurisdiction under Colorado's long-arm statute, C.R.S. § 13-1-124(a),(b).

20. The violations alleged herein occurred, in part, in Denver, Colorado. Therefore, venue is proper in the City and County of Denver, Colorado, pursuant to C.R.S. § 6-4-109 and C.R.C.P. 98.

VI. ANESTHESIA – GENERAL

A. Anesthesia.

21. The focus of this complaint is the use of anesthetics to prevent patients from feeling pain during surgical procedures. To create an anesthetic effect, health care providers may use general, regional, and local anesthetics depending, in part, on the severity or duration of a surgical procedure.[3]

22. Local anesthesia is an anesthetic agent given to temporarily stop the sense of pain in a particular area of the body. Regional anesthesia is used to numb only the portion of the body that will undergo surgery. General anesthesia is an anesthetic used to induce unconsciousness during surgery.

23. According to the Joint Commission, deep sedation, regional blocks, and general anesthesia must be performed by an anesthesia provider in accordance with a hospital's policies and state scope of practice laws.[4]

B. Anesthesia providers.

24. There are three types of anesthesia providers with varying degrees of education and training: physician anesthesiologists, certified registered nurse anesthetists (CRNA), and certified anesthesiologist assistants (CAA). The American Society of Anesthesiology provides this description of each:[5]

i. Anesthesiologists are medical doctors (M.D.s or D.O.s) who specialize in the field of anesthesiology. They have significantly longer and more extensive training than other classifications of anesthesia providers, so they are the most qualified to make anesthesia- related perioperative medical decisions.

ii. A CRNA is a registered nurse who has satisfactorily completed an accredited nurse anesthesia training program. Except in certain rural counties in Colorado, CRNAs are usually supervised by a physician anesthesiologist, but may also work under the supervision of other physicians.

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[3] https://www.nigms.nih.gov/education/fact-sheets/Pages/anesthesia.aspx#:~:text=%E2%80%8B%E2%80%8B%E2%80%8BWhat%20is%20anesthesia%3F.

[4] https://www.jointcommission.org/standards/standard-faqs/ambulatory/provision-of-care-treatment-and-services-pc/000001645/#:~:text=Deep%20Sedation%2FRegional%20Blocks%2FGeneral,state%20scope%20of%20practice%20laws

[5] https://www.asahq.org/education-and-career/career-resources/anesthesia-as-a-career.

iii. A CAA has completed a four-year undergraduate pre-med program, followed by an accredited anesthesiologist assistant education program. CAAs must work under the direction or supervision of a physician anesthesiologist.

25. These providers may all work together in what is referred to as a "care team" under the direction of an anesthesiologist. In a care team model, overall responsibility for the team's actions and patient safety ultimately rests with the anesthesiologist.[6]

C. Typical anesthesia settings.

26. Anesthesia services are utilized in one of three settings:

i. Surgical anesthesia provided in a hospital or outpatient surgery center.

ii. Clinical/office setting. This includes minimally invasive surgical and other procedures which typically do not involve the use of general anesthesia, including eye and dental procedures, some plastic surgeries, and endoscopic and gastrointestinal procedures.

iii. Pain medicine. While this can be provided both during an inpatient or out-patient procedure, pain medicine for the treatment of chronic pain usually involves a multidisciplinary non-surgical approach to pain management and treatment and is performed in a clinical or office setting. Various local or regional anesthetics may be used to compliment physical therapies and other non-surgical treatments.

27. This action concerns only the provision of surgical anesthesia in a hospital inpatient setting.

D. Commercial health plans and reimbursement for anesthesia services.

28. The five largest commercial health plans offered in the Denver MSA are from UnitedHealthcare, Cigna, Aetna, Anthem Blue Cross/Blue Shield, and Kaiser Permanente (Kaiser). For commercial health plans sold directly to consumers, these health plans develop networks of hospitals and hospital-based physicians, such as anesthesia providers.

29. Unlike these other health plans, Kaiser is a fully integrated health maintenance organization where doctors, hospitals (not in Colorado) and medical groups are combined into one entity. Anesthesia providers employed by the

[6] https://www.asahq.org/standards-and-guidelines/statement-on-the-anesthesia-care-team.

Colorado Permanente Medical Group (CPMG) work exclusively on behalf of Kaiser health plans and their members.

30. Patients are responsible for payment of health plan premiums and any copayments, co-insurance, and deductibles under their policies. For those plans, the health insurers are responsible for settling and paying all health care costs for their members, including those billed by surgical anesthesia providers. Increases in the cost of those services results in increased costs to plan members.

31. The largest share of health insurance coverage in the Denver MSA—as much as 80 percent—are employer-funded plans for which these insurance companies provide administrative services only and are not responsible for paying claims. Those employers, or employer groups, contract with health insurers for access to existing health care networks and administrative support in managing those plans. Unlike individual health plans, however, the employer is responsible for payment of all health insurance claims filed by its employees.

32. Hospital-based anesthesia providers—like USAP—typically negotiate directly with health plans for inclusion in plan networks. Employer-funded plans administered by commercial insurers typically rely upon these same networks for their employees' coverage. Network contracts for anesthesia rates range from one to three years, and may automatically renew unless amended or terminated. Reimbursement for anesthesia may be on a per unit basis, a discount off of billed charges, or a negotiated flat fee or "case rate" for certain procedures, such as labor and delivery—or some combination of all three.

33. The most common reimbursement model for surgical anesthesia is a per-unit rate based on several factors, including the difficulty of the procedure (base unit); the time a procedure takes in fifteen minute increments (time unit); any special conditions including the patient's health (modifying unit); and a dollar amount to be paid for each time unit (conversion factor). The total of the base units, time units, and any modifying units are multiplied by the conversion factor to calculate the negotiated rate. For example, assume that a complex procedure like a liver transplant begins with 30 base units and takes 8 hours to complete (for a total of 120 time units). Assuming no modifying units and a conversion factor of $100/unit, anesthesia services provided for that surgical procedure will cost $15,000 (30+120x$100). A less complex procedure, such as a hernia repair, may have 5 base units and take 1.5 hours (or 6 time units). With no modifying units and the same $100 conversion factor, anesthesia services provided for that procedure will cost $1,100 (5+6x$100).

34. A reimbursement model based on a negotiated discount from an anesthesia provider's full charges existed in some older legacy reimbursement contracts, but have largely disappeared in the Denver MSA.

35. Certain procedures, especially labor and delivery, are reimbursed at a flat or case rate, ranging from several hundred to several thousand dollars per procedure.

36. Most people in Colorado have some form of health insurance. According to a 2021 study by the Kaiser Family Foundation, 92% of Coloradans were either covered through an employer sponsored plan (51.3%), an individual or family plan (7%), Medicaid (18.5%), Medicare (13.1%) or military plan (2.2%). Depending on the type of coverage, a Colorado patient will be responsible for all or a portion of plan premiums, deductibles, copayments, and/or co-insurance. The amount that a commercial or governmental health plan reimburses a hospital, other health care facility, or health care provider will directly impact the cost of health coverage for those patients.

37. As described in detail below, USAP is reimbursed under both a per unit model and a flat fee model. USAP leveraged its dominant position in the market to maintain reimbursement rates, under both models, as much as 30 to 40 percent higher than other surgical anesthesia providers in the Denver MSA.

