UNITED STATES DISTRICT COURT FOR THE

EASTERN DISTRICT OF LOUISIANA

FEDERAL TRADE COMMISSION Plaintiff, v. LOUISIANA CHILDREN'S MEDICAL CENTER and HCA HEALTHCARE, INC. Defendants.	CIVIL ACTION NO. 23-1305 c/w 23-311 c/w 23-890 REF: ALL CASES SECTION I

INTERVENOR, THE STATE OF LOUISIANA'S MOTION FOR JUDGMENT ON THE PLEADINGS OR ALTERNATIVELY MOTION FOR SUMMARY JUDGMENT

The State of Louisiana ("State"), by and through Attorney General Jeff Landry ("Attorney General"), moves this Court pursuant to Fed. R. Civ. P. 12(c) for the judgment on the pleadings and dismissal of the lawsuit filed by the Federal Trade Commission ("FTC"). The entry of judgment based upon the pleadings filed by the parties in this case due to the Attorney General's issuance of a Certificate of Public Advantage ("COPA") authorizing the transaction the FTC is seeking to enjoin.

At all times prior to instituting this action, it has been the policy of the FTC to challenge only mergers that will have anticompetitive effects, and to only challenge assertions of state action immunity when a state's supervision of private conduct was

perceived to be deficient. The FTC has alleged neither circumstance in its complaint, and has acknowledged the COPA issued by the Attorney General, and dismissal is therefore appropriate.

Alternatively, the State moves the Court pursuant to Fed. R. Civ. P. 56 for the entry of summary judgment in favor of defendants HCA Healthcare, Inc. and Louisiana Children's Medical Center, as there is no genuine dispute of any material fact, and the entry of a judgment dismissing the FTC's complaint is appropriate as a matter of law.

Accompanying this Motion are: (1) a Statement of Undisputed Facts, (2) a Memorandum in Support of this Motion, (3) the Declaration of Angelique Freel and (4) the Declaration of Terrence J. Donahue, Jr., all of which are incorporated herein by reference.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I certify that on July 18, 2023, a copy of the foregoing Motion was filed electronically with the Clerk of Court via the CM/ECF system. Notice of this filing will be sent to all counsel of record by operation of the court's electronic filing system.

s/ Terrence J. Donahue, Jr.
Terrence J. Donahue, Jr.

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MEMORANDUM IN SUPPORT OF THE STATE OF LOUISIANA'S MOTION FOR JUDGMENT ON THE PLEADINGS OR, ALTERNATIVELY, MOTION FOR SUMMARY JUDGMENT

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I. INTRODUCTION

The Federal Trade Commission ("FTC") filed this suit against Louisiana Children's Medical Center ("LCMC") and HCA Healthcare, Inc. ("HCA") seeking injunctive relief for alleged violations of federal antitrust law, including the Hart-Scott-Rodino Antitrust Improvements Act of 1976 ("HSR Act"). The State of Louisiana ("State"), through its Attorney General, Jeff Landry ("Attorney General") subsequently intervened, and now moves this Honorable Court to enter a judgment dismissing the FTC's suit as it is foreclosed by the Attorney General's and Louisiana Department of Justice's ("LADOJ") issuance of a Certificate of Public Advantage ("COPA") to LCMC and HCA that authorized the transaction challenged by the FTC in accordance with the provisions of Louisiana Revised Statute 40:2254.1 *et seq.* ("COPA Law")

II. FACTUAL BACKGROUND

A. FTC's Petition and HCA's and LCMC's Answers

On January 1, 2023 LCMC acquired three hospitals in the New Orleans area from HCA for $150 million. [Doc. 1][1] at ¶¶ 4-5; [Doc. 5] at ¶6; [Doc. 52] at ¶ 5. The acquisition was consummated after Louisiana's Attorney General approved the transaction and issued a COPA pursuant to statutes enacted by the Louisiana Legislature. [Doc. 1] at ¶¶ 15; [Doc. 5] at ¶¶ [Doc. 5-1]; [Doc. 5-5]; [Doc. 5-6] at pp. 2, 4; [Doc. 52] at ¶ 15; [Doc. 54] at ¶ 15.

Over three months after the transaction between LCMC and HCA had closed,

[1] Unless otherwise specified, all docket entries appear in Case No. 2:23-cv-01890-LMA-MBN.

representatives of the FTC contacted counsel for LCMC asking to be "walked through" the analyses required for compliance with federal antitrust laws. [Doc. 5-6] at p. 4. Counsel for LCMC responded that "Attorney General Jeff Landry of Louisiana approved a Certificate of Public Advantage (COPA) under Louisiana Revised Statute 40:2254[.]1 … prior to the closing of the transaction." *Id.* The FTC's representative responded that the Attorney General's issuance of a COPA approving the transaction "is not sufficient to explain why your client didn't file an HSR notification prior to its January 2023 acquisition" and requested "more detail on how the Louisiana COPA analysis exempts the acquisition from HSR notification." *Id.* at p. 3. Counsel for LCMC again identified the FTC's representative of LADOJ's approval of the transaction and issuance of a COPA, further explaining that the "state action immunity" doctrine announced in *Parker v. Brown,* 317 U.S. 341 (1943) "exempted the transaction from the Clayton Act and its HSR filing amendments…" *Id.* at pp. 3-4. Counsel for LCMC also stated that he understood the FTC disfavors both COPAs and assertions of state action immunity, but noted that the position advanced by LCMC and HCA was consistent with prior FTC actions in mergers accomplished through the issuance of a COPA. *Id.* at p. 4.

Both LCMC and HCA concede they did not file the HSR Act's pre-merger notification with the FTC prior to closing the transaction. [Doc. 52] at ¶ 11; [Doc. 54] at ¶ 11. Moreover, neither LCMC nor HCA contests the fact that neither they, and the transaction at issue, meet the monetary thresholds that would trigger the need to file a pre-merger notification with the FTC in the absence of the COPA issued by

the Attorney General. [Doc. 52] at ¶ 9; [Doc. 54] at ¶9. In addition, all parties agree that LCMC and HCA consistently informed the FTC of their understanding that they were not required to file the pre-merger notification provided for in the federal antitrust laws due to the Attorney General's issuance of a COPA and application of the state action immunity doctrine. [Doc. 5-6] at pp. 2-4; [Doc. 52] at ¶¶ 9, 15; [Doc. 54] at ¶15.

B. The State of Louisiana's Intervention

On June 9, 2023, the State, appearing through the Attorney General, moved to intervene in the suit initiated by the FTC. [Doc. 37]. The Court granted the request for leave to intervene on , and the State's Original Petition of Intervention ("Intervention") was filed July 7, 2023. [Docs. 67 and 68].[2] The Intervention asserts the following:

The Louisiana Legislature enacted the State's COPA law, La. R.S. 40:2254.1 *et seq*., to control health care costs and improve the quality of and access to health care. *See* Affidavit of Angelique Freel, attached hereto, at ¶ 7; *see also* La. R.S. 40:2254.1; Act No. 1331 of the 1997 Louisiana Legislative Regular Session.[3] The COPA Law grants LADOJ direct supervision and control over cooperative agreements, mergers, joint ventures, and consolidations among health care facilities for which a COPA is issued. *Id*. at ¶ 9. Louisiana's COPA Law is intended to serve

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[2] Entered in Case No. 2:23-cv-01305-LMA-MBN

[3] Courts must consider all sources ordinarily examined when ruling on a motion to dismiss, including matters subject to judicial notice. *Tellabs, Inc. v. Makor Issues & Rts., Ltd.,* 551 U.S. 308, 322 (2007). A court may take judicial notice of legislative facts. *Matter of Waller Creek, Ltd.,* 867 F.2d 228, 238 (5th Cir. 1989).

as a substitute for other methods of regulating the types of transactions within its scope and to grant immunity from state and federal antitrust laws to the parties who are issued a COPA. *Id.* at ¶ 9; La. R.S. 40:2254.1; La. R.S. 40:2254.2(1).

A COPA may only be issued after the public has been notified of the proposed transaction and afforded the opportunity to provide comment. *Id.* at ¶¶ 10, 21; La. R.S. 40:2254.4(B). Similarly, a COPA may only be issued if LADOJ finds that the proposed transaction is likely to result in lower health care costs or is likely to result in improved access to health care or higher quality health care without any undue increase in health care costs. *Id.*at ¶ 10; La. R.S. 40:2254.4(B). Thus, a COPA may be issued subject to terms and conditions not provided in the parties' agreement, but which LADOJ has determined are appropriate to ensure that the transaction accords with the COPA Law's stated purpose. *Id.* at ¶ 30; La. R.S. 40:2554.4(C).

Upon issuance of a COPA, the parties to the subject transaction may not amend their agreement or effect any material change in their operations or conduct unless they apply for and receive a new COPA. *Id.* at Exhibit C, p. 2, ¶ I.A; La. R.S. 2254.4(D). All entities to which LADOJ issues a COPA must submit reports addressing whether the terms and conditions approved or unilaterally imposed by LADOJ upon issuing the COPA have been complied with, and in turn, LADOJ must itself issue findings as to whether such terms and conditions are being met or otherwise satisfied. *Id.* at ¶ 31; *id.* at Ex. C at pp. 5-6; La. R.S. 2254.11. If necessary, the Attorney General and LADOJ may institute legal proceedings to enforce the terms and conditions upon which issuance of a COPA was premised. *Id.* at ¶¶ 13, 37;

La. R.S. 40:2254.10. Moreover, if it later determines that a transaction for which a COPA was issued fails to fulfill the purposes stated in the COPA Law, LADOJ is required to revoke the COPA after affording the parties to the transaction notice and an opportunity for hearing. *Id.* at ¶ 14; La. R.S. 40:2254.6.

After complying with the procedures mandated by Louisiana's Legislature and determining that the transaction met the standards expressed in the COPA Law, the Attorney General issued a COPA approving the transaction between LCMC and HCA on December 28, 2022. *Id.* at Exhibit D; *see also id.* at ¶¶ 15-29. As permitted by the COPA Law, LADOJ also imposed numerous additional terms and conditions on the transaction not contained within HCA's and LCMC's agreement that ensure the State's ongoing ability to supervise the transaction for compliance with the standards set forth in the COPA Law and that the transaction continues to benefit the citizens of Louisiana. *Id.* at ¶¶ 30-33, Exhibit C. LADOJ is currently engaged in actively engaged in active supervision of the effects of the transaction between LCMC and HCA and these parties' compliance with the COPA's terms and conditions. *Id.* at ¶¶ 34-35.

The FTC did not contact LADOJ prior to approval of the COPA application, nor did the FTC provide any comments to LADOJ concerning the proposed transaction. *Id.* at ¶ 38. If the relief the FTC has requested in this lawsuit is granted, it would interfere with the State's right to implement and supervise the transaction approved in the COPA and would compromise the access to and the quality of healthcare available in Louisiana. *Id.* at ¶ 39.

III. LEGAL STANDARD

A. Motion for Judgment on the Pleadings

After the pleadings are closed – but early enough not to delay trial – a party may move for judgment on the pleadings. Fed. R. Civ. P. 12(c). The standard for a Rule 12(c) motion is the same as the standard used for Rule 12(b)(6) motions. *Terry Black's Barbecue, L.L.C. v. State Auto. Mut. Ins. Co.*, 22 F.4th 450, 454 (5th Cir. 2022). In conducting a Rule 12(c) analysis, the court accepts all well-pled facts as true, drawing "all reasonable inferences in favor of the nonmoving party." *Armstrong v. Ashley*, 60 F.4th 262, 269 (5th Cir. 2023). But the court "does not presume true a number of categories of statements, including legal conclusions; mere labels; threadbare recitals of the elements of a cause of action; conclusory statements; and naked assertions devoid of further factual enhancement." *Id.* The plaintiff must plead "enough facts to state a claim to relief that is plausible on its face." *Guidry v. Am. Pub. Life Ins. Co.*, 512 F.3d 177, 180 (5th Cir. 2007).

B. Motion for Summary Judgment

Summary judgment is appropriate where there is no genuine dispute as to any material fact and the moving party is entitled to judgment as a matter of law. A party may move for summary judgment, identifying each claim or defense—or the part of each claim or defense—on which summary judgment is sought. Fed. R. Civ. P. 56. The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law. Summary judgment shall be granted when the non-movant fails to make a showing sufficient to establish any one of the essentials elements, on which

he bears the burden of proof at trial. *Piazza's Seafood World, LLC v. Odom*, 448 F.3d 744, 752 (5th Cir.2006). Failure of proof concerning an essential element of the non-movant's case necessarily renders all other facts immaterial**.** Thus, there can be "no genuine issue as to any material fact." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-323 (1986) In such a case, the mover's burden on summary judgment is satisfied by merely pointing out that a lack of sufficient evidence in the record to support an essential element of the non-movant's claim. On summary judgment, a party can no longer rest on "mere allegations," but must "set forth" by affidavit or other evidence "specific facts which for purposes of the summary judgment motion will be taken to be true." *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992).

C. Injunctive Relief

Injunctive relief is an extraordinary and drastic remedy, not to be granted routinely, but only when the movant, by a clear showing, carries the burden of persuasion. *Holland Am. Ins. Co. v. Succession of Roy*, 777 F.2d 992, 997 (5th Cir. 1985). The elements that must be proven to obtain a permanent injunction are "nearly identical" to those of a preliminary injunction, except that a "plaintiff must show actual success on the merits rather than a mere likelihood of success." *Amoco Prod. Co. v. Village of Gambell*, 480 U.S. 531, 546 n.12 (1987). In order to succeed, a plaintiff must establish each of the following elements: (1) actual success on the merits; (2) a substantial threat of immediate and irreparable harm for which it has no adequate remedy at law; (3) that greater injury will result from denying the injunction than from its being granted; and (4) that an injunction will not disserve the public interest. *Clark v. Prichard*, 812 F.2d 991, 993 (5th Cir. 1987); *Amoco Prod.*,

480 U.S. at 546 n.12, 107 S.Ct. 1396. A trial court is vested with broad discretionary power in deciding whether to grant or deny an injunction. *See Lemon v. Kurtzman*, 411 U.S. 192, 200-201 (1973).

III. ARGUMENT

A. The FTC's Suit Impinges Upon the State's Sovereignty

In its petition, the FTC asserts that the exemption from antitrust scrutiny afforded by the state action immunity doctrine "appears nowhere in the text of the HSR Act," that the exemption "has never been recognized as an exemption from the HSR Acts notification requirements by any court," and that "neither the FTC nor the [U.S.] DOJ has promulgated an interpretation of the HSR Act exempting" parties to State-regulated and supervised mergers parties from filing pre-merger notifications. [Doc. 1] at p. 3. The FTC's statements are disingenuous, at best, and refuted below.

The state action immunity doctrine does not arise from statutory language affirmatively expressing Congressional intent, but rather from the *lack* of any indication that Congress intended to supplant the States' regulation of their own domestic commerce when enacting the federal antitrust laws. *See Parker v. Brown,* 317 U.S. 341 (1943) ("an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress"). In addition, there is a very simple explanation for why no court has previously found the state action immunity to provide an exemption to the HSR Act's pre-merger notification requirements – while it has had the opportunity to do so, the FTC has never previously attempted to enforce these requirements in circumstances where state action immunity would apply. *See Antitrust Federalism, Preemption, and Judge-*

Made Law, 133 Harv. L. Rev. 2557, 2575 (2020) ("the [federal antitrust] agencies choose when to enforce antitrust laws, thus affecting the kinds of cases and controversies that the judiciary sees"). Finally, while neither the FTC nor US DOJ have promulgated regulations exempting COPAs or other state action from the HSR Act's pre-merger notification requirements, these agencies have long been aware of the belief amongst regulated parties that the state action immunity doctrine provided such an exemption, yet made no effort to communicate a different view. As such, the FTC failed to provide "fair warning of the conduct [it] prohibits or requires." *See Christopher v. SmithKline Beecham Corp.,* 567 U.S. 142, 156 (2012).

1. The FTC's Suit Is an Unauthorized Attempt to Preempt the State's COPA Law

While the FTC does not appear to dispute its awareness that the State reviewed and approved the transaction between LCMC and HCA prior to the transaction being consummated months before the FTC filed this suit, the agency's petition makes no attempt to address the State's role in the transaction. Nor does the FTC acknowledge that its suit plainly seeks to not only interfere with, but effectively undo altogether a transaction the Attorney General determined will benefit the health and welfare of the State's citizenry.

The Constitution limits, but does not abolish, the sovereign powers of the States, which retain "a residuary and inviolable sovereignty." *Murphy v. Nat'l Collegiate Athletic Ass'n,* 138 S.Ct. 1461, 1475 (2018). Both the federal government and the States wield sovereign powers, making our system of one of "dual sovereignty." *Id.* As a result, federal supervision over either the legislative or the

judicial action of the States is in no case permissible, except as to matters specifically authorized or delegated to the United States in the Constitution. *Erie R. Co. v. Tompkins,* 304 U.S. 64, 78–79 (1938). Any interference with the States' conduct of their governments which is not authorized by the Constitution is an invasion of the authority of the state and a denial of its independence. *Id.* The powers delegated by the Constitution to the federal government are "few and defined" while those remaining with the States are "numerous and indefinite." *Gregory v. Ashcroft,* 501 U.S. 452, 458 (1991). The powers reserved to the several States "extend to all the objects which, in the ordinary course of affairs, concern the lives, liberties, and properties of the people, and the internal order, improvement, and prosperity of the State." *Id.* While the States have retained their status as sovereigns, their sovereignty is constitutionally limited by the Supremacy Clause's requirement that state law must yield to federal law in cases of conflict. *Murphy,* 138 S.Ct. at 1475 (2018).

Still, federal agencies "literally ha[ve] no power to act, let alone pre-empt the [law] of a sovereign State, unless and until Congress confers power upon it." *New York v. FERC*, 535 U.S. 1, 18 (2002) (citation omitted). Furthermore, the Supreme Court has repeatedly stated that "it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers a statute's primary objective must be the law." *See e.g., Norfolk Southern R. Co. v. Sorrell,* 549 U.S. 158, 171 (2007) (citation omitted). Under these parameters, "[t]he case for federal pre-emption is particularly weak where Congress has indicated its awareness of the operation of

state law in a field of federal interest, and has nonetheless decided to stand by both concepts and to tolerate whatever tension there is between them." *Bonito Boats, Inc. v. Thunder Craft Boats, Inc.,* 489 U.S. 141, 166-167 (1989).

With respect to antitrust matters, there is a "long history of state common-law and statutory remedies against monopolies and unfair business practices," and therefore "it is plain that this is an area traditionally regulated by the States." *California v. ARC Am. Corp.,* 490 U.S. 93, 101 (1989). As a result, courts must be certain that Congress has conferred the requisite authority upon an agency before giving its interpretations legal effect. *New York,* 535 U.S. at 18. Congressional intent may be discerned by looking to legislative history an overall legislative scheme, and the traditional role of the States in providing relief. *Texas Indus., Inc. v. Radcliff Materials, Inc.,* 451 U.S. 630, 639 (1981) (citations omitted). Even so, while consideration of Congressional policies is proper when defining the reach of federal antitrust laws, it is inappropriate to consider such policies "as defining what federal law allows States to do under their own antitrust law." *California v. ARC Am. Corp.,* 490 U.S. 93, 103, n. 20 (1989). The Fifth Circuit has summarized the interplay between the coexistent federal and state antitrust regulatory regimes as follows:

> A state statute is not preempted merely "because the state scheme might have an anticompetitive effect." If any conflict between a state law and the Sherman Act meant that the state law were preempted, "the States' power to engage in economic regulation would be effectively destroyed." This cannot be the case, for as the Court has recognized, "the function of government may often be to tamper with free markets, correcting their failures and aiding their victims." State police powers and regulatory authority extend legitimately to a range of anticompetitive schemes.

Xcaliber Int'l Ltd. LLC v. Atty. Gen. State of Louisiana, 612 F.3d 368, 377–78 (5th

Cir. 2010) (citations omitted).

2. Congress Did Not Intend the HSR Act to Authorize Challenges to State Regulation by the FTC

Far from declaring any intent for the HSR Act to displace States' ability to regulate competition, the legislation explicitly *delegates* authority to State attorneys general to enforce the federal antitrust laws "because a primary duty of the State is to protect the health and welfare of its citizens." *See* H.R. Rep. No. 94-499 at 5, 1975 WL 12521. The committee reports generated during passage of the HSR Act make clear that Congress looked favorably on the delegation of federal antitrust authority to State attorneys general because of their elected status, as this makes them accountable to their constituents. *Id.* Moreover, the legislative history of the HSR Act also establishes the amendments made to Section 7 of the Clayton Act (including the pre-merger notification and waiting period requirements added in Section 7A) were intended only to afford the government a reasonable opportunity to detect and investigate large mergers that were "illegal" or "of questionable legality" under prior law—not to effect changes to the legal standards by which such transactions are judged, stating instead that these standards would "remain unaffected" by the HSR Act. *See* H.R. Rep. No. 94-1373 at 5, 1976 WL 13988; S. Rep. No. 94-803 at 2, 8.

While the HSR Act delegated rulemaking authority to the FTC and US DOJ, the legislative history further establishes that the exercise of such authority could not be undertaken in a manner that derogates from Congressional intent and that the promulgation of such rules must be accompanied by "notice and submission of views" pursuant to the Federal Administrative Procedure Act. *See* S. Rep. No. 94-

803 at 67. The legislative history also confirms that Congress contemplated only the promulgation of rules exempting additional "classes of persons," "businesses," or "transactions" from the HSR Act's pre-merger notification requirements, and contains no suggestion that the provisions of the law could be utilized in the context of State action. *Id.* at 67-68. The history does, however, reflect Congress' expectation that the FTC would strike a "proper balance" between "the needs of effective enforcement of the law ***and the need to avoid burdensome notification requirements or fruitless delays.***" S. Rep. 94-803 at 67 (emphasis added).

Though the FTC attempts to draw a distinction between "substantive" and "procedural" requirements of the federal antitrust laws, nothing in the text of the HSR Act or its legislative history suggests any Congressional intent for such a distinction. Furthermore, the legislative history directly contradicts the FTC's assertion that Congress intended 15 U.S.C. § 18a(c) to provide an *exclusive* list of exemptions from the HSR Act's pre-merger notification and waiting period requirements:

> Subsection (b)(4)(B) provides a general listing of statutory exemptions. ***Many transactions that are literally subject to the reporting requirements are not within the intent of Section 7***…

S. Rep. 94-803 at 68. Both the HSR Act's text and its legislative history establish that when enacting the law, Congress expressed no intent to displace the States' role in regulating their domestic commerce. This silence, and the eighty years that have elapsed since the Supreme Court rendered its decision in *Parker v. Brown* was decided without Congressional action altering its result, firmly establish that Congress has acquiesced to its holding, and did not intend to subject State action to

the HSR Act's provisions. *See S. Motor Carriers Rate Conf., Inc. v. United States,* 471 U.S. 48, 56 (1985)

3. The FTC's Suit Reflects a Dramatic Shift in Policy Without Notice to Regulated Parties or the State

The requirement that a federal agency provide reasoned explanation for its actions demands that it display awareness when it changes its position. *F.C.C. v. Fox Television Stations, Inc.,* 556 U.S. 502, 515–16 (2009). As a result, an agency may not depart from a prior policy sub silentio or simply disregard rules that are still on the books. *Id.,* citing *United States v. Nixon,* 418 U.S. 683, 696 (1974). When an agency's policy has engendered serious reliance interests in regulated parties, it must take these interests into account and provide more detailed justification for the shift in policy than what would suffice for a new policy created on a blank slate. *Id.,* citing *Smiley v. Citibank (South Dakota), N. A.*, 517 U.S. 735, 742 (1996). A court should not defer to an agency's "convenient litigating position," a new interpretation of requirements that creates "unfair surprise" to regulated parties, or when an agency's interpretation would impose retroactive liability "for longstanding conduct that the agency had never before addressed." *Kisor v. Wilkie*, 139 S.Ct. 2400, 2417–18 (2019) (citations omitted).

In this case, Court is not faced with an agency regulation bearing the force of law that purportedly prohibits the conduct at issue, but rather "an agency's mere assertion that state law is an obstacle to achieving its statutory objectives." *See Wyeth v. Levine,* 555 U.S. 555, 576 (2009). When such a position is adopted without first offering States or other interested parties notice or opportunity for comment, the

agency's views are "inherently suspect." *Id.* This is particularly true when an agency "reverses [its] own longstanding position." *Id.*

Since Congress' enactment of the HSR Act, the FTC has issued numerous policy statements expounding its views on the state action immunity doctrine and COPA transactions.[4] *See* Declaration of Terrence J. Donahue, Jr., attached hereto.[5] The FTC acknowledged that the conferral of state action immunity to a transaction would prevent antitrust authorities from scrutinizing, moderating, or preventing anticompetitive mergers. *See e.g.* March 8, 1993 Letter to Attorney General of North Dakota, attached as Exhibit 1 at p. 2 (COPA issued by attorney general "would immunize the agreement from state or federal antitrust liability"); February 14, 2008 Letter to Hon. William J. Seitz, attached as Exhibit 2 at p. 7 ("[t]he state action doctrine … shields certain anticompetitive conduct by the states from federal antitrust scrutiny"); June 5, 2015 Letter to Hon. Michael H. Ranzenhofer and Hon. Thomas Abinanti, attached as Exhibit 3 at p. 5 (legislative instruments "appear[ed] to confer broader antitrust immunity than the COPA regulations"); May 2, 2016 Letter to Hon. Larry Stutts, attached as Exhibit 4 at p. 6; November 1, 2017 FTC Staff Notice of COPA Assessment, attached as Exhibit 5 at p. 1 ("COPA laws … have been extended to shield provider mergers that might otherwise attract the attention of antitrust enforcers"); October 7, 2022 Submission to New York State Health

[4] It is "clearly proper" for a court to take judicial notice of a federal agency's publicly available documents that are directly relevant to the matter under consideration. *Funk v. Stryker Corp.,* 631 F.3d 777, 783 (5th Cir. 2011), quoting *Norris v. Hearst Trust,* 500 F.3d 454, 461 n. 9 (5th Cir.2007).
[5] All references to exhibits appearing in this section refer to exhibits attached to the declaration.

Department, attached as Exhibit 6 at p. 1 (COPA regulatory schemes "shield[] specific hospital transactions from vigorous antitrust enforcement").

The FTC has also identified certain specific issues that could prevent application of the state action immunity doctrine. *See e.g.* May 13, 1999 Letter to Hon. Rene O. Oliveira, attached as Exhibit 7 at p. 2; March 18, 2009 Letter to Rep. Tom Emmer, attached as Exhibit 8 at pp. 8-9 May 18, 2011 Letter to Rep. Phillip Johnson, attached as Exhibit 9; May 18, 2011 Letter to Rep. Elliott Naishtat, attached as Exhibit 10 at p. 6; June 8, 2011 Letter to Sen. Eric D. Coleman, Sen. John A. Kissel, Rep. Gerald Fox and John W. Heatherington, attached as Exhibit 11 at pp. 6-7; October 20, 2011 Letter to Sen. John J. Bonacic, attached as Exhibit 12 at p. 6.

In at least one instance, the FTC determined that a State's issuance of a COPA was effective in conferring state action immunity upon a hospital merger, resulting in the agency's dismissal of an ongoing investigation into a transaction that "raise[d] significant antitrust concerns." *See* June 28, 1996 FTC Letter to Columbus Hospital and Montana Deaconess Medical Center, attached as Exhibit 13. In doing so, the FTC described how state action immunity could effectively be conferred:

> The Montana Department of Justice ("the Department") issued a COPA for the merger of Montana Deaconess and Columbus on March 7, 1996. The Department issued the COPA after it had received public comments on the proposed transaction, and considered an independent analysis of the projected cost savings resulting from the consolidation. The Department rejected several of the grounds asserted by the hospitals in favor of the merger, and attached to the COPA numerous conditions which go beyond the obligations initially offered by the hospitals. These conditions are ongoing, and do not expire after a specified time period.

If every use of "Montana" in the foregoing FTC policy statement were replaced with "Louisiana," it would describe the exact circumstances under which the Attorney

General issued the COPA authorizing the transaction between LCMC and HCA, yet nothing in the FTC's petition suggests any justification for the agency's differing approach to two seemingly identical transactions. Notably, Louisiana's COPA Law was enacted slightly more than a year after the FTC expressed the policy above

In addition, in its brief to the Supreme Court in *F.T.C. v. Phoebe Putney Health Care System, Inc.,* the FTC memorialized its awareness that regulated entities understood the conferral of state action immunity to nullify the HSR Act's pre-merger notification requirements. *See Federal Trade Commission v. Phoebe Putney Health System, Inc.*, No. 11-1160, Brief for the Petitioner, 2012 WL 3613363 at *12 (U.S. 8/20/2012); Joint Appendix, 2012 WL 6947832 at *149-*150. While the FTC ultimately did file suit contesting the hospital merger, it did not assert that the hospitals had violated the HSR Act's pre-merger notification and waiting period requirements, further illustrating the agency's recent shift in position.

B. The State Action Immunity Doctrine Immunizes LCMC's and HCA's Transaction from Federal Antitrust Laws

There are basically three approaches to analyzing the applicability of the state-action immunity doctrine in a particular case. *Spec's Fam. Partners, Ltd. v. Nettles*, 972 F.3d 671, 682 (5th Cir. 2020). First, "true state action" is *ipso facto* exempt from antitrust scrutiny. *N. Carolina State Bd. of Dental Examiners v. F.T.C.,* 574 U.S. 494, 504 (2015); *Hoover v. Ronwin*, 466 U.S. 558, 568 (1984). Second, acts by a municipalities and similar sub-state agencies are entitled to state-action immunity if "their conduct is pursuant to a 'clearly articulated and affirmatively expressed state policy' to replace competition with regulation." *Hoover*, 466 U.S. at 568–69. Third,

for acts by private parties, or by state agencies composed of individuals who actively participate in the market they regulate, a court inquires whether the acts were taken pursuant to a clearly articulated state policy and whether the acts were supervised by the state. *See North Carolina Dental,* 574 U.S. at 506; *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.,* 445 U.S. 97, 100 (1980). Under each of these approaches, the state action immunity doctrine forecloses the relief sought by the FTC.

1. Issuance of the COPA Was "True State Action"

In *Hoover v. Ronwin* the Supreme Court affirmed a lower court's dismissal of a plaintiff's antitrust claims because the action complained of—denial of admission to the State's Bar—was "that of the state itself." 466 U.S. at 568. *Hoover* clarified that, under *Parker,* acts of a state legislature "ipso facto are exempt from the operation of the antitrust laws," and further concluded that conduct of a State's supreme court, undertaken pursuant to authority granted in a State's constitution, is also to be considered "action of the state itself." *Id.* at 568, 579-80; *see also City of Columbia v. Omni Outdoor Advert., Inc.,* 499 U.S. 365, 379 (1991).

State agencies are not simply by their governmental character sovereign actors for purposes of state-action immunity. *N. Carolina State Bd. of Dental Examiners v. F.T.C.,* 574 U.S. 494, 505 (2015). For purposes of the state action immunity doctrine, a sovereign actor is one whose conduct automatically qualifies as that of the sovereign State itself. *Id.,* citing *Hoover,* 466 U.S. at 567–568. The Supreme Court's *Hoover* decision was premised upon the fact that the Arizona Constitution vested authority in the state's Supreme Court to determine who would be allowed to practice law

within the state. 466 U.S. at 561. The Court reserved the question of whether officials in the executive branch of a state's government stand in the same position as the state's legislature and supreme court for purposes of the state-action doctrine. 466 U.S. at 568, n. 17.

Though the Supreme Court has never definitively resolved the applicability of the state action immunity doctrine to executive branch officials, every circuit to have considered the issue has determined that the doctrine applies with equal force to such actors. *See Deak-Perera Hawaii, Inc. v. Dep't of Transp.,* 745 F.2d 1281, 1282 (9th Cir. 1984), *cert. denied* 470 U.S. 1053 (1985); *Neo Gen Screening, Inc. v. New England Newborn Screening Program,* 187 F.3d 24, 28–29 (1st Cir. 1999), *cert. denied,* 528 U.S. 1061 (1999); *VIBO Corp. v. Conway,* 669 F.3d 675, 687 (6th Cir. 2012),The analysis used by the Supreme Court in *Hoover* directs the same result in this case. The Louisiana Constitution provides that:

> [t]here shall be a Department of Justice, headed by the attorney general, who shall be the chief legal officer of the state. The attorney general shall be elected for a term of four years at the state general election.

La. Const. art. IV, § 8. In addition to granting the Louisiana Attorney General certain authority for "the assertion or protection of any right or interest of the state," the State's Constitution goes on to mandate that "[t]he attorney general shall exercise other powers and perform other duties authorized by this constitution or by law." *Id.*

Along with the powers and duties conferred upon the Louisiana Attorney General by Louisiana's Constitution and the State's COPA Law, other statutory enactments require him to "[r]epresent the public interest" and to "[o]rganize, plan, supervise, administer, execute, and be responsible for" the functions and programs

vested in the State's Department of Justice. La. R.S. 36:702(1); La. R.S. 36:702(4). The legislature has also designated the Attorney General as the State's exclusive legal representative in all litigation arising out of or involving tort or contract and granted him authority "to determine the purposes of the State … to be served by the litigation" La. R.S. 49:257. Still other statutes make the Attorney General "responsible to the legislature and the public" and require him to submit reports to the legislature identifying the goals of the Department of Justice and to report his progress in meeting these goals and implementing such programs. La. R.S. 36:702(1); La. R.S. 36:702(6).

Like the Louisiana Legislature and the Louisiana Supreme Court, the Attorney General is capable of exercising constitutionally-delegated authority. There is no readily apparent distinction between the Supreme Court's grant or denial of an application for admission to the Bar and the Attorney General's grant or denial of a COPA application – both are "acts of government," both implicate constitutional authority and duties, and in both instances granting of the applications is accompanied by obligations and responsibilities that further State policy. As a result, the Attorney General's issuance of a COPA renders the transaction between LCMC and HCA "true action" of the State "as sovereign" which is "ipso facto" exempt from operation of the federal antitrust laws.

2. The Transaction Was Undertaken Pursuant to a Clearly Articulated State Policy

To answer the question of whether anticompetitive conduct engaged in by nonsovereign actors should be deemed state action and thus shielded from federal

antitrust laws, the Supreme Court formulated the two-part test announced in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.* *See N. Carolina State Bd. of Dental Examiners,* 574 U.S. at 504. Under the *Midcal* test, "a state law or regulatory scheme cannot be the basis for antitrust immunity unless, first, the State has articulated a clear … policy to allow anticompetitive conduct, and second, the State provides active supervision of [the] anticompetitive conduct. *Id.,* quoting *FTC v. Ticor Title Ins. Co.,* 504 U.S. 621, 631; *Midcal,* 455 U.S. at 105.

Later, in *Hallie v. Eau Claire,* 471 U.S. 34, 45 (1985), the Supreme Court held that municipalities are subject only to the first prong of the *Midcal* test, i.e. that its anti-competitive conduct must be undertaken pursuant to a "clearly articulated" state policy. *North Carolina Dental,* 574 U.S. at 504. While *Hallie* alsostated that it was "likely that active state supervision would also not be required for State agencies, the Supreme Court later clarified that the municipality in *Hallie* was similar to a "*prototypical* state agency" inasmuch as it was electorally accountable, possessed general regulatory powers, and had no price-fixing agenda, distinguishing agencies comprised primarily of active participants in the market subject to the agency's regulation. *Id*. at 511. It is readily apparent that the provisions of the COPA Law satisfy the "clear articulation" requirement, therefore the COPA and the transaction it authorized also qualify for state action immunity under the second approach.

3. The State Actively Supervised the Transaction Before Its Completion and Continues to Supervise Its Effects

The third approach employs both the "clear articulation" and "active supervision" elements of the *Midcal* test. The active supervision requirement of the

Midcal test stems from the recognition that "[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State." *Hallie,* 471 U.S. at 47. The federal antitrust laws and the state action immunity doctrine work cooperatively to "prohibit[] the restriction of competition for private gain but permit[] the restriction of competition in the public interest." *N. Carolina State Bd. of Dental Examiners,* 574 U.S. at 509. Here, the Attorney General determined that LCMC's and HCA's transaction would benefit the State, at least as long as the terms and conditions imposed by the Attorney General are complied with. The Attorney General's issuance of the COPA is not subject to invalidation on the basis of "ad hoc and *ex post* questioning" as allowing such challenges would "transform[] state administrative review into a federal antitrust job." *See id.*; *Omni,* 499 U.S. at 372.

In any event, it is beyond dispute that that the Attorney General and LA DOJ have engaged in active supervisions of both the transaction between LCMC and HCA and the operations of the merged entity. *See* Affidavit of Angelique Freel. The terms and conditions imposed upon the transaction, along with the oversight authority the Attorney General and LA DOJ retained and continue to exercise removes any doubt that the State's officials possess and have exercised their authority to review HCA's and LCMC's actions, and that the State remains authorized to take corrective action if the results of the transaction ever fail to accord with the State policy. *See Patrick,* 486 U.S. at 101. The detailed affidavit of the Director of LADOJ's Division, definitively establishes that the State' supervision mandated in the COPA Law far

exceeds the "few contant requirements of active supervision" identified by the Supreme Court. *See N. Carolina State Bd. of Dental Examiners,* 574 U.S. at 515.

4. The COPA Immunizes the Transaction from Antitrust Scrutiny and Shields HCA and LCMC from the Federal Antitrust Laws

As the Fifth Circuit has aptly noted on several occasions, the use of the phrase state action *immunity* "is actually a misnomer because the doctrine is but a recognition of the limited reach of the Sherman Act." *See Louisiana Real Est. Appraisers Bd. v. United States Fed. Trade Comm'n,* 976 F.3d 597, 602, n. 5 (5th Cir. 2020). This is not to say, however, that the state action immunity doctrine is merely a run-of-the mill defense as the FTC suggests. *See* [Doc. 4] at pp. 7-8. To be sure, in certain circumstances the state action immunity doctrine may serve as defense to liability under the federal antitrust laws, and the Supreme Court has indicated so on numerous occasions. *See e.g. Ticor,* 504 U.S. at 640; *Omni,* 499 U.S. at 378,; *Patrick,* 486 U.S. at 98; *Southern Motor Carriers*, 471 U.S. at 66. Just as frequently, however, the Supreme Court has indicated that the state action immunity doctrine exempts eligible individuals from "antitrust *scrutiny*." *F.T.C. v. Phoebe Putney Health Sys., Inc.,* 568 U.S. 216, 225 (2013); *Patrick,* 486 U.S. at 98; *Fisher v. City of Berkeley, Cal.,* 475 U.S. 260, 265 (1986); *Hallie*, 471 U.S. at 44.

The allegations of FTC's petition indicate that the purpose of the agency's suit is to subject LCMC and HCA to the precisely the same "antitrust scrutiny" that the Attorney General's issuance of the COPA is intended to avoid. That the state action immunity doctrine would preclude the FTC from interfering with the transaction the Attorney General determined would benefit the State is completely sensible and

logical. There are other factors other than competition that a state may find more compelling when regulating its domestic commerce:

> *Parker* was not written in ignorance of the reality that determination of "the public interest" in the manifold areas of government regulation entails not merely economic and mathematical analysis but value judgment, and it was not meant to shift that judgment from elected officials to judges and juries.

Omni, 499 U.S. at 377. The FTC is attempting to do precisely what the state action immunity doctrine is intended to prevent—nullify the "value judgment" made by the Attorney General in order to impose its own judgment of what is in the State's best interest through the use of the purely economic and mathematical analyses prescribed by federal antitrust laws.

C. *Noerr Motor Freight* Precludes the Relief Sought by the FTC in this Suit

In *Omni,* the Supreme Court stated that "it is both inevitable and desirable that public officials often agree to do what one or another group of private citizens urges upon them," acknowledging the "obvious peculiarity" that would result if there existed some category of lawful state action that citizens were not permitted to urge government officials to undertake. 499 U.S. at 375, 379. This "peculiarity" fostered the formation of a "corollary" to *Parker's* state action immunity doctrine which provides that federal antitrust laws do not apply to the conduct of private individuals who petition their government to engage in anticompetitive conduct. *Id.*; citing *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.,* 365 U.S. 127 (1961) and *United Mine Workers of Am. v. Pennington,* 381 U.S. 657 (1965).

Parker v. Brown and *Noerr* are "two faces of the same coin" with *Parker's*

concept of state action immunity looking at potentially anti-competitive conduct from the perspective of governmental participants, and the *Noerr-Pennington* Doctrine viewing the conduct from the standpoint of private participants. *Omni,* 499 U.S. at 383. In other words, *Parker* and *Noerr* "are complementary expressions of the principle that the antitrust laws regulate business, not politics; *Parker* protects the States' acts of governing, and *Noerr*, the citizens' participation in government." *Id.* If private individuals were susceptible to federal antitrust laws for seeking anticompetitive government action, it would "reduce *Parker* 's holding to a formalism that would stand for little more than the proposition that Porter Brown sued the wrong parties." *Southern Motor Carriers* 471 U.S. at 57.

Pursant to *Noerr,* since the COPA constitutes state action that is exempt from federal antitrust laws, LCMC and HCA are themselves exempt from the application of these laws because they petitioned the Attorney General for its issuance in the first instance.

VI. CONCLUSION

For the foregoing reasons, Attorney General Jeff Landry respectfully requests that the Court dismiss FTC's claims and all other relief to which he is or may be entitled.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I certify that on July 18, 2023, a copy of the foregoing Motion was filed electronically with the Clerk of Court via the CM/ECF system. Notice of this filing will be sent to all counsel of record by operation of the court's electronic filing system.

s/ Terrence J. Donahue, Jr.
Terrence J. Donahue, Jr.

UNITED STATES DISTRICT COURT FOR THE

EASTERN DISTRICT OF LOUISIANA

FEDERAL TRADE COMMISSION Plaintiff, v. LOUISIANA CHILDREN'S MEDICAL CENTER and HCA HEALTHCARE, INC. Defendants.	CIVIL ACTION NO. 23-1305 c/w 23-311 c/w 23-890 REF: ALL CASES SECTION I

INTERVENOR, STATE OF LOUISIANA'S STATEMENT OF UNDISPUTED FACTS

In accordance with Local Rule 56.1 and Fed. R. Civ. P. 56(c), Intervenor, the State of Louisiana, by and through Attorney General Jeff Landry submits the following Statement of Undisputed Facts in support of its Motion for Judgment on the Pleadings or, alternatively, Motion for Summary Judgment.

Certificates of Public Advantage

1. Louisiana is one of 19 States that have enacted certificate of public advantage (COPA) statutes. Amy Y. Gu, Updated: States with Certificate of Public Advantage (COPA) Laws, Source on Healthcare Price & Competition (Aug. 10, 2021), https://sourceonhealthcare.org/updated-states-with-certificate-of-public-advantage-copa-laws/.

2. Louisiana's statute creates a regulatory program to authorize healthcare mergers and place them under State "supervision and control." La. Stat. § 40:2254.1.

3. The statute provides that "the intent of the legislature" is to "substitute state regulation of [healthcare] facilities for competition between facilities," and to "grant[] … state action immunity … [from] federal antitrust laws." Id.

4. The Louisiana Attorney General, as head of the Louisiana Department of Justice ("Department"), administers the COPA statute. Id. § 40:2254.4.

5. Parties may apply to the Department for a COPA. Id. § 40:2254.4.

6. After review, the Department may grant a COPA only if it "finds that the agreement is likely to result in lower health care costs or is likely to result in improved access to health care or higher quality health care without any undue increase in health care costs." Id.

7. The Department may issue a COPA "subject to terms and conditions" to ensure compliance with state policy. Id.

8. After approval, the Department must "active[ly] supervis[e]" the merger. Id. § 40:2254.9(3).

9. The Department has authority to promulgate supervision regulations, enforce compliance with a COPA's terms and conditions, and to "revoke a certificate." Id. §§ 40:2254.9(3); 40:2254.4, 40:2254.6(A).

The Acquisition and COPA Approval

10. The Hospitals applied for COPA approval on October 10, 2022. Dkt. 23-4.

11. Louisiana Children's Medical Center (LCMC) is a non-profit health system operating as an Organized Health Care Arrangement under Louisiana law. Dkt. 23-5 ¶ 3; Dkt. 23-4 at B-3; Dkt. 19-1 ¶ 4.

12. HCA Healthcare, Inc. (HCA) previously owned and operated three hospitals in Louisiana through a joint venture with Tulane University of Louisiana. Dkt. 23-4 at B-7–8.

13. Under the transaction (the "Acquisition"), LCMC would acquire Tulane University Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital from HCA. Id. at B-8–9.

14. The COPA application explained that the Acquisition was designed to increase access to high-quality clinical services and health care in the New Orleans region and to expand hubs for specialty care, innovation, and academic medicine. Id. at B-10–17.

15. In the COPA application process, the LCMC committed to making $220 million in capital investments to modernize the facilities (such as investing in robotic surgical systems), offer new medical services (such as kidney, pancreas, liver, bone marrow, and stem cell transplants), and add new specialty care units. Id. at B-10–17.

16. The Hospitals supplemented their COPA application on November 2, 2022; November 4, 2022; November 10, 2022; November 15, 2022; and November 18, 2022. Dkt. 23-2 at 2.

17. The Department extensively reviewed the application's substantive information regarding the transaction, the facilities, and the likely effects on health care and competition in the state. Dkt. 23-5 ¶¶ 12, 19–31; Dkt. 23-5 at 2; Dkt. 19-1 ¶ 12; Dkt. 23-4 at B-3–73; Declaration of Angelique Freel at ¶¶ 15-29

18. The Department obtained input from expert consultants who reviewed the COPA application. Dkt. 23-5 ¶ 12; Declaration of Angelique Freel at ¶¶ 25,28

19. The Department held a notice and comment period, received and reviewed numerous comments from the public, and held a public hearing. Dkt. 23-5 ¶¶ 12, 14, 20–29; Dkt. 23-5, Attachments 1–8; Dkt. 19-1 ¶¶ 12–13; Declaration of Angelique Freel at ¶¶ 23, 26

20. The Department approved the Acquisition and granted a COPA on December 28, 2022. Dkt. 23-2, 23-3; Declaration of Angelique Freel at Ex. D

Supervision Under the COPA

21. The COPA's "Terms and Conditions" provide for ongoing supervision. Dkt. 23-3; Dkt. 23-5, LADOJ Pet. of Intervention ¶¶ 29, 32–33, 35, 49.

22. Under the "Rate Review" provision, LCMC "may not contract with a third-party payor for a change in rates" without prior written approval. Id. at 6.

23. LCMC must also submit quarterly, semi-annual, and annual reports, enabling the Louisiana Attorney General to ensure that LCMC's activity remains consistent with the State's policy goals. Id. at 7–10.

24. If a problem arises, the Department may impose "a plan to correct any deficiency." Id. at 2.

25. The Department may "revoke the COPA" if it is "not satisfied with any submitted corrective action plan," if LCMC fails to comply with the Terms and Conditions, or if the Department "otherwise determines that the transaction is not resulting in lower health care costs or greater access to or quality of health care." Id. at 3.

26. Relying on the COPA and the Department's supervision, Respondents LCMC and HCA closed the transaction on January 1, 2023, and announced the closing on January 3, 2023.

Interference with State Regulatory Process

27. The Commission has previously participated in States' COPA processes by submitting comments and participating in state-led hearings during COPA review processes, without raising Sections 7 or 7A. FTC Policy Perspectives on Certificates of Public Advantage, at 1 n.2, 11 n.49, 12 n.62 (Aug. 15, 2022), https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-policy-paper-warns-about-pitfalls-copa-agreements-patient-care-healthcare-workers.

28. The Commission has previously determined that other State's COPA programs succeeded in affording State Action Immunity in Hospital Mergers. Declaration of Terrence J. Donahue, Jr.

29. The Commisson is aware of the widespread belief among the parties it regulates that state action immunity relieves the obligation to file pre-merger notification. Declaration of Terrence J. Donahue, Jr.

30. The Commission did not participate in the Louisiana COPA approval process for the Acquisition. Dkt. 23-5 ¶ 28; Declaration of Angelique Freel at ¶ 38.

31. The Commission first informed the Hospitals of its view that Section 7A applies to COPA-approved mergers on April 4, 2023. See Dkt. 5-6.

32. The Commission insisted that the Hospitals make a Section 7A filing and halt integration of the hospitals while it determined whether the transaction violates Section 7. See Dkt. 5-8; Dkt. 5-12.

33. The Commission threatened penalties for failure to comply, stating that "civil penalties are accruing." Dkt. 5-12 at 1.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I certify that on July 18, 2023, a copy of the foregoing Motion was filed electronically with the Clerk of Court via the CM/ECF system. Notice of this filing will be sent to all counsel of record by operation of the court's electronic filing system.

s/ Terrence J. Donahue, Jr.
Terrence J. Donahue, Jr.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

FEDERAL TRADE COMMISSION,

Petitioner,

v.

LOUISIANA CHILDREN'S MEDICAL CENTER,

and

HCA HEALTHCARE, INC.,

Respondents.

Case No. 2:23-cv-01890

DECLARATION OF ANGELIQUE FREEL

I, Angelique Freel, declare as follows:

1. I am a United States citizen over the age of eighteen. I make and submit this Declaration pursuant to 28 U.S.C. § 1746.

2. If called upon as a witness, I could testify to the matters to which this Declaration refers and would be competent to do so.

3. I am the Director of the Civil Division for the Louisiana Department of Justice, Office of the Attorney General, and I have served in that capacity since May 2, 2017. Prior to serving as Director, I worked in various capacities in the Civil Division since July 16, 2007, including Assistant Attorney General, Section Chief of the Education Section, Section Chief of the Governmental Litigation Section, and Deputy Director of the Civil Division.

4. I submit this declaration upon personal knowledge or information and belief, including inquiry of relevant attorneys and staff of the Louisiana Department of Justice ("LADOJ").

5. Pursuant to Louisiana Administrative Code ("LAC"), Title 48, Part XXV, Section 501, *et seq.* the application for the underlying Certificate of Public Advantage ("COPA"), was submitted to me in my capacity as Director of the Civil Division. I personally received and reviewed the application; requested supplementation of the COPA application; presided over the public hearing; conferred with consultants, attorneys, staff of the LADOJ, and the Attorney General relative to consideration of the COPA application.

Louisiana's COPA Statute

6. In 1997, the Louisiana State Legislature passed, and Governor Mike Foster signed into law, La. R.S. 40:2254 (the "COPA Statute"). This COPA statute provided the framework for the LADOJ's review and consideration of the COPA.

7. The COPA Statute is the result of "the legislature['s] find[ing] that the goals of controlling health care costs and improving the quality of and access to health care will be significantly enhanced in some cases by cooperative agreements and by mergers and consolidations among health care facilities." La. R.S. 40:2254.1. The stated purpose is to provide the state, through the LADOJ, with direct supervision and control over the implementation of cooperative agreements, mergers, joint ventures and consolidations among health care facilities for which certificates of public advantage are granted. *Id.*

8. The express stated "intent of the legislature [is] that supervision and control over the implementation of these agreements, mergers, joint ventures, and consolidations substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements, mergers, joint ventures, or consolidations state action immunity for actions that might otherwise be considered to be in violation of state antitrust laws, federal antitrust laws, or both." La. R.S. 40:2254.1.

9. The COPA Statute placed responsibility for the supervision and control of proposed agreements with the LADOJ. Specifically, it established a process for merger parties to apply for, and the LADOJ to consider and approve or reject, a COPA. La. R.S. 40:2254.1-2254.12.

10. After review, the LADOJ may grant a COPA if it "finds that the agreement is likely to result in lower health care costs or is likely to result in improved access to health care or higher quality health care without any undue increase in health care costs." La. R.S. 40:2254.4. In order to make that determination, the process for approving a COPA requires submissions by applicants, consultation with experts, notice to the public, input from a range of stakeholders, a public hearing, and consideration by State officials.

11. Pursuant to the COPA Statute, and in accordance with the Louisiana Administrative Code, the LADOJ promulgated rules and regulations that specify the required form of COPA applications, the substantive information to be included, and the procedures to be followed. LAC 48:XXV.501-519. Among other things, applicants are required to (i) provide descriptions of the products and services offered by the parties to the agreement, (ii) provide descriptions of the market and regulatory conditions and competitive dynamics, (iii) identify business plans and other documents discussions each party's projected performance, business strategies, and competitive analyses, (iv) describe performance goals for achieving (and the quantitative standards for measuring) reductions in health care costs and improvements in quality and access, (v) provide descriptions of anticipated efficiencies and cost savings from the proposed transaction and how they will be passed on to consumers, (vi) provide descriptions of meetings held by the parties with financial advisors, partners, outside experts and consultants, government officials, and other parties regarding the transaction, (vii) submit any fairness opinions analyzing the transaction along with any supplemental expert analysis, (vii) submit minutes of the parties' board meetings addressing the transaction and the documents, presentations, or reports distributed at such meetings, (viii) provide six years of detailed financial records and five years of valuation information for each party, (ix) provide contact information for each party's officers, directors, managers, executives, experts, and others that had substantial input into any phase of decision-making or planning of the transaction, and (x) submit any market studies or analysis conducted by each party. LAC 48:XXV.507.

12. If a COPA is issued, the COPA Statute requires the LADOJ to conduct "active supervision" of the transaction. La. R.S. 40:2254.9(3). Specifically, the COPA Statute requires recipients of a COPA to submit, and the LADOJ to review, periodic reports demonstrating

compliance with any terms and conditions imposed by the LADOJ in connection with the COPA issuance. La. R.S. 40:2254.11. The LADOJ's regulations further require the recipients of a COPA to submit annual reports evaluating the continued benefits of the agreement, including information regarding their progress towards meeting specific benchmark goals of health care cost, quality, and access. LAC 48:XXV.517.

13. The Attorney General may bring an enforcement action to enforce any terms or conditions imposed by the LADOJ relative to the COPA. La. R.S. 40:2254.10.

14. The LADOJ shall revoke a COPA if it determines that the COPA is not resulting in lower health care costs or greater access to or quality of health care that would occur in the absence of the agreement. La. R.S. 40:2254.6.

COPA Application Submitted by LCMC and HCA

15. On October 10, 2022, LADOJ received an application for a COPA regarding the proposed transaction between LCMC Health, HCA, Tulane University ("Tulane"), and University Healthcare System, L.C. ("UHS").

16. The parties' initial COPA application spanned 175 pages, including, among other things, information about the parties and their operations, the services they offer, their contractual relationships, the competitive dynamics and market conditions for health care services in the New Orleans area, the projected cost-savings that would result from the transaction (including from the elimination of certain duplicative expenses and optimization of capital expenditures), and specific investments and other patient-friendly initiatives that LCMC would be able to undertake as a result of the Acquisition.

17. In addition, the COPA application included exhibits reflecting the parties' financials, strategic plans, board deliberations, and consultant analysis of the transaction, among other subjects.

18. After a review of the initial application, the LADOJ requested additional information and supplemental information before deeming the application complete.

19. As part of that iterative review process, the parties made supplemental submissions to LADOJ on November 2nd, 4th, 10th, 15th, and 18th, after which time the LADOJ deemed the COPA application complete.

20. The completeness determination commenced a 30-day period within which the applicable regulations required the LADOJ to hold a public hearing for the public to provide input regarding the COPA application. *See* LAC 48:XXV.511.B.2. The LADOJ scheduled the public hearing for December 8, 2022.

21. Consistent with the applicable regulations, which require the LADOJ to publish notice of the public hearing in the official journal of the parishes where the hospitals are located at least 10 days prior to the scheduled hearing, the LADOJ caused notice of the hearing and instructions to provide public comments to be published in the St. Tammany Farmer – the official journal for St. Tammany Parish, where Lakeview Regional Medical Center is located – and the Times Picayune/The New Orleans Advocate – the official journal of Jefferson and Orleans Parishes, where Tulane University Medical Center and Tulane Lakeside Hospital are located. The notice in the St. Tammany Farmer ran on November 24, and November 30, 2022, and the notice in the Times Picayune/The New Orleans Advocate ran on November 21, 22, and 23, 2022.

22. On December 5, 2022, the LADOJ posted notice of the hearing on the Attorney General's website at https://agjefflandry.com/Article/13095, and a physical notice was posted at

the Claiborne Building, located at 1201 N. 3rd St., Baton Rouge, Louisiana, where the hearing was scheduled to take place.

23. Written comments were submitted to the LADOJ in advance of the public hearing. All written comments were made part of the public hearing record. *See* Exhibit A (attachments to transcript).

24. The public hearing on the COPA application was held on December 8, 2022, at the Claiborne Building in Baton Rouge. All interested persons were allowed to present testimony, facts, or evidence related to the COPA application, and were permitted to ask questions. The hearing began at 10:00 a.m., and it adjourned at 1:40 p.m.

25. Attorneys and staff from LADOJ, along with consultants, considered and discussed the comments that were presented at the hearing.

26. At the conclusion of the public hearing, I announced that I would extend the public comment period and continue to accept written comments through December 13, 2022.

27. A transcript of the public hearing (with all attachments, including the written public comments received) is attached hereto as Exhibit A.

28. After consideration of the COPA application and the public comments received in connection with the hearing, and after extensive analysis by LADOJ attorneys and staff regarding the transaction, the facilities, and the likely effects on health care and competition in the state, which also included input from expert consultants who reviewed the COPA application, the LADOJ determined that the application materials satisfied the statutory requirements and that a COPA should be issued in connection with the Acquisition.

29. The Attorney General approved the COPA. The COPA approval is reflected in a letter from Louisiana Attorney General Jeff Landry to the parties dated December 28, 2022. *See* Exhibit B.

30. The Attorney General's approval remains subject to various terms and conditions as the statute authorized. The terms and conditions empower the LADOJ to "actively supervise" both the transaction itself and the new health system on an ongoing basis to promote the value-based health care objectives of the COPA Statute. *See* Exhibit C.

31. Notably, one of the conditions set out in the approval letter is a requirement for the newly-created health system to submit periodic reports (on quarterly, semi-annual, and annual bases) regarding the investments and other initiatives that the parties described in the COPA, and to collect and submit a wide range of data in order to benchmark the new health system's progress towards the health care cost, quality, and access objectives contemplated by the COPA.

32. With each report, the LADOJ is evaluating the progress towards the proposed improvements to quality and access to healthcare. The LADOJ recently received a quarterly report and evaluated progress towards the following:

- Creation of a new nursing program at Tulane Medical Center;
- Development of Tulane's Downtown Campus;
- Redevelopment of the Abandoned Charity Hospital Downtown;
- Creation of a Premier Academic Medical/Teaching Center at East Jefferson General Hospital;
- Capital investments at East Jefferson General Hospital, Tulane Medical Center, Lakeside Hospital, and Lakeview Hospital;
- Creation of Centers of Excellence--a planned comprehensive stroke program, cardiac care services, solid organ/bone marrow transplant services;
- Medical research;
- Expansion of electronic medical records systems;
- Material openings, closures, mergers of outpatient facilities;
- Material openings, closure or mergers of inpatient facilities; and
- Any required reporting events.

33. In addition to ongoing reporting and monitoring requirements, the COPA also requires that the new health system obtain prior written approval from the LADOJ for any proposed changes in the rates it charges payors for health care services.

34. The LADOJ reviewed LCMC Health's Rate Review Application submitted on April 21, 2023, and subsequent submissions made during May 2023 and June 2023. The LADOJ approved Blue Cross Blue Shield of Louisiana and United Health Care contracts on June 30, 2023. *See* Exhibit D.

35. The LADOJ is currently reviewing LCMC Health's Rate Review Application submitted on June 30, 2023, for Vantage Health Plan Inc., and Aetna Network Services, LLC.

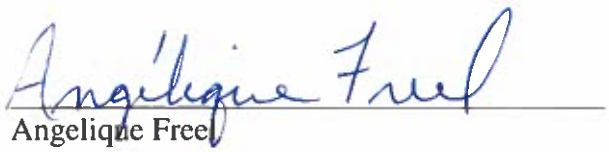
36. The terms and conditions of the COPA require the new health system to adopt a corrective action plan if the LADOJ determines at any time that its activities are inconsistent with the COPA Statute's policy goals, and it expressly reserves to the LADOJ the right to revoke the COPA if it determines that the transaction is not achieving its objectives for health care cost, quality, or access.

37. The LADOJ may also bring an enforcement action to enforce the terms of the COPA or revoke the COPA.

38. The FTC did not contact the LADOJ prior to the approval of the COPA application, nor did the FTC provide a public comment to the LADOJ concerning the proposed transaction.

39. The relief requested by the FTC in this lawsuit, if granted, would interfere with the State's right to implement and actively supervise the COPA, as well as the access and quality of healthcare available in the State.

I declare under the penalty of perjury that the foregoing is true and correct.



Angelique Freel
Director of the Civil Division
Louisiana Department of Justice

Executed on July 18, 2023

Freel Declaration Exhibit A

LOUISIANA DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

CIVIL DIVISION

* * *

PUBLIC HEARING RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE REGARDING A PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

* * *

THURSDAY

DECEMBER 8, 2022

10:00 A.M.

REPORTED BY: CORI M. RODGERS, CCR, CVR

LA CCR# 2020003

PROCEEDINGS

MS. ANGELIQUE FREEL: My name is Angelique Freel. I'm the director of the civil division. And it is my division that receives the COPA application and assists the Attorney General with review and a determination as to the application.

First off, I want to thank everyone that is here today. You know, we occasionally have hospital transactions, but they're not this well attended. And so we appreciate everyone here today, coming here, hopefully, to provide a comment when it's appropriate. And so thank you for being here. We are -- we certainly do appreciate your input.

I'd like to start by just introducing who's up here today. And right here is Brett Robinson, he's also an Assistant Attorney General in the civil division.

We have Nicole Hebert, and she's an Assistant Attorney General in the federalism division.

And then to my right, we have consultants that are assisting us with the review. We have Ben Gaines and Lanzi Meyers with the Gachassin Law Firm. We have CPA Chris Rainey.

To my left, we have Nancy Cassagne, and we have Eric Marshall and Eric Pfeifer from Leavitt. And so this is the team that is assisting the AG's office in review of the application.

At this time, I'd like to give you a little bit of background of the COPA process. And, as everyone knows, this is an application for a Certificate of Public Advantage regarding a proposed transaction between HEA, Healthcare, Inc., Tulane University, Tulane Healthcare System, LLC, and Louisiana Children's Medical Center d/b/a LCMC Health.

So the purpose of a COPA is to better serve the citizens of Louisiana by pursuing and attaining the key aims of value-based healthcare, namely a decreased cost of care, improved quality of care, and our increased access to care.

And for COPA and other transactions, the State of Louisiana aspires to work with healthcare organizations to help the State and to lead the nation to achieve these goals.

For approval to be granted, the State must have reasonable assurance that the goals will be met. So in terms of this specific application, the application was received by our office on October

10, 2022.

As we started reviewing the application, we felt like additional information was needed for it to be complete. And so we did not deem it complete until November 18, 2022.

Once that happened, that triggered some delays as to when we had to make our decision and when we needed to hold this public hearing. And so under the law, we had to hold the hearing by December 18, 2022. We are here today. We decided we didn't want it to be that close to the holidays. We wanted to make sure that people had an opportunity to come here.

And so we're here today for the public hearing. And in an appropriate time, you'll be able to give comment. And then by February 16th, the office has to administer a decision.

