Supplemental Report and Recommended Conditions
Madera Community Hospital

Contents

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Background

This supplemental report incorporates additional information and recommended conditions based on new information provided as part of the review process relative to the Competitive Impact Assessment.[1] At the same time, my conclusions and proposed conditions in the Health Care Impact Assessment remain largely unchanged. My initial Health Impact analysis found that Madera Community Hospital is an essential component of the local health care delivery system to ensure access to needed health care services for Madera County residents. That is still the case. And this finding supports the conditions I propose here to minimize any negative and/or adverse health care impacts that might result from the transaction related to any potential closure or reduction in essential services (e.g., ER or OB/GYN) or related to both inpatient and outpatient services provided for the initial five years post transaction. Specifically, this supplemental report modifies the Conditions 1 and 2 (of 17) of the proposed Health Care Impact conditions. The remaining Health Care Impact conditions remain unchanged, but their terms may be adjusted in accordance with the notification procedures for substantial changes in services and/or capacity proposed in this supplemental report.[2]

The Parties

The proposed transaction involves Madera Community Hospital and St. Agnes Medical Center. St. Agnes Medical Center is located in Fresno County and is part of Trinity Health, a large national health care system, headquartered in Michigan. Under the transaction as now noticed, St. Agnes Medical Center, as part of Trinity Health, will execute a formal affiliation agreement with Madera Community Hospital whereby Madera Community Hospital will be operated by and under the control of St. Agnes Medical Center and Trinity Health. For all intents and purposes, the affiliation agreement can be considered to have the same meaning as Madera Community Hospital being acquired by St. Agnes Medical Center and Trinity Health and/or also

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[1] See Appendix for List of Supplemental Information and Documents.

[2] The original Health Impact conditions required St. Agnes Medical Center/Trinity Health to meet their promised financial commitments to Madera Community Hospital. At the time, however, it appeared that those commitments were in the form of transfers of funds without conditions. Now, it is clear that those commitments involve the extension of intra-system loans to Madera Community Hospital on the same terms and conditions as are made available to any hospital in the Trinity Health system and which terms and conditions were set out in the materials provided with the notice and application. I recommend those conditions to allow for the promised financial commitments to be made in the form of the promised intra-system loans on the terms and conditions set out in those materials, with an independent Monitor empowered to review those commitments to ensure that they are being made.

as a merger of the two hospitals, Madera Community Hospital and St. Agnes Medical Center. For purposes of this report, the transaction will be referred to as either an acquisition or a merger event.

St. Agnes Medical Center is a large General Acute Care hospital with a wide range of acute and other services and is located in neighboring Fresno County (approximately 22 miles from Madera Community Hospital). St. Agnes Medical Center is part of a large national health system (Trinity Health) headquartered outside of California (in Michigan). While it is more financially stable than Madera Community Hospital, the acquisition of what is essentially a small rural hospital locally governed by members of the community underscores the need to carefully consider the competitive, community, and equity impacts of the proposed transaction.[3] Research on transactions where the acquired hospital had been locally governed, but post-transaction is governed by a multi-hospital system headquartered outside of the community, raises concerns that the acquiring system lacks familiarity with local health care needs and market factors, increases administrative burdens, and delays timely operations (e.g., hiring, credentialing, etc.).

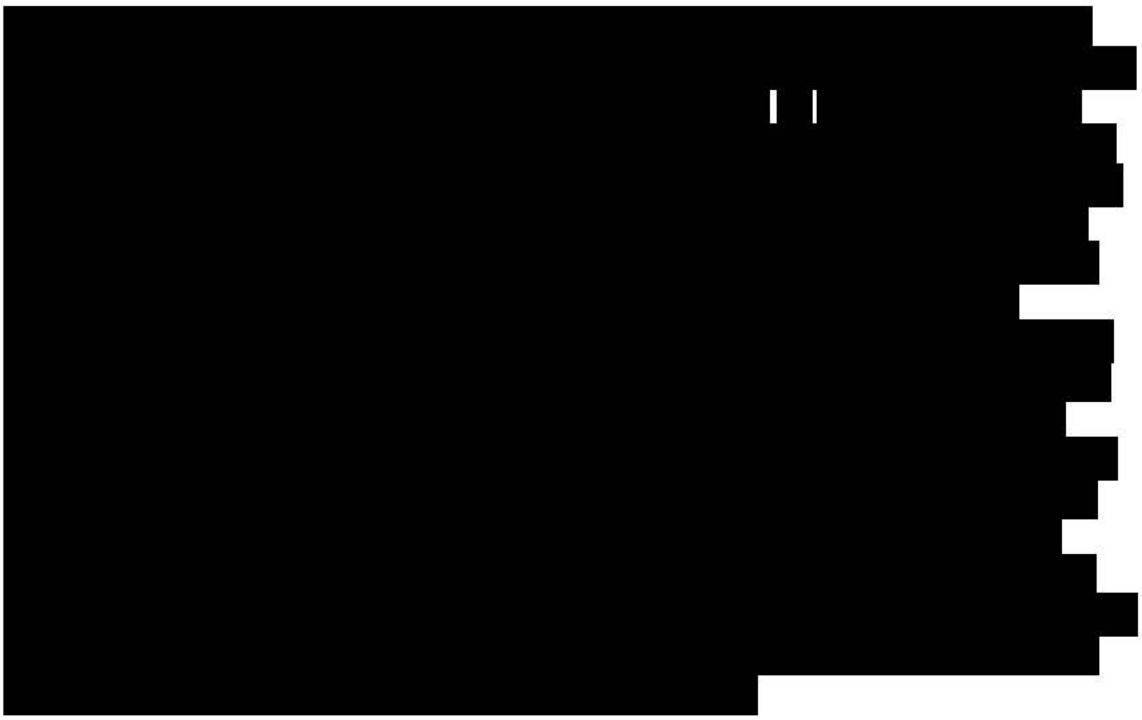
Supplemental Information: Madera Community Hospital Will Fail If the Transaction is Not Approved with Fewer Conditions Reflecting Its Status as a Failing Firm

Subsequent to the initial analysis and development of proposed conditions related to the proposed transaction, Madera Community Hospital ("Madera") and St. Agnes Medical Center/ Trinity Health have provided additional financial and other pertinent information as part of the formal notice and application process. Most important, Madera has provided information relevant to it being considered a failing firm for antitrust purposes. [redacted] An additional round of interviews was conducted with the payors, and other third parties, as set out in the Appendix. All of this new information, reported as part of the formal notice and application process, warrants adjustments to the conditions initially proposed in the Assessment of the Effects of the Proposed Acquisition of Madera by St. Agnes Medical Center. These revised conditions are set out in this supplemental report.

[3] Per Madera Community Hospital Community Benefits Report (June 2020), the hospital is governed by a Board of Trustees that includes 21 members comprised of community members and local physicians. https://www.maderahospital.org.

Proposed Affiliation Agreement – Madera and Trinity Health

First, Madera provided supplemental information regarding their decision to seek approval of an Affiliation Agreement with St. Agnes Medical Center/Trinity Health, including the following:



I have analyzed the information provided as part of the notice, application, and materials relating to this statement.

Competitive Concerns and Initial Proposed Conditions Related to Transaction

Under the proposed transaction, St. Agnes Medical Center and Trinity Health system will gain control of all operational processes and decisions including contracting with third party payors. The proposed transaction and initial set of proposed conditions allowed for the possibility that Madera could benefit from the negotiating and contracting expertise that St. Agnes Medical Center and Trinity Health system could bring to bear. At the same time, the initial set of proposed conditions recognized that the proposed transaction generates significant anti-competitive and market power concerns as the two merging hospitals are direct competitors.[4] The proposed initial conditions were designed to limit the ability of the merging hospitals to exploit their increased market power, mainly by limiting various forms of anti-competitive negotiating behavior, while at the same time allowing for prices adjustments, post transaction.

[4] Summary of Initial Competitive Analysis and Initial Proposed Conditions included in Appendix.

At that time, the parties had not raised the failing firm defense nor submitted evidence that supported it.