VII. USAP'S ENTRY INTO THE DENVER MSA

A. Denver MSA surgical anesthesia market in 2014.

39. Immediately prior to USAP's entry into the Denver MSA, the largest surgical anesthesia providers were Greater Colorado Anesthesia (GCA), South Denver Anesthesiologists (SDA), and University Physicians (UPI). UPI was made up of faculty members at the University of Colorado Health Sciences Center and worked exclusively at the University Hospital and, pursuant to affiliation agreements, at the Children's Hospitals.

40. Other surgical anesthesia groups in the Denver MSA at the time included Children's Hospital Anesthesia, Kaiser Permanente (through its Colorado Permanente Medical Group (CPMG)), Team Health (variously d/b/a North Denver Anesthesia, Anesthesia Professionals, and Anesthesia Consultants), Physicians Anesthesia Services, Peak Anesthesia & Pain Management, and Guardian Anesthesia Professionals.

41. Several of these groups—UPI, Children's, and CPMG—worked exclusively at their respective hospitals, or with their respective plan members, and did not openly compete with or against the remaining independent surgical anesthesia groups for privileges at the other Denver MSA hospitals.

42. As described in more detail below, USAP would ultimately own most of these independent surgical anesthesia groups and dominate the Denver MSA market for hospital inpatient surgical anesthesia services.

B. Denver hospital market in 2014.

43. Denver MSA hospitals are generally characterized as either "open staffing" or "closed staffing" facilities. In the former, independent surgical anesthesia providers may apply for privileges and compete against each other to provide anesthesia services for inpatient surgical procedures.

44. In a closed staffing facility, the hospital either employs all of its anesthesia providers (*e.g.*, Denver Health), is mandated by statute to employ only faculty members at the University of Colorado Health Sciences Center (*e.g.*, UC Health University of Colorado Hospital), or utilize a combination of employed surgical anesthesia providers and CU faculty through a formal affiliation agreement (*e.g.*, Children's Hospitals).

45. Independent surgical anesthesia providers are not able to compete to provide services at closed staffing facilities. By the same token, surgical anesthesia providers at closed staffing facilities do not compete with independent surgical anesthesia providers at hospitals with open staffing models.

46. In 2014, the Denver MSA hospital market was dominated by three open staffing health systems: Centura Health (Centura), HCA/HealthONE (HCA), and SCL Health (SCL). As indicated in the chart below, these systems owned seventeen (17) of the eighteen (18) Denver MSA hospitals at which independent surgical anesthesia providers could compete. The other Denver MSA hospitals were and remain closed staffing facilities.

Hospital	County	Owner/Operator	Beds
Littleton Adventist Hospital	Arapahoe	Centura	231
Porter Adventist Hospital	Denver	Centura	368
Parker Adventist Hospital	Douglas	Centura	179
Castle Rock Adventist Hospital	Douglas	Centura	90
St. Anthony North Hospital	Adams	Centura	121
St. Anthony Central Hospital	Jefferson	Centura	237
OrthoColorado Hospital	Jefferson	Centura	48
North Suburban Medical Center	Adams	HCA/HealthONE	157
Swedish Medical Center	Arapahoe	HCA/HealthONE	408

The Medical Center of Aurora	Arapahoe	HCA/HealthONE	269
Rose Medical Center	Denver	HCA/HealthONE	422
Presbyterian/St. Luke's Hospital	Denver	HCA/HealthONE	680
Rocky Mountain Hospital for Children	Denver	HCA/HealthONE	53
Sky Ridge Medical Center	Douglas	HCA/HealthONE	304
Platte Valley Medical Center	Adams	SCL	98
Saint Joseph's Hospital	Denver	SCL	400
Lutheran Medical Center	Jefferson	SCL	338
National Jewish Hospital	Denver	National Jewish Health	46

39. Many of these hospitals operated open staffing for surgical anesthesia providers in 2014. At the time, surgical anesthesia providers were often selected by surgeons based on familiarity and experience with a particular anesthesiologist. The Denver MSA was known as a "follow the surgeon" market.

40. In 2014 GCA had near exclusive contracts at Presbyterian St. Lukes Medical Center, Rose Medical Center, and The Medical Center of Aurora – all HCA facilities. GCA also shared exclusivity at Saint Joseph's Hospital for non-Kaiser patients. GCA had a much smaller presence at Centura hospitals in the Denver MSA, and at HCA's Sky Ridge Medical Center. All of these hospitals were in the central and eastern portions of the Denver MSA.

41. SDA, by comparison, had no exclusive contracts, but had a semi-exclusive contract to provide anesthesia services at Swedish Medical Center (HCA) and was the primary surgical anesthesia provider at Sky Ridge Medical Center (HCA) and at Porter, Littleton, Parker, and Castle Rock Adventist Hospitals (all Centura facilities). These hospitals operated primarily with open staffing models. All of these hospitals were in the southern portion of the Denver MSA.

42. Team Health had exclusive contracts at North Suburban Medical Center (HCA), and at St. Anthony's Hospital, OrthoColorado Hospital, and St. Anthony's North Hospital (all Centura facilities). All of these hospitals were in the west and northwest portions of the Denver MSA.

C. WCAS and USAP discuss entry into the Denver MSA.

51. By mid-2014, USAP and WCAS were actively engaged in discussions about entry into the Denver MSA surgical anesthesia market. Their initial target

was GCA, an anesthesia practice group that was formed in 2012-2013 with the merger of Metro Denver Anesthesia (MDA), Colorado Anesthesia Consultants (CAC), and Pediatric Anesthesia Associates. With 102 physicians, GCA was the largest independent surgical anesthesia group in the Denver MSA.

52. USAP formally acquired GCA in February 2015. That acquisition brought more than 100 surgical anesthesia providers under the USAP banner. At the same time, WCAS and USAP were already looking for opportunities to grow its presence in the Denver MSA. Its first priority was to acquire SDA, GCA's largest competitor in this market.

53. USAP acquired SDA on December 31, 2015, which added an additional 100 surgical anesthesia providers to USAP, making it by far the largest independent surgical anesthesia group in the Denver MSA.

54. USAP would later complete additional acquisitions of competing independent surgical anesthesia groups in connection with its efforts to tie up most of hospital market in the Denver MSA.

VIII. USAP TIES UP THE DENVER MSA HOSPITAL MARKET

A. USAP acquires two of its biggest rivals to become the exclusive provider for Centura Health.

55. In 2017 USAP began discussions with Centura about a system-wide exclusive surgical anesthesia contract covering all of that system's hospitals in the Denver MSA. As part of its efforts to finalize that contract, USAP acquired all other competing surgical anesthesia groups servicing these hospitals, under exclusive contracts or otherwise. The biggest target was Team Health, which USAP viewed as its primary competitor for an exclusive contract with Centura.

56. On January 1, 2019, USAP acquired Team Health, a surgical anesthesia group with approximately 111 providers. The Team Health acquisition also brought with it exclusive surgical anesthesia contracts at three of Centura's Denver MSA hospitals, as well as an exclusive contract at a Denver MSA hospital owned by HCA.

57. On January 1, 2020, USAP acquired approximately 15 surgical anesthesia providers from Guardian Anesthesia Services, which cemented USAP's exclusive contracts at two additional Centura hospitals in the Denver MSA.

58. In each of these acquisitions, the hospital's gave notice to these providers that their privileges to practice at these hospitals would terminate, leaving those providers little choice but to agree to be acquired by USAP.

59. In short order, USAP had rid itself of most of its remaining competitors in the Denver MSA market. By the end of 2020, there were no independent surgical anesthesia groups with sufficient size and scale to fully staff a single hospital—

other than a couple of hospitals where a surgical anesthesia group was already the incumbent provider. However, none of those groups had sufficient size and scale to compete against USAP to service a multi-hospital system.