So I alluded to the fact that there will be a public comment period. That is why we are here, primarily. And it's important that you do give us some input because the comments will help the Department identify potential benefits and risks associated with the COPA, and help form additional questions that we might need to pose to the applicants.

To my left, in the front, is an assistant with the AG's office, Michelle Boutte. She has cards. We're going to ask that if you would like to provide public comment, that you please just fill out a card. And when it's appropriate, we'll go through those cards and call you up to the mics to provide that comment.

The green card indicates that you're in support of the transaction. You don't have to speak, but you can elect that on the card. You can just show your support for it, or you can indicate that you're in support, but you'd like to speak.

The white card is for information. And the red card is if you're against the transaction. And, again, you don't have to speak. You can indicate whether or not you want to speak. Just to get through everyone, the public comment period will be limited to three minutes.

We do have a court reporter here. She's to the left. She'll be transcribing everything. It'll be part of a record.

And we also, per our publication in the official journals, we gave an address for public comment. And we have received a good many public comments in writing, in advance of this transaction.

And we will go through those after everyone in this room has had an opportunity to testify. That way, if you need to leave, we don't want you to be delayed by us going through the paper comments.

If you want to submit a comment in writing, my email is below. I ask that you do that very soon. We'll -- we're going to close the record, probably the early part of next week, I'd say by Tuesday.

And at this time, we are going to go ahead and turn this over to the applicant for a presentation to provide some history and a general description of the proposed transaction.

MR. PATRICK NORTON: All right. Good morning. My name is Patrick Norton. I'm the senior vice president, chief operating officer, and treasurer of the Cotton Bowl-bound Tulane University. And we are looking forward to describing our partnership and the benefits that will accrue to New Orleans, our region, Louisiana, and beyond. Thank you.

MS. JOANN KUNKEL: And good morning. My name is JoAnn Kunkel and I'm the chief financial officer for LCMC Health. I live in New Orleans, and I'm honored to be here today to talk about the

history of LCMC Health and the combined vision of our partnership with Tulane University.

Today, LCMC Health is a six-hospital health system, proud to call Louisiana home. Each year, nearly one million primary and specialty care clinic visits are delivered by over twenty-seven hundred LCMC physicians and providers.

We're a large employer with almost eleven thousand employees. We've been recognized as a top place to work in healthcare. Recently, over seventy-five percent of our employees participated in an annual employee engagement survey. We saw year-over-year gains in our employee overall rating as a place to work, and in both employee and provider overall ratings as a place for care.

Overall scores are higher than national average. This is exemplified by our mission statement: Health, care, and education beyond extraordinary. And live daily through our values. We bring heart and soul. We're in it together. We give a little extra.

LCMC Health has a long history of serving the community and its healthcare needs. In the beginning, we were Louisiana's only standalone children's hospital. The devastation of Hurricane

Katrina and the closing of Charity Hospital displaced the indigent population. Caring for the neediest patients created financial distress at many of the local hospitals.

In 2009, Touro Infirmary was experiencing financial stress. And as a long-time partner of Louisiana Children's, the two came together to preserve the community assets of Touro and to form LCMC Health.

Similar to Touro, other local hospitals found themselves facing financial hardship. And throughout the next decade, LCMC Health continued to respond to the call in the community by stepping up when asked to partner with and preserve the community health assets, including: New Orleans East Hospital in 2012; in 2015, pursuing and entering into the public private partnership with the University Medical Center in downtown New Orleans; and in Jefferson Parish, adding both West Jefferson Medical Center and East Jefferson General Hospital in 2015 and 2020.

We, LCMC Health, believe we are better together.

MR. PATRICK NORTON: Tulane University has a long and stored history. We're nearly two hundred

years old. We are the largest private employer in Orleans Parish. We contribute over $3 Billion to the Louisiana economy a year. We have over four hundred faculty positions. And we have over seven hundred and fifty medical students.

We have the most engaged -- second most engaged students in community service as ranked by the Princeton Review. And Forbes ranked us as #2 in the state, across all industries, for employee satisfaction.

And if you think about the pandemic and what different industries went through during the pandemic, we had no furloughs, no layoffs. We made commitments to our employees. And we care deeply about our community, our employees. We've been around for over two hundred years, or nearly two hundred years, and we aren't going anywhere.

We have over five thousand employees, as well. And we are the second oldest medical school in the south. Okay.

MS. JOANN KUNKEL: LCMC Health and Tulane University are both mission-based not-for-profit organizations that call Louisiana home. We have shared values and a vision to bring the best community healthcare and academic medicine to all

those we serve.

Together, we will not only increase access to comprehensive and specialty care across the region, but also advance groundbreaking research, innovative technology, and life-saving treatments that ensure all our patients and communities can receive the highest quality care.

As part of the transaction, the three Tulane hospitals are joining LCMC Health: Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital. We are, and remain, committed to all employees and are offering jobs to everyone. And we are committed to quality care and access for all current and future patients.

LCMC Health has committed to investing $220 Million toward the economic development of East Jefferson General Hospital to create a premier academic medical center, which will serve as Tulane's primary teaching facility. The investment will also contribute to enhancing access, services, and quality at the system's downtown University Medical Center.

We will create an expanded hub for specialty care, innovation, and academic medicine at East Jefferson. We will expand clinical services

and academic expertise at University Medical Center. And we will -- ensuring that our patients and communities downtown have increased access and quality care close to home.

MR. PATRICK NORTON: So in addition to creating two academic medical centers, two: one in Orleans Parish right where the UMC is; and one in Jefferson Parish where EJ is. We are also committed to the quality of care and increase access to quality healthcare.

In addition to that, this now allows us to take the property downtown and to re-purpose it for, really, for the benefit of the citizens of New Orleans and for the citizens of Louisiana.

So the Tulane downtown campus will also be a home to a new nursing program. There is a shortage of nurses, not only city-wide, regionally, but also nationally. And we look to start a cohort in 2024. And in steady state, we will be graduating two hundred and twenty nurses a year out of this new nursing program that will be in downtown in the property that -- where the hospital is now.

This could not have been done at the speed or the scale without the partnership of LCMC. Just not possible.

In addition to a new nursing program, we're going to be doing some more clinical research. And that's really important, right? Academic medical centers bring research from the bench to the bedside. And that really does help with health outcomes and a quality of care that we provide to New Orleanians and everybody in Louisiana. We want to be destination healthcare. We want people from Louisiana to stay here in our state, as opposed to going outside of our state for healthcare.

We're also looking at other uses -- and I'll speak about that in a moment -- that's going to happen in that property as well.

So we are committed to improving care in Louisiana, both LCMC and Tulane. Two Hundred and Twenty Million Dollars ($220,000,000.00) will be invested in the community at East Jefferson, at Lakeside, and Lakeview, to provide best-in-class academic medical center facility improvements. So $220 Million have been committed to be deployed out into our healthcare eco system.

In addition, Tulane has committed $100 Million in capital investments dedicated to creating a new nursing program, clinical research programs, and educational space for students at the Tulane

downtown campus.

The hospital building as it is now sits at the epicenter of our downtown campus. Our downtown campus is where our research is happening, where School of Public Health's home is, where our School of Medicine's home is, and where our School of Social Work is as well.

That is part of this. And if you know New Orleans, it's between Claiborne and Elks, and between Canal and Gravier, is really the Tulane downtown campus. This hospital building, all 600,000 square feet of it, is at the center of it. And that's going to be redeveloped for the School of Medicine, for other purposes, but also for the benefit of the citizens of the area.

We also create $286 Million -- or will create $286 Million in annual economic impact and potential creation of 2,300 new jobs in downtown New Orleans and throughout the state.

And just to further talk about our downtown development, we are creating this vibrant community and a research hub. So we are investing, or what's being invested, is approximately $600 Million to downtown New Orleans, including new constructions and enhancements.

And one big project downtown, which you may have heard of, is the revitalization and renovation of the iconic Charity Hospital. Right? A million square feet of space that has been dormant since after Katrina. And when we move into it, along with others, it will be twenty years after Katrina. Twenty years after Katrina. So it would have been laid dormant for that long.

In this building, which is going to be, you know, predominantly housing the School of Medicine and the School of Tropical Medicine -- of Public Health and Tropical Medicine, will be lots of research labs. There's an explosion of research that's happening at Tulane University.

We've done over $200 Million of research and plan to do $300 Million a year of research in the foreseeable future. And we're going to take that research and, once again, from the bench to the bedside, and fuse it into our new healthcare system -- right? -- with LCMC, but also at the same time, scale it, commercialize it, monetize it, through incubator startups, through Art Tulane Innovation Institute, which just got launched over the summer.

So Tulane is doubling, tripling, quadrupling down on research and healthcare. And

this is just an example of it right here.

MS. JOANN KUNKEL: And as was mentioned in the opening, this slide is really why we're here today. We believe this transaction will improve healthcare for all Louisianans.

This partnership will expand access by creating a new and vibrant academic medical center at East Jefferson, while maintaining UMC as a premier academic medical center for downtown New Orleans, and by expanding clinical programming, provider recruitment, and retention.

This partnership will improve quality by combining clinical expertise to enhance patient outcomes and investing in facilities and higher quality services, delivering the highest patient experience.

And this partnership will contain costs by creating efficiencies, allowing for reinvestment in local operations, and eliminating out-of-state overhead funding for hospital management, bringing operational oversight local.

MR. PATRICK NORTON: And this is just a sampling of some of the overwhelming public support we've received so far, and I believe you've received a lot as well, or certainly probably lots of emails,

as you mentioned on this, from our council, from the New Orleans council, from our state senators, from presidents of parishes, parish presidents, and from the chancellor of LSU healthcare system. That just shows the positive overwhelming support. This is just a small sampling.

And you see here, in this room, some more public support. We couldn't fit in this room, or probably in this building, all of the individuals that have been coming up to us and expressing their public support about this transaction and how it's going to affect the lives of New Orleanians and citizens of Louisiana and beyond.

And we look forward to hearing some of the comments and coming back and having some closing comments. Thank you.

MS. ANGELIQUE FREEL: Okay. In advance of this hearing, there were some people that indicated that they are here. And I just want to go ahead and recognize them. And then we'll start with comments.

So we have Jennifer Van Vrancken, Jefferson Parish Council Member, District 5; Jerry Bologna, President and CEO of JEDCO; Ruby Brewer, Chief Nursing Officer, East Jefferson General Hospital; John -- Dr. John Heaton, President and Chief Medical

Officer of LCMC Health; Allison Guste, Vice President of Quality and Nursing, LCMC Health; Charlotte Parent, AVP of Community Affairs, University Medical Center New Orleans; Chip Cahill, Board Member of LCMC Health; Sam Valera, Marketing Director, LCMC Health; LaDana Williams, Director of Public Relations, LCMC Health; John Pourciau, AVP Government Affairs, LCMC Health; Peter Waggonner, Greater New Orleans, Inc.; Terrie Sterling, LCMC Health; Percy Manson; and other persons affiliated with Tulane University, including physicians, residents, and students; Dr. Lee Hamm, Dean, Tulane University School of Medicine.

So with regard to the public comment, notice of the hearing and opportunity for public comment appeared in the official journals of St. Tammany, Orleans, and Jefferson Parish. They were published in both the Times-Picayune, in Advocate, as well as the St. Tammany Farmer. And at this time, for purposes of the record, we will be giving the court reporter the Notices and Certifications of Publication.

All right. And just a reminder, if you would like to speak today, you can fill out a card. We encourage you to do so. And at this time, we'll

start with public comment.

Michelle, can you provide me with the cards that have been submitted as of now?

We'll go ahead and start with Jennifer Van Vrancken, Jefferson Parish Council member, District 5.

MS. JENNIFER VAN VRANCKEN: Okay.

MS. ANGELIQUE FREEL: Thank you. And I apologize if I mispronounced your name.

MS. JENNIFER VAN VRANCKEN: No. You got it fine.

MS. ANGELIQUE FREEL: Okay. Great. Thanks.

MS. JENNIFER VAN VRANCKEN: Do I sit here?

MR. BRETT ROBINSON: Yes.

MS. ANGELIQUE FREEL: And does she need to press something for the mic? It should be on? The mic should be on.

MS. JENNIFER VAN VRANCKEN: So I'm Jennifer Van Vrancken. I'm a Jefferson Parish Councilwoman, and I represent the Metairie area, which is where East Jefferson General Hospital is based. So I have a little prepared statement that I'll read into the record. But funny enough, as I was driving here this morning from Jefferson Parish, I had on WWL

Radio. Tommy Tucker is doing a Radiothon this morning to raise money for Children's Hospital.

And it just so happens that in the 9:00 hour, as I was driving here, he was interviewing a doctor, Dr. Bradford. She is a pediatric cardiologist. So she explained she teaches -- or treats, rather, children who have heart issues. She even treats in utero before their born. And then she explained she treats as adults, those patients who started their heart treatment as children because she said she has specialized training that cardiologists who trained to treat adults don't have.

I am the oldest of three siblings. My youngest sibling, my brother, had heart surgery at a year-and-a-half. And back in the '80s, they were really just on the cusp of being able to fix things that he had. He had Tetralogy of Fallot. We had an older cousin who passed away from that same situation.

So at a year-and-a-half -- I was the oldest in the family. My mom said -- I was, roughly, 10. She said, "When you see him running around, if he starts to turn blue, make sure to slow him down and, you know, let him catch his breath." And so I

remember that very well.

So he had surgery at a year-and-a-half. And they were able to fix those three conditions that he had. Today, he is 42, has a wife and a son of his own. And it is because of that specialized training that he's here and he is, you know, part of our family and, obviously, like I said, has a family of his own.

So it very much hits home with me when we talk about East Jefferson General Hospital becoming a training facility for the next generation of doctors.

So, personally, as someone who lives in the community, I want to be here to submit my personal support as a resident and a family member who calls the area around East Jefferson Hospital home.

More formally, as the councilwoman in whose district the hospital sits, I have to say this proposed partnership between LCMC Health and Tulane University is absolutely phenomenal news for Jefferson Parish and, of course, for our entire region because they don't just serve the Jefferson Parish boundaries, but serve the Metro New Orleans Region.

Two years ago, LCMC Health provided a major

win to patients, providers, and employees when it purchased East Jefferson General Hospital. Their focus on our local community and the high quality healthcare access earned them overwhelming support from East Jefferson and beyond, putting the future of East Jefferson on solid ground.

I've been an elected office for seven years. I had some resounding wins of my own. I will tell you I've never been part of a campaign that will be as successful as that East Jefferson sale to LCMC because voters supported that ninety-five percent.

That is unheard of. Your most, you know, popular politicians always have about twenty percent who vote against them, just because. So ninety-five percent support for the sale of East Jefferson to LCMC shows you the level of support there is in our community for LCMC Health and East Jefferson.

As a result of the LCMC Health and Tulane University partnership, Jefferson Parish is going to gain a premier academic medical center right there on the campus of East Jefferson, wherein partnership with Tulane and LSU, the next generation of medical professionals will be trained.

People from all across the country will

seek to travel to Jefferson Parish for specialized healthcare. And I can't think of anything more exciting than the educational opportunities ahead for the students, the young medical students and residents, as well as the positive economic impact that I know it will have on Jefferson Parish.

This investment is transformational for both residents who will now have the opportunity to train at a world-class facility, as well as for the patients who will continue to receive excellent healthcare right at home in Jefferson Parish.

These two organizations share a deep commitment to our community, and I am absolutely delighted to welcome Tulane University into Jefferson Parish. I wholeheartedly support this partnership and look forward to a prosperous and healthy future for Jefferson Parish. Thank you.

MS. ANGELIQUE FREEL: Thank you.

All right. Next, we have -- and I apologize if I mispronounce the name, please correct me -- Jerry Bologna, President and CEO of JEDCO. Am I saying it correctly?

MR. JERRY BOLOGNA: Close enough.

MS. ANGELIQUE FREEL: Okay.

MR. JERRY BOLOGNA: Bologna, yes.

MS. ANGELIQUE FREEL: Okay. Okay.

MR. JERRY BOLOGNA: Better than most. Good morning, members. My name is Jerry Bologna. I'm president and CEO of JEDCO, the Jefferson Economic Development Commission. I'm here to speak in support.

And I want to start by saying long before this partnership was even discussed, Jefferson Parish, our elected leadership, our business leadership, had identified medical innovation and destination healthcare as a priority for our parish. We saw it as a growing sector, something that we knew would create job opportunities for our residents. And we've been working to that end.

Additionally, while we're the largest parish in Southeast Louisiana, we've always lacked strong university linkages and partnerships. So to that end, we believe that this partnership helps serve both, and helps us get to where we need to be.

The proposed partnership of LCMC Health and Tulane University is a significant win for Jefferson Parish. With the commitment -- with their commitment to invest over $222 Million into the three Tulane facilities, Jefferson Parish will see an infusion of investment in our medical sector that

will benefit our community tremendously.

The new academic medical center that will be created at East Jefferson General Hospital will provide research, innovation, and healthcare access that will be second to none. With someone who had both of my daughters born at East Jefferson, and my primary care physician, who I started seeing at age 18, is still there, we certainly welcome this partnership.

We look forward to strengthening our partnership with LCMC and Tulane in the future.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Ruby Brewer, Chief Nursing Officer, East Jefferson General Hospital.

MS. RUBY BREWER: Good morning. My name is Ruby Brewer. I'm the Chief Nursing and Quality Officer at East Jefferson General Hospital. I've been a nurse forty-three years. I can say it's a career that I have had -- I have found great joy in. I've never regretted becoming a nurse. And leading nursing has been one of the most rewarding experiences of my life, especially at East Jefferson.

I have a master's degree in nursing, and I

have a master's degree in business, as well as an advanced nursing executive board certification.

During my tenure at East Jefferson, I've been the senior vice president of quality for eleven years, and I assumed the chief nursing officer role nine years ago.

My role has really evolved around advancing the quality of patient care and developing the clinical team to achieve the highest standards in patient care. So I can tell you that nursing is truly valued at East Jefferson and LCMC Health.

I represent five hundred and fifteen nurses who work hard every day to make sure that the care we're delivering to our community provides the highest standard of care.

(Fire alarm interruption.)

MS. RUBY BREWER: East Jefferson is well known for excellence in nursing practice. And to demonstrate this commitment, East Jefferson was the first hospital in Louisiana to achieve Magnet designation, and is the only hospital that's been designated five consecutive times. This is --

MS. ANGELIQUE FREEL: Oh, can you just pause for just a second? I just realized that the court reporter is having an issue.

Okay. I think we're good.

MS. RUBY BREWER: Okay.

MS. ANGELIQUE FREEL: Thank you.

MS. RUBY BREWER: As I said, we've been designated five consecutive times. Our most recent designation was this year. And that does take a lot of work, commitment, and dedication of our nursing team.

So you may say, well, what is a Magnet designation? Well, the Magnet Recognition Program demonstrates organizations worldwide, where nursing leaders successfully align their nursing strategic goals to improve the organization's patients outcomes. The Magnet Recognition Program provides a roadmap to nursing excellence, which benefits the whole of an organization. To nurses --

(Fire alarm interruption.)

MS. ANGELIQUE FREEL: I was worried that they were going to tell us there was a fire alarm, so that worked out well. Sorry. You just keep getting interrupted. I apologize.

MS. RUBY BREWER: That's okay. That's okay. Nurses are flexible.

MS. ANGELIQUE FREEL: Okay.

MS. RUBY BREWER: To nurses, Magnet

recognition means education and development through every career stage which leads to greater autonomy at the bedside. To patients, it means the very best care delivered by nurses who are supported to be the best that they can be.

So you've kind of heard a little bit about the plans for promoting and advancing the career of nursing in the community, so that's very exciting. East Jeff and LCMC support for this designation demonstrates ongoing support for the advancement of nursing practice and patient care.

Nurses are empowered to have a voice in patient care delivery design. And to become a Magnet organization, you have to prove that you have achieved these standards through involvement of bedside nurses.

I love working at East Jeff. I'll say this, I was from the area and this was an opportunity for me to return home. And I love working for East Jeff and LCMC because we support each other in serving our community, region, and state. We get patients from all over the state. LCMC -- and some of our neighboring states.

LCMC's commitment and support has allowed East Jeff to continue fulfilling our mission to

deliver extraordinary care with pride. The East Jefferson team has worked tirelessly during the pandemic, Hurricane Ida, and current workforce shortages to find innovative ways to deliver patient care with great outcomes. Strong collaboration and teamwork is the foundation of our care delivery model.

I've worked at East Jeff, like I said, for eleven years, which means through the uncertainty of potential sales to other hospitals. And I'm glad that we ended up with LCMC Health. And as Jennifer was talking about, it was an initiative that was approved with a ninety-five percent approval. And I will tell you our nurses were big campaign leaders in that sale approval. We wanted to be part of LCMC Health.

I've seen firsthand how LCMC Health values communities and the voice of nurses. I know that our voices will be prioritized moving forward, and I look forward to working with all nurses at EJ and Tulane hospitals to ensure we are really showing our -- allowing our nurses to shine. Thank you.

MS. ANGELIQUE FREEL: Thank you for coming today. I appreciate it.

Next, Allison Guste with LCMC Health, Vice

President of Quality and Nursing.

MS. ALLISON GUSTE: Good morning. My name is Allison Guste, and I am the Vice President of Quality and Nursing for LCMC Health. I've been a registered nurse for seventeen years, and have spent most of my nursing career with LCMC Health. They have developed me into the leader that I am today.

In 2004, I started my healthcare career in the emergency department at Touro Infirmary. I was a nurse tech and a nursing student at the time. I knew immediately within the first week at that ER and at Touro, that that was my home. These people were my family.

After nursing school graduation in 2005, I continued my career as a BSN nurse at Touro. As a front-line leader, in 2009 I was a clinical supervisor in the ER when LCMC Health acquired Touro Infirmary.

This was a very positive experience for the hospital, for myself, and for the staff that I called my family. The hospital began to thrive post-acquisition. We all know that Katrina brought hard financial times for many of the local hospitals. And this is what saved the hospital and the community.

My professional development -- I'm sorry -- over the years, LCMC Health has not only invested in the community, but they have invested in me, personally. My professional development and career growth are evident as my start as just a nursing student at the hospital, and now standing before you today is the vice president of quality and nursing.

Still, the journey continues, as they continue to support me through certifications, professional development, and I'm in the final semester of my master's program. It's a great honor and privilege to represent and work with the three thousand plus nurses across our health system.

Nursing at LCMC Health is the backbone of everything that we do. They are the glue that holds our health system together. They're with the patients and their families during some of life's most critical and vulnerable moments. That means nurses, like all caregivers in our facilities, have the opportunity to make a difference, positively impacting the outcomes and the experience for every patient we serve.

Beyond the time-honored reputation that nurses have for compassion and dedication, LCMC Health nurses have risen to the challenge of today's

complex healthcare environment. As patient advocates and skilled providers, the role of nurses has never been more critical at LCMC. Our nurses have received recognition, as you heard Ruby Brewer speak of, in various avenues over the last years.

East Jefferson, as you know, has obtained their Magnet designation for the fifth time. They are one of only forty-three hospitals in this country that has obtained that designation consecutively.

Children's Hospital obtained their first designation this year in 2022. And University Medical Center is in the process of applying for designation.

Magnet status is regarded as the highest recognition of excellence in nursing a hospital can receive. Only nine percent of U.S. hospitals achieve this designation. It is the model around nursing excellence, the model of professional practice culture, and it is the voice for nurses.

Our nurses were recognized not only as a group via Magnet designation, but also individually via the Louisiana State Great 100 Awards. Out of those one hundred awards, forty-three nurses were LCMC Health nurses.

Over the last month, I've been honored to participate in several town halls and leadership meetings at Tulane, Lakeview, and Lakeside; most recently, yesterday. The nurses and staff have repeatedly expressed excitement about working with a local healthcare system that invest in their community, where they receive the returns to their hospital.

When local systems collaborate and work together, we put our patients best interests first. Great things happen when we work together. Together, while we listen and leverage the voice of our nurses, this partnership will expand professional development in cases like you've seen with me, and training opportunities, and bring new clinical, educational, and support, and new jobs, as we keep and attract our top talent here in New Orleans.

This partnership will create more opportunities and integrate care at facilities that can support the new growth and even better patient care, and an even more extraordinary nursing experience.

I am proud to be an LCMC Health nurse. I look forward to welcoming the six hundred new nurses

at Tulane, Lakeview, and Lakeside. We are an LCMC Health nursing family. Thank you.

MS. ANGELIQUE FREEL: Thank you for your time.

Next, we have Charlotte Parent, RN, AVP of Community Affairs, University Medical Center, New Orleans.

MS. CHARLOTTE PARENT: Good morning.

MS. ANGELIQUE FREEL: Good morning.

MS. CHARLOTTE PARENT: My name is Charlotte Parent, and it's my privilege to serve as the vice president of business development at University Medical Center, part of LCMC Health.

I joined LCMC Health in 2016 in the role as assistant vice president of community affairs and network navigation, and after previously serving as a City of New Orleans Health Director. I was born and raised in New Orleans; trained at Charity School of Nursing; received my diploma in nursing; then went on to Loyola University; and then finally, University of New Orleans, where I received my degree in healthcare management.

My career as a nurse and nurse leader was invaluable to me in my current leadership role and community affairs work at UMC. It has been an

essential role for the community and the region. UMC is the largest training center for future healthcare professionals in the state, serving as a training center for two major medical schools.

It is because of our experience in providing care to our community through the two medical schools at UMC that I can wholeheartedly support the partnership.

The proposed partnership between LCMC Health and Tulane builds on the already game-changing investments both organizations have made in downtown New Orleans. This investment includes a revitalization of the Charity Hospital building and re-purposing of the Tulane Medical Center building.

The downtown campus will become a thriving center of cutting-edge research and innovation, and represents $286 Million in economic impact to New Orleans.

I say this because the downtown is University Medical Center at that center. A state-of-the-art facility built after Katrina provides services for the State of Louisiana. We have over seventy specialty clinics. We are the region's only level 1 trauma center, and have an accredited burn center.

All of these services are currently provided by Tulane and LSU physicians and learners. Collaboration is not new to us. It is our culture. As an academic medical center, we provide care to all patients, but we understand one of our primary missions is servicing the under-served.

A majority of our patients are on Medicaid or uninsured. We welcome the patients who have received their care at Tulane, who still need us, and we'll provide that quality care focused on the patient. We have always, and will continue to, serve as the area safety net.

Many of the Tulane programs will shift to UMC and East Jefferson, and we embrace that change. We know how to take care of the community because we've been doing it. And we have the best track record of doing it.

Thank you for your time, and I urge you to support the partnership.

MS. ANGELIQUE FREEL: Thank you for your time.

Next, we have Dr. John Heaton, President and Chief Medical Officer, LCMC Health.

MR. BRETT ROBINSON: I just want to make a quick announcement. If you come to the table to

speak, make sure you sign in on the sign-in form.

MS. ANGELIQUE FREEL: Thank you.

MR. BRETT ROBINSON: And you can sign after.

DR. JOHN HEATON: Will do. Thank you for having me this morning. My name is John Heaton. I am the President and Chief Medical Officer of LCMC Health. In that role, I am the Senior Clinical Executive for the health system. I oversee a number of operational roles, none more important than the delivery of a consistent and safe quality product to all of the people that we serve across our hospitals.

I am a native New Orleanian. I've lived in St. Tammany Parish for about twenty-five years. I am a trained pediatric anesthesiologist. I obtained my undergraduate degree in Louisiana at Nicholls, and went to LSU Medical School, obtained my post-graduate medical education in New Orleans, with the exception of a year of fellowship, and have a business degree from Carnegie Mellon.

I provided healthcare in New Orleans for decades. And the proposed partnership between LCMC Health and Tulane University represents a transformational opportunity to fulfill the promise

of world-class healthcare delivered at home.

As I said, I've been at this for quite a while, both directly delivering care to patients in the operating room, but also as a clinical faculty member of both Tulane and LSU Medical School over the years teaching their residents and students. This has always made sense, and we're proud to see it come to fruition.

A primary driver of this partnership is our shared desire with Tulane to invest in the future of healthcare in our community and increase the quality and access to advanced life-saving academic medicine. We will enhance the services at UMC to serve Orleans Parish and we establish -- and we will establish a new premier academic medical center and leading teaching institution in Jefferson Parish.

This allows us to provide more training, give us less the -- more recruitment, and retention of high-caliber clinicians.

Additionally, we already support a, at LCMC, a vast array of research across the biomedical spectrum from lab-based science, to translational research, to clinical trials in all major disease areas.

Tulane, alone, conducts something on the

order of $230 Million worth of research per annum. Together, we will be able to collaborate to further research -- further these research endeavors and offer clinical trials closer to home for our residents, to push the boundaries of our medical practice, to provide patients and students access to enhanced healthcare services.

The evolution of our healthcare system in New Orleans over the last forty years is nothing short of extraordinary. And this will be a key catalyst to making the next forty years equally extraordinary. Thank you.

MS. ANGELIQUE FREEL: Sorry, I had my mic off. Thank you for your time.

Next, we have a red card from Steven Morelock, representing New Orleans community.

MR. STEVEN MORELOCK: Hello.

MS. ANGELIQUE FREEL: Hello.

MR. STEVEN MORELOCK: My name is Steven Morelock. I'm a resident of New Orleans and I'd like to read a letter that's been signed by a lot of my fellow community members.

We write as denominational and community leaders across New Orleans and Louisiana, in our support of the nurses of Tulane Medical Center, who

are demanding a voice in the future of healthcare in New Orleans. We are asking for the upcoming public hearing on the sale to be held locally in New Orleans, not Baton Rouge, ensuring meaningful participation and input from our frontline healthcare workers and the community they serve.

We're deeply concerned that the proposed sale of Tulane Medical Center to LCMC Health will negatively impact access to quality and affordable healthcare services for thousands of Louisianians. LCMC has already announced plans to shut down most inpatient services at Tulane Medical Center within twelve to twenty-four months of acquiring the hospital.

Many of our community members have gone to Tulane Medical Center for years. Losing such a popular hospital serving patients not only in New Orleans, but across Louisiana, is a loss for communities around the state.

We fear a two-system duopoly in New Orleans, made up of LCMC and Ochsner Health, will raise healthcare costs and reduce services. This is especially worrisome in such a precarious time in our nation. Now more than ever, high-quality healthcare needs to be made more accessible and

affordable.

When Charity Hospital closed, New Orleans lost one of the state's last public hospitals that served everyone, regardless of income level. Now, we stand to lose another hospital in downtown New Orleans that has long served low-income patients. We worry Medicaid patients, who are disproportionately black and people of color, will lose access to care.

Louisiana's minority residents already experience significantly lower life expectancies than white residents, and the closure of services and a higher healthcare cost may exacerbate this health equity crisis.

Nurses are on the front lines of keeping our communities and congregants healthy and safe. We stand with Tulane Medical Center nurses because we trust nurses to put patients first. We urge you to block the sale in order to ensure that there are no cuts to jobs or patient care services at Tulane Medical Center, and that there is no increase in healthcare costs for the community.

Sincerely signed, Shawn Moses Anglim, Pastor of First Grace United Methodist Church; Margaret Washington, retired RN and nurse educator;

Betty Roberson, the CEO of EDUTRONICS; Callie Winn Crawford, a retired United Methodist pastor; Jonah Evans, Neutral Ground, Founder and CEO; Charlotte Clarke, Common Ground Relief, Co-Director; Rev. Dr. Joe Connelly, Bethany United Methodist Church, Senior Pastor and Community Engagement Officer; Travis Cleaver, Grow Dat Youth Farm, Site Coordinator; Bonnie Sniegowski, Society of St. Vincent de Paul, Director of Adult Learning Center; Deon Haywood, Women with a Vision, Executive Director; Harold John, National Association of Letter Carriers, Second Congressional District Liaison; Matthijs Herzberg, Herzberg Design Company, CEO; Elizabeth Widerquist, Xavier Louisiana -- excuse me, University of Louisiana Professor; Stephanie Martin, FGUMC Administrator; Rev. Dr. J.C. Richardson, Cornerstone United Methodist Church, Pastor; Bettie Rhode, Cornerstone United Methodist Church, and Parish Nurse, Lay Minister; Lexi Peterson, New Orleans Worker Center, Co-Director; Byron Johnson, Central Missionary Baptist Church, Reverend; Jeanne Nathan, Tannathan, Inc., President; Mary Lowry of Now Love; J. Christopher Johnson, Mobilizing Millennials, Executive Director; Mark Behar, Temple Sinai, former board member; Eugenia

Rainey, Tulane Professor -- excuse me -- I can't talk -- Professor at Tulane University; Bennie Wilson, Mantle Tabernacle Holiness Church, Senior Pastor; Dave Cash, United Teachers of New Orleans, President; Darla H. Durham, St. Charles Avenue Baptist Church, Deacon and Former Trustee; Margaret Maloney, New Orleans Workers Assembly, Organizer; Mike Howells, We Can't Wait NOLA, Organizer; Amy Stelly, Claiborne Avenue Alliance, Executive Director; and Rev. Paul Beedle, First Unitarian Church -- Universalist Church, Minister.

Thank you very much.

MS. ANGELIQUE FREEL: Thank you for coming today. And I just wanted you to be aware that the reason that the hearing is here is because the law dictates that. There is a specific rule that says that the hearing must take place in Baton Rouge, Louisiana, and that's in the Louisiana Administrative Code.

MR. STEVEN MORELOCK: I understand that. Just please take into consideration that that's going to affect turnout for people who are stakeholders in this conversation.

MS. ANGELIQUE FREEL: Well, I appreciate that. We did publish the Notice in the official

journal, and we did allow people to provide comment in writing in advance of the hearing. So that was an option.

Do you want to provide us with a copy of that letter?

MR. STEVEN MORELOCK: Absolutely.

MS. ANGELIQUE FREEL: Thank you.

All right. Next, we have a red card from Olivia Cooper, present, and would like to speak.

So it indicates you're representing Tulane Medical Center. Are you -- can you -- are you here, sent from Tulane, or you just work there? What's -- can you just tell us the connection?

MS. OLIVIA COOPER: Yes. I'm a registered nurse at Tulane Medical Center.

MS. ANGELIQUE FREEL: Okay.

MS. OLIVIA COOPER: Good morning. Thank you to the Attorney General's Office for holding this important forum. My name is Olivia Cooper, and I am a nurse in the transplant ICU at Tulane Medical Center, where I have worked just over a year.

The lack of transparency by HCA and LCMC in this process has completely dismayed me. The only information we have been given is that LCMC will acquire Tulane Medical Center and subsequently close

the hospital, removing vital services to our patient population. The hospital and the Attorney General's Office should want to collaborate with nurses in deciding the future of Tulane Medical Center. We are the ones most involved in the direct care of patients.

We see firsthand, every day, the dire needs for quality and accessible healthcare options for patients across Louisiana. Nurses are the key cog in keeping the hospital running and our patients safe and cared for, yet our voices are not even considered in the decision-making process of the future of our hospital.

It is evident to anyone working in healthcare that the increased need for healthcare services will only continue. Being able to provide services for a population of people who are getting sicker should be a top priority of not only New Orleans, but for Louisiana's public healthcare priorities at large.

Spending money trying to promote a system for, quote, destination healthcare, just results in decreased accessibility to care for residents of Orleans Parish.

The Tulane transplant ICU has an enormous

population of patients who come, not only for surgeries, but for lifelong care after receiving a transplant. Additionally, many of the patients we serve come to us as transfers from other hospitals, who don't have the resources to care for them. Where will these patient populations go if the hospital shuts down?

Just in this past year, I have seen the astronomical need for our services in New Orleans and throughout the South. Shutting down this hospital would be a huge loss for the community and the patients we serve.

My understanding of the COPA law is that the application cannot be approved unless it results in improved access to healthcare. With LCMC making clear its intentions to shut down Tulane, a hospital at the epicenter of New Orleans Parish, how would this improve access to healthcare for its residents?

Not only can access to healthcare decrease, the cost of care will surely increase as well. LCMC would hold over fifty percent of the New Orleans healthcare market if this sale goes through. What's going to stop them from employing the same practices, of higher costs and less care, the other systems in heavily concentrated markets do?

Look around the room and acknowledge the presence and voices of those that are most directly impacted by this decision. I implore you to grant our community their civic right to give input in this process. Thank you for your time.

MS. ANGELIQUE FREEL: Thank you for coming here today.

Next, we have Michael Robertshaw, who submitted a red card and is present, and would like to speak.

MR. MICHAEL ROBERTSHAW: Can I speak from here or should I be over there?

MS. ANGELIQUE FREEL: The mic is on --

MR. BRETT ROBINSON: I think that one.

MS. ANGELIQUE FREEL: Wait. Which one?

MR. BRETT ROBINSON: All those mics are on, but that -- the furthest to the left, or right, seems to be the best.

MS. ANGELIQUE FREEL: And your card indicates that you're a nurse at Tulane Medical Center; is that right?

MR. MICHAEL ROBERTSHAW: Yeah. I'm sorry for that confusion. I'm actually -- so I'll just state my name for the record. It's Michael Robertshaw. I'm a ICU nurse at Tulane Medical

Center, representing the unionized Nurses at Tulane Medical Center.

MS. ANGELIQUE FREEL: Okay. Okay.

MR. MICHAEL ROBERTSHAW: Okay. Thank you very much to the board for being here. Gosh, I have so much to say and I'm going to try to whittle it down into some comprehensive statements within three minutes.

I was hoping I could just ask a favor. Do you mind putting back up here on the board the original three things that this board is considering? The very first slide. Can I ask you to do that, please?

MR. BRETT ROBINSON: So you're talking about lower healthcare costs, improved access --

MR. MICHAEL ROBERTSHAW: Yeah. What this board is charged with making a decision based on, I would really appreciate it if you could put that up.

MS. ANGELIQUE FREEL: Yeah. We can get with our IT people to do that.

MR. BRETT ROBINSON: I'll just state it real quick, just so -- for your purposes. It's lower healthcare costs or improved access to healthcare, higher quality healthcare without any undue increase to healthcare costs.

MR. MICHAEL ROBERTSHAW: Great. Thank you very much for that. I really appreciate it. So we have heard a lot of statements here today that essentially say those exact three points. There has been very little detail as to how that is going to be accomplished.

The nurses at our hospital learned about this sale through Nola.com. We were never involved in the process. And we have continually heard those three points are going to be satisfied, with incredibly little detail as to how they will be satisfied. I encourage this board to dig down into the numbers and actually ask the hard questions. How are you going to satisfy the roughly twenty-eight thousand patients that come through the emergency room at Tulane?

We have emergency room patients who come to our emergency room because they are waiting too long at UMC, and they come to our emergency room. It is totally unclear to the nurses at Tulane Medical Center downtown how you can decrease cost, improve quality of care, and increase access when you close a downtown hospital. That has yet to be made clear. And I think it needs to be made clear before this body makes a decision.

We are the ones who are holding your families' hands when they die. We are the ones who are cleaning your family when they are soiled. We are the ones that are comforting our community and taking care of them day-in and day-out. And no disrespect to the nurse administrators who have spoken here today, I'm grateful for your work, but nobody is asking the nurses on the ground, who are doing the hard work day-in and day-out, what we think. And that needs to happen.

Thank you for your time.

MS. ANGELIQUE FREEL: Thank you.

Next, we have Kaylen Edwards. Again, it says representing Medical Center. Are you a nurse at -- a nurse? Okay. Thank you for coming. If you don't mind, when you finish, just sign the sign-in sheet.

MS. KAYLEN EDWARDS: I did this morning when I walked in. Good morning, everyone. My name is Kaylen Edwards, and I am a new nurse at Tulane Medical Center. I really appreciate the opportunity to speak with you guys today about the sale and the pending closure of our hospital.

As a new nurse, I'm still learning. I'm still training. Most of my colleagues are new

nurses as well, and have only started practicing within the last year or two. We only have a few experienced nurses throughout the facility, which has made my education journey very challenging.

There's been so much uncertainty with the sale and the closure since the closure has been announced. We don't know where we will be transferred to and when. We don't know the pay -- our pay or our benefits, if those will be maintained.

This has even led to more experienced nurses leaving our facilities in droves to go and travel. I worry that our patients, that our community, is going to continue to suffer. We have so many long-standing patients who have been coming to our hospitals for years, ones that I've taken care of myself -- I've had the privilege of taking care of myself.

It takes time to build those relationships, to build trust with doctors and nurses. And our patients will -- are unsure if they will be able to maintain those relationships.

We have -- we already have a health equity crisis in our city and our state. Louisiana's black, homeless, and patients with mental illness

face higher rates of comorbidities, multiple diagnoses, and less access to care, and they seek care at lower rates than others. This happens for many reasons, including a history of exclusion in healthcare that has led to mistrust in the healthcare system.

This means that the relationship, the trust between doctors and patients and nurses is even more important for these patients. I worry that closing our hospital is only going to exacerbate that problem. If we close an accessible community hospital, it's going to make it harder for our community to access that care.

In the wake of COVID-19 it highlighted how unprepared we are for pandemics. And to need -- and the need to prepare for those future pandemics is now. We didn't have enough beds, PPE, or nurses. And, now, we're facing new viruses like monkey pox and future ones that are still unknown.

How does losing a hospital, hundreds of beds downtown, better prepare us for another pandemic? We need to be increasing our capacity to provide good, quality care. I worry that if the sale is improved -- approved and the hospital closes, we're only going backwards from here.

Our community needs more time to discuss potential impacts of the sale, and the hospital closure on nurses, other healthcare workers, and especially our patients before any decision is made. Thank you so much for your time.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Chip Cahill, present and would like to speak, Board Member, LCMC Health.

MR. CHIP CAHILL: Thank you, and good morning.

MS. ANGELIQUE FREEL: Thank you.

MR. CHIP CAHILL: My connection with LCMC is a trustee and board chairman for West Jefferson Medical Center. But before we were affiliated with LCMC, we found ourselves to be, at West Jefferson, to be a struggling community hospital. We were a standalone hospital. We were fortunate enough to have a leader who saw that we wouldn't be able to survive as a standalone hospital. We wouldn't be able to survive merely by affiliating ourselves with East Jefferson and standing as two community hospitals together.

And we reached out to the public, and convinced the public that this would be the right

thing to do, that we would find a suitor that would best meet the needs of the Westbank.

And we began a long journey of meeting with suitors. And every suitor showed me a picture and told me, "This is what your ugly hospital is going to look like after we invest in it." Well, along came a suitor, finally, one of the last ones that I met with. LCMC showed me what the inside of our hospital would become, how they would fix the things that we wanted to fix, but didn't have the money to fix.

And as time went by, everything worked out. Everything they said they were going to do, they did. The promises came true.

I was a bad little kid. And one year, I burned my hand on New Year's Eve, and my mom had to take me to the West Jeff emergency room. And she took my younger brother and my younger sister also. And in those days, the emergency room, the waiting room, was wide open and all of the families sat waiting to go in to the back of the hospital in the reception area.

And several ambulances came in while my mom was there with her three children. She couldn't leave the other two at home by themselves. And

people came in who had serious injuries. I saw two people who I'm sure died that night; one was a serious car wreck, the other was a stabbing. And my mom was trying to cover all of our eyes. She couldn't do it. And she told us to try to forget about it, but I never did forget about it.

One of the first things that LCMC did is rebuilt our emergency room. So now, the ambulances pull up at their own bay in the back. You don't have to parade in front of the families anymore. The affiliation with LCMC caused the creation of a children's emergency room on the Westbank, which was something that was a real blessing and was really needed. Geriatric emergency room was next.

Everything that they talked about, they did. And when all the smoke cleared, we're getting a pretty facade on the outside of the building, too, but nobody from LCMC ever called our building ugly.

Thank you very much. And I think this would be a great thing.

MS. ANGELIQUE FREEL: Thank you.

MR. CHIP CAHILL: Sure.

MS. ANGELIQUE FREEL: Next, we have Nathaniel Beech, green card, present, and would like to speak. Senator Cameron Henry said to thank you

for stopping by.

MR. NATHANIEL BEECH: Thank you. Good morning, everyone. My name is Nate Beech, and I'm the second-year class president of the med school class at Tulane School of Medicine. I'm a New Orleans native. I attended Jesuit High School. I attended Tulane University for my undergrad, and now have the privilege to go to Tulane Medical School and further my education, and follow my father in his footsteps to becoming a physician. And he is a person who's practiced in this city for over twenty years now, both at LSU and now at Tulane.

The partnership between Tulane and LCMC offers an immense opportunity and possibility of building an even stronger academic medical centers throughout the city in New Orleans and across the state. These teaching hospitals are groundbreaking for research and education, with the goal of creating new treatments and techniques that physicians, residents, and students can use to provide and improve quality of care for patients in New Orleans systems and across the state.

In addition, it will also offer the ability and opportunity for a new nursing program to be built in the hospital, while also addressing the

projected twenty-five hundred nursing positions that will be unfilled in 2025 in the City of New Orleans.

Overall, this partnership has the ability to improve quality of care, not only across the City of New Orleans, but across the state, and allowing Louisiana to become a hub for medical care and education across the southeastern United States.

Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a red card from Mea Ratcliff present, and would like to speak, Tulane Medical Center nurse, patients, and community.

MS. MEA RATCLIFF: Good morning. My name is Mea Ratcliff. I am a registered nurse. I've been a registered nurse for twenty-two years. I graduated from Southern University School of Nursing here in Baton Rouge.

I want to talk about a couple things that I've heard today. I heard that $220 Million is going to be invested in Lakeside Hospital in Jefferson Parish, and East Jefferson General Hospital, also in Jefferson Parish, and in Lakeview, which is in Covington.

I've not heard anything about what's going to happen in Orleans Parish as far as the hospital

system. How is this going to decrease the cost of care with only two major hospital systems in New Orleans?

I hear that our services and our beds are going out to Jefferson Parish. I hear everything that's good for Jefferson Parish. I don't hear anything good here for Orleans Parish. This COPA that you mentioned: decreased cost of care, improve quality of care, and increase access to care. Tulane serves a huge indigent population. How are these people going to get to Jefferson Parish?

And then we're talking about moving them over to UMC that's already overburdened and overloaded in our healthcare system. We have gunshot wounds frequently, unfortunately, in Orleans Parish. So we're going to close down an emergency department in Orleans Parish? And we're going to close down a hospital in Orleans Parish?

And our hospital is ugly, but I really don't care that much about that. I do care that we're there for our community and for our patients that have been coming to us for years now. I don't see how it's going to improve any services in Orleans Parish. And I'm very worried about that, and for our patients.

We don't have a great bus system. We don't have -- the train bypasses Baton Rouge. There's not very good infrastructure for patients to get around. A lot of our patients walk to our hospital or they bike to our hospital. So I don't see any increase in services to them.

And for us, we're going to lose a hospital that we've been at for years and years and years. We love our hospital. We love our patients. We love taking care of our patients. We love our community. And I don't hear anything proactive for Orleans Parish with this hospital being shut down and our emergency department being shut down.

And during COVID, there were not enough beds anywhere. And so we're talking about shutting down a 230-bed hospital and half of our services being moved to Jefferson Parish. I think that's a huge concern, and that should be taken into consideration.

It all sounds great. It all sounds beautiful because they're able to make it sound that way, but who it's going to affect is our community and our patients. So please take that into consideration before moving forward with this.

MS. ANGELIQUE FREEL: Thank you. Did you

do the sign-in sheet?

MS. MEA RATCLIFF: I did.

MS. ANGELIQUE FREEL: Okay, great.

MS. MEA RATCLIFF: And is there going to be another hearing? And will it be in New Orleans?

MS. ANGELIQUE FREEL: This is the only hearing.

Next, we have a green card, Terrie Sterling, present and would like to speak, with LCMC Health.

MS. TERRIE STERLING: Good morning, and thank you. I'm Terrie Sterling, and I'm speaking on behalf of Deon Guidroz, the ACNO, the Assistant Chief Nursing Officer, at Tulane, who requested that I read these comments into the record.

My name is Deon Guidroz, and I am the assistant chief nursing officer for Tulane Medical Center. I've worked for Tulane for thirteen years. During that time, I've had several roles from managing quality and patient experience initiatives, to directing the medical surgical units for the system. I worked on matters such as staff retention, and quality, and patient safety.

I know what Tulane means to the New Orleans community, and how important that community is to

our staff and to our health system. It is with that community in mind that I ask you to approve this partnership. If approved, this merger would join two local institutions who are deeply invested in the health and safety of our city and our region. That will lead to clear benefits to the patients you've heard people speak about seeking care at Tulane Hospital.

With a plan to invest millions of dollars in mid city, and an assurance to retain the existing workforce, LCMC Health is making a commitment.

Having worked in both staff engagement and patient experience, I know that quality facilities matter, not just to patients, but to the staff who work in our hospitals. The people of Tulane Health System, both those who work for us and those who we serve, deserve world-class facilities and world-class care.

If approved, this partnership would lead to a clear win-win for everyone in our community. Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Dr. Gary Haynes, Tulane University School of Medicine.

DR. GARY HAYNES: Good morning. Thank you

for the opportunity to address this panel. I'm Dr. Gary Haynes. I'm the chair of the Department of Anesthesiology at Tulane School of Medicine. I've been with Tulane about seven years, and in academic medicine and a bit in private practice for more than thirty years.

And with that range of experience, which has been in the Midwest, in the Southeast, and now in the Central South here in Louisiana, that range of experience informs me that this is a very positive affiliation plan, and it's one that I strongly approve. I think there are many advantages that we could talk about, but just to be brief, I'll only address three.

First, the purpose of this Tulane/LCMC affiliation will be to create an academic medical center with East Jefferson General Hospital as the premier flagship hospital for a place where I want to emphasize it's for maximally effective education of doctors and nurses. This is a huge problem that the United States has. It's a problem that this state has right now, New Orleans, particularly, with the shortage of nurses. This is not going to get any better if we don't do something different and take a new path.

One of the challenges I have right now is how to find the clinical experience for our residents in anesthesiology and in other specialties, that not merely meets a minimum requirement, but goes beyond that and has a much more robust experience for our resident physicians and medical students.

As you've heard, the LCMC/Tulane affiliation will create a nine-hospital system, and that will allow us to expand our opportunities for clinical research. Now, Tulane University is one of the nation's, and North America's, premier research institutions. Much of that is in basic research. We need to do more in clinical research because that brings new healing, new therapies, new opportunities to our patients and everyone in the state, and even beyond the borders of the state.

As you know, there's a very serious shortage of nurses, also physicians. And in doing this, we'll be able to create this program for nurse training. Right now, it's estimated that we might need nearly twenty-five hundred nurses by the year 2025. I do not know if that's accurate, but I can tell you right now we need hundreds of nurses in New Orleans and in the state. And we have to do

something to address this.

The second point is that the affiliation will promote additional comprehensive and specialized care in the New Orleans area. We will continue some outpatient services, outpatient clinics, at the Tulane Hospital location, and increase our role at University Medical Center, while creating a new role at East Jefferson General Hospital for Tulane doctors.

This will not decrease and we're not interested in decreasing our presence in the downtown area. We will increase our clinical presence at University Medical Center and shift some of our other clinical activities to East Jefferson General Hospital.

But this is important because in making these shifts and these moves, it will open up space that is much needed for a nursing program in the immediate downtown area.

And the third thing I would just focus on, or mention, is that hospital consolidation is often a focus of hospital systems throughout the country. Our focus is on growth, expanding services, and improving the efficiency and delivery of quality medical care. I think this will happen because LCMC

Healthcare and Tulane are mission-based nonprofit organizations that have shared interests and goals. We share values and commitment in emphasizing the high quality efficient and effective healthcare. And, along the way, that means keeping an eye and a focus on how to reduce hospital and medical costs, not just let them expand indefinitely.

So, in closing, I would just say this is all about developing a robust academic medical center, and growing EJ General Hospital into a major teaching hospital, growing comprehensive and specialized medical care while maintaining Tulane's presence in the city, and increasing the range of what we do by aligning major institutions that share common goals and values.

Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a red card from Caleb Holmes in opposition.

MR. CALEB HOLMES: I'll waive speaking.

MS. ANGELIQUE FREEL: Okay. So you do not want to speak, but you're in opposition; is that correct?

MR. CALEB HOLMES: Yes.

MS. ANGELIQUE FREEL: Thank you.

All right. We also have a red card from Curtis Williams, Step Up Louisiana, present and would like to speak.

MR. CURTIS WILLIAMS: Good morning everyone. How are you doing?

MS. ANGELIQUE FREEL: Great.

MR. CURTIS WILLIAMS: To the Attorney General's Office, to LCMC, Tulane, and HCA, my name is Curtis Williams, and I'm a lifelong resident of the Greater New Orleans area, and a member of Step Up Louisiana. Thank you for providing us with the opportunity to express our comments and concerns. There are four major points that we would like to highlight about this proposed merger.

First, the process feels a bit rushed. This deal has huge consequences for patients, and the community, and workers, and should have included the opportunities for input from all stakeholders before, during, and this hearing, including a community meeting in New Orleans.

Second of our major concerns is what will happen to the employees. We would like to offer that LCMC consider these very reasonable economic justice demands laid out by the nurses union to be considered for all Tulane Hospital employees

involved in this deal: One will be no cuts to jobs or services, guaranteed placement, and new facilities; Number two, workers are given the power and equity to make decisions that best serve all of stakeholders during a transition; Number three, workers' pay and benefits maintained; Number four, LCMC recognize the nurses union and remain neutral for all unionization efforts.

The third concern is the concerns of the patients. I personally have sat in UMC for over eight hours to be seen, only to be told that they weren't able to help me because it wasn't a big enough trauma. That would be a concern. And how would that impact more wait times? We are concerned with losing another ER in New Orleans and having a negative impact on additional wait times. Also, patients having to get transported to East Jeff or West Jeff.

Hospital isn't always feasible and it isn't always affordable. By reducing the competition in the city to only two hospital networks, we worry about higher costs and lower pay to workers. Can you assure the community this won't happen?

Fourth, and final, we hope and believe that LCMC will continue to work well with Step Up and

communities throughout this process. We are extremely happy -- we were extremely happy to partner with LCMC during our Get out the Vax efforts in late 2021 and early 2022 on over a dozen vaccine events, and were happy to be in contact with LCMC administration in the lead-up to this hearing.

Step Up wants to continue to be your partner, but those are our concerns, and that's where we stand for right now.

Thank you.

MS. ANGELIQUE FREEL: Thank you for coming here today.

I still have some cards to go through. I just want to make sure, in case anyone walked in late, that if you would like to speak, you can get a card at the front from -- they're just placed up here -- to complete a card, and we'll call you up.

Next, we have Percy Manson, representing a faith-based community, present and would like to speak.

MR. PERCY MANSON: Good morning. My name is Percy Manson. I am one of the many community leaders in the New Orleans area, and I'm here today representing the faith-based community, and I'll read their statement.

Recently, LCMC Health and Tulane University announced a new partnership that will increase access to comprehensive and specialty care, advance groundbreaking research, and expand life-saving treatment that ensure all our patients and communities can receive the highest quality of care right here in the Greater New Orleans Area.

We write this as a faith-based community. Through this partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join the LMCE [sic] Health family. The majority of the services provided to Tulane Medical Center will shift to University Medical Center New Orleans and East Jefferson Hospital.

LCMC Health has publicly committed to all employees at three hospitals: Tulane Medical Center, Tulane Lakeside Hospital, and Lakeview Regional Medical Center, that they will continue to have jobs under the new partnership. This includes nurses, physicians, and all staff.

Additionally, this partnership will allow the repositioning of Tulane Medical Center building with multiple use, including a new nursing program. Through this initiative, Tulane University will

create an estimated twenty-three hundred jobs across the State of Louisiana.

Downtown will continue to have high-quality access to care for the Medicaid and under-served population at the University Medical Center in New Orleans. UMC services and offerings will actually grow, allow for more access for the community. We understand that Tulane Hospital operates -- operations will continue as normal as LCMC Health and Tulane plans for a gradual transition over the next twelve to twenty-four months.

We support this partnership and its intent given to the above commitments, and we are grateful that LCMC Health and Tulane keeps line of communication open to the community. Representing this is one of the largest minister alliances, which is President Willie Gable, Interdenominational Ministerial Alliance of Greater New Orleans, and Rev. Bishop Tom Watson of Watson Memorial Ministries, and Pastor Rev. Jamaal Weathersby of New Hope Baptist Church in New Orleans.

Thank you for your time.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from LaDana Williams, present and would like to speak, Director

of Public Relations, LCMC Health.

MS. LADANA WILLIAMS: Good afternoon. My name is LaDana Williams, and I'm reading a statement on behalf of Rhonda LaBat, University Medical Center patient.

Over the last thirty years, I've had my fair share of ups and downs with my health. For years I went back and forth to different hospitals for treatment. Most of the doctors gave me medication that kept me lethargic and feeling miserable. I suffered from massive weight gain, which led to me being a diabetic. Also, my thyroid and esophagus conditions were getting worse.

A few years ago, things got really bad. University Medical Center was recommended to me through Daughters of Charity. Because I had so many issues with my thyroid, esophagus, stomach, back, and other chronic conditions, a team of doctors worked together to get me better. Seeking care at UMC was life changing. The UMC doctors diagnosed me with anemia and treated me for my condition.

Since receiving this great care from doctors, nurses, and the hospital staff, I'm a non-medicated diabetic with thyroid levels that have been lowered and my esophagus is better, which has

really enhanced my quality of life. I am here today because of the excellent treatment I received at UMC. It's such a big hospital, but the doctors and nurses all know me, which makes it feel more like a -- more than just a hospital.

My mom and my son both receive treatment at UMC. Unfortunately, my mom passed away a few years ago, but I'll always be grateful for the nurses that took such great care of us. My son was treated at UMC for COVID. He received great care as well. It means a lot when you go to the place and get treated well.

LCMC Health and Tulane coming together will be good -- a good thing for our community. There's a lot of learning that takes place at UMC, and that's important because that's one of the reasons they were able to diagnose my condition. I'll always be eternally grateful and thank God for giving my physicians wisdom, knowledge, and healing hands, and for leading me to UMC for care. It changed my life.

Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from John Pourciau, present and would like to speak, AVP

Government Affairs, LCMC Health.

MR. JOHN POURCIAU: That was a great pronunciation of the last name, there, by the way. Brett should be able to get you right, though. We went to school together.

And it's good to see you take a bit of a step back from your busy schedule as the face of the ethics annual videos, too. So we appreciate that.

MS. ANGELIQUE FREEL: Yes. Face and voice.

MR. JOHN POURCIAU: Indeed, and voice.

MS. ANGELIQUE FREEL: Yes. Yes.

MR. JOHN POURCIAU: It's true.

Good afternoon. My name is John Pourciau. I'm the AVP of Government Affairs for LCMC Health, and today I would like to read a statement from Newell Normand, the former sheriff of Jefferson Parish.

I have both personal and professional experience with East Jeff General Hospital. I could not be more supportive of the proposed partnership between its parent, LCMC Health, and Tulane University.

My mother received care at EJ for stage 4 lung cancer, more than seven years ago. She was given six months to live. The top-notch care she

received from EJ's doctors and nurses turned around her quality of life and she is still alive today.

This partnership will transform EJ into an academic medical center that will attract the best and the brightest healthcare professionals to our area so that we can continue to provide excellent care. The Tulane and LCMC Health partnership brings something to the table that didn't exist before. The partnership will broaden and deepen the level of service and delivery of care, and give the community more options.

This partnership's proposed investments in downtown are masterful. Investing in our healthcare corridor will benefit our entire region in a tremendous way. It is a difference maker for us here in the City of New Orleans.

Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card in support from Peter Waggonner, present and would like to speak, Greater New Orleans, Inc.

MR. PETER WAGGONNER: Hi. I'm Peter Waggonner, Public Policy Manager for GNO, Inc., reading a prepared statement from Michael Hecht, President and CEO of GNO, Inc.

MR. BRETT ROBINSON: Can you pull the microphone closer to you? Thank you.

MR. PETER WAGGONNER: The proposed partnership between LCMC Health and Tulane University helps realize a long-held vision by many, including myself, of transforming our region into a hub for destination healthcare. With these investments, our region will have increased access to the latest medical breakthroughs and clinical trials that are intrinsic to academic medical centers.

Jefferson Parish will gain a world-class academic medical center at East Jefferson General Hospital, with an estimated economic impact of nearly $475 Million. Tulane University can build on its historic investment to grow its downtown campus with a vision of becoming a world-renowned research and innovation powerhouse. And patients in St. Tammany, Jefferson, and New Orleans Parishes, and the entire region and state will receive state-of-the-art enhanced care from a locally-owned nonprofit system.

There is much to be excited about when you look at collaboration between LCMC Health, LSU, and Tulane from the estimated 2,300 jobs that will be

created to the thousands of lives that will be improved.

Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Emily Brown, present and would like to speak. And this says representing Tulane Medical School. Are you a student there?

MS. EMILY BROWN: Yeah, I'm a medical student.

MS. ANGELIQUE FREEL: Great. Thank you.

MS. EMILY BROWN: Good morning. I'm Emily Brown. I'm a third-year medical student at Tulane. And I came to Tulane from Florida because I wanted to learn medicine at a program with a mission to serve its community, and that's the reputation that it has for medical applicants.

I've not been disappointed. I see a deep commitment to serve. And in the last year, I've had the privilege of working at a wide variety of hospitals in and around New Orleans, and I've seen firsthand that there's a difference at LCMC facilities. And it can be hard to define, especially for me, as I don't have much experience, but there's a feeling that there are adequate

resources, a feeling of strong teamwork, and I see consistently high-quality patient care.

As a Tulane student, having hospital administrators who share my values of compassionate, mission-driven care, is really exciting. It's exciting for me, and I know it's exciting for my fellow students. From where I stand, I see great benefit to our patients in partnering with LCMC.

Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, Jacquelyn Turner, Tulane University. And are you a med student also?

DR. JACQUELYN TURNER: I wish. I'm a physician.

MS. ANGELIQUE FREEL: Oh, sorry. Sorry.

DR. JACQUELYN TURNER: That's okay.

MS. ANGELIQUE FREEL: Well --

DR. JACQUELYN TURNER: Hi. My name is Jacquelyn Turner, and I'm actually the Vice Chair of Surgical Education in the department of surgery. So I'm going to come and speak on two different aspects.

One, I didn't -- I wasn't born and raised -- I didn't grow up in New Orleans, so I can't give some of that background, but as a newcomer, I can

tell you that the mission of HCA has been surprising to me. And I appreciate that you brought up the mission of LCMC. There has been a malalignment of the mission statement with HCA, in my opinion. As an educator, I've helped to implement programs for our medical students, for our undergraduate students, through pathway programs that helped under-represented minorities get into med school.

And I did this for years in Atlanta, Georgia, with Grady Memorial Hospital, with the help of a couple of schools, Morehouse School of Medicine and Emory University. And I came here trying to do the same thing, and it has been a challenge under the current HCA leadership and council. I appreciate that LCMC has included education in their mission statement, and I firmly believe that when that's in your mission statement, that that goal is going to be executed. So I believe that the education -- from an education standpoint, that our mission is much more aligned with the current LCMC mission.

Two, as a provider, most of my patients are under-served with Medicare, Medicaid, or not having any insurance, about forty percent when I look at my patient-pair mix. And with that said, again, I see

malalignment of my mission in serving my patients with the current HCA mission statement. I say that because, as a provider, I came and I am operating under an archaic electronic medical record system that, to me, belongs in 1980.

