Via E-Mail

June 8, 2022

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Supervising Deputy Attorney General
State of California
455 Golden Gate Ave., 11th Floor
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Re: Competition Conditions Relating to Proposed Affiliation Between Madera Community Hospital and Saint Agnes Medical Center

Dear Emilio,

Thank you for previewing the competitive impact conditions that the staff is considering recommending in connection with the proposed affiliation between Madera Community Hospital ("MCH"), Saint Agnes Medical Center ("Saint Agnes"), and Trinity Health Corporation ("Trinity"). We appreciate the analysis you have performed and have studied the competition conditions implemented in past approvals of hospital affiliations.

We want to make sure you are aware of certain information underlying the viability of MCH and that affects the ability of Saint Agnes and Trinity to make the type of commitments needed to rescue MCH and preserve the hospital and its rural health clinics, which are essential health care resources for the Madera and Central Valley communities, particularly for poor and underinsured people in the area. We know you are aware of the deteriorating financial condition of MCH, but want to provide additional insights into the underlying causes of MCH's financial distress and the steps we believe are needed to correct course.

I. The Problems Facing Madera Community Hospital

MCH has been a provider of community healthcare in the Central Valley for over 50 years. MCH operates a 106-bed adult acute care facility in Madera, California, as well as rural health clinics and outpatient services in Chowchilla, Madera, and Mendota, California. MCH provides essential services to some of the Central Valley's most vulnerable, serving a disproportionately large number of low-income patients (approximately 56% of MCH's patients are Medi-Cal patients).

As you know, MCH faces very serious financial problems. In fact, based on our most recent review of its current financial situation, MCH is in imminent danger of financial failure. (Saint Agnes has recently extended a line of credit intended to help permit continued operations until

closing of the proposed transaction.) MCH's weakened finances not only risk its closure but also jeopardize its ability to continue to provide quality care to local residents (especially the poor and underserved who critically depend on it). For example, you might not be aware that the hospital is utilizing a 20 year old nuclear medicine camera. There are very old monitors used in the surgery department, most of the hospital's air handlers are 50 years old, and MCH operates a rural health clinic in a trailer which is at the end of its lifespan. The parking lots are in poor condition, and there are significant issues with other essential infrastructure.

We are informed these resource shortages have also interfered with MCH's ability to recruit physicians. [redacted] MCH has been unable to attract new physicians in part because it has no money to provide income guarantees, and it lacks the numbers of physicians needed to set up a medical foundation. It is unable to attract new obstetricians in particular because it cannot afford a laborist program.

Of course, Trinity has agreed to a significant capital commitment to improve MCH. But that alone will not solve the hospital's problems. [redacted]

[redacted]

II. MCH Will Not Be Able to Negotiate Adequate Rates on Its Own

We have learned that the most important cause of these serious difficulties arises from MCH's extremely poor payor mix and the extraordinarily low rates it has received from managed care plans. MCH is virtually unique in the simultaneous combination of low rates and low commercial volume which it faces. *See* Exhibit 1, a "scatter diagram" which shows that MCH is very near the bottom among all California hospitals when considering both payor mix and rates. MCH's commercial payor mix puts it at the 22nd percentile among California's hospitals (in contrast, its percentage of Medi-Cal is at the 89th percentile). Its commercial rates, according to RAND, are at the 4th percentile nationally and 6th percentile in California for 2018 to 2020. According to OSHPD (HCAI) data, it is between the 18th and 33rd percentile in California for 2002 to 2019.[2]

These problems are both a cause of, and result from, MCH's unusually poor bargaining position. As a hospital with an extremely low percentage of commercially insured patients, MCH is simply not important to commercial payors, and therefore is unable to negotiate a competitive rate with those payors. MCH's extremely limited complement of services also makes it unattractive to commercial payors. For example, we have learned that MCH offers no interventional cardiology, inpatient cancer services, robotic surgery, electrophysiology, neurology, neurosurgery, urology, cardiac surgery, inpatient rheumatology, dermatology, occupational medicine, or infusion for cancer care. The absence of these services makes MCH less important to patients, and therefore less important to payors.

We have found that this weakness is also reflected in patient preference data. More than 70% of commercially insured inpatients migrate out of Madera County for hospital care, and more than 80% from the city of Madera. For these reasons, managed care plans do not face significant

[2] Based on a measure of dollars per adjusted discharge, MCH ranks at the 18th percentile. Based on a measure of percentage of Medicare, MCH ranks at the 33rd percentile.

risks if MCH is not in their networks. They can therefore refuse to pay MCH rates which would allow its viability.