60. On July 1, 2020, USAP entered into a Master Professional Services Agreement with Centura to provide exclusive surgical anesthesia services for all seven (7) of Centura's hospitals in the Denver MSA.

61. As with most hospital contracts, USAP was obligated to provide defined coverage for both elective and emergency surgical cases and to do so in a timely fashion so as not to disrupt the hospital's surgical schedules through delay, postponement, or cancellation of surgical procedures.

62. Also, as with most hospital contracts, USAP was obligated to stay in network with major health plans so as not to expose the hospital—or the hospital's patients—to USAP's full charges or balance billing.

63. Violation of either of these obligations would be grounds for termination of this exclusive contract.

B. USAP captures all the HCA hospitals as well.

64. In 2020, USAP and HCA began negotiations to enter into a new exclusive agreement that would encompass all of HCA's hospitals in the Denver MSA.

65. Because of USAP's acquisition of its competitors, there were no other surgical anesthesia groups with sufficient size and scale to compete for HCA's system-wide business.

66. USAP and HCA entered into a new Professional Services Agreement on March 1, 2021. The contract covered all of HCA's eight hospitals in the Denver MSA and gave USAP the exclusive right to provide surgical anesthesia services at seven of those hospitals.

67. As with its other exclusive contracts, USAP was obligated to provide defined coverage for both elective and emergency cases and to do so in a timely fashion so as not to disrupt the hospital's surgical schedules through the delay, postponement, or cancellation of surgical procedures.

68. USAP was also obligated to stay in network with major health plans so as not to expose the hospital or the hospital's patients to USAP's full charges or balance billing.

69. Violation of either of these obligations would be grounds for termination of this exclusive contract.

C. USAP enters into an exclusive contract with SCL.

70. On April 1, 2019, USAP entered into a Professional Services Agreement with SCL to provide surgical anesthesia services for non-Kaiser patients at one of SCL's Denver MSA hospitals. SCL owned and operated two other hospitals in the Denver MSA. Each of those other hospitals had long-standing exclusive contracts with different—and much smaller—surgical anesthesia groups.

71. Again, as with its other contracts, USAP was obligated to provide defined coverage for both elective and emergency cases and to do so in a timely fashion so as not to disrupt the hospital's surgical schedules through the delay, postponement, or cancellation of surgical procedures.

72. USAP was also obligated to stay in network with major health plans so as not to expose the hospital or the hospital's patients to USAP's full charges or balance billing.

73. Violation of either of these obligations would be grounds for termination of this exclusive contract.

D. USAP enters into an exclusive contract with National Jewish Health.

74. Finally, USAP also had an exclusive contract, dating back to July 1, 2016, to be the exclusive surgical anesthesia provider at National Jewish Health.

75. USAP was obligated to provide defined coverage for both elective and emergency cases and to do so in a timely fashion so as not to disrupt the hospital's surgical schedules through the delay, postponement, or cancellation of surgical procedures.

76. USAP was also obligated to stay in network with major health plans so as not to expose the hospital or the hospital's patients to USAP's full charges or balance billing.

77. Violation of either of these obligations would be grounds for termination of this exclusive contract.

E. USAP dominates the Denver MSA hospital market in 2021.

78. By the time USAP had concluded negotiations with Centura, HCA, SCL, and National Jewish it had acquired a dominant market share of the Denver MSA hospital market. As the chart below shows, USAP now had exclusive or semi-exclusive contracts at sixteen (16) of the twenty-one (21) Denver MSA open staffing hospitals (76%) at which independent surgical anesthesia providers could compete.

Hospital	County	Owner/Operator	Anesthesia Provider
St. Anthony Central Hospital	Jefferson	Centura	USAP
OrthoColorado Hospital	Jefferson	Centura	USAP
St. Anthony North Hospital	Adams	Centura	USAP
Littleton Adventist Hospital	Arapahoe	Centura	USAP
Porter Adventist Hospital	Denver	Centura	USAP
Parker Adventist Hospital	Douglas	Centura	USAP
Castle Rock Adventist Hospital	Douglas	Centura	USAP
Swedish Medical Center	Arapahoe	HCA/HealthONE	USAP
Sky Ridge Medical Center	Douglas	HCA/HealthONE	USAP
Rose Medical Center	Denver	HCA/HealthONE	USAP
Presbyterian/St. Luke's Hospital	Denver	HCA/HealthONE	USAP
Rocky Mountain Hospital for Children	Denver	HCA/HealthONE	USAP
The Medical Center of Aurora	Arapahoe	HCA/HealthONE	USAP
Centennial Hospital	Arapahoe	HCA/HealthONE	Open Staffing
North Suburban Medical Center	Adams	HCA/HealthONE	USAP
Lutheran Medical Center	Jefferson	SCL Health	Physician Anesthesia Services
Platte Valley Medical Center	Adams	SCL Health	Anesthesia Services of Platte Valley
Saint Joseph's Hospital	Denver	SCL Health	USAP/CPMG
National Jewish Hospital	Denver	National Jewish Health	USAP
UC Health Highlands Ranch Hospital	Douglas	UC Health	CU Medicine
UC Health Broomfield Hospital	Broomfield	UC Health	Boulder Valley Anesthesia

79. Following the acquisition of its primary competitors, and following its system-wide exclusive contracts with Centura and HCA, USAP had increased its share of inpatient surgical procedures in the Denver MSA by more than thirty-three percent (33%). Data on hospital inpatient surgeries collected by the Colorado Hospital Association shows the total inpatient surgeries in 2021 at these hospitals was 46,224—again, not including Denver Health, Children's Hospital Colorado, or University of Colorado Hospital. Of the total inpatient surgeries, hospitals served exclusively or semi-exclusively by USAP totaled 40,083 or 86.70% of all such surgeries in the Denver MSA in 2021.

IX. USAP LEVERAGED ITS DOMINANT MARKET SHARE IN NEGOTIATIONS WITH HEALTH PLANS

80. When USAP acquired GCA in February 2015, GCA's average reimbursement rate (conversion factor) across the four major health plans covering the Denver MSA was $98.75/unit.

81. SDA and Team Health had the next highest reimbursement rates, although each had several contracts with health plans that paid above-market rates—even higher than GCA's—as discounts off of their respective fully billed charges.

82. The rest of the surgical anesthesia groups in the Denver MSA were reimbursed at an average of approximately $65.66/unit—40 percent lower than USAP.

83. Almost immediately after acquiring GCA in February 2015, as health plan contracts were due for renewal, USAP approached health plans looking to renegotiate higher reimbursement rates.

84. One tactic USAP repeatedly used to exert pressure on health plans was to give notice of its intent to terminate existing contracts as those contracts were about to expire. Before the adoption of state and federal surprise billing laws, a commercial health plan or an employer-funded health plan would have to bear the cost of USAP's much higher out-of-network billing in order to protect their members/employees from those full charges. That could cost these plans millions of dollars in extra surgical anesthesia costs.

85. For years these health plans tried to reign in USAP's above market reimbursement rates, arguing for either modest or non-existent year-over-year increases—or even reductions in some cases. Even considering inflationary pressures on reimbursement rates, no health plan was successful in bringing USAP's rates down to the average rates charged in the rest of the Denver MSA.