US Department of Justice in their Horizontal Merger Guidelines: Failing Firm

The failing firm argument allows for an otherwise anti-competitive transaction, when one of the parties is a financially distressed firm. The basic argument is that harm to competition will ensue regardless of the transaction (competition will be reduced in either case) while allowing it provides a preferable alternative, maintaining commercial activity and protecting employment and access to needed health care services. This argument, generally referred to as the "failing firm defense," had been formally adopted by the US Department of Justice in their Horizontal Merger Guidelines[5] (Section 11), as follows:

> Notwithstanding the analysis above, a merger is not likely to enhance market power if imminent failure, as defined below, of one of the merging firms would cause the assets of that firm to exit the relevant market. This is an extreme instance of the more general circumstance in which the competitive significance of one of the merging firms is declining: the projected market share and significance of the exiting firm is zero. If the relevant assets would otherwise exit the market, customers are not worse off after the merger than they would have been had the merger been enjoined.
>
> The Agencies do not normally credit claims that the assets of the failing firm would exit the relevant market unless all of the following circumstances are met: (1) the allegedly failing firm would be unable to meet its financial obligations in the near future; (2) it would not be able to reorganize successfully under Chapter 11 of the Bankruptcy Act; and (3) it has made unsuccessful good-faith efforts to elicit reasonable alternative offers that would keep its tangible and intangible assets in the relevant market and pose a less severe danger to competition than does the proposed merger.
>
> Similarly, a merger is unlikely to cause competitive harm if the risks to competition arise from the acquisition of a failing division. The Agencies do not normally credit claims that the assets of a division would exit the relevant market in the near future unless both of the following conditions are met: (1) applying cost allocation rules that reflect true economic costs, the division has a persistently negative cash flow on an operating basis, and such negative cash flow is not economically justified for the firm by benefits such as added sales in complementary markets or enhanced customer goodwill; and (2) the owner of the failing division has made unsuccessful good-faith efforts to elicit reasonable alternative offers that would keep its tangible and intangible assets in the

[5] https://www.justice.gov/atr/horizontal-merger-guidelines-08192010#11. While I recognize that the federal antitrust authorities are reconsidering the Merger Guidelines, I have no reason to believe that they are reconsidering that defense.

relevant market and pose a less severe danger to competition than does the proposed acquisition.

[redacted] I am comfortable with the application of that defense to this setting based on economic principles.

Madera has now submitted additional information to support the claim that the failing firm framework should be applied to this transaction. Application of this framework to this transaction would not only allow for the consummation of what is otherwise an anticompetitive horizontal merger but also would further relax my recommended competitive impact remedies and conditions that in whole, or in part, would require the acquired asset to operate separately (e.g., the anti-conditioning/anti-bundling conditions), as an alternative to blocking the transaction altogether based on the negative horizontal impact on competition.

Madera's Search for Potential Transferees

Second, Madera provided supplemental information, which I reviewed regarding their search for transferees and/or alternative partners. That information is summarized by Madera as follows:

[redacted]

Under the proposed transaction, St. Agnes Medical Center and Trinity Health system will gain control of all operational processes and decisions including contracting with third party payors. Research has shown small and or rural hospitals prices rise following affiliation and/or mergers with larger hospitals and health systems[7]. This research supports the finding that smaller, rural hospitals can benefit from the third party contracting and negotiating expertise and experience of larger hospitals and/or systems to achieve prices that are higher and closer to market prices.

[6] [redacted]

[7] See my Initial Report for detailed literature references and citations.

Further research indicates that allowing bundled contracting of potential competitors in a concentrated market can result in prices that are higher than if providers negotiate separately.

Madera, in fact, states the following in a recent filing:

> MCH is not in a position by itself to negotiate significantly higher rates from any payors. Its current low, inadequate rates are a function of its many weaknesses as described in our initial letter. Joint negotiations will very likely be necessary to provide MCH with viable rates.... We believe that without the ability to engage in joint contracting, and without higher caps, there is simply too great a risk that Trinity will be unable to effect a successful turnaround at MCH. Such a failure would jeopardize the financial viability not only of MCH, but of Saint Agnes. It would therefore in turn jeopardize the care provided to patients throughout the Fresno and Madera areas.
>
> As we have discussed, we do not believe that MCH (given its missing services and limited appeal to commercial patients) will have the bargaining power to obtain high enough rates to make a turnaround successful...The fact is that rates will have to increase *dramatically* in order to make MCH successful. We believe this is very unlikely without the ability of Saint Agnes and MCH to jointly contract. MCH is not in a position by itself to negotiate significantly higher rates from any payors. Its current low, inadequate rates are a function of its many weaknesses as described in our initial letter. Joint negotiations will very likely be necessary to provide MCH with viable rates.

St. Agnes Medical Center/Trinity Health "Turnaround" Plan for Madera

Third, St. Agnes Medical Center/Trinity Health have provided a "turnaround plan" for stabilizing the financial condition of Madera. [redacted] A more detailed list of turnaround interventions is included in the Appendix. The Table below summarizes their plan. [redacted]

Summary of Turnaround Plan Interventions

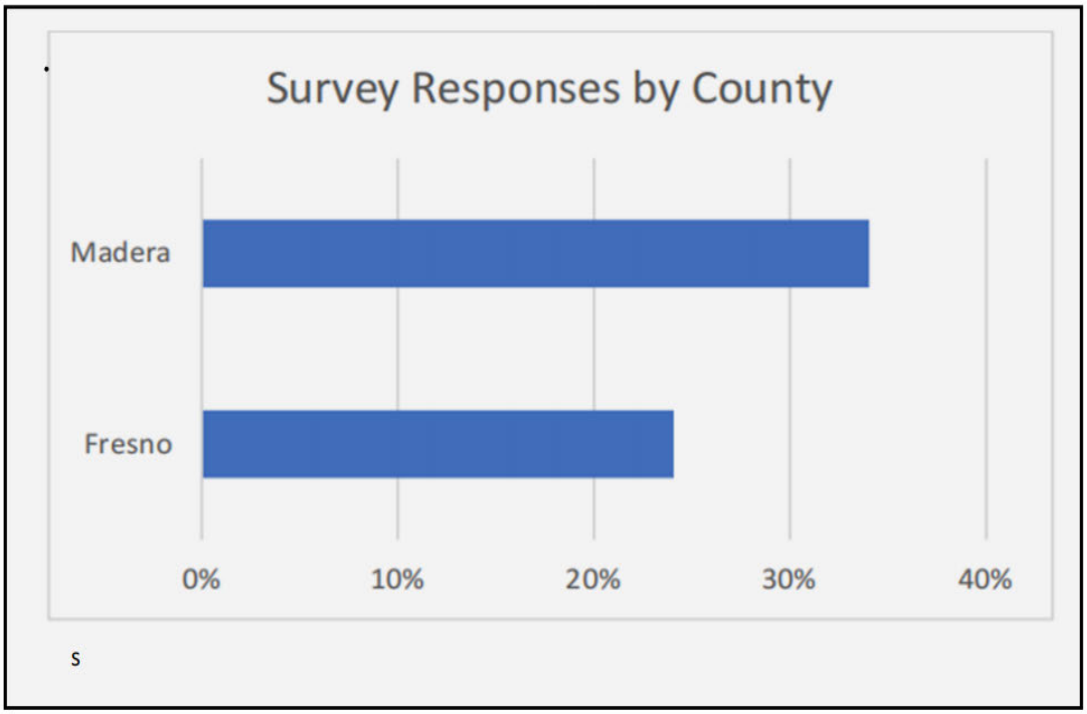
[redacted]			
[redacted]			
[redacted]			
[redacted]			

Several of the proposed efficiency and other improvements reflect the geographic proximity of St. Agnes Medical Center and Madera as well as their existing overlapping services areas (which contributes to the increase in concentration for the proposed transaction). The summary, below, of St. Agnes Medical Center's planning documents, including their Community Health Needs Assessment reports, documents this geographic overlap and that St. Agnes Medical Center considers Madera County residents as part of their current and historical geographic service area. This historical and geographic overlap contributes to the feasibility and likelihood of the proposed turnaround interventions.