III. Rescuing MCH Requires Coordinated Efforts to Increase Commercial Rates and Cases

For these reasons, any turnaround plan for MCH would necessarily include a plan to rapidly and substantially increase the rates that MCH is paid by managed care plans. But we believe that the competitive impact conditions being considered by the staff would prevent such a turnaround in this unusual case.

We know that the staff has recommended, and the Attorney General has obtained, restrictions on "all or nothing" contracting and bundling in a number of consent judgments relating to hospital mergers. We agree that these kinds of restrictions can under some circumstances prevent anticompetitive tying. But in this unusual case, we believe that such restrictions (if not modified) would prevent MCH from achieving viability, and would also create disincentives against important efficiencies that would benefit managed care plans and consumers.

The core of the problem is that MCH does not have the ability to negotiate competitive rates on its own. As described above, its status as a small hospital in a rural county with very limited services and a very limited ability to attract patients with choices makes it highly unlikely that MCH on its own would ever be able to negotiate competitive rates.

MCH faces a "double whammy" from its low commercial volume on top of its low rates. Because of its extremely poor payor mix, and the losses that it suffers from government payment, it faces a far greater need than most hospitals for higher than normal commercial rates that can provide it with a reasonable margin to offset these losses. But it cannot even negotiate normal competitive rates.

These problems are even greater given the Attorney General's goals here. In a competitive, unregulated market, a small, rural hospital with a poor payor mix like MCH could not continue to provide the range of services the Attorney General wishes to preserve and which Trinity is willing to maintain. But to restrict MCH's ability to obtain higher rates while requiring MCH to maintain uncompetitive services makes no financial sense. In order to achieve the state's policy goals, which are shared by Trinity, the combined Trinity and Saint Agnes need to be able to pool their resources to attempt to improve MCH's rates in order to pay for these uncompetitive services and benefit the people of Madera and the Central Valley.

The only solution to these problems is to allow Trinity to negotiate jointly on behalf of Saint Agnes and MCH. Under those circumstances, Trinity can offer bundled rates that may be more attractive to payors than separate rates for the two hospitals.

As you know, it is well established in the economic and antitrust literature that bundling is most often procompetitive. See e.g. *Cascade Health v. PeaceHealth*, 515 F.3d 883 (9th Cir. 2007). That is true even without the unusual competitive conditions here that make it likely that, absent bundling, MCH would receive sub-competitive rates, under circumstances which require that it obtains higher than competitive rates in order to meet the social needs the Attorney General seeks to satisfy in Madera County. "Bundled pricing" makes particular sense here, where Saint Agnes is considering moving services from Saint Agnes to MCH. In this case, the "bundling" would likely involve efforts to persuade payors to provide higher rates at MCH by linking those higher rates to lower rates at Saint Agnes than would otherwise be provided. It would not be economically sensible to negotiate rates entirely separately when services are not being provided entirely separately.

At the extreme, such "bundled" negotiations could involve a requirement that the sufficient rates be paid to MCH as a condition to the payor obtaining a contract with Saint Agnes. While this is certainly not Trinity's plan, and such conditions would never be demanded at the beginning of a negotiation, it is inevitable in managed care contracting that all negotiations are affected by the ability of one party to walk away. As is well established in the bargaining literature, without that ability, there is ultimately no incentive for the other party to make concessions. Therefore, in order to make joint contracting between Saint Agnes and MCH successful, Saint Agnes and Trinity would need to consider (and, if need be, threaten or impose) termination at both Saint Agnes and MCH if a satisfactory result could not be attained. If the state prohibited Saint Agnes from walking away in these situations, payors would enter these negotiations knowing that Saint Agnes was effectively "disarmed" in the event that it could not obtain the rates that were necessary for MCH's viability. This could make it impossible for Saint Agnes to effectively negotiate sufficient rates for MCH and could doom MCH to subcompetitive rates.

This is certainly not the kind of situation where anticompetitive tying is a risk. That is true, first, because Saint Agnes is hardly a dominant hospital. It possesses significantly less volume than the two Community hospitals, and has less than 19% of commercial discharges in Fresno and Madera Counties (less than 25% even ignoring Kaiser's volume). Therefore, it is not in a position to force an anticompetitive result here. Moreover, the potential harm from tying, anticompetitive effects in the tied product market (here, Madera County), is not a concern. Higher prices at MCH are precisely what is needed in order to allow it to maintain its services to the community, particularly to Medi-Cal and indigent patients.