86. During the period between its entry into the Denver MSA and 2022, health plans estimated that USAP received between 70% and 80% of their total anesthesia spend in the Denver MSA. One health plan calculated that USAP's

market share in the Denver MSA grew from 76% of the hospital-based charges in 2017 to 84% of those charges in 2019, and to an estimated 87% of all anesthesia charges in 2020.

87. USAP's dominant market share—coupled with its near monopoly control over hospital inpatient surgical anesthesia in the Denver MSA—meant that these plans had little to no choice but to cave in to USAP's demands for ever-increasing reimbursement rates.

88. And, despite calling for USAP to demonstrate that it was providing higher quality, lower cost care to the plan members/employees, these plans were forced to accept pay-for-performance bonuses for USAP, based on easily attained metrics, that were unavailable to any other surgical anesthesia group in the Denver MSA.

89. With the exception of a few health plan contracts paying for surgical anesthesia services based on a discount off of a provider's full charges, all of USAP's competitors in the Denver MSA received reimbursement rates significantly below those of USAP.

90. With each successive USAP acquisition of a competing surgical anesthesia group, USAP was able to move all of the acquired clinicians to its higher reimbursement rates, costing health plans millions of dollars in extra costs for surgical anesthesia.

91. In one example, a health plan estimated that a single USAP acquisition would cost it nearly $800,000 over the previous year.

92. Another health plan estimated that USAP's demand for a rate increase as it was acquiring a large competing surgical anesthesia group would have a $2.3 million impact on its health care budget in the Denver MSA.

93. USAP's ever-increasing reimbursement rates also had an impact on health plans' dealings with USAP's competitors in the Denver MSA. Many of those competitors, faced with threatened acquisition by USAP, and the termination of their hospital privileges, made repeated demands for higher reimbursement rates themselves. As a result, these health plans had to pay overall higher rates to these competitors, although never to the same level as USAP.

94. All told, between 2015 and the present, USAP was able to use its ever-growing market power to keep its rates between thirty percent (30%) and forty percent (40%) higher than any other independent surgical anesthesia group in the Denver MSA.

X. THE DECLINE IN AVAILABLE SURGICAL ANESTHESIA PROVIDERS PUT DENVER MSA HOSPITALS IN A BIND

96. After acquiring many of the independent surgical anesthesia providers in the Denver MSA, and tying up nearly seventy-six percent (76%) of the hospitals in the Denver MSA with exclusive contracts, surgical anesthesia providers in the Denver MSA—including USAP—found themselves with increasing staffing shortages. Some of this was due to physician attrition, significant difficulties in recruiting new physicians and other clinicians, and the lingering effects of the COVID pandemic.

97. Coming out of COVID, with the ability to once again schedule elective surgeries, hospitals in the Denver MSA were anxious to expand their surgical offerings to make up for revenues lost during the pandemic.

98. At the time, however, many of these hospitals were bound by exclusive contracts awarded to USAP, with little opportunity to bring in supplemental coverage in the event USAP was unable to handle increased surgical needs.

99. Even the large number of clinicians that left USAP during this period were unable to fill these staffing needs due to strict non-compete clauses in their employment agreements that prevented them from seeking work at any facility at which USAP also provided surgical anesthesia services.

100. So, these hospitals had a choice to make. Maintain their exclusive contracts with USAP and the ever-increasing need for higher subsidies to support its work, or look elsewhere for a competitor able to meet their surgical needs. Unfortunately, by the end of 2021, there were no alternative competitors left in the Denver MSA.

101. As a result of the numerous USAP acquisitions of competing surgical anesthesia groups in the years prior to and after the onset of the pandemic, there were literally no other independent surgical anesthesia group with sufficient size or scale to service an additional single hospital, let alone a multi-hospital system.

XI. WITHOUT ALTERNATIVES, HOSPITALS EXTENDED THEIR CONTRACTS WITH USAP AND INCREASED USAP'S SUBSIDIES

102. Historically, hospitals in the Denver MSA paid subsidies to surgical anesthesia providers for particular lines of service requiring twenty-four hour coverage every day of the week. The most common needs were in labor/delivery and trauma/ER. Subsidies were not paid for coverage of scheduled elective surgeries. Generally, the subsidy was to compensate a practice needing to pay a doctor for providing twenty-four hour coverage regardless of the amount of business that was actually generated during that coverage period.

103. There were many other examples of subsidies at other Denver MSA hospitals for specific lines of service, including bariatric surgery and certain transplant surgeries. Some of these were "fixed" subsidies paying the same amount each day/week/month while others were characterized a "revenue guarantees." In the latter formulation, the actual subsidy earned would adjust periodically to consider the revenues earned by the surgical anesthesia provider to reduce the amount of the actual subsidy paid. On average, revenue guarantee subsidies were significantly less expensive for a hospital than a fixed subsidy.

104. One strategy utilized by USAP to gain access to and eliminate competition at Denver MSA hospitals was to offer to dramatically reduce or eliminate the hospital's existing subsidy obligations. In exchange, USAP expected to receive exclusive contracts to cover all surgical procedures at the hospitals, not just those occurring after hours or on weekends. USAP believed that the loss of subsidies would be more than made up for with increased revenues covering elective surgical procedures.

105. Despite USAP being out of network with the largest commercial insurance company in the Denver MSA for more than a year, not one of those hospitals terminated USAP.

106. Instead, those hospital systems retained USAP as their exclusive surgical anesthesia provider, adjusted the sites of service USAP was expected to cover, and agreed to dramatically increase the overall fixed subsidies they were paying USAP.

107. In some instances, those increases in subsidies ranged from 180% to nearly 1200% increases in the subsidies USAP had been earning. Some hospitals went from paying zero subsidies to agreeing to pay hundreds of thousands of dollars in subsidies per year.

108. For the most part, these dramatically increased subsidies took the form of fixed subsidies, meaning that the subsidies owed would not be reduced by USAP's revenue earnings at those hospitals.

109. By 2021, hospitals in the Denver MSA were left with no alternatives to USAP in the Denver MSA.

XII. RELEVANT PRODUCT MARKETS

A. Hospital inpatient surgical anesthesia market.

110. The relevant product market is surgical anesthesia services provided in open staffing hospitals for inpatient surgical procedures. This product market recognizes the unique and non-substitutable nature of these procedures compared to anesthesia needs in an office/clinical setting or even in an ASC setting.

i. Office and clinic-based surgical procedures are not a substitute for hospital inpatient surgical procedures.

111. Clinic or office-based minor surgical procedures and pain management anesthesia practices are not an appropriate substitute for open-staffing hospital inpatient surgical anesthesia. Unlike minor surgical procedures in those settings, hospitals handle many more complex surgeries on significantly more acute patients requiring overnight stays. Complications from hospital inpatient surgeries may require the full suite of additional services not available in an office/clinical setting, including pathology, invasive radiology, cardiac catheterization labs, blood transfusions, etc. Further, general anesthesia can be used in both inpatient and out-patient surgical settings, such as hospitals and ASCs, but is rarely used in a purely office or clinical setting due to the potential complications from anesthetic drugs that affect cardiovascular and respiratory functions.

112. Further, while an office or clinical setting may provide some minor or less invasive surgical procedures, such facilities are not regulated or licensed by Colorado. The Colorado State Board of Medical Examiners has issued a detailed policy relating to surgical procedures in those settings. In particular, the Board advises that certain surgical procedures should not be performed in these settings, including procedures that may result in excessive blood loss; procedures requiring major or prolonged intracranial, intrathoracic, or abdominal cavity entry; joint replacement procedures; procedures directly involving major blood vessels; and emergency or life threatening procedures.[7]

113. Finally, USAP does not compete for the vast majority of office or clinical-based anesthesia needs which, at most, involve purely local anesthetics or so-called conscious sedation.

ii. ASC-based surgical procedures are not a substitute for hospital inpatient surgical procedures.