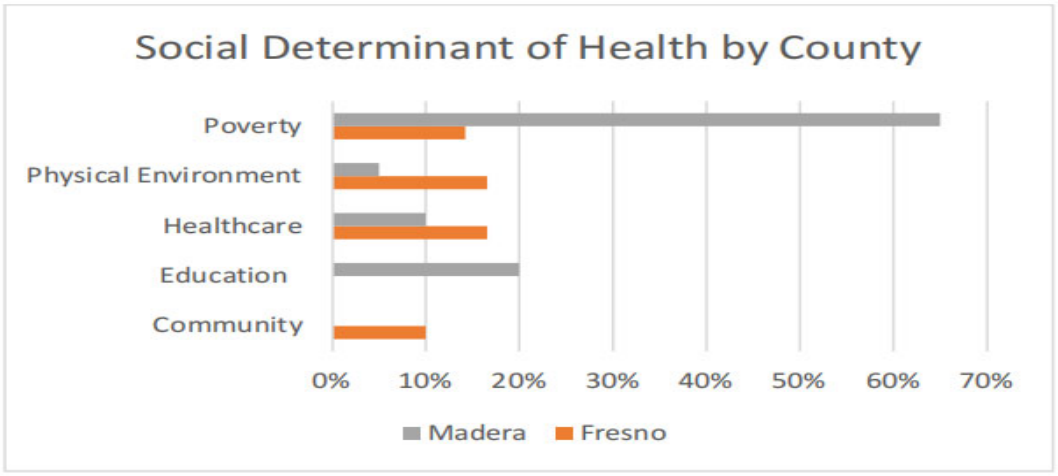
St. Agnes Medical Center Defines the Community It Serves to Include Fresno and Madera Counties

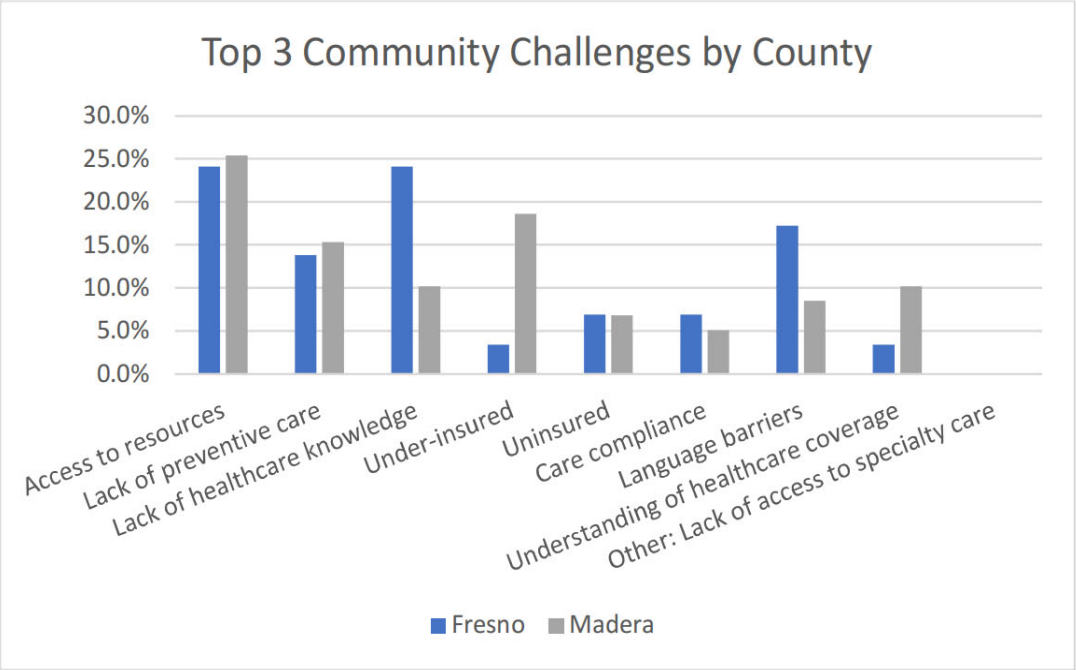
Fourth, in my analysis and recommendations in this supplemental report, including the extent to which I recognized the failing firm defense as well as addressing issues regarding requiring the continued operation of Madera and its rural health clinics, I also considered St. Agnes Medical Center's own consideration of the community health needs, including its focus on the scope of the geographies it serves that includes both Madera and Fresno counties. As St. Agnes Medical Center states:

> The Community Health Needs Assessment (CHNA) represents the commitment of Saint Agnes and Fresno Surgical to improve health outcomes in the community we serve through rigorous assessment of health status in our service area. Our goal with this CHNA was not only to fulfill a legal requirement, but to also to partner for improved outcomes.
>
> For the purposes of this Community Health Needs Assessment, Saint Agnes and Fresno Surgical Hospitals used a geographic approach focusing on the area from which most patients come for care. This area includes Fresno and Madera. By defining the geographic area and population, we were diligent to ensure that no groups, especially minority, low-income, or medically under-served, were excluded from the assessment process or data collection. The Central Valley Health Policy Institute (CVHPI) was engaged to conduct the qualitative and quantitative data analysis and provide a list of significant health needs for Fresno and Madera Counties. Between October and December 2021, community-wide surveys were collected in Fresno and Madera counties. Sample findings are provided below. As can be seen, data were collected covering both Madera and Fresno Counties and the data show both unique and overlapping health system issues for the two counties within St. Agnes' self defined service area.


Survey Responses by County
Madera
Fresno
0%
10%
20%
30%
40%

s


Social Determinant of Health by County
Poverty
Physical Environment
Healthcare
Education
Community
0%
10%
20%
30%
40%
50%
60%
70%
Madera
Fresno



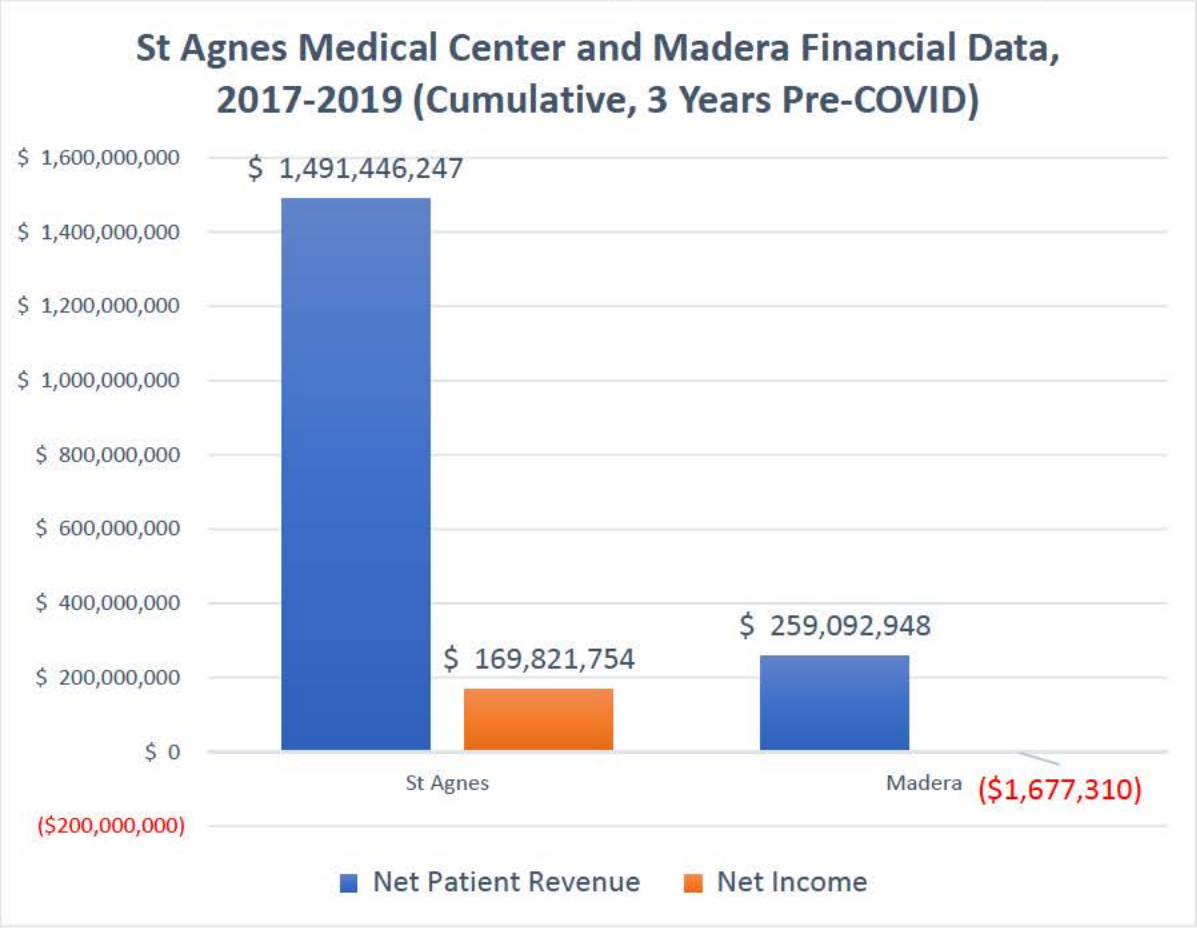
Problems in the Healthcare System that Impact Community Health