I -- it's very hard and difficult to take care of patients when the electronic medical system is so outdated. And it's sad to say that because, you know, it's my understanding that Tulane has lost funding, and so we're not the premier HCA child. So we were not given the updated electronic medical records system that some of the other HCA hospitals have. So, again, with LCMC already having some of these up-to-date technologies, it's in line with the care of their mission statement -- aligned with their mission statement.

In terms of diversity, I am truly a proponent of improving health equity and educational equity. And I really appreciate HCA's ten-page document on their website that details out their priority for improving the community health plan. It's a plan that's going to begin this year that is supposed to be carried out until at least 2025, with five priorities. On this priority, they want to include access and continuity of care, improve

mental and behavioral health, improve health education and health literacy, improve discrimination in healthcare, and improve health-related impacts of violence.

So I wouldn't support an arrangement or an acquisition that did not put our community first. So as an African-American, I do believe that HCA is trying to help with -- I'm sorry -- LCMC is trying to help with healthcare disparities for both its community and for its workers.

MS. ANGELIQUE FREEL: Thank you, Dr. Turner.

I see we're getting close to noon, but I would like to push through and get through these cards, and then break before we get to all of the written comments, because I know some of you may need to leave.

The next green card we have is Dr. Robert Hoover, present and would like to speak.

DR. ROBERT HOOVER: Good morning.

MS. ANGELIQUE FREEL: Good morning.

DR. ROBERT HOOVER: I am Robert Hoover. I am the chief of nephrology, which a lot of people don't know what nephrology is. Everybody knows what cardiology is. But nephrology is the study of

kidney diseases, and I'm the Chief of Nephrology at Tulane University.

I have a somewhat different perspective than many of the folks that have spoken here. I'm kind of a newbie to Louisiana and New Orleans. I've been here now for a year-and-a-half. And I think the perspective that I bring is a broad-based understanding of what a true academic medical center is, and what a true academic medical center brings to a region and to a state.

And to talk about that background: previously, I was at Emory University; University of Chicago; Vanderbilt University; Yale; and Harvard. And so I've seen what a true academic medical center is, and can be, and what it can do. And I think it really starts with the three missions of any true academic medical center, which is: research, patient care, and education.

And any true academic medical center has to cover all of those three things. They synergize together. They form a union that, essentially, improves all of those aspects, so that when you join the patient care, and you join the research, and you join the education all together, it creates a synergy that is really unrivaled in medicine. And I

think it is in the short term and long term, essential for a region to have if they are going to advance to the best quality healthcare that we can have.

And I will tell you, honestly, when I got here I was surprised that Tulane University Medical Center was not meeting that standard. And I didn't understand why at first. It took me a while to figure this out. And what I figured out was that our partner at Tulane University Medical Center was completely misaligned with our missions. They did not have any of those missions that we had. I -- you know, they did healthcare and they made money. And, you know, that -- the other parts of our mission were not part of their mission.

And, in fact, this means that our main hospital has not received the resources that you have to have to be a true academic medical center. We have not received the, really, the commitment that is absolutely necessary if you're going to make a true academic medical center. And so I believe we've fallen short of that measure. And we've done so because we've had a bad partner. And it is absolutely essential, and it was and is absolutely essential, that we find a better partner.

And I think we have found a better partner now with LCMC. As others have detailed, they are, I think, aligned with our mission. And I think we will be able to achieve the goal of getting access to a true academic medical center in New Orleans and in Louisiana.

The one other point I want to make, us kidney doctors we're kind of numbers people. So some of this, for me, is about numbers. And, for example, Tulane University Medical Center, due to staffing issues, is not able to actually open all of its beds right now. About half of our beds are open, about a hundred and twenty beds instead of the two hundred and forty that we actually have. And then there's another twenty or thirty patients that are in the ER, boarding in the ER.

These patients -- so, really, right now, Tulane University Medical Center is only about a 150-bed hospital. And UMC is also, because of short staffing, which is plaguing all of us, is also not have all of their beds open. About half of their beds are closed.

So there are plenty of beds at University Medical Center and plenty of beds at East Jefferson Hospital to accommodate those 150 patients that

we're presently caring for at Tulane University Medical Center. All it will require is staffing. And since LCMC has pledged that every employee at Tulane Medical Center will have a job at LCMC, the staffing will be able to move to the other facilities and open up those beds. And so the number of beds will not decrease. In fact, I think, really, the synergy will allow the number of beds to increase in the metro Louisiana area.

Those are my comments. Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Jordan Lo, present and would like to speak. Now, are you a student?

MR. JORDAN LO: I am, yes.

MS. ANGELIQUE FREEL: Okay. Thanks. Thank you.

MR. JORDAN LO: My name is Jordan Lo, and I am a first-year medical student at Tulane University. I am also the class president of my class.

I would like to take a brief moment to express why I believe this partnership between LCMC Health and Tulane will be pivotal and beneficial to the New Orleans region, as well as the School of

Medicine student body. As a first-year medical student, fresh out of the medical school application cycle, I, and many of my classmates, chose Tulane because we wanted to make this institution our destination for getting our medical education here. And this partnership with LCMC will only bolster and confirm that we made the right decision in making Tulane our home for the next four years.

First, we chose Tulane because we wanted to serve and provide for the community of New Orleans. And with this partnership, we will improve our ability to accomplish this goal because it'll increase access to comprehensive care in the downtown New Orleans area and Jefferson Parishes, ultimately allowing our class to serve the community even further and better than before.

Second, we wanted to come here to Tulane for the opportunity to help with advancements in groundbreaking research and lifesaving treatments. With this partnership, we will be able to achieve this goal as well with the increase funding, resources, and faculty in these new academic medical centers that we can then engage in research with.

And lastly, we also -- I support this partnership because it will provide more

opportunities for us to rotate through the different facilities during our clinical years in our third year. This will -- not only will this be more beneficial to providing more care to our community, but this will also strengthen the pipeline of physicians, nurses, and others who will choose to make New Orleans the place where they live and practice for decades to come.

I am excited about the future here at Tulane and LCMC, and I am confident that New Orleans will benefit tremendously from this partnership. Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Dr. Ralph L. Corsetti, Tulane University School of Medicine.

DR. RALPH L. CORSETTI: I am also not a medical student. I'd like --

MS. ANGELIQUE FREEL: Sorry. She didn't -- a lot of y'all had put M.D. behind your name, and so that's why I got confused. I'm sorry.

DR. RALPH L. CORSETTI: It's all good.

MS. ANGELIQUE FREEL: Yeah, so, thanks.

DR. RALPH L. CORSETTI: I'd like to thank the panel and committee for the opportunity to speak this morning. I'll be relatively brief, since a lot

of comments have already been made. I certainly appreciate the red-card comments, predominantly from the nursing staff at Tulane. I understand their emotions and feelings about the issues at hand.

I'm Ralph Corsetti. I'm a surgical oncologist, which is a cancer surgeon. I did my training at Tulane thirty years ago in the early '90s. I've been a Tulane staff member. I'm a full professor of surgery in the Department of Surgery, and a Vice Chair for Clinical Affairs in the Department of Surgery.

Number one, this merger, to me, is undoubtedly a great thing for the residents and citizens of the State of Louisiana, and also for the state itself. As we know, Louisiana is often called the cancer ally between Baton Rouge and New Orleans because of everything that comes down the river. And for patients to often leave the state to head to Houston or Birmingham, which are both five-hour drives, for NCI-designated cancer centers is just something I've seen happen over the thirty years that I've been here.

I grew up in the Northeast. I'm not a native of Louisiana, but I've been here for over thirty years, and taken care of tens -- over ten

thousand cancer patients, probably, in my career.

This affiliation will allow access to basic science and clinical practitioners. So with Tulane's intense basic science commitment and RO1 grants, which are significant research grants funded by the federal government, to have access to clinical patient volume will improve all of those things up there. It will decrease cost. It will improve quality of care. It will increase access to care by providing clinical trials.

We have doctors, myself, we've written clinical trials. I've just got a clinical trial approved, but we need to access patients. We have methods now where we can do less invasive things for -- and I take care of a lot of breast cancer patients. And, you know, we are now moving towards, you know, just removing lumps without even doing radiation or mastectomies. In these clinical trials, we need access to the patients. And this partnership will allow for that.

I think it's going to be a great thing. I can't wait until it gets started. Certainly, there's precedent in this area. I was a resident when Charity became a designated level 1 trauma center. That would have never happened without the

cooperation of the two trauma directors between Tulane and LSU, who worked very collaboratively to make that happen and created, basically, a one-plus-one-equals-three kind of situation, and improved quality for the patients in the state and the city.

This designation and partnership will allow retention. There's a lot of doctors that leave Louisiana. And we see in the healthcare rankings that Louisiana is often in the bottom five, if not often fiftieth in healthcare rankings. And these are a lot of the factors that drive those healthcare rankings. And increased access to care means having -- retaining and retention of the brightest minds.

So these collaborative agreements will hopefully lead to bright -- a bright future for the State of Louisiana.

MS. ANGELIQUE FREEL: Thank you. And make sure you sign in, if you didn't.

DR. RALPH L. CORSETTI: I have.

MS. ANGELIQUE FREEL: Okay.

Next, we have a green card by Dr. Jose Wiley, present and would like to speak, from Tulane.

DR. JOSE WILEY: Good morning. I'm Dr. Jose Wiley. I'm the Chief of Cardiology at Tulane University School of Medicine. I'm actually very

excited over the opportunity of Tulane transferring affiliation from a national level for-profit partner to a local Louisiana nonprofit organization vested in caring for the well being of the people of Louisiana.

As a cardiologist and a trained public health officer, since I have a degree in public health as well, allow me to speak of what I know better, about cardiology. Six point two million adults in the United States have heart failure. And Louisiana falls into the top quintile of highest heart disease death rates; most of them from heart failure.

However, years ago, when I was a trainee at Tulane under Dr. Elma LeDoux, who's here with us, Dean Hamm, who's also here with us, we had a robust advanced heart failure mechanical circulatory support and cardiac transplantation program that provided great care to the people of Louisiana. Not long after, HCA pulled the plug and shut the program down; perhaps because it was not profitable to them. But that left the people of Louisiana with only one cardiac transplantation program: Ochsner. Now, talking about monopoly.

Now, we have the opportunity to partner

with a local organization that will offer the opportunity to have a choice, a deserved choice for better care.

In regards to having Tulane and LSU working together closely, under this affiliation, what better news than that? The sick don't care whether you're Tulane or LSU. They care about good doctors, nurses, and caregivers. This affiliation will foster a new generation of better physicians and healthcare providers to serve the great people of Louisiana.

Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Dr. Nakeisha Pierre, present and would like to speak, from Tulane School of Medicine.

DR. NAKEISHA PIERRE: Good morning --

MS. ANGELIQUE FREEL: Good morning.

DR. NAKEISHA PIERRE: -- and thank you for the invitation to speak. I am a New Orleans native. Most of my medical training was done between the LSU healthcare system and Tulane healthcare system. And I have been on staff with Tulane, as faculty, for fourteen years as a cardiac anesthesiologist.

So I had the opportunity, in conjunction

with my surgical partners, to care for the liver transplant patients that our nurses have mentioned, and patients whose disposition is the critical care unit.

Our relationship with HCA is unsustainable. Their goals are not aligned. The predecessor to our current CEO, William Lunn, shared with our medical community that their model of care was not a tripod of healthcare, education, and research. He mirrored it to a tricycle, where the big wheel was healthcare, and then the tiny little pedals were research and education.

I will share with you that healthcare and the quality of healthcare, as a partner with HCA, has not been a big wheel. They've all been very small pedals. I'll give you a clinical example.

I was called to our post-anesthesia care unit, or the recovery room, emergently to reintubate a patient that was clearly in respiratory distress. The support that I had from the nursing staff was there. All of the personnel that I needed was there. When I asked for the critical equipment that I needed to secure this patient's airway, our airway box was handed to us with masking tape around the box. That delayed our ability and opportunity to

access the equipment that I needed. And when we finally were able to break the tape, and open the box, and get the things that were essential, irreparable brain damage was caused to this patient.

That patient is a father. The patient is a husband. That patient is a brother.

I take care of liver transplant cases. These are critical cases. They're very sick. Those patients often lose their ability to be able to develop blood clots during a surgical procedure. I rely on a very critical piece of equipment, called a TEG machine, to be able to assess in realtime how great of a job we're doing in restoring that patient's critical ability to be able to form blood clots.

I walk into the hospital. I just happen to take the long way to our anesthesia surgical unit. And I walk past our TEG machine, and there's just a sign on it that says "Out of Order." No one had been alerted; not the transplant team, none of our surgeons, none of our transplant anesthesiologists. This is a critical piece of equipment.

This is what we have been experiencing with HCA for far too long. There is no investment in patient care. There's no investment in patient

safety. It is incredibly difficult to make meaningful changes. The leadership changes so often, that most times now I'm not sure who, with the exception of CEO and COO, who are in positions of leadership there because it's a revolving door.

We're able to recruit good people, but it's impossible to retain them because you're not in a system that's invested in the patients, nor are they invested in the clinicians, the practitioners, and the nurses. The morale is the lowest that it has ever been over my past fourteen years.

We're encouraged now to have a partner like LCMC that we know is focused on all of those things that are important to us as Tulane providers. I've never considered leaving Tulane. Tulane has been my home for the last fourteen years. My goal is to retire and to be able to continue to make a meaningful career. Prior to the announcement of this merger, it was the first time that I considered having to leave the state and look for a position elsewhere because I knew that the partnership with HCA, it just -- we were at the point where we were providing unsafe care. And that's very difficult for me to do, as someone that's invested in patient advocacy.

So I would ask that you strongly consider what it means to our patients, what it means to the providers, what it means to our nurses to have a partnership that really aligns with what we should be in academic medicine.

Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Darren Cheng, present and would like to speak, Tulane University School of Medicine student.

MR. DARREN CHENG: Good afternoon, everybody. Thank you for the opportunity to speak. As Dr. Corsetti alluded to earlier, you know, definitely want to acknowledge the opposition and, you know, the perspectives of many of the nurses here.

I'm an MD/MBA student at Tulane and also one of the founding members of the Racial and Social Justice in Medical Education committee at Tulane. And I'm here to really just bring a lot of shared perspective and lived experiences to this partnership with LCMC.

In my role at Tulane, I also oversaw twenty plus student-run free clinics, which served the under-served community in the Greater New Orleans

area as well. And so I certainly appreciate and understand this idea of health equity in serving the community of New Orleans for the last four years. I attended Tulane as an undergraduate student in 2010, so I've lived in New Orleans for a good twelve years. And by the time I'm done, it'll be almost fifteen years. And so I've gotten a really good lay of the land of both Orleans Parish, Jefferson Parish, and really the entire state.

There's a few things that I can touch on. You know, before medical school, I was in nursing. I did EMS, and so I certainly have the appreciation of a frontline worker and what it takes to successfully and almost seamlessly have a good running hospital from the emergency department, all the way up to the wards.

And so, you know, one of the linchpins is the nursing profession. And I truly do believe that this partnership will create a pipeline of nurses to be able to sustain the demand of nurses in this state and all around the country.

And there are opportunities for growth at University Medical Center. And we can see it when we're on the wards, in the emergency department, in terms of beds not being filled. And that's always

been the problem when we have boarders in the emergency department, having to go to other emergency departments because of long waits, but you know, if we are able to -- able to fulfill the need of that nursing shortage, we can get beds opened up on the wards and be able to clean up the emergency department, and ensure those wait times stay low.

You know, I think another thing, too, is -- is being able to utilize and leverage this LCMC network and the various hospitals that they have within their network to open up different service lines and the research across those different hospitals. And I think from a long-term perspective, there's definitely going to be more of a spectrum of primary care in Orleans and Jefferson Parish as well. There's certainly no secret that there is a lack and a large disparity of primary care in this country. And from a sustainability and longevity perspective, we can bridge that health equity gap by fostering this more physician and patient alignment in a minority-majority population like New Orleans, by exposing our trainees and our medical students to primary care, not at just in Orleans Parish, but in Jefferson Parish.

And being a former LCMC employee myself

working in nursing, I truly do believe that they do foster and embody the values and the pillars that they boast, and that they do give back to the community. And, you know, this is certainly something that I do believe that this partnership with Tulane University School of Medicine and LCMC Health is one that's going to be successful, and I do think it is a win-win for everybody, not just the community, but the patients and the trainees and everybody else involved. So thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Paul Gladden, present and would like to speak, Tulane University School of Medicine, GME.

DR. PAUL GLADDEN: Good morning, and thank you. I didn't put M.D. on there, hoping for the student comment, too, but I guess I don't look young enough. I do want to thank you for this chance to speak in favor of this partnership. Having been married for a significant amount of time, I'll also tell you three minutes is more time than I normally get to make my point, so we should be just fine.

I did train up in New York City, where I did my residency and my medical school. And I learned early on that if you're not looking for

improvements, and if you're not looking for change, you're not evolving, you're actually devolving and you're going to die. I think this is a great opportunity.

Here in Louisiana, I am the Dean of Graduate Medical Education, as well as the Chief of Orthopaedic Trauma Surgery. And in that field, in my clinical role, I can't thank LCMC enough for their support and their true commitment for making sure we're at our best when people are at their worst. That is truly something I've seen over the years that we do exceedingly well. That is a service that we will never continue -- never not provide, and it's with their support, we're able to do so well for the people of not only Louisiana, but the states around us.

As far as in an academic role, I need to advocate for 540 residents and 40 different programs. But actually, though, the best way I see for doing that is to advocate for the millions of people who potentially they will treat and the thousands that they actually do. And by doing that, they feel the success of having a good career, and, more importantly, give good outcomes to patients that Louisiana deserves.

So I'm not so much advocating for just my residents, even though I think the world of them. I'm advocating for the people they'll get a chance to touch. And this partnership, I think, will greatly improve their ability to take good care of the people of Louisiana.

I'll just close by saying the partnership will not only improve clinical care, it will improve nursing numbers. We all realize that's been quite a problem. And it will improve research. And in that way, we can all take much, much better care of our patients.

Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card, present and would like to speak, Lee Hamm, Tulane School of Medicine.

DR. LEE HAMM: Thank you for having the hearing. I'm Lee Hamm. I've been in New Orleans thirty years. I wish I was a student. I'm the Dean of the School of Medicine and the Senior Vice President of the university, and have been up close to this evolving plan and assessment of what will happen.

The economic and research advantages of

this partnership are pretty straightforward and obvious in a way, but I think what does need to be focused on, in my mind, first are the patients. You know, that's our ultimate responsibility as caregivers and as a medical school. And it's the patients today and the patients tomorrow. as well.

I love that first story about the heart problem and the young child. That says a lot, but it also is access to care. And we've got to ensure that. And this plan will, undoubtedly. If we're satisfied with the status quo -- no one is satisfied with the status quo. This is a chance to make things better in the community, this good partnership between Tulane and LCMC.

The second for the medical school is the learners. Is it going to make things better for the students and residents? And because they represent the care of the patients in the future. And it also clearly will for them. One of the things that's great about sitting in my position is I get to see all the passion that they bring to this. And the Tulane students frequently, as a few of them have mentioned, they frequently come, not only for the skill they'll learn, the compassion they'll learn, but they really want to help communities. And this

will help us do this.

I love the passion of the nurses. They're striving for making certain that the patients are cared for properly. So we've got to have a great plan, which is still evolving. But this is a great partnership. You've heard a lot of the particulars, and I don't need to do them.

Thank you for listening.

MS. ANGELIQUE FREEL: Next, we have a green card. We actually have two green cards. I think it's the same person. Dr. John Stewart, present and would like to speak.

DR. JOHN STEWART: I'd like to thank you for the opportunity to come before you to discuss why I think that the LCMC's acquisition of Tulane and its assets will have a favorable impact upon our state.

So I'm Dr. John Stewart. I'm the cancer center director for the LSU-LCMC cancer center. I am a native of Louisiana. Yes, Shreveport does count. I'm a proud graduate of Louisiana Tech. I had the opportunity to leave the state thirty years ago, and trained at institutions throughout the East and Southeast, including: Howard, Temple University, National Cancer Institute, and Vanderbilt

University. I then was on faculty at institutions throughout the Southeast, including Wake Forest University School of Medicine, as well as Duke University. And I was recruited to the University of Illinois as the deputy director of the cancer center.

So I think that it has been, personally, my greatest professional privilege to come back to the state of Louisiana to serve as the Cancer Center Director, as we begin to understand how we address issues and inequities in cancer throughout our state.

So through partnerships with LSU and Tulane, the LCMC system has thousands of -- has trained thousands of medical, dental, and nursing students. Why is this important? It is important because our health outcomes in this state are directly proportional to the opportunity to have face-to-face interactions. We need more medical professionals in our state. This partnership represents an opportunity for us to train professionals in the state and to stay local to serve our citizens.

As was mentioned, I was recruited by LCMC Health and LSU a year-and-a-half ago after being

away for thirty years. I came back to the state of Louisiana knowing that there are tremendous challenges in our current cancer rates, as cancer visits an unequal burden on the citizens of our state. This challenge presents a tremendous opportunity to collaborate and address these cancer rates and drive equitable care to all patients of our state.

Together with LSU, LCMC Health has invested $75 Million in pursuing the first and only National Cancer Institute designation in the region to support families and communities impacted by cancer. I'm extremely optimistic that our path ahead, and I look forward to collaborating with Tulane in the future.

I'll end with a statement from my interim chancellor, Dr. Steve Nelson: This unique partnership will bring together highly trained specialists in a multi-disciplinary approach, combined with advanced medical technology that will offer the best patient outcomes for complex life-threatening diseases. Together, we will conduct innovative research leading to critical advancements to prevent, diagnose, and treat disease. Our city and state will reap the benefits of the engine that

drive robust economic development, generating good jobs, and enormous economic impact.

Again, thank you so much for the opportunity to speak before you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Jeff DeMond, Tulane School of Medicine, present and would like to speak.

And after that, we have three more green cards, and then we'll take a break.

MX. JEFF DEMOND: Good afternoon, everyone. My name is Jeff DeMond. I use they/them pronouns. I am a third-year medical student at Tulane University School of Medicine. I'm honored to also serve as our class president of the third-year class. I'm a dual M.D. Masters of Public Health student. And I'm a certified community engagement advocate through the Uptown Office of Multi-Cultural Affairs and Center for Public Service.

I've been reflecting a lot lately on what the role of a medical student is in a hospital. I think that it boils down to two main components that have one central tenant. I think the components are, of course, learning; and second, patient advocacy. And I think that they are united in a

pursuit of love, not just for ourselves, but for our colleagues, for our communities, and, of course, for our patients.

I think that a partnership with LCMC Health is the next step forward towards providing, not just compassionate care, but the care that our patients deserve. It's hard to provide the best patient care to a patient who must be roomed in a hallway in Tulane University's emergency room, something that we see very often. Right?

I believe that LCMC shares a vision of developing better opportunities for medical students to learn, to engage in research, to become the best providers that we can be. Right? In a short year-and-a-half, I will have all of my little degrees, and I'll go out into the world and be a resident, and I'll be providing care in a way that I want to speak to my own beliefs, and the reason that I decided to attend Tulane University School of Medicine. And I believe that LCMC and Tulane share that vision.

Thank you for your time.

MS. ANGELIQUE FREEL: Do you know what you would like to get a residency in?

MR. JEFF DEMOND: Currently, I -- so I

worked with Dr. Corsetti a bit this summer, and I did kind of fall in love with surgery at the time, so that's what I'm thinking at the current moment.

MS. ANGELIQUE FREEL: I should have -- I missed out. I should have asked all the students. I'm sorry. I thought that you were going to tell me you were going to want to do medicine because you're just -- I thought your personality. So I was just curious.

All right. Next, is Holly Lassere, who has a green card, present and would like to speak.

MS. HOLLY LASSERE: Hi. Good afternoon. My name is Holly Lassere. I am the marketing and communication director at East Jefferson General Hospital. And I have a statement to read on behalf of one of our patients, Tatum Clautaire (phonetic).

My name is Tatum Clautaire, and when I was 18 years old, I had a stroke. As you can imagine, this was a very scary time for me and my family, but my fear was a little more bearable because of the amazing care I received at East Jefferson General Hospital and the LCMC Health family of hospitals.

The reason I went to East Jefferson was because my grandmother suffered a massive stroke when she was 54. She received care at East

Jefferson and had a favorable outcome because of a new drug that was administered to her and reversed the effects of her stroke. Because of that positive experience, when I started showing signs of a stroke, my mom knew exactly where she wanted to bring me for treatment. Even though we lived closer to Ochsner-Kenner, my mom instructed EMS to bring me to East Jefferson General Hospital.

The emergency room nurses, Allison, Kimmy (phonetic), and several others were amazing and eased my fears. And then Dr. Peterson, an E.J. Neurologist, diagnosed my stroke and started my treatment. Dr. Dumont, a Tulane neurosurgeon, operated and removed the clot on my brain. Dr. Deffer also played a key role in my recovery. He went out of his way and worked overtime to check on me every day after my stroke to make sure I was strong enough for my neck surgery, and then referred me to LSU Cardiologist Dr. Cox.

Dr. Cox and Children's Hospital New Orleans Cardiologist Dr. Bartakian performed a heart procedure to close a hole in my heart. After that procedure, I was still having an issue with bleeding, so I followed up with Dr. Cox at University Medical Center, where he was seeing

patients that day. Nurses from East Jefferson, Lori and Nicole, helped coordinate all of my care. The team at LCMC Health was instrumental to my recovery and turned a very overwhelming experience into my testimony.

The assistance, care, and concern of the nursing staff, Lakiesha and others, was comforting to my entire family. I'm happy to share that I am in good health today, and currently a student at LSU. After my experience, my mom shared a thank you note with the team at East Jefferson stating: I can't thank you all enough for the gift of peace it gave our family to be so well cared for. Please be assured that you will stay in our prayers. You are truly angels on earth. My family is forever grateful for what East Jefferson gave us. We know that the partnership between LCMC Health and Tulane will help even more families.

MS. ANGELIQUE FREEL: Thank you.

MS. HOLLY LASSERE: Thank you.

MS. ANGELIQUE FREEL: Michelle, are we missing a card?

MS. MICHELLE BOUTTE: Yes.

MS. ANGELIQUE FREEL: Okay. Okay. Let me just make sure they didn't get stuck together. We

have: Steven Morelock, Olivia Cooper, Michael Robertshaw, Kaylen Edwards, Mea Ratcliff, Meg M -- okay, sorry. Let me just make sure I didn't miss any other ones -- Caleb Holmes and Curtis Williams. Okay.

Meg, do you want to go ahead speak? We have a red card from Meg Maloney, in opposition, would like to speak, representing the New Orleans Workers Assembly. And I apologize. The paper is kind of thin and it just got stuck together.

MS. MEG MALONEY: It's okay. Good morning.

MS. ANGELIQUE FREEL: Thank you.

MS. MEG MALONEY: My name is Meg Maloney. I'm a New Orleans resident and member of the New Orleans Workers Assembly. New Orleans Workers Assembly is a network of unions, worker organizing committees, and community organizations. I know many people who cannot make it to this hearing because it's being held in Baton Rouge instead of New Orleans, the city which this is happening and whose residents will be directly affected.

I do not see a single working-class person on the screen while they were speaking of overwhelming public support. In the words of Bethany James, a patient who cannot be here today:

Healthcare is a luxury. It's not a luxury. It's a necessity. The fact that this decision is being made without the full input of those most affected is honestly unacceptable.

Many people do not have the ability to take off work to be here, nor can many afford to do so. On top of this, countless residents do not have a way to get to Baton Rouge, all the way from New Orleans. There needs to be a hearing in the city of New Orleans that's fully accessible to community members and patients who are the most affected by this decision.

The New Orleans healthcare system already took a huge hit when Charity Hospital was closed, a loss that rippled across the community. We need access to care within our city limits. The last thing our city needs is the closure of another hospital. Access to care needs to be prioritized above profit. The needs and input of patients, and working-class community members needs to be a top priority.

Myself and the New Orleans Workers Assembly as a whole stand in full support of nurses and patients who oppose the sale and closure of Tulane Hospital. There is nothing stopping y'all from

holding a second hearing in the City of New Orleans. This entire process feels rushed.

We call for an accessible hearing to be held in the city of New Orleans and call on the Attorney General to block the sale and not close down Tulane Hospital.

Thank you.

MS. ANGELIQUE FREEL: Thank you.

Next, we have a green card from Jason Otis, LCMC Health, present and would like to speak.

MR. JASON OTIS: Hi. I'm Jason Otis, Senior Creative Director, LCMC Health, reading a statement on behalf of Mayra Pineda of the Hispanic Chamber of Commerce of Louisiana.

LCMC Health has been a strong partner to our organization and is truly committed to the betterment of Southeast Louisiana and to our community. In fact, LCMC Health will be opening a Hispanic clinic at West Jefferson Medical Center later this month. This facility specializes in the health needs of the Hispanic community, offering a variety of primary and specialized care services from highly-trained Spanish-speaking healthcare providers. This is just one example of LCMC Health's longstanding tradition of investing in New

Orleans and our region.

The partnership between LCMC Health and Tulane University will ensure residents of our area receive high quality and accessible healthcare, along with investments in medical research, innovation and training.

In addition, this partnership will bring substantial economic benefits to the region through various investments, ranging from facilities to training programs, such as revitalizing downtown facilities and launching a program to train the next generation of nurses.

Moreover, this partnership will preserve jobs in our healthcare sector and will create additional opportunities across a range of disciplines, including clinical, educational, and support positions. It will cement New Orleans as a destination for highly qualified medical professionals, and the planned nursing program will help immensely in addressing our nursing shortage, which is particularly acute in Louisiana.

We believe this partnership will bring an array of benefits, and is positive for our community. On behalf of the Hispanic Chamber of Commerce of Louisiana, I encourage you to approve

this partnership.

MS. ANGELIQUE FREEL: Thank you.

And the last green card we have is for Mike Enlow, and it's not marked. I'm not sure if he wants to speak or not.

Okay. Anybody else wanted to provide a public comment?

(No response.)

Okay. We're going to go ahead and break for twenty minutes until 12:45. There's a little cafeteria if anybody needs anything. We have a lot of public comments that were submitted to us in writing. It's going to take a while to go through them. And I'm just letting you know, so that you can manage your expectations if you decide you're going to stay for that. Thank you.

(A break was taken from 12:15 p.m. to 12:53 p.m.)

MS. ANGELIQUE FREEL: At this time, we're going to allow closing remarks by the applicant, and then we will continue recognizing the public comment that was submitted to our office in writing.

MS. JOANN KUNKEL: Thank you. And thank you for all of the comments. In closing, what we want to reiterate is as we went through this,

develop this relationship and this new partnership, our number one priority always has been, and always will be, our patients. We seek to partner with Tulane to be able to provide even higher quality care to more patients than we do today.

In response to some of the comments that we heard earlier, both TMC and University Medical Center Downtown are currently underutilized and have significant open unfilled capacity. Last year, Tulane Medical Center was less than fifty percent occupied. LCMC Health hospitals have more than enough available space to care for the TMC patients, including significant capacity that exists downtown at University Medical Center, just blocks and a short walk away from TMC.

Tulane students and staff regularly walk from TMC to University Medical Center, and patients will be able to do the same to access services at UMC downtown, including significant Medicaid and Medicare populations.

MR. PATRICK NORTON: So, yeah, just to reiterate, one of our guiding principles, really from day one when we were talking to LCMC, was how to continue high-quality accessible healthcare in downtown New Orleans. And as JoAnn had mentioned,

there is that just underutilization at both hospitals, and there is plenty of space and not just that, a commitment, right, to ensure that we are going to meet the needs of all New Orleanians downtown. So I just wanted to just reiterate that. It's really important. And we heard it from the nurses that were represented. And it's something that, really, was our guiding principal.

I just want to go back and just, kind of, summarize a few things from our perspective. And one is we're local. LCMC Health, Tulane University are local, mission-based, nonprofit organizations that call Southeast Louisiana our home. We're neighbors. We see each other all over. And there's really, in my mind, nothing like home cooking. Right? Everybody's home and we're kind of working together.

We have shared values and a vision to partner to bring the best of community healthcare. Right? I mean, taking care of the patients that come through the doors. And academic medical center. You heard from a lot of the speakers, and much more eloquently than I can make, about the power of academic medicine. Right? And just to reiterate, we're going to have two academic medical

centers: one at the UMC, that's, by the way, already staffed with LSU docs, and Tulane docs, and residents; and at East Jeff, which doesn't have an academic medical center now. There will be two within our area, which is going to be really amazing.

We're going to increase access to comprehensive and specialty care across our region, advanced groundbreaking research, innovative technologies, and lifesaving treatments to ensure all of our patients throughout the region and communities can receive the highest quality of care right here in New Orleans.

MS. JOANN KUNKEL: And we do believe this partnership will expand access to quality care. We're committed to ensuring a seamless transition for our patients, all of whom will continue to receive the high quality care they need and deserve. All patients who currently receive care at Tulane Medical Center will be able to access the same high quality care at LCMC's University Medical Center, which is located downtown, and at East Jefferson Hospital, as well as the other hospitals across LCMC Health.

The combination of our efforts and clinical

volumes will increase the frequency of treatment and services that our physicians provide, advancing clinician's capabilities and directly resulting in improved patient outcomes.

We will continue to engage and work with the staff as we plan for the relocation of the services.

MR. PATRICK NORTON: So when you think -- so when we -- in my role as COO and treasurer, I have a long lense, and also a pretty large portfolio, and one of them is strategy. And this is one of these times that -- we talk about moments of time, and this is one of those. Right? So where we can provide that high quality accessible healthcare, create two academic medical centers, and also increase our research footprint downtown, provide a scalable nursing program to meet a tremendous shortage in our city and our state around just a shortage of nurses. And we can do that really, really quickly with that space.

So when I look at these assets and what we're trying to accomplish, and we've heard win-win, maybe we heard win-win-win, but this is one of those moments in time when you look at these assets, and you say, wow, we could leverage this, we could

expand the research footprint of Tulane University, these nursing programs, clinical services, and create two academic medical centers by joining forces with LCMC.

So we're looking at continuing our investment in downtown New Orleans, including new construction, a multitude of enhancements, the Charity Hospital building, it's -- it's -- you're going to see a lot more activity happening outside Charity in the next four weeks. And we're going to repurpose that Tulane Medical Center building to better serve the needs of our communities. Right? Thriving center of cutting-edge research and innovation is going to happen. That new nursing program I mentioned; clinical research; educational space; graduate programs in public health, social work, professional advancement, all those things are going to be enhanced and invigorated in that downtown space.

You've heard us talk about the demand for nurses. I don't need to go more into that.

And lastly on this point, Tulane University will approximately add 2,300 jobs across New Orleans and Louisiana. Twenty-three hundred jobs by our development of downtown.

MS. JOANN KUNKEL: We also want to reiterate that we are -- we do value the providers and all employees. And they will continue to have jobs. We value the providers and the employees across all of the LCMC Health and Tulane Hospital facilities, and are committed to retaining staff across both organizations.

All employees at the three Tulane hospitals will continue to have jobs under this exciting partnership. Being able to staff appropriately will also help us with the underutilization and the capacity that we do have at our facilities, utilizing the expertise of the staff that we do have.

And, specifically, this partnership transitions the operating interest of Tulane Medical Center, Lakeside, and Lakeview, from an out-of-state for-profit operator to a local not-for-profit with demonstrated track record of putting the health of the community first.

MR. PATRICK NORTON: So we -- just to reiterate, we believe this partnership will result in this, in really those three elements that the COPA provides for: high quality and improved access to healthcare for patients throughout our region

without any, really, undue increase in healthcare costs. So we believe that is going to happen with this partnership.

Both organizations currently operate with excess capacity, as I mentioned, as JoAnn mentioned, presenting a significant opportunity to be a more efficient use of our resources, realize operational and financial benefits that will attract higher skilled labor and fund cutting-edge clinical technologies, advanced patient care delivery in New Orleans.

Patients will continue to have many options when it comes to choosing what they want, where they want to receive their care, as there will continue to be multiple hospitals, health systems, and other healthcare facilities that provide inpatient and outpatient services in the region.

As was mentioned about the UMC, literally, our school of med students walk. It's a few blocks. They walk from taking classes from Hutchinson or from the Murphy building, and they literally walk across the highway and they're at the UMC. So the proximity of our downtown hospital, UMC, is just a couple of blocks.

And, lastly, this partnership will enhance

delivery of care, and advance health equity by increasing access to comprehensive care in downtown New Orleans -- we've said that many times, but we can't say it enough -- and create expanded hubs for specialty care, innovation, in both Orleans and Jefferson Parishes, the two academic medical centers that I spoke of.

MS. JOAN KUNKEL: And finally, combining clinical services at East Jefferson General Hospital, and expanding clinical services and academic expertise at the University Medical Center New Orleans, will enhance the delivery of care across both Orleans and Jefferson Parishes.

We're excited to bring these and many other benefits to patients in New Orleans and throughout the State of Louisiana.

MR. PATRICK NORTON: So I hope our presentation and all of the great public comments we had really highlighted the extraordinary benefits that will accrue to the citizens of Louisiana and beyond. And we thank you.

MS. ANGELIQUE FREEL: Thank you. I just wanted to say that I am happy to hear that you're going to take efforts to retain employees since we did hear some concerns and some red cards from

nurses that were concerned about maybe losing jobs or having changes in pay and benefits. And so I wish they were here to hear that.

MS. JOANN KUNKEL: We have tried to communicate the commitment. We have so many positions available. We are very committed to all of the staff.

MS. ANGELIQUE FREEL: Okay.

MR. PATRICK NORTON: And by the way, we've been very public about that as well. This is not a secret. We've been public in all kinds of communications. Actually been in the press, too, about that commitment by LCMC to retain jobs.

MS. ANGELIQUE FREEL: And services?

MS. JOANN KUNKEL: Yes.

MR. PATRICK NORTON: And services.

MS. ANGELIQUE FREEL: Okay. Thank you.

At this time, we are going to go through the written comments that were received by our office. They will be attached to the court reporter's transcript of this proceeding. I will not read them all, but I will indicate who sent them. And if there's a date, I'll indicate that as well. Thank you.

MR. PATRICK NORTON: Thank you.

MS. ANGELIQUE FREEL: Okay. So we received a letter that's undated from the National Nurses Organizing Committee from Bradley Van Waus, W-A-U-S, who expressed some concerns with regard to the application.

We were sent a copy of a Jefferson Parish press release dated October 21, 2022. It was sent to us on December 5th, in support of the transaction.

We received an email from Jay DeSalvo -- Dr. Jay DeSalvo in support of the transaction.

We received an email from Margie Galloway in support of the transaction.

We received an email from Norman Barnum in support of the transaction. I realize I didn't say the date, but this one's dated December 6th.

We received an email from Walt Leger, III, and he is in support of the transaction. And his email is from Tuesday, December 6th.

We received an email from Christopher Roth December 6, 2022, in support of the transaction.

We received a comment via email from Charlotte Parent, dated December 7, 2022, in support of the transaction.

We received a comment in support of the

transaction from Misty Sherlock December 7, 2022, in support of the transaction.

We received a comment from Terri Taylor Joseph in support of the transaction, and the email is dated December 7, 2022.

We received a comment from Stephen Hales in support of the transaction. The comment is dated December 7, 2022.

We received a comment in favor of the transaction from JoAnn Kunkel. The comment is dated December 7, 2022.

We received a comment from Suzanne Haggard in support of the transaction, via email, and it's dated December 7, 2022.

For purposes of this record, just all of the dates are 2022.

So we received an email in support of the transaction from Andy Leblanc on December 7th.

We received a public comment from Lisa Miranda, via email, in support of the transaction on December 7th.

We received a public comment, via email, from Shannon Belanger in support of the transaction on December 7th.

We received an email, or a public comment

via email, from John R. Cook on December 7th in support of the transaction.

We received a comment from Alison Anderson in support of the transaction on December 7th, via email.

We received a comment from Amy Edwards, via email, on December 7th in support of the transaction.

We received a comment from Eli Smith, via email, on December 7th in support of the transaction.

We received a comment, via email, from Byron Stockstill on December 7th in support of the transaction.

We received a comment, via email, from Ruby Brewer on December 7th in support of the transaction.

We received a comment from Lucio Fragoso, via email, in support of the transaction on December 7th.

We received a comment in support of the transaction on December 7th from Elias Ayoub.

We received a comment in support of the transaction on December 7th from Robert Calhoun.

We received a comment, via email, from

Victoria Nguyen on December 7th, via email, in support of the transaction.

Sorry, I'm kind of -- if I say things duplicative, I apologize. It gets repetitive after a while.

We received a comment, via email, in support of the transaction from Quitman Gahagan. It's dated December 7th.

We received a comment in support of the transaction from Jonathan Brouk, and it is dated December 7th.

We received a comment, via email, from Robert Bradshaw in support of the transaction. And the email is dated December 7th.

We received a comment, via email, from Eryn Piper in support of the transaction. And that's dated December 7th.

We received a comment, via email, from Manuel Linares in support of the transaction. And then that is dated December 7th.

We received a comment from Robin McGoey, via email, in support of the transaction. And that comment is dated December 7th.

We received a comment, via email, in support of the transaction from Julissa Castro. And

that email is December 7th.

We received a comment, via email, in support of the transaction from Lindsey Casey, and that email is December 7th.

On December 7th, we received a comment, via email, from Scott Cornwell in support of the transaction.

On December 7th, we received an email from Troy Bond in support of the transaction.

On December 7th, we received a comment, via email, from Allison Guste in support of the transaction.

On December 7th -- that's an easier way to say it. I think I found my rhythm now.

On December 7th, we found -- we received a comment -- on December 7th, we received an e -- I don't know what I said. Okay. We received a -- now, I messed up my rhythm. Shoot. Okay. On December -- I had it down. Now, I got to start over. Sorry.

On December 7th, we received a comment, via email, in support of the transaction from Chip Cahill.

On December 7th, we received a comment, via email, from Jennifer Schwehm in support of the

transaction.

We received on December 7th a comment, via email, from Mark Kline in support of the transaction.

On December 7th, we received an email -- public comment, via email, from Brad Sinclair in support of the transaction.

On December 7th, we received a comment, via email, from Jessica Cahill in support of the transaction.

On December 7th, we received a comment, via email, from Ryan Hildebrand in support of the part -- Tulane University, LCMC partnership.

On December 7th, we received a comment, via email, from Rosanne Halford in support.

On December 7th, we received a comment, via email, from James Zanewicz, spelled Z-A-N-E-W-I-C-Z, in support of the partnership.

On December 7th, we received a comment, via email, from Judy Vitrano in support.

On December 7th, we received a comment, via email, from Scott Landry in support.

On December 7th, we received a comment, via email, from Gabriella Pridjian in support.

On December 7th, we received a comment, via

email, from Hans Andersson in support.

On December 7th, we received a comment, via email, from Richard Chau in support.

On December 7th, we received a comment, via email, from Frances Vickers in support.

On December 7th, we received a comment, via email, from Brian Johnson in support.

On December 7th, we received a comment from Courtney Marbley, via email, in support.

On December 7th, we received a comment, via email, from Jonathan Small in support.

On December 7th, we received a comment, via email, from William Guste, IV, in support.

On December 7th, we received a comment, via email, from William Von Almen in support.

On December 7th, we received a comment, via email, from Cary Becker in support.

On December 7th, we received a comment, via email, from Kady Weingart in support.

On December 7th, we received a comment, via email, from Lelia Peyronnin in support.

On December 7th, we received a comment, via email, from Sharonda Williams in support.

On December 7th, we received a comment, via email, from Denice Eshleman in support.

On December 7th, we received a comment, via email, from Marie Krousel-Wood in support.

On December 7th, we received a comment, via email, from Representative Timothy Kerner in support. And he also sent -- we also received a letter that was from Shawn Moses Anglim, First Grace UMC pastor and Margaret Washington, retired nurse/nurse educator in support. It's not dated.

We received a comment, via email, on December 7th in support from Elwood Cahill.

We received an email December 7th, which included a comment from Kirk Bouyelas in support.

On December 7th, we received a comment, via email, from Deborah Pennison in support.

On December 7th, we received a comment, via email, from Takiesha Davis in support.

On December 7th, we received a comment, via email, from Rachel Bonacorso, along with a letter that was in support.

We received a letter signed Dickie Brennan, Steve Pettus, Lauren Brennan-Brower, dated December 7th, on behalf of established business and restaurant owners in the Greater New Orleans area, in support.

We received on December 7th a comment, via

email, from Molly Mallory in support.

On December 7th, we received a comment, via email, from Darlene Gondrella in support.

On December 7th, we received a comment, via email, from Robert Hinyub in support.

On December 7th, we received a comment, via email, from Jessica Shedd in support.

On December 7th, we received a comment, via email, from Laura Sutton in support.

On December 7th, we received a comment, via email, from Maggie Gentry in support.

On December 7th, we received a comment, via email, from Kathan Dearman in support.

On December 7th, we received a comment, via email, from Paula Alford-Estrade in support.

On December 7th, we received a comment, via email, from P.J. Sibille in support.

On December 7th, we received a comment, via email, from Jody Martin in support.

On December 7th, we received a comment, via email, by Mark Ranatza in support.

On December 7th, we received a comment, via email, from Michael McKendall in support.

On December 7th, we received a comment, via email, from Robin Barnes in support.

On December 7th, we received a comment, via email, from Nemy Galindo in support, via email.

On December 7th, we received a comment, via email, from Terrie Sterling in support.

On December 7th, we received a comment, via email, from Patrick Norton in support.

On December 7th, we received a comment, via email, from Carolyn Scofield in support.

On December 7th, we received a comment, via email, from Jai Shankar in support.

On December 7th, we received a comment, via email, from Erin Perry in support.

On December 7th, we received a comment, via email, from Donna Carnajal in support.

On December 7th, we received a comment, via email, from Kyle Ruckert in support.

On December 7th, we received a comment, via email, from Christe Brewton in support.

On December 7th, we received a comment, via email, by Ian McLachlan in support.

On December 7th, we received a comment, via email, from Lee Linda in support.

On December 7th, we received a comment, via email, from Meg Vitter in support.

On December 7th, we received a comment, via

email, from D.K. Willard in support.

On December 7th, we received a comment, via email, from Amanda Ortego in support.

On December 7th, we received a comment from Damon Dietrich, via email, in support.

On December 7th, we received a comment, via email, from Shayne Benedetto in support.

On December 7th, we received a comment, via email, from Josh Collen in support.

On December 7th, we received a comment, via email, from Kathy Willard in support.

On December 7th, we received a comment, via email, from Jeffrey Elder in support.

On December 7th, we received a comment from Lu Jones, via email, in support.

On December 7th, we received a comment, via email, from Valerie Norton in support.

On December 7th, we received a comment, via email, from Walter Zollinger in support.

On December 7th, we received a comment, via email, from Ernest Mitchel in support.

On December 7th, we received an email from -- a comment, via email, from Matthew Rainwater in support.

On December 7th, we received a comment, via

email, from Elizabeth Crawford in support.

On December 7th, we received a comment, via email, from Berni Caitlin in support.

On December 7th, we received a comment, via email, from Mark Heck in support.

On December 7th, we received a comment, via email, from Paul Rainwater in support. I had printed one out twice. I was just making sure it wasn't a different time. It wasn't. It was just my error. I had printed a comment out twice.

On December 7th, we received a comment, via email, from Dawn Bonnecaze in support.

On December 7th, we received a comment, via email, from Melissa Lorio in support.

On December 7th, we received a comment, via email, from Nic Hunter in support.

On December 7th, we received a comment, via email, from Sarah Kracke in support.

On December 7th, we received a comment, via email, from Alexandra Napoli in support.

On December 7th, we received a comment, via email, from Daniel Zollinger in support.

On December 7th, we received a comment, via email, from Julia Kaplow in support.

On December 7th, we received a comment, via

email, from Joshua Sumrall in support.

On December 7th, we received a comment, via email, from Dean Roy in support.

On December 7th, we received a comment, via email, from Patrice Delafontaine in support.

On December 7th, we received a comment, via email, from Brittany Poirrier in support. And that was via email.

On December 7th, we received a comment, via email, from Michael Enlow in support. Again, I printed one twice, it looks like.

On December 7th, we received a comment, via email, from Jill Israel in support.

On December 7th, we received a comment, via email, from Jerri Rayes in support.

On December 7th, we received a comment, via email, from Claiborne Christian in support.

On December 7th, we received a comment, via email, from Blair David in support.

On December 7th, we received a comment, via email, from Belden Craig in support.

On December 7th, we received a comment, via email, from Robert Hailey in support.

On December 7th, we received a comment, via email, from Keith Crawford in support.

On December 7th, we received a comment, via email, from Catherine Favrot in support.

On December 7th, we received a comment, via email, from Matt Hughes in support.

On December 7th, we received a comment, via email, from Anna-Kate France in support.

On December 7th, we received a comment, via email, from Jackson Landry in support.

On December 7th, we received a comment, via email, from Ana Lopez in support.

On December 7th, we received a comment, via email, from Sara Feirn in support.

On December 7th, we received a comment, via email, from Elizabeth Wooten in support.

On December 7th, we received a letter. I guess it's an email, but it looks like it's a letter, from Justin Crossie, and it is in support of the transaction, and it was sent via email.

We received a comment, via email, from Kara Schonberg on December 7th in support of the transaction.

We received a comment, via email, on December 7th from Justin Crossie in support.

We received on December 7th a comment, via email, from Gregory Nielsen in support.

On December 7th, we received a comment, via email, from Christine Albert in support.

We received a letter December 7th from John Thompson, Professor and Chair, Department of Psychiatry and Behavioral Sciences, Director, Division of Forensic Neuropsychiatry, Tulane University School fo Medicine, and that's in support.

On December 7th, we received a comment, via email, from Mary Warren in support.

On December 7th, we received a comment, via email, from Dusty Porter in support.

On December 7th, we received a comment from Adam Eckstein, via email, in support.

On December 7th, we received a comment, via email, from John Heaton in support.

On December 7th, we received a comment, via email, from Suzie Terrell in support.

On December 7th, we received a comment, via email, from Jeff Hardin in support.

On December 7th, we received a comment, via email, from Ian Morrison in support.

On December 7th, we received a comment, via email, from Misty Sherlock in support.

On December 7th, we received an emailed

comment and letter from David Ziccardi. Okay. This particular person specifically asked Brett to read it.

So I'll let you do that, Brett.

MR. BRETT ROBINSON: Okay.

MS. ANGELIQUE FREEL: And it'll give people a break -- you have it?

MR. BRETT LANDRY: Sure. Yeah. Yeah.

MS. ANGELIQUE FREEL: -- from hearing me. Okay. Well, I'll just put it here.

MR. BRETT LANDRY: All right. His name -- this is his letter, David Ziccardi. He sent it over December 7th, but it actually is dated December 8th.

Dear Attorney General Landry, my name is David Ziccardi. I'm a registered nurse at Tulane Hospital in the emergency room and the post anesthesia care unit. I've been in medicine and/or the emergency services my entire life, fifteen of which have been at Tulane. I'm writing to express my concern about the pending sale of Tulane Hospital to Louisiana Children's Medical Center and request that you either deny the sale or place it on hold until further details can be worked out.

There are many concerns that have been expressed, such as the duopoly that would be

created, the likely rise in healthcare costs, and the lack of communication from the parties involved. I would, however, like to look at some of the operational aspects that I do not believe have been addressed by the corporations.

One of the proposals is to shut down Tulane Hospital. Tulane is one of the two hospitals in downtown New Orleans and the closest to the French Quarter. University Medical Center is a Level 1 trauma center, located approximately three blocks north of the other side of the interstate. Tulane's emergency room routinely has patients coming over citing ten plus hours sitting in their waiting room. New Orleans police routinely bring psychiatric patients to Tulane, stating that they were told by UMC to go to Tulane because of the extended wait times.

How will UMC absorb, not only those patients, but the ones that Tulane treats exclusively? Can UMC open and staff an equal number of beds that are in Tulane's emergency room? Based on the present conditions, it's extremely unlikely.

Another issue is the New Orleans Medical Services. New Orleans Medical Services runs approximately five ambulances for a city of almost

400,000. They routinely rely on Acadian and other ambulance services to handle the calls that they cannot service. If services are transferred to Jefferson Parish, as it has been stated, how can NOMES maintain even this level of service if patients are requesting transport out of the parish? As NOMES has told us in the past, you have to transport the patient where they request, or it is kidnaping otherwise. Longer transport times means fewer ambulances available to take emergency calls. Perhaps the patient could be convinced to go to a local hospital. But once again, are those hospitals resourced to handle this influx of patients?

Finally, and most importantly, I would like this hearing to consider the sale from the patient's perspective. The Census Bureau estimates that twenty-three percent of New Orleans population lives in poverty. Many of the patients and some of the employees of Tulane rely on public transportation, family and/or friends to get to their medical appointments and jobs.

It is not uncommon for patients to express they missed the dialysis treatment or doctor's appointment because they have no transportation. It is also not uncommon for patients to activate 911

with a minor complaint to secure a ride to the clinics. If patients struggle to make appointments that are in the parish, how will they make appointments if services are moved out of the parish as has been proposed? This would be a huge hurdle for many of our patients to overcome, and compliance with medical treatment plans will certainly decrease.

Although there are numerous issues at hand, the nurses at Tulane are willing to help address these operational issues and perhaps make this a win-win situation. To that end, I'm asking again that you either deny or place on hold the sale until there is input from the nurses on the conditions of the proposed sale, and there is more transparency from HCA and LCMC about the process.

Sincerely, David Ziccardi.

MS. ANGELIQUE FREEL: Okay. Mr. Ziccardi's letter dated December 8th will be part of the record.

On December 7th, we received a comment, via email, from Carling Dinkler in support.

On December 7th, we received a comment, via email, from Aaron Dumont in support.

On December 7th, we received a comment, via

email, from Camille Nelson in support.

On December 7th, we received a comment, via email, from Zoe Bluffstone, and it's in support.

We received a comment, via email, from Joshua Cox on December 7th in support.

On December 7th, we received a comment, via email, from Leslie Leavoy in support.

On December 7th, we received a comment, via email, from Judy Scanlon in support.

On December 7th, we received a comment, via email, from Christopher Olsen in support.

On December 7th, we received a comment, via email, from Ann Marie Allen in support.

On December 7th, we received a comment from -- I think I just said this lady. Let me make sure she didn't do two. Yep, she did two. We received another comment from Judy Scanlon, via email, on December 7th in support.

Okay. On December 7th, we received a comment, via email, from Catherine Harrell in support.

On December 7th, we received a comment, via email, from Liana Narcisse in support.

On December 7th, we received a comment, via email, from Aja Fitz-Ritson in support.

On December 7th, we received a comment, via email, from Jennifer Parks in support.

On December 7th, we received a comment, via email, from Windie Muller in support.

On December 7th, we received a comment, via email, from Jean Sconza in support.

On December 7th, we received a comment, via email, from Richard Tanzella in support.

On December 7th, we received a comment, via email, from Paula Adamcewicz in support.

On December 7th, we received a comment, via email, from Lauren Rabalais in support.

On December 7th, we received a comment, via email, from Tara Hawkins in support.

On December 7th, we received a comment, via email, from Jared Stroderd in support.

On December 7th, we received a comment, via email, from Karen Arceneaux in support.

On December 7th, we received a comment, via email, from Scott Hunter in support.

On December 7th, we received a comment, via email, from Erin Boh.

On December 7th, we received a -- and that was in support -- we received a comment on December 7th from Jason King, and it was via email, and he

was in support.

We received a comment, via email, on December 7th from Ahmed Mohiuddin, M-O-H-I-U-D-D-I-N, Chief Physician Officer, and he was in support.

On December 7th, we received a comment, via email, from Demetrius Maraganore, and he was in support.

All right. On December 7th, we received a comment, via email, from Katie Acuff in support.

On December 7th, we received a comment, via email, from Justin Lorio in support.

On December 7th, we received a comment, via email, from Greg Elder, and he's in support.

On December 8th, this morning, I received a comment, via email, from Dr. Jennifer Avegno, Director, New Orleans Health Department, in support.

On December 8th, I received a comment, via email, from Cynthia Hanemann in support.

On December 8th, via email, we received a comment from Beverly Brooks Thompson, and this is in support.

And then, today during the hearing, it looks like more comments were sent. And I will just go through these quickly.

Okay. We received a comment today,

December 8th, from Jennine Elardo in support.

We received a comment, via email, from Corky Thompson in support.

We received a comment, via email, from Charmaine Caccioppi in support.

We received a comment, via email, from Natasha Richardson in support.

All right. It's my understanding you have an additional document you want to provide?

Okay. And what's your name?

MS. OLIVIA COOPER: My name is Olivia Cooper.

MR. BRETT ROBINSON: Okay.

MS. ANGELIQUE FREEL: Olivia?

MS. OLIVIA COOPER: Olivia Cooper.

MS. ANGELIQUE FREEL: Cooper. Okay.

MS. OLIVIA COOPER: Yes. I'm a registered nurse at Tulane. I spoke earlier in opposition. I just, at this time, would like to support a document, or put a document on the record that is a petition that the majority of registered nurses at Tulane Medical Center have signed.

The petition states: We, the undersigned nurses and community members, demand to have a say in the future of Tulane Medical Center. On Monday,

October 10th, LCMC and Tulane announced the proposed sale of our hospital, with the intention to shut it down. Many of us learned about this plan suddenly, with no discussion or warning. We are gravely concerned about what this pending sale and subsequent closure of our hospital means to our community and the patients we serve.

Together, we are demanding: Recognition of our union, formed with the National Nurses Organizing Committee/National Nurses United; no cuts to patient care services or jobs; input of RN staff on the conditions of the proposed sale; and transparency from Tulane and LCMC in this process.

And I'd just like to reiterate that we have a majority of staff nurses signing this petition, as well as various members of the community who have signed it as well.

MS. ANGELIQUE FREEL: Okay. Thank you. We will make it part of the record. That's the court reporter on the end, if you want to hand it down there. Thank you.

MS. OLIVIA COOPER: Thank you.

MS. ANGELIQUE FREEL: All right.

Do y'all have anything?

I think that's it. At this time, we will

adjourn.

Thank you.

(PUBLIC HEARING ADJOURNED AT 1:40 P.M.)

REPORTER'S PAGE

I, Cori M. Rodgers, Certified Court Reporter in and for the State of Louisiana, the officer, as defined in Rule 28 of the Federal Rules of Civil Procedure and/or the Article 1434(B) of the Louisiana Code of Civil Procedure, before whom this proceeding was taken, do hereby state on the Record:

That due to the spontaneous nature of the interaction and discourse of the proceeding, double-dashes (--) have been used to indicate pauses, changes of thought and/or talkovers; that such is the universally accepted method for a court reporter's transcription of a proceeding; that double-dashes (--) do not indicate that words or phrases have been left out of the transcript;

And that the spelling of any words and/or names which could not be verified through reference resources have been denoted with the parenthetical phrase "(spelled phonetically)."

CERTIFICATE

This certification is valid only for a transcript accompanied by my original signature and original required seal on this certificate.

I, Cori M. Rodgers, Certified Court Reporter in and for the State of Louisiana, as the officer before whom this hearing was held, do hereby certify that this a true and correct transcript of the Public Hearing held on the 8th day of December 2022, at Baton Rouge, Louisiana, as hereinbefore set forth in the foregoing 148 pages; that this hearing was reported by me in the stenomask reporting method, was prepared and transcribed by me or under my personal direction and supervision, and is true and correct to the best of my ability and understanding; that the transcript has been prepared in compliance with the transcript format guidelines required by statute and rules of the board; that I am informed about the complete arrangement, financial or otherwise, with the person or entity making arrangements for reporting services; that I have acted in compliance with the prohibition on contractual relationships, as defined by Louisiana Code of Civil Procedure Article 1434 and rules of

the board; that I have no actual knowledge of any prohibited employment or contractual relationship, direct or indirect, between a court reporting firm and any party litigant in this matter, nor is there any such relationship between myself and a party litigant in this matter; that I am not related to counsel or to any of the parties hereto, I am in no manner associated with counsel for any of the interested parties to this litigation, and I am in no way concerned with the outcome thereof.

This 20th day of December 2022, Springfield, Louisiana.

_____
Cori M. Rodgers, CVR, CCR #2020003
Certified Court Reporter

1374288

CAPITAL CITY PRESS

Publisher of
THE ADVOCATE

PROOF OF PUBLICATION

The hereto attached notice was published in THE ADVOCATE, a daily newspaper of general circulation published in Baton Rouge, Louisiana, and the Official Journal of the State of Louisiana, City of Baton Rouge, and Parish of East Baton Rouge or published daily in THE TIMES-PICAYUNE/THE NEW ORLEANS ADVOCATE, in New Orleans Louisiana or published daily in THE ACADIANA ADVOCATE in the following issues:

11/21/2022, 11/22/2022, 11/23/2022

Joy Newman, Public Notices Representative

Sworn and subscribed before me, by the person whose signature appears above

29 Nov 2022

M. Monic McChristian,

Notary Public ID#88293

State of Louisiana

My Commission Expires: Indefinite

M. MONIC McCHRISTIAN NOTARY PUBLIC NOTARY NO. 88293 STATE OF LOUISIANA

RECEIVED
DEC 06 2022
CIVIL DIVISION
OFFICE OF THE
ATTORNEY GENERAL

Ad No: 14583

Brett Robinson
Louisiana Department of Justice
1885 North 3rd Street
BATON ROUGE, LA 70802

EXHIBIT
tabbies
1

PUBLIC NOTICE

NOTICE OF PENDING APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE REGARDING A PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.C. AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

The Department of Justice, Office of the Attorney General, State of Louisiana, hereby provides notice that it has received an Application for a Certificate of Public Advantage regarding a proposed transaction between HCA Healthcare, Inc. ("HCA"), Tulane University ("Tulane"), University Healthcare System, L.C. ("UHS"), and Louisiana Children's Medical Center d/b/a LCMC Health.

Under the proposed transaction, HCA will transfer its ownership interest in UHS to Tulane. LCMC Health will subsequently acquire the membership interests of UHS from Tulane and will become the sole member of UHS. UHS (which consists of Tulane University Medical Center, Tulane Lakeside Hospital and Lakeview Regional Medical Center) will operate as a local not-for-profit entity under LCMC Health.

Under the proposed agreement, the majority of services currently provided at Tulane Medical Center will shift to nearby East Jefferson General Hospital and University Medical Center New Orleans. Additionally, LCMC Health has committed to capital investments in the operations of East Jefferson General Hospital, Lakeview Regional Medical Center, and Tulane Lakeside Hospital. The proposed transaction is expected to close as soon as practicable if and when the COPA application is approved by the Louisiana Attorney General.