114. ASC's are not an appropriate substitute for many surgical procedures that must be performed in a hospital inpatient setting. Unlike an ASC, hospitals are licensed to provide various levels of emergency care and related surgeries around the clock. For their part, an ASC does not handle emergency cases and, in fact, are required by law to have a written emergency transfer agreement with a local hospital should an emergency situation arise with one of its patients.[8] Hospitals also provide a wide array of OB/GYN procedures, including vaginal and

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[7] Colorado Medical Board Policy 42-12, issued on November 8, 2001, and last revised on May 19, 2016. Available at https://drive.google.com/file/d/0BzKoVwvexVATMGFNdW9SX0IyLTA/view?resourcekey=0-0LfJFmpKBmiS4Ch2plAdVw.

[8] 6 CCR 1011-1-20-12, sec. 12.3.

C-Section births, neonatal intensive care, and other procedures that require specialized anesthesia professionals. Those procedures are not available at an ASC.

115. Hospitals also employ or retain many other specialists in areas such as pathology, radiology, and cardiac catheterization for both emergency and elective surgical procedures. Neither the specialized equipment needed for these procedures, nor the physician, nurses, and technicians needed to perform these procedures, are available at an ASC.

116. Further, many complex surgical procedures – both emergency and elective – require the patient spend a night or longer in the hospital. While Colorado does allow for an ASC to have a separately licensed "convalescent center" to provide overnight care to patients, those centers are for patients "for whom an uncomplicated recovery is anticipated and for whom acute hospitalization is not required."[9] Such convalescent centers are not designed to handle acute patients requiring more intensive or extensive hospital inpatient care.

117. Courts examining product markets that exclude outpatient facilities have concluded that patients will not substitute outpatient services in response to a price increase where clinical considerations dictate that such procedures must be performed in a hospital inpatient setting. *See, e.g., FTC v. ProMedica Health Sys., Inc*., No. 3:11-CV-47, 2011 WL 1219281, at *9 (N.D. Ohio Mar. 29, 2011) (relevant market "exclude[d] outpatient services" because "[p]atients would not substitute outpatient services in response to price increases for inpatient services, because such substitution is instead based on clinical considerations"); cf. *BRFHH Shreveport, LLC v. Willis-Knighton Med. Ctr*., 49 F.4th 520, 530 (5th Cir. 2022) (parties agreed relevant market was limited to inpatient services).

118. Colorado law also limits the types of surgical procedures that can be performed in an ASC: "(1) Those in which the expected combined operating and recovery time does not exceed 24 hours from the time of admission, and (2) Those that do not generally result in extensive blood loss, require major or prolonged invasion of body cavities, directly involve major blood vessels or constitute an emergency or life-threatening procedure."[10]

119. More significantly, the Centers for Medicare & Medicaid Services (CMS) publishes an annual Ambulatory Surgical Center (ASC) Payment Guide which identifies surgical procedures that will be paid only as inpatient services and not as outpatient surgeries at a hospital or ASC "because of the invasive nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can

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[9] 6 CCR 1011-1-20-2, sec. 2.3.
[10] 6 CCR 1011-1-20-9, sec. 9.2.

be safely discharged."[11] Payment for outpatient surgeries at an ASC do not include those surgical procedures that: (1) generally result in extensive blood loss, (2) require major or prolonged invasion of body cavities,(3) directly involve major blood vessels, (4) are generally emergency or life-threatening in nature, (5) commonly require systemic thrombolytic therapy, (6) are designated as requiring inpatient care under § 419.22(n), (7) can only be reported using a CPT unlisted surgical procedure code, or (8) are otherwise excluded under § 411.15."[12]

120. Finally, the American Society of Anesthesiology has published a physical status classification system to assess and communicate a patient's pre-anesthesia medical co-morbidities to be used to help predict perioperative risks.[13] Thus, even for procedures that are otherwise appropriate for an ASC, a patient with co-morbidities placing them within ASA III-IV classifications (patients with severe systemic disease, a severe systemic disease that is life-threatening, or a patient who is likely to die without the surgery) must be treated in a hospital inpatient setting.

121. Thus, for these and many other procedures, and ASC is not an appropriate substitute for hospital inpatient surgeries.

122. Thus, the relevant product market is defined as surgical anesthesia provided in a hospital inpatient setting.

XIII. RELEVANT GEOGRAPHIC MARKET

123. The relevant geographic market is the "area of effective competition where buyers can turn for alternate sources of supply."[14] Put differently, "a market is the group of sellers or producers who have the actual or potential ability to deprive each other of significant levels of business."[15]

124. In identifying potential markets for entry, USAP looked exclusively at the MSA level—rather than at state or even regional levels—to identify favorable

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[11] 88 FED. REG. 81540 (November 22, 2023) (Final Rule revising the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for calendar year 2024), at 81858-59.

[12] *Id.*, at 81923.

[13] ASA *Statement on ASA Physical Status Classification System*, October 15, 2014, found at https://www.asahq.org/standards-and-practice-parameters/statement-on-asa-physical-status-classification-system.

[14] *Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System, Ltd.*, 778 F.3d 775, 784 (9th Cir. 2015); 2015778 F.3d 775*Morgan, Strand, Wheeler & Biggs v. Radiology, Ltd.*, 924 F.2d 1484, 1490 (9th Cir.1991) (alteration omitted) (quoting *Oltz v. St. Peter's Cmty. Hosp.*, 861 F.2d 1440, 1446 (9th Cir.1988)).

[15] *Rebel Oil Co. v. Atl. Richfield Co.*, 51 F.3d 1421, 1434 (9th Cir.1995).

characteristics in each desirable MSA, such as population size and demographics, health care costs, and insurance payer mixes. Early on, WCAS and USAP identified the Denver MSA as a favorable target for expansion. They separately evaluated other Colorado MSAs, such as Colorado Springs, Boulder, and Fort Collins as potential markets for entry.

125. In fact, because patients rarely select their anesthesia provider, and instead rely on their surgeon or hospital to select an appropriate anesthesia provider, the relevant geographic market is dependent on where patients are likely to go for most of their inpatient hospital needs, especially elective surgical needs.

126. Because most surgeons seek privileges to work in hospitals within a relatively short distance from where they live, the geographic market for anesthesia providers is similarly narrow. That is especially true for hospitals where surgeons and surgical anesthesia providers have on-call responsibilities and must be able to respond within thirty minutes to handle births and emergency cases.

127. Colorado law requires health plans to create provider networks that are "sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay."[16] To meet these requirements, health plans will negotiate with hospitals and other health care facilities for inclusion in their networks, as well as with primary and specialized care providers. Where those providers are employed by a hospital or other health care facility, the hospital or facility will include reimbursement for such providers in its network contract. For hospital-based, but not employed, providers, those providers will negotiate directly with the health plans for inclusion in provider networks.

128. Health plans in Colorado are required by the Colorado Division of Insurance to adhere to a variety of network adequacy rules, including those relating to so-called geographic access standards.[17] In establishing network adequacy requirements for Affordable Care Act compliant plans in the Denver MSA, those plans must include inpatient acute care hospitals in commercial health plans within ten miles of a covered patient.[18]

129. Thus, the relevant geographic market in which surgical anesthesia services are performed in a hospital inpatient setting is the Denver MSA. If anything, this geographic market is overinclusive as hospitals in the southern part of the Denver MSA (for example, Castle Rock, Parker, and Sky Ridge) are 53 mile,

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[16] C.R.S. § 10-16-704(1).