In order to assure that any bundling that occurs will not create a risk of anticompetitive results, we would be willing to accept a prohibition against new "all or nothing" contracting if, and only after, MCH was able to reach a stage where it could remain viable without the aid of such contracting. We believe that such a prohibition should be put into place only after MCH was able to operate in a self-sustaining way for two consecutive years.

Hospitals need to obtain a margin of at least 3% in order to fund their capital expenditures and keep up with changes in technology. Harrison, M. G., & Montalvo, C. C. (2002). The financial health of California hospitals: a looming crisis. *Health Affairs, 21*(1), 118-126, at 120 ("Although generalizing about 'healthy' levels of operating margin may be misleading in some circumstances, an industry 'rule of thumb' is that an operating margin of 3–5 percent is considered 'healthy.'"). Therefore, we believe a prohibition on bundling would be reasonable after MCH had attained a 3% margin for two consecutive years.

Moreover, price caps ensure that prices are appropriate, even during a time when the parties' conduct is not restricted. Our thoughts on appropriate price caps follow.

IV. The Proposed Price Caps are Too Low to Make MCH Viable

A. Proposed Price Cap of 150% of Medicare for Out-of-Network Emergency Services

We understand that you do not contemplate a formal cap on commercial rates, but the cap of 150% of Medicare for out-of-network emergency services for commercially insured patients is effectively a cap on commercial rates at that (or more likely a lower) level. If a managed care plan is not required to pay more than 150% out of network even without a contract, it loses any incentive to reach a contract with MCH at a higher or even comparable rate, since if a contract is not completed, the payor will have to pay 150% of Medicare for fewer patients on an out of network basis. This is especially true because MCH is particularly vulnerable to any losses resulting from payor termination.

The contemplated out of network cap would prevent MCH from obtaining reasonably competitive rates, let alone the higher rates it would need to maintain or improve its operations. Our analysis of the most recent data on this issue reveals that 150% is well below the national and statewide averages for commercial in-network rates (and only slightly higher than MCH's current rate of 133% according to RAND). The RAND data show averages of 247% nationally and 258% for California for 2018-2020. OSHPD (now HCAI) data shows a statewide average of 209% for California for 2019.

Moreover, these historical numbers are undoubtedly at too low a level at which to limit rates in the *future*. In particular, the very recent shortages of nurses and other medical personnel, and the resulting rocketing wage rates, mean that managed care rates are certain to increase in the future. Given Medicare's budget constraints, this is highly likely to result in managed care rates at a higher percentage of Medicare in the future.

We do not oppose a cap on out of network commercial rates (and such a cap would provide protection against the possibility of anticompetitive abuses from the use of bundling or "all or nothing" contracting). But the cap ought to be no lower than 275% of Medicare (as you have

agreed to in your Kaiser/Providence and USC/Methodist conditional approvals). This would provide incentives for an in-network rate that is comparable to the averages discussed above.

B. Proposed Price Cap of 110% of Medi-Cal FFS

We believe a cap of 110% of Medi-Cal FFS for Medi-Cal MCO business is also too low, given what we have discovered regarding MCH's unusual and severe financial and operational problems. While that rate is not below statewide averages, given MCH's extraordinary difficulties and its unusual reliance on Medi-Cal (it is at the 89th percentile among California hospitals in its percentage of Medi-Cal patients), it needs the ability to negotiate a higher rate in order to achieve the state's goals. Additionally, given increasing costs, these rates are also highly likely to increase substantially in the future. We believe that that cap ought to be at least 150% of Medi-Cal FFS.

C. Duration of Proposed Price Caps

Finally, we understand you have not yet settled on a duration for the proposed price caps. We propose restricting the prohibitions to a five year period (as you agreed to in the Cedars-Sinai/Huntington affiliation). We believe that health care markets and government financing are changing far too rapidly for conditions to be imposed over a longer period of time without a high risk of unintended effects.

We are enclosing the competitive impact conditions that we believe are appropriate in light of the foregoing concerns.

We are of course happy to discuss these issues with you further.

In accordance with Title 11, Chapter 15, Section 999.5(c)(3) of the California Code of Regulations, we write to request that Section I to this letter be kept confidential and out of the public record.

The information in Section I contains competitively sensitive information regarding confidential business plans, MCH's financial condition, and other sensitive business information that if released, would put MCH and Saint Agnes at a competitive disadvantage in the market. Moreover, publicizing it could affect the parties' business relationships and public confidence. Accordingly, we believe the need for the parties to keep the information confidential outweighs any public interest in seeing them.

Thank you very much.

Very truly yours,

HONIGMAN LLP

/s/David A. Ettinger
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DAVIS WRIGHT TREMAINE LLP

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