Pursuant to La. R.S. 40:2254.4 and L.A.C. 48:XXV.511, on or before December 7, 2022, all interested persons may submit comments regarding the transaction to:

Angelique Freel
Director, Civil Division
Office of the Attorney General
Louisiana Department of Justice
1885 North 3rd St., 6th Floor
Baton Rouge, Louisiana 70802
(225) 326-6000
(Telephone)
(225) 326-6096 (Fax)

14583 STF Nov 24 TP 21-25

ST. TAMMANY FARMER

STATE OF LOUISIANA PARISH OF ST. TAMMANY

PROOF OF PUBLICATION

The hereto attached notice was published in ST. TAMMANY FARMER, a weekly newspaper of general circulation within the Parish of St. Tammany, in the following issues:

11/24/2022, 11/30/2022

Joy Newman, Public Notices Representative

Sworn and subscribed before me, by the person whose signature appears above

30 Nov 2022

M. Monic McChristian,

Notary Public ID#88293

State of Louisiana

My Commission Expires: Indefinite

M. MONIC McCHRISTIAN NOTARY PUBLIC NOTARY NO. 88293 STATE OF LOUISIANA

Ad No: 14609

Brett Robinson
Louisiana Department of Justice
1885 North 3rd Street
BATON ROUGE, LA 70802

EXHIBIT 2

PUBLIC NOTICE

NOTICE OF HEARING FOR AN APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE REGARDING A PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

The Department of Justice, Office of the Attorney General, State of Louisiana, hereby provides notice that it has received a completed application for a Certificate of Public Advantage regarding a proposed transaction between HCA Healthcare, Inc. ("HCA"), Tulane University ("Tulane"), University Healthcare System, L.C. ("UHS"), and Louisiana Children's Medical Center d/b/a LCMC Health.

Under the proposed transaction, HCA will transfer its ownership interest in UHS to Tulane. LCMC Health will subsequently acquire the membership interests of UHS from Tulane and will become the sole member of UHS. UHS (which consists of Tulane University Medical Center, Tulane Lakeside Hospital and Lakeview Regional Medical Center) will operate as a local not-for-profit entity under LCMC Health.

Under the proposed agreement, the majority of services currently provided at Tulane Medical Center will shift to nearby East Jefferson General Hospital and University Medical Center New Orleans. Additionally, LCMC Health has committed to capital investments in the operations of East Jefferson General Hospital, Lakeview Regional Medical Center, and Tulane Lakeside Hospital. The proposed transaction is expected to close as soon as practicable if and when the COPA application is approved by the Louisiana Attorney General.

THE PUBLIC IS INVITED TO ATTEND A HEARING ON THIS MATTER THAT WILL TAKE PLACE ON **DECEMBER 8, 2022 AT 10:00 A.M. AT:**

CLAIBORNE BUILDING
1201 NORTH THIRD STREET
LOUISIANA PURCHASE ROOM, 1-100
BATON ROUGE, LA 70802

All interested persons shall be allowed to present testimony, facts or evidence related to the Application and shall be permitted to ask questions. The Department shall also receive comments regarding the transaction from any interested person by December 7, 2022. For further information or to provide comments regarding the transaction, please contact:

Angelique Freel
Director, Civil Division
Office of the Attorney General
Louisiana Department of Justice
1885 North 3rd Street,
6th Floor
Baton Rouge LA 70802
(225) 326-6000
(Telephone)
(225) 326-6096 (Fax)

14603 STF NOV 24,30
TP NOV 22

CAPITAL CITY PRESS

Publisher of
THE ADVOCATE

PROOF OF PUBLICATION

The hereto attached notice was published in THE ADVOCATE, a daily newspaper of general circulation published in Baton Rouge, Louisiana, and the Official Journal of the State of Louisiana, City of Baton Rouge, and Parish of East Baton Rouge or published daily in THE TIMES-PICAYUNE/THE NEW ORLEANS ADVOCATE, in New Orleans Louisiana or published daily in THE ACADIANA ADVOCATE in the following issues:

11/22/2022

Joy Newman, Public Notices Representative

Sworn and subscribed before me, by the person whose signature appears above

29 Nov 2022

M. Monic McChristian,

Notary Public ID#88293

State of Louisiana

My Commission Expires: Indefinite

M. MONIC McCHRISTIAN NOTARY PUBLIC NOTARY NO. 88293 STATE OF LOUISIANA

Ad No: 14609

Brett Robinson
Louisiana Department of Justice
1885 North 3rd Street
BATON ROUGE, LA 70802

EXHIBIT 3

PUBLIC NOTICE

NOTICE OF HEARING FOR AN APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE REGARDING A PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

The Department of Justice, Office of the Attorney General, State of Louisiana, hereby provides notice that it has received a completed application for a Certificate of Public Advantage regarding a proposed transaction between HCA Healthcare, Inc. ("HCA"), Tulane University ("Tulane"), University Healthcare System, L.C. ("UHS"), and Louisiana Children's Medical Center d/b/a LCMC Health.

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Under the proposed agreement, the majority of services currently provided at Tulane Medical Center will shift to nearby East Jefferson General Hospital and University Medical Center New Orleans. Additionally, LCMC Health has committed to capital investments in the operations of East Jefferson General Hospital, Lakeview Regional Medical Center, and Tulane Lakeside Hospital. The proposed transaction is expected to close as soon as practicable if and when the COPA application is approved by the Louisiana Attorney General.

THE PUBLIC IS INVITED TO ATTEND A HEARING ON THIS MATTER THAT WILL TAKE PLACE ON DECEMBER 6, 2022 AT 10:00 A.M. AT:

CLAIBORNE BUILDING
1201 NORTH THIRD STREET
LOUISIANA PURCHASE ROOM, 1-100
BATON ROUGE, LA 70802

All interested persons shall be allowed to present testimony, facts or evidence related to the Application and shall be permitted to ask questions. The Department shall also receive comments regarding the transaction from any interested person by December 7, 2022. For further information or to provide comments regarding the transaction, please contact:

Angelique Freel
Director, Civil Division
Office of the Attorney General
Louisiana Department of Justice
1885 North 3rd Street,
6th Floor
Baton Rouge LA 70802
(225) 326-6000
(Telephone)
(225) 326-6096 (Fax)

14603 STF NOV 24,30
TP NOV 22

1374281

ST. TAMMANY FARMER

STATE OF LOUISIANA PARISH OF ST. TAMMANY

PROOF OF PUBLICATION

The hereto attached notice was published in ST. TAMMANY FARMER, a weekly newspaper of general circulation within the Parish of St. Tammany, in the following issues:

11/24/2022, 11/30/2022

Joy Newman, Public Notices Representative

Sworn and subscribed before me, by the person whose signature appears above

30 Nov 2022

M. Monic McChristian,

Notary Public ID#88293

State of Louisiana

My Commission Expires: Indefinite

M. MONIC McCHRISTIAN NOTARY PUBLIC NOTARY NO. 88293 STATE OF LOUISIANA

RECEIVED
DEC 06 2022
CIVIL DIVISION
OFFICE OF THE
ATTORNEY GENERAL

Ad No: 14583

Brett Robinson
Louisiana Department of Justice
1885 North 3rd Street
BATON ROUGE, LA 70802

EXHIBIT 4

PUBLIC NOTICE

NOTICE OF PENDING APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE REGARDING A PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.C. AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

The Department of Justice, Office of the Attorney General, State of Louisiana, hereby provides notice that it has received an Application for a Certificate of Public Advantage regarding a proposed transaction between HCA Healthcare, Inc. ("HCA"), Tulane University ("Tulane"), University Healthcare System, L.C. ("UHS"), and Louisiana Children's Medical Center d/b/a LCMC Health.

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Under the proposed agreement, the majority of services currently provided at Tulane Medical Center will shift to nearby East Jefferson General Hospital and University Medical Center New Orleans. Additionally, LCMC Health has committed to capital investments in the operations of East Jefferson General Hospital, Lakeview Regional Medical Center, and Tulane Lakeside Hospital. The proposed transaction is expected to close as soon as practicable if and when the COPA application is approved by the Louisiana Attorney General.

Pursuant to La. R.S. 40:2254.4 and L.A.C. 48:XXV.511, on or before December 7, 2022, all interested persons may submit comments regarding the transaction to:

Angelique Freel
Director, Civil Division
Office of the Attorney General
Louisiana Department of Justice
1885 North 3rd St., 6th Floor
Baton Rouge, Louisiana 70802
(225) 326-6000
(Telephone)
(225) 326-6096 (Fax)

14583 STF Nov 24 TP 21-25

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN OPPOSITION

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in opposition

Please Print:

Name: Mea Ratcliff

Signature: M. Ratcliff, RN

Representing: Tulane Medical Center Nurses / Patients Kommunity

Address: 1941 S. Chippewa St NOOLA 70130

Primary telephone: 504-988-5254 Cell: 225-324-5932

Email address: mea-michell6@yahoo.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN OPPOSITION

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in opposition

Please Print:

Name: CURTIS WILLIAMS

Signature: Curtis L. Williams

Representing: STAT UP LA

Address: 2

Primary telephone: _____ Cell: 504 214-6478

Email address: WILLIAMSC653@YAHOO.COM

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN OPPOSITION

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in opposition

Please Print:

Name: Caleb Holmes

Signature: Caleb Holmes

Representing: Step Up Louisiana

Address: 2455 Weldwood dr Baton Rouge

Primary telephone: 318-638-9500 Cell: _____

Email address: Calebh53@gmail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN OPPOSITION

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in opposition

Please Print:

Name: Kaylen Edwards

Signature: Kay L Edwards

Representing: Tulane Medical Center

Address: 923 Rupp St. Gretna, LA 70053

Primary telephone: (678)472 7793 Cell: (678) 472 7793

Email address: Kaylenedwards@ymail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN OPPOSITION

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ~~ONE~~:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in opposition

Please Print:

Name: MICHAEL ROBERTSHAW

Signature: [signature]

Representing: RN's @ Tulane Medical Center

Address: 2009 ST CLAUDE AVE

Primary telephone: 504 373-2074 Cell: _____

Email address: bobshaw31@gmail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN OPPOSITION

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in opposition

Please Print:

Name: Olivia Cooper

Signature: Olivia D. Cooper

Representing: Tulane Medical Center registered nurse

Address: 3343 Esplanade Ave NOLA 70119

Primary telephone: 503.679.0127 Cell: _____

Email address: odavecooper@gmail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN OPPOSITION

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in opposition

Please Print:

Name: Steven Morelock

Signature: [signature]

Representing: New Orleans Community

Address: 2498 Jonquil St. New Orleans LA 70122

Primary telephone: 213 494 8723 Cell: _____

Email address: steven.morelock@gmail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN OPPOSITION

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(√) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in opposition

Please Print:

Name: Meg Maloney

Signature: Meg M

Representing: New Orleans Workers Assembly

Address: 3818 chestnut st New Orleans, LA

Primary telephone: 504-444-9096 Cell: _____

Email address: margaretskyethomasmaloney99gmail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: JoAnn Kunkel

Signature: JoAnn Kunkel

Representing: LCMC Health

Address: 1820 Octavia Street, NOLA 70115

Primary telephone: 605-351-9356 Cell: 605-351-9356

Email address: joann.kunkel@lcmchealth.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: PATRICK NORTON

Signature: [signature]

Representing: LCMC HEALTH

Address: 1555 POYDRAS Ave, NEW ORLEANS, LA

Primary telephone: 802 989 3715 Cell: 802 989 3715

Email address: PJN@TULANE.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Jennifer VanVranken

Signature: J VanVranken

Representing: Jefferson Parish

Address: _____

Primary telephone: _____ Cell: _____

Email address: _____

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Jerry Bologna

Signature: [signature]

Representing: JEDCO

Address: 700 Churchill Pkwy

Primary telephone: 504 289 9410 Cell: 504-289-9410

Email address: jbologna@jedco.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Ruby Brewer

Signature: Ruby Brewer

Representing: LCMC Health

Address: 4200 Houma Blvd Metairie LA 70006

Primary telephone: 504-259-5379 Cell: 504-259-5379

Email address: ruby.brewer@lcmchealth.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: ALLISON GUSTE

Signature: Allison Guste

Representing: LCMC HEALTH

Address: 920 FILMORE AVE, NEW ORLEANS, LA 70124

Primary telephone: 504-281-4869 Cell: 504-258-2252

Email address: allison.guste@lcmchealth.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Charlotte PARENT

Signature: C P

Representing: LCMC HEALTH / University Medical Ctr

Address: 3740 Red Oak Ct NOLA 70131

Primary telephone: Cell 504-813-4189 Cell: _____

Email address: charlotte.parent@lcmchealth.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: JOHN HEATON, MD

Signature:

Representing: LCMC

Address: 29 RIVER CYPRESS LN MADISONVILLE, LA

Primary telephone: 504 432 2010 ~~Cell~~

Email address: JGHEATON@GMAIL.COM

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Chip Cahill

Signature: [signature]

Representing: LCMC - West Jeff Medical Center

Address: 3740 Lake Michel Ct. Gretna LA 70056

Primary telephone: 5042279898 Cell: 5042697394

Email address: chipcahill@icloud.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Nathaniel Beech

Signature: Nate Beech

Representing: Tulane University School of Medicine

Address: 344 St. Joseph Street, New Orleans, LA, 70130

Primary telephone: 5048132159 Cell: 5048132159

Email address: Nbeech@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Terrie P. Sterling

Signature: Terrie P. Sterling

Representing: LCMC Health

Address: 1101 Poydras New Orleans, LA 70163

Primary telephone: (225)658-8144 Cell: (225) 202-8298

Email address: terrie.sterling@lcmchealth.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Gary Haynes, MD, PhD

Signature: [signature]

Representing: Tulane University School of Medicine

Address: 1430 Tulane Avenue

Primary telephone: (504) 988-5068 Cell: (314) 882-0483

Email address: ghaynes@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Percy Manson

Signature: [signature]

Representing: Faith based community

Address: 1100 Poydras

Primary telephone: _____ Cell: _____

Email address: percy.manson@gmail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: LaDana Williams

Signature: [signature]

Representing: Rhonda LaBat

Address: 1100 Poydras St. New Orleans, LA 70163

Primary telephone: 504-896 2759 Cell: _____

Email address: ladana.williams@lcmchealth.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: John Pourciau (Poo-show)

Signature: [signature]

Representing: LCMC Health

Address: 1100 Poydras, New Orleans, LA

Primary telephone: _____ Cell: 225 247-2833

Email address: johnpourciau@lcmchealth.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Peter Waggonner

Signature: [signature]

Representing: GNO, Inc.

Address: 1100 Poydras St. NO LA 70163

Primary telephone: 504-527-6980 Cell: 504-312-9529

Email address: pwaggonner@gnoinc.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: EMILY M BROWN

Signature: Emily M Brown

Representing: Tulane Medical School

Address: [redacted], 1430 Tulane Ave, N.O., LA 70112

Primary telephone: 813-310-7948 Cell: _____

Email address: ebrown34@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Jacqualyn Turner

Signature: [signature]

Representing: Tulane University

Address: ~~1415~~ 1430 Tulane AVE, New Orleans, LA 70112

Primary telephone: 504-999-5169 Cell: 832-656-7474

Email address: jturner16@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Robert Hoover, MD

Signature: [signature]

Representing: Tulane

Address: 768 Amethyst St., New Orleans, LA 70124

Primary telephone: 773-960-2149 Cell: 773-960-2149

Email address: rhoover3@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Jordan Lo

Signature: [signature]

Representing: Tulane University School of Medicine

Address: 2424 Tulane Ave, Apt 216

Primary telephone: 949 309 7744 Cell: _____

Email address: jlo2@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Ralph L. Corsetti MD

Signature: Ralph L. Corsetti MD

Representing: Tulane University School of Medicine

Address: 1430 Tulane Ave., Dept. of Surgery, NOLA 70112

Primary telephone: 985-900-7071 Cell: 504-352-8013

Email address: rcorsetti1@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Todd Wiley, M.D., MPH

Signature: [signature]

Representing: Tulane

Address: 1430 Tulane Ave. New Orleans, LA 70112

Primary telephone: _____ Cell: 914-708-9379

Email address: twiley1@tulane.edu

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Dr. Nakeisha Pierre

Signature: [signature]

Representing: Tulane School of Medicine

Address: 1415 Tulane Ave, SL-4

Primary telephone: _____ Cell: (504) 258-6570

Email address: npierre@tulane.edu

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: DARREN CHENG

Signature: [signature]

Representing: TULANE UNIVERSITY SCHOOL OF MEDICINE

Address: 1430 TULANE AVE. NEW ORLEANS, LA 70112

Primary telephone: _____ Cell: 714-478-3968

Email address: DCHENG@TULANE.EDU

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Paul Gladden

Signature: PG

Representing: Tulane University School of Medicine GME

Address: 1430 Tulane Ave 70112

Primary telephone: (504) 988-3515 Cell: (904) 252-3526

Email address: pgladden@tulane.edu

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Lee Hamm

Signature: [signature]

Representing: Tulane School of Medicine

Address: 1430 Tulane Ave., New Orleans 70112

Primary telephone: 504 988 5462 Cell: 504-228-5530

Email address: lhamm@tulane.edu

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: JOHN STEWART, MD, MBA

Signature: [signature]

Representing: LSU

Address: 6925 Canal Blvd NOLA 70124

Primary telephone: (336) 306-0181 Cell: _____

Email address: jstew17@lsuhsc.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: John Stewart

Signature: JS

Representing: LCMC Health

Address: 6925 Canal Blvd NOLA 70124

Primary telephone: (336)306-0181 Cell: _____

Email address: jste17@LSUHSC.edu

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(X) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Jeff De Mond

Signature: [signature]

Representing: Tulane School of Medicine

Address: 7309 Sycamore Street New Orleans, LA 70118

Primary telephone: 618-973-6534 Cell: _____

Email address: jdemond@tulane.edu

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Holly Lassere

Signature: Holly Lassere

Representing: LCMC Health

Address: 1100 Poydras, New Orleans 70163

Primary telephone: (504) 250-1615 Cell: (504) 250-1615

Email address: holly.lassere@lcmchealth.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

(✓) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Jason Otis

Signature: [signature]

Representing: LCMC Health

Address: 457 Audubon Blvd. NOLA 70125

Primary telephone: 504-237-8284 Cell: 504-237-8284

Email address: Jason.Otis@LCMChealth.com

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
( ) Although I do not wish to speak, I am present and in support

Please Print:

Name: Mike Enlow

Signature: Mike Enlow

Representing: Tulane

Address: 309 Laurel St.

Primary telephone: 225-975-2460 Cell: _____

Email address: menlow@LGAGroup.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

PUBLIC HEARING REGARDING PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE OF HEARING: Thursday, December 8, 2022 at 10:00 a.m. (CST)

LOCATION OF HEARING: Claiborne Building
1201 North Third Street
Louisiana Purchase Room, 1-100
Baton Rouge, LA 70802

ATTENDANCE SIGN-IN SHEET:

Name	Party Represented	Address, Phone, Email
Angelique Duhon Freel Assistant Attorney General	Attorney General, State of Louisiana	**LA. Dept. of Justice** **1885 North Third Street** **Civil Division, 6th Floor** **Baton Rouge, LA 70802** **225-326-6000;** **freela@ag.louisiana.gov**
Brett Robinson Assistant Attorney General	Attorney General, State of Louisiana	**LA. Dept. of Justice** **1885 North Third Street** **Civil Division, 6th Floor** **Baton Rouge, LA 70802** **225-326-6000;** **robinsonbr@ag.louisiana.gov**
Lee Hamm	Tulane Sch. of Medicine	1430 Tulane Ave NOLA 70112 504-988 5462 Lhamm@tulane.edu
Ralph Corsetti	Tulane Univ School of Medicine	1430 Tulane Ave NOLA 70112 504-352-8013 rcorsetti1@tulane.edu

PUBLIC HEARING REGARDING PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

ATTENDANCE SIGN-IN SHEET:

Name	Party Represented	Address
Dr. Nakeisha Pierre	Tulane School of Medicine	1415 Tulane Ave SL-4 N.O. LA 70112
Jeff DeMond	Tulane School of Medicine	7309 Sycamore St NOLA, 70118
Nathaniel Beech	Tulane University School of Medicine	344 St Joseph Street NOLA, 70130
EMILY BROWN	Tulane School of Medicine	1430 Tulane Ave NOLA 70112
Elma I. LeDoux, MD.	Tulane School of Medicine	131 S. Robertson St Suite 1530 NO LA 70112
Josewitey	Tulane School Of Medicine	1430 Tulane Ave. NOLA 70112

PUBLIC HEARING REGARDING PROPOSED TRANSACTION
BETWEEN
HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER
d/b/a LCMC HEALTH

ATTENDANCE SIGN-IN SHEET:

Name	Party Represented	Address
Amaraoma .C. Ugoji	Tulane School of Medicine	1430 Tulane Avenue, New Orleans LA, 70112
GARY Haynes, MD, PhD	Tulane University School of Medicine	1430 Tulane Ave. Hc 73 New Orleans LA 70112
Jacquelyn Turner	Tulane School of Medicine	1430 Tulane Ave, New Orleans, LA 70112
DARREN CHENG	TULANE SCHOOL OF MEDICINE	1430 TULANE AVE. NEW ORLEANS, LA 70112
Kimberly Allen	Tulane	5342 Camp NOLA 70115

PUBLIC HEARING REGARDING PROPOSED TRANSACTION
BETWEEN
HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER
d/b/a LCMC HEALTH

ATTENDANCE SIGN-IN SHEET:

Name	Party Represented	Address
Peiton Jarmon	TUSOM	1430 Tulane Ave. New Orleans, LA 70112
Carlyn Scafeld	Tulane School of Medicine	316 Fawn Dr. Avala, LA 70032
Kaylen Edwards	Tulane Medical Center	923 Rupp St. Gretna, LA 70053
Meg Maloney	New Orleans Workers Assembly	3818 chestnut st New orleans
Olivia Cooper	Tulane Medical Center	3343 Esplanade Ave, NOLA 70119
Mea Ratcliff	TMC	1941 S. Chippewa St NOLA 70130

PUBLIC HEARING REGARDING PROPOSED TRANSACTION
BETWEEN
HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER
d/b/a LCMC HEALTH

ATTENDANCE SIGN-IN SHEET:

Name	Party Represented	Address
MICHAEL ROBERTSHAW	TULANE RN's	2009 ST CLAUDE AVE 70116
Jerry Bologna	JEDCO	700 Churchill Pkwy Avondale, LA 70094
Ruby Brewer	LCMC Health	4200 Houma Blvd Metairie LA 70006
Jennifer VanVranken	Jefferson Parish Government	1221 Elmwood Park Blvd Suite 1014 Jefferson LA 70123
ALLISON GUSTE	LCMC HOSPITAL	926 FILMORE AVE NO, LA 70124

PUBLIC HEARING REGARDING PROPOSED TRANSACTION
BETWEEN
HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER
d/b/a LCMC HEALTH

ATTENDANCE SIGN-IN SHEET:

Name	Party Represented	Address
Charlotte Parent	LCMC Health	3740 Red Oak Ct NOCA 70131
John Heaton	LCMC Health	29 River Cypress Ln Mandeville, LA 70471
Steven Morelock	NOCA Community	2458 Jonquil St NOCA 70122
Chip Cahill	LCMC	3740 LK Michel Ct. Gretna
Terrie Sterling	LCMC	1100 Poydras New Orleans
Gary Hamaker MD	Tulane	1430 Tulane Ave

PUBLIC HEARING REGARDING PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

ATTENDANCE SIGN-IN SHEET:

Name	Party Represented	Address
CURTIS WILLIAMS	STEP UP LA	
PERCY Manson	Minister Alliance Greater N.O.	
LaDana Williams	LCMC Health	1100 Poydras St. New Orleans LA 70163
John Bourciau	LCMC Health	//
Peter Waggonner	GNO, Inc.	1100 Poydras NOLA 70163
Jacqueline Turner	Tulane	1430 Tulane Ave New Orleans 70112

PUBLIC HEARING REGARDING PROPOSED TRANSACTION
BETWEEN
HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER
d/b/a LCMC HEALTH

ATTENDANCE SIGN-IN SHEET:

Name	Party Represented	Address
Robert Hoover, MD	Tulane	1430 Tulane Ave NOLA Louisiana
Jose' Wiley	Tulane	1430 Tulane Ave NOLA, LA
Nakeisha Pierre	Tulane	" "
DARREN CHENG	TULANE	" "
Pat Glade	Tulane	" "
John Stewart	LSU	2000 Canal Nola

PUBLIC HEARING REGARDING PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

ATTENDANCE SIGN-IN SHEET:

Name	Party Represented	Address
Kelly Tarver	LCMC Health	Poydras St. NOLA
Jason Otis	"	"

PUBLIC HEARING REGARDING PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

ATTENDANCE SIGN-IN SHEET:

Name	Party Represented	Address
Jordan Lo	Tulane SOM	2424 Tulane Ave Apt 216 NOLA 70119
Holly Gulden	Tulane University	726 Pontalba St NOLA 70124

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: Kimberly Allen

Signature: Kim Allen

Representing: Tulane

Address: 5342 Camp Street.

Primary telephone: _____ Cell: 504 313 2806

Email address: kallen19@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Sharon Courtney

Signature: [signature]

Representing Tulane

Address: 1555 Poydras St. NOLA 70112

Primary telephone: _____ Cell: 504-491-2909

Email address: sharonc@tulane.edu

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C. AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE

( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print

Name: Barrett Hawkins

Signature: [signature]

Representing: Tulane University

Address: 145 Tulane Ave / New Orleans 70112

Primary telephone: _____ Cell: 918 260 2887

Email address: bhawkins3@tulane.edu

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

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( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Ellen Palminteer

Signature: Ellen Palminteer

Representing: Tulane University

Address: 1555 Poydras St. NOLA 70112

Primary telephone: _____ Cell: 225-454-7797

Email address: epalminteer@tulane.edu

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: Elma I. LeDoux, MD

Signature: Elma I. LeDoux, MD

Representing: Tulane University

Address: 131 S. Robertson St. Suite 1530

Primary telephone: (504) 988-5331 Cell: (504) 289-3610

Email address: eledoux@tulane.edu

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DATE: December 8, 2022

CHECK ONE
( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print

Name: Stephen Leder

Signature: Steph Leder

Representing: Tulane

Address: 304 Laurel Street

Primary telephone: 225-939-6170 Cell: 225-939-6170

Email address: sleder@chg2004p.com

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: SUSAN POLLACK

Signature: Susan Pollack

Representing: Tulane University

Address: 1430 Tulane Ave

Primary telephone: 504 782 7864 Cell: same

Email address: spollack@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C. AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE December 8, 2022

CHECK ONE

( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Jennifer Cataldie, RN

Signature: [signature]

Representing: self

Address: 2326 Dawson's Creek Dr. BR 70808

Primary telephone: _____ Cell 415-676-8376

Email address: _____

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C. AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Rachael Farmer

Signature: Rachael Farmer

Representing: Tulane

Address: 304 Laurel Street

Primary telephone: 205-572-1726 Cell

Email address: RFarmer@LGAGroup.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE
( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Amaraoma C. Ugoji

Signature: Ugoji

Representing: Tulane School of Medicine

Address: 1430 Tulane Avenue, New Orleans, LA 70112

Primary telephone: Cell: 731-394-2127

Email address: augoji@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: Perton Jarmon

Signature: Perton A. Jarmon

Representing: Tulane University School of Medicine

Address: 1432 Tulane AVE New Orleans, LA 70112

Primary telephone: (615) 593-3230 Cell:

Email address: pjarmon@tulane.edu

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak.
(X) Although I do not wish to speak, I am present and in support.

Please Print:

Name: Holly M Gulden

Signature: Holly M Gulden

Representing: Tulane University

Address: 726 Pontalba Street, New Orleans LA 70124

Primary telephone: 504-432-5394 Cell: same

Email address: hgulden@tulane.edu.

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print

Name: Ann Shaw, OD

Signature: [signature]

Representing: 2242 Myrtledale Ave Baton Rouge 70808-5

Address: self

Primary telephone: _____ Cell: 225-205-1467

Email address: _____

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C. AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Payton diFalco

Signature: [signature]

Representing: Self

Address: 1115 Westmoreland Dr. BR 70808

Primary telephone: _____ Cell: 225-368-5125

Email address: _____

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE
( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print

Name: Jordan Gleason

Signature: Jordan Gleason

Representing: Tulane

Address: 304 Lowerl Street

Primary telephone: 225-270-8183 Cell: _____

Email address: jgleason@cgagroup.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE
( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: Arwin Bascle

Signature: Arwin P. Bascle

Representing: Tulane

Address: 900 Stanford Ave #1209

Primary telephone: _____ Cell 504 296 4349

Email address: arwin@arwinbascle.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Gabrielle Kress

Signature: Gabrielle Kress

Representing: Tulane

Address: 304 Canal Street

Primary telephone: 225-939-7723 Cell:

Email address: gkress@lbtgroup.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE
( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print

Name: Carolyn Scofield

Signature: [signature]

Representing: Tulane University School of Medicine

Address: 316 Fawn Drive, Arabi LA 70032

Primary telephone: _____ Cell: (504) 881-4542

Email address: scofield@tulane.edu

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:

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(X) Although I do not wish to speak, I am present and in support

Please Print

Name: Beverly Brooks Thompson, PhD, CFRE

Signature: Beverly Brooks Thompson

Representing: LCMC Health / Brooks Thompson CBC

Address: 1521 Sugar Cane Lane BRCA 70820

Primary telephone: 225-274-6420 Cell:

Email address: beverly.brooksthompson@yahoo.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

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(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: AYAME DINKLER

Signature: [signature]

Representing: LCMC Health

Address: 2437 Tenn St

Primary telephone: Cell: 702 744 3590

Email address: Ayame.dinkler@gmail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print

Name: Blaine Bourgeois

Signature: [signature]

Representing: Self

Address: 540 S. Broad St.

Primary telephone: 504-669-4531 Cell: _____

Email address: blain@lsnola.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: ADAM ECKSTEIN

Signature: [signature]

Representing: LCMC HEALTH

Address: 1100 POYDRAS, NEW ORLEANS LA 70163

Primary telephone: _____ Cell: (901) 489-1150

Email address: Adam.Eckstein@LCMCHealth.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Beverly Matherney

Signature: Beverly Matherney

Representing: LCMC Health

Address: 295 English Turn Dr LA 70131

Primary telephone: _____ Cell: _____

Email address: _____

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Josceline Frank

Signature: Josceline Frank

Representing: LCMC Health

Address: 1137 St Michael Dr Harvey LA 70058

Primary telephone: _____ Cell: _____

Email address: _____

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak.
(✓) Although I do not wish to speak, I am present and in support.

Please Print:

Name: Dottie Briese

Signature: Dottie Briese

Representing: LCMC Health

Address: 4424 Bancroft Dr 70122

Primary telephone: _____ Cell: _____

Email address: _____

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Mark Klink

Signature: Mark Klink

Representing: LCMC Health

Address: 1100 Girod Str NOLA 70113

Primary telephone: _____ Cell: _____

Email address: _____

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE
( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: MARY FLORES

Signature: Mary Flores

Representing: LCMC Health

Address: 2400 Ramsey Dr 70131

Primary telephone: _____ Cell: 313-418-6929

Email address: _____

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: Charles Parent

Signature: C P

Representing: Self

Address: 3740 Red Oak Ct

Primary telephone: all 504-289-6885 Cell: _____

Email address: Chetp508@hotmail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak.
(✓) Although I do not wish to speak, I am present and in support.

Please Print:

Name: Denise Parent

Signature: NPC

Representing: self

Address: 4914 Meadow Park Dr NOLA 70128

Primary telephone: _____ Cell: 504-491-3372

Email address: CNParent1@gmail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE
( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: TONI HARRIGAN

Signature: Toni Harrigan

Representing: LCMC Health

Address: 1100 Poydras St. New Orleans, LA

Primary telephone: [redacted] Cell: _____

Email address: toni.harrigan@lcmchealth.org

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE
( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: Steven Yost

Signature: Steven Yost

Representing: My Self

Address: 2915 Bordeaux St. New Orleans La. 70119

Primary telephone: _____ Cell: 504 427-3794

Email address: _____

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: Leonzell Brown

Signature: Leonzell Brown

Representing: —

Address: 7110 Beauvoir Ct. N.O. La. 70128

Primary telephone: _____ Cell: 504-669-4573

Email address: —

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak
(—) Although I do not wish to speak, I am present and in support

Please Print:

Name: Kenneth DiLosa

Signature: [signature]

Representing Observer Supporter

Address: 12355 Lake Carmel Place, New Orleans, LA 70136

Primary telephone: _____ Cell: 504-266-3962

Email address: KennethDiLosa@Yahoo.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Gregory A. Nielsen

Signature: [signature]

Representing: LCMC Health

Address: 1100 Poydras NOLA

Primary telephone: _____ Cell: 308.660.7451

Email address: gregory.nielsen@lcmchealth.org

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: P.J. Sibille

Signature: PJ Sibille

Representing: LCMC Health

Address: 1100 Poydras St Ste 2500 NO 70130

Primary telephone: 504.702.3410 Cell: _____

Email address: pj.sibille@lcmchealth.org

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE

( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: Rev. Tyrone Smith

Signature: T. Smith

Representing: OMSBC

Address: 2917 Pendido St. New Orleans

Primary telephone: 504-782-3616 Cell:

Email address: TySmith@gmail.com

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Dalton Dugas

Signature: Dalton Dugas

Representing: LCMC Health / public support

Address: 329 Millicent Way

Primary telephone: (318) 754-9245 Cell:

Email address: dugrisdalton@gmail.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:

( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Pike Philibert

Signature: Pike Philibert

Representing: LCMC Health | Public Support

Address: 1 Duckhook Drive

Primary telephone: (504) 444-9779 Cell: _____

Email address: pike1023@cox.net

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

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(X) Although I do not wish to speak, I am present and in support

Please Print

Name: Robert L. Colomb, Jr.

Signature: Robert Colomb, Jr.

Representing: LCMC Health / Public Support

Address: 108 Evangeline Lane

Primary telephone: 504-607-3572 Cell: 504-607-3572

Email address: rlcoljr@outlook.com

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AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

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DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak
(X) Although I do not wish to speak, I am present and in support

Please Print:

Name: Jackson Landry

Signature: Jackson Landry

Representing LCMC Health / public comment

Address: 3530 Stowers Dr ~~3530~~ 51 71201

Primary telephone: (318) 914-2744 Cell: (318) 914-2744

Email address: jackson@idealstrategiestu.com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

AG PUBLIC HEARING WITNESS CARD - AFFIRMATION IN SUPPORT

RE: APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE, PROPOSED TRANSACTION BETWEEN HCA HEALTHCARE, INC., TULANE UNIVERSITY, UNIVERSITY HEALTHCARE SYSTEM, L.L.C., AND LOUISIANA CHILDREN'S MEDICAL CENTER d/b/a LCMC HEALTH

DATE: December 8, 2022

CHECK ONE:
( ) I am present and would like to speak
(✓) Although I do not wish to speak, I am present and in support

Please Print:

Name: Mark Ellmann

Signature: [signature]

Representing: _____

Address: 1201 Governor Nicholls St New Orleans LA 70116

Primary telephone: _____ Cell: (504) 255-1517

Email address: MarkEllmann@Gmail.Com

*Your signature is certification that your testimony is true and correct and an acknowledgement that you are testifying under oath.

Freel, Angelique

From: Elardo, Jennine M <Jennine.Elardo@lcmchealth.org>
Sent: Thursday, December 08, 2022 10:30 AM
To: Freel, Angelique
Cc: Elardo, Jennine M
Subject: Subject: I support the LCMC Health – Tulane University Partnership

Good morning,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the System Director of Revenue Integrity at LCMC Revenue Cycle Administration and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We can transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,
Jennine Elardo, MPA, LSSBB
System Director, Revenue Integrity

LCMC Health
Westpark Campus
3401 Gen. DeGaulle Drive
New Orleans, LA 70114

C 317.332.3553

Jennine.elardo@lcmchealth.org
LCMChealth.org

Freel, Angelique

From: Corky Thompson <w2thompson@cox.net>
Sent: Thursday, December 08, 2022 10:36 AM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane University Parntership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

William Thompson
1521 Sugar Cane Lane
Baton Rouge, Louisiana 70810

Freel, Angelique

From: Charmaine D. Caccioppi <CharmaineC@UnitedWaySELA.org>
Sent: Thursday, December 08, 2022 10:59 AM
To: Freel, Angelique
Cc: Pamela Allison
Subject: I support the LCMC Health – Tulane University Partnership

Importance: High

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration.

Charmaine D. Caccioppi
Executive Vice President & COO
United Way of Southeast Louisiana
Pronouns: she/her/hers

P. O. Box 791790 | New Orleans, LA 70179-1790
ph: 504.827.6823 | cell: 504.669.8529 | charmainec@unitedwaysela.org

LIVE UNITED | unitedwaysela.org | Facebook | Twitter | Shutterfly | YouTube | Instagram

Freel, Angelique

From: Natasha Richardson <Natasha.Richardson@lcmchealth.org>
Sent: Thursday, December 08, 2022 11:22 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

To whom it may concern:

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Natasha N. Richardson, MBA (she/her)
Vice President, Operations and Clinical Research Infrastructure
Chair, Walter Pierre Diversity Committee – Children's Hospital
President, GNO Women's Healthcare Executive Network

LCMC Health
1100 Poydras St., Ste. 2500
New Orleans, LA 70163

C 504.782.0275
Natasha.Richardson@LCMCHealth.org

Freel, Angelique

From: Kyle France <kylef@laba-group.com>
Sent: Thursday, December 08, 2022 12:43 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Dear Attorney General

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I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

KYLE M. FRANCE

Louisiana Business Advisory Group
3421 N Causeway Blvd.
Suite 105
Metairie, La 70002
504.358.8111

Freel, Angelique

From: Sullivan, Jarrod D <jsulliv@tulane.edu>
Sent: Friday, December 09, 2022 7:37 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Best Regards,

Jarrod D. Sullivan
Deputy Chief of Support Services
Tulane University Police Department

Freel, Angelique

From: Shawn Bridgewater <sbridgewater8@cox.net>
Sent: Friday, December 09, 2022 7:41 AM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Shawn M. Bridgewater-Normand, Esq.

321 Homestead Ave.
Metairie, LA

Sent from my iPhone

Freel, Angelique

From: Paul Flower <phflower@woodwarddesignbuild.com>
Sent: Monday, December 12, 2022 9:59 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Paul

Paul Flower
Chief Executive Officer

Woodward Design+Build | Woodward Interests
1000 S. Norman C. Francis Parkway
New Orleans, LA 70125

Office: (504) 822-6443
Direct: (504) 826-1116
woodwarddesignbuild.com | woodward-interests.com
LinkedIn | Facebook | Instagram

Freel, Angelique

From: Dinkler, Ayame <Ayame.Dinkler@lcmchealth.org>
Sent: Monday, December 12, 2022 11:32 AM
To: Freel, Angelique
Cc: Field, Kenneth W.; Brewer, Ruby; Guste, Allison
Subject: Public Comment
Attachments: Public Hearing Follow up Letter 12.12.22 Final.pdf

Ms. Freel:

Please accept this letter for the public record as follow up to the December 8th public hearing related to the LCMC Health – Tulane University partnership.

I am sending this on behalf of Ruby Brewer and Allison Guste.

Best,
Ayame

Ayame N. Dinkler
Chief Administrative Officer

LCMC Health
1100 Poydras Street, 2500
Energy Centre
New Orleans, LA 70163

O 504.894.5462
C 202.744.3590

Ayame.Dinkler@LCMChealth.org
LCMChealth.org

LCMC Health

1100 Poydras Street
Suite 2500
New Orleans, LA 70163

LCMChealth.org

December 12, 2022

Angelique Freel
Director, Civil Division
Louisiana Department of Justice
1885 North 3rd Street
Baton Rouge, LA 70802
Via email: freela@ag.louisiana.gov

Dear Director Freel:

Thank you for hosting a public hearing on December 8, 2022, regarding the application for a certificate of public advantage related to the proposed transaction between HCA Healthcare, Inc., Tulane University, University Healthcare System, LLC, and LCMC Health.

We write today as the nursing leaders at LCMC Health. The voice of nurses matters greatly to LCMC. We have closely listened to their feedback, including the concerns repeated by the five TMC nurses who testified at the public hearing, and we appreciate the opportunity to submit for the record, our engagement with TMC nurses to date and our commitments moving forward.

1. **Engagement to date:** Since October 10, 2022, LCMC Health has repeatedly engaged with employees of Tulane Medical Center ("TMC"), Lakeview Regional Medical Center, and Tulane Lakeside Hospital (collectively, the "three Tulane hospitals") to the extent allowed by HCA and the law. LCMC Health leaders have spent time across the three Tulane hospitals to introduce ourselves, share information about the transaction, and provide a forum for questions and feedback. We have held four town halls at TMC, two at Tulane Lakeside Hospital, and three at Lakeview Regional Medical Center. These were held at hours to accommodate both day and evening shift employees. Approximately 300+ employees across the three Tulane hospitals attended these town halls. We were encouraged by this participation.

   In an effort to provide increased engagement with nurses at TMC, we participated in a 1.5 hour meeting with nurse leaders at TMC on December 7th, 2022. Approximately 20 TMC nursing leaders were present in addition to TMC's Chief Nursing Officer and Associate Chief Nursing Officer. In addition to general introductions, we used this meeting to continue relationship building and engagement. The key themes we heard during that meeting were excitement about the future with LCMC Health, and also apprehension regarding the unknown, particularly related to the relocation of services. We reiterated then, and will rearticulate now for the public record, that key stakeholders including nurses and physicians will be involved in relocation planning. We are committed to continuing to engage with all HCA employees about our partnership and their place in the LCMC Health family.

2. **Employment commitment:** All employees at the three Tulane hospitals will continue to have jobs under this partnership. LCMC Health and Tulane University intend to work together, following the close of the transaction, to not only retain the current nursing staff but to actively promote

LCMC Health

education through a new nursing program, attracting and employing additional nurses to support the level of patient demand beyond current levels. Maintaining and increasing nursing staff will allow the combined organization to address existing and potential patient capacity concerns. We are hopeful that this clarifies any misunderstanding held by TMC nurses regarding our commitment to their employment.

Both LCMC Health and Tulane University value our providers and employees and are committed to retaining our staff across both organizations. As stated in our application and articulated in each communication to the staff of the three Tulane hospitals, LCMC Health values the employees of the three Tulane hospitals, and looks forward to them joining the LCMC Health family.

3. **Pay and Benefits:** Offering competitive compensation and benefits packages is essential to not only retain but to also attract the best talent as we work together to make our community healthy. LCMC Health is committed to fair and equitable salaries. As committed to in the Unit Purchase Agreement ("UPA"), employees of the three Tulane Hospitals will be provided wage or salary levels and cash incentive opportunities substantially equal in the aggregate to those provided currently and benefits that will be no less favorable than those provided to similarly situated LCMC Health employees.

Thank you for accepting this letter as part of the public record.

Sincerely,

Ruby Brewer, RN
Chief Nursing Officer
East Jefferson General Hospital

Allison Guste, RN
VP, Nursing & Quality
LCMC Health

Freel, Angelique

From: Charmaine D. Caccioppi <CharmaineC@UnitedWaySELA.org>
Sent: Tuesday, December 13, 2022 6:13 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Dear Attorney General Landry,

We write as denominational and community leaders across New Orleans and Louisiana, in our support of the nurses of Tulane Medical Center, who are demanding a voice in the future of healthcare in New Orleans. We are asking for the upcoming public hearing on the sale to be held locally in New Orleans, not Baton Rouge, ensuring meaningful participation and input from our frontline health care workers and the community they serve.

We are deeply concerned that the proposed sale of Tulane Medical Center to LCMC Health will negatively impact access to quality and affordable health care services for thousands of Louisianans. LCMC has already announced plans to shut down most inpatient services at Tulane Medical Center within 12 to 24 months of acquiring the hospital. Many of our community members have gone to Tulane Medical Center for years. Losing such a popular hospital serving patients not only in New Orleans, but across Louisiana, is a loss for communities around the state.

We fear a two-system duopoly in New Orleans, made up of LCMC and Ochsner Health, will raise health care costs and reduce services. This is especially worrisome in such a precarious time in our nation. Now, more than ever, high-quality health care needs to be made more accessible and affordable.

When Charity Hospital closed, New Orleans lost one of the state's last public hospitals that served everyone, regardless of income level. Now, we stand to lose another hospital in downtown New Orleans that has long served low-income patients. We worry Medicaid patients, who are disproportionately Black and people of color, will lose access to care. Louisiana's minority residents already experience significantly lower life expectancies than white residents, and the closure of services and higher health care costs may exacerbate this health equity crisis.

Nurses are on the front lines of keeping our communities and congregants healthy and safe. We stand with Tulane Medical Center nurses because we trust nurses to put patients first. We urge you to block the sale in order to ensure there are no cuts to jobs or patient care services at Tulane Medical Center and that there is no increase in healthcare costs for the community.

Sincerely,

Shawn Moses Anglim, First Grace UMC, Pastor

Margaret Washington, Retired RN/Nurse Educator

Betty Roberson, EDUTRONICS, CEO

Callie Winn Crawford, Retired United Methodist Pastor

Jonah Evans, Neutral Ground, Founder and CEO

Charlotte Clarke, Common Ground Relief, Co-Director

Rev. Dr. Joe D Connelly, Bethany United Methodist Church, Sr. Pastor & Community Engagement Officer

Travis Cleaver, Grow Dat Youth Farm, Site Coordinator

Bonnie Sniegowski, Society of St. Vincent de Paul, Director of Adult Learning Center

Deon Haywood, Women With a Vision, Executive Director

Harold John, National Association of Letter Carriers, 2nd Congressional District Liaison

Matthijs Herzberg, Herzberg Design Co, CEO

Elizabeth S Widerquist, Xavier University of Louisiana, Professor

Stephanie Martin, FGUMC, Administrator

Reverend Dr. J.C. Richardson, Cornerstone United Methodist Church, Pastor

Bettie Rhode, Cornerstone United Methodist Church, Parish Nurse/Lay Minister

Lexi Peterson, New Orleans Workers Center, Co-director

Byron Johnson, Central Missionary Baptist Church, Reverend

Jeanne Nathan, Tannathan inc., dba Creative Industry, President

Mary Lowry, Now Love

J. Christopher Johnson, Mobilizing Millennials, Executive Director

Marc Behar, Temple Sinai, Former Board Member

Eugenia Rainey, Tulane University, Professor

Bennie Wilson, Mantle Tabernacle Holiness Church, Sr. Pastor

Dave Cash, United Teachers of New Orleans, President

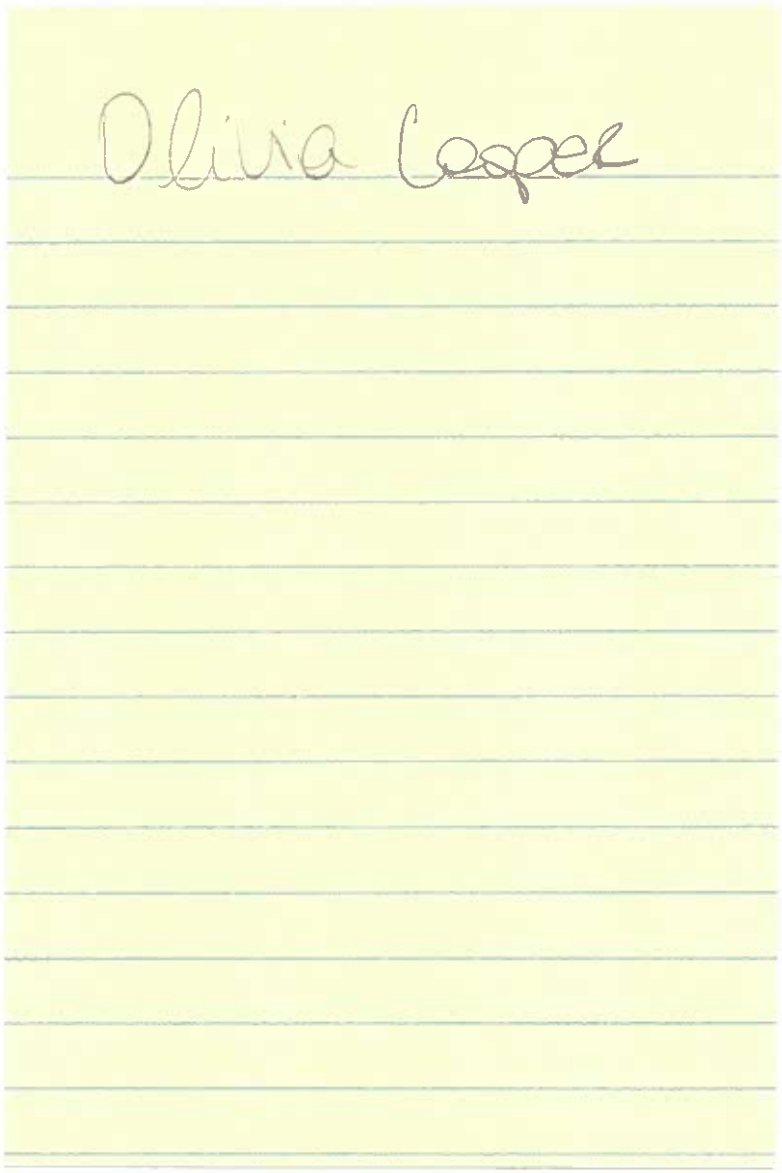
Darla H Durham, St. Charles Avenue Baptist Church, Deacon and Former Trustee

Margaret Maloney, New Orleans Workers Assembly, Organizer

Mike Howells, We Can't Wait NOLA, Organizer

Amy Stelly, Claiborne Avenue Alliance, Executive Director

Reverend Paul Beedle, First Unitarian Universalist Church, Minister


Olivia Cooper

Nurses and Community Demand a Voice in the Future of Tulane

We, the undersigned nurses and community members, demand to have a say in the future of Tulane Medical Center. On Monday, October 10, LCMC and Tulane announced the proposed sale of our hospital with the intention to shut it down. Many of us learned about this plan suddenly, with no discussion or warning. We are gravely concerned about what this pending sale and subsequent closure of our hospital means to our community and the patients we serve.

Together We Are Demanding »

- » Recognition of our union, formed with the National Nurses Organizing Committee/National Nurses United.
- » No cuts to patient care services or jobs.
- » Input of RN staff on the conditions of the proposed sale.
- » Transparency from Tulane and LCMC in this process.

Name	Facility	Unit	Cell Phone	Email	Signature	Date
Lea Lourdes Astrono	Tulane	7W	504 333 2233	leeastro.rn@gmail.com		11/3/22
Lindsey Simons	Tulane	7W	7202028151	lcsimons99@gmail.com		11/4/22
Princess Carino	Tulane	7W	504 9199127	princesscantillo@yahoo.com		11/04/22
Stephanie Zepeda	Tulane	7W	504 982-1614	szepeda0228@gmail.com		11/4/22
Krystine Dagal	Tulane	7W	985 602 9570	krystine.dagal@icloud.com		11/04/22
Steven Andrews	Tulane	7W	504-598-4079	Sandrews@yahoo.com		11/6/22
Keith Theyard	Tulane	7W	504-610-6940	Ktheyard@gmail.com		11/6/22
Billie Davis	Tulane	7W	601-754-6584	billie718@hotmail.com	BillieDavis	11/6/22

OUR PATIENTS. OUR UNION. OUR VOICE.

National Nurses Organizing Committee

National Nurses United

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Adjoa Andoh	Tulane medical	Scenter	614 432 4787	aandoh93@gmail		11/14/22

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National Nurses Organizing Committee

National Nurses United

www.NationalNursesUnited.org » NationalNurses » @NationalNurses

102422

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Stephanie Hauke	Tulane Downtown	BMT	337 499 3888	Stephanie.Lilake@gmail.com	SHauke	10/25/22
Jerica Jenning	Tulane Downtown	BMT	504 8105332	jsimpson@gmail.com	Jjen	10/26/22
Christina Benjamin	Tulane Downtown	BMT	504-221-8815	Christinatandry18@yahoo.com	C Benjamin	10/26/22
Ariana Rusner	Tulane Downtown	BMT	228-324-9620	arianarusner@ymail.com	Ariana Rusner	10/26/22
Latasha Cooper	Tulane Downtown	BMT	225-200-0163	latasha.skyler.marquis.nyc@gmail.com	Latasha Cooper	10/27/22
LaTonya Dorsey	Tulane Downtown	CCU	(601) 880-1239	DorseyRN@gmail.com	LaTonya Dorsey	10/28/22
Sushma Rawat	Tulane Downtown	BMT	508-713-7647	sushmarawat86@gmail.com	Sushma Rawat	10/28/22
Hoffmann-Eveline	Tulane Med. Center	BMT	504-756-3216	eboehlen99@gmail.com		10/28/22
Heather Sinclair	Tulane Downtown	BMT	337 967 8383	hsinclair@yahoo.com	HSinclair	10/28/22

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National Nurses United

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
David ZICCARDI	TULANE	PACU	504-615-6966	ZICCARDI@[illegible]SON		10.25.22
Mallory Beard	TULANE	MICU	(662) 603-3764	mkillonykbeard@icloud.com	Mallory K. Beard	10/25/22
Larissa D'Amiello	TMC Downtown	TATU	203-530-0835	d.larissa12@gmail.com		10/25/22
Qalid Chaney	TCA	TATU	337-291-9559	QalidChaney8@ymail.com		10/25/22
Lauren Glaser	Tulane	SICU	757-319-0058	lauren.glaser3@gmail.com		10/25/22
Olivia Cooper	Tulane	TATU	503.679.0127	oliviacooper[illegible]@gmail.com	Olivia Cooper	10/25/22
Dion Merritt	Tulane	MICU	504-432-4656	dion.merritt@gmail.com		10/25/22
Katherine Kramer	Tulane	ER	504 388-1603	Kakramer12@yahoo.com		10/26/22
Devon Williams Herke	Tulane	ER	951-355-6416	mrsherke@ymail.com		10/26/22

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National Nurses Organizing Committee

National Nurses United

www.NationalNursesUnited.org » NationalNurses » @NationalNurses

102422

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Hollie Mayeux	Tulane	Derm	318 840 4498	hollie mayeux 2@gmail.com		10-27-22
Terry LE	TULANE	RT	504-231-0411	Terry LE@ [illegible]		10/27/22
Christian B. Abraf	Tulane	Surg/GI	504-606-5747	Charisba2021@gmail.com		10/27/22
[illegible]	Tulane	Transplant	3188014128	jfoster11@tulane.edu		10/28/22
[illegible]	Tulane	Transplant	985-445-8570	[illegible]@medexpro.com		10/28/22
Jenny Labre	Tulane	Transplant	504.905.0998	jennylabre@gmail.com		11/1/22
[illegible]	Tulane	Transplant	256.318.8347	charissagordon88@gmail.com		11/2/22
Tara Bates	Tulane	Transplant	504-314-1257	tbatesRN@gmail.com		11-2-22
Sydney Searls	Tulane	Cardiology	313-433-8106	ssearls32@gmail.com		11/2/22

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National Nurses United

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Marie W Payton	TUMC	Cardiology	504.256.4755	mwpayton40@gmail.com	MWPayton, RN BSN	11/2/22
Rebecca Bonds	TUMC	Cardiology	904-2145796	Rebecca.Evans7.RE@Gmail.com	Rebecca Bonds	11/2/22
Alexander Castillo	TUMC	ACCU	504-564-5577	acastillo140@hotmail.com	Alexander Castillo	11/8/22
Christy Clark	Tumc	Accu	504-610-4407	christyclark25@ymail.com	C. Clark	11-12-22
JAPANICA LEWIS	TUMC	ACCU	5043396444	japanica.lewis@lca	[illegible]	11-12-22
Michelle Prevost	TUMC	Surgery	504-638-1755	m.prevost9@gmail.com	[illegible]	11/12/22
Shannon Beach	TUMC	cardio pulmonary	504-303-9878	SDBEACH7@aol.com	[illegible]	11/14/22
Ryan Fernandez	Tumc	Emergency	(541) 613-7966	Ryan.fernandez@tulane.edu	[illegible]	11/15/22
Bryan Braddick	Tulane	Dialysis	504-858-3677	bbraddick@yahoo.com	[illegible]	11-16-22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Meghan Dufrene	Tulane	SICU	504-812-8270	meghan.dufrene@yahoo.com		10.29.22
G Brewer	Tulane	4W	504-782-3516	gcobrencer@gmail.com		10/29/22
Catrice Collins	Tulane	SICU	504 759 7216	c.collinsrn@hotmail.com		10/29/22
Jaz'Mine Green	Tulane	SICU	985-685-6339	jazmine.green00@gmail.com		10/29/22
[illegible]	Tulane	Med Surg		[illegible]@gmail.com		10/29/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Devin Robinson	TMC	4West	(225) 916-3730	devinrbnsn@gmail.com	Devin Robinson	11/9/22
Naycha Grandberry	TMC	7E	601-320-6436	naychagrandberry@gmail.com		11/9/22
Treschell Howard	TMC	7E	504.413.3049	trehoward30@gmail.com	T. Howard	11/9/22
Lesley Laup	TMC	7E	504-234-8343	laup.lesley@gmail.com	Lesley Laup	11/9/22
Jasmine Milton	TMC	7E	985-215-5320	jasmine.batiste@selu.edu		11/9/22
Jazmine Blunt	TMC	lowest	985 294 1705	jazmineblunt@gmail		11/9/22
Kristina Andrews	TMC	6W	9855105479	KKandrews23@yahoo.com		11/9/22
Chalaine M. Crawford	TMC	6W	9855079478	C_Morgan_6@yahoo.com	CMCrawford	11/9/22
Trish Williams	TMC	6 west	2135005902	williamstrish22@gmail.com		11/9/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Maureen Gibson	Tulane Medical Center	5 Center	(828) 301-9627	mail@mrgibson.us ★		11/12/2022
BHAGWATI BERMA	Tulane Medical Center	5 East	850 326 0370	bhagwati0103@gmail.com	Bhagwati	11/12/2022
Elizabeth Hebert	TUMC	7th	504-251-0695	Elizabeth.Hebert2@HCAHealthcare.com		11/12/22
Jennifer Stark	TUMC	7	504-920 9488	jstark2@tulane.edu		11/12/22
Kelly Ziegler	TUMC	ORTHO	504-957-7903	K2ig9932@yahoo.com		11/14/22
INNA Goldvarg	TUMC	Surgery	504-806-1404	Igoldvarg@tulane.edu		12/15/22
Sheila Warner	TUMC	Surgery CL	504-352-4763	SpWarner1D@gmail.com		11/18/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Julie Dimond	Tulane Medical	PACU	504-390-0607	nog336@gmail.com	Julie Dimond	10/28/22
Otalys Gonzalez	Tulane Medical	OPS	504-621-4656	ogonzalez91965@gmail.com	Otalys Gonzalez	10/28/22
Sunita Varghese	Tulane Medical	PACU	832-917-2173	sunita.svarghese@gmail.com	Sunita Varghese	11/3/2022
Kathy Reggio	Tulane Medical	ER	504-913-1561	RNPILSBERRY@AOL.COM	Kathy Reggio	11/5/2022

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Jill Walker	Tulane	7W	8655480851	JMMACOW@hotmail.com	Jill Walker	9/31/22
Deondray Warren	Tulane	7West	(504)317-5799	deondray510@yahoo.com	D Warren	11/2/2022
Trechell Washington	Tulane	7west	(504) 521-5048	trechell95@gmail.com	Trechell	11/02/2022
William Pullium	Tulane	7west	[redacted] 662-822-883	gopeapullium@yahoo.com	Pullium	11/02/2022
barbara gonzalez mercedo	tulane	7west	281-203-4508	bababarbaragegmail.com		11/3/2022
Sydney Oplinger	Tulane	7west	(801) 750-6787	sydney.oplinger@gmail.com	Sydney Oplinger	11/3/22
Heather Phillips	tulane	7west	(765)404-8398	hbphillips9776@gmail.com		11/3/22
Andrea Rankin	Tulane		251-623-2882	andrearankin98@gmail.com	Rankin	11/3/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Dongelia Landry	HCA Tulane	WCC	5045752532	dongelia@gmail.com	Dongelia Landry	10-26-22
Lisa Rongstad	HCA Tulane	WCC	850-207-9068	LErongstad1@gmail.com		10/26/22
Clara Araujo	HCA Tulane	MICU	630 877 6056	araujo.cte@gmail.com		10/26/22
Jane Seaton	Fresenius Acute	Dialysis	(504) 975-1890	dnllseaton@yahoo.com	Jane Seaton	10/27/22
Geri Carr	Fresenius	Dialysis	(504) 813-9321	gbcarr24@bellsouth.net		10/27/22
Andrew Triche	Fresenius	Dialysis	504 441-8434	andrew.triche@gmail.com		10/27/22
Julie Hamberger	Fresenius	Dialysis	504-875-7695	julie.hamberger@freseniusmedicalcare.com		10-27-22
Marilyn Arcachon	HCA Tulane	Dem	701 575-1415	m2maps@att.net		10/27/22

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Tanya Smith	Tulane	4W	(504)259-8291	beautiful_1ne@yahoo.com		11/3/22
Raymond Ramos	Tulane	4W	504-491-2251	ramosraymond1120@gmail.com		11-10-22
Me'Asia Edwards	TMC	6W	(504)3802969	measialashum@yahoo.com		11/10/22
Ashland Brown	Tulane	6W	(601)-867-1150	abred994@yahoo.com		11/10/22
Vicki Metoyer		6W	504-376-4668	vickiMetoyer1027@gmail		11-10-22
Jemelca Harris	Tulane	4W	504 416 8195	harrisjemelca@gmail		11/11/22
Kathleen Ary	Tulane	7W	504 605 5003	iamkfary23@outlook.com		11/12/22
Marissa Bergeron	Tulane	7E	504-481-2595	marissabaj@gmail.com		11/13/22
Jessica Utter	Tulane	7E	772-919-1995	utterjess34@gmail.com		11/13/22
Diana Morris	Tulane	neuroICU	5046554895	diamond6887@gmail.com		11/13/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Calia Chavis	TATU HCA	TATU	337-281-9559	CaliaChavis8@gmail.com		10/25/22
Natalie Aguirre	SICU	SICU	512-903-118	leannnatalia@gmail.		10/25/22
Lauren Glaser	SICU Tulane	SICU	757-319-0058	lauren.glaser3@gmail.com		10/25/22
Olivia Cooper	Tulane	TATU	318.679.0127	oliviacooper00@gmail.com		10/25/22
DAVID ZIEGLER	TULANE	PACU	504-615-6966	ZIEGLERD06@YAHOO.COM		10.25.22
Mallory Beard	Tulane	MICU	(662) 603-3764	mallorykbeard@icloud.com		10/25/22
Larissa D'Aniello	TMC Downtown	TATU	203-530-0835	dilarissa12@gmail.com		10/25/22
Dominique Stack	Tulane	USSU	504 919-3022	dominiquestack		10/25/22
Tomisha Acaberman	Tulane	USSU	504) 320-9430	tomisha46@gmail.com		10-30-22
Duma Sen	Tulane	SICU	850-963288	senouma42@gmail.com		10-30-22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Brandon Lepine	TMC-downtown	CCL	3374998484	brandon.lepine@gmail.com		10/27
Jessica Rivarde	TMC Downtown	CCL	504-400-2585	mrs.jessica.rivarde@gmail.com		10/27
Vilma Chavez	TMC downtown	CCL	504 460-8151	Vilma.Chavez@Yahoo.com		10/27
Amy Barke	TMC-downtown	CVRA	504 715 5729	amybarke011@gmail.com		10/27
Christine May	TMC-downtown	CCL	609-548-1537	maychristinemarie@gmail.com		10/27/22
Marie Locke	TMC downtown	CVRA	847-372-0775	mlocke525@gmail.com		10/28/22
Lorie Bowers	TMC downtown	CVRA	985 966 0555	rlorien@aol.com		10/28/22
Wes Thibodeaux	TMC-Downtown	CVRA	504-444-7116	Westhibs@gmail.com		10/31/22