[17] 3 CCR 702-4 Series 4-2-53-8.

[18] *Id.*

37 mile, and 45 mile drive times, respectively, to some northern Denver facilities (such as North Suburban Medical Center in Thornton).

130. A hypothetical monopolist of surgical anesthesia services for hospital inpatient surgeries in the Denver MSA could impose a small but significant and non-transitory price increase without fear of competition from anesthesia providers working in communities outside the Denver MSA.[19]

XIV. USAP EXERCISED MARKET POWER IN THE DENVER MSA

A. USAP is presumed to have market power in the Denver MSA under the Horizontal Merger Guidelines.

131. Through its acquisitions of GCA and SDA, and its subsequent acquisitions of other competing surgical anesthesia groups, USAP dramatically increased concentration in the Denver MSA market for surgical anesthesia services in a hospital inpatient setting.

132. When it acquired GCA to enter the Denver MSA hospital inpatient surgical anesthesia market, USAP controlled approximately 17% of this market, measured by the size of its practice (102 physicians).

133. Once it acquired SDA at the end of 2015, USAP controlled nearly 32% of the Denver MSA surgical anesthesia market with more than 200 physician anesthesiologists. One health plan complained that USAP, with the SDA acquisition, controlled nearly 80% of its health care spend on anesthesia in this market.

134. By 2019, after USAP's acquisitions of Guardian Anesthesia Services and Team Health in the Denver MSA, another health plan estimated that USAP now controlled 87% of the surgical anesthesia market in the Denver MSA, excluding the University of Colorado Hospital and its employed, faculty member surgical anesthesia providers.

135. The most accepted measure of market concentration is known as the Herfindahl-Hirschman Index (HHI) which squares the market share of competitors in a given market and sums the results. According to the 2010 Horizontal Meger Guidelines adopted by the U.S. Department of Justice and Federal Trade Commission—and utilized by nearly every court considering market concentration in an antitrust context—a highly concentrated market has an HHI of 2500 or

[19] 2010 USODJ/FTC Horizontal Merger Guidelines, Sec. 4.1.2; 2023 USDOJ/FTC Merger Guidelines, Sec. 4.3.A.

higher.[20] An acquisition in such a market that produces an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power.[21]

136. The recently issued 2023 Merger Guidelines suggests that markets with an HHI greater than 1,800 are highly concentrated, and a change of more than 100 points is a significant increase,[22] leading to a presumption that the merger will substantially lessen competition or tend to create a monopoly.[23]

137. A merger that eliminates competition between the merging parties prior to the merger also suggests that the merger may substantially lessen competition.[24]

138. Prior to USAP's acquisition of Team Health in 2019, the HHI for surgical anesthesia services in the Denver MSA was nearly 2500, a highly concentrated market in which USAP was easily the dominant provider. USAP's acquisition of Team Health increased the concentration in the Denver MSA to nearly 3000, an increase of approximately 500 index points. That acquisition is presumed to substantially lessen competition or tend to create a monopoly in the hospital inpatient surgical anesthesia market in the Denver MSA.

139. Hospitals seeking an exclusive contract with a surgical anesthesia group require a group that employes dozens of surgical anesthesia providers for a single hospital and hundreds of providers for an entire hospital system.

140. When USAP acquired Team Health in January 2019, it acquired the last remaining surgical anesthesia group in the Denver MSA with sufficient size and scale to challenge USAP for exclusive contracts at individual hospitals and for entire multi-hospital systems. That also creates a presumption that the merger substantially lessened competition for hospital inpatient surgical anesthesia in the Denver MSA.

B. USAP's market power has had and will continue to have adverse competitive effects.

141. USAP has exercised its market power in at least two ways. First, USAP leveraged its market power to increase and maintain its reimbursement rates with health plans at levels far in excess of rates earned by other independent surgical anesthesia providers in the Denver MSA.

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[20] USDOJ/FTC Horizontal Merger Guidelines, August 19, 2010, at 19.
[21] *Id.*
[22] USDOJ/FTC Horizontal Merger Guidelines, December 18, 2023, at 5.
[23] *Id.*, at 6.
[24] *Id.* at 6-7.

142. As described above, health plans regularly tried to hold the line on USAP's rates and continuously pushed back on USAP's demands for even higher rates. Not only did they largely fail to do that, but these health plans were also pressured by much smaller groups to increase their reimbursement rates as those groups tried to fend off purchase overtures from USAP.

143. And, as also described above, these health plans consistently complained that USAP's rates were as much as forty-five percent (45%) higher than any other surgical anesthesia group in the Denver MSA. Even after being taken out of network by one health plan in an effort to force USAP to accept a dramatically lower reimbursement rate, that plan ultimately had to bring USAP back in network at rates there were still its highest in the Denver MSA.

144. Second, USAP sought and obtained significantly increased fixed subsidies from hospitals and hospital systems by leveraging its position as the only remaining surgical anesthesia provider in the Denver MSA with sufficient size and scale to provide those services.

145. But for the fact that USAP had acquired so many former competitors in the Denver MSA, individual hospitals and entire hospital systems would have had the ability to replace USAP—or at least bring in supplemental coverage—when USAP lost so many anesthesia providers to attrition. Instead, these hospital systems were left with no choice but to continue to use USAP and to pay ever-increasing fixed subsidies in order to keep USAP a viable entity.

C. USAP has erected significant barriers to entry to maintain its market power.

146. USAP has engaged in several strategies to foreclose potential entry of surgical anesthesia groups to compete for hospital inpatient surgical anesthesia in the Denver MSA. Each of these strategies were designed to erect near impenetrable barriers in order to protect and maintain USAP's monopoly position in this market.

147. First, as described in detail above, USAP utilized its ever-increasing share of anesthesia providers in the Denver MSA to leverage its relationships with critical hospital systems to gain exclusive contracts at more than seventy percent (70%) of the available open staffing hospitals in the Denver MSA. It obtained those exclusive contracts in part by eliminating or significantly reducing stipends those hospitals had to pay in exchange for exclusive service. These exclusive contracts were in effect for up to five (5) years, with automatic renewals each year after that. This made it impossible for competing surgical anesthesia groups to practice in those facilities or to acquire sufficient size and scale to seek such business in the future.

148. Further, hospital exclusive contracts with surgical anesthesia providers are inherently "sticky;" once established, the expense of finding and

replacing an incumbent provider, and the attendant risks to continuity of care to their patients, make hospitals very reluctant to switch surgical anesthesia providers. Both WCAS and USAP recognized this fact as they developed plans to win exclusive contracts at the largest hospital systems in the Denver MSA.

149. Second, USAP cemented its dominant position in the Denver MSA by enforcing non-compete and non-solicitation agreements that had the potential to impose hundreds of thousands, if not millions, of dollars in "liquidated damages" if departing clinicians attempted to compete against USAP.

150. The non-compete provisions purported to extend for the entire period of a provider's employment at USAP, and for two additional years after termination of that employment.

151. Under those provisions, ex-employees were precluded from working at any hospital or ASC serviced by USAP or at any hospital or ASC formerly serviced by USAP at any time during the term of employment and for the preceding twelve months. These restrictive provisions also applied to any hospital or ASC USAP had only been in inactive negotiations to service, whether it ever provided that service or not described above.