Financial Capacity of St. Agnes Medical Center and Trinity Health to Effect Turnaround

Fifth, the proposed transaction and planned turnaround plan, by their very nature, have some degree of uncertainty. For example, St. Agnes Medical Center provided the following supplemental information:

However, a review of financial data for St. Agnes Medical Center and Trinity Health documents their financial capacity to underwrite the proposed transaction and turnaround plan and to ensure the continued operation of Madera and its rural health clinics for a reasonable period of time. The Exhibit below shows the relative size and financial performance of St. Agnes Medical Center and Madera for the 3-year period prior to the COVID pandemic. As can be seen, St. Agnes Medical Center collected nearly $1.5 billion in net revenue, including $169.82 million in revenue in excess of expenses while during the same period Madera collected $259.09 million in net revenue and suffered a cumulative financial loss of $1.68 million.

Relative Size and Financial Performance of St. Agnes Medical Center and Madera, 2017-2019



Community Benefits Provided by Trinity Health

Trinity Health is one of the largest health care systems in the United States and one of the largest non-profit organizations in the United States. The Exhibits summarize data from Trinity Health demonstrating both their commitment to provide community benefits as well as their financial ability to support the proposed transaction, should the turnaround plan not achieve the forecasted results as quickly or effectively hoped for. As can be seen, Trinity Health provided in excess of $1 billion in broad community benefits and nearly that same level for the poor and underserved. And, per the St. Agnes Medical Center, CHNA Report, Madera residents likely fall within the poor and underserved category.

Trinity Health System Community Benefits, 2020 and 2019

The quantifiable costs of the Corporation's community benefit ministry for the years ended June 30 are as follows (in thousands):

	2020	2019
Ministry for those who are poor and underserved:		
Financial assistance	$ 207,123	$ 203,581
Unpaid cost of Medicaid and other public programs	724,831	586,161
Programs for those who are poor and the underserved:		
Community health improvement services	26,792	29,073
Subsidized health services	49,282	49,287
Financial contributions	18,975	19,675
Community building activities	1,565	2,130
Community benefit operations	6,393	5,976
Total programs for those who are poor and underserved	103,007	106,141
Ministry for those who are poor and underserved	1,034,961	895,883
Ministry for the broader community:		
Community health improvement services	14,735	13,223
Health professions education	189,591	168,132
Subsidized health services	57,439	45,039
Research	4,869	4,531
Financial contributions	27,160	28,321
Community building activities	1,449	1,639
Community benefit operations	4,940	3,889
Ministry for the broader community	300,183	264,774
Community benefit ministry	$ 1,335,144	$ 1,160,657

Trinity Health System Financial Status and Cash and Cash Equivalents, 2020 and 2019

Trinity Health, as one of the largest health systems in the U.S., has substantial financial reserves. The Table below summarizes data provided by Trinity Health as part of their routine report regarding their Cash and Cash Equivalents. As can be seen, Trinity Health is well positioned to provide needed financial support for the proposed transaction for an additional reasonable amount of time should the turnaround plan not achieve the hoped-for results on the planned timetable.

	2020	2019
Cash and cash equivalents	$ 2,191,598	$ 474,314
Restricted cash included in assets limited or restricted as to use - current portion		
Held by trust under bond indenture	11,578	11,415
Self insured benefit plans & other	64,720	54,670
By donors	4,698	5,798
Total restricted cash included in assets limited or restricted as to use - current portion	80,996	71,883
Restricted cash included in assets limited as to use - noncurrent portion		
Held by trust under bond indenture	6,676	5,845
Self insured benefit plans & other	27,761	27,485
By donors	32,350	26,343
Total restricted cash included in assets limited or restricted as to use - noncurrent portion	66,787	59,673
Total cash, cash equivalents, and restricted cash shown in the statements of cash flows	$ 2,339,381	$ 605,870

	2020	2019
Cash and cash equivalents	$ 2,191,598	$ 474,314
Restricted cash included in assets limited or restricted as to use - current portion		
Held by trust under bond indenture	11,578	11,415
Self insured benefit plans & other	64,720	54,670
By donors	4,698	5,798
Total restricted cash included in assets limited or restricted as to use - current portion	80,996	71,883
Restricted cash included in assets limited as to use - noncurrent portion		
Held by trust under bond indenture	6,676	5,845
Self insured benefit plans & other	27,761	27,485
By donors	32,350	26,343
Total restricted cash included in assets limited or restricted as to use - noncurrent portion	66,787	59,673
Total cash, cash equivalents, and restricted cash shown in the statements of cash flows	$ 2,339,381	$ 605,870

Application of Failing Firm Framework and Updated Conditions for Approval of the Proposed Transaction

The initial report included a set of proposed recommendations based on information available at that time. Madera has recently submitted additional information to support a new supplemental analysis of the transaction within a failing firm framework. The initial analysis and recommended competitive impact conditions did not consider this factor.

This supplemental report incorporates this additional information and concludes that the failing firm framework should be applied to this transaction and provides an updated set of proposed competitive impact conditions for approval of the transaction.

Updated Price Caps under Permitted Bundled Contracting

The additional information from Madera, as supported by additional information from St. Agnes Medical Center/Trinity Health and from the payors, supports removal of the limitation of the previously proposed bundled/all-or-nothing contracting restrictions. I had previously recommended those conditions as an alternative to blocking the transaction outright absent any consideration of a failing firm defense.

Removal of the limitation of bundled/all-or-none contracting will allow for the combined entities to coordinate their negotiations with payors, with price increases that may allow for Madera to raise its prices to the same level as St. Agnes Medical Center. However, research has shown that bundled/all-or-none contracting, especially in concentrated markets, can result in anticompetitive behavior and above existing market prices. Permitting this otherwise anticompetitive behavior, particularly in a highly concentrated market, requires conditions that limit the ability of the merging hospitals to exploit their increased market power, mainly by limiting the degree to which they can leverage their increased market power to gain excessive prices from payors, i.e., prices beyond what St. Agnes Medical Center is currently paying.

A revised set of proposed price caps recognizes that the proposed transaction which, if evaluated under the failing firm framework, allows for bundled contracting to negotiate higher prices for Madera but also recognizes that allowance of bundled contracting generates significant anti-competitive and market power concerns as, per my initial report,[8] the two merging hospitals are direct competitors in an already concentrated geographic market. The proposed price cap conditions are designed to limit the ability of the merging hospitals to exploit their increased market power, mainly by limiting the effects of various forms of anti-competitive negotiating behavior, while at the same time allowing for prices adjustments, post transaction, along with other managerial and administrative changes that are designed to

[8]My initial report titled, "Assessment of the Effects of the Proposed Acquisition of Madera Community Hospital by St. Agnes Medical Center," is posted on the California Attorney General's website together with this supplemental report.

stabilize the financial condition of Madera. The imposition of such price caps is supported not just by economic analysis as set out in my initial report and supplemented here, but also from supplemental feedback received from payors.