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Michelle Morgan	TUlane	ER	(937)869-8555	Mendricksmichelle@yahoo.com	Michelle Morgan	10/29/22
Fredie Escultero	Tulane	ER	708-830-5009	fred_ece2000@yahoo.com		10/29/22
JON ANG	TULANE	ER	504 616 0214	MAC.JON.MICHAEL@GMAIL.COM		10/29/22
Jean-R Magbanua	Tulane	ER	504 782 7856	magbanua.jr@gmail.com		10/29/22
Kari Francis	Tulane	ER	(928)445-996	KdBrancil@gmail.com		10/29/22
Alyssa Morgan	Tulane	ER	(810) 212-0682	alyssa.april49@gmail.com		10/30/22
Diana Estrada	Tulane	ER	(504) 352-2177	estrada_diane@yahoo.com		10/31/22
Jonathan Duclos	Tulane	ER	(907) 990-4264	DCGUARD83@gmail.com	Jonathan Duclos	11/4/22
Sarah Petit	Tulane	ER	210 232 4877	sarahtaylor5209@gmail.com	Sarah Petit	11/4/22
Nicholas Bradley	Tulane	ER	318-353-1357	nlbradley@yahoo.com		11/4/22

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CHERYL JAMES	TULANE	ER	601-273-2923	damngypsygal@gmail.com		10/25/22
Haley Arnouville	Tulane	ER	318-587-1709	haleynsula@gmail.com		10/25/22
Amya parfait	Tulane	ER	(504)615-2627	amyaparrain@icloud	A. Parr	10/28/22
Sophia DeNucci	Tulane	ER	6174806848	sophed.21@gmail.com		10/28/22
KERRYN O'FLAHERTY	TULANE	ER	504-400-2190	Kerrynof@aol.com	K. O'Flaherty	10/28/22
Breyon Laby	Tulane	ER	504-715-9850	blaby5@yahoo.com	B. L	10/28/22
Jaclyn Morgan	Tulane	ER	504-875-6949	Jackielynn31389@aol.com		10/28/22
Leslie Batson	Tulane	ER	504-237-0859	ljbatson@cox.net	L Batson	10-29-22
Sarah Sixbey	Tulane	ER	870-814-6659	sarahosixbey@gmail.com	Sarah Sixbey	10/29/22
Zach Nemr	Tulane	ER	504-973-1083	znemr0370@gmail.com		10/29/22

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Charity Bergeron	Tulane	ED	504-872-5070	charitybergeron@att.net	CBergeron	11/4/22
Mitchell Webb	Tulane	ED	601-600-0584	mwebbemt52@gmail	MWebb	11/4/22
Ashley Stanley	Tucane	ER	(504)615-8215	agenevay@gmail.com	[illegible]	11/4/22
Mzmn Nicolai	TUMC	ER	(315)573-2806	nicolai16m@gmail.com	[illegible]	11/4/22
JAVIER LOPEZ	TUHC	ER	(504)905-2094	javicoba@yahoo.com	[illegible]	11/4/22
Maria Reed	Tulane	ER	251-533-0400	mariadreed98@gmail.com	[illegible]	11/4/22
Brittany Bygg	Tulane	ED	325. 212. 2700	bygg17@yahoo.com	[illegible]	11/13/22
Kasey James	Tulane	ED	(318)581-7172	jameskasey9@gmail	[illegible]	11/15/22
ANDY SEAL	TULANE	ED	(601)916-2659	raseal90@gmail.com	[illegible]	11/20/22
Jennifer Denney	Tulane	ED	(228)990-6722	jdenney1710@gmail.com	Jennifer Denney	11/20/22

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Mallory K. Beard	TMC	SICU	(662) 603-3764	mallorykbeard@icloud.com	Mallory K. Beard	11/9/22
Henri Wesley	TMC	TATU	318-550-7775	henriwesley2015@gmail.com	Henri Wesley	11/10/22
Billie Davis	TMC	TKU	601-754-6534	billie718@hotmail.com	Billie Davis	11/10/22
Krystal Dupre	TMC	SICU	(985) 855-6259	kdupre994@gmail.com	Krystal Dupre	11/10/22

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Calia Chaus	HCA	TATU	337-291-9554	Caliachaus8@gmail.com		10/25/22
Olivia Cooper	Tulane	TATU	503.679.0127	oliviacooper00@gmail.com	Olivia Cooper	10/25/22
DAVID ZICCARDI	TULANE	PACU	504-615-6966	ZICCARDI06@YAHOO		10.25.22
Mallory Beard	Tulane	MICU	(662)603-3764	malloykbeard@icloud.com	Mallory Beard	10/25/22
Larissa D'Amiello	TMC Downtown	TATU	203-530-0835	d.larissa12@gmail.com		10/25/22
[illegible]	TMC	[illegible]	[illegible]	[illegible]		[illegible]
Sasha Iwuagwu	TMC	MICU	210-906-3242	rebchumovskaya@gmail.com		10/25/22
Lily LeRoy	TMC	SICU	7069935909	lily.leroy101@gmail.com		11/16/22
Hilya Castillo	Tulane	ACCU	504-982-2822	tati121282@yahoo.com		11/22/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Mallory K Beard	Tulane	SICU	(662) 603-3764	mallorykbeard@icloud.com	Mallory K. Beard	11/21/22
Kellie Landa	Tulane	Cancer Center	504-249-1550	kejupenoire@gmail.com		11/22/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
MICHAEL ROBERTSHAW	TULANE MEDICAL	SICU	504-373-2074	bobshaw31@gmail.com		10/27/22
Shannon Faulstick	Tulane Medical Downtown	Imaging	504 249 1000	faulstick@gmail.com		10/27/22
Ashleigh Smith	Tulane Medical Downtown	SICU	985-789-2892	acsmith2011@gmail.com		10/27/22
Chelsea Young	Tulane Medical	MICU	225-200-2660	chelsea.michelle.young@gmail		10/27/22
Franklin Cox	Tulane Medical Center	MICU	769-230-7469	fec7799@yahoo.com		10/30/22
Peter Corby	Tulane Medical Center	MICU	504-473-9897	peter.a.corby@Gmail		10/30/22
Jenn Jacheson	Tulane Medical Cen	TATU	504-202-8458	jennzijacheson@yahoo.com		10/30/22
Ava Martin	Tulane Medical Center	SICU	(225) 225-718-7074	martin.ava8@gmail.com		10/30/22
Ephraim Coffee	Tulane Medical Cen	Elect	504-729-7207	rjjfree@gmail.com		11/12/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Gabrielle Trapani	Tulane	SICU	504681-1148	gatrapani@gmail.com		11/17/22
Sadonia Maxwell	Tulane DT	OPS	5042709639	sadoniamaxwell@gmail.com		11/21/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Inziya Magee	Tulane	ER	(504)881-3592	inziyamagee@gmail.com		10/26/22
Stacey Ledner	Tulane	ER	(504)628-4320	nola010271@gmail.com		10/26/22
JOSEPH FLORES	Tulane	ER	2254922105			10/26/22
Kayla Gasper	Tulane	ER	(318)355-4021	akwilkay@gmail.com		10/26/22
Tarah Bailey	Tulane	ER	985-445-0530	tarah.parker@yahoo.com		10/26/22
Nick Lang	Tulane	ER	504 615 4851	NickLang234@yahoo.com		10/26/22
BRIAN MOREHOUSE	TULANE	ER	504-446-2677	BUD9855@YAHOO.COM		10-26-22
Constance Buffinet	Tulane	ER	985-515-5643	Conniebcake@gmail		10/26/22
Kandice Robinson	Tulane	ER	(504)900-6823	Robinson1116@yahoo.com		10/26/22
Angelle Oneal	Tulane	ER	(504) 616 9145	Angelleoneal@gmail.com		10/26/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Lauren Glaser	Tulane Medical Center	SICU	757-319-0058	lauren.glaser3@gmail.com		10/25/22
Olivia Cooper	Tulane	TATV	503.679.0127	oliviacooper@gmail.com		10/25/22
DAVID ZICCARDI	TULANE	PACU	504-615-6966	ZICCARDI06@YAHOO		10.25.22
Mallory Beard	Tulane	MICU	(662) 603-3764	mallory.kbeard@icloud.com	Mallory Beard	10/25/22
Larissa D'Aniello	TMC Downtown	TATV	203-550-0835	d.larissa12@gmail.com		10/25/22
Celia Chum	HCA	TATV	337 281 9559	Celia.Chum8@gmail.com		10/25/22
Jack Gidaro	Tulane	SICU	610 675 8149	Jack.Gidaro@gmail.com		11.4.22
Kendrid Lewis	Tulane	SICU	(334) 301-3902	Kendrid.lewis7@gmail		11/08/22
Oliver Parker	NOLA	Engineer	856-470-8038	oliverparker15@gmail.com		11/9/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Nga Pham	Tulane	OPS	504-432-2979	nurse23.pha@gmail.com	Nga Pham	11/09/2022
Kecha Hampton	Tulane	NIMU	5043521419	kecha7116@gmail.com		11/9/22
Tina Nickles	Tulane	NIMU	504-376-4532	teeny005@yahoo.com	T. Nickles	11/9/22
Fluyette Alexander	Tulane	NIMU	504-660-2030	fluyem2002@yahoo.com		11/9/22
Chelsea Dennis	Tulane	NIMU	(504)247-2383	Chelsea909@gmail.com		11/9/22
Rachel Nwia	Tulane	NIMU	(847)840-2774	rachelnwia@gmail.com		11/9/22
Terika owens	Tulane	AIMU	985-551-1352	terikaowens@yahoo.com	Terika Owens	11/9/22
Kanisha McKnight	Tulane	AIMU	601-814-0287	Kmcknightrn@gmail.com		11/9/22
Brianna James	tulane	AIMU	985-264-2950	bjames0425@gmail.com	Brianna James	11/9/22
Bridget Daley	Tulane	BMT	228-234-9494	daley1011@yahoo.com		11/9/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Heather Zimmerman	Tulane	Infusion (Amb.)	504-432-9418	heather22t@gmail.com		4Nov22
Missy Bean-Tanner	Tulane	Amb Infusion	(504) 251-8758	missybean21@yahoo.com		11/4/2022
Valerie Langford	Tulane	Amb. Infusion	504 813-2905	Valglangford@yahoo.com		11/4/2022
Alisha Siegl	Tulane	MedSurg	318-502-2050 *	baum.alisha36@yahoo.com		11/4/22
Katelyn Cipes	Tulane	MedSurg	318-446-[illegible]616	katiecipes@[illegible].com		11/4/22
Paulette Green	Tulane	Nursing	504 473-9736	paulette81598@yahoo.		11/12/22
Christian Dinos	Tulane	CPRC	504-782-4720	Christian.dinos90@gmail		11/14/22
Jennifer Guillot	Tulane	CPRC	504-915-7661	jenguillot@gmail.com		11-14-22
Larissa Fogleman	Tulane	GI Surgery	509-225-0634	TLFogleman888@gmail.com		11/28/22
[illegible]	Tulane	Vascular Access	(504) 920 7134	[illegible]		11/29/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
RUTH Mitchell	TPS Tulane	OPS	(504)2748094	ruthlogan1212@gmail.com	Ruth Mitchell	11-29-22
Gena Dyer	Tulane OT	OPS	901 215-2298	gillespiega3@gmail.com	Gena Dyer	11/29/22
Ellie Bergeron	Tulane PT	OPS	504-621-9449	elliebergeron16@gmail.com	Ellie Bergeron	11/29/22
Jennifer Hammat	Tulane OR	OR	601-405-7097	JL Hammat1216@gmail.com		11/29/22
MICHAEL MILAN	TULANE OR	OR	(504) 884-0163	MSMIKE MILAN330@YAHOO.COM		11-29-22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Nelson Nguyen	Hea Tulane	Vascular	504-473-1140	neo777win@yahoo.com		11-29-22
Rolo Alarson RN	TULANE MC	ORS	504 491-7843	RoloZAlarsonRN		11.29.22
Sheryl Coleman	Tulane Hosp	ORS	504 650-7084	shcoleate@netzero.net		11-29-22
Rolonda Cooper	TORS	ORS	2255052444	rocooper36@gmail.com		11-29-22
Stacey Lemoine	OR Tulane	OPS	504-939-1752	Staceyteal2020@yahoo.com		11/29/22
Tonya Bowers	Tulane Hosp	OR	985-640-0055	evans245@yahoo.com		11/29/22
CECILIA SCHMIDT	TUMC	CCL	(504)861-5972	schmidt3274@gmail.com		11/30/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
John Clements	Tulane Medical	Trauma Center	504-377-2492	Johnclements3@gmail.com		10/26/22
Mea Ratcliff	TMC	Transplant Clinic	225-324-5932	mea_michelle@yahoo.com		10-26-22
Casey Hoy	TMC	AC	5043823784	CASO3176@YAHOO.COM		10.27.22
Heidi Fillmen	TMC	Transplant	504-487-9363	Heiserlan@gmail.com		11/1/22
Ashley Pemba	TMC	Liver Transplant Clinic	504-432-9155	ashleypemba@gmail.com		11/1/22
Jasmine Chaney	TMC	Cardiology	5049404586	Jadahchaney@gmail.com		11-2-22
Alfred Fausch	TMC	Cardiology	504-259-8681	afausch@yahoo.com		11-2-22
Andrea Dastin	TMC	Transplant	504-258-5814	Amspar@cox.net		11/3/22
Lauren Fitzgerald	Tulane	Transplant	504 491 4883	lafitzgerald@gmail.com		11/3/22
MONIQUE MADDING	TMC	Accu	504 975-9640	[redacted] msmo1109@gmail.com		11-8-22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Kaylen Jenkins	Tulane Medical	5E	6784727793	Kayleneduards@ymail.com		11/7/22
Shankelle Scott	Tulane Medical	5E	6049147466	Shankelle.scott@yahoo.com		11/10/22
Jasmin Jackson	Tulane Medical	5E	9852951737	jasminjackson1@gmail.com		11/10/22
Trishay Broussard	Tulane Medical	5E	5042506293	trishayy97@gmail.com		11/10/2022
LaShawn Davis	Tulane Medical	5E	504-256-7306	Ladyc101681@gmail.com		11/10/22
Tarlisha Gray	Tulane Medical Center	5E	985-413-3392	tarlishagray@yahoo.com		11/14/22
Tatiana Gresko	Tulane medcenter	5E	727-916-0922	tatigresko@gmail.com		11/14/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Sandra Clingan	Tulane	ER	318-280-5344	buffyclingan@yahoo.com	Clingan RN	10/26/22
Kim T Padilla	Tulane	ER/RAD	504-722-8372	KTERRANOVA16@gmail.com	Kim T Padilla	10-26-22
Samantha Girod	Tulane	ER	321-278-6148	samanthag1458@gmail.com		11/3/22
Champ Phuphanich	Tulane	ER	504-914-3624	CHAMP645@AOL.com		11/3/22
TIFFANY Wells	Tulane	ER	231-342-8035	TIFFANYBeam1995@		11-3-22

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Markila Tate	TMC	4-West	(901)480-3668	T.markila@gmail.com		10/27/2022
Kelsey Delatte	TMC	4-West	(504)338-3774	delatteKelsey@gmail.com		10/27/22
Hailey Thompson	TMC	MICU	6014473315	haileymariethompson2018@gmail.com		10/27/22
Effie John Mcnzano	TMC	MICU	443-735-1981	ejmanzano@gmail.com		10/27/22
Chandrel Rumoney	TMC	4 West	(504) 975-4289	Crenmoney@hotmail.com		10/28/22
Ruth Driscoll	TMC	SICU	(207)208-2408	ruthanndriscoll@aol.com		10/28/22
HUY PHAM	TMC	4West	504 857 6985	HUY.PHD5630@gmail.com		11/5/22
Bobby Nguyen	TMC	4West	225 223 1588	bobbynguyen225@gmail.com		11/5/22
Yazmyne Abbott	TMC	4west	732-589-9219	yabbott1221@gmail.com		11/5/22
Brittany Johnson	TMC	4 West	(504)221-6895	brittanyjohnson2019@gmail.com		11/06/22

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Larissa D'Amiello	TMC Downtown	TATU	203-530-0835	d.larissa12@gmail.com		10/25/22
Celia Chavis	HCA	TATU	337 281-955	celiaChavis8e@gmail.com		10/25/22
Lauren Glaser	Tulane	SICU	757-319-0858	lauren.glaser3@gmail.com		10/25/22
Natasha Nguiene	Tulane	SICU	512-903-1108	kamnatasha@gmail.com		10/25/22
Olivia Cooper	Tulane	TATU	503.679.0127	Oliviacooper0@gmail.com		10/25/22
Connor Haag	TMC	TATU	504-256-5181	Connorhaag99@gmail		10/26/22
Gemma Wood	TMC	TATU	805 292 2964	GMW0002@CRIMSON.UAL.EDU		10/26/22
Zoë Talbot	TMC	TATU	985-228-4969	Zoeannatalbot@gmail.com		10/26/22
ERIKA YOUNGER	TMC	TATU	(985)687-9342	erika.young@outlook.com		10-26-22
Victoria Conley	TMC	TATU	843 860 7044	victoriaconley99@gmail.com		10/26/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Ashleigh Dlinger	TUMC	BMT	318-265-3295	ashleighmoue@yahoo.com		11/30/22
Latoska Cooper	TUMC	BMT	225-206-0163	latoska.skyle.marquis.hrt@gmail.com	Latoska Cooper	11/30/22
Summer Austin	Tumc	BMT	504 453 3163	Summeraustin2@gmail.com		12/1/22
Chrishon Fortenberry	TUMC	Float	504-307-5241	chrishon.f@gmail.com		12/1/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Teri Corte	Tulane	5E	504-418-3076	tcorte@live.com	Teri Corte	11-11-22
Jasmarelda Smith	Tulane	5E	504-710-8268	jasmarelda@hotmail.com	J. Smith RN	11-11-22
Kylah Davis	Tulane	5C	601-716-7683	kysdavi7@gmail.com	KDavis RN	11-11-22
Jasmine Raymond	Tulane	5C	504 858 0870	jasminebraymond@gmail.com	J Raymond RN	11-11-22
Leigh Volpe	tulane	5C	504-707-1241	volpe.leigh@gmail.com	LVolpe	11/11/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Catherine Spanola	4West	TMC	708-548-4377	SpanolaC@gmail.com		11/10/22
Lauren Mervant	TUMC	4west	985-637-3124	lvaray@gmail.com		11/10/22
Sonny Miller	4W	4W	601-500-0752	Sgmiller@gmail.com		11/10/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Chantrel Lemoneng	Tulane Medical Center	4 West	(504) 975-4289	c.clemoneng@hotmail.com	C Lemoneng	10/28/22
Star Adams	Tulane Medical Ctr	Resp	985-860-9048	04ie1112eyahwa		10/28/22
Devin Dickerson	Tulane Medical Ctr	4 West	(504) 881-6898	devindckrsn633@gmail.com	D. Dick	10/28/22
Kalya Hardnett-Jones	Tulane Medical Ctr	4West	(702) 408-2326	kalyajones@yahoo.com		10/28/22
Victoria Gabriel	Tulane Medical Ctr	4West	(504) 428-6145	vgabr2@gmail.com	V. Gabriel	10/28/22
Chantell LaCava	Tulane Medical Center	4W	(504) 491-3099	chantelllacava@gmail.com	CLaCava	10/28/22
Tammy McFadden	Tulane Medical Center	CCU	(985) 507-4628	rwh5142@gmail.com		10/29/22
Rebecca Pierre	TMC	4W	239-385-8427			10/29/22
Charlene Thelemaque	TMC	4W	516 701-9604	Charlene.thelemaque@gmail.com		10/4/22
Brittany Johnson	TMC	4west	(504) 221-6840	brittanyjohnson1109@gmail.com	Brittany	11/10/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Rynesha Taylor	Tulane Downtown	4West	504 982 8386	rynesha taylor@yahoo.com	Rynesha Taylor	11/03/22
Callen Fernandez	Tulane Downtown	4W	9802544975	callenfernandez@me.com	Callen Fernandez	11/3/22
Megan Rodriguez	Tulane Downtown	4W	(210)784-8407	mmrodz@gmail.com	Megan Rodriguez	12/1/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Maureen Gibson	Tulane Medical	ALMU	(828) 301-9627	mail@mgibson.us		10/30/22
Ashley Henderson	Tulane Medical	ALMU	504-881-4444	aah387@gmail.com		10/17/22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Stephanie Santelli	Tulane	BMT	770 335 1019	Stephsantelli@aol.com	Stephanie Santelli	11.13.22
Ernest Iguyi	Tulane	6West	5046359762	ernestiguyi@gmail.com	E. Iguyi	11.13.22

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Pamela Davidson						
Maryellen Rose						
Haley Hampton						
Wendy King						
Freddye Hill						
Cynthia Sarthou						
Michele Gielis						
Darryl Malek-Wiley						
Patricia Walters						
Valeria Lindsey Schexnayder						

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Elizabeth Argus						
James McDaniel						
Jeff Conner						
Adelaida Melendez						
Jennifer Lloyd						
Elton Love, Sr.						
Morris Robicheaux						
Gale Pick						
Margaret Runyon						
Amelia Parenteau						

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Therese Close						
Jamie Hill						
Lawrence Robinson						
Leah Wooden						
Kelly Reynolds						
Barbara Guichet						
Yvonne Mitchell-Grubb						
Stephanie Abbott						
Jeanne Nathan						
Julia W Reagin						

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Megan Peake						
Jesse Chanin						
Bob Murrell						
Helen Bost						
Mary Lowry						
Aubrey Inman						
Joie Todd Kerns						
Ariel Moyal						
Val Massimi						
Graham da Ponte						

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Kanitra Caston-Hill						
David Perkins Jr.						
Andrew McDaniel						
Nadir Hasan						
Corliss Smith						
Gilbert Bennett						
Erika Stenner						
Deborah Wilson						
Myiesha Armstead						
Judy Schwartzer						

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Key Bernard						
Carol Leslie Runnels						
Anne McGinnis						
Amy Stelly						
Michael Zaloudek						
Avery Zervigon						
Holly Terrie						
Colette Tippy						
Jyl C. Benson						
Kimberly Cadena						

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Melissa Evans						
Sr. Mary Sartor						
Eric Bajon						
Amelia Bird						
Lenora Gobert						
VP Franklin						

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Corletta Smothers						
Cynthia Scott						
Sherry Fortenberry						
Kristen Luchsinger						
Tricia Domino						
Lisa Robinson						
Lucy McMellan						
Bob Beatty						
Dawn Carl						
Barbara Yates						

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Patrick Brimner						
George Bosnakis						
Katie Nunez						
Abigail Brunzell						
Brendan Wall						
Marilyn Stamm						
Jennifer Thompson Falla						
Diane Barth						
Peter Bennett						
Judith Steward						

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Melissa Creath						
Jennifer Broome						
Mary Foley						
Valeria Brunache						
Lora Walters						
Esther Walters						
Gabrielle Gemma						
Dustin Reynolds						
Peter Bennett						
Roberta Wilson						

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Tracy Dalton						
Jean Barbe						
Janine Theodore						
Cathleen Pailet						
Margery Pertuis						
Christie Schaefer						
Jenny Green						
Theresa Turner						
Benitta Wesco						
Antionette Julien						

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Denise Paddock						
Nanette Stierle						
John Hyman						
Lyle Diehl						
Anthony Ferrara						
Charyl Jarrell						
Sister Janine Beniger						
Mary Hall						
Margaret Mary Downey						
Mathilde Burguad						

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Barbara Carlton						
Frank Mayes						
John Hyman						
Wayne Sizemore						
jennifer Borden						
Dominique Le Bouteiller						
Gail Ordes						
Simone Francois						
Janet Hall						
Denise Davis						

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Raven Gray						
Calvin Johnson						
Wanda Ryals						
Tom Lane						
Richard Hebert						
Michael Brown						
Dianne Kelly						
Christie Oleaga						
Mary Burns						
Matthew LaGrange						

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Name	Facility	Unit	Cell Phone	Email	Signature	Date
Peter Bennett						
Kellye Schroeder						
Yvonnie Oakley						
Sandra Goodliffe						
Ann Marks						
Lottie Doskey						
Sheila B. Dennis						
Clarence Shields						
Arthur Brands						
Marian Moore						

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Wayde Dubroc						
Lottie Doskey						
Linda Waguespack						
Heidi Winborne						
Raymond Goubert						
Natasha Barahona						
Zachary Kirwood						
Vanessa Leland						
Leisa Farrar						
Perez Ann						

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» Transparency from Tulane and LCMC in this process.

Name	Facility	Unit	Cell Phone	Email	Signature	Date
Crystal Retif						
Mel Martino						
Jeanette Boettcher						
Leslie Gunn						
Marie Joseph						
Barbara Rupp						
Paul Doolan						
Sandra Rodrigue						
Patricia Harrington						
Phyllis Sikes						

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National Nurses Organizing Committee

National Nurses United

www.NationalNursesUnited.org » NationalNurses » @NationalNurses

102422

Nurses and Community Demand a Voice in the Future of Tulane

We, the undersigned nurses and community members, demand to have a say in the future of Tulane Medical Center. On Monday, October 10, LCMC and Tulane announced the proposed sale of our hospital with the intention to shut it down. Many of us learned about this plan suddenly, with no discussion or warning. We are gravely concerned about what this pending sale and subsequent closure of our hospital means to our community and the patients we serve.

Together We Are Demanding »

- » Recognition of our union, formed with the National Nurses Organizing Committee/National Nurses United.
- » No cuts to patient care services or jobs.
- » Input of RN staff on the conditions of the proposed sale.
- » Transparency from Tulane and LCMC in this process.

Name	Facility	Unit	Cell Phone	Email	Signature	Date
Linda Love						
Brenda Melady						
Christine Valteau						
Danita McDaniel						
Charlene R Berger						
Carolyn Jallow						
Cynthia Siddiq						
Rene Gelsomino						
Kate Welsh						
Lois Blatter						

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» Input of RN staff on the conditions of the proposed sale.
» Transparency from Tulane and LCMC in this process.

Name	Facility	Unit	Cell Phone	Email	Signature	Date
Katina Wilson						
Debbie Homer						
Cynthia Madison						
Joan Collet						
Thomas Hofer						
Nicole Miller						
Shawn Hudson						
Delores Archuleta						
Melanie Belanger						
Linda Wegmann						

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» Transparency from Tulane and LCMC in this process.

Name	Facility	Unit	Cell Phone	Email	Signature	Date
Belinda Page						
Patricia Jones						
Vicki Bowen						
Wardel Smith						
Katherine A Simon						
Catherine Johnson						
Lisa McLendon						
Roxie Lundin						
Sara Graybill						
Susan Hihar						

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National Nurses Organizing Committee

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» Transparency from Tulane and LCMC in this process.

Name	Facility	Unit	Cell Phone	Email	Signature	Date
Bambi Clement						
Annette Hickman						
Cecilia Schmidt						
Waverly Parsons						
Noel Twilbeck						
Yvonne M Sterling						
Barbara McClue						
Donald Diggs						
Katie Conner						
Russell Moran						

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National Nurses Organizing Committee

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» No cuts to patient care services or jobs.
» Input of RN staff on the conditions of the proposed sale.
» Transparency from Tulane and LCMC in this process.

Name	Facility	Unit	Cell Phone	Email	Signature	Date
Evangeline						
Erin Wallus						
Rachel Houge						
Travis Cleaver						
Kim Diaz						
Michael Bourg						
Bonnie Sniegowski						
Alaina DiLaura						
Demetria Christo						
Matthijs Herzberg						

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National Nurses Organizing Committee

National Nurses United

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102422

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- » No cuts to patient care services or jobs.
- » Input of RN staff on the conditions of the proposed sale.
- » Transparency from Tulane and LCMC in this process.

Name	Facility	Unit	Cell Phone	Email	Signature	Date
Killian Jordan						
Stephanie Martin						
George Bond						
Samara D. Poche						
Fern zKruget						
Cynthia Scott						
Kimberly Carter						
Beverly Barry						
Lorraine Washington						
Charles Allen III						

OUR PATIENTS. OUR UNION. OUR VOICE.

National Nurses Organizing Committee

National Nurses United

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102422

National Nurses Organizing Committee
National Nurses United
OUR PATIENTS. OUR UNION. OUR VOICE.

OAKLAND
155 Grand Avenue
Suite 100
Oakland CA 94612
phone: 800-504-7859
fax: 510-663-1625

TAMPA
201 East Kennedy Boulevard
Suite 1410
Tampa FL 33602
phone: 813-223-5312
fax: 813-223-5679

Jeff Landry, Attorney General
1885 North Third Street
Baton Rouge, LA 70802

Dear Attorney General Landry,

On behalf of 222,000 Registered Nurses (RN), with members in all fifty states, National Nurses United is writing to express our objection to the anticompetitive behavior exhibited in the greater New Orleans area by LCMC Health. The recent acquisitions from HCA Healthcare add three hospitals to the system's six-hospital portfolio, creating a two-system duopoly in New Orleans and giving LCMC and its competitor, Ochsner Health, unrestrained leverage over patients and health care workers. We fear this goes against the public interest, by leading to further consolidation, higher healthcare prices, and cuts to vital services. If your office approves this deal, we ask for contract conditions requiring LCMC to maintain all facilities and services, along with incorporating RN and patient priorities into the final sale agreement.

LCMC's acquisition of Tulane Medical Center drastically increases New Orleans' market concentration in an already highly concentrated market. Our analysis of the Herfindahl-Hirschman Index (HHI) in the New Orleans market finds LCMC's market share would increase to 55 percent—raising the HHI by 1,357 points to 4,995. Such a significant increase of HHI warrants the strictest scrutiny by the Louisiana Department of Justice.

Studies show highly concentrated health care markets often result in worse care and increasing healthcare prices. Accordingly, LCMC is already announcing cuts. LCMC plans to eliminate most in-patient services at Tulane Medical Center, a well-utilized hospital serving low-income patients. This spells disaster for many Louisiana residents. Tulane Medical Center has the state's only comprehensive stroke center and performs specialized transplants not done anywhere else in Louisiana.

With LCMC already announcing its intent to close the majority of inpatient services at Tulane Medical Center, and the substantial research tying highly concentrated markets to price increases, it is clear the sale does not meet Louisiana's threshold to garner a certificate of public advantage, as detailed in LA Rev Stat § 40:2254.4 (2015): *B. The department may not issue a certificate unless the department finds that the agreement is likely to result in lower health care costs or is likely to result in improved access to health care or higher quality health care without any undue increase in health care costs.*

LCMC and Ochsner controlling the entire New Orleans health care market virtually guarantees less access to health care services. We appreciate your attention to the concerns raised in this letter and urge you to block the proposed transaction. If you are interested in hearing directly from Tulane Medical Center nurses, please contact me at BVanWaus@NationalNursesUnited.Org and we can arrange a meeting.

Sincerely,

Bradley Van Waus
Southern Region Director

Freel, Angelique

From: Gretchen Hirt <GHirt@jeffparish.net>
Sent: Monday, December 05, 2022 10:45 AM
To: Freel, Angelique
Subject: FW: JP PRESIDENT & COUNCIL SUPPORT LCMC HEALTH & TULANE PARTNERSHIP

Jefferson Parish President Cynthia Lee Sheng, along with members of the Jefferson Parish Council, announced their support of a proposed partnership between LCMC Health and Tulane University. See below for a press release with additional information.

NEWS RELEASE

JEFFERSON PARISH, LOUISIANA

October 21, 2022
FOR IMMEDIATE RELEASE

JEFFERSON PARISH PRESIDENT AND COUNCILMEMBERS ANNOUNCE SUPPORT OF PROPOSED PARTNERSHIP BETWEEN LCMC HEALTH AND TULANE UNIVERSITY

JEFFERSON, LA – Jefferson Parish President Cynthia Lee Sheng, along with members of the Jefferson Parish Council, announced their support of a proposed partnership between LCMC Health and Tulane University. The partnership will expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide community investments and benefits for Jefferson Parish.

"This partnership will greatly benefit the residents of Jefferson Parish because many services will shift to East Jefferson General Hospital, creating more opportunities for comprehensive, integrated care at a local facility that can support new growth and provide an enhanced patient experience," said Jefferson Parish President Cynthia Lee Sheng. "Collaborations like these help propel our parish and region forward, and set us up as an example of what quality healthcare can and should look like in a community."

Under the proposed plan, Tulane Medical Center, Lakeview Regional Medical Center and Tulane Lakeside Hospital will be acquired from HCA Healthcare and will join LCMC Health. Over the

next 12-24 months, the majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans. As part of the partnership, LCMC Health has committed to an initial capital investment of $220 million in the operations of East Jefferson General Hospital, Lakeview Regional Medical Center and Tulane Lakeside Hospital.

"The proposed partnership between LCMC Health and Tulane University is phenomenal news for Jefferson Parish and the region," said Jefferson Parish Councilwoman Jennifer Van Vrancken (District 5), whose district includes East Jefferson General Hospital. "As a result of the LCMC Health and Tulane University partnership, Jefferson Parish will gain a premiere academic medical center on the campus of East Jefferson, where, in partnership with Tulane and LSU, the next generation of medical professionals will be trained. People from across the country will seek to travel here to access specialized healthcare. I can't think of anything more exciting than the educational opportunities ahead for students and residents, and the economic impact of that activity in Jefferson Parish."

"Having LCMC Health in Jefferson Parish has been a blessing," said Jefferson Parish Councilman Marion Edwards (District 1). "Their focus is on their patients, employees and our community and we are better, and healthier, for it. I wholeheartedly welcome Tulane University into Jefferson Parish and look forward to a productive partnership between these two nonprofits."

"We look forward to this planned partnership between LCMC Health and Tulane University, which will expand access to health care across our region and parish," said Jefferson Parish Council Chairman Ricky Templet (Division A). "This will set us up to be a destination for medical innovation and training, proving many community investments and benefits for years to come."

"LCMC Health is a valued partner in Jefferson Parish. Its proposed purchase of three area hospitals, including Tulane Lakeside, will strengthen our ability to provide quality health care to our citizens and, in turn, make the region stronger as well," said Jefferson Parish Councilman At-Large Scott Walker (Division B).

"This proposed partnership is great news for all our residents throughout Jefferson Parish because every individual deserves access to quality healthcare," said Jefferson Parish Councilman Deano Bonano (District 2). "I'm proud to join my colleagues in support of this, and I look forward to the long-term quality of life benefits it will provide across the entire parish."

"Access to quality healthcare for all residents of Jefferson Parish, including those in District 3, is absolutely critical," said Jefferson Parish Councilman Byron Lee (District 3). "I am pleased to hear that LCMC Health and Tulane University are working together to build on their ongoing commitment to meeting the needs of our community."

CLICK HERE for more information from LCMC about the proposed partnership.

For more information about Jefferson Parish, visit www.JeffParish.net. Residents can also receive regular updates by following the Parish on Facebook, Twitter and Instagram (@JeffParishGov) or by texting JPALERT or JPNOTICIAS to 888-777.

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Freel, Angelique

From: Jay DeSalvo <jaydesalvo@gmail.com>
Sent: Monday, December 05, 2022 12:58 PM
To: Freel, Angelique
Subject: LCMC Health – Tulane University proposed partnership

Ms Freel,

My name is Jay DeSalvo. I am a board certified emergency medicine physician who has worked at Lakeview Regional Medical center since the hospital opened in 1995. I am from New Orleans and trained at LSU-NO Medical School and Charity Hospital. I am in strong support of the LCMC Health – Tulane University proposed partnership.

LCMC Health is a known partner in our region. I have watched their growth for the last several years and have seen their commitment to the communities they serve. Physician colleagues at neighboring hospitals have shared with me that the integration, at West Jefferson Medical Center for example, demonstrates the respect LCMC Health has for the practice of medicine and physician relations. We have also heard that nurses are very happy at LCMC Health hospitals.

Our hospital deserves the chance to continue to grow. My understanding is that LCMC Health has put a $220 million capital commitment on the table, some of which will go to infrastructure and informational technology upgrades at Lakeview. An upgrade to the Epic electronic health record will benefit my patients in a myriad of ways, including more efficient use of provider time, ease of access to patient's own records, and interoperability among referring hospitals.

Given that LCMC is a local non profit, all of the revenue generated by this partnership will be invested locally- to pay salaries, invest in health care infrastructure and provide improved care to our patients.

This partnership is exciting and will benefit our region.

Many thanks for your time,

Jay DeSalvo MD

121 Rio Vista Ave.

Jefferson, LA 70121

504-427-9612

jaydesalvo@gmail.com

Freel, Angelique

From: Margie Galloway <mgallowa44@gmail.com>
Sent: Monday, December 05, 2022 4:33 PM
To: Freel, Angelique
Subject: EJGH

My name is Margie Galloway and I live in Metairie. As someone who has been to many area hospitals in the recent years as a patient, and a partner to a patient, I am in support of the LCMC Health / Tulane University transaction.

East Jefferson General Hospital is closest to my house. I was so relieved when LCMC Health bought the hospital a couple years ago. I know they will do a great job at the Tulane hospitals because they really care about people.

Sincerely,
Margie Galloway
60 Oaklawn Drive
Metairie, LA 70005

Freel, Angelique

From: Norman Barnum <nbarnum@nolaba.org>
Sent: Tuesday, December 06, 2022 11:34 AM
To: Freel, Angelique
Subject: Public Comment: LCMC Health - Tulane University partnership

My comment on behalf of NOLABA

We at NOLABA believe that collaborations amongst New Orleans' anchor institutions is a critical factor for actualizing growth of our economy. The partnership between LCMC Health and Tulane University exemplifies a strong focus on our greatest asset – our people, and NOLABA looks forward to supporting the strengthening of one of our premier academic medical centers (UMC), as it is a collaborative catalyst for healthcare innovation and research happening in our downtown BioDistrict."

NEW ORLEANS BUSINESS ALLIANCE
CULTURE. EQUITY. PROSPERITY.

Norman E. Barnum IV| President & CEO
New Orleans Business Alliance | 1250 Poydras Street, Suite 2150 | New Orleans, LA 70113
D: 504-934-4572 | nbarnum@nolaba.org | www.nolaba.org

Sign up for NOLA Business HERE

Freel, Angelique

From: Walt Leger III <Walt@neworleans.com>
Sent: Tuesday, December 06, 2022 1:46 PM
To: Freel, Angelique
Subject: Public Comment Submission Proposed LCMC Health-Tulane Partnership

I am writing to submit the following comment for the meeting this Thursday related to the Proposed partnership between LCMC Health and Tulane University.

The proposed partnership between LCMC Health and Tulane University is a once in a generation opportunity to make New Orleans and Southeast Louisiana a destination for world class healthcare. These two local nonprofits have been vital community partners for the city and the Greater New Orleans region at large for many years. Having them join forces to create a new academic medical center will draw students and scholars to the region while giving more patients access to the complex and high-quality medical care found at academic medical centers. New Orleans and Louisiana have long been destinations for visitors, and I am excited that we have this opportunity to make southeast Louisiana the destination for world class healthcare and education as well.

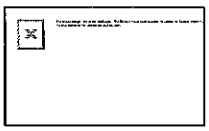
Thanks. Please let me know if you require any other information.

Walter J. Leger III
Incoming President & CEO and
Executive Vice-President &
General Counsel
DIRECT: (504) 556-5889
walt@neworleans.com
2020 St. Charles Avenue
New Orleans, Louisiana 70130

NewOrleans.com

NEW ORLEANS & COMPANY

THE OFFICIAL DESTINATION
MARKETING AND SALES ORGANIZATION FOR THE
NEW ORLEANS TOURISM INDUSTRY



Sent from Walt's IPhone

Freel, Angelique

From: Roth, Christopher <Christopher.Roth@lcmchealth.org>
Sent: Tuesday, December 06, 2022 10:38 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a pediatric urologist at Children's Hospital New Orleans and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Christopher Roth, MD
Chief of Urology
Children's Hospital New Orleans

Freel, Angelique

From: Parent, Charlotte (VP) <Charlotte.Parent@lcmchealth.org>
Sent: Wednesday, December 07, 2022 4:53 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the VP for Business Development at University Medical Center New Orleans and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Charlotte Parent
VP Business Development

University Medical Center New Orleans
2000 Canal Street
New Orleans, LA 70112

O 504.702.5212
F 504.702.2118

charlotte.parent@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Sherlock, Misty <Misty.Sherlock@lcmchealth.org>
Sent: Wednesday, December 07, 2022 6:14 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm an Associate Vice President of Case Management at LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Misty Sherlock, DNP, MHA, APRN, FNP-C, CCM
LCMC, AVP Case Management

LCMC Health
1100 Poydras St.
2500 Energy Centre
New Orleans, LA 70163

O 504.896.3016
C 504.915.3351
Misty.Sherlock@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: TaylorJoseph, Terri <Terri.TaylorJoseph@lcmchealth.org>
Sent: Wednesday, December 07, 2022 6:39 AM
To: Freel, Angelique
Subject: I Support the LCMC Health - Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm an HR Director at LCMC Health Corporate and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Terri Taylor-Joseph, MS, PHR
Human Resources Director

Freel, Angelique

From: Stephen Hales <shales@halespediatrics.com>
Sent: Wednesday, December 07, 2022 7:14 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Attorney General Landry,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a pediatrician, practice owner and board member and I have seen the value LCMC Health places in high-quality patient care and its employees.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Stephen Hales

Stephen W. Hales, M.D.
170 Walnut, Apt. 2F
New Orleans, LA 70118

shales@halespediatrics.com

504-866-1779 (home)
504-957-5560 (cell)

Freel, Angelique

From: Kunkel, JoAnn L <JoAnn.Kunkel@lcmchealth.org>
Sent: Wednesday, December 07, 2022 7:16 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Finance Officer at LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

JoAnn Kunkel

Freel, Angelique

From: Haggard, Suzanne <C.Suzanne.Haggard@lcmchealth.org>
Sent: Wednesday, December 07, 2022 7:22 AM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

Dear Sirs,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I serve as Chief Revenue Officer to LCMC Health in our Corporate Office, and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Suzanne Haggard, CPA
Chief Revenue Officer

LCMC Health
Westpark Campus
3401 General DeGaulle
New Orleans, LA 70114

O 504.702.5454

Suzanne.Haggard@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Leblanc, Andy (Andrew) <Andrew.Leblanc@lcmchealth.org>
Sent: Wednesday, December 07, 2022 7:32 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm an Assistant Vice President, Financial Planning & Analysis, at LCMC Health's Corporate Offices and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,
Andrew (Andy) D. LeBlanc, MHA
Assistant Vice President - Financial Planning & Analysis

LCMC Health
1100 Poydras St.
2500 Energy Centre
New Orleans, LA 70163

O 504.896.9529
C 504.583.7990

andrew.leblanc@LCMChealth.org
Lcmchealth.org

Freel, Angelique

From: Miranda, Lisa <Lisa.Miranda@lcmchealth.org>
Sent: Wednesday, December 07, 2022 7:42 AM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I have been with LCMC for over 35 years, starting work right out of college at Children's Hospital. Today, I am the COO at University Medical Center and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Lisa P. Miranda
Chief Operating Officer

University Medical Center
2000 Canal Street
New Orleans, LA 70112

O 504.702.4411
C 504.905-4682
F 504.962-7050

lisa.miranda@LCMChealth.org
umcno.org

Freel, Angelique

From: Belanger, Shannon M <Shannon.Belanger@lcmchealth.org>
Sent: Wednesday, December 07, 2022 7:55 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Revenue Cycle AVP at LCMC and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Regards,

Shannon Belanger
System AVP Revenue Cycle Operations

LCMC Health
3401 General De Gaulle Drive
New Orleans, LA 70114

O 504.702.2920
F 504.962.6004

Shannon.Belanger@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Cook, John R. <John.Cook@lcmchealth.org>
Sent: Wednesday, December 07, 2022 7:57 AM
To: Freel, Angelique
Subject: I Support the LCMC Health/Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the AVP of Risk Management for LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself. In fact, I accepted this position after working for HCA over the Risk Management Department at the Tulane facilities in Orleans and Jefferson Parishes so can speak with clarity on the value that LCMC Health can bring to this partnership at these very hospitals.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

John R. Cook
AVP, Risk Management

LCMC Health
1100 Poydras Street
New Orleans, LA 70163

O 504.894.5278
C 504.202.1808

john.cook@LCMCHealth.org
LCMChealth.org

Freel, Angelique

From: Anderson, Alison <Alison.Anderson2@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:00 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm Chief of Staff to Greg Feirn and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Alison Anderson
Executive Administrator & Chief of Staff

LCMC Health
1100 Poydras Street
2500 Energy Centre
New Orleans, LA 70163

O 504.896.3038
C 504.940.8520

Freel, Angelique

From: Edwards, Amy <Amy.Edwards@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:04 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Director at LCMC Westbank location and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Amy Edwards

Director Patient Access

LCMC Health West Park
3401 General De Gaulle Drive
New Orleans, LA 70114

D 504-702-3925

amy.edwards@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Smith, Eli <Robert.Smith@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:10 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

For the past five-plus years, it has been my good fortune to work at LCMC Health. It is a fine organization comprised of incredibly talented women and men, all of whom share common goals of delivering patients unsurpassed clinical care while, at the same time, exhibiting that "little something extra" that makes the New Orleans region—and this system—such a remarkable place. It is an enterprise that is deeply community-driven and academically minded, both of which are attributes essential to the betterment of our region and, more specifically, to the health and well-being of those we have the great privilege to serve.

As a leader at LCMC Health—and as the Chief Operating Officer at West Jefferson Medical Center—I have seen first-hand the value LCMC Health places in high-quality patient care and employees like myself. And so it is, I am extraordinarily proud to endorse the proposed partnership with Tulane University.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. Indeed, this integration will undoubtedly transform the healthcare landscape by bringing new investments and growing the system's teaching mission, all while serving the community. Examples include West Jefferson Medical Center's master facility plan (a $95MM planned campus-wide renovation), as well as the planned investments and campus development plans cast for East Jefferson General Hospital.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Eli Smith, FACHE
Chief Operating Officer—West Jefferson Medical Center
1101 Medical Center Boulevard
Marrero, Louisiana 70072
C 217.419.6629
eli.smith@lcmchealth.org

Freel, Angelique

From: Stockstill, Byron <Byron.Stockstill@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:22 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the AVP Business Development at LCMC Health System located at 1100 Poydras St., New Orleans, LA and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration.

Byron Stockstill MHA
System AVP Business Development

LCMC Health
1100 Poydras St.
2500 Energy Center
New Orleans, LA 70163
C 601.347.2066
D 504.702.4386
byron.stockstill@LCMChealth.org

******As rate increases become the norm, employers need to future-proof their benefits by finding alternative health plans that support the needs of their employees – while supporting the financial needs of their business***

Freel, Angelique

From: Brewer, Ruby <Ruby.Brewer@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:26 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

To Whom It May Concern:

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the Chief Nursing and Quality Officer at East Jefferson General Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Ruby Brewer

Ruby Brewer, MSN/MBA, RN, NEA-BC
Chief Nursing and Quality Officer

East Jefferson General Hospital
4200 Houma Blvd.
Metairie, LA 70006

O 504.503.6497
C 504.259.5379
F 504.456.8151

ruby.brewer@LCMChealth.org
ejgh.org

Freel, Angelique

From: Fragoso, Lucio A. <Lucio.Fragoso@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:32 AM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Chief Financial Officer at Children's Hospital New Orleans and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Lucio Fragoso

Lucio A. Fragoso
Senior Vice President
Chief Financial Officer / Chief Administrative Officer

Children's Hospital
200 Henry Clay Avenue
New Orleans, LA 70118-5798

O 504.896.9400 x85482
C 312.307.8708
D 504.894.5482
F 504.896.9707

Lucio.Fragoso@lcmchealth.org
LCMChealth.org

Freel, Angelique

From: Ayoub, Elias A <Elias.Ayoub@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:37 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a VP, Specialty Pharmacy at LCMC Health Pharmacy Services and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Elias Ayoub
VP, Specialty Pharmacy

LCMC Health
1100 Poydras St.
2500 Energy Centre
New Orleans, LA 70163

O 504.702.3188
C 508.769.4649

Elias.Ayoub@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Calhoun, Robert M. <Robert.Calhoun@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:38 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a President and CEO at West Jefferson Medical Center and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,

Rob Calhoun

Rob Calhoun, MHA
President and Chief Executive Officer

West Jefferson Medical Center
1101 Medical Center Blvd.
Marrero, LA 70072

O 504.349.1103
C 205.876.3158

Robert.Calhoun@LCMChealth.org
WJMC.org

Freel, Angelique

From: Nguyen, Victoria M <victoria.nguyen3@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:46 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Pharmacist in Charge at LCMC Health Pharmacy Services, LLC and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration.

Victoria Nguyen, PharmD
Clinical Pharmacy Manager

LCMC Health Pharmacy Services, LLC
Children's Hospital New Orleans
200 Henry Clay Avenue Suite 2107
New Orleans, LA 70118

O 504.896.7780
F 504.867.4517
C 504.450.5688

Victoria.Nguyen3@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Gahagan, Quitman <Quitman.Gahagan@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:47 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the Manager of Managed Care Contracting at LCMC Health's Westpark location and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Quitman Gahagan, MBA, PMP
Manager, Managed Care Contracting

LCMC Health

O 504-702-3512
M 504-343-2393

Quitman.Gahagan@lcmchealth.org
LCMChealth.org

Freel, Angelique

From: Brouk, Jonathan <Jonathan.Brouk@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:50 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Good Morning,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the Chief Operating Officer / Chief Strategy Officer at Children's Hospital New Orleans and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jonathan

Jonathan E. Brouk
SVP, Chief Operating Officer / Chief Strategy Officer

Children's Hospital New Orleans
200 Henry Clay Avenue
New Orleans, LA 70118

O 504.894.5395
C 314.277.9407

Jonathan.Brouk@LCMChealth.org
chnola.org

Freel, Angelique

From: Bradshaw, Robert G <Robert.Bradshaw@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:53 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Good Morning

I hope this message finds you well.
As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Director of Compliance with responsibilities at Touro Infirmary, East Jefferson General Hospital, as well as New Orleans East Hospital and I have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I respectfully urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Best,

R. Graham Bradshaw
Director of Compliance

LCMC Health
1100 Poydras Street
2500 Energy Centre
New Orleans, LA 70163

D 504.896.2967
O 504.896.3030

Robert.Bradshaw@lcmchealth.org
LCMChealth.org

Freel, Angelique

From: Piper, Eryn E <eryn.piper@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:56 AM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Clinical Pharmacist in the LCMC Health Pharmacy Services department inside Children's Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Regards,

Eryn Piper, PharmD, CSP
Clinical Pharmacist, Specialty Pharmacy

LCMC Health Specialty Pharmacy
Children's Hospital New Orleans
200 Henry Clay Avenue Ste 2107
New Orleans, LA 70118

O 504.896.7780
C 337.298.8324

Eryn.Piper@LCMCHealth.org
LCMChealth.org

Freel, Angelique

From: Linares, Manuel <Manuel.Linares@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:56 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the President and CEO at Touro Infirmary and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Manny Linares
President and CEO

Touro Infirmary
1401 Foucher Street
New Orleans, LA 70115

O 504.897.8246
C 305.775.4740

Freel, Angelique

From: McGoey, Robin <Robin.Mcgoey@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:57 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Dear Mr. Landry,

As a leader at LCMC Health, I wholeheartedly support the proposed partnership with Tulane University.

I have had the distinct privilege of working with or for LCMC Health since its inception, initially as an attending physician who attended medical school and residency locally, followed by progressive leadership roles overseeing the academic operations across our family of hospitals.

Currently, I am honored to serve LCMC Health as the **Chief Academic Officer** for the health system- a health system that puts the health, care, and education of its community before all else.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership promises to expand and advance not only the quality of healthcare but also the pipeline of future healthcare providers for our State.

Between LSU and Tulane, there are more than 100 graduate medical education programs, training >1,200 resident physicians, and in front of us is the unprecedented opportunity to support, promote, train, and retain these physicians for the State of Louisiana.

I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration.

Robin R. McGoey, MD
Chief Academic Officer

LCMC Health
1100 Poydras St, 2500 Energy Center
New Orleans, LA 70163

O 504.702.4381
C 504.231.0011

Robin.McGoey@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Castro, Julissa M <Julissa.Castro@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:58 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Executive Coordinator at LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Julissa M. Castro
Executive Coordinator – Finance

LCMC Health
1100 Poydras St.
2500 Energy Centre
New Orleans, LA 70163

O 504.702.5412
C 504.570.3012

Freel, Angelique

From: Casey, Lindsey <Lindsey.Casey@lcmchealth.org>
Sent: Wednesday, December 07, 2022 8:58 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Good morning,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the Chief Nursing Officer at Children's Hospital New Orleans and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Respectfully,

Lindsey Casey, MSN, RN, NEA-BC (she/her)
Senior Vice President, Chief Nursing Officer

Children's Hospital New Orleans
200 Henry Clay Ave.
New Orleans, LA 70118

O 504.896.2716
C 504.975.8758
F 504.894.5451

Lindsey.casey@LCMChealth.org
chnola.org

Freel, Angelique

From: Scott Cornwell <Charles.Cornwell@lcmchealth.org>
Sent: Wednesday, December 07, 2022 9:00 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a System Director of Government Reimbursement at LCMC Health Corporate and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We could transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

C. Scott Cornwell

LCMC
System Director of Reimbursement
3410 General DeGaulle
New Orleans, LA 70114
Office (504) 702-3659
Mobile (228) 328-8242

Freel, Angelique

From: Bond, Troy <Troy.Bond@lcmchealth.org>
Sent: Wednesday, December 07, 2022 9:03 AM
To: Freel, Angelique
Subject: Support of LCMC / Tulane Partnership

Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am happy to support the proposed partnership with Tulane University. I'm an AVP of Human Resources at Touro Infirmary and have seen the value LCMC Health places in high-quality patient care. With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community. Additionally, the consolidation of services will make things more efficient and help to concentrate nurses instead of being spread out and less efficient.

Please support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Troy Bond
AVP of Human Resources

Touro
1401 Foucher St.
New Orleans, LA 70115

O 504.897.7811
F 504.897.8719

Troy.Bond@LCMChealth.org
touro.com

Freel, Angelique

From: Guste, Allison <Allison.Guste@lcmchealth.org>
Sent: Wednesday, December 07, 2022 9:09 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Importance: High

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a nurse and servie as the Vice President of Quality and Nursing at LCMC Health Corporate and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Allison Guste, RN, BSN, CPHQ
System Vice President, Quality and Nursing

LCMC Health
1100 Poydras Street
2500 Energy Center, 25th Floor
New Orleans, LA 70163

O 504.896.3056
C 504.258.2252

Allison.Guste@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Chip Cahill <chipcahill@icloud.com>
Sent: Wednesday, December 07, 2022 9:15 AM
To: Freel, Angelique
Subject: Fwd: LCMC - Tulane

Sent from my iPhone

Begin forwarded message:

From: Harry Cahill <chipcahill@outlook.com>
Date: December 7, 2022 at 9:12:10 AM CST
To: Chip Cahill <chipcahill@icloud.com>
Subject: LCMC - Tulane

The Honorable Jeff Landry
Louisiana Attorney General

Dear Attorney General Landry, as a leader at LCMC Health, I proudly support the proposed partnership with Tulane University. I'm the board chairman at West Jefferson Medical Center and a trustee at LCMC and have seen the value LCMC Health places in high-quality patient care and our employees.
With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.
I urge you to support the proposed LCMC Health - Tulane University partnership. Thank you for your consideration.
Harry L. "Chip" Cahill

Freel, Angelique

From: Schwehm, Jennifer K. <Jennifer.Schwehm@lcmchealth.org>
Sent: Wednesday, December 07, 2022 9:19 AM
To: Freel, Angelique
Subject: FW: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm an AVP of Quality and Care Management at University Medical Center New Orleans and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jennifer Schwehm, RN, MSN CPHQ
Assistant Vice President Quality, Safety & Care Management
Certified Green Belt
University Medical Center
2000 Canal Street
New Orleans, LA 70112

O 504.702.4390
C 504.232.7440
Jennifer.Schwehm@LCMChealth.org

Freel, Angelique

From: Kline, Mark W <mark.kline@lcmchealth.org>
Sent: Wednesday, December 07, 2022 9:38 AM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I am the Physician-in-Chief and Chief Medical Officer at Children's Hospital New Orleans and have seen the value LCMC Health places in high-quality patient care and the support of providers like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Mark Kline, M.D.

Mark W. Kline, M.D.
Senior Vice-President and Chief Medical Officer
Physician-in-Chief

Professor of Pediatrics
Tulane University School of Medicine

Clinical Professor of Pediatrics
LSU Health New Orleans

Children's Hospital New Orleans
200 Henry Clay Avenue
New Orleans, LA 70118

O 504.896.9400

Mark.Kline@lcmchealth.org
LCMChealth.org

Children's Hospital New Orleans

Tulane University School of Medicine

LSU Health New Orleans School of Medicine

Freel, Angelique

From: Sinclair, Brad <Brad.Sinclair@lcmchealth.org>
Sent: Wednesday, December 07, 2022 9:47 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Senior Vice President of Finance at LCMC Health, and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Brad Sinclair, CPA
Senior Vice President - Finance

LCMC Health
1100 Poydras Street
Suite 2500
New Orleans, LA 70163

O 504-897-8485

Brad.Sinclair@lcmchealth.org

Freel, Angelique

From: Cahill, Jessica <Jessica.Cahill@lcmchealth.org>
Sent: Wednesday, December 07, 2022 9:49 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

To Whom it may Concern,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the VP of Finance at Children's Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We can transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,

Jessica Cahill, CPA
Vice President, Finance and Analytics

Children's Hospital New Orleans
200 Henry Clay Ave.
New Orleans, LA 70118

O 504-894-6995
C 504-913-6892

Jessica.Cahill@LCMChealth.org
chnola.org

Freel, Angelique

From: Hildebrand, Ryan <Ryan.Hildebrand@lcmchealth.org>
Sent: Wednesday, December 07, 2022 9:50 AM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I am the Innovation Administrator for the LCMC system and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Ryan J Hildebrand, MBA, MHA
Innovation Administrator

LCMC Health
1100 Poydras St.
2500 Energy Centre
New Orleans, LA 70163

O 504.894.6749
C 504.458.8438

Ryan.Hildebrand@LCMChealth.org

Freel, Angelique

From: Hallford, Rosanne <Rosanne.Hallford@lcmchealth.org>
Sent: Wednesday, December 07, 2022 9:51 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Good Day,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Senior Director of Patient Care Services at Children's Hospital New Orleans and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Rosanne Hallford MSN, RN, CCRN-K
Senior Director of Patient Care Services, Heart Center

Children's Hospital New Orleans
200 Henry Clay Ave.
New Orleans, LA 70118

Freel, Angelique

From: Zanewicz, James R <zanewicz@tulane.edu>
Sent: Wednesday, December 07, 2022 9:52 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of the Tulane school of medicine, I am very proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

This new partnership will allow LSU Health and Tulane to work closer than ever before, and create truly two great academic medical centers (one in orleans and one in Jefferson parish) that are able to serve our full community with leading-edge healthcare advances.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

James Zanewicz
CBO, Tulane School of Medicine

Freel, Angelique

From: Vitrano, Judy R <jvitrano@tulane.edu>
Sent: Wednesday, December 07, 2022 9:53 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

Importance: High

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Judy R. Vitrano
Chief of Staff to the COO
504-314-2783 (office)
504-314-2781 (fax)
jvitrano@tulane.edu

Freel, Angelique

From: Landry, Scott <Scott.Landry@lcmchealth.org>
Sent: Wednesday, December 07, 2022 9:54 AM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane University Partnerhsip

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the Senior Vice President of Facilities and Support Services at LCMC and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Scott C. Landry
Senior Vice President,
Facilities & Support Services

LCMC Health
3401 General DeGaulle Drive
Suite 1020
New Orleans, LA 70114

O 504.702.2001

Scott.Landry@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Pridjian, Gabriella <pridjian@tulane.edu>
Sent: Wednesday, December 07, 2022 9:54 AM
To: Freel, Angelique
Subject: Support for Tulane University-LCMC Partnership

Importance: High

Ladies and Gentlemen,

For 30 years as faculty member of Tulane University Medical School and resident of New Orleans, I have contributed to patient care, education, research, and community service in the Greater New Orleans area as well as the state of Louisiana.

I urge you to support the proposed Tulane University - LCMC Health partnership.

Below are some of the reasons this partnership is important:

1. Tulane (along with LSU and LCMC) will transform the future of healthcare in our region by creating centers of extraordinary care for our communities. True academic healthcare systems provide increased access to the latest medical breakthroughs and clinical trials.

2. The partnership will allow further opportunities to expand the training of the next generation of physicians, scientists and other allied health professionals.

3. The partnership between Tulane and LCMC will be transformational for the greater New Orleans area. It will provide increased access to the latest medical breakthroughs and clinical trials to our community and establish national and ultimately international centers of excellence.

4. A non-for-profit, mission-based partner like LCMC (who understands academic medicine) aligns well with the Tulane's mission and philosophy. The partnership will allow Tulane to create an integrated and comprehensive health system right here in our community.

5. It's the right thing to do for our community, our state, and for Tulane.

Thank you in advance,

Gabriella Pridjian, MD, MBA
Associate Dean of Surgical Services
Professor and Chairman & the C. Jeff Miller Chair in Obstetrics & Gynecology
Adjunct Professor of Pediatrics
Maternal Fetal Medicine
Clinic Geneticist in Human Genetics Program
Tulane University School of Medicine

Academic Office Phone: 504-988-2145
Academic Office Fax: 504-988-2943
Email: pridjian@tulane.edu
Cell: 504-231-0708

Freel, Angelique

From: Andersson, Hans C <handers@tulane.edu>
Sent: Wednesday, December 07, 2022 9:56 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

I am the Director of the Tulane Hayward Genetics Center, am the Karen Gore Chair in Human Genetics and am a tenured Professor in the department of Pediatrics. I was born in New Orleans and have been a life-long resident of my city, except for 7 years of training in other states and countries.

Since March 2019, the Tulane Department of Pediatrics has transferred all of its in-patient and out-patient activities to Childrens Hospital of New Orleans, an LCMC facility. Previous to that time, we were at Lakeside under HCA management, a for-profit corporation. Having started in December 1993 at Tulane as a genetics faculty member, I observed firsthand the deterioration of the quality and breadth of pediatric services under HCA and its malingering management in the ensuing 25 years since they took major ownership. Tulane Pediatrics lost its sleep lab, the inpatient child psychiatry unit, pediatric urology and pediatric otolaryngology. HCA made no serious efforts to address the deterioration under they management. Our clinical genetics diagnostics laboratories at Hayward Genetics Center lost all clinical volume from Tulane in-patients and outpatients when HCA referred these samples to a new unknown Montana laboratory, removing these samples from use in our ABMGG-acredited laboratory genetic training program. Our genetic training program is the only one in Louisiana and we make every effort to keep Louisiana patient samples in Louisiana.

Since transitioning all pediatric care to CHNOLA in 2019, pediatric services have flourished and the care for Louisiana children has dramatically improved. LCMC has been a serious management partner and I have been part of many meetings which demonstrated LCMC eagerness to listen to ideas. They have instituted many efforts to improve Louisiana pediatric care, not the least of which was completing a $300million renovation of CHNOLA. The merger has encouraged successful collaboration between LSU and Tulane pediatric specialty services and the benefit to students and residents has been dramatic.