152. Moreover, former USAP providers were also prohibited from working at any other hospital or ASC within fifteen (15) miles of any of the hospitals or ASCs described above.

153. The end result was that a former USAP physician was basically prohibited from practicing anywhere in the Denver MSA without risking exposure to massive damages.

154. USAP also required its CRNAs to sign a non-compete agreement with similar terms, although the geographic reach of those agreements was only five (5) mile radius around any current or former USAP facility.

155. While USAP made some changes to its non-compete clauses that are less restrictive than those in effect prior to 2020, those modified clauses still violate Colorado law and effectively restrict the ability of former USAP physicians to effectively compete with it, especially for hospital inpatient surgical anesthesia.

156. Even absent USAP's market power, Colorado law governs non-compete agreements "between physicians" and mandates that such non-competes may not restrict the right of a physician to practice medicine. If they do, they are declared "void."[25]

157. While a physician non-compete may provide for damages against a physician violating its provisions, those damages must be "reasonably related to the

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[25] C.R.S. § 8-2-113(5) (2023).

injury suffered by reason of termination of the agreement . . . and may include damages related to competition."[26]

158. Colorado law also requires that any non-compete agreement must be reasonable in duration and geographic scope.[27] Neither version of the non-compete agreements used by USAP meets these standards.

159. For all of these reasons, these non-complete clauses violate Colorado law which does not allow physician non-compete clause to restrict the practice of, medicine, allow for broad damages unrelated to USAP's actual damages due to breach, and are grossly unreasonable in scope and geography.

160. USAP's non-compete limitations need also be viewed under the additional lens of the antitrust law because USAP used its non-compete provisions to cement its market power for surgical anesthesia service to hospitals in the Denver MSA.

161. In addition to non-compete clauses, USAP's employment contracts contain broad "non-solicitation" clauses that bar former employees from soliciting business from any patient, facility, surgeon, or existing USAP employee for a period of two years following termination of their employment with USAP. These clauses apply to facilities that USAP no longer serves, surgeons for whom USAP no longer provides surgical anesthesia services, and USAP employees even after they leave USAP.

162. Moreover, breach of these non-solicitation clauses allows USAP to recover, as liquidated damages, up to three times any actual damages USAP suffers as a result of said breach.

163. Under Colorado law, breach of such non-solicitation clauses can provide for remedies no broader than is necessary to protect USAP's legitimate interests in protecting trade secrets.

164. The effect of these illegal non-solicitation provisions was to further restrain ex-USAP providers from competing for hospital inpatient surgical anesthesia in the Denver MSA.

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[26] *Id.*

[27] *Reed Mill & Lumber Co. v. Jensen*, 165 P.3d 733, 736 (Colo. App. 2006); *Crocker v. Greater Colorado Anesthesia, P.C.*, 463 P.3d 860, 866 (2018).

FIRST CLAIM FOR RELIEF

(C.R.S. § 6-4-107 – USAP's acquisition of Anesthesia Consultants (TeamHealth) substantially lessened competition and tended to create a monopoly)

165. Plaintiff re-alleges and incorporates by reference the allegations in paragraphs 1-164, above.

166. USAP has monopoly power in the market for open staffing hospital inpatient surgical anesthesia services in the Denver MSA.

167. The market for hospital inpatient surgical anesthesia services in the Denver MSA was already highly concentrated due to USAP's earlier acquisitions of GCA and SDA. By 2019, the HHI in this market was approximately 2500.

168. When it subsequently acquired its last remaining large competitor in 2019—Team Health—USAP had not only eliminated its largest remaining competitor, but it eliminated its primary competitor for an exclusive statewide contract with the Centura hospital system, which included seven hospitals in the Denver MSA.

169. As a result of that acquisition, the HHI index for hospital inpatient surgical anesthesia services rose to 3000, an increase of nearly 500 points. Under the Horizontal Merger Guidelines, that acquisition was presumptively anticompetitive in violation of C.R.S. § 6-4-107.

170. There is no valid procompetitive justification for USAP's exclusionary conduct in the market for hospital inpatient surgical anesthesia services in the Denver MSA in violation of C.R.S. § 6-4-107.

SECOND CLAIM FOR RELIEF

(C.R.S. § 6-4-105 – Unlawful Monopolization, Attempted Monopolization and Monopoly Maintenance)

171. Plaintiff re-alleges and incorporates by reference the allegations in paragraphs 1-170, above.

172. Beginning with its acquisition of GCA and SDA in the Denver MSA in 2015, USAP has undertaken a course of conduct intentionally designed to create and maintain a monopoly in the hospital inpatient surgical anesthesia market in the Denver MSA.

173. That conduct included the subsequent acquisition of additional competitors and, using its size and leverage in this market, tie up nearly eighty percent (80%) of the open staffing hospitals in the Denver MSA at which independent surgical anesthesia providers could compete for business.

174. USAP took steps to ensure that none of the remaining independent surgical anesthesia providers in the Denver MSA, or any new entrant into this market, could gain size and scale sufficient to compete for the exclusive hospital contracts that USAP controlled. In addition to its exclusive contracts, USAP enforced non-compete and non-solicitation clauses in its provider employment contracts.

175. This conduct has foreclosed a significant portion of the market for open staffing hospital inpatient surgical anesthesia in the Denver MSA.

176. The direct consequence of all of this conduct is that USAP has maintained health plan reimbursement rates between 30-40 percent (30-40%) higher than any other independent surgical anesthesia group in the Denver MSA.

177. USAP has left hospitals in the Denver MSA with literally no alternative to replace it, particularly in multi-hospital systems.

178. There is no valid procompetitive justification for USAP's monopoly conduct in the market for hospital inpatient surgical anesthesia in the Denver MSA.

179. Hospital inpatient surgical anesthesia is part of the trade and commerce in the State of Colorado and in the Denver MSA.

THIRD CLAIM FOR RELIEF
(C.R.S. §§ 6-4-104 and 105 – Exclusive Dealing)

180. Plaintiff re-alleges and incorporates by reference the allegations in paragraphs 1-179, above.

181. In 2020 USAP entered into a Professional and Administrative Services Agreement with Centura Health to become the exclusive hospital inpatient surgical anesthesia provider at all fourteen Centura hospitals in Colorado, including seven in the Denver MSA. These hospitals accounted for thirty-three percent (33%) of the open staffing hospitals in the Denver MSA at which independent surgical anesthesia providers could practice. Those hospitals today perform approximately thirty-three percent (33%) of the inpatient surgeries among all open staffing hospitals in the Denver MSA.

182. In order to finalize that statewide contract, USAP acquired competing surgical anesthesia practice groups working at most of these hospitals.

183. In 2021 USAP finalized a system-wide Professional Services Agreement with HCA to become the exclusive hospital inpatient surgical anesthesia provider at seven if the eight HCA hospitals in the Denver MSA. These hospitals accounted for thirty-eight percent (38%) of the hospitals in the Denver MSA at which independent surgical anesthesia service providers could practice. Those

hospitals today perform forty-seven percent (47%) of the inpatient surgeries among those open staffing hospitals in the Denver MSA.

184. In total, these two exclusive contracts gave USAP exclusive control of over seventy percent (70%) of the open staffing hospitals in the Denver MSA at which independent surgical anesthesia groups could practice and exclusive rights to provide surgical anesthesia services for eighty percent (80%) of the inpatient surgeries performed at these hospitals in 2022.