Limit Post-Transaction Price Increases to Limit Negative Effects of Increased Concentration

Hospitals in California negotiate with health plans to determine whether they will be included in the health plans list of preferred "in-network" providers, including the terms of the contract, should the hospital be contracted as an "in-network" provider. The combination of Madera with St. Agnes Medical Center will substantially increase concentration within the market and thereby reduce competition. Under existing hospital market conditions, hospitals generally negotiate prices with third party payors for several different segments of the overall market while in other segments of the market prices are set unilaterally by the payors (e.g., Traditional Medicare and Medi-Cal fee for service (FFS) as opposed to Medi-Cal and Medicare Managed Care). The proposed price caps, which would all last for 5 years, are targeted at the market segments where prices are negotiated and subject to market conditions and market forces.

Limit Price Increases in Renewed Contracts with Medi-Cal Managed Care Plans to No More Than Current Medi-Cal Managed Care Contract Rates (2022) for St. Agnes Medical Center

Madera currently has contracts with different Medi-Cal Managed Care health plans where the contract prices for services rendered to Medi-Cal Managed Care patients approximate 100% of the Statewide Medi-Cal Fee for Service. The combination of Madera with St. Agnes Medical Center will substantially increase concentration within the market and thereby reduce competition, potentially allowing St. Agnes Medical Center the opportunity to increase Medi-Cal Managed Care rates for both St. Agnes Medical Center and Madera beyond what it is currently receiving.

It is proposed that, should the transaction be approved without any anti-bundling prohibitions, price increases for Medi-Cal services being provided by Madera be limited to no more than St. Agnes Medical Center's current (2022) Medi-Cal Managed Care contract rates for those services Such a price cap would be exclusive of any state or federal support payments such as Disproportionate Share Hospital, Quality Assurance Facility, or other direct payments in the Managed Care context. This price cap is consistent with and supported by the turnaround plan provided by St. Agnes Medical Center, information I have received from the Department of Health Care Access and Information (HCAI), information I have received from the [redacted], and is otherwise generally reflective of the population and local market conditions prevailing prior to the transaction (and any increases in market concentration).

In addition, beyond any increase in the rates for Madera's Medi-Cal services to St. Agnes Medical Center's current (2022) rates for those services upon initial contract renewals or any price adjustments permitted by existing contracts, any/all subsequent Madera contract renewals with Medi-Cal Managed Care plans (will be subject to price increase limits tied to the overall annual average update for the Medi-Cal FFS price/fee schedule). This limit in price increases should be in force for 5-years from the date of the initial contract renewal or price adjustment for Madera's Medi-Cal rates to St. Agnes Medical Center's current (2022) rates.[9] The combination of an initial price adjustment along with a cap on future price increases would allow for joint contracting by Madera and St. Agnes Medical Center/Trinity Health for future contracts between Medi-Cal Managed Care health plans and allow Madera the flexibility to negotiate higher rates, post transaction, but would provide an upper bound to the anticipated price increases at Madera that are a product of the increase in market concentration and reduced market competition.

The Table below illustrates the potential impact of the removal of the anti-bundling condition combined with a limit on price increases in renewed contracts with Medi-Cal Managed Care plans to no more than St. Agnes Medical Center's current (2022) contract rates. This example assumes a 20% differential/increase in Medi-Cal Managed Care revenue under the recommended price cap.

Madera currently has contracts with different health plans where the contract prices for services rendered to Medicare Managed Care patients approximate 100% of the Statewide Medi-Cal Fee for Service and reported annual revenue under the Medi-Cal Managed Care program at $40.52 million (for four quarters ending 2022 Q1). The price cap is thus well-above Madera's current Medi-Cal rates, and, as detailed in the initial report, is well-above comparable rural hospitals as well.

Under the proposed price cap, net revenues for Madera under the Medi-Cal Managed Care program could increase to $48.62 million or by $8.1 million over current net revenues.

Madera Net Revenue under Medi-Cal Managed Care (for four quarters ending 2022 Q1)

Net Revenue by Source and Program	Total Amount - Four Quarters Ending 2022 Q 1	Net Revenue Assuming Maximum to Price Cap	Incremental Net Revenue
NET_MCAL_MC	$ 40,517,204	$ 48,620,644.80	$ 8,103,440.80

This increase in revenue from Madera's rates increasing to St. Agnes Medical Center's current rates not only does not include any revenue from the further adjustments that may be made based on adjustments in the average Medi-Cal fee for service rates, but also does not include supplemental Medi-Cal payments from the state that I understand from information supplied

[9] My understanding is that Medi-Cal fee for service rates are adjusted on average, with many rates being tied to Medicare.

from various sources and from HCAI data may make Medi-Cal profitable for hospitals with substantial Medi-Cal populations.

Limit Price Increases in Renewed Contracts with Medicare Managed Care Plans to No More Than 110 Percent of Prevailing Medicare FFS Prices for Similar Patients.

Madera currently has contracts with different health plans where the contract prices for services rendered to Medicare Managed Care patients approximate 100%of the Medicare PPS Traditional Fee for Service rates. The combination of Madera with St. Agnes Medical Center will substantially increase concentration within the market and thereby reduce competition. It is proposed that should the transaction be approved without any anti-bundling prohibitions, limits on price increase conditions be included that would limit price increases in renewed contracts with Medicare Managed Care plans to no more than 110 % of prevailing Medicare (PPS, Prospective Payment System) Traditional Fee for Service rates for all services in the aggregate, adjusted for patient case-mix.

This would allow for joint contracting by Madera and St. Agnes Medical Center/Trinity Health for future contracts between health plans and Madera and the ability to negotiate higher rates, post transaction, but would provide an upper bound to potential price increases. This price cap is justified for reasons set out in the initial report.

The Table below illustrates the potential impact of removal of the anti-bundling condition combined with a limit on price increases in renewed contracts with Medicare Managed Care plans to no more than 110 % of prevailing Medicare PPS Traditional Fee for Service rates (as determined by the Center for Medicare and Medicaid Services (CMS)) for similar patients (adjusted for the case-mix of patients, referred to above as “similar patients”). Madera currently has contracts with different health plans where the contract prices for services rendered to Medicare Managed Care patients approximate 100% of the Medicare PPS Traditional Fee for Service rates for similar patients. Reported annual revenue under the Medicare Managed Care program at $10.54 million (for four quarters ending 2022 Q1). Under the price cap, Madera could increase to net revenue to $11.59 million or by $1.05 million under the Medicare Managed Care program.

Madera Net Revenue under Medicare Managed Care (for four quarters ending 2022 Q1)

Net Revenue by Source and Program	Total Amount - Four Quarters Ending 2022 Q 1	Net Revenue Assuming Maximum to Price Cap	Incremental Net Revenue
NET_MCAR_MC	$ 10,537,200	$ 11,590,920	$ 1,053,720

Limit Prices for Out-of-Network Emergency Services for Commercially Insured Patients/Health Plans for Similar Patients

Hospitals in California negotiate with health plans to determine whether they will be included in the health plans list of preferred "in-network" providers, including the terms of the contract, should the hospital be contracted as an "in-network" provider. In the event that Madera cannot reach agreement with a commercial health plan and becomes out-of-network with respect to any of the health plan's products, commercial health plans are required to reimburse Madera for emergency services provided to their members. The regulations requiring commercial health plans to reimburse out of network providers for emergency services provided to their members do not provide a limit on the amount that providers can charge for emergency services.

It is recommended that Madera will limit prices for out of network emergency services rendered to patients covered by this plan/product to no more than 220% of the Medicare (Prospective Payment System) Traditional Fee for Service rates (as determined by CMS) for similar patients (adjusted for case-mix). The 220% threshold is designed to allow for the higher case-mix index (CMI) for emergency patients (compared to elective admission) as well as the possibility of reduced commercial volume, should Madera become an out of network provider to commercially insured patients. This price cap is justified for reasons set out in the initial report but has been adjusted in this supplemental report to reflect additional feedback from the parties and from others.