In every way, the transition for pediatrics out of an HCA facility and into the LCMC management has been positive for Tulane and Louisiana. I anticipate the same benefit to Louisiana if all other services at Tulane transition to management/ownership by the not-for-profit LCMC. Healthcare in Louisiana has long suffered from fragmentation and this transition offers the possibility of dramatic improvement in access to care. The benefits to residency training will also be positive with access of learners to speciality services which are currently unavailable or difficult to access. This has the potential of keeping mare more of our students in Louisana as residents and physicians to begin to alleviate our physician shortages in all areas.

I am happy to address questions or telephone calls about this email or the proposed transition.

Hans
Cell. 504-452-0359

Hans C. Andersson, MD, FACMG
Director, Hayward Genetics Center
Karen Gore Chair of Human Genetics
Hayward Genetics Center SL-31

Tulane University Medical Center
New Orleans, LA 70112
http://www.haywardgenetics.tulane.edu/

Freel, Angelique

From: Chau, Richard K <rchau@tulane.edu>
Sent: Wednesday, December 07, 2022 10:01 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Richard Chau
Chief Investment Officer
Tulane University
9 Old Kings Highway South
Darien, CT 06820
rchau@tulane.edu
203-716-8473

Freel, Angelique

From: Vickers, Frances R <fvickers@tulane.edu>
Sent: Wednesday, December 07, 2022 10:01 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

To Whom It May Concern:

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,
Frances R. Vickers

Freel, Angelique

From: Johnson, Brian <johnson@tulane.edu>
Sent: Wednesday, December 07, 2022 10:04 AM
To: Freel, Angelique
Subject: Tulane/LCMC partnership

Dear Louisiana State leadership,

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Dr. Brian Johnson
Associate Vice President for Campus Operations
Tulane University

Sent from my iPhone

Freel, Angelique

From: Marbley, Courtney J. <Courtney.Marbley@lcmchealth.org>
Sent: Wednesday, December 07, 2022 10:10 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Good Morning Sir,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the Chief Nursing Officer and Chief Operation Officer at New Orleans East Hospital and have seen the value LCMC Health places in high-quality patient care and employees at all levels.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement, as have I in my 6 years at LCMC. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. I appreciate your consideration.

C.J. Marbley, RN,(*he/him*)
CNO, COO
Vice President of
Patient Care Services

New Orleans East Hospital
5620 Read Blvd.
New Orleans, LA 70127

O 504.592.6610
D 504.592.6620
F 504.592.6519

Courtney.Marbley@LCMChealth.org
NOEHospital.org

Freel, Angelique

From: Small, Jonathan A <jsmall4@tulane.edu>
Sent: Wednesday, December 07, 2022 10:12 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care.

Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Thanks,

Tulane
Office of Human Resources & Institutional Equity
Jonathan A. Small, MBA, SPHR, SHRM-SCP
Vice President, HRIE and Tulane University Leadership Institute
Tulane University | 1555 Poydras St., Suite 964 | New Orleans, LA 70112
Office: 504-247-1758 | Fax: 504-865-6727

Freel, Angelique

From: William Guste IV <wguste4@yahoo.com>
Sent: Wednesday, December 07, 2022 10:15 AM
To: Freel, Angelique
Subject: LCMC Health – Tulane University Partnership

To Whom It May Concern,

Please consider this my letter of support for the proposed partnership between LCMC Health and Tulane University. As a resident of New Orleans, I have seen firsthand the level of quality care and professionalism the LCMC Health team provides through numerous clinical, out-patient, and hospital interactions for my primary and extended family as well as myself.

The addition of the Tulane hospitals into the LCMC Health system is a significant opportunity to expand this exemplary level of care to a broader population, increase health outcomes, and bring new investment and opportunities into our community.

Your support and approval of the LCMC Health – Tulane University partnership would be appreciated.

Thank you.

William J. "Billy" Guste, IV
920 Filmore Avenue
New Orleans, LA 70124

Freel, Angelique

From: Von Almen, William <William.VonAlmen@lcmchealth.org>
Sent: Wednesday, December 07, 2022 10:24 AM
To: Freel, Angelique
Subject: Tulane University/LCMC Health partnership

Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the MED EXEC PRESIDENT at TOURO INFIRMARY, and a practicing community OB/GYN and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

William von Almen, II MD FACOG
CCPI-Gynecology
Touro
3434 Prytania Suite 320
New Orleans, LA 70115
O 504.897.7142-Touro
O 504.367.6971-WestBank
O 504.325.2700-Metairie
F 504.210.4286-Touro
william.vonalmen@LCMChealth.org

Freel, Angelique

From: Becker, Cary A. <Cary.Becker@lcmchealth.org>
Sent: Wednesday, December 07, 2022 10:24 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Good morning,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the assistant vice president of facilities and support services for the LCMC Health system and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Regards,

Cary A. Becker
Assistant Vice President
Facilities & Support Services

LCMC Health
Westpark Campus
504.702.5255
LCMChealth.org

Freel, Angelique

From: Weingart, Kady D <kady@tulane.edu>
Sent: Wednesday, December 07, 2022 10:31 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

Importance: High

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

[illegible]
Assistant Provost for Finance and Operations and Chief of Staff
Office of Academic Affairs & Provost | Tulane University

O: 504.865.5075 | M: 504.231.5274 | E: kady@tulane.edu
6823 St. Charles Ave., 200 Gibson Hall, New Orleans, LA 70118
[illegible]

Freel, Angelique

From: Peyronnin, Lelia S <sutton64@tulane.edu>
Sent: Wednesday, December 07, 2022 10:36 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Lelia S. Peyronnin, CFA
Associate Vice President of Treasury and Investments
Tulane University
New Orleans, LA 70112
Cell: (504) 952-8123
Work (504) 314-2823

Freel, Angelique

From: Sharonda Williams <shwillia@loyno.edu>
Sent: Wednesday, December 07, 2022 10:38 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a member of the Board of Directors at LCMC and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sharonda R. Williams

General Counsel and Director of Government Affairs

6363 St. Charles Avenue, Box 58

New Orleans, LA 70118

504.864.7082

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UNIVERSITY
NEW ORLEANS

notified that any review, dissemination, distribution or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Freel, Angelique

From: Eshleman, Denice <Denice.Eshleman@lcmchealth.org>
Sent: Wednesday, December 07, 2022 10:41 AM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane University Partnership

Good morning,
As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the System Director of Emergency Preparedness for LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership.
Thank you for your consideration.

Denice Eshleman
Director, Emergency Preparedness

LCMC Health
3401 General De Gaulle Drive
Suite 1020
New Orleans, LA 70114

D 504.894.5167
F 504.897.8992

Denice.Eshleman@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Krousel-Wood, Marie A <mawood@tulane.edu>
Sent: Wednesday, December 07, 2022 10:51 AM
To: Freel, Angelique
Subject: Support for partnership with LCMC

As an employee of Tulane Medical School, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

M. "Tonette" Krousel-Wood MD, MSPH, FACPM, FAHA
Professor and The Jack Aron Chair in Primary Care Medicine
Associate Provost for the Health Sciences|Senior Associate Dean for Faculty Affairs-SOM|
Associate Dean for Public Health & Medical Education-SPHTM and SOM
Tulane University|1430 Tulane Avenue|New Orleans, LA 70112

Freel, Angelique

From: Kerner, Rep. Timothy (District Office) <hse084@legis.la.gov>
Sent: Wednesday, December 07, 2022 10:56 AM
To: Freel, Angelique
Subject: LCMC Health – Tulane

On behalf of Representative Timothy Kerner:

I would like to submit this as a public comment for the December 8th hearing on the LCMC Health – Tulane partnership. I am supportive of their partnership.

Since it first began operating hospitals in Jefferson Parish in 2015, LCMC Health has proven to be a trusted, valuable healthcare partner for our people, and I am proud to support the proposed partnership between LCMC Health and Tulane University. Jefferson Parish stands to gain tremendously, both through the anticipated $474 million in economic impact and $220M in investments to hospital infrastructure. Jefferson Parish is world-class, and we deserve a world-class academic medical center.

Nicole Cooper
Legislative Assistant
for Timothy Kerner
State Representative District 84

799 Jean Lafitte Blvd.
Lafitte, LA 70067
(504) 689-7725 | Office
(504) 401-7314 | Cell
(504) 689-7727 | Fax

Dear Attorney General Landry,

We write as denominational and community leaders across New Orleans and Louisiana, in our support of the nurses of Tulane Medical Center, who are demanding a voice in the future of healthcare in New Orleans. We are asking for the upcoming public hearing on the sale to be held locally in New Orleans, not Baton Rouge, ensuring meaningful participation and input from our frontline health care workers and the community they serve.

We are deeply concerned that the proposed sale of Tulane Medical Center to LCMC Health will negatively impact access to quality and affordable health care services for thousands of Louisianans. LCMC has already announced plans to shut down most inpatient services at Tulane Medical Center within 12 to 24 months of acquiring the hospital. Many of our community members have gone to Tulane Medical Center for years. Losing such a popular hospital serving patients not only in New Orleans, but across Louisiana, is a loss for communities around the state.

We fear a two-system duopoly in New Orleans, made up of LCMC and Ochsner Health, will raise health care costs and reduce services. This is especially worrisome in such a precarious time in our nation. Now, more than ever, high-quality health care needs to be made more accessible and affordable.

When Charity Hospital closed, New Orleans lost one of the state's last public hospitals that served everyone, regardless of income level. Now, we stand to lose another hospital in downtown New Orleans that has long served low-income patients. We worry Medicaid patients, who are disproportionately Black and people of color, will lose access to care. Louisiana's minority residents already experience significantly lower life expectancies than white residents, and the closure of services and higher health care costs may exacerbate this health equity crisis.

Nurses are on the front lines of keeping our communities and congregants healthy and safe. We stand with Tulane Medical Center nurses because we trust nurses to put patients first. We urge you to block the sale in order to ensure there are no cuts to jobs or patient care services at Tulane Medical Center and that there is no increase in healthcare costs for the community.

Sincerely,

Shawn Moses Anglim, First Grace UMC, Pastor

Margaret Washington, Retired RN/Nurse Educator

Betty Roberson, EDUTRONICS, CEO

Callie Winn Crawford, Retired United Methodist Pastor

Jonah Evans, Neutral Ground, Founder and CEO

Charlotte Clarke, Common Ground Relief, Co-Director

Rev. Dr. Joe D Connelly, Bethany United Methodist Church, Sr. Pastor & Community Engagement Officer

Travis Cleaver, Grow Dat Youth Farm, Site Coordinator

Bonnie Sniegowski, Society of St. Vincent de Paul, Director of Adult Learning Center

Deon Haywood, Women With a Vision, Executive Director

Harold John, National Association of Letter Carriers, 2nd Congressional District Liaison

Matthijs Herzberg, Herzberg Design Co, CEO

Elizabeth S Widerquist, Xavier University of Louisiana, Professor

Stephanie Martin, FGUMC, Administrator

Reverend Dr. J.C. Richardson, Cornerstone United Methodist Church, Pastor

Bettie Rhode, Cornerstone United Methodist Church, Parish Nurse/Lay Minister

Lexi Peterson, New Orleans Workers Center, Co-director

Byron Johnson, Central Missionary Baptist Church, Reverend

Jeanne Nathan, Tannathan inc., dba Creative Industry, President

Mary Lowry, Now Love

J. Christopher Johnson, Mobilizing Millennials, Executive Director

Marc Behar, Temple Sinai, Former Board Member

Eugenia Rainey, Tulane University, Professor

Bennie Wilson, Mantle Tabernacle Holiness Church, Sr. Pastor

Dave Cash, United Teachers of New Orleans, President

Darla H Durham, St. Charles Avenue Baptist Church, Deacon and Former Trustee

Margaret Maloney, New Orleans Workers Assembly, Organizer

Mike Howells, We Can't Wait NOLA, Organizer

Amy Stelly, Claiborne Avenue Alliance, Executive Director

Reverend Paul Beedle, First Unitarian Universalist Church, Minister

Freel, Angelique

From: Cahill, Elwood <ECahill@SHERGARNER.com>
Sent: Wednesday, December 07, 2022 11:16 AM
To: Freel, Angelique
Cc: Ayame.dinkler@lcmchealth.org
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I am a Board member of LCMC, as well as a former Chair of the Children's Hospital Board and have seen firsthand the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Elwood

ELWOOD F. CAHILL, JR. | ATTORNEY AT LAW | SHER GARNER CAHILL RICHTER KLEIN & HILBERT, L.L.C.
909 Poydras Street | Suite 2800 | New Orleans, LA 70112 | ecahill@shergarner.com | O: 504-299-2103 | C: 504-723-5485 | F: 504-299-2303

Freel, Angelique

From: Bouyelas, Kirk M <kbouyela@tulane.edu>
Sent: Wednesday, December 07, 2022 11:16 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As the Chief of Police for the Tulane University Police Department, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Kirk M. Bouyelas
Chief of Police
Tulane University Police Department
(504) 247-1252
kbouyela@tulane.edu

Freel, Angelique

From: Pennison, Deborah B <dpenniso@tulane.edu>
Sent: Wednesday, December 07, 2022 11:18 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane University School of Medicine, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

As a result of this partnership, Tulane will be creating a new nursing program in downtown New Orleans. We already know the nursing shortage that is affecting healthcare systems and communities across the country. This shortage is felt deeply in Louisiana, where almost one-third (29%) of Registered Nurses plan to retire within 10 years.
Tulane University's new nursing program will create new paths and expand the pipeline of students eager to enter the nursing field – making meaningful progress towards addressing the projected 2,475 unfilled full-time nursing positions projected in New Orleans by 2025.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Stay Well,
Debbie

Deborah Pennison Web Designer
Tulane University School of Medicine - Dean's Office
Office: 504-988-1701
dpenniso@tulane.edu

Freel, Angelique

From: Davis, Takeisha <Takeisha.Davis@lcmchealth.org>
Sent: Wednesday, December 07, 2022 11:39 AM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

Good Morning.

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the President and Chief Executive Officer at New Orleans East Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Takeisha C. Davis, MD, MPH
President and Chief Executive Officer

New Orleans East Hospital
5620 Read Blvd.
New Orleans, LA 70127

O 504.592.6610
F 504.592.6619

Takeisha.Davis@LCMChealth.org
NOEHospital.org

Freel, Angelique

From: Bonacorso, Rachel D <rbonacor@tulane.edu>
Sent: Wednesday, December 07, 2022 11:49 AM
To: Freel, Angelique
Subject: Support for Tulane LCMC partnership

Dear Attorney General Jeff Landry,

As an employee of Tulane University School of Medicine, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I hope that you will support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,

Rachel Bonacorso
Program Manager, Office of the CBO
Tulane University School of Medicine
+1 504.390.1598(M)
rbonacor@tulane.edu | http://engage.tulane.edu

TULANE
MEDICINE

Dickie Brennan & Co

Office
605 Canal Street
New Orleans, LA 70130
504.521.8313
Fax 504.523.1633
frenchquarter-dining.com

Dickie Brennan's PALACE café
established 1991

DICKIE BRENNAN'S Steakhouse
established 1998

Dickie Brennan's BOURBON HOUSE
established 2002

DICKIE BRENNAN'S TABLEAU
established 2013

Dickie Brennan & Co. CATERING + EVENTS
established 2018

Acorn
A DICKIE BRENNAN & CO. CAFÉ
established 2019

DICKIE BRENNAN & CO.
THE COMMISSARY
MARKET + KITCHEN
established 2020

December 7, 2022

To whom it may concern:

As established business and restaurant owners in the Greater New Orleans area, we are proud to support the proposed Tulane partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Furthermore, teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

We urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,

Dickie Brennan
Managing Partner

Steve Pettus
Managing Partner

Lauren Brennan-Brower
Managing Partner

Freel, Angelique

From: Mallory, Molly E <MOLLY.MALLORY@lcmchealth.org>
Sent: Wednesday, December 07, 2022 11:52 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Strategic Planning Analyst at Children's Hospital New Orleans and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Molly Mallory, MHA
Strategic Planning Analyst

Children's Hospital New Orleans
200 Henry Clay Avenue
New Orleans, LA 70118

C 225.910.0757
D 504.899.0162
Molly.Mallory@lcmchealth.org

Freel, Angelique

From: Gondrella, Darlene <Darlene.Gondrella@lcmchealth.org>
Sent: Wednesday, December 07, 2022 11:55 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Vice President at West Jefferson Medical Center and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Darlene Gondrella
VP, Quality and Service Excellence
West Jefferson Medical Center
LCMC Health

Freel, Angelique

From: Hinyub Jr., Robert S. <Robert.Hinyub2@lcmchealth.org>
Sent: Wednesday, December 07, 2022 11:55 AM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I serve as General Counsel at East Jefferson General Hospital and have seen the value LCMC Health places in high-quality patient care and in employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration.

Rob Hinyub, J.D., CHC
General Counsel
East Jefferson General Hospital
4200 Houma Boulevard
Metairie, LA 70006
O 504.503.5558
D 504.503.4937
Robert.Hinyub2@lcmchealth.org

Freel, Angelique

From: Shedd, Jessica M <jshedd@tulane.edu>
Sent: Wednesday, December 07, 2022 11:59 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Best,
Jessica

Jessica Shedd
Assistant Provost for Assessment & Institutional Research
Tulane University
504.314.2898
jshedd@tulane.edu

Freel, Angelique

From: Sutton, Lauren <Lauren.Sutton@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:05 PM
To: Freel, Angelique
Subject: I Support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Strategic Planning Analyst at Children's Hospital New Orleans and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Lauren Sutton McCaughey
Strategic Planning Analyst

Children's Hospital New Orleans
200 Henry Clay Avenue
New Orleans, LA 70115

O 504.896.9363
C 985.789.3429

Lauren.Sutton@lcmchealth.org

Freel, Angelique

From: Gentry, Maggie E <mgentry1@tulane.edu>
Sent: Wednesday, December 07, 2022 12:06 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

Hello,

My name is Maggie Gentry. I am a mom to a two-year-old boy, Isaiah, I have a great job in Marketing at the Tulane School of Medicine and I care deeply for the city of New Orleans. As a New Orleanian and an employee of Tulane University School of Medicine, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

The partnership between LCMC Health and Tulane University will be transformational for the New Orleans region, and greatly benefit patients, staff, and our community.
It will advance groundbreaking research, innovative technology, and lifesaving treatments that ensure patients and communities can receive the highest quality of care, right here in the greater New Orleans region.

Expanded access to affordable, high-quality care will begin to close the gap in healthcare for historically underserved communities and increase quality of life for all our citizenry. As mission-based organizations, LCMC Health and Tulane working together makes sense.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Maggie Gentry
Clinical Marketing Manager, Office of the CBO
Tulane University School of Medicine
504.313.0046 (M)
mgentry1@tulane.edu | tulanedoctors.com

Schedule a meeting with me: calendly.com/mgentry1

TULANE MEDICINE Tulane DOCTORS Healing People. Defining Medicine.

Freel, Angelique

From: Kathan Dearman <kathan@cypressplanninggroup.com>
Sent: Wednesday, December 07, 2022 12:13 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an resident of Louisiana, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Kathan Dearman

Freel, Angelique

From: Alford-Estrade, Paula <Paula.Estrade@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:13 PM
To: Freel, Angelique
Subject: Tulane University Partnership

Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the Post-Acute Nursing Director at East Jefferson General Hospital LCMC Health Metairie, La and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Paula Alford-Estrade

Paula Alford-Estrade, MSN
Director Post-Acute Nursing
EJGH LCMC Health
4200 Houma Blvd
Metairie, La 70006

O 504-503-4306
C 504-442-1601
F 504-456-5009
Paula.Estrade@lcmchealth.org

Sent from Mail for Windows

Freel, Angelique

From: Sibille, PJ <PJ.Sibille@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:18 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm AVP of Marketing & Communications at LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

PJ Sibille
AVP, Marketing and Communications

LCMC Health
1100 Poydras Street
2500 Energy Centre
New Orleans, LA 70163

D 504.702.3470
C 504.427.7648

PJ.Sibille@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Martin, Jody B. <Jody.Martin@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:19 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the Chief Legal Officer and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jody B. Martin
Chief Legal Officer

LCMC Health
1100 Poydras Street
2500 Energy Centre
New Orleans, LA 70163

O 504.894.6734
C 504.432.0400

Jody.martin@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Ranatza, Mark <Mark.Ranatza@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:20 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Senior Director at Children's Hospital New Orleans and I have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,

Mark Ranatza, MHA, BSN, RN
Senior Director – Emergency and Behavioral Health Services

Children's Hospital New Orleans
Behavioral Health Center
210 State Street, Building 10
New Orleans, LA 70118

O 504.896.7200
D 504.896.7224
C 225.715.8691

Mark.Ranatza@LCMChealth.org
chnola.org

Freel, Angelique

From: Mckendall, Michael <Michael.McKendall@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:25 PM
To: Freel, Angelique
Subject: I support the LCMC Health- Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Vice President of Operations at East Jefferson General Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Michael McKendall MS, PharmD
Vice President of Operations

East Jefferson General Hospital
4200 Houma Blvd.
Metairie, LA 70006

O 504.503.5239
F 504.503.6151

michael.mckendall@LCMChealth.org

Freel, Angelique

From: Robin Barnes <robinaimee99@gmail.com>
Sent: Wednesday, December 07, 2022 12:25 PM
To: Freel, Angelique
Subject: LCMC Health – Tulane University partnership

To Whom it May Concern,

As an resident of Louisiana, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Robin A Barnes

Sent from my iPhone

Freel, Angelique

From: Galindo, Nemy <Nemy.Galindo@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:26 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a project coordinator in facilities management at LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Nemy Galindo
Project Coordinator
Facilities

LCMC Health
200 Henry Clay Avenue
New Orleans, LA 70118

O 504.896.3063

nemy.galindo@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Sterling, Terrie <Terrie.Sterling@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:26 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I lead the effort for NCI designation at LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Terrie P. Sterling

LCMC Health
1100 Poydras Street
Suite 2500
New Orleans, LA 70163

O 504.962.6002
C 225.202.8298

Terrie.Sterling@LCMCHealth.org

Freel, Angelique

From: Norton, Patrick J <pjn@tulane.edu>
Sent: Wednesday, December 07, 2022 12:29 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Patrick Norton

Patrick Norton
SVP/Chief Operating Officer/Treasurer
Tulane University

Freel, Angelique

From: Scofield, Carolyn M <cscofiel@tulane.edu>
Sent: Wednesday, December 07, 2022 12:41 PM
To: Freel, Angelique
Subject: I support the Tulane University/LCMC partnership

I've been an employee of Tulane University since 2015, and I work closely with all of our wonderful physicians, researchers and students. I'm also a patient at Tulane, and I benefit from the services and support I receive from all the doctors, nurses and staff here. I'm proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Thank you,
Carolyn

Carolyn Scofield
Assistant Director of Marketing & Communications
Tulane University School of Medicine
(504) 881-4542 cell
scofield@tulane.edu

Want to schedule a meeting? Here's my availability:
https://calendly.com/cscofiel

TULANE
MEDICINE

Freel, Angelique

From: Shankar, Jai <jshankar@tulane.edu>
Sent: Wednesday, December 07, 2022 12:41 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jai Shankar
AVP Strategic Consulting and Project Management
Tulane University

Freel, Angelique

From: Perry, Erin <Erin.Perry2@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:42 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Vice President at University Medical Center and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Erin E. Perry, MS.Ed, PMP, SHRM-SCP
She/her

LCMC Health
Vice President - Talent Development
2000 Canal Street, Tower 2 - Human Resources
New Orleans, LA 70112
erin.perry2@LCMChealth.org

Freel, Angelique

From: Carbajal, Donna M. <Donna.Carbajal@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:46 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Sr. Director of Quality at LCMC East Jefferson General Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Donna Carbajal RN, RRT, RRT-NPS, MBA, CJCP
Senior Director of Quality, Organizational Effectiveness,
Nursing Education, Medical Staff Office, Volunteer/Guest Services

EJGH LCMC Health
4200 Houma Blvd.
Metairie, LA 70006

C 504.236.3404
D 504.503.6959
F 504.503.5256

Donna.Carbajal@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Kyle Ruckert <kyle@boldstrategiesllc.com>
Sent: Wednesday, December 07, 2022 12:51 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Kyle Ruckert
1557 Brame Drive Baton Rouge, LA

Freel, Angelique

From: Brewton, Christe <Christe.Brewton@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:52 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a LCMC Health System Assistant Vice President for Patient Access Services and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Christe

Christe Brewton LOTR, MBA
System Assistant Vice President
Patient Access Services

LCMC Health Westpark
3401 General DeGaulle Drive
New Orleans, LA 70124

O 504.702.5027
D 504.702.4385
F 504.896.6630

Christe.Brewton@LCMChealth.org

Freel, Angelique

From: McLachlan, Ian P <imclachlan@tulane.edu>
Sent: Wednesday, December 07, 2022 12:54 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

Hello!

As an employee of Tulane Medical School, I just wanted to pledge my support for the proposed Tulane/LCMC partnership. I'm excited about the possibilities that this partnership could offer to medical education in New Orleans, and it could really affect the city for the better. Teaching hospitals are incredibly important for the next generation of doctors, and Tulane being able to partner with LSU and LCMC is a positive step in creating more opportunities. I'm especially excited about the potential for a nursing program at Tulane, as I know the shortage of nurses has been affecting the entire country.

Thank you for your consideration!

Ian McLachlan | Multimedia Specialist
Tulane University School of Medicine - Marketing & Communications
Hutchinson Bldg-Rm 1550, 1430 Tulane Avenue, New Orleans, LA 70112
Mobile: 504.444.6424
Pronouns: he/him

Freel, Angelique

From: Linda Lee <lee33br@gmail.com>
Sent: Wednesday, December 07, 2022 12:54 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration.

Linda Lee

Freel, Angelique

From: Vitter, Meg <Meg.Vitter@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:56 PM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Vice President of Population Health at LCMC Health on the corporate leadership team and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Meg Vitter
VP, Population Health & Network Development

LCMC Health
1100 Poydras Street
2500 Energy Center
25th Floor, Office 2555
New Orleans, LA 70163
(504) 896-3049

Freel, Angelique

From: DK Willard <dkwillard1419@gmail.com>
Sent: Wednesday, December 07, 2022 12:57 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration

DK Willard
809 K St
Monroe, LA 71201

Freel, Angelique

From: Ortego, Amanda C <aortego@tulane.edu>
Sent: Wednesday, December 07, 2022 12:58 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

Good afternoon,

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration.

Amanda Ortego
Senior Treasury Analyst | Tulane University
1555 Poydras Street, Suite 862
Mailbox #8705
New Orleans, Louisiana 70112
Office: (504)314-2892

Freel, Angelique

From: Dietrich, Damon <damon.dietrich@lcmchealth.org>
Sent: Wednesday, December 07, 2022 12:58 PM
To: Freel, Angelique
Subject: Free LA

Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Damon Dietrich MD
West Jefferson Medical Center
1101 Medical Center Boulevard Marrero LA 70072

Freel, Angelique

From: Shayne Benedetto <shaynebenedetto@gmail.com>
Sent: Wednesday, December 07, 2022 12:59 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

--

Shayne Benedetto
CCA Louisiana
Board Member - East Jefferson Chapter
shaynebenedetto@gmail.com

Freel, Angelique

From: Josh Collen <jcollen@hriproperties.com>
Sent: Wednesday, December 07, 2022 12:59 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration,

Josh Collen
President

HRI COMMUNITIES

504-566-3058 direct
504-566-0204 main
504-377-7364 mobile

Elevating the Urban Experience
hricommunities.com

Freel, Angelique

From: Kathy Willard <kthwillard23@gmail.com>
Sent: Wednesday, December 07, 2022 1:00 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Kathy Willard
809 K St
Monroe, LA 71201

Freel, Angelique

From: Elder, Jeffrey <Jeffrey.Elder@lcmchealth.org>
Sent: Wednesday, December 07, 2022 1:01 PM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm an emergency physician at University Medical Center and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jeffrey Elder, MD
Medical Director
Emergency Management | Transfer Center

LCMC Health
1100 Poydras Street
2500 Energy Centre
New Orleans, LA 70163

Freel, Angelique

From: Lu Jones <finkshideaway@gmail.com>
Sent: Wednesday, December 07, 2022 1:02 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Lu Jones, RN
1419 Finks Hideaway Rd
Monroe, LA 71203

Freel, Angelique

From: Valerie Norton <valeriemiller@gmavt.net>
Sent: Wednesday, December 07, 2022 1:03 PM
To: Freel, Angelique
Subject: Support for Tulane and LCMC Partnership

As resident of New Orleans – I couldn't be happier about the proposed partnership between Tulane and LCMC – and I am proud to strongly endorse it. Academic medical centers create and provide new treatments, and they provide the most complex and high-quality care – and would be most beneficial to all the residents of our region. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Valerie Norton
New Orleans, LA

Freel, Angelique

From: Walter Zollinger <walterzollinger5@gmail.com>
Sent: Wednesday, December 07, 2022 1:05 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Walter Zollinger
3805 Placid Dr.
Monroe LA 71201

Freel, Angelique

From: ernest mitchel <ernest.mitchel@gmail.com>
Sent: Wednesday, December 07, 2022 1:06 PM
To: Freel, Angelique

Copy and paste into a new email - FREELA@AG.LOUISIANA.GOV (mailto:FREELA@AG.LOUISIANA.GOV)

Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Ernest Mitchel
6611 Ellen Drive
Lake Charles, La 70607

Freel, Angelique

From: Matthew J. Rainwater <mattjrainwater@gmail.com>
Sent: Wednesday, December 07, 2022 1:12 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Matt Rainwater
4715 East Greenfield Circle
Lake Charles, LA 70605

Freel, Angelique

From: Elizabeth Crawford <elizcrawford@gmail.com>
Sent: Wednesday, December 07, 2022 1:15 PM
To: Freel, Angelique
Subject: Support for TU/LCMC partnership

As an resident of Louisiana, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,

Elizabeth Crawford

Freel, Angelique

From: Caitlin Berni <caitlin@berniconsulting.com>
Sent: Wednesday, December 07, 2022 1:18 PM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

Dear Attorney General Landry and Team,

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Thank you,

Caitlin Berni
6701 Canal Blvd
New Orleans, LA 70124

Freel, Angelique

From: Mark Heck <markh@studiorisedesign.com>
Sent: Wednesday, December 07, 2022 1:18 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

--

studioRISE
Mark Heck, *AIA*
1541 Tulane Avenue
New Orleans, LA 70112
Principal
504.430.0076
studiorisedesign.com

Freel, Angelique

From: Mark Heck <markh@studiorisedesign.com>
Sent: Wednesday, December 07, 2022 1:18 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

--

studioRISE
Mark Heck, *AIA*
1541 Tulane Avenue
New Orleans, LA 70112
Principal
504.430.0076
studiorisedesign.com

Freel, Angelique

From: P Rainwater <rainwater97@gmail.com>
Sent: Wednesday, December 07, 2022 1:22 PM
To: Freel, Angelique
Subject: Support letter

Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Paul Rainwater
5117 Cheneau lane
Baton Rouge, La 70808

Sent from my iPhone

Freel, Angelique

From: Dawn Bonnecaze <Dawn.Bonnecaze@bblawla.com>
Sent: Wednesday, December 07, 2022 1:26 PM
To: Freel, Angelique
Subject: Support LCMC Health - Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration.

Dawn Bonnecaze

Dawn Dietrich Bonnecaze
Bienvenu, Bonnecaze, Foco & Viator, LLC
4210 Bluebonnet Boulevard
Baton Rouge, Louisiana 70809
(225) 388-5600 Main
(225) 388-5602 Direct
(225) 388-5622 Fax
(225) 354-5872 Cell
dawn.bonnecaze@bblawla.com
www.bblawla.com

Freel, Angelique

From: Lorio, Melissa J. <Melissa.Lorio@lcmchealth.org>
Sent: Wednesday, December 07, 2022 1:35 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Senior Director of Perioperative Services at LCMC East Jefferson General Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Melissa Lorio, MBA, BSN, RN, CNOR
Perioperative and Surgical Services, Senior Director

O 504.503.4335

East Jefferson General Hospital
4200 Houma Blvd.
Metairie, LA 70006

melissa.lorio@LCMChealth.org

eigh.org

Freel, Angelique

From: Nic Hunter <nhunter@cityoflc.us>
Sent: Wednesday, December 07, 2022 1:40 PM
To: Freel, Angelique
Subject: I Support the LCMC Health/Tulane University Partnership

To Whom It May Concern,

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Nic Hunter
Mayor, City of Lake Charles

326 Pujo St.
Lake Charles, LA 70601

Freel, Angelique

From: sarah [lady in a tie] <sarah.kracke@sarahkracke.com>
Sent: Wednesday, December 07, 2022 1:41 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

To Whom It May Concern:
I am writing to express my solid support for the proposed partnership between Tulane and LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care.

In particular, teaching hospitals provide patients with increased access to the latest medical breakthroughs and clinical trials. Along with LSU and LCMC, Tulane will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health –Tulane University partnership.
Sincerely,
Sarah Kracke

kracke consulting
IDEAS | SOLUTIONS | EXECUTION

543 Spanish Town Road
Baton Rouge, LA 70802
c [504] 289-3537
o [225] 381-0166 x120

Freel, Angelique

From: Alexandra napoli <alexandra@milieuandyou.net>
Sent: Wednesday, December 07, 2022 1:42 PM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, Covington, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Alexandra Napoli
15615 Linden View Road
Baton Rouge La 70817

Thanks very much.

Freel, Angelique

From: Daniel Zollinger <danielfz7@yahoo.com>
Sent: Wednesday, December 07, 2022 1:42 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Daniel Zollinger
3805 Placid Dr.
Monroe LA 71201

Freel, Angelique

From: Kaplow, Julie B <JULIE.KAPLOW@lcmchealth.org>
Sent: Wednesday, December 07, 2022 1:43 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I serve as Executive Director of the Trauma and Grief Center at the Children's Hospital New Orleans and Professor of Psychiatry at Tulane University School of Medicine and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,

Julie Kaplow

Julie B. Kaplow, PhD, ABPP
Executive Director, Trauma and Grief Center
Children's Hospital New Orleans
210 State Street, Bldg. 10, Rm. 1118
New Orleans, LA 70118
Julie.Kaplow@lcmchealth.org
Cell: 734.355.9227

Freel, Angelique

From: Sumrall, Joshua <Joshua.Sumrall@lcmchealth.org>
Sent: Wednesday, December 07, 2022 1:43 PM
To: Freel, Angelique
Subject: Tulane/LCMC

I fully support the acquisition of Tulane facilities to LCMC. I believe it will ultimately increase access to care as well as providing higher quality of services to patients in our community.

Josh

Joshua Sumrall, MBA, BSN, RN, NEA-BC
Assistant Vice President, Patient Services

East Jefferson General Hospital
4200 Houma Blvd
Metairie, LA 70006

O 504.503.5809
C 985.226.5024

Joshua.sumrall@LCMChealth.org

Freel, Angelique

From: Roy, Dean <Dean.Roy@lcmchealth.org>
Sent: Wednesday, December 07, 2022 1:44 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Vice President of Physician Services at West Jefferson Medical Center and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Dean Roy
Vice President of Physician Services

West Jefferson Medical Center / Physician Services
1111 Medical Center Blvd
Suite S670
Marrero, LA 70072

O 504.349.2460
C 504.909.2476
F 504.349.6740

dean.roy@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Delafontaine, Patrice <pdelafon@tulane.edu>
Sent: Wednesday, December 07, 2022 1:44 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane Medical School, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

P. Delafontaine MD, FACC, FACP, FAHA, FESC
Executive Dean
Jack R. Aron Chair of Administrative Medicine
Professor of Medicine, Physiology and Pharmacology
Tulane University Health Sciences Center

Freel, Angelique

From: Poirrier, Brittany L <brittany.poirrier@lcmchealth.org>
Sent: Wednesday, December 07, 2022 1:46 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

To whom it may concern,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a clinical pharmacist at LCMC Health Pharmacy Services and I have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Brittany Poirrier, PharmD, MHA
Clinical Pharmacist, Specialty Pharmacy

LCMC Health Specialty Pharmacy
Children's Hospital New Orleans
200 Henry Clay Avenue Suite 2107
New Orleans, LA 70118

O 504.896.7780
C 504.638.3266

brittany.poirrier@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Michael Enlow <menlow@cgagroup.com>
Sent: Wednesday, December 07, 2022 1:47 PM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Mike Enlow
304 Laurel Street 1A
Baton Rouge, LA

Freel, Angelique

From: Michael Enlow <mikeenlow@icloud.com>
Sent: Wednesday, December 07, 2022 1:49 PM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Mike Enlow
304 Laurel Street 1A
Baton Rouge, LA

Freel, Angelique

From: Jill Israel <jisraelnola@gmail.com>
Sent: Wednesday, December 07, 2022 1:53 PM
To: Freel, Angelique
Subject: In support of the LCMC Health / Tulane University Partnership

Good afternoon. I am currently the Board chair of Touro Infirmary, one of the LCMC hospitals and on the LCMC Board. I have been on the Touro Infirmary board for more than 6 years and have seen and experienced the high-quality patient care provided by Touro. As a member of the LCMC Board, I see the LCMC system plans, actions, and results. I see how LCMC values its staff. I see the dedication to improving healthcare outcomes for its patient population. I am proud to be on these Boards.

I write in support of the proposed partnership between Tulane University and LCMC Health. Bringing Tulane hospitals in to the LCMC Health system creates new and expanded opportunities for research, medical education, patient care, and increased medical industry employment and investment in this region. This is truly transformationally positive!

I urge you to support this proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jill Israel
(504) 782-1199

Freel, Angelique

From: Rayes, Jerri <Jerri.Rayes@lcmchealth.org>
Sent: Wednesday, December 07, 2022 2:00 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jerri Lynn Rayes
Executive Assistant to Chief Legal Officer

LCMC Health
1100 Poydras St., Ste. 2500
New Orleans, LA 70163

O 504.894.6735
F 504.896.3088

Jerri.Rayes@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Christian, Claiborne M <cchrist6@tulane.edu>
Sent: Wednesday, December 07, 2022 2:02 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

To whom it may concern,

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplaces of new treatments and technologies, and they provide the most complex and high-quality care to patients. These teaching hospitals provide patients with increased access to the latest medical breakthroughs and clinical trials. Tulane, along with LSU and LCMC, will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

This initiative is especially important to me as an employee within the Tulane University Innovation Institute. The proposed partnership will catalyze biomedical innovations that we can help germinate and nurture; innovations that will ultimately benefit not only our region, but will help solidify the state as a source of cutting-edge medical breakthroughs and care that the entire country can one day benefit from.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Warmest regards,

-Clay

Claiborne M. Christian, PhD
Director of Commercialization Intelligence and Assessment
Tulane University | Innovation Institute
504.909.3905
christian@tulane.edu
LinkedIn

Freel, Angelique

From: David, Blair <bdavid3@tulane.edu>
Sent: Wednesday, December 07, 2022 2:04 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Blair David, MBA, CIA
Director of Internal Audit
Tulane University
1555 Poydras, Suite 842
New Orleans, LA 70112
(504) 314-2899 – Direct
(504) 352-4198- Cell
(855) 5GO-WAVE - Fraud Hotline

Freel, Angelique

From: Craig Belden <craigbelden@gmail.com>
Sent: Wednesday, December 07, 2022 2:04 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Good afternoon,

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Craig Belden

900 Camp St.

New Orleans, LA 70130

If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Freel, Angelique

From: Hailey, Robert C <rhailey@tulane.edu>
Sent: Wednesday, December 07, 2022 2:04 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Rob Hailey

Robert C. Hailey (He/Him)
Executive Director, Tulane University Leadership Institute
Tel 504-247-1121

Sent from a mobile device

Freel, Angelique

From: Keith Crawford <klc@loftingroup.com>
Sent: Wednesday, December 07, 2022 2:04 PM
To: Freel, Angelique
Subject: Support for LCMC Tulane partnership

To whom it may concern,

As a resident of Louisiana, I am proud to support the proposed partnership with LCMC.

Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I strongly urge you to support the proposed LCMC Health – Tulane University partnership. We are very supportive of this and

Thank you for your consideration.

Keith L. Crawford
Founder / Principal
The Loftin Group LLC
935 Gravier St, Ste 1006
New Orleans, LA 70112
p | 504.717.3821
klc@loftingroup.com

Freel, Angelique

From: Catherine Favrot <cfavrot@cox.net>
Sent: Wednesday, December 07, 2022 2:08 PM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Catherine Favrot

1904 Palmer Ave.

New Orleans, LA 70118

Freel, Angelique

From: Matt Hughes <matt@mattphughes.com>
Sent: Wednesday, December 07, 2022 2:14 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Matt Hughes
8242 Wildwood Dr.
Denham Springs, La. 70706
--
Matt Hughes
Realtor
Keller Williams Realty Premier Partners
291 Veterans Blvd.
Denham Springs, La. 70726
225-664-1911
225-416-0100

Freel, Angelique

From: anna-kate France <akfrance15@gmail.com>
Sent: Wednesday, December 07, 2022 2:15 PM
To: Freel, Angelique
Cc: Kyle France
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Anna-Kate France
3421 N Causeway Blvd.
Suite 105
Metairie, La 70002

Freel, Angelique

From: Jackson Landry <jackson@idealstrategiesla.com>
Sent: Wednesday, December 07, 2022 2:19 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jackson Landry
3530 Stowers Drive, Monroe, Louisiana 71201

Freel, Angelique

From: Lopez, Ana M <lopez@tulane.edu>
Sent: Wednesday, December 07, 2022 2:21 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership.
Thank you for your consideration.

Ana M. Lopez

Ana M. López
Professor and Chair of Communication
Associate Provost for Faculty Affairs and Director,
Cuban and Caribbean Studies Institute
Office of Academic Affairs
200 Gibson Hall
Tulane University
New Orleans, LA 70118
(504) 865-5261

Freel, Angelique

From: Sarah Feirn <sarahsfeirn@gmail.com>
Sent: Wednesday, December 07, 2022 2:24 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sarah Feirn
1222 Jena St
New Orleans, La 70115

Sent from my iPhone

Freel, Angelique

From: Elizabeth Wooten <elizsmart@gmail.com>
Sent: Wednesday, December 07, 2022 2:23 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Hi,

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Elizabeth Wooten

12 Lasalle Place

New Orleans, LA 70118

Freel, Angelique

From: Justin Crossie <justincrossie@hotmail.com>
Sent: Wednesday, December 07, 2022 2:28 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Dear Attorney General Landry:

It has come to my attention that LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Justin Crossie
206 Wildwood Dr.
Hammond, LA
70401

Get Outlook for iOS

Freel, Angelique

From: Kara Schonberg <karaschonberg@gmail.com>
Sent: Wednesday, December 07, 2022 2:29 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Kara Schonberg
(504) 864-3177
484 Walnut Street
New Orleans LA 70118

Sent from my iPhone

Freel, Angelique

From: Justin Crossie <justincrossie@hotmail.com>
Sent: Wednesday, December 07, 2022 2:30 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Dear Attorney General Landry:

It has come to my attention that LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Mary Beth Crossie
206 Wildwood Dr.
Hammond, LA

70401

Get Outlook for iOS

Freel, Angelique

From: Nielsen, Gregory A <Gregory.Nielsen@lcmchealth.org>
Sent: Wednesday, December 07, 2022 2:31 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

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I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Greg Nielsen
Chief Operating Officer

LCMC Health
1100 Poydras Street
2500 Energy Centre
New Orleans, LA 70163

O 504.702.2673

Freel, Angelique

From: Albert, Christine <Christine.Albert@lcmchealth.org>
Sent: Wednesday, December 07, 2022 2:32 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Christine Albert, MPP, APR
Chief Marketing & Experience Officer

LCMC Health
1100 Poydras Street
Suite 2500
New Orleans, LA 70163

O 504.896.9345
C 504.460.3822

Christine.albert@LCMChealth.org
LCMChealth.org

TULANE UNIVERSITY
DEPARTMENT of PSYCHIATRY
& BEHAVIORAL SCIENCES

Chairman's Office

SCHOOL OF MEDICINE
Department of Psychiatry and Behavioral Sciences
1440 Canal St., Mail Code 8448, New Orleans, Louisiana 70112
(504) 988-5246 | Fax (504) 988-4270

December 7, 2022

The Honorable Jeff Landry
Attorney General of the State of Louisiana
Louisiana Department of Justice
freela@ag.louisiana.gov

Re: Support for Tulane-LCMC Partnership

Dear Mr. Attorney General,

As an employee of Tulane Medical School, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. These technologies and treatments are often the drivers of growth, which create industries and jobs that improve quality of life for the entire region. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane, along with LSU and LCMC, will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

LCMC Health and Tulane University are mission-based organizations that call Southeast Louisiana home. We have shared values and a vision to partner to bring the best of community healthcare and academic medicine to all those we serve. The partnership between LCMC Health and Tulane University will be transformational for the New Orleans region, and greatly benefit patients, staff, and our community. It will advance groundbreaking research, innovative technology, and lifesaving treatments that ensure patients and communities can receive the highest quality of care, right here in the greater New Orleans region. It will also expand opportunities to train the next generation of physicians, nurses, and scientists—Tulane University's new nursing program will create new paths and expand the pipeline of students eager to enter the nursing field, making meaningful progress towards addressing the projected 2,475 unfilled full-time nursing positions projected in New Orleans by 2025.

This partnership will also increase access to comprehensive care in downtown New Orleans and create new hubs for specialty care, innovation, and academic medicine in both Orleans and Jefferson Parishes. The organizations involved will be collaborating and working together to put patients' best interests first to make great things happen.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Very truly yours,

John W. Thompson, Jr., MD
Professor and Chair
Department of Psychiatry and Behavioral Sciences
Director, Division of Forensic Neuropsychiatry
Tulane University School of Medicine

Freel, Angelique

From: MARY WARREN <mwarren100@aol.com>
Sent: Wednesday, December 07, 2022 2:42 PM
To: Freel, Angelique
Subject: Tulane/partnership

As an resident of Louisiana, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,
Mary Warren
Baton Rouge, LA

Sent from my iPhone

Freel, Angelique

From: Porter, Dusty D <jporter6@tulane.edu>
Sent: Wednesday, December 07, 2022 2:43 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane, along with LSU and LCMC, will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

J. Davidson "Dusty" Porter
3612 Camp Street, New Orleans, LA 70115

Freel, Angelique

From: Eckstein, Adam J <Adam.Eckstein@lcmchealth.org>
Sent: Wednesday, December 07, 2022 2:46 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm an Associate Corporate Counsel at LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Adam J. Eckstein
Associate Corporate Counsel

LCMC Health
Suite 2500, Office 2403
1100 Poydras Street
New Orleans, LA 70163

O 504.896.3048
C 901.489.1150

Adam.Eckstein@LCMChealth.org
www.LCMCHealth.org

Freel, Angelique

From: Heaton, John <John.Heaton@lcmchealth.org>
Sent: Wednesday, December 07, 2022 2:49 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

John F. Heaton, MD
President and Chief Medical Officer
LCMC Health
1100 Poydras St., 25th Floor
New Orleans, LA 70163
O 504.896.3035
C 504.432.2010
D 504.894.6702
John.Heaton@LCMCHealth.org
LCMChealth.org

Freel, Angelique

From: Suzie Terrell <suzieterrell@gmail.com>
Sent: Wednesday, December 07, 2022 2:49 PM
To: Freel, Angelique
Subject: Tulane Merger: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, Covington, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Suzie Terrell
suzieterrell@gmail.com
(504) 952-4252

Sent from my iPhone

Freel, Angelique

From: Jeff Hardin <JHardin@SimmsHardin.com>
Sent: Wednesday, December 07, 2022 2:49 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

To whom it may concern:

As a resident of Louisiana, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jeff Hardin

Freel, Angelique

From: Morrison, Ian <imorrison@tulane.edu>
Sent: Wednesday, December 07, 2022 2:52 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

Dear Attorney General Landry,

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane, along with LSU and LCMC, will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration.

Best regards,
Ian Morrison
6823 St. Charles Avenue
Suite 215, Gibson Hall
New Orleans LA, 70118

Freel, Angelique

From: Sherlock, Misty <Misty.Sherlock@lcmchealth.org>
Sent: Wednesday, December 07, 2022 3:00 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Misty Sherlock
3705 Palmisano Blvd
Chalmette, La 70043

Misty Sherlock, DNP, MHA, APRN, FNP-C, CCM
LCMC, AVP Case Management

LCMC Health
1100 Poydras St.
2500 Energy Centre
New Orleans, LA 70163

O 504.896.3016
C 504.915.3351
Misty.Sherlock@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Robinson, Brett
Sent: Wednesday, December 07, 2022 3:06 PM
To: Freel, Angelique
Subject: FW: Tulane Hearing
Attachments: Landry.docx; ATT00001.htm

From: David Ziccardi <ziccardi06@yahoo.com>
Sent: Wednesday, December 7, 2022 3:03 PM
To: Robinson, Brett <RobinsonBr@ag.louisiana.gov>
Subject: Tulane Hearing

Mr. Robinson

My name is David Ziccardi. I am a nurse at Tulane. I wanted to speak at the hearing tomorrow but have a commitment out of town.

Please include this letter as my contribution to the discussions. I have forwarded it from an email I sent to Lingran Kong who directed me to you.

Thank you
David

Begin forwarded message:

> **From:** David Ziccardi <ziccardi06@yahoo.com>
> **Date:** December 7, 2022 at 04:06:38 AST
> **To:** LKong@calnurses.org
> **Subject: David Hearing Statement**
>
> Lingran -
>
> If it's possible, attached is a letter to be used as a statement for the hearing.

The information contained in this transmission may contain privileged and confidential information. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby

David Ziccardi
1415 Tulane Ave
New Orleans, LA 70118
12/08/22

Attorney General Landry
1885 N. 3rd Street
Baton Rouge, LA 70802

Dear Attorney General Landry:

My name is David Ziccardi. I am a registered nurse at Tulane Hospital in the Emergency Room and the Post Anesthesia Care Unit. I have been in medicine and/or the emergency services my entire life, 15 of which have been at Tulane.

I am writing to express my concern about the pending sale of Tulane Hospital to Louisiana Children's Medical Center and request that you either deny the sale or place it on hold until further details can be worked out. There are many concerns that have been expressed such as the duopoly that would be created, the likely rise in health care costs, and the lack of communication from the parties involved. I would however like to look at some operational aspects that I do not believe have been addressed by the corporations.

One of the proposals is to shut down Tulane Hospital. Tulane is one of two hospitals in downtown New Orleans and the closest to the French Quarter. University Medical Center (UMC) is a Level 1 trauma center located approximately 3 blocks North on the other side of the interstate. Tulane's emergency room routinely has patients come over citing 10+ hours sitting in their waiting room. New Orleans Police routinely bring psychiatric patients to Tulane stating they were told by UMC to go to Tulane because of extended wait times. How will UMC absorb not only those patients but the ones that Tulane treats exclusively? Can UMC open and staff an equal number of beds that are in Tulane's Emergency Room? Based on present conditions it is extremely unlikely.

Another issue is New Orleans Emergency Medical Services. (NOEMS). NOEMS runs approximately 5 ambulances for a city of almost 400,000. They routinely rely on Acadian and other ambulance services to handle the calls they can not service. If services are transferred to Jefferson Parish as it has been stated, how can NOEMS maintain even this level of service if patients are requesting transport out of the parish? As NOEMS has told us in the past, you have to transport the patient where they request or it is kidnapping otherwise. Longer transport times means fewer ambulances available to take emergency calls. Perhaps the patient could be convinced to go to a local hospital but once again are those hospitals resourced to handle this influx of patients?

Finally, and most importantly, I would like this hearing to consider the sale from the patient's perspective. The census bureau estimates that 23% of New Orleans population lives in poverty. Many of the patients and some of the employees of Tulane rely on public transportation, family and/or friends to get to their medical appointments/ jobs. It is not uncommon for patients to express they missed a dialysis treatment or a doctor's appointment because they have no transportation. It is also not uncommon for patients to activate 911 with a minor complaint to secure a ride to the clinics. If patients struggle to make appointments that are in the parish, how will they make appointments if services are moved out of the parish as has been proposed? This would be a huge hurtle for many of our patients to overcome and compliance with medical treatment plans will certainly decrease.

Although there are numerous issues at hand, the nurses at Tulane are willing to help address these operational issues and perhaps make this a win/win situation. To that end, I am again asking that you either deny or place on hold this sale until there is input from the nurses on the conditions of the proposed sale and there is more transparency from HCA and LCMC about the process.

Sincerely,
David Ziccardi

Freel, Angelique

From: Carling Dinkler <carling@customconventions.com>
Sent: Wednesday, December 07, 2022 3:09 PM
To: Freel, Angelique
Subject: Tulane Hospital/LCMC

My name is Carling Dinker and I live in the greater New Orleans area. As someone who has been a patient in many area hospitals in the last year, I am in support of the LCMC Health / Tulane University transaction.

Tulane, University and Turo Hospitals are three of the hospitals I have used this past year. I was excited when I read about the intended purchase by LCMC Health as it will provide expertise and depth in our medical care. I know they will do a great job at the Tulane hospital because they really care about people.

Sincerely,

Carling Dinkler

507 Mandeville Street

New Orleans, LA 70117

--

Freel, Angelique

From: Dumont, Aaron S <adumont2@tulane.edu>
Sent: Wednesday, December 07, 2022 3:11 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership
Attachments: COPA-Letter of support.pdf

Please find attached a letter in strong support of the proposed Tulane-LCMC partnership.

Sincerely,
Aaron Dumont

Aaron S. Dumont, MD, MBA, FACS, FAHA
Associate Dean & Vice President of Health System Clinical Affairs
Director, Tulane Center for Clinical Neurosciences
Charles B. Wilson Professor & Chair
Department of Neurosurgery
Professor of Pediatrics
Tulane University School of Medicine
131 South Robertson St., Suite 1300
New Orleans, LA 70112
Phone # 504-988-5565
Fax# 504-988-5793
EMERGENCY PATIENT TRANSFER #
1-855-522-3648
E-mail: adumont2@tulane.edu

Freel, Angelique

From: Camille Nelson <camille.nelson8@yahoo.com>
Sent: Wednesday, December 07, 2022 3:27 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Camille Nelson
Baton Rouge, LA

Freel, Angelique

From: Bluffstone, Zoe <Z.Bluffstone@mail.house.gov>
Sent: Wednesday, December 07, 2022 11:51 AM
To: Freel, Angelique
Subject: Public Comment from Congressman Carter on LCMC - Tulane Partnership

Good afternoon,

On behalf of Congressman Troy Carter, I would like to submit a public comment for the December 8th public hearing for the LCMC Health – Tulane partnership.

Congressman Troy A. Carter, Sr.:

"This is a pivotal moment not just for Tulane University and LCMC Health, but also for the wider community's health and wellness. This extraordinary partnership will allow these powerhouse institutions to combine their collective strengths to not only reach more patients, but also to enhance patient care to the highest level. The long-term potential of this partnership's impact on the clinical, economic, and educational innovation is enormous, and I am thrilled to celebrate this partnership that will help improve quality of life across the entire region."

Thank you,
Zoe

Zoe Bluffstone (she/her)
Communications Director
Congressman Troy A. Carter Sr. (LA-02)
(202) 819-6372 (c)
z.bluffstone@mail.house.gov

Freel, Angelique

From: Joshua Cox <joshua.cox08@gmail.com>
Sent: Wednesday, December 07, 2022 3:35 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

To whom it may concern:

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Josh Cox
3113 Orleans Ave
New Orleans, LA 70119

Freel, Angelique

From: Leslie Leavoy <lleavoy1@gmail.com>
Sent: Wednesday, December 07, 2022 3:43 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

To Whom It May Concern:

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Regards,

Leslie A. Leavoy

1463 Mithra St.

New Orleans, LA 70122

--

Leslie A. Leavoy
lleavoy1@gmail.com
337.401.8881

Freel, Angelique

From: Scanlon, Judy <Judy.Scanlon@lcmchealth.org>
Sent: Wednesday, December 07, 2022 3:54 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Judy R Scanlon BSN, RN
Senior Director of Acute and Telemetry Services
East Jefferson General Hospital
LCMC Health
Judy.Scanlon@LCMCHealth.org

Freel, Angelique

From: Olsen, Christopher <Christopher.Olsen@lcmchealth.org>
Sent: Wednesday, December 07, 2022 4:00 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Christopher Olsen

105 Chateau Papillon
Mandeville, LA. 70471

Freel, Angelique

From: Allen, Ann Marie <AMAllen@libertybank.net>
Sent: Wednesday, December 07, 2022 4:01 PM
To: Freel, Angelique
Subject: I support the LCMC Health, Tulane University Partnership

Good afternoon,

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Alden J. McDonald, Jr.
Chief Executive Officer
Liberty Bank and Trust Company
Phone: 504-240-5161
Email: ajmcdonald@libertybank.net
6600 Plaza Drive, Suite 600
New Orleans, LA 70127
www.libertybank.net

bank shall be understood as neither given nor endorsed by it. Thank You. The information contained in this transmission may contain privileged and confidential information. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Freel, Angelique

From: Judy Scanlon <jscanlonrn@yahoo.com>
Sent: Wednesday, December 07, 2022 4:01 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Judy Scanlon

21 St Thomas Drive
Kenner, La
70065

Freel, Angelique

From: Catherine Harrell <cstephens.harrell@gmail.com>
Sent: Wednesday, December 07, 2022 4:03 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Catherine S. Harrell
3955 S. Ramsey Drive
Baton Rouge, LA 70808

Freel, Angelique

From: L. Narcisse <llnarcis@gmail.com>
Sent: Wednesday, December 07, 2022 4:05 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

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I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Sincerely,
Liana Narcisse
Louisiana Resident

--
Good judgment comes from experience, and experience comes from bad judgment.
- Barry LePatner

Freel, Angelique

From: Fitz-Ritson, Aja N <aja.fitzritson@lcmchealth.org>
Sent: Wednesday, December 07, 2022 4:08 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm an Executive Coordinator at LCMC Health – Corporate and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Aja Fitz-Ritson
Executive Coordinator

LCMC Health
1100 Poydras St.
2500 Energy Centre
New Orleans, LA 70163

O: 504.702.4267
C: 904.566.0745

Freel, Angelique

From: Parks, Jennifer L <Jennifer.Parks@lcmchealth.org>
Sent: Wednesday, December 07, 2022 4:11 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm the Chief Administrative Officer at East Jefferson General Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Freel, Angelique

From: Muller, Windie V. <Windie.Muller@lcmchealth.org>
Sent: Wednesday, December 07, 2022 4:13 PM
To: Freel, Angelique
Subject: LCMC East Jefferson General Hospital Team Member

To Whom It May Concern,

Thank you in advance for the opportunity to share this letter with you.

My name is Windie Vignes Muller, Senior Director of Post Acute Services at East Jefferson General Hospital (EJGH). I am entering my 40th year in the healthcare field and it is truly been a privilege to service the Jefferson Parish and Orleans community over many years. I am a native of Metairie, Louisiana and am extremely committed and dedicated to the field of Rehabilitation. I currently manage the Inpatient Rehab Unit, the Skilled Nursing Unit, the Geriatric Behavioral Unit, the Wellness Center, Outpatient Rehabilitation and the Physical, Occupational and Speech Therapy teams.

My letter to you is to share the positive outcomes that EJGH has experienced since we were purchases by LCMC. Our team was most familiar with LCMC since they were managing Children's Hospital, West Jefferson Medical Center, Touro, and New Orleans East Hospital and Touro. It was an exciting day when we found out that LCMC was going to buy us and fully commit to our organization and the community. EJGH was unable to survive independently without becoming a part of a health system. We were fortunate to have LCMC purchase EJGH and now we have become a part of a health system that I am most proud to work with.

Over my years of working in many hospitals in the New Orleans area, LCMC healthcare has been a breath of fresh air to us at EJGH. The best part is that LCMC has continued the great personalized culture we have here and added even more to make us extraordinary!! Our team has felt most welcomed to become part of LCMC as of day one. LCMC has a personal touch with care that makes us more than a number. We actually feel part of a great team that serves many across our community. In addition, shortly after the purchase, we were quick to see capital dollars roll into EJGH with upgrades on the exterior part of the building to enlarging the Emergency Department and the Surgery Department. It means a lot to see the hospital move from a maintaining position to proactive in technology, growth, and team member engagement and patient satisfaction.

I was unsure how my career would end several years ago, but now I stand confident with LCMC in my future and the future of our community.
I am one thankful team member of LCMC and proud to call myself part of the LCMC family.

Warmest Regards,
Windie

Sent from Mail for Windows

Freel, Angelique

From: Sconza, Jean <Jean.Sconza@lcmchealth.org>
Sent: Wednesday, December 07, 2022 4:26 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a director of Quality Management at East Jefferson General Hospital LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jean Sconza, PhD, RN
Director, Quality Management

East Jefferson General Hospital
4200 Houma Blvd.
Metairie, LA 70006

O 504.503.6958

jean.sconza@LCMChealth.org
ejgh.org

Freel, Angelique

From: Tanzella, Richard <Richard.Tanzella@lcmchealth.org>
Sent: Wednesday, December 07, 2022 4:39 PM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I am the President and Chief executive Officer at East Jefferson General Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Richard Tanzella
President & Chief Executive Officer
LCMC- East Jefferson General Hospital

Freel, Angelique

From: Adamcewicz, Paula C. <Paula.Adamcewicz@lcmchealth.org>
Sent: Wednesday, December 07, 2022 4:46 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Senior Director at East Jefferson General Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Paula Adamcewicz BSN, RN, NE-BC, MEDSURG-BC
Senior Director of Women and Newborn Care

East Jefferson General Hospital
4200 Houma Blvd.
Metairie, LA 70006

O 504.503.6002
F 504.503.5486

Paula.Adamcewicz@LCMChealth.org
ejgh.org

Freel, Angelique

From: Rabalais, Lauren <Lauren.Rabalais@lcmchealth.org>
Sent: Wednesday, December 07, 2022 4:47 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

Importance: High

To whom it may concern:

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I have the pleasure of serving as the AVP of Academic Affairs for LCMC Health. Previously, I served in the role of Director of Academic Affairs at University Medical Center New Orleans. In my time with this organization, I have seen the true value LCMC Health places in high-quality patient care and employees like myself. I tell everyone how I am blessed to work for an organization that cares so much about the well-being of its patients and employees.

Before I joined the LCMC Health family of hospitals, I spent several years at a Baton Rouge teaching hospital, also serving in a leadership role within academic affairs.
I can tell you from my own experience working in different health systems---the importance LCMC Health places on the level of excellence for 1) patient care within the Greater New Orleans community and 2) academics and our future healthcare workforce-----it is like no other.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community. I am extremely excited about the potential for this partnership and its positive impact. I urge you to support the proposed LCMC Health – Tulane University partnership.

Thank you for your consideration.