185. In sum, highly trained and equally skilled surgical anesthesia providers living and working in the Denver MSA were foreclosed by the actions of USAP from assisting with eighty percent of the surgeries performed on an inpatient basis in the Denver MSA. This included former USAP clinicians bound by non-compete and non-solicitation clauses.

186. USAP's exclusive hospital contracts typically had a term of five (5) years, and some extended beyond that by automatically renewing for one-year each year until termination. Even though terminable without cause upon 180 day notice, these exclusive hospital contracts were "sticky" because replacing one surgical anesthesia group with another was expensive and potentially interfered with a hospital's critical need for continuity of care for its patients.

187. While these contracts contained provisions allowing for termination for cause and, in more recent amendments, terminations upon notice without cause, the fact is that these agreements were even "stickier" because of USAP's dominance in the Denver MSA. These hospitals literally were left with no alternatives to replace USAP.

188. In addition to foreclosing a substantial portion of the market for open staffing hospital inpatient surgical anesthesia in the Denver, USAP's exclusive contracts furthered its leverage with commercial and employer-funded health plans in its largely successful effort to keep its anesthesiology reimbursement rates between thirty and forty percent (30-40%) higher than its competitors in the Denver MSA.

FOURTH CLAIM FOR RELIEF
(C.R.S. § 6-4-112(1) – Unfair methods of competition)

189. Plaintiff re-alleges and incorporates by reference the allegations in paragraphs 1-188, above.

190. Section 6-4-112(1) of the Colorado State Antitrust Act of 2023 authorizes the Colorado Attorney General to bring an action to prevent or restrain any unfair methods of competition in or affecting commerce.

191. The provision of hospital inpatient surgical anesthesia affects commerce in the Denver MSA.

192. Hospitals look to competing surgical anesthesia providers in the Denver MSA to meet the totality of their inpatient surgical anesthesia needs. While most hospitals in the Denver MSA previously had open staffing models where competing surgical anesthesia providers could compete for business, USAP was able to convert most of those hospitals to exclusive anesthesia contracts that foreclosed its competitors from practicing in those facilities.

193. Among the steps undertaken by USAP were, first, promises to dramatically reduce or eliminate any hospital subsidies, including those paid to reimburse surgical anesthesia providers for 24/7 coverage obligations or to reimburse for government insured, underinsured, and uninsured patients. Smaller surgical anesthesia providers dependent on such subsidies simply could not compete with USAP under those conditions.

194. Second, USAP was able to take advantage of hospital termination of incumbent surgical anesthesia providers, in order to convince competing surgical anesthesia providers to be acquired by USAP.

195. Third, USAP utilized and enforced non-compete and non-solicitation clauses in its employment contracts to foreclose virtually the entire Denver MSA open staffing hospital inpatient surgical anesthesia market from employees departing USAP.

196. USAP, through its conduct, created and maintained a monopoly for open staffing hospital inpatient surgical anesthesia in the Denver MSA to the detriment of commercial and self-funded health plans forced to pay above-market reimbursement rates despite numerous efforts to bring USAP's rates in line with its competitors.

197. USAP, through its conduct, created and maintained a monopoly for hospital inpatient surgical anesthesia in the Denver MSA to the detriment of hospitals, which were left with no options in the Denver MSA to replace USAP.

198. USAP's conduct interfered with competitive conditions for hospital inpatient surgical anesthesia services and deprived the Denver MSA of a competitive market for such services. The effect of this conduct was to raise the cost of surgical anesthesia to health plans, and eliminate the ability of hospitals to retain either supplemental or alternative surgical anesthesia providers to meet their demands for increased surgical revenues in the aftermath of the COVID pandemic.

199. The conduct alleged in this complaint, separately and in the aggregate, is an unfair method of competition.

FIFTH CLAIM FOR RELIEF

(C.R.S. § 8-2-113 -- Violation of Colorado Non-Compete Statute)

200. Plaintiff re-alleges and incorporates by reference the allegations in paragraphs 1-199, above.

201. Under C.R.S. § 8-2-113(8)(b), the Colorado Attorney General is authorized to bring an action for injunctive relief and penalties of five thousand dollars ($5,000) per worker or prospective worker subject to a covenant not to compete that is void under Colorado law.

202. The public policy of the State of Colorado, expressed through § 8-2-113(2)(a), is that "any covenant not to compete that restricts the right of any person to receive compensation for performance of labor for any employer is void." That is equally true for any covenant not to compete contained in an employment agreement between physicians, where such covenant restricts the right of a physician to practice medicine. C.R.S. § 8-2-113(5).

203. Colorado law only allows a physician non-compete agreement to allow the payment of damages "in an amount that it reasonably related to the injury suffered by reason of termination of the agreement [which] may include damages related to competition."

204. In interpreting non-compete agreements in those few areas in which they are permissible, courts generally require that such agreements be reasonable in scope and geography.

205. First, non-compete provisions contained in employment agreements with non-physician employees of USAP are void, without exception. This includes CRNA employment agreements, which included a two-year prohibition against working at any "facility" within a five mile radius of a USAP facility.

206. Legacy non-compete provisions in physician employment contracts entered into before 2019, with a prohibition against practicing for a period of two years following employment in any facility within a fifteen-mile radius of any USAP facility effectively prohibited those former physicians from practicing medicine in the entire Denver MSA and are void for that reason.

207. Further, those employment agreements entitled USAP to recover "liquidated damages" equal to three times its actual losses due to termination in violation of Colorado law, which prohibits such liquidated damages provisions.

208. Finally, both legacy and current non-compete agreements prohibited ex-employees from working at hospitals that USAP has never serviced, no longer services, or that USAP was at most engaged in active negotiations to service. Because USAP cannot have suffered any damages, competitive or otherwise, from a

former employee seeking work at such facilities, those provisions likewise violate Colorado law and are void.

209. USAP's non-solicitation clauses in employment contracts are also in violation of Colorado law. Section 8-2-113(2)(d) allows only very narrow non-solicitation clauses and then only to the extent "reasonably necessary to protect the employer's legitimate interest in protecting trade secrets."

210. USAP's non-solicitation clauses make no mention of trade secrets and allow for the recovery of damages wholly unrelated to the protection of USAP's legitimate trade secrets. Instead, they are designed solely to punish former employees who solicit work from facilities, surgeons, and patients who may also have been served by USAP.

PRAYER FOR RELIEF

Section 6-4-112 authorizes the Colorado Attorney General to bring an action to prevent or restrain violations of the Colorado State Antitrust Act. Section 6-4-113 authorizes the Attorney General to seek civil penalties for any violation of the Act. Therefore, the Colorado Attorney General requests that this Court enter final judgment against USAP declaring, ordering, and adjudging:

A. Find and declare that USAP's course of conduct violates sections 6-4-104, 105, and 107 of the Antitrust Act, and constitutes an unfair method of competition under section 6-4-112(a) of the Antitrust Act;

B. Declare that any non-compete clause in any employment contract is null and void, and award the Attorney General penalties equal to $5,000 per USAP employee affected by such illegal non-compete clauses;

C. Permanently enjoined USAP from engaging in similar and related conduct in the future;

D. Award the Attorney General his reasonable costs and attorney fees, including investigative costs, and expert witness fees, as provided in § 6-4-112(5).

E. Grant other such equitable relief, including but not limited to any other structural relief, as the Court finds necessary to redress and prevent recurrence of USAP's violations of the Antitrust Act, as alleged herein.

Dated: February 26, 2024.

Respectfully Submitted,

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