Relevant data on these factors are provided in the following Tables.

The Table below includes data regarding the prevailing relationship between prices for commercially insured patients relative to Medicare Traditional (Fee-for-Service) patients for all rural hospitals in California. As can be seen, the prevailing commercial prices across all rural hospitals (most similar to Madera) are, on average, 186% of the Medicare FFS price schedule.

Prevailing Prices for Commercially Insured Patients Relative to Medicare Traditional (FFS) Patients for All Rural Hospitals in California (2020)

Source/Program	Amount (per diem)
Net I/P Rev Per Day-Commercial	$ 5,070
Net I/P Rev Per Day-Medicare	$ 2,729
Commercial % Medicare FFS	186%

The average value of 186% includes both emergency and non-emergency patient admissions. HCAI data show that the average case-mix index for emergency admissions is higher than non-emergency patient admissions. In addition, not all patients are admitted to Madera via the Emergency Department. The Table below summarizes Madera inpatient admissions by type of admission for 2020. As can be seen, slightly more than half all admissions are coded as emergency admissions.

Madera Inpatient Admissions by Type of Admission for 2020 – All Patients/Payors, 2020

01/01/2020 - 06/30/2020		**07/01/2020 - 12/31/2020**			**Total - Year**	**Total**
TYPE OF ADMISSION	**Discharges**	**%**	**Discharges**	**%**	**Discharges**	**%**
Elective	399	21%	400	19%	799	20%
Emergency	1,081	58%	1,284	60%	2,365	59%
Newborn	370	20%	410	19%	780	19%
Urgent	28	1%	39	2%	67	2%
Total	1,878	100%	2,133	100%	4,011	100%
Source: HCAI, Hospital Report						

Data for the commercially insured population, provided in the Table below show that slightly less than half of all inpatient admissions are admitted via as emergency admissions.

Madera Inpatient Admissions by Type of Admission for 2020 – Commercial Patients/Payors, 2020

Admission type	**Admission type**	**Count**	**% Discharges**
1	Emergency	193	44%
2	Urgent	6	1%
3	Elective	154	35%
4	Newborn	89	20%
Total		442	100%
	Source: HCAI PDD 2019		

Recommended Conditions Related to Health Care Impacts for Transaction Approval by the California Attorney General

It is recommended that if the California Attorney General approves the proposed transaction with the recommended removal or relaxation of the anti-bundling conditions and the changes or increases in the proposed price caps, the following conditions be considered or required in order to minimize any potential disruptions to access to needed health care services and community benefits historically provided by Madera[10] and in so doing minimize negative and/or adverse health care impacts that might result from the transaction. These conditions are also justified by the trade-off inherent in the failing firm defense under the public interest analysis, i.e., that an anticompetitive transaction is being excluded because at least the asset will remain

[10] The term Madera as used herein includes the rural clinics described in the initial report.

in the market for an appreciable and reasonable amount of time, and in the event that the asset is later repurposed or sold that a reasonable opportunity will be made available for a third party to come in and purchase the asset.

Maintain Capacity and Availability of Existing Services for Initial 5-Year Period Post Transaction

For at least five (5) years from the closing date of the transaction:

1. The Hospital shall continue to operate as a general acute care hospital, shall maintain 24-hour emergency and inpatient medical services, at no less than current licensure and designation with the same types and/or levels of services as reported to HCAI,[11] and shall provide the following:

    (a) basic emergency medical beds and basic emergency medical services providing services 24 hours a day, 7 days a week, including: maintaining the unit's necessary and required nursing staff, physicians, emergency medical personnel and necessary and required, equipment, supplies, services and space, in order to provide prompt and safe care for any patients presenting with urgent and emergency medical conditions;
    (b) 73 unspecified general acute care medical/surgical beds;
    (c) 23 perinatal beds;
    (d) 10 intensive care beds;
    (e) Labor & Delivery services, including four Labor and Delivery Recovery Suites, operating rooms, lactation consultants, maternity care, and education;
    (f) Primary Care and Specialty Care services;
    (g) Specialty Surgical services including Orthopedic, Interventional, Thoracic, Endoscopic, Gynecological, Podiatric, Otolaryngological, and, Urological surgeries;
    (h) General Surgical services; and
    (i) Outpatient services, including Telemedicine, and Outpatient Imaging and X-ray services.

2. The Hospital shall maintain all health care services provided at the current locations or at similar locations with equivalent services, including but not limited to:

[11] It is recognized that licensed bed capacity generally differs from available and staffed capacity. This difference is reflected in data reported to HCAI (PIVOT 2020: licensed beds= 96,594; available beds=91,597; staffed beds=60,447 (# hospitals, n=435). Changes by Madera to current levels of licensed bed capacity to allow for addition and/or substitution of additional services (e.g., Skilled Nursing Beds) would be permitted subject to review by the Monitor, maintaining the Hospital's General Acute Care Hospital license including ER designation and subject to maintaining availability of the existing service at the capacity needed to meet community demand at Madera.

- Rural Health Clinics located at 285 Hospital Drive, Chowchilla, California, 93610; 1210 E. Almond Avenue, Suite A & B, Madera, California 93627; and 121 Belmont Avenue, Suite 100, Mendota, California, 93640;
- Medical Specialty Clinic at 1250 E. Almond Avenue, Suite A, Madera, California, 93637;
- Outpatient X-Ray, at 1250 E. Almond Avenue, Madera, California, 93627;
- Outpatient Center at 1270 E. Almond Avenue, Madera, California, 93610; and
- MRI and Mammography at 1270 E. Almond Avenue, Madera, California, 93610.

Notification and Procedures for Substantial Changes in Services and/or Capacity at Madera after the Initial 5-Year Period

The proposed Initial 5-year time period condition is designed to provide St. Agnes Medical Center/Trinity Health a reasonable time period to implement, test, and hopefully achieve their proposed turnaround plan. Per the data shown above on the financial status of St. Agnes Medical Center and Trinity Health, the combined organizations have more than sufficient financial and managerial capacity and detailed knowledge of Madera County and the health care needs of the population to undertake and underwrite the proposed turnaround plan with a time horizon of 5 years. The 5-year period also provides some degree of protection and certainty to Madera residents and Madera patients and personnel with respect to the availability of essential inpatient and outpatient health care services in Madera County pursuant to supplemental feedback received from payors and other parties.

At the same time, given the uncertain nature of the proposed timing, implementation and effectiveness of the proposed turnaround plan, it is further recommended that the following conditions be applied after the initial 5-year period (from the date of approval and completion of the transaction):

(1) if any of the rural health clinics are identified to be closed or their capacity substantially reduced, there will be a required one (1) year (prior) notice period (supervised by a Monitor) to provide a fair and reasonable opportunity for a potential bidder to acquire the clinics or for some other potential provider to enter the market, and thus minimize or prevent disruption to the availability of services provided by the rural health clinics.

(2) if the parties determine that the Madera facility is not viable and that it must either be closed or repurposed from being a General Acute Care Hospital, there will be a required one (1) year (prior) notice period (supervised by a Monitor) to provide a fair and reasonable opportunity for a potential bidder to acquire the facility or for some other potential provider to enter the market, and thus minimize or prevent the disruption to the availability of services provided by the facility.

(3) if the parties determine that the current mix of services at the Madera facility is not sustainable and it is determined that there will be a significant reduction in essential services (e.g., ER or OB/GYN) and/or inpatient bed capacity, there will be a required one (1) year (prior) notice period (supervised by a Monitor) to provide a fair and reasonable opportunity for a potential bidder to acquire the facility or for some other potential provider to enter the market, and thus minimize or prevent the disruption to the availability of services provided by the facility.

(4) that any potential bidder be allowed to assume outstanding debt owed to St. Agnes/Trinity Health incurred as part of the turnaround plan under the same terms offered to and agreed upon by Madera under the Affiliation Agreement, including the terms and rates included in the intra-system loan contained within the Approved Affiliation Agreement, and that Madera not incur or be obligated for any Trinity Health system level expenses or debt during the Initial 5-Year period and/or until it is determined that any of the above (1), (2) and/or (3) above is applied/invoked.