Sincerely,

Lauren Rabalais, MPA
AVP, Academic Affairs

LCMC Health
1100 Poydras St, 2500 Energy Center
New Orleans, LA 70163

O 504.702.4496

Lauren.Rabalais@LCMChealth.org
LCMChealth.org/academicaffairs

Freel, Angelique

From: Hawkins, Tara <Tara.Hawkins@lcmchealth.org>
Sent: Wednesday, December 07, 2022 5:00 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a CBO Acute Director at LCMC Westpark location and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Tara Hawkins
System Director Acute Central Business Office

LCMC Health
Westpark Campus
3401 General DeGaulle Drive
New Orleans, LA 70114

O 504-702-4675
F 504-702-4861
C 504-717-5867

Tara.hawkins@LCMChealth.org
LCMC health.org

Freel, Angelique

From: Stroderd, Jared <Jared.Stroderd@lcmchealth.org>
Sent: Wednesday, December 07, 2022 5:26 PM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Vice President of Finance & Analytics at LCMC Health and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jared Stroderd
Vice President of Finance & Analytics

LCMC Health
1100 Poydras Street
2500 Energy Center
New Orleans, LA 70163

D 504.896.2847
C 504.615.5015
F 504.896.3088

jared.stroderd@LCMChealth.org
LCMChealth.org

Freel, Angelique

From: Arceneaux, Karen <Karen.Arceneaux@lcmchealth.org>
Sent: Wednesday, December 07, 2022 5:26 PM
To: Freel, Angelique
Subject: I support the LCMC Health - Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Karen Arceneaux
4200 Houma Blvd.
Metairie, LA 70006

Freel, Angelique

From: Hunter, Scott <Scott.Hunter@lcmchealth.org>
Sent: Wednesday, December 07, 2022 5:45 PM
To: Freel, Angelique
Subject: I support LCMC - Tulane Partnership

Subject: I support the LCMC Health – Tulane University Partnership

As a leader at LCMC Health, I am proud to support the proposed partnership with Tulane University. I'm a Sr. Director at East Jefferson General Hospital and have seen the value LCMC Health places in high-quality patient care and employees like myself.

With the addition of the Tulane hospitals into the LCMC Health system, this partnership will bring LCMC Health and Tulane University employees new and expanded opportunities for growth and advancement. We have the opportunity to transform the healthcare landscape by bringing new investments and growing our teaching mission, all while serving the community.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Scott Hunter

Scott Hunter, MSN, RN-BC
Sr. Director Nursing
Critical Care (ICU/CCU)
Emergency Department (ED/OEU)
Respiratory (Respiratory, Pulmonary, Wound Care/HBO Center)
Dialysis

East Jefferson General Hospital
4200 Houma Blvd.
Metairie, LA 70006

O 504.503.5963
scott.hunter@LCMChealth.org
ejgh.org

Freel, Angelique

From: Boh, Erin E <eboh@tulane.edu>
Sent: Wednesday, December 07, 2022 6:15 PM
To: Freel, Angelique
Subject: support for Tulane and LCMC partnership

As an employee of Tulane Medical School, I am proud to support the proposed partnership with LCMC. This partnership will create an integrated and comprehensive health system that will offer best-in-class, destination health care located right here in our community. The majority of services provided at Tulane Medical Center will shift to nearby University Medical Center New Orleans and East Jefferson General Hospital. Some outpatient services will remain at Tulane Medical Center, which will become home to a new nursing program, meeting a critical need in our state for nursing staff.

Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials.
Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities. It will expand opportunities to
train the next generation of doctors, nurses and other health car professionals.
I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Erin Boh Boh MD PhD FAAD
Joseph Chastain Professor of Dermatology
Professor & Chair
Department of Dermatology
Tulane University School of Medicine
New Orleans LA

Freel, Angelique

From: JRK <jasonrking@gmail.com>
Sent: Wednesday, December 07, 2022 6:50 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Jason King
733 Solomon Place
New Orleans 70119

Freel, Angelique

From: Mohiuddin, Ahmed <Ahmed.Mohiuddin@lcmchealth.org>
Sent: Wednesday, December 07, 2022 6:55 PM
To: Freel, Angelique
Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Ahmed Mohiuddin MD MBA
Chief Physician Officer

East Jefferson General Hospital
4200 Houma Blvd.
Metairie, LA 70006

O 504.503.5250
C 803.429.3929

ahmed.mohiuddin@LCMChealth.org
ejgh.org

Freel, Angelique

From: Maraganore, Demetrius <dmaraganore@tulane.edu>
Sent: Wednesday, December 07, 2022 7:30 PM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

To whom it may concern:

With this email I give my most emphatic, highest support for the Tulane-LCMC Partnership.

I am a neurologist. I have been in leadership positions at: 1) the Mayo Clinic in Rochester, MN (where I trained, was then faculty for 20 years, and then served as the system wide Chief of the Movement Disorders Division), 2) at NorthShore University HealthSystem in Chicago (where I was Chair of Neurology and co-Director of the NorthShore Neurological Institute), 3) at the University of Florida, where I has an endowed Chair in Alzheimer's Disease Research, and 4) now at Tulane (where I am Chair of Neurology, and co-Director of the Center for Clinical Neurosciences). I have been a physician for 37 years, and have worked in some of the most acclaimed medical centers in the world. I believe my experiences to be relevant to this discussion.

I support the Tulane-LCMC Partnership for the following reasons:

- Our vision for neurology at Tulane is to lead change: from survivorship to thriver-ship, creating a culture of joy. The LCMC Health affiliation is powerful support of our change vision.
- LCMC Health has demonstrated a clear interest in Tulane Neurology, as evidenced by: 1) our established University Medical Center (UMC) inpatient service, 2) our established UMC residents clinics, 3) compensation for Tulane neurology resident slots, 4) the anticipated launch in 2023 of the multidisciplinary Tulane-LSU-UMC Parkinson's Disease Center, 5) the anticipated relocation and consolidation of the multidisciplinary Tulane Healthy Brain Aging Initiative at UMC also in 2023 (https://tulanedoctorsneuro.com/healthy-brain-aging-initiative/) . Further, at East Jefferson Hospital, 5) we have recently launched a Tulane neurocritical care service, and 6) Tulane neurology outpatient clinics at that venue receive many referrals from hospital.
- We will be on one electronic medical record (EMR) platform, Epic, inpatient and outpatient. EPIC is considered by many to be best EMR in the world. This will improve the efficiency of our clinical practices. It will facilitate quality improvement and practice-based research in neurology using the EMR. It will also improve fair billing and collections.

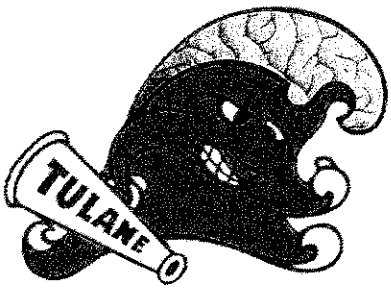
- We will collaboratively build the premier academic neurology service line in the New Orleans region with two medical schools and a health system partner that are local and committed to this community. Even predating this announcement, there have been meetings of Tulane and LSU neurology and UMC hospital leadership to create EMR referral orders, triage algorithms, general neurology access, and to envision additional new programs.
- There will be no immediate changes following the approval of the Tulane-LCMC Partnership. It will be a strategic process of incremental change over two years. The needs of the community we serve and of our Tulane employees will be addressed thoughtfully.
- Tulane and LCMC Health are committed to retaining the faculty and staff at Tulane Health System who support inpatient and outpatient services. We anticipate new positions and opportunities with growth initiatives.
- We fully expect that the education of our medical students and residents will benefit from the LCMC Health relationship, to include better facilities, a better EMR platform, and a larger referral source of patients, with more inpatient and outpatient practice sites. We are encouraged that the new relationship will support residency program growth, clinical research, and our overall academic mission.

The Tulane-LCMC Partnership, if approved, will transform healthcare in New Orleans, Louisiana, and the Gulf Coast and South-Central US regions. I plead for your support.

In Brain Health,

Demetri

Demetrius M. Maraganore, MD, FAAN
Chair of the Department of Neurology
Professor of Neurology
Herbert J. Harvey, Jr. Chair in Neurosciences
Co-director of the Tulane Center for Clinical Neurosciences
Tulane University School of Medicine
131 S. Robertson Street, Ste. 1300 #8047
New Orleans, LA 70112 U.S.A.
Office: +1 (504) 988-2235/ Fax: +1 (504) 988-5793/ Cell: +1 (847) 912-5771
https://news.tulane.edu/news/neurology-chair-dedicated-dementia-prevention-and-brain-health



We Teach. We Innovate. We Care.

Freel, Angelique

From: Acuff, Katie E. <kacuff@tulane.edu>
Sent: Wednesday, December 07, 2022 7:40 PM
To: Freel, Angelique
Subject: Support of Tulane/LCMC partnership

As an employee of Tulane University, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Katie Acuff, Esq.
ASSOCIATE VICE PRESIDENT | OFFICE OF ADVANCEMENT | TULANE UNIVERSITY
O: 504.314.7334 | C: 504.491.1930 | E: kacuff@tulane.edu

Freel, Angelique

From: Justin Lorio <justin.lorio1998@gmail.com>
Sent: Wednesday, December 07, 2022 8:30 PM
To: Freel, Angelique
Subject: Subject: I support the LCMC Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Justin Lorio

932 Sena Dr.

Metairie, LA

70005

Freel, Angelique

From: Greg Elder <gregelder7@gmail.com>
Sent: Wednesday, December 07, 2022 8:40 PM
To: Freel, Angelique
Subject: LCMC HEALTH AND TULANE

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Gregory Elder
869 Chretien Point Ave.
Covington, La. 70433

Freel, Angelique

From: Rhonda Elder <rhondaelder@gmail.com>
Sent: Wednesday, December 07, 2022 8:47 PM
To: Freel, Angelique
Subject: LCMC Health – Tulane University partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Rhonda R. Elder
869 Chretien Point Ave.
Covington, LA 70433

Freel, Angelique

From: Jennifer L. Avegno M.D. <Jennifer.Avegno@nola.gov>
Sent: Thursday, December 08, 2022 7:30 AM
To: Freel, Angelique
Subject: Support for LCMC/Tulane partnership - public comment for today's meeting

Dear Ms. Freel:

As the Director of the New Orleans Health Department and a practicing physician in New Orleans, I write in support of the proposed collaboration between LCMC Health and Tulane University. This partnership is a critical opportunity to improve access to high quality care for residents, advance medical education and training, and strengthen the biomedical sector in the region.

The partnership between LCMC and Tulane unites community and academic medicine - a partnership that will have important implications for graduate medical education. It creates more opportunities for medical residents to rotate at facilities across the region, enhancing the care provided to patients today and strengthening the pipeline of healthcare professionals who will choose to make New Orleans the place they practice in the future.

The financial investments that both entities have committed to this collaboration are also greatly needed. Funding for capital and programmatic improvements will be used to maintain the highest clinical standards of care and patient experience, invest in new equipment and facilities, and ensure that health care facilities attract the best and brightest medical providers. New investments by LCMC and Tulane University will also drive job creation and economic activity in and around downtown New Orleans.

The union of these two well-respected organizations is a win-win for the city of New Orleans and its residents and I urge the State to grant its approval.

Sincerely,

Dr. Jennifer Avegno
Director, New Orleans Health Department

Freel, Angelique

From: Hanemann, Cynthia W <chaneman@tulane.edu>
Sent: Thursday, December 08, 2022 8:31 AM
To: Freel, Angelique
Subject: Support for Tulane-LCMC Partnership

To the Office of the Attorney General:

As an employee of Tulane Medical School, I am proud to support the proposed partnership with LCMC. Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. Teaching hospitals provide patients with increased access to the latest medical breakthroughs and clinical trials. Tulane along with LSU and LCMC will transform the future of healthcare in our region by creating centers of extraordinary care for our communities.

The partnership between LCMC Health and Tulane University will be transformational for the New Orleans region, and greatly benefit patients, staff, and our community.
It will advance groundbreaking research, innovative technology, and lifesaving treatments that ensure patients and communities can receive the highest quality of care, right here in the greater New Orleans region.

It will expand opportunities to train the next generation of physicians, nurses, and scientists.
This partnership will increase access to comprehensive care in downtown New Orleans and create new hubs for specialty care, innovation, and academic medicine in both Orleans and Jefferson Parishes.
The organizations involved will be collaborating and working together to put patients' best interests first to make great things happen.

Maintaining access to affordable, high quality health care is essential to this partnership.

This partnership will create an integrated and comprehensive health system that will offer best-in-class, destination health care located right here in our community.
The majority of services provided at Tulane Medical Center will shift to nearby University Medical Center New Orleans and East Jefferson General Hospital. Some outpatient services will remain at Tulane Medical Center, which will become home to a new nursing program, meeting a critical need in our state for nursing staff.

Why?

LCMC Health and Tulane University are mission-based organizations that call Southeast Louisiana home.

We have shared values and a vision to partner to bring the best of community healthcare and academic medicine to all those we serve.

This partnership will strengthen the relationship between LCMC Health and Tulane University which already exists at Children's Hospital.
It will also deepen Tulane's long standing relationship with LSU Health.

Academic Medical Centers (teaching hospitals)

Academic medical centers are the birthplace of new treatments and technologies, and they provide the most complex and high-quality care. These technologies and treatments are often the drivers of growth, which create industries and jobs that improve quality of life for the entire region.

These centers are unique with doctors and researchers all working together to provide to create new therapeutics, treatments and increased clinical trials that are only possible with academic medical centers.

The partnership will make UMC stronger and create a new teaching hospital in Jefferson Parish, creating a robust health care system which will allow LA citizens to stay home for their care and bring new patients for outside the region looking for quality care.

Medical schools and major teaching hospitals also provide communities with the kind of complex care often unavailable elsewhere and provide treatment for a disproportionately high percentage of Medicare and Medicaid beneficiaries, and the uninsured.

Education & Training
Tulane University, LCMC Health, and LSU Health's shared commitment will create more opportunities for students and residents to rotate at facilities across the region. These training experiences will not only enhance the care provided to patients today, but strengthen the pipeline of physicians, nurses and others who will choose to make New Orleans the place they live and practice for decades to come.

As a result of this partnership, Tulane will be creating a new nursing program in downtown New Orleans. We already know the nursing shortage that is affecting healthcare systems and communities across the country. This shortage is felt deeply in Louisiana, where almost one-third (29%) of Registered Nurses
plan to retire within 10 years.

Tulane University's new nursing program will create new paths and expand the pipeline of students eager to enter the nursing field – making meaningful progress towards addressing the projected 2,475 unfilled full-time nursing positions projected in New Orleans by 2025.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Kind regards,

Cynthia W. Hanemann, MD, FACR
Professor of Radiology
Interim Chair of Radiology
Tulane University School of Medicine
(504) 988-7627
chaneman@tulane.edu

Freel, Angelique

From: Beverly Brooks Thompson <bthompson@carter.global>
Sent: Thursday, December 08, 2022 8:56 AM
To: Freel, Angelique
Subject: Health – Tulane University Partnership

Health – Tulane University Partnership

LCMC Health and Tulane University have announced plans to join forces to expand access to comprehensive and specialty care across Southeast Louisiana, enhance the region's capabilities as a destination for medical innovation and training, and provide extensive community investments and benefits. I am proud to support the proposed partnership. Both organizations call Louisiana home and have contributed significantly to the vibrancy of our state.

Upon approval of the proposed partnership, Tulane Medical Center, Lakeview Regional Medical Center, and Tulane Lakeside Hospital will join LCMC Health. The majority of services provided at Tulane Medical Center will shift to East Jefferson General Hospital and University Medical Center New Orleans.

This partnership will bring together an award-winning, community-based healthcare system and a nationally recognized, leading research university, resulting in the collaboration our state and region need to make Louisiana a destination for healthcare.

I urge you to support the proposed LCMC Health – Tulane University partnership. Thank you for your consideration.

Beverly Brooks Thompson, PhD, CFRE
1521 Sugar Cane Lane
Baton Rouge La 70810
225.274.6420 C

Freel Declaration Exhibit B

State of Louisiana
DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
P.O. BOX 94005
BATON ROUGE
70804-9005

Jeff Landry
Attorney General

December 28, 2022

Kenneth W. Field
Jones Day
51 Louisiana Avenue N.W.
Washington, D.C. 20001

Louisiana Children's Medical Center
Attn: Jody Martin
Senior Vice President, Chief Legal Officer
1100 Poydras St., Suite 2500
New Orleans, LA 70163

Tulane Educational Fund
Tulane University
Attn: Victoria D. Johnson
General Counsel
6823 St. Charles Ave.
300 Gibson Hall
New Orleans, LA 70118

HCA Healthcare, Inc.
Attn: Joseph A. Sowell, III
Senior VP and Chief Development Officer
One Park Plaza, Bldg. 2
Nashville, TN 37203

Re: ***Application for Certificate of Public Advantage – Louisiana Children's Medical Center/LCMC Health; The Administrators of the Tulane Educational Fund; Columbia/HCA of New Orleans, Inc.; Medical Center of Baton Rouge, Inc.; Columbia Healthcare System of Louisiana, Inc.; HCA Inc.***

Dear Counsel:

This correspondence is intended to serve as notification that the above-referenced application for Certificate of Public Advantage, filed with this office pursuant to La. R.S. 40:2254.1, et seq. on October 10, 2022 and supplemented on November 2, 2022, November 4, 2022, November 10, 2022, November 15, 2022, and November 18, 2022 (collectively referred to herein as "COPA

Application"), is hereby approved. The approval is based on the representations and information contained in the COPA Application, criteria set forth in Louisiana law and regulations, testimony at the public hearing held on December 8, 2022, and the large number of public comments received.

The approval is subject to the following conditions:

1. The execution of all documents necessary to close the transaction as described in the COPA Application;

2. Pursuant to Louisiana Revised Statute 40:2254.11 and the regulations promulgated in accordance therewith, the submission of annual reports, as more specifically described in the Terms and Conditions of Compliance attached hereto;

3. Full compliance with all requirements described in the Terms and Conditions of Compliance attached hereto.

Please note that the annual reports will be due on or before December 28th of the applicable year ("Anniversary Date"), quarterly reports will be due in 90-day increments from the Anniversary Date, and semi-annual reports will be due in 180-day increments from the Anniversary Date.

Should you have any questions or comments, please let us know.

Sincerely,

Jeff Landry

Encl.: Terms and Conditions of Compliance

Freel Declaration
Exhibit C

Jeff Landry
Attorney General

State of Louisiana
DEPARTMENT OF JUSTICE
CIVIL DIVISION
P.O. BOX 94005
BATON ROUGE
70804-9005

CERTIFICATE OF PUBLIC ADVANTAGE

TERMS AND CONDITIONS OF COMPLIANCE FOR:

LOUISIANA CHILDREN'S MEDICAL CENTER/LCMC HEALTH; THE ADMINISTRATORS OF THE TULANE EDUCATIONAL FUND; COLUMBIA/HCA OF NEW ORLEANS, INC.; MEDICAL CENTER OF BATON ROUGE, INC.; COLUMBIA HEALTHCARE SYSTEM OF LOUISIANA, INC.; HCA INC. (referred to herein as "Applicants")

Table of Contents

CERTIFICATE OF PUBLIC ADVANTAGE
TERMS AND CONDITIONS OF COMPLIANCE
Effective: December 28, 2022

I. Legally Binding Effect of these Terms and Conditions and Corrective Action Plans

A. Conditions of COPA Approval and Applicability of Terms and Conditions. The terms and conditions set forth herein ("Terms and Conditions") are required as a condition for approval of the Certificate of Public Advantage ("COPA") submitted by the above-named Applicants. The Louisiana Department of Justice, Office of the Attorney General ("DOJ") may, at any time, alter these terms and conditions as it deems necessary to ensure that the COPA meets statutory and regulatory requirements. Pursuant to the terms of the proposed transaction among the Applicants for which a COPA application was submitted, LCMC Health will become the sole owner of Tulane University Medical Center, Tulane Lakeside Hospital, and Lakeview Regional Medical Center (collectively, the "UHS Hospitals"). As the sole owner of the UHS Hospitals and the operator of LCMC Health's six hospitals (Children's Hospital New Orleans, East Jefferson General Hospital, New Orleans East Hospital,[1] Touro Infirmary, University Medical Center New Orleans, and West Jefferson Medical Center) (together with the UHS Hospitals, the "Combined Entity"), LCMC Health (the "New Health System") will serve as the sole continuing operator of the Combined Entity and the sole entity subject to these Terms and Conditions. The New Health System does not have the right to withdraw from these COPA Terms and Conditions during the term of the COPA. Further, pursuant to Louisiana Revised Statute 40:2254.4(D), any amendment to the terms of the transaction submitted by the Applicants or any material change in the operations or conduct of the New Health System shall be considered to be a new agreement and shall not take effect or occur until the DOJ has issued a new COPA approving such amendment or material change. The New Health System shall follow the timeframes and procedures set forth in the statutory and regulatory framework for COPA applications with regard to notifying the DOJ of any amendments or material changes.

B. Corrective Action Plan. If, at any time, the DOJ determines that an activity of the New Health System is inconsistent with the policy goals described in Louisiana Revised Statute 40:2254.1, *et. seq*, the DOJ will notify the New Health System that it must adopt a plan to correct any deficiency in its activities. Within thirty (30) calendar days of notification, the New Health System shall return a written corrective action plan to the DOJ responding to each cited deficiency, including timeframes for corrections, together with any additional evidence of compliance. If the DOJ determines that the corrective action plan does not sufficiently address each cited deficiency, it will notify the New Health System that it must submit a revised corrective action plan within twenty (20) days of notification. If the DOJ determines that the corrective action plan does sufficiently address each cited deficiency ("Corrective Action Plan"), the New Health System shall use best efforts to implement the Corrective Action Plan and submit progress reports to the DOJ as set forth therein.

[1] New Orleans East Hospital ("NOEH") is not owned by LCMC Health; LCMC Health manages NOEH, which is not financially integrated into LCMC Health. NOEH is a Hospital Service District hospital and a political subdivision of the state. Accordingly, NOEH contracts separately and is not part of the LCMC Health payor contracting process.

C. Remedies. If the DOJ is not satisfied with any submitted corrective action plan, if the New Health System fails to comply with the terms and conditions set forth herein, fails to comply with any Corrective Action Plan, or if the DOJ otherwise determines that the transaction is not resulting in lower health care costs or greater access to or quality of health care, the DOJ reserves the right to revoke the COPA as provided for in Louisiana Revised Statute 40:2254.6. Additionally, the DOJ may pursue any other enforcement mechanisms available to it by law, including but not limited to injunctive relief.

D. Court Costs and Attorney Fees. If it becomes necessary for the DOJ to file suit to enforce any provision of law, regulation, the terms and conditions of any Corrective Action Plan, or these terms and conditions, the New Health System shall be responsible for all costs associated with any such litigation, including but not limited to all court costs and attorneys' fees.

E. Release of Liability for Corrective Action Plans. Subject to Louisiana Revised Statute 40:2254.7, the approval of any Corrective Action Plan does not confer any responsibility or liability for damages on the State of Louisiana or any of its officers, directors, employees, agents, or consultants. Applicants and their successors and assigns hereby RELEASE AND FOREVER DISCHARGE the State of Louisiana and all of its officers, directors, employees, agents, and consultants from any and all damages claims, debts, demands, losses, and liabilities whatsoever, known or unknown, whether in law or in equity, resulting from, respecting, relating to, or arising out of any Corrective Action Plan, which either party now has or may later discover. The New Health System may appeal a final decision on a corrective action plan or rate review decision in the manner provided in the Administrative Procedure Act.

F. The New Health System may designate as "Confidential" and redact any document or material submitted to the DOJ that is exempt from disclosure under the Louisiana Public Records Act, including any document or material containing trade secret, proprietary, or competitively sensitive information. In accord with Louisiana Revised Statute 44:4 *et seq*. and other applicable statutes, rules, and regulations, nothing in the Terms and Conditions limits the New Health System from claiming any exceptions, exemptions, and limitations to the laws pertaining to public records.

II. Purpose and Vision – Creating Value for Louisiana Citizens

The purpose of COPA law and similar statute-regulated transactions is to better serve the citizens of Louisiana by pursuing and attaining the key aims of value-based healthcare, namely—

- Cost: Decreased costs of care
- Quality: Improved quality of care
- Access: Increased access to care

For COPA and other transactions, the State of Louisiana, through the Louisiana DOJ, aspires to work with healthcare organizations to help the DOJ and the nation to achieve these goals. For approval to be granted, the DOJ must have reasonable assurances that these goals will be met.

Ultimately, decreased costs, improved quality, and increased access to healthcare aim to create better patient engagement, higher patient satisfaction, and more value for patients.

III. Guiding Principles and Expectations for Monitoring

The New Health System agrees to pursue these goals and to employ these guiding principles, which will be key to monitoring the transaction and ensuring its future success.

A. Relevant Metrics: The New Health System will be responsible for gathering, analyzing, and presenting its performance on relevant metrics to cost, quality, and access on a regular basis. The DOJ reserves the right to change, add, or remove metrics as it deems necessary to ensure that the COPA meets statutory and regulatory requirements.

B. Competitive Benchmarking: The New Health System will be expected to measure and report its performance in cost, quality, and access compared to national benchmark or relevant peer competitors within the markets it serves, the State of Louisiana, or any other areas (such as neighboring states or similar metropolitan areas in other states, etc.) as appropriate and as may be added at the discretion of the DOJ as it deems necessary to ensure that the COPA meets statutory and regulatory requirements, to the extent that relevant information on such competitors is publicly available.

C. Continuous Improvement: The New Health System should strive to create, build, and maintain a culture of excellence and continuous improvement. The DOJ expects the New Health System to show meaningful improvement in cost, quality, and access every year. The New Health System should improve beyond its baseline performance (past performance for the quarter and year prior to approval), and also relative to its peer group or competitive set.

IV. Key Monitoring Elements in the Louisiana Statute

Louisiana Revised Statute 40:2254.11 provides as follows:

> If the department issues a certificate of public advantage, the facilities to whom the certificate has been issued shall submit a report to the department evaluating whether the cooperative, merger, joint venture, or consolidation agreement submitted to and approved by the department has been complied with during the preceding year and, if applicable, evaluating whether any terms and conditions imposed by the department when it issued the certificate have been met or otherwise satisfied during the preceding year. The report must be submitted annually or more frequently if required by the department. The department shall in turn issue findings as to whether the terms and conditions are being met or otherwise satisfied. The department shall keep copies of all reports and findings based on the reports.

Louisiana Admin. Code tit. 48, Part XXV, §517 outlines the information and supporting data that must be submitted by the New Health System. Annual reports following an approved COPA transaction shall include, but not be limited to, the following information:

- an update of all the information required in the COPA application;
- any change in the geographic territory that is served by the health care equipment, facilities, personnel, or services which are subject of the transaction;
- a detailed explanation of the actual effects of the transaction on each party, including any change in volume, market share, prices, and revenues;
- a detailed explanation of how the transaction has affected the cost, access, and quality of services provided by each party; and
- any additional information requested by the DOJ.

Louisiana Admin. Code tit. 48, Part XXV, §509 provides that the fee due with the filing of the reports required by Louisiana Revised Statute 40:2254.11 and described in Sections VIII-X shall be $15,000. If the actual cost incurred by the DOJ is greater, the parties involved shall pay any additional amounts due as instructed by the DOJ.

V. Structure of Monitoring

The DOJ will direct the monitoring of an approved COPA application. At its discretion, the DOJ may assign another existing or new department within the State of Louisiana, or an external organization, to monitor the New Health System and the terms of the COPA application, or to provide monitoring support to the DOJ. (The DOJ or other organization that does the monitoring is hereafter referred to as the "Monitoring Agency" or together, the "Monitoring Agencies").

The New Health System will be required to submit advanced written notice of certain events and reports that include specific information at the request of the Monitoring Agency. The Monitoring Agency will require reports according to the following schedule:

A. Rate Review – During the term of the COPA, the New Health System will be required to submit information related to changes in rates to the Monitoring Agency as described in Section VI.

B. Quarterly Reports – Quarterly reports will include an update on the transaction objectives as set forth in the COPA application and supplemental submission, with specific focus on updates on the investment and repurposing of facilities claims. Quarterly reports will be required for first three (3) years or until completion of application objectives, whichever is longer.

C. Semi-Annual Reports – Semi-annual reports will require submission of a set of key metrics tied to cost, quality, and access. The reports will be submitted semi-annually for first five (5) years following the transaction.

D. Annual Reports – During the term of the COPA, the New Health System will be required to submit annual reports that detail an update on its application, a description of any change

to geographic territory, any changes in volume, market share, prices, and revenues, and a detailed explanation of how the transaction has affected cost, quality, and access.

The time periods for which quarterly and semi-annual reports will be required may be shortened or extended at the discretion of the Monitoring Agency. All annual reports should be submitted on or before the anniversary of the COPA approval date. Quarterly reports are to be submitted in 90-day increments after the anniversary of the COPA approval date and semi-annual reports are to be submitted in 180-day increments, while applicable, after the anniversary of the COPA approval date. In the event of a hurricane, earthquake, flood, tornado, natural disaster, public health emergency, epidemic, pandemic or disease outbreak, or other force majeure event or "act of God" that affects the ability of the New Health System to submit a report during the time periods outlined herein, the New Health System must contact the DOJ to determine a late report submission date that is mutually agreed upon by the New Health System and the DOJ.

VI. Rate Review

A. The New Health System may not contract with a third-party payor for a change in rates for any services provided by such New Health System without the prior written approval of the DOJ. At least sixty (60) days before the proposed implementation of any change in rates for any services provided by the New Health System under a newly negotiated third-party payor contract, the New Health System shall submit any proposed changes in rates to the DOJ for approval. The information submitted to the DOJ must include, at a minimum:

i. Completion of any Rate Review application form which may be adopted by the DOJ;

ii. The proposed change in rate(s);

iii. For an agreement with a third-party payor other than an agreement with a managed care organization that provides or arranges for the provision of services under the Medicare or Medicaid programs, information showing:

a. That the New Health System and the third-party payor have agreed to the proposed rates;

b. Whether the proposed rates are less than the corresponding amounts in a relevant price index published by the Bureau of Labor Statistics of the United States Department of Labor relating to services for which the rates are proposed, or a comparable price index chosen by the DOJ if the relevant price index is abolished; and

c. If the proposed rates are above the corresponding amount in the relevant price index, a justification for proposing rates above the corresponding amounts in such index.

iv. To the extent allowed by federal law, for an agreement with a managed care organization that provides or arranges for the provision of services under the Medicare or Medicaid programs, information showing:

a. Whether the proposed rates are different from rates under an agreement that was in effect before the date of the transaction;

b. Whether the proposed rates are different from the rates most recently approved by the DOJ for the New Health System, if the DOJ has previously approved rates following the issuance of the COPA; and

c. If the rates exceed the rates those described in subparagraphs (a) or (b) of this paragraph, a justification for proposing rates in excess; and

v. Any information concerning costs, patient volumes, acuity, payor mix, or other information requested by the DOJ.

a. To the extent that the DOJ requests such information, such information shall be provided no later than twenty (20) business days from the request.

B. The Monitoring Agency shall approve or deny the proposed rate change within sixty (60) days from receipt of a notice of proposed rate change.

C. The rate review process intends to ensure that rates remain at a level that is supported by economic, cost, or other growth trend indicators. The DOJ, in its sole discretion, may designate an individual or entity to review the provided materials and make a recommendation to the DOJ. The Monitoring Agency may evaluate proposed rate increases by comparing the proposed rates to: (1) price indexes, (2) cost report data and trends, (3) governmental program rates, and (4) other information as provided by the New Health System or as deemed necessary by Monitoring Agency. Based on evaluation, the DOJ shall approve the proposed rates unless the DOJ determines that rates inappropriately exceed competitive rates for comparable services in the New Health System's market area.

VII. Notice

The New Health System must provide written notice to the DOJ at least ninety (90) days in advance of any mergers, acquisitions, joint ventures, or other partnership arrangements.

VIII. Report Elements – Quarterly Reports

The New Health System must submit quarterly reports, in accordance with the schedule set forth in Section V, providing an update on the transaction objectives cited in the COPA application regarding the investments and repurposing of facilities, including but not limited to the following:

A. Changes in services at the Tulane University Medical Center New Orleans ("TUMC") facility in Orleans Parish, to the extent available, related to:

i. Creation of new nursing program in Orleans Parish;
ii. Development of downtown campus;

B. Creation of a new, premier academic medical center and leading teaching institution in Jefferson Parish at East Jefferson General Hospital ("EJGH"), including:
   i. Transition or relocation of advanced clinical services from TUMC to EJGH;
   ii. Investment in capital improvements at EJGH, Tulane Lakeside, and Lakeview;

C. Creation of Centers of Excellence;

D. Engagement in medical research;

E. Expansion of electronic medical record system to Tulane Lakeside and Lakeview;

F. Access changes such as:
   i. Material openings, closures, or mergers of outpatient facilities;
   ii. Material openings, closures, or mergers of inpatient services; or
   iii. Material service line changes.

G. Any changes or events requiring reporting to The Joint Commission or other accrediting bodies, including any change in accreditation status.

IX. Report Elements – Semi-Annual Reports

The New Health System must submit semi-annual reports in accordance with the schedule set forth in Section V. To serve as long- and short-term baseline comparators, the New Health System should include data from one (1) year prior to the merger and one (1) quarter before the merger. Semi-annual reports should include data from these two (2) baseline comparators, in addition to the data from all preceding reports. Where possible, the New Health System should also compare the following measures to the top two (2) to four (4) competitors in the area. The semi-annual reports must include the following elements, to the extent available:

Cost

- Number of patients who benefited from charity care
- Description of capital investments
- Overall cost of agency nurses (details to be kept confidential)
- List of open care delivery positions
- Summary of charges billed and payments received for inpatient care, including drugs, from each facility
- Dollar value and service volume of programs and services for poor and underserved communities
- Final Medicare cost reports

Quality

- Patient satisfaction ratings

- Readmission rates
- A summary of quality improvement measures for each hospital
- CMS star ratings
- Leapfrog safety rating

Access

- Staffed bed changes greater than ten percent (10%) compared to the same period in the prior year.
- Inpatient volumes, broken down by major classifications such as pediatrics, women's health, Med Surg, ICU, etc.
- Outpatient volumes, broken down by each outpatient category, such as primary and specialty clinic visits, emergency department, outpatient surgery, etc.
- Emergency department times in minutes for each hospital
- Number of providers who have privileges to practice
- Current number of physicians, nurses, PAs in the market area and employed by the New Health System
- Number of newly recruited physicians seeing patients by the New Health System to the area in the past year

X. Report Elements – Annual Reports

In addition to the quarterly and semi-annual reports, the New Health System must submit annual reports as required by Louisiana law. The report must include all report elements listed for the quarterly and semi-annual reports, in addition to the following:

A. An update of all the information required in the application. Provide an update on the claims made in the initial and supplemental COPA applications.

B. Any change in the geographic territory that is served by the health care equipment, facilities, personnel, or services which are subject of the transaction. Provide detailed explanation of any change in geographic territory that is served by the health care equipment, facilities, personnel, or services which are subject to the transaction.

C. A detailed explanation of the actual effects of the transaction on each party, including any change in volume, market share, prices, and revenues:

i. Volume: Provide a detailed account of how volumes have been impacted by the transaction.

ii. Market share: Provide a detailed account of how market share has been impacted by the transaction.

iii. Price: Provide a detailed account of how prices have been impacted by the transaction. Provide prices for a key group of services/procedures – recommend the most common

ten (10) to thirty (30) procedures or services. Include charts that compare change in price to general inflation and health care inflation.

iv. Revenue: Provide a detailed account of how revenues have been impacted by the transaction.

D. A detailed explanation of how the transaction has affected the cost, access, and quality of services provided by each party. Provide a narrative explanation of the transaction's impact on cost, quality, and access.

XI. Release of Liability

Subject to Louisiana Revised Statute 40:2254.7, the granting of a COPA application does not confer any responsibility or liability for damages on the State of Louisiana or any of its officers, directors, employees, agents, or consultants. Applicants and their successors and assigns hereby RELEASE AND FOREVER DISCHARGE the State of Louisiana and all of its officers, directors, employees, agents, and consultants from any and all damages claims, debts, demands, losses, and liabilities whatsoever, known or unknown, whether in law or in equity, resulting from, respecting, relating to, or arising out of any COPA application or approval, which such party now has or may later discover.

Freel Declaration
Exhibit D

State of Louisiana
DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
P.O. BOX 94005
BATON ROUGE
70804-9005

Jeff Landry
Attorney General

June 30, 2023

Jody B. Martin
Chief Legal Officer
LCMC Health
1100 Poydras St.
New Orleans, LA 70163

RE: Rate Review Application April 21, 2023

Dear Jody:

Our office has reviewed LCMC Health's Rate Review Application submitted on April 21, 2023, and the subsequent submissions made during May 2023 and June 2023. Based on comparisons to Bureau of Labor Statistics data available, we believe the rate increases are reasonable, and we are approving the Blue Cross Blue Shield and United Healthcare contracts as provided by LCMC Health, with the following notations:

1. Regarding the Blue Cross Blue Shield contracts for Children's Hospital, Touro, University Medical Center, and West Jefferson Medical Center, the rate increases should not be effective until June 21, 2023 rather than the April 1, 2023 date used. However, given the number of claims and the system changes that would be required to re-bill these claims, we are willing to approve the April 1, 2023 effective date, if you delay the proposed second-year increase for these contracts to July 1, 2024 rather than April 1, 2024, this will result in LCMC receiving approximately the same increase if the June 21, 2023 effective date had been used.
2. We want to monitor the actual transplant cases performed by the Tulane Health System under the Blue Cross Blue Shield contract to ensure the caseload is comparable to historical volumes.
3. We strongly urge LCMC to comply with all provisions of Section VI, Rate Review Section of the Certificate of Public Advantage dated December 28, 2022. LCMC Health should devise processes, communication methods, and timelines that will allow for proper effective dates for rate review going forward.

If you have any questions or if you would like to discuss this matter further, feel free to contact us.

Sincerely,

Jeff Landry

Attorney General

UNITED STATES DISTRICT COURT FOR THE

EASTERN DISTRICT OF LOUISIANA

FEDERAL TRADE COMMISSION Plaintiff, v. LOUISIANA CHILDREN'S MEDICAL CENTER and HCA HEALTHCARE, INC. Defendants.	CIVIL ACTION NO. 23-1305 c/w 23-311 c/w 23-890 REF: ALL CASES SECTION I

Declaration of Terrence J. Donahue, Jr.

I, Terrence J. Donahue, Jr., declare as follows:

1. I am a United States citizen over the age of eighteen. I make and submit this Declaaration pursuant to 28 U.S.C. § 1746.

2. If called upon as a witness, I could testify to the matters to which this Declaration refers and would be competent to do so.

3. I am an Assistant Attorney General for the Louisiana Department of Justice.

4. I submit this declaration upon personal knowledge.

5. Attached hereto as Exhibit 1 is March 8, 1993 Letter David W. Huey, Assistant Attorney General of North Dakota downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-north-dakota-attorney-general-concerning-s.b.2295-2426-authorize-certain-cooperative-agreements-among-health-care-providers/v930010-nd-hospitals.pdf

6. Attached hereto as Exhibit 2 is a February 14, 2008 Letter from the Federal Trade Commission to the Hon. William J. Seitz, downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.william-j.seitz-concerning-ohio-executive-order-2007-23s-establish-collective-bargaining-home-health-care/v080001homecare.pdf

7. Attached hereto as Exhibit 3 is a June 5, 2015 Letter to Hon. Michael H. Ranzenhofer and Hon. Thomas Abinanti, downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-new-york-state-senator-ranzenhofer-new-york-state-assemblyman-abinanti-concerning/150605nypublichealthletter.pdf

8. Attached hereto as Exhibit 4 is a May 2, 2016 Letter to Hon. Larry Stutts, downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-alabama-state-senate-regarding-alabama-house-bill-241-senate-bill-243/160504commentalabama.pdf

9. Attached hereto as Exhibit 5 is a November 1, 2017 FTC Staff Notice of COPA Assessment, attached as Exhibit 5 downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/system/files?file=attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf

10. Attached hereto as Exhibit 6 is an October 7, 2022 Submission to New York State Health Department, downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/system/files/ftc_gov/pdf/2210126NYCOPACommentPublic.pdf

11. Attached hereto as Exhibit 7 is a May 13, 1999 Letter to Hon. Rene O. Oliveira, attached as Exhibit 7 downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-rene-o.oliveira-concerning-texas-s.b.1468-act-relating-regulation-physician-joint-negotiation/v990009.pdf

12. Attached hereto as Exhibit 8 is a March 18, 2009 Letter to Rep. Tom Emmer, downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-representative-tom-emmer-minnesota-house-representatives-concerning-minnesota-ok-h.f.no.120-and-senate-bill-s.f.no.203-health-care-cooperatives/v090003.pdf

13. Attached hereto as Exhibit 9 is a May 18, 2011 Letter to Rep. Phillip Johnson, downloaded from the Federal Trade Commission's website at:

https://www.justice.gov/sites/default/files/atr/legacy/2011/05/25/271584.pdf

14. Attached hereto as Exhibit 10 is a May 18, 2011 Letter to Rep. Elliott Naishtat, downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.elliot-naishtat-concerning-texas-s.b.8-exempt-certified-health-care-collaboratives-antitrust-laws/1105texashealthcare.pdf

15. Attached hereto as Exhibit 11 is a Letter to Sen. Eric D. Coleman, Sen. John A. Kissel, Rep. Gerald Fox and John W. Heatherington, downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-john-j.bonacic-concerning-new-york-s.b.3186-allow-health-care-providers-negotiate-collectively-health-plans/111024nyhealthcare.pdf

16. Attached hereto as Exhibit 12 is a October 20, 2011 Letter to Sen. John J. Bonacic, downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-john-j.bonacic-concerning-new-york-s.b.3186-allow-health-care-providers-negotiate-collectively-health-plans/111024nyhealthcare.pdf

17. Attached hereto as Exhibit 13 is a June 28, 1996 Letter to Columbus Hospital and Montana Deaconess Medical Center, downloaded from the Federal Trade Commission's website at:

https://www.ftc.gov/sites/default/files/documents/closing_letters/columbus-hospital/montana-deaconess-medical-center/960628columbushospitalletter.pdf

I declare under penalty of perjury that the foregoing is true and correct.

Date: July 18, 2023 *s/ Terrence J. Donahue, Jr.*

V930010

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

COMMISSION AUTHORIZED

March 8, 1993

EXHIBIT
tabbies
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The Honorable David W. Huey
Assistant Attorney General
State Capitol
600 East Boulevard
Bismarck, North Dakota 58505-0040

Dear Mr. Huey:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for views on Senate Bills 2295 and 2426, which would authorize certain cooperative agreements among hospitals or other health care providers and immunize those agreements from antitrust liability. Competition in health care markets has benefited consumers, and antitrust enforcement has been a significant factor in the emergence of potentially procompetitive methods of delivering health care services, such as managed care. Statutory antitrust exemptions could permit behavior that injures consumers and the economy. We know of no instances of antitrust challenges to cooperative agreements to improve efficiency or enhance the quality of care; thus, we question whether granting antitrust immunity is necessary to achieve the goals sought. Because it may be difficult to ensure that these agreements, once authorized, continue to operate as intended, we recommend that, if programs such as these bills would authorize are nonetheless adopted, measures be taken to make it easier to terminate agreements that fail to achieve those goals.

I. Interest and experience of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, and in the delivery of health care services generally, to the maximum extent

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[1] These comments are the views of the staff of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

[2] 15 U.S.C. §§ 41 et seq.

compatible with other state and federal goals. For several years, the Commission and its staff have investigated the competitive effects of business practices of hospitals and health care professionals.[3] The Commission has investigated and taken action concerning the competitive effects of mergers between hospitals.[4] The staff of the Commission has also commented, in response to requests, on legislative and regulatory proposals that may affect competition and consumer interests. On several occasions, the staff of the Commission has commented on the effects of state certificate-of-need ("CON") laws on competition among hospitals and other health care providers.[5] The staff of the Commission has authored three studies dealing with CON regulation.[6]

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[3] See, e.g., American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d. 443 (2d Cir. 1980), aff'd by an equally divided court, 455 U.S. 676 (1982); Medical Staff of Doctors' Hospital of Price George's County, 110 F.T.C. 476 (1988); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988); Medical Staff of Holy Cross Hospital, No. C-3345 (consent order, Sept. 10, 1991); Medical Staff of Broward General Medical Center, No. C-3344 (consent order, Sept. 10, 1991).

[4] See, e.g., FTC v. Columbia Hospital Corp., No. 93-30-CIV-FTM-23D (M.D.Fla., complaint filed February, 1993); FTC v. University Health, Inc., 1991-1 Trade Cas. (CCH) ¶69,400, 69,444 (S.D. Ga.), rev'd, 938 F. 2d 1206 (11th Cir. 1991); Hospital Corporation of America, 106 F.T.C. 361 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987); American Medical Int'l, 104 F.T.C. 1 (1984).

[5] See, e.g., Comments to the Maryland Health Resources Planning Commission (August 6, 1987); Georgia Senate (March 4, 1988); Michigan House of Representatives (March 7, 1988); Pennsylvania House of Representatives (March 30, 1988); Georgia Senate (February 6, 1989); Nebraska Senate (February 22, 1989). See also Statement of Keith B. Anderson, Special Assistant to the Director, Bureau of Economics, Federal Trade Commission, before the North Carolina State Goals and Policy Board (March 6, 1989); Testimony of Mark D. Kindt, Regional Director, Cleveland Regional Office, Federal Trade Commission, before the Ohio Senate Health and Human Services Committee (June 21, 1989).

[6] Keith B. Anderson and David I. Kass, Certificate of Need Regulation of Entry into Home Health Care: A Multi-Product Cost Function Analysis, FTC Bureau of Economics Staff Report (1986); Monica Noether, Competition Among Hospitals, FTC Bureau of Economics Staff Report (1987); Daniel Sherman, The Effect of State Certificate of Need Laws on Hospital Costs: An Economic Policy Analysis (1988).

II. Description of S.B. 2295 and S.B. 2426.

Each of these bills provides a means for issuing a "certificate of public advantage" to a cooperative agreement among health care providers. The intended effect of these certificates, which is explicit in S.B. 2295 and implicit in S.B. 2426, would be to immunize these agreements against antitrust liability.

A. S.B. 2295.

Under this bill, institutional health care providers may, through their boards and directors, negotiate with each other about allocating equipment or services, immune from state or federal antitrust liability so long as their discussions are designed to reduce costs, improve access, or improve quality of care.[7] Immunity would not extend to discussions that involved predatory pricing or price fixing.[8] Parties reaching a cooperative agreement through such negotiations could obtain a "certificate of public advantage" for it from the state attorney general, which would immunize the agreement from state or federal antitrust liability.[9] The agreement could deal with sharing or allocating patients, personnel, programs, support services, facilities, or procedures.[10] A certificate would be issued if the attorney general determined that the benefits likely to result from the agreement substantially outweighed any disadvantages attributable to a reduction in competition likely to result, and that any such reduction in competition was reasonably necessary to obtain the likely benefits.[11] The likely benefits must include at least one of the following: enhanced quality of care, preservation of facilities, increased cost efficiency, improved use of resources and equipment, or avoidance of duplicated resources.[12] In determining whether the reduction in competition is necessary, the attorney general must

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[7] S.B. 2295, 53rd Legis. Assembly, §2. (1993).

[8] Id.

[9] Id. §3. It is not clear whether the final agreements, unlike the negotiations leading to them, could encompass price fixing or predatory pricing and still retain antitrust immunity.

[10] Id. §1(2).

[11] Id. §4(1).

[12] Id. §4(2).

consider the impact on payors' ability to negotiate "optimal payment and service arrangements", possible reductions in competition among other health care providers, and whether there are less anticompetitive alternatives.[13] The certificates would apparently be of indefinite duration.[14]

B. S.B. 2426, §§6-16.

These provisions[15] of this bill are substantively nearly the same as S.B. 2295, but it differs from S.B. 2295 in some details, particularly concerning coverage and procedures. Although S.B. 2426 does not confer antitrust immunity as explicitly as S.B. 2295 does, that appears to be its intention.[16] S.B. 2426 would apply only to hospitals and their affiliates, and would not apply to mergers or other outright transfers of control.[17] Certificates would be issued by the department of health, although applications would also be filed with the attorney general, who must be consulted about possible reductions in competition and would be notified of the action taken.[18] Hearings would be required before certificates were issued,[19] and a certificate could be issued only if the applicants carry the burden of showing, by "clear and convincing

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[13] Id. §4(3).

[14] The attorney general could revoke a certificate on determining that the balance no longer favored the reduction in competition, but the certificate holder could contest that action. Id. § 5.

[15] The rest of the bill proposes other changes in health insurance and health care services.

[16] The scope of the immunity it would grant to the negotiation process is slightly different. S.B. 2426, 53rd Legis. Assembly, §§ 8, 16 (1993). Under S.B. 2426, the conduct of the parties in negotiating an agreement would be "lawful conduct" if an application for a certificate is filed (even if the certificate is not ultimately issued); by contrast, S.B. 2295 does not condition immunity for negotiations on filing an application for a certificate. On the other hand, S.B. 2426 does not identify price fixing or predatory pricing as matters that could not be discussed without losing immunity.

[17] Id., § 16.

[18] Id., §§8, 9.

[19] Id., §8.

evidence," that the likely advantages outweighed the disadvantages from reduction in competition.[20] The lists of possible benefits and disadvantages are essentially the same as in S.B. 2295, except that S.B. 2426 also calls for considering possible adverse effects on the quality, availability, and price of health care services.

S.B. 2426 also sets out detailed procedures and standards for actions by the attorney general to enjoin and cancel agreements. In an action to enjoin an agreement for which an application has been filed, the parties would bear the burden of demonstrating that it passed the cost-benefit test by clear and convincing evidence; in considering the possible reduction in competition, the court would consider whether it constituted an unreasonable restraint of trade under state or federal law.[21] In an action to cancel an agreement after a certificate is issued, the attorney general would bear the burden of showing, by a preponderance of the evidence, that because of changed circumstances, the benefits of maintaining the agreement (plus the unavoidable costs of cancelling it) were outweighed by the disadvantages of the loss of competition.[22] The parties to an agreement shown to have been obtained by fraud or coercion could salvage it by demonstrating, by clear and convincing evidence, that it passed the cost-benefit test.[23]

III. Hospital competition, joint ventures, and mergers.

The premise of each of these bills appears to be that antitrust litigation or prosecution, or the fear of antitrust liability, prevents or inhibits beneficial agreements among hospitals or other providers of health care services. We believe it would be useful to review the record of antitrust enforcement involving hospital mergers and cooperative agreements, to show

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[20] Id., §9.

[21] Id., §13.

[22] It would apparently not be possible for the attorney general to initiate a challenge to a certificated agreement on the grounds that the grant of the certificate had been in error, unless the action is brought within 40 days after the department of health issues the certificate. Id., §§ 13, 14. It is unclear whether showing changed circumstances would also be necessary for the department of health to revoke a certificate. Id., § 10.

[23] Id., §14.

how the kinds of benefits described in S.B. 2295 and S.B. 2426 have been considered in that process.[24]

The Commission's antitrust enforcement activities concerning hospital mergers and joint ventures attempt to maintain the competitive market forces needed to make the current health care system work, and provide opportunities for improvements in the system to make it work better.[25] The Commission believes that competition significantly improves the performance of hospitals within the existing health care system. Competition will continue to play such a role in foreseeable circumstances.

The clearest benefit to consumers of competition in the hospital industry results from the ability of third-party payers, such as health maintenance organizations and preferred provider plans, to contain costs. Under various forms of "managed care," health plans use their ability to contract selectively with hospitals, and their extensive knowledge of hospitals' prices and quality of care, to direct their beneficiaries to the hospitals offering the best combination of cost-effectiveness and quality of care reasonably available to them. This strategy encourages hospitals to reduce costs (while maintaining acceptable levels of quality of care), by rewarding hospitals that do so with additional patients, or at least by steering patients away from high-cost institutions. Consumers benefit from this process in two ways: from how it may tend to control increasing hospital costs generally, and from the ability to choose health care payment plans that offer cost-reducing features.

Managed care competition for hospital and other health services is becoming increasingly widespread, and many efforts to reform America's health care system would rely more heavily upon

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[24] The following discussion is based on a statement the Commission recently submitted to a joint committee of Congress concerning antitrust enforcement in health care. Testimony of the Federal Trade Commission, Before Subcommittee on Investment, Jobs and Prices, Joint Economic Committee (June 24, 1992).

[25] The Commission is not in a position to make broad predictions or recommendations about what the hospital industry will or should look like in the next century. The Commission's involvement in the health care field is limited to the enforcement of certain antitrust and consumer protection statutes. While that role is important, the Commission's experience with and expertise in health care is limited and specialized, as compared to agencies such as the Department of Health and Human Services, whose regulatory responsibilities are much broader and more extensive and which is also responsible for the formulation of general health care policy.

it. The information gathered in our investigations, where we frequently obtain the perspective of managed care payers, generally indicates that managed care slows hospital price increases where health plans have at least several hospitals to choose from in the markets they serve. This occurs because the plans can engage hospitals in a competitive process to obtain low prices, and can avoid doing business with those hospitals unwilling or unable to offer cost-effective care.[26] The Commission places particular importance in its hospital merger enforcement activities on the preservation of the hospital alternatives needed to make competition work.

The benefits of competition to the American health care system extend even to markets where managed care has not taken hold. For example, even the less intensive price competition that prevails in non-managed care markets places additional pressure on unusually high-cost hospitals to confront their inefficiencies and take the steps necessary to contain their costs.

This will be of particular importance as the Medicare system, and other payers with aggressive cost-containment programs, place more stringent reimbursement limitations on inefficient hospitals. Medicare in particular, through its prospective reimbursement system, is already forcing hospitals to absorb excessive operating costs rather than pass them on to the federal government. Medicare has also started moving in the same direction with respect to excessive capital costs, which may by the 21st century also be denied Medicare reimbursement. This strategy provides powerful incentives for hospitals to reexamine their operations and take the sometimes painful steps needed to eliminate inefficiencies. But those incentives would be undermined if high-cost hospitals could freely "cost-shift" onto private payers the excessive costs Medicare refuses to pay for, without competition from hospitals with lower costs and more reasonable prices. It has been our experience that the presence of lower-priced competitors to whom consumers can turn

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[26] Some economic studies also indicate that managed care can substantially constrain hospital prices or costs, at least when managed care health plans can choose among a wide range of hospitals available to their beneficiaries. See, e.g., Glenn A. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. Health Econ. 217 (1992); J. Robinson, HMO Market Penetration and Hospital Cost Inflation in California, J. Am. Med. Ass'n (November 20, 1991); J. Zwanziger and G. Melnick, The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California, 7 J. Health Econ. 301 (1988).

significantly helps motivate inefficient hospitals to confront and overcome their inefficiencies and contain their costs.

Some in the hospital industry and elsewhere apparently believe that antitrust enforcement effort impedes rather than promotes the provision of economical, high-quality hospital care, because it blocks or discourages efficient mergers and joint ventures among hospitals. Indeed, it is said that the Commission's focus on preserving competitive hospital markets is at odds with other policies being implemented by HHS that encourage hospitals to become more efficient.

But sound antitrust policy does not conflict with health care cost containment efforts. HHS seeks to promote low-cost, high-quality hospital care. So does the Commission, in its health care antitrust enforcement program.

The Commission and the Justice Department have jointly issued merger guidelines which set forth the analytical framework the agencies use in determining whether a merger is likely to lessen competition.[27] Those Guidelines emphasize the need to look beyond market concentration to determine whether a particular merger is inconsistent with the federal antitrust laws' objective of preserving competition and thereby promoting low-priced, high-quality goods and services for the consumer. In any industry, it is necessary to look at a broad range of market characteristics to determine whether the increase in concentration and the elimination of a competitor through a merger would likely threaten consumer interests.[28] These other factors include efficiencies and other consumer benefits that the merger might make possible.[29] The Commission accordingly is

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[27] Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines (April 2, 1992).

[28] Id.

[29] Claims of efficiencies will only be considered if they are realistic and supported by the evidence. Notably, in three of the four hospital merger cases decided after litigation in which potential efficiencies were a significant issue, the hospitals' arguments on that issue were rejected as factually unpersuasive. See FTC v. University Health, Inc., 938 F.2d 1206, 1223-24 (11th Cir. 1991); United States v. Rockford Memorial Corp., 717 F. Supp. 1251, 1287-91 (N.D. Ill. 1989), aff'd, 898 F.2d 1278 (7th Cir.), cert. denied, 111 S.Ct. 295 (1990); American Medical Int'l, 104 F.T.C. 1, 148-155, 218-20 (1984). However, the Commission has weighed potential efficiencies in reaching its decision not to challenge certain hospital transactions.

careful to make sure that its enforcement actions in hospital markets in fact serve consumer interests.

The federal agencies' enforcement record reflects their recognition that most mergers and joint ventures, in the hospital industry as in any other, are likely to help (or at least not harm) consumers. Out of approximately 50-100 hospital mergers and similar transactions each year (including leases, management contracts, and other non-purchase, non-merger transactions consolidating the operations of previously independent hospitals), on average only a handful are investigated by either the Commission or the Justice Department. And less than once a year has the Commission actually challenged a hospital merger as anticompetitive. Moreover, neither the Commission nor the Justice Department has ever challenged any of the numerous joint ventures among hospitals. Indeed, when they have challenged proposed mergers, the agencies have identified joint ventures--for example, an existing magnetic resonance imaging ("MRI") service shared between two hospitals in Augusta, Georgia, where the Commission challenged a proposed hospital merger[30]--as desirable alternatives for hospitals to achieve efficiencies to improve specific services without sacrificing the larger benefits of price and quality competition by merging their entire operations.[31] Consequently, the vast majority of the more than five thousand hospitals in the United States are able to go about their business and pursue whatever cost-containment measures they find necessary without any intervention from the antitrust enforcement agencies.

The Commission not only has limited its enforcement actions to hospital mergers that could have been genuinely harmful, but also has made considerable efforts to publicize and clarify its enforcement policies in that area so as not to discourage legal,

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[30] FTC v. University Health, Inc., 1991-1 Trade Cases (CCH) ¶¶ 69,400, 69,444 (S.D. Ga.), rev'd, 938 F.2d 1206 (11th Cir. 1991).

[31] See Reading Hospital, 55 Fed. Reg. 3264, 3266, 15290 (1990) (consent order) (Commission determined that voluntary separation of merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continued to participate in a hospital-sponsored health plan joint venture, and to share laundry, laboratory and biomedical equipment repair services). In addition, the consent order to settle the administrative proceedings in University Health, Inc., FTC Docket No. 9246, 57 Fed. Reg. 29,084, 44,748 (1992) exempts a wide range of support service joint ventures between hospitals from the order's provisions for Commission oversight of respondents' future hospital mergers and joint ventures.

beneficial transactions. The court and Commission decisions in litigated hospital merger cases explain in great detail how to apply antitrust principles to such transactions. These decisions are amply supplemented by formal statements, such as the 1992 Merger Guidelines issued by the Department of Justice and the Federal Trade Commission, and also by well over a dozen speeches by senior agency officials discussing hospital mergers and joint ventures,[32] as well as the hospital industry's own efforts to educate itself on how the antitrust laws apply to mergers and joint ventures.[33] And the Commission's staff is readily available for informal consultation to provide additional clarification and assistance to hospital officials thinking about a merger or joint venture. All of these resources are available to help hospital executives ensure that their proposed mergers and joint ventures comply with the antitrust laws, and dispel any unwarranted fears to the contrary.

Antitrust enforcement has played an important role in facilitating reforms in the health care sector and the hospital industry in particular, by removing obstacles to the use of innovations such as managed care to take advantage of competition to contain costs and overcome some of the inefficiencies of health care markets. It continues to have a useful role in improving the performance of the hospital industry as it is now structured, and also in leaving the door open to further reforms of the health care system that would rely even more heavily on competition as a cost-containment strategy.

IV. Effects of Senate Bills 2295 and 2426.

We believe that antitrust enforcement action has not prevented cooperative agreements among hospitals or other health care institutions that would have been beneficial to consumers.[34] To the extent that the proposed legislation would

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[32] See, e.g., Speech by Janet Steiger, Chairman, FTC, to the National Health Lawyers Association (February 19, 1993).

[33] See, e.g., American Hospital Ass'n, Hospital Mergers: An Executive's Guide through the Antitrust Thicket (Sept. 1989).

[34] We know of no antitrust actions brought by private parties against cooperative agreements of the kind contemplated by these two bills. In theory, the risk of facing the costs of antitrust litigation or enforcement could discourage even some joint arrangements that would not be found illegal. In practice, though, the threat of government or private antitrust action has not, to

(continued...)

merely authorize the kinds of agreements that would not have been subject to antitrust challenge anyway, the legislation would have no adverse effect on competition. However, the provisions of these bills could be interpreted to encourage or permit agreements that are more explicitly anticompetitive in intention and effect than those contemplated before.[35] The chief source of concern would be agreements to allocate responsibilities that did not reflect efficiency-enhancing integration and coordination of capacities, but instead amounted to agreements to divide markets and refrain from competition. Such division and allocation of markets can be just as harmful to consumers as explicit price-fixing.

We recognize that policy concerns other than those considered in competition law enforcement may be important here. Some of the considerations that the bills list as possible benefits to be weighed against the disadvantages of reducing competition may indeed be such different and independent considerations. Many of them, though, describe the kinds of issues that the Commission considers in its competition enforcement decisions. For example, two factors, increased cost efficiency and improved use of resources, could include the kinds of considerations of true efficiencies that the Commission usually considers in antitrust analysis.[36] Others may be

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[34](...continued)
our knowledge, discouraged beneficial cooperative arrangements. Reports in trade journals suggest that the threat of antitrust action has not chilled collaborations. See, e.g., D. Burda, Mergers thrive despite wailing about adversity, Modern Healthcare (October 12, 1992).

[35] One kind of agreement among hospitals that was actually found to violate the antitrust laws would not have been protected from liability by either of these bills. See United States v. North Dakota Hospital Ass'n, 640 F.Supp. 1028 (D.N.D., 1986). The hospitals agreed not to negotiate contracts with the Indian Health Service that contained certain kinds of discount terms. This agreement did not involve any collaboration to offer services or combine operations to improve efficiency. The court found that this agreement violated the Sherman Act.

[36] For examples of consideration of such efficiencies in particular hospital mergers, see the cases cited in n. 29, supra. See generally Massachusetts Board of Registration in Optometry, 110 F.T.C. 549 (1988), for a discussion of how the Commission considers factors such as these in deciding other kinds of antitrust cases. These factors would not be considered in a case of pure price fixing among competitors, but would be important in a case involving a joint venture or other combination.

ambiguous. "Preservation of facilities" and "avoidance of duplication", although perhaps intended to include similar issues of efficiency, might include less clearly desirable results as well. Preservation of facilities may not be beneficial if the facilities are uneconomic or inefficient. Thus, in some circumstances eliminating redundant, underused facilities can improve the efficiency of operating those that remain. But the goal of avoiding duplication, to improve efficiency, may contradict the goal of preserving facilities.[37] Moreover, care may be needed to ensure that "avoiding duplication" does not become simply "avoiding competition" -- that is, the "avoiding duplication" goal might be interpreted, paradoxically, to suggest that a reduction in competition should be counted as a benefit, to be weighed against itself as a cost.