These conditions are to be supervised by an outside Monitor (similar to all other proposed conditions).

Submitted November 3, 2022:

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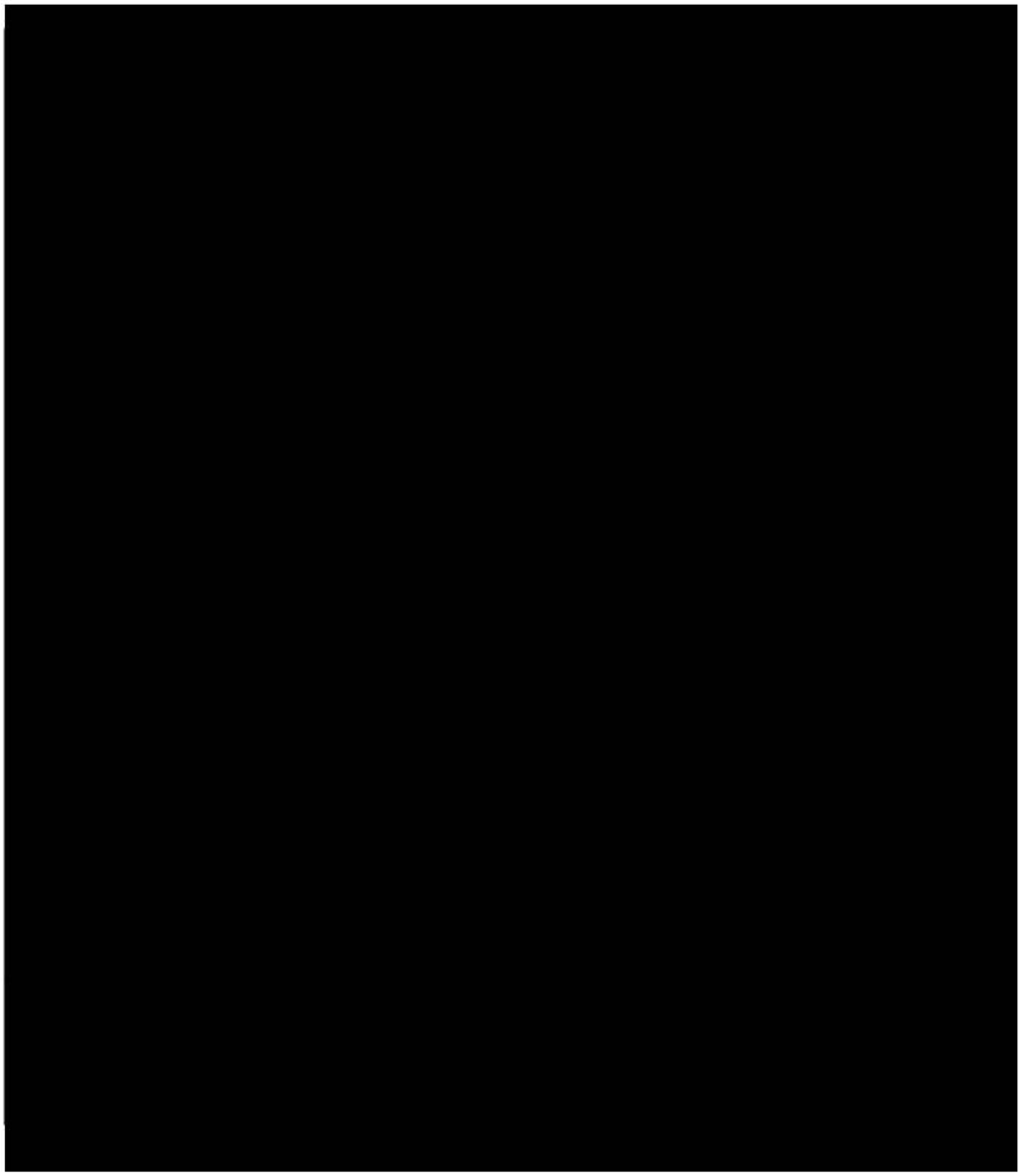
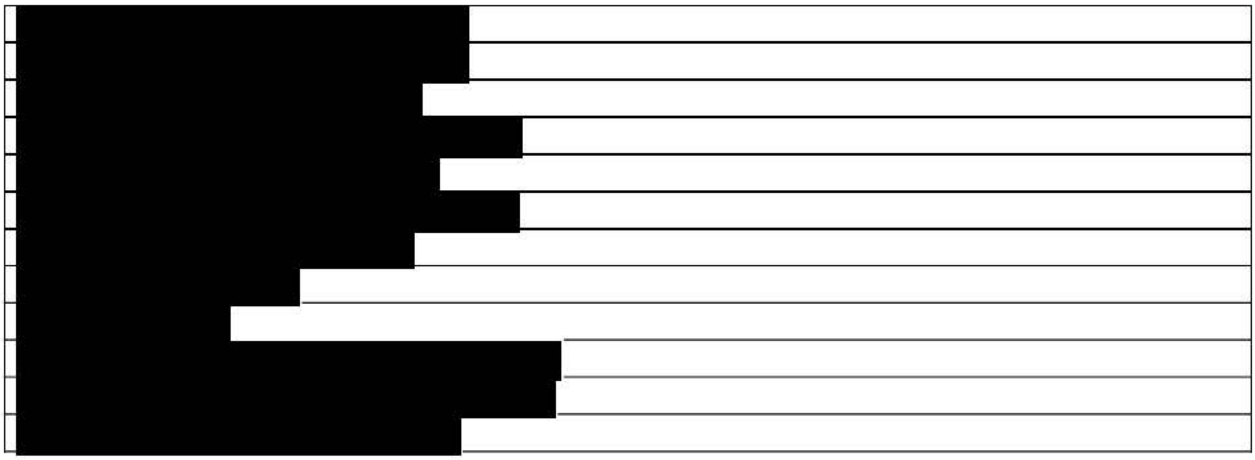
Appendix

Detailed Outline of St. Agnes Medical Center's Turnaround Plan for Madera Transaction



Supplemental Information Provided by Madera

Madera Formal Notice and Exhibits (8/19/22)
3A - Affiliation Agreement
3B - Madera Amended Articles of Incorporation
3C - Madera Amended Bylaws
3D - Schedule 9.01(a) to the Affiliation Agreement
13A - Madera Articles of Incorporation
13B - Madera 2021 Bylaws and 2022 Amendment
15A - Madera's 2022 community health needs assessment and community health needs assessment implementation plan.
15B - Madera's 2019 community health needs assessment and community health needs assessment implementation plan.
16A - Financial Assistance Policy
16B - Financial Assistance Application
16C - Amounts of Charity Care
17A - 2017-2021 Inpatient and Outpatient Services
18A - 2017 Community Benefit Report
18B - 2018 Community Benefit Report
18C - 2019 Community Benefit Report
18D - 2020 Community Benefit Report
18E - 2021 Community Benefit Report
21A - SAMC Informed Consent Policy
23A – Madera County Indigent Contract
29A - Resolutions of the Madera Board to Authorize Notice Filing
29B - Statement by Chair of Madera Board
30A - SAH Officers and Directors
30B - Trinity Health June 30, 2021 Financial Statements
30C - SAH articles of Incorporation
30D - SAH Bylaws
30E - Trinity Health Financial Assistance Policy
31A - Fresno Bee Article
32A - Copy of the letter of intent between Madera, Trinity Health, and SAMC dated February 3, 2022.
32B - Copy of the Board of Trustee minutes dated August 11, 2021.
32C - Copy of the Board of Trustee minutes dated December 8, 2021.
32D - Copy of the Board of Trustee minutes dated December 16, 2021.
32E - Copy of the Board of Trustee minutes dated January 12, 2022.
32F - Copy of the Board of Trustee minutes dated March 16, 2022.
32G - Copy of the resolutions of the Madera Board approving the letter of intent on February 2, 2022.
32H - Copy of the resolutions of the Madera Board approving the Affiliation on August 15, 2022.
37A - Madera's 2021 audited financial statements.
37B - Madera's 2020 audited financial statements.
37C - Madera's unaudited interim financial statements for June 2022, including a balance with current capital asset valuation data.



Summary of Interviews with Payors

In preparation for this supplemental report, additional videoconference interviews were separately conducted with representatives from the) and with representatives from the following public and private health plans doing business in Madera County: . Below are summaries of these interviews.

I. Madera Rate Increases: Health Plan Concerns & Expectations

In general, health plans express concerns about price increases at Madera should the transaction be approved. However, health plans also recognize that Madera's financial condition may result in increased rates to ensure Madera's continuing operations. The health plans express different concerns about excessive rates at Madera, as follows:

(a) Opinions about excessive rates for Medi-Cal Fee-For-Service

[redacted]

Health plans all agreed that a 200% Medi-Cal Fee-For-Service rate would be considered far too excessive, and they would not pay it. The health plans advise that a 150%-180% Medi-Cal Fee-For-Service rate is rarely something that health plans would agree to reimburse. In those uncommon cases where this rate or similar has been paid, health plans recall a dominant multi-county health system with market power and its requirement for inclusion in a health plan's network for adequacy. One plan added that paying those (to them excessive rates) would be inappropriate here because there would be no value proposition attached to such a rate either. Health plans finally opine that even a 125% Medi-Cal Fee-For-Service rate is too high for the area.

[redacted]

(b) Impact from excessive rates on payors and their members

The health plans express that a hypothetical 200% Medi-Cal Fee-For-Service rate at Madera would create difficulty for health plans to continue transacting business in Madera County, or would dissuade contracting with Madera for hospital or rural clinic services. Consequently, an inadequate network for purposes of Medi-Cal may result from excessive rates. Specifically, health plans indicate that if they do not contract with Madera, they would need to apply for an exception (referred to as alternative access standards) for network adequacy from the Department of Managed Health Care. Alternatively, health plans believe that paying excessive rates would result in financial losses for the health plans because individual providers are not sufficiently reimbursed through Medi-Cal to cover those costs. And that plans can and do subsidize their lesser Medi-Cal rates by offering a total package for a hospital of commercial, Medicare, and Medi-Cal, does not allow for coverage of excessive Medi-Cal prices.

Medi-Cal members would also experience higher financial burdens or gaps in access to health care because those members are not able to afford any increase in costs not covered by Medi-Cal funds, or may experience delays in care by having to travel long distances for services.

(**c) Price caps for excessive rate increases**

Health plans believe that Madera and St. Agnes Medical Center may demand substantial rate increases as part of bundled contract negotiations. Consequently, health plans believe that a cap on prices would be an appropriate condition to prevent excessive rate increases. One plan also stated that consistency in pricing for Medi-Cal Managed Care is especially important for them to remain competitive given limited reimbursement provided by the state.

(d) Presence for network adequacy

Health plans opine it is important to create an adequate network for the Medi-Cal program and the sizeable Medi-Cal member population located in Madera County. Health plans believe Madera is very important for network adequacy. For example, if health plans do not have a contract with Madera, there will be no in-network hospital for Medi-Cal members within 15 miles or 30 minutes required of Managed Care plans. Madera's emergency room is critical to the community because Madera is a hub for extremely rural counties where, in some instances, it may take up to an hour or more to travel to Fresno. In addition, there are thousands of patients managed by Madera's rural health clinics and those patients would no longer have access to an in-network physician in Madera County. One health plan has over 40,000 members enrolled in a Medi-Cal plan and those members receive services at Madera's general acute care hospital. Further, 7,000 of those members also receive care at Madera's rural health clinics. Put a different way as one plan did, while people in rural communities are used to traveling farther for services like groceries, people in those communities are dependent on what is still there for services provided by a hospital like Madera and its rural clinics, especially when you have a community like Madera that is so Medi-Cal dependent and has fewer transportation options.

As noted above, the health plans believe that network adequacy cannot be met without Madera such that they would need to seek an exception from the Department of Managed Health Care if Madera were not in network. But if Madera closed, such that there was no choice, Madera residents would have to go to a Fresno-area competitor, such as Community Regional Medical Center. One plan noted that aside from the geographical disparities, Community Regional Medical Center could provide the same services, but it would cost more.

Outside of the Medi-Cal context, plans believe they meet network adequacy requirements with Madera. Whether they would if Madera were out of network is something they would have check into; one plan informed us of the extreme difficulty they had in finding a hospital that could replace another hospital that had closed for purposes of network adequacy.

(e) Expectations for Madera if rate increases occur

In the event Madera's rates do increase, health plans advise they would like to see tangible improvements at Madera related to the quality of health care services that Madera provides, as well as expansion and access to specialty services. Health plans suggest that access to specialty services such as pulmonology or neurology and the establishment of a hospital quality program at Madera would be significantly beneficial for health plan members.

According to health plans, expanding or investing in the outpatient rural health clinic infrastructure would also be a significant improvement for Medi-Cal members. More importantly, health plans expect that the hospital and rural health clinics of Madera remain open if rates increase, as it is the only general acute care hospital and emergency services provider in Madera County, as well as a significant provider of outpatient services to the community.

Finally, for health plans to consider paying higher rates, they expect Madera to implement improved care management practices so that services occur more frequently at the outpatient (rather than inpatient) setting, while demonstrating improved health quality outcomes for health plan members.

(**f) Impact from excessive rate increases on Medi-Cal program**

Health plans opine that paying higher or excessive rates may have a ripple effect on available funds in the Medi-Cal program. [redacted]

II. Madera Closure or Reduction of Services: Negative Health Outcomes for Madera County Residents or Medi-Cal Members & Concerns for Transition

Madera serves the population of Madera County and is the only general acute care hospital and emergency services provider located in the county. Health plans believe that if closure or reduction of essential services occurs, the entire population of residents will experience negative health outcomes because of the loss of access to hospital and emergency services with no nearby alternatives. Plans note that maintaining some level of pre and post-natal and labor and delivery services at Madera is also important given how far patients would need to travel if Madera did not offer or limited such services. Madera also operates three rural health clinics and a specialty clinic for outpatient services for the Medi-Cal population. Health plans advise that if these clinics shut down, thousands of Medi-Cal patients will lose access to a physician. Other physicians may be present in Madera County, but many do not accept Medi-Cal.

Health plans opine that Madera's rural clinics help maintain the routine health care needs of the community and a closure or reduction in services will negatively impact the overall health of the community. For example, with a closure or reduction in services, low-income residents may not receive necessary or preventative family, reproductive, and pediatric services that they may only afford to obtain from the rural health clinics. Senior citizens may also be particularly disadvantaged. In addition, if residents must travel to Fresno to receive care, many of those residents will require transportation assistance or may otherwise not seek care. Medi-

Cal Managed Care plans must provide transportation to members and those health plans believe they would need more available transportation services.

The health plans opine that if Madera decides to shutter the hospital, eliminate or significantly reduce its essential services, the best option for the community is to continue to operate Madera for a reasonable time period to allow potential purchasers to evaluate and consider acquiring the hospital and its clinics. The best option for the community, according to health plans, is to allow a new owner to take over and continue Madera's necessary and essential services rather than cease services.

In addition, health plans opine that before any hospital closure, or significant reduction in essential services goes into effect, Madera should continue operations for a reasonable time period so health plans may adequately and timely notify members of where they may alternatively receive care, and to safely and thoughtfully transition and reassign members to alternative primary care physicians or specialists. Further, health plans advise they need a reasonable time period to prepare and submit a request for an exception or alternate standards for network adequacy to regulators if Madera closes or reduces essential services.

In conclusion, all health plans agreed that one year is both preferable and a reasonable amount of time for these transition options to occur. Specifically, a year is reasonable to allow another prospective operator to acquire Madera so that services can continue for the benefit of the community, and for sufficient time to notify members, transition care, and obtain network adequacy exceptions.