Because an informed assessment would conclude that antitrust risks are not inhibiting desirable cooperative agreements, and because permitting the health care industry to become accustomed to agreements to eliminate competition could harm consumers' interests without producing clear countervailing benefits, we recommend caution in proceeding with programs such as these bills propose. The process of negotiation among competitors could lead to anticompetitive understandings and market behavior even where no agreement is ever requested and no certificate is granted. And once certificates are granted, it will be more difficult to ensure that the agreements are implemented in ways that maintain the balance that justified their issuance.

The law sets two requirements for state action to remove the risk of federal antitrust liability for private actions such as these cooperative agreements among health care providers. First, the actions must be taken pursuant to a clearly articulated state policy to displace competition; and second, the state must actively supervise the policy.[38] The "active supervision"

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[37] Economic theory has suggested some specific, unusual circumstances, such as conditions of unsustainable natural monopoly, in which agreements or regulations preventing the entry of new capacity might prevent inefficiencies. See J. C. Panzer and R. D. Willig, Free Entry and the Sustainability of Natural Monopoly, 8 Bell J. of Econ. 1 (1977); see generally R. R. Braeutigam, Optimal Policies for Natural Monopolies, in R. Schmalensee and R. D. Willig, eds., 2 Handbook of Industrial Organization 1289 (1989). In such circumstances, theory would support the claim that preventing duplication would be consistent with promoting efficiency. But it has not been established whether these circumstances apply in health care or hospital markets.

[38] See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980).

requirement means that supervision must extend to specifics of implementation.[39] The Supreme Court has said that the purpose of the requirement is to ensure that the state has determined the specific details of a scheme that supplants competition; the mere potential for a state supervisory action is not enough.[40] Applying this requirement to health care, it has been held that an authorizing certificate would not confer antitrust immunity, in the absence of post-certificate monitoring of the parties' conduct to ensure that it was consistent with the state's policies.[41] Both of these bills would require that applications for certificates be reviewed and specifically approved before the certificates would be issued, but neither calls for subsequent scrutiny of the parties' actual operation, except by providing generally for the possibility of reexamination and revocation.[42] More particularized scrutiny of actual conduct under these agreements may not only be desirable to ensure that they continue to serve their intended purposes, but might also be necessary to accomplish the apparent goal of conferring antitrust immunity.

One additional way to reduce the risk that anticompetitive agreements would become institutionalized would be to issue certificates only for defined, limited terms. The burden would then clearly be on the parties, not the attorney general or the

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[39] F.T.C. v. Ticor Title Insurance Co., 112 S. Ct. 2169 (1992).

[40] Ticor, supra n. 39 at 2177 (the state must have exercised independent judgment and control "so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties"), 2179.

[41] See P.I.A. Asheville, Inc. v. North Carolina, 740 F.2d 274, 278 (4th Cir. 1984), cert. denied, 471 S. Ct 1003 (1985) (CON approval for hospital acquisition did not immunize from antitrust challenge; there was no active supervision of post-certificate conduct, and the federal program that the CON process implemented did not displace the antitrust laws).

[42] S.B. 2295 authorizes actions by the attorney general to revoke certificates, but does not specify whether the attorney general or the certificate holders have the burden of proof in an ensuing challenge to the revocation. S.B. 2295, §5(2). And although S.B. 2426 contains detailed provisions about challenges by the attorney general, the section that provides for the department of health to "initiate proceedings to terminate" a certificate (on finding that the benefits no longer outweigh the disadvantages) establishes no standards or procedures for its decision in those proceedings. S.B. 2426, §10.

department of health, to demonstrate that the benefits continue to outweigh the disadvantages.

V. Conclusion.

In summary, we believe that competition has been an important factor in bringing about beneficial changes in how health care services are delivered to consumers. Experience does not demonstrate that immunity from antitrust liability is necessary to permit hospitals or other institutional providers to undertake cooperative arrangements to improve the quality of care they provide and make their operations more efficient. Thus, we recommend that, if measures such as these bills are nonetheless considered desirable for other policy reasons, measures be included to make it easier, rather than more difficult, to terminate "agreements" whose net effect is detrimental to consumers' interests. We hope these comments are of assistance.

Sincerely,

Michael O. Wise
Acting Director

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

February 14, 2008

The Honorable William J. Seitz
Ohio Statehouse
Ground Floor, RM # 38
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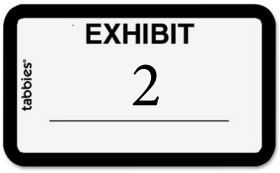

Dear Senator Seitz:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] are pleased to respond to your request that we review and comment on the likely competitive effects of Ohio Executive Order 2007 – 23S (Executive Order or Order), which establishes collective bargaining for home health care workers. In your letter, you asked the Federal Trade Commission (FTC or Commission) whether the Executive Order is liable to create competition problems because it confers collective bargaining powers on some health care providers and not others, whether "the unionization of small business owners who contract with the state for provision of home health care services funded under the Medicaid program violates federal antitrust laws," and "whether the program established by the Executive Order is immune from the federal antitrust laws under either the 'state action' immunity doctrine" or federal labor law.[2]

The Executive Order provides for collective bargaining on behalf of all Independent Home Care Providers (IHCPs), "regarding reimbursement rates, benefits, and other terms."[3] In our judgment, such collective bargaining may raise the cost of home health care services, and reduce access to them. At the same time, collective bargaining is not likely to ensure better quality care as a countervailing benefit for health care consumers. For those reasons, the Commission has enforced the antitrust laws when certain private groups of health care providers have colluded to fix prices,

[1] This letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Federal Trade Commission (FTC or Commission) or of any individual Commissioner. The Commission has, however, voted to authorize us to submit these comments.

[2] Letter from Rep. William J. Seitz, Ohio House of Representatives, to Maureen K. Ohlhausen, Director, Office of Policy Planning, Federal Trade Commission (Sept. 24, 2007).

[3] Ohio Exec. Order 2007 – 23S, Establishing Collective Bargaining for Home Health Care Workers, 4 (July 17, 2007) (Executive Order), *available at* http://www.governor.ohio.gov/Portals/0/Executive%20Order%202007-23S.pdf.

and the Commission consistently has opposed legislative proposals to exempt from antitrust scrutiny various categories of health care providers. In fact, the Executive Order appears to require that private parties engage in conduct that normally would be deemed *per se* violations of federal antitrust law, including price fixing between competitors, unless protected by an immunity or exemption from antitrust scrutiny.

Interest and Experience of the Federal Trade Commission

Congress has charged the FTC with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Pursuant to its statutory mandate, the Commission seeks to identify business practices and regulations that impede competition without offering countervailing benefits to consumers. For several decades, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[5] The FTC and its staff have issued studies and reports regarding various aspects of the health care industry,[6] and the Commission has brought numerous enforcement actions against entities in the industry that have violated federal antitrust laws.[7] In addition, the FTC and its staff have analyzed competition issues raised by proposed state and federal regulation of health care markets.[8]

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[4] Federal Trade Commission Act, 15 U.S.C. § 45.

[5] *See* Federal Trade Commission, *FTC Antitrust Actions in Health Care Services and Products*, *available at* http://www.ftc.gov/bc/hcupdate031024.pdf.

[6] *See, e.g.*, FEDERAL TRADE COMMISSION, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005), *available at* http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf; FEDERAL TRADE COMMISSION, THE STRENGTH OF COMPETITION IN THE SALE OF CONTACT LENSES: AN FTC STUDY (2005), *available at http://www.ftc.gov/reports/contactlens/050214contactlensrpt.pdf*; FEDERAL TRADE COMMISSION AND DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004) (IMPROVING HEALTH CARE), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[7] *See, e.g.*, In the Matter of Colegio de Optometras de Puerto Rico, FTC File No.: 051 0044 (Sept. 11, 2007) (Decision and Order), *available at* http://www.ftc.gov/os/caselist/0510044/070730decision.pdf (price fixing and concerted refusal to deal with vision and health plans by optometrists); In the Matter of Advocate Health Partners, et al., FTC File No. 031-0021 (Dec. 29, 2006) (Agreement Containing Consent Order to Cease and Desist), *available at* http://www.ftc.gov/os/caselist/0310021/061229agree0310021.pdf (horizontal agreements to fix prices, engage in collective bargaining, and refuse to deal individually with health plans by competing independent physicians and physician practice groups accounting for over 2,900 physicians in Chicago metropolitan area).

[8] *See Prepared Statement of the Federal Trade Commission Concerning H.R. 971, "the Community Pharmacy Fairness Act of 2007," Before the Antitrust Task Force of the H. Comm. on the Judiciary*, 110th Cong. (Oct. 18, 2007), available at http://www.ftc.gov/os/testimony/P859910pharm.pdf (analyzing critically proposal to exempt non-publicly traded pharmacies from antitrust scrutiny); *see also* FTC Staff Comment to the Hon. Nelie Pou Concerning New Jersey A.B. A-310 to Regulate Contractual Relationships Between Pharmacy Benefit Managers and Health Benefit Plans (Apr. 2007), *available at* http://www.ftc.gov/opp/advocacy_date.shtm; Comments of the FTC Staff Before the FDA In the Matter of Request for Comments on Agency Draft Guidance Documents Regarding Consumer-Directed Promotion (May 10, 2004), *available at* http://www.ftc.gov/os/2004/05/040512dtcdrugscomment.pdf.

More specifically, the FTC has focused on competition issues raised by collective bargaining by health care service providers. In addition to investigations conducted in the course of enforcement actions, there have been more general inquiries by the Commission and its staff into market issues pertinent to the Executive Order. For example, the FTC and the Department of Justice Antitrust Division (DOJ) jointly issued Health Care Statements dealing with, among other things, practitioner integration issues.[9] In 2003, FTC and DOJ considered diverse competition issues raised by health care markets in joint hearings.[10] Among the issues investigated in those hearings were the following: competition, regulation, and market entry issues for diverse health care professionals and para-professionals; unionization issues for health care service providers; professional vertical and horizontal integration issues; Medicaid and Medicare issues; and the impact of the state action doctrine on competition law and policy.[11] In 2004, the FTC and DOJ issued a report based on the hearings, a 2002 FTC-sponsored workshop, and independent research.[12]

In addition, the Commission's staff has conducted an in-depth review of the state action doctrine and has issued a report regarding the doctrine and its impact on competition in diverse markets.[13] FTC staff have presented testimony on the state action doctrine to the Antitrust Modernization Commission (AMC),[14] and FTC enforcement activities have been central to defining the scope of the doctrine.[15]

Discussion

A. The Executive Order Establishes Collective Bargaining for Certain Home Health Care Workers.

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[9] *See* STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (Aug. 1996) (Health Care Statements), *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf. An application is discussed *infra*, at text accompanying notes 33-38.

[10] *See* Hearings on Health Care and Competition Law and Policy, June 26, 2003. An overview of the hearings, with links to agendas and supporting materials, including hearing transcripts and public comments, is available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

[11] *See id.*

[12] *See generally* IMPROVING HEALTH CARE, *supra* note 6.

[13] FEDERAL TRADE COMMISSION, OFFICE OF POLICY PLANNING, REPORT OF THE STATE ACTION TASK FORCE (Sept. 2003), *available at http://www.ftc.gov/os/2003/09/stateactionreport.pdf*; *cf.* FEDERAL TRADE COMMISSION, ENFORCEMENT PERSPECTIVES ON THE NOERR-PENNINGTON DOCTRINE: AN FTC STAFF REPORT (2006), *available at* http://www.ftc.gov/reports/P013518enfperspectNoerr-Penningtondoctrine.pdf (regarding scope of protection for anticompetitive conduct that petitions for government action).

[14] *See, e.g.*, Prepared Statement of Maureen K. Ohlhausen, Director, Office of Policy Planning, Federal Trade Commission Before the Antitrust Modernization Commission, on the State Action Doctrine 2 (Sept. 29, 2005), *available at* http://www.ftc.gov/os/2005/09/050929antitrustmod.pdf.

[15] *See, e.g.*, Federal Trade Commission v. Ticor Title Ins. Co., 504 U.S. 621, 639-40 (1992) (upholding FTC determination that horizontal price fixing by rate regulation boards established by Montana and Wisconsin was not immune because they failed the "active supervision" requirement).

In July 2007, Ohio Governor Ted Strickland issued Executive Order 2007 – 23S, "Establishing Collective Bargaining for Home Health Care Workers."[16] The Executive Order seeks to establish collective bargaining for IHCPs, defined as "those providers of ongoing Medicaid reimbursed direct care services that are paid for through a Medicaid waiver program in the State of Ohio and not employed by a private agency."[17] The Executive Order stipulates state recognition of "one representative as the exclusive collective bargaining representative for all IHCPs."[18] Procedures for creating an "eligible voter list," certification and decertification of the exclusive bargaining representative, and bargaining between the state and the exclusive bargaining representative are also specified.[19] The Order also stipulates that "the State, acting throughout the Office of the Governor or his designee, shall engage in collective bargaining with the elected representative of IHCPs regarding reimbursement rates, benefits, and other terms."[20]

We note that the Executive Order states that collective bargaining should be undertaken "to ensure that the quality of services provided to in-home health care recipients remains constant,"[21] but that it contains no particular quality of care provisions.[22] We note, too, that the Executive Order specifies that, "the State intends that the 'State action exemption' to the application of the federal and state antitrust laws be fully available to the State, IHCPs, and their elected representative to the extent that their activities are authorized pursuant to this Executive Order."[23] At the same time, the Executive Order does not offer, and appears not to be accompanied by, any analysis of the state action doctrine or its potential application to the instant case.

B. The Contemplated Collective Bargaining Would Be Anticompetitive.

Since the advent of active antitrust enforcement in health care services markets, health care providers have sought antitrust exemptions in state and federal legislatures. Although varied in certain regards, such proposals have all, at bottom, sought protection from antitrust scrutiny for anticompetitive conduct that would tend to raise the prices of health care services without conferring countervailing benefits on health care consumers. Recognizing that many Americans face difficult health care choices in the market already, the FTC consistently has opposed such proposals. The Commission

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[16] Executive Order, *supra* note 3.

[17] *Id.* at 2.

[18] *Id.*

[19] *See id.* at 2-5.

[20] *Id.* at 4.

[21] *Id.* at 1.

[22] The Executive Order does observe that "the State retains its responsibilities … to take appropriate action when an IHCP fails to behave in a manner consistent with his or her provider agreement." *Id.* at 4.

[23] *Id.* at 5.

has enforced the antitrust laws when certain private groups of health care providers have colluded to fix prices,[24] and the Commission has opposed legislative proposals to exempt from antitrust scrutiny various categories of health care providers.[25]

In the FTC staff's judgment, the Executive Order raises the same sorts of competition concerns as have those cases and legislative proposals. As FTC staff explained in a 2002 letter to then-Representative Stapleton,

> There is widespread agreement among antitrust authorities that this type of naked horizontal price-fixing is among the most serious of competitive concerns, as such conduct predictably and consistently results in substantial consumer harm. . . . Without antitrust enforcement to block price fixing . . . we can expect prices for health care services to rise substantially. . . . For example, collective fee demands by pharmacists in the State of New York cost the state an estimated $7 million in increased health benefits expenditures for state employees. In other cases, the Commission accepted consent orders settling charges that physician collective bargaining forced health plans to raise their reimbursement rates - with the attendant risk of increases in premiums for policy holders - and state and local governments to raise . . . reimbursement levels . . . .[26]

The analysis is consistent across different types of health care service providers.[27] Just this year the AMC – the body created by Congress to evaluate the application of our nation's antitrust laws – addressed the subject of antitrust exemptions. The AMC urged Congress to exercise caution, pointing out that antitrust exemptions typically "create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a

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[24] *See, e.g.*, In the Matter of Colegio de Optometras de Puerto Rico, *supra* note 7 (price fixing and concerted refusal to deal with vision and health plans by optometrists); In the Matter of Advocate Health Partners, et al., *supra* note 7 (horizontal agreements to fix prices, engage in collective bargaining, and refuse to deal individually with health plans by competing independent physicians and physician practice groups accounting for over 2,900 physicians in Chicago metropolitan area).

[25] *See, e.g.*, Letter from Federal Trade Commission Staff to the Hon. Dennis Stapleton, Ohio House of Representatives (Oct. 16, 2002) (criticizing proposed antitrust exemption for health care providers), *available at* http://www.ftc.gov/os/2002/10/ohb325.htm; *see also Prepared Statement of the Federal Trade Commission Concerning H.R. 971*, *supra* note 8 (analyzing critically proposal to exempt non-publicly traded pharmacies from antitrust scrutiny); *Testimony of Robert Pitofsky, Chairman, Federal Trade Commission, on H.R. 1304, the "Quality Health-Care Coalition Act of 1999" Before the H. Comm. on the Judiciary*, 106th Cong. (June 22, 1999), *available at* http://www.ftc.gov/os/1999/06/healthcaretestimony.htm (regarding federal legislation that would have exempted all health care workers from antitrust scrutiny).

[26] Letter from Federal Trade Commission Staff to the Hon. Dennis Stapleton, *supra* note 25, at 2 (internal citations omitted). The magnitude of consumer harm – or potential consumer harm – can vary according to market size, market power, conduct, and other factors difficult to specify absent detailed analysis of particular markets. We note too that the Executive Order limits the power of the collective entity to strike, which may also be a factor.

[27] That is, the competition concerns are analogous across these various markets. *See id.*

large population of consumers through higher prices, reduced output, lower quality, and reduced innovation."[28]

Although the Executive Order only requires collective bargaining with the State itself, and only for services provided under Ohio's Medicaid waiver, Ohio consumers are not insulated from the effects of such collective bargaining. First, to the extent that the Executive Order raises reimbursement under the waiver, it raises the cost of a program supported by Ohio and federal taxpayers.[29] Second, the anti-consumer effects of the Executive Order are liable to spill over into other segments of the market for home health care services. Home health care services represent diverse medical and social support services billed to diverse payers.[30] Among the payers are private individuals who self-pay, private third-party payers, and public third party payers – including not just Medicaid but Medicare, the Veterans Administration, and others.[31] Although the Executive Order defines IHCPs as "those providers of ongoing Medicaid reimbursed direct care services that are paid for through a Medicaid waiver program in the State of Ohio and are not employed by a private agency,"[32] it does not define IHCPs as those who provide only such services and no others. Indeed, it may not be practicable to restrict such collective bargaining to service providers who deliver no professional services, and receive no reimbursement, except under the State's Medicaid waiver program. To that extent, there is a very real risk of unanticipated anticompetitive effects.

In brief, once IHCPs are organized – or combined – for the purpose of negotiating price and other terms with the State, there is a significant likelihood that such anticompetitive conduct will harm other payers beyond Medicaid.

C. Unless Shielded from Antitrust Scrutiny, the Private Conduct Contemplated in the Executive Order Would Violate Federal Antitrust Law.

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[28] ANTITRUST MODERNIZATION COMMISSION, REPORT AND RECOMMENDATIONS 335 (Apr. 2007) *available at* http://www.amc.gov/report_recommendation/toc.htm.

[29] Title XIX of the Social Security Act establishes the joint federal and state Medicaid program and sets forth terms for federal payments to the states. *See* 42 U.S.C. § 1396b (payments to the states).

[30] *See, e.g.*, *Home Health Care Overview*, Ohio State University Medical Center, *available at* http://medicalcenter.osu.edu/patientcare/healthcare_services/senior_health/home_healthcare_overview/. The Executive Order recognizes that there are home health care services that fall outside its terms, as well as providers who do not meet its definition of an IHCP. *See* Executive Order, *supra* note 3, at 2 (contemplating conditions under which state should consider expanding IHCP definition to include long-term personal care services and noting that IHCPs are only those providers "not employed by a private agency").

[31] *See, e.g.*, *Paying for Home Health and Hospice Care*, Ohio State University Medical Ctr, *available at* http://medicalcenter.osu.edu/patientcare/healthcare_services/senior_health/paying_for_home_health_hospice_care/.

[32] Executive Order, *supra* note 3, at 2.

Unless shielded from antitrust scrutiny by an exemption or immunity, the private conduct contemplated by the Executive Order would violate the antitrust laws. Specifically, the Order would permit competing providers to agree on the prices they would accept for their services, which constitutes *per se* illegal price fixing. The Health Care Statements issued by the FTC and DOJ address this issue directly.[33] In Example 3 of Statement 8, competing providers form a hypothetical independent practice association (IPA) to "combat the power" of managed care plans by negotiating with them collectively rather than individually.[34] The IPA involves no integration that is likely to result in significant efficiencies (*i.e.*, no financial risk sharing among the members; no indicia of clinical integration, such as joint development of protocols for improving care). In addition, as noted above, the Executive Order contains no particular quality of care provisions and makes reference to no particular means of ensuring the quality of care.[35] Collusion under these terms could, in fact, tend to reduce competition on qualitative aspects of home health care services. This combination – collective negotiation over price and no significant efficiency-enhancing integration – means that the agreement to bargain "will be treated as *per se* illegal price fixing."[36] In short, collective bargaining over prices is *per se* illegal price fixing[37] and is inconsistent with antitrust law and policy.[38]

D. The State Action Doctrine and Federal Labor Laws.

1. The State Action Doctrine: The Executive Order says that "[t]he State Action Doctrine Applies for the Purpose of Antitrust Laws."[39] The state action doctrine – first articulated by the Supreme Court in *Parker v. Brown*[40] – shields certain anticompetitive conduct by the states from federal antitrust scrutiny. Although a legal analysis of the state action doctrine, and its application to the Executive Order and private conduct related to the Executive Order, is beyond the scope of this letter, we

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[33] *See generally* HEALTH CARE STATEMENTS, *supra* note 9.

[34] Although the professional health care providers in the hypothetical are physicians, the antitrust analysis is the same.

[35] The Executive Order does observe that "the State retains its responsibilities … to take appropriate action when an IHCP fails to behave in a manner consistent with his or her provider agreement." Executive Order, *supra* note 3, at 4.

[36] HEALTH CARE STATEMENTS, *supra* note 9, at Example 3, Statement 8.

[37] *See, e.g.*, FTC v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411, 422 (1990).

[38] As the Supreme Court has observed, "The preservation of the free market and of a system of free enterprise without price fixing or cartels is essential to economic freedom." *Ticor Title*, *supra* note 15, at 632 (citing United States v. Topco Associates, Inc., 405 U.S. 596, 610 (1972)). We also note that, with reference to the spillover effects discussed above, such conduct may violate the antitrust laws independent of any explicit agreement to negotiate price with such payers. *See, e.g.* , United States v. General Motors Corp., 384 U.S. 127, 142-43 (1966) ("it has long been settled that explicit agreement is not a necessary part of a Sherman Act conspiracy"); Alvord-Polk, Inc. v. F. Schumacher & Co., 37 F.3d 996, 1000 (3d Cir. 1994); ES Dev., Inc. v. RWM Enterprises, Inc., 939 F.2d 547, 553 (8th Cir. 1991).

[39] Executive Order, *supra* note 3, at 5.

[40] 317 U.S. 341 (1943).

note that it is settled law that states cannot immunize private anticompetitive conduct merely by stipulating the application of state action immunity.[41]

Parker represents the Court's reading of the preemptive reach of the Sherman Act,[42] a reading "grounded in principles of federalism."[43] In *Parker*, the Court found "nothing in the language of the Sherman Act or its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by the legislature."[44] Accordingly, the Court held that the Sherman Act does not prohibit state regulation that tends to suppress competition when "the state itself exercises its legislative authority" and, "as sovereign," adopts and enforces such regulation.[45] Notably, however, the Court has recognized that the principles of federalism underlying the state action doctrine are best served if *Parker* immunity is narrowly construed: "Neither federalism nor political responsibility is well served by a rule that essential national policies are displaced by state regulations intended to achieve more limited ends."[46]

Under the state action doctrine, the conduct of the state, as sovereign, generally is immune from antitrust scrutiny. However, "[t]he national policy in favor of competition cannot be thwarted by casting … a gauzy cloak of state involvement over what is essentially a private price fixing arrangement."[47] Although states *themselves* may adopt and implement policies in tension with federal antitrust law, subordinate political entities, including state regulatory boards and municipalities, "are not beyond the reach of the antitrust laws because they are not themselves sovereign."[48] Private parties, moreover, are not insulated from antitrust scrutiny merely because a state legislature stipulates their immunity.[49] When a state expresses a policy to displace competition in favor of regulation, but delegates to private parties the implementation of that policy, *Parker* immunity requires establishing that the anticompetitive conduct

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[41] *See* text accompanying notes 46-54, *infra*, regarding certain state action doctrine limits. Analysis of the question whether the Order is preempted by the federal Social Security Act and its implementing regulations is also outside the scope of this letter.

[42] "We may assume also, without deciding, that congress could, in the exercise of its commerce power, prohibit a state from maintaining … [such a program] because of its effect on interstate commerce." Parker, 317 U.S. at 350.

[43] *Ticor Title*, *supra* note 15, at 633.

[44] *Parker*, 317 U.S. at 350-351.

[45] *Id.* at 352.

[46] *Ticor Title*, 504 U.S. at 636.

[47] Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, 445 U.S. 97, 106 (1980).

[48] Town of Hallie v. City of Eau Claire, 471 U.S. 34, 38 (1985) (municipality not the sovereign); *see also* Southern Motor Carriers Rate Conference v. United States, 471 U.S. 48, 62-63 (1985) (state Public Service Commissions "acting alone" could not shield anticompetitive conduct from antitrust scrutiny); Goldfarb v. Virginia State Bar, 421 U.S. 773, 791-92 (1975) (state bar association, which was state agency for certain purposes, not entitled to state action exemption).

[49] *Midcal*, 445 U.S. at 106 ("a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful.")

is sufficiently "the state's own."[50] Two tests are required for that purpose: "First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; second, the policy must be 'actively supervised' by the State itself."[51] Because "IHCPs are not State employees,"[52] collective bargaining by them or their privately elected representatives cannot be immune unless it passes both of these tests. For example, in *California Retail Liquor Dealers Association v. Midcal Aluminum Inc.*,[53] California's system for wine pricing was not immune from antitrust scrutiny because the legislature itself did not establish prices, review the reasonableness of price schedules, or engage in any "pointed reexamination" of the program – hence, failing the active supervision test.[54]

2. Federal Labor Law Issues: The Executive Order seeks to confer antitrust immunity styled as a labor exemption. Although FTC staff is primarily concerned with the competition and antitrust law implications of the Executive Order, the staff does note that the Order appears entirely at odds with federal labor policy. The federal labor exemption is limited to the employer-employee context; it does not protect combinations of independent business people.[55] The Order, however, expressly excludes employees in favor of independent contractors,[56] inverting the distinction Congress drew between them. Unlike the labor law system, the Executive Order also lacks the exclusions from protected negotiations for subjects unrelated to the intended purpose of those laws, as well as the oversight of the process by the National Labor Relations Board.

Moreover, the creation of a labor exemption for home health care workers is offered as a remedy for problems that collective bargaining was never intended to address. The stated goal of the Executive Order is to "ensure that the quality of services provided to in-home health care recipients remains constant."[57] The labor exemption, however, was not created to ensure the safety or quality of products or services. Collective bargaining rights are designed to raise the incomes and improve

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[50] *Ticor Title*, 504 U.S. at 635.

[51] Midcal, 445 U.S. at 105 (quoting City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978)).

[52] Executive Order, *supra* note 3, at 4.

[53] *Supra* note 51.

[54] *Id.* at 105-106.

[55] *See, e.g.*, Columbia River Packers Ass'n v. Hinton, 315 U.S. 143 (1942); United States v. Women's Sportswear Mfg. Ass'n, 336 U.S. 460 (1949); American Medical Ass'n v. United States, 317 U.S. 519, 533-36 (1943) (rejecting assertions that the labor exemption to the antitrust laws applied to joint efforts by independent physicians and their professional associations to boycott an HMO in order to force it to cease operating). NLRA Section 2 (3) gives the right to bargain collectively only to "employees." The 1947 Taft-Hartley amendments to the NLRA included a provision expressly stating that the term "employee" does not include "any individual having the status of an independent contractor." 29 U.S.C. § 152 (3).

[56] Executive Order, *supra* note 3, at 2.

[57] *Id.* at 1.

the working conditions of union members. The law protects, for example, the United Auto Workers' right to bargain for higher wages and better working conditions, but we do not rely on the union to bargain for safer, more reliable, or more fuel-efficient cars. Congress has addressed those concerns in other ways, as well as relying on competition among automobile manufacturers to encourage product improvements. The quality of home health care deserves serious consideration, but a labor exemption is ill-suited to the task.

In sum, the Executive Order is designed to confer a labor exemption on parties whose situations are very different from those eligible for the exemption under well-established principles of labor law. Instead, it would grant private independent contractors a broad immunity to present a "united front" when negotiating price and other terms in dealing with the State of Ohio and very likely other public and private payers.

Conclusions

Since the advent of active antitrust enforcement in health care services markets, health care providers have sought antitrust exemptions in state and federal legislatures. Although varied in certain regards, such proposals have all, at bottom, sought protection from antitrust scrutiny for anti-competitive conduct that would tend to raise the prices of health care services without conferring countervailing benefits on health care consumers. Recognizing that many Americans face hard health care choices in the market already, the FTC consistently has opposed such proposals.

In staff's judgment, the Executive Order raises the same competition concerns raised by those legislative proposals. Horizontal price fixing by independent health care providers tends to work to the substantial detriment of health care consumers and is inconsistent with federal antitrust law. Claims of immunity from antitrust scrutiny based on, for example, federal labor laws, are, in our judgment, problematic.

In brief, FTC staff is concerned that the Executive Order is likely to foster certain anticompetitive conduct that is inconsistent with federal antitrust law and policy, and that such conduct could work to the detriment of Ohio home health care consumers.

Respectfully submitted,

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Director
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Director
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UNITED STATES OF AMERICA
Federal Trade Commission
WASHINGTON, D.C. 20580

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EXHIBIT
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June 5, 2015

The Honorable Michael H. Ranzenhofer
New York State Senate
188 State Street
Legislative Office Building, Room 609
Albany, New York 12247

The Honorable Thomas Abinanti
New York State Assembly
198 State Street
Legislative Office Building, Room 744
Albany, New York 12248

Re: New York Senate Bill 2647 and New York Assembly Bill 2888, Acts to Amend the Public Authorities Law, in Relation to Authorizing the Erie County Medical Center Corporation and the Westchester County Health Care Corporation, respectively, to Enter into Agreements for the Creation and Operation of a Health Care Delivery System Network

Dear Senator Ranzenhofer and Assemblyman Abinanti:

The staffs of the Federal Trade Commission's ("FTC" or "Commission") Office of Policy Planning, Bureau of Competition, Bureau of Economics, and Northeast Regional Office[1] respectfully submit this letter regarding of the impact of New York Senate Bill 2647 ("S-2647") and New York Assembly Bill 2888 ("A-2888") (collectively, "the bills") on competition for health care services. FTC staff is aware that the New York Attorney General's office ("NY AG") recently submitted a letter opposing this legislation,[2] and we share its concerns. The proposed bills would authorize Erie County Medical Center Corporation ("ECMC") and Westchester County Health Care Corporation ("WCHC") to collaborate with other public and private health care providers and payors. The proposed bills purportedly would provide these health care corporations, as well as the entities with which they collaborate, with broad immunity from liability under the federal and state antitrust laws – even though this purported immunity would cover the kinds of information sharing and joint contract negotiations that are likely to result in reduced competition and higher prices for consumers. For the reasons described below, FTC staff urges the New York State Senate and Assembly to reconsider whether these entities need state action immunity to engage in beneficial collaborative activities.

FTC staff fully recognizes that collaborations among health care providers often are procompetitive, and we applaud state efforts to achieve meaningful health care reforms, including initiatives that lower the costs of health care services, improve their quality, and expand patient access. We are concerned, however, that the proposed legislation is based on inaccurate premises regarding the antitrust laws and the value of competition among health care providers. The FTC recently submitted a public comment to the New York State Department of Health ("NY DOH") to express similar concerns regarding the potential competitive impact of the Certificate of Public Advantage ("COPA") applications submitted by three performing provider systems participating in the Delivery System Reform Incentive Program ("DSRIP").[3]

Antitrust immunity is unnecessary for ECMC and WCHC to engage in procompetitive collaborative activities. The antitrust laws are not a barrier to the formation of efficient health care collaborations that benefit health care consumers, as explained in extensive guidance issued by the federal antitrust agencies. Indeed, very few health care provider mergers, joint ventures, or other types of collaborations are challenged by the federal antitrust agencies. Because procompetitive or competitively benign health care collaborations already are permissible under the antitrust laws, the main effect of this legislation is to immunize conduct that would *not* generate efficiencies that are greater than consumer harms, and therefore would *not* pass muster under the antitrust laws. Therefore, these bills are likely to lead to increased health care costs – in the form of higher premiums, co-pays, deductibles, and other out-of-pocket expenses – and decreased access to health care services for New York consumers. As discussed in greater detail below, this may result from information sharing and joint contract negotiations among competitors, as well as increased market power through provider consolidation.

I. Interest and Experience of the Federal Trade Commission

Congress has charged the FTC with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Competition is at the core of America's economy,[5] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality goods and services, greater access to goods and services, and innovation.[6] Pursuant to its statutory mandate, the FTC seeks to identify business practices, laws, and regulations that may impede competition without providing countervailing benefits to consumers.

Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,[7] research,[8] and advocacy.[9] Of particular relevance, the Commission and its staff have long advocated against federal and state legislative proposals that seek to create antitrust exemptions for collective negotiations by health care providers, as such exemptions are likely to harm consumers.[10]

II. New York Senate Bill 2647 and New York Assembly Bill 2888

These two bills, introduced in the New York state legislature in January 2015, are intended to extend state action immunity to ECMC and WCHC, public benefit corporations created by the New York State Public Authorities Law,[11] as well as any private and public entities with which they collaborate. These bills are identical to a bill enacted in June 2013, which conferred state action immunity to the Nassau Health Care Corporation ("NHCC") and the entities with which it collaborates.[12]

Sponsors of the bills claim that ECMC and WCHC have always had the authority to collaborate with private and public entities under the general and special powers granted to them under the Public Authorities Law.[13] However, following the recent U.S. Supreme Court decision in *FTC v. Phoebe Putney Health System, Inc.*,[14] the bills "seek[] to clarify [the state's] intention that such collaborations may be carried out regardless of whether they displace competition and may otherwise be considered violations of state or federal antitrust laws."[15]

According to the proposed bills, "the benefits of collaboration by the corporation outweigh any adverse impact on competition."[16] These purported benefits include expanding access to health care services, as well as consolidating unneeded or duplicative health care services, enhancing the quality of health care services, lowering the costs and improving the efficiencies of health care services, and achieving improved reimbursement from commercial payors. Based on these alleged benefits, the bills propose to amend the public authorities law to expressly allow these corporations "to engage in collaborative activities consistent with [their] health care purposes, notwithstanding that those collaborations may have the effect of displacing competition in the provision of hospital, physician or other health care-related services."[17]

The bills also discuss the state's oversight of ECMC and WCHC. However, it is unclear to what degree the collaborative activities of ECMC and WCHC will be actively supervised by the state. States may provide antitrust immunity for certain activities when there is a clearly articulated state policy to displace competition and there is active supervision of the policy or activity.[18] FTC staff takes no position at this time on whether the amendments contemplated by the bills would satisfy the active supervision prong of the state action doctrine. According to the language in the bills, it appears that these corporations would oversee their own operations, with the NY DOH providing some additional state oversight by reviewing annual reports filed by ECMC and WCHC.[19] The bills specify that these reports must include information concerning the benefits of collaboration and disadvantages of reduced competition, as identified by the NY DOH in its "Restructuring Initiatives in Medicaid Redesign" initiative.[20] These reports must also assess the impact on reimbursement by managed care organizations, particularly the extent to which negotiated rates "more fairly compensate the corporation's facilities for the cost of providing services to commercial enrollees, without cross-subsidy from Medicaid or other governmental programs."[21] The NY DOH would have 60 days from the date a report is filed to request that ECMC or WCHC make policy changes to ensure that the collaborations further the state's interests.[22]

III. Concerns Regarding Potential Anticompetitive Effects of New York Senate Bill 2647 and New York Assembly Bill 2888

FTC staff recognizes the stated need for ECMC and WCHC to collaborate with other public and private health care providers to improve their ability to deliver high-quality health care to medically underserved patient populations. Despite what some health care providers – and proponents of the bills – may claim, however, the antitrust laws already allow for efficient competitor collaborations in health care markets. FTC staff is concerned that the proposed legislation may encourage ECMC and WCHC, as well as any public or private health care providers with whom they choose to collaborate, to share competitively sensitive information and engage in joint negotiations with payors in ways that will not yield efficiencies or benefit consumers. These types of activities are unlikely to further the legitimate public policy goals of health care reform. Indeed, FTC staff is unaware of any credible economic evidence demonstrating that these types of activities are likely to lower the cost or improve the quality of health care services, or expand access to health care services for medically underserved patient populations. Rather, there is a significant and growing body of empirical economic research showing that increased consolidation and certain kinds of coordination among health care providers increase the risk of higher prices without offsetting improvements in quality.[23]

The bills specifically authorize these corporations "to engage in arrangements, contracts, information sharing and other collaborative activities[,]" which "may include without limitation: joint ventures, joint negotiations with physicians, hospitals and payors, whether such negotiations result in separate or combined agreements; leases; and/or agreements which involve delivery system network creation and operation[.]"[24] Among the purported benefits of the corporations' collaborative efforts, as described in the bills, is "achieving improved reimbursement from non-governmental payors."[25] Thus, it appears that a goal of the bills is to allow ECMC and WCHC to engage in collaborations or transactions that improve their bargaining leverage with commercial payors to increase their reimbursement rates. These higher reimbursement rates are likely to lead to higher health care costs for employers and commercially insured patients. Commercially insured patients likely would face higher premiums, co-pays, deductibles, and other out-of-pocket expenses. Self-insured employers would be particularly vulnerable to higher prices because they pay directly for the costs of their employees' health care claims.

Notwithstanding the bills' stated goal of improving health care services for medically underserved patients, it is important to understand that competition among health care providers benefits *all* patients, regardless of whether covered by commercial or governmental programs. FTC staff disagrees with the bills' suggestion that Medicaid or other governmental programs can cross-subsidize commercially insured patients.[26] In reality, case-mix-adjusted commercial health care prices are usually higher than Medicaid or Medicare prices, and there is little evidence of dynamic cost-shifting in either direction.[27] Furthermore, charging higher prices for providing services to commercial patients is unlikely to benefit Medicaid, Medicare, and uninsured patients. Empirical

economic literature shows that non-profit hospitals with market power – which ECMC and WCHC may achieve through many of the activities that purportedly would now be immunized by the bills – tend to have higher commercial prices and higher costs, the latter of which can harm non-commercial patients, particularly the uninsured.[28] Finally, economic literature also shows that competition among health care providers usually leads to higher quality care for all patients.[29]

Another cause for concern is that, unlike the New York COPA regulations that were the subject of FTC staff's recent comment to the NY DOH,[30] the bills do not expressly preserve the authority of the NY AG to challenge any collaborative activity undertaken by these public health care entities in the event that the anticompetitive harms outweigh the potential benefits of coordination. Notwithstanding our overall concerns with the purported grant of antitrust immunity in the COPA regulations, these bills appear to confer broader antitrust immunity than the COPA regulations without the same degree of state oversight and, if needed, remedial authority.

Finally, FTC staff has concerns that, as written, these bills may be construed to purport to grant antitrust immunity when ECMC and WCHC collaborate with private or public entities located outside of New York, even if neighboring states have not themselves attempted to confer antitrust immunity to health care collaboratives. Such geographically unbound antitrust immunity would cause FTC staff to further question whether this legislation is appropriately tailored to further New York's legitimate public policy goals.

IV. Legislation Is Unnecessary Because the Antitrust Laws Already Permit Efficient Health Care Collaborations

The proposed legislation appears to be based on two fundamentally flawed premises: that efficient, procompetitive collaborations among otherwise independent health care providers are prohibited under the antitrust laws, and that antitrust immunity is necessary to encourage such collaborations.

The antitrust laws already recognize, and, indeed, have long stood for the proposition that competitor collaborations can be procompetitive. As explained in numerous sources of guidance issued by the federal antitrust agencies,[31] this position extends to collaborations among competing health care providers. FTC officials have recently emphasized that "[t]he FTC supports the key aims of health care reform, and . . . recognize[s] that collaborative and innovative arrangements among providers can reduce costs, improve quality, and benefit consumers. But these goals are best achieved when there is healthy competition in provider markets fostering the sort of dynamic, high-quality, and innovative health care that practitioners seek and patients deserve."[32] The federal antitrust agencies have challenged very few of the thousands of health care provider mergers, joint ventures, and other types of collaborations that have occurred in recent years, and have "brought those challenges only after rigorous analysis of market conditions showed that the acquisition was likely to substantially lessen competition."[33]

Moreover, the goals of antitrust are consistent with the goals of the Patient Protection and Affordable Care Act ("ACA"),[34] and health care reform efforts more generally. Despite what some health care industry participants have claimed, the antitrust laws do not prohibit the kinds of collaboration necessary to achieve the health care reforms contemplated by the ACA.[35] Specifically, antitrust is not a barrier to New York health care providers who seek to form procompetitive collaborative arrangements that are likely to reduce costs and benefit health care consumers through increased efficiency and improved coordination of care. Indeed, the antitrust agencies seek only to prevent mergers and other collaborations when there is substantial anticompetitive harm and when that harm is not offset by likely procompetitive benefits of the transaction, including reduced costs, higher quality, and increased access to care.

V. Antitrust Exemptions That Immunize Otherwise Anticompetitive Conduct Pose a Substantial Risk of Consumer Harm and Are Disfavored

Because antitrust law permits procompetitive collaborations among health care providers, no special "exemption" or "immunity" from existing antitrust laws is necessary to ensure that such procompetitive or competitively benign collaborations occur. The U.S. Supreme Court recently reiterated its long-standing position that "the antitrust laws' values of free enterprise and economic competition" make such special exemptions or immunities "disfavored."[36] There is no reason to treat the health care industry differently with regard to application of the antitrust laws. Indeed, in the health care industry, just like in other industries, consumers benefit from vigorous competition and are harmed by anticompetitive conduct and transactions.[37]

Health care providers have repeatedly sought antitrust immunity for various forms of joint conduct, including agreements on the prices they will accept from payors, asserting that immunity for joint bargaining is necessary to "level the playing field" so that providers can create and exercise countervailing market power.[38] In a 2004 report on health care competition, the federal antitrust agencies jointly responded to and countered this argument, explaining that antitrust exemptions "are likely to harm consumers by increasing costs without improving quality of care."[39] In its 2007 report, the bipartisan Antitrust Modernization Commission succinctly stated a widely recognized proposition: "[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality and reduced innovation."[40] In other words, antitrust exemptions threaten broad consumer harm while benefitting only certain market participants.

FTC officials further have noted that state legislation aimed at exempting health care providers engaging in collaborative activities from antitrust scrutiny may "encourage providers to negotiate collectively with health plans in order to extract higher rates, in effect allowing providers to fix their prices. By permitting conduct that would ordinarily violate antitrust laws, the bills would lead to higher prices and lower-quality care – undercutting the very objectives they aim to achieve."[41] While FTC officials have acknowledged that "[c]ollaboration designed to promote beneficial integrated care can

benefit consumers," they also have warned that "collaboration that eliminates or reduces price competition or allows providers to gain increased bargaining leverage with payors raises significant antitrust concerns. Antitrust concerns can arise if integration involves a substantial portion of the competing providers of any particular service or specialty[.]"[42] We note that NHCC, ECMC, and WCHC all participate in performing provider systems under the DSRIP program, and all of these systems appear to involve substantial portions of competing health care providers in their respective geographic regions,[43] thereby increasing the potential for anticompetitive harm.

Given that efficient collaborations among health care providers likely to benefit consumers are already consistent with the antitrust laws, FTC staff is concerned that these bills will encourage precisely the types of agreements among competitors that likely would *not* pass muster under the antitrust laws – conduct that would reduce competition, raise prices, and provide few or no benefits to consumers. Any effort to shield such harmful conduct from antitrust enforcement, including attempts to confer state action immunity, is likely to harm New York health care consumers.

VI. Conclusion

In summary, FTC staff believes that the antitrust immunity contemplated by the proposed bills is unnecessary to facilitate procompetitive collaborations, and is concerned that the bills are likely to foster anticompetitive conduct to the detriment of New York health care consumers. FTC staff urges the New York State Senate and Assembly to carefully consider whether antitrust immunity – especially the broad immunity these bills purport to grant – would further legitimate public policy goals or, instead, result in higher prices for consumers without any offsetting improvements to health care quality and access.

As always, the FTC will investigate and challenge transactions that are anticompetitive. In addition, we will continue to challenge defenses based on asserted state action immunity where the state fails to provide adequate active supervision.

Respectfully submitted,

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Northeast Regional Office

[1] This letter expresses the views of the FTC's Office of Policy Planning, Bureau of Competition, Bureau of Economics, and Northeast Regional Office. The letter does not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] *See* Dan Goldberg, *Senate Passes Antitrust Bill Despite A.G.'s Concern*, CAPITAL NEW YORK (Jun. 1, 2015), http://www.capitalnewyork.com/article/albany/2015/06/8569185/senate-passes-antitrust-bill-despite-ags-concern.

[3] *See* FTC Staff Comment to New York State Department of Health, Concerning Certificate of Public Advantage Applications, Intended to Exempt Performing Provider Systems from the Antitrust Laws (Apr. 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf.

[4] Federal Trade Commission Act, 15 U.S.C. § 45.

[5] Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[6] *See* Nat'l Soc. of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978) (The antitrust laws reflect "a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[7] *See generally* FED. TRADE COMM'N, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (Mar. 2013), https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/hcupdate.pdf. *See also Competition in the Health Care Marketplace*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care ("Cases").

[8] *See, e.g.*, FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf [hereinafter FTC & DOJ, IMPROVING HEALTH CARE]. The report was based on, among other things, 27 days of formal hearings on competitive issues in health care, an FTC sponsored workshop, independent research, and the Agencies' enforcement experience. *See also* FTC-DOJ workshop series, *Examining Health Care Competition*, Mar. 20-21, 2014 and Feb. 24-25, 2015, https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition.

[9] FTC and staff advocacy may comprise letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports.

[10] *See, e.g.*, FTC Staff Comment to Sen. John J. Bonacic, N.Y. State Senate, Concerning N.Y. Senate Bill S.3186-A, Intended to Permit Collective Negotiations by Health Care Providers (Oct. 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-john-j.bonacic-concerning-new-

york-s.b.3186-allow-health-care-providers-negotiate-collectively-health-plans/111024nyhealthcare.pdf; FTC Staff Comment to Sen. Chip Shields, Or. State Legislature, Concerning S.B. 231-A, Intended to Exempt Certain Collaborations Among Competing Health Care Providers and Payers Participating in a Primary Care Transformation Initiative (May 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-oregon-senate-bill-231a-which-includes-language-intended-provide-federal/150519oregonstaffletter.pdf; FTC Staff Comment to Sen. Catherine Osten and Rep. Peter Tercyak, Conn. Gen. Assembly, Concerning H.B. 6431, Intended to Exempt Health Care Collaboratives from the Antitrust Laws (June 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-connecticut-general-assembly-labor-and-employees-committee-regarding-connecticut/130605conncoopcomment.pdf; FTC Staff Comment to Sens. Coleman and Kissel and Reps. Fox and Hetherington, Conn. Gen. Assembly, Concerning Connecticut H.B. 6343, Intended to Exempt Members of Certified Cooperative Arrangements from the Antitrust Laws (June 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-senatorscoleman-andkissel-and-representativesfox-and-hetherington-concerning.b.6343intended-toexempt-members-certified-cooperative-arrangements-antitrust-laws/110608chc.pdf; FTC Staff Comment to the Hon. Elliott Naishtat Concerning Tex. S.B. 8 to Exempt Certified Health Care Collaboratives from the Antitrust Laws (May 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.elliot-naishtat-concerning-texas-s.b.8-exempt-certified-health-care-collaboratives-antitrust-laws/1105texashealthcare.pdf; FTC Staff Comment to Rep. Tom Emmer of the Minn. House of Reps. Concerning Minn. H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-representative-tom-emmer-minnesota-house-representatives-concerning-minnesota-ok-h.f.no.120-and-senate-bill-s.f.no.203-health-care-cooperatives/v090003.pdf; FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.william-j.seitz-concerning-ohio-executive-order-2007-23s-establish-collective-bargaining-home-health-care/v080001homecare.pdf; FTC Staff Comment before the P.R. House of Reps. Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-puerto-rico-house-representatives-concerning-s.b.2190-permit-collective-bargaining-health-care-providers/v080003puerto.pdf. All advocacies are available at https://www.ftc.gov/policy/advocacy/advocacy-filings.

[11] N.Y. PUB. AUTH. LAW §§ 3300-3321 (2015) ("Title 1: Westchester County Health Care Corporation"); *id.* §§ 3625-3646 ("Title 6: Erie County Medical Center Corporation").

[12] *See* S.B. 4624, 2013-2014 Leg., Reg. Sess. (N.Y. 2013) (same as New York Assembly Bill 7993-A). FTC staff learned of this legislation after it had passed. In October 2013, the Governor of New York signed S-4624/A-7993 into law. The NY AG opposed this bill as unnecessary and overbroad. *See* Memorandum Regarding New York Assembly

Bill 7993-A, from Harlan A. Levy, Chief Deputy Attorney General and Counsel to the Attorney General, to Mylan L. Denerstein, Counsel to the Governor of New York (Aug. 13, 2013). Interestingly, the Nassau University Medical Center DSRIP PPS (which is affiliated with NHCC) stated its intention to apply for a COPA to protect itself from regulatory challenges based on antitrust laws. *See* Nassau University Medical Center DSRIP PPS Organizational Application 9 (Dec. 22, 2014), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/nassau_university_medical_center/nassau_queens_organizational_application.pdf. This antitrust exemption would presumably be in addition to the broad exemption already purportedly conferred to NHCC under S-4624/A-7993.

[13] *See* New York State Senate Memorandum In Support Of Legislation S-2647, submitted by Sen. Ranzenhofer; New York State Assembly Memorandum In Support Of Legislation A-2888, submitted by Rep. Abinanti. However, although the current Public Authorities Law states that ECMC has the ability to participate in "joint and cooperative arrangements for the provision of general comprehensive and specialty health care services" and WCHC has the ability to "[t]o provide health and medical services for the public directly or by agreement or lease with any person, firm or private or public corporation or association through or in the health facilities of the corporation or otherwise[,]" there are no provisions that allow them to collaborate with private and public entities in violation of the antitrust laws. N.Y. PUB. AUTH. LAW §§ 3306.2, 3621.5 (2015).

[14] FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003 (2013).

[15] New York State Senate Memorandum In Support Of Legislation S-2647, *supra* note 13.

[16] S.B. 2647, 2015-2016 Leg., Reg. Sess. § 1 (N.Y. 2015) (amending § 3626 of New York public authorities law); A.B. 2888, 2015-2016 Leg., Reg. Sess. § 1 (amending § 3301 of New York public authorities law).

[17] S.B. 2647 § 1; A.B. 2888 § 1.

[18] *See* Parker v. Brown, 317 U.S. 341 (1943); *Phoebe Putney*, 133 S. Ct. at 1003 (2013); and North Carolina State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101 (2015).

[19] S.B. 2647 § 2 (amending § 3631 of New York public authorities law); A.B. 2888 § 2 (amending § 3306 of New York Public Authorities Law).

[20] N.Y. STATE DEP'T OF HEALTH, RESTRUCTURING INITIATIVES IN MEDICAID REDESIGN, REQUEST FOR APPLICATIONS § 7 (2011), http://www.health.ny.gov/funding/rfa/inactive/1111091042/1111091042.pdf ("§ 7 Competition and Antitrust Concerns" references the state budget legislation and NY DOH COPA regulations).

[21] S.B. 2647 § 2; A.B. 2888 § 2.

[22] S.B. 2647 § 2; A.B. 2888 § 2.

[23] *See, e.g.*, Jeff Goldsmith, Lawton R. Burns, Aditi Sen, & Trevor Goldsmith, *Integrated Delivery Networks: In Search of Benefits and Market Effects*, NAT'L ACAD. OF SOCIAL INSURANCE (Feb. 2015), http://www.nasi.org/sites/default/files/research/Integrated_Delivery_Networks_In_Search_of_Benefits_and_Market_Effects.pdf;

Katherine Baicker & Helen Levy, *Coordination versus Competition in Health Care Reform*, 369 NEW ENG. J. MED. 789 (2013), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1306268; Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update* (Robert Wood Johnson Found., Synthesis Project Report, June 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*, Center for Studying Health System Change, Research Brief No. 16 (Nov. 2010), http://www.hschange.com/CONTENT/1162/; Robert A. Berenson, Paul B. Ginsburg & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFFAIRS 699 (2010), *available at* http://content.healthaffairs.org/content/29/4/699.full; Lawton Robert Burns & Ralph W. Muller, *Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration*, 86 MILBANK Q. 375 (2008), *available at* http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2008.00527.x/epdf; William B. Vogt & Robert Town, *How has hospital consolidation affected the price and quality of hospital care?* (Robert Wood Johnson Found. Synthesis Project Report, Feb. 2006), http://www.rwjf.org/files/research/no9researchreport.pdf; Cory Capps & David Dranove, *Hospital Consolidation & Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175 (2004), *available at* http://content.healthaffairs.org/content/23/2/175.full.

[24] S.B. 2647 § 2; A.B. 2888 § 2.

[25] S.B. 2647 § 1; A.B. 2888 § 1.

[26] *See supra* note 21 and accompanying text.

[27] For a review of the economic literature on this subject, *see* Austin Frakt, *Hospitals Are Wrong About Shifting Costs to Private Insurers*, THE INCIDENTAL ECONOMIST (Mar. 25, 2015), http://theincidentaleconomist.com/wordpress/hospitals-are-wrong-about-shifting-costs-to-private-insurers/.

[28] *See* Jeffrey Stensland, Zachary R. Gaumer, & Mark E. Miller, *Private-Payer Profits Can Induce Negative Medicare Margins*, 29 HEALTH AFFAIRS 1045 (2010), *available at* http://content.healthaffairs.org/content/early/2010/03/18/hlthaff.2009.0599.full. Under the Patient Protection and Affordable Care Act, prices that non-profit hospitals charge to uninsured patients eligible for financial assistance can be no more than "amounts generally billed to insured patients." *See infra* note 34, at § 9007; Sara Rosenblum, *Additional Requirements For Charitable Hospitals: Final Rules On Community Health Needs Assessments And Financial Assistance*, HEALTH AFFAIRS BLOG (Jan. 23, 2015), http://healthaffairs.org/blog/2015/01/23/additional-requirements-for-charitable-hospitals-final-rules-on-community-health-needs-assessments-and-financial-assistance/. Therefore, hospitals with market power that negotiate higher commercial prices can also charge higher prices to uninsured patients.

[29] *See supra* note 23.

[30] *See supra* note 3.

[31] To assist the business community in distinguishing between lawful and potentially harmful forms of competitor collaboration, the FTC and its sister federal antitrust

agency, the DOJ, have issued considerable guidance over the years. Key sources of guidance include the Agencies' general guidelines on collaborations among competitors, as well as joint statements specifically addressing the application of the antitrust laws to the health care industry, including physician network joint ventures and other provider collaborations. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000), https://www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf; U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf (*see, e.g., id.* at Statement 8 regarding physician network joint ventures, Statement 7 regarding joint purchasing arrangements among providers of health care services, and Statement 6 regarding provider participation in exchanges of price and cost information).

In addition, FTC staff has issued and made public numerous advisory opinion letters containing detailed analyses of specific proposed health care collaborations. These letters have helped the requesting parties avoid potentially unlawful conduct as they seek to devise new ways of responding to the demands of the marketplace. They also have provided further guidance to the health care industry as a whole. *See, e.g.*, Letter from Markus H. Meier, Fed. Trade Comm'n, to Michael E. Joseph, Esq., McAfee & Taft, Re: Norman PHO Advisory Opinion, Feb. 13, 2013, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr_0.pdf; Letter from Markus H. Meier, Fed. Trade Comm'n, to Christi Braun, Ober, Kaler, Grimes & Shriver, Re: TriState Health Partners, Inc. Advisory Opinion, Apr. 13, 2009, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/tristate-health-partners-inc./090413tristateaoletter.pdf; Letter from Markus Meier, Fed. Trade Comm'n, to Christi Braun & John J. Miles, Ober, Kaler, Grimes & Shriver, Re: Greater Rochester Independent Practice Association, Inc. Advisory Opinion, Sept. 17, 2007, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/greater-rochester-independent-practice-association-inc./gripa.pdf.

[32] Edith Ramirez, *Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245 (2014), http://www.nejm.org/doi/pdf/10.1056/NEJMp1408009. *See also* Deborah L. Feinstein, Dir., Bureau of Competition, Remarks at the Fifth National Accountable Care Organization Summit in Washington, DC: Antitrust Enforcement in Health Care: Proscription, not Prescription (June 19, 2014), https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf ("We continue to hear claims that antitrust principles are at odds with the mandates of the Affordable Care Act. I believe these arguments misunderstand the focus and intent of federal antitrust enforcement. . . . In the final analysis, our actions make clear the important role of antitrust in health care policy. Ultimately, we believe that the imperatives of developing lower cost, higher quality health care can coexist with continued enforcement of the antitrust laws."); Commissioner Julie Brill, Fed. Trade Comm'n, Keynote Address at the Catalyst For Payment Reform 2013 National Summit on Provider Market Power: Promoting

Healthy Competition in Health Care Markets: Antitrust, the ACA, and ACOs (June 11, 2013), https://www.ftc.gov/sites/default/files/documents/public_statements/promoting-healthy-competition-health-care-markets-antitrust-aca-and-acos/130611cprspeech.pdf ("By serving as a watchdog against anticompetitive conduct, antitrust promotes market behavior that creates efficiencies and benefits consumers.").

[33] Feinstein, *supra* note 32. From 2002 to 2012, the Commission challenged six hospital mergers out of 970 total hospital transactions, less than one percent. *See* Greg Koonsman, *Analyzing the Health System Market*, VMG Health 24 (Oct. 24, 2013), http://www.vmghealth.com/Downloads/BeckerASCKoonsman2013.pdf.

[34] Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395 (2010).

[35] *See, e.g.* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM, 76 Fed. Reg. 67026 (Oct. 28, 2011), http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf. *See also* Brill, *supra* note 32 ("Antitrust law permits providers to engage in a wide array of legitimate collaborative activities, including ACO [Accountable Care Organization] arrangements, as well as many mergers and consolidations, so long as the conduct is likely to promote consumer welfare through lower cost or improved quality.").

[36] FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003, 1010 (2013) (quoting FTC v. Ticor Title Ins. Co., 504 U.S. 621, 636 (1992)). *See also* North Carolina State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1117 (2015) ("The Sherman Act protects competition while also respecting federalism. It does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies. If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked.").

[37] *Phoebe Putney*, 133 S. Ct. at 1015 (state legislature's objective of improving access to affordable health care does not logically suggest contemplation of anticompetitive means, and "restrictions [imposed upon hospital authorities] should be read to suggest more modest aims."). As the U.S. Court of Appeals for the Fourth Circuit has observed, "[f]orewarned by the [Supreme Court's] decision in *National Society of Professional Engineers* . . . that it is not the function of a group of professionals to decide that competition is not beneficial in their line of work, we are not inclined to condone anticompetitive conduct upon an incantation of 'good medical practice.'" Va. Acad. of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476, 485 (4th Cir. 1980).

[38] In general, the Supreme Court has flatly rejected the notion that members of the learned professions should be free from antitrust scrutiny: "The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . nor is the public-service aspect of professional practice controlling in determining whether § 1 includes professions." Goldfarb v. Va. State Bar, 421 U.S. 773, 787 (1975). *See also* Nat'l Soc. of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978) (Supreme Court rejection of argument that competition itself poses a "potential threat . . . to the public safety"); FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986).

[39] FTC & DOJ, IMPROVING HEALTH CARE, *supra* note 8, at 14.

[40] ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 335 (2007), http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[41] Ramirez, *supra* note 32.

[42] Feinstein, *supra* note 32. There is a significant and ever-growing body of empirical research showing that increased concentration among health care providers results in higher prices without offsetting improvements in quality. *See, e.g.*, Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update* (Robert Wood Johnson Found., Synthesis Project Report, June 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

[43] *See* Nassau University Medical Center DSRIP PPS Organizational Application 25-26 (Dec. 22, 2014), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/nassau_university_medical_center/nassau_queens_organizational_application.pdf (stating that this PPS would include all 15 hospitals in this region, as well as a substantial portion of ambulatory surgical centers, primary care providers, specialty care providers, rehabilitative and behavioral health services facilities, and skilled nursing facilities); Millennium Collaborative Care DSRIP PPS (ECMC) Organizational Application 14 (Dec. 22, 2014), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/erie_county/millenium_collaborative_care__pps_org_app.pdf (stating that the Millennium Collaborative Care LLC will be a wholly-owned subsidiary of Erie County Medical Center Corporation, the lead entity in the PPS), *id.* at 17 ("All providers in the region have been invited to participate in the PPS, including the Catholic Medical Partners PPS and Finger Lakes PPS."), *id.* at 27-28 (throughout western New York, there are 22 acute care hospitals, 10 of which are in the MCC PPS; 74 nursing home facilities, 41 of which are in the MCC PPS; in addition, MCC PPS will include all of the urgent care centers, health homes, rehabilitative and behavioral health services facilities, specialty medical programs, home care services, and managed care organizations, and more than half of the ambulatory surgical centers, federally qualified health centers, primary care and specialty medical providers, laboratory and radiology services, and pharmacies); and Westchester Medical Center DSRIP PPS Organizational Application 26-27, 33 (Dec. 22, 2014), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/westchester_medical_center/westchester_org_app.pdf (it appears that this PPS covers 8 counties in the Hudson Valley region, and may include lower percentages of health care providers than the PPS networks associated with NHCC and ECMC, with 11 of 51 hospitals, 1,868 of 5,048 primary care providers, and 1,551 of 43,460 specialty care providers).

UNITED STATES OF AMERICA

FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

May 2, 2016

The Hon. Larry C. Stutts
Alabama State Senate
Alabama State House
11 South Union Street, Suite 735
Montgomery, Al 36130 – 4600

Dear Senator Stutts:

The Federal Trade Commission ("FTC") Office of Policy Planning, Bureau of Competition, and Bureau of Economics (collectively, the "staff") appreciate your request for comments on Alabama House Bill 241 / Senate Bill 243 (collectively, the "Bill").[1] The Bill would permit any public university that operates a school of medicine to form a new type of corporation in Alabama, to be known as an "authority," in collaboration "with all types of health care providers."[2] FTC staff submit this letter to address the Bill's attempt to exempt authorities, their "collaborative activities," and their "university affiliates, as well as the public or private entities and individuals with which they collaborate" from the federal antitrust laws.[3]

If effective, the broad antitrust exemption the Bill purports to provide would immunize anticompetitive mergers, price fixing, boycotts, and a wide variety of other anticompetitive conduct that harms consumers. Many health care provider collaborations can be efficient and beneficial, and no antitrust exemption is needed to permit them from occurring. Indeed, the Bill appears to reflect mistaken beliefs about the antitrust laws and the benefits of competition among health care providers. If enacted, the exemption would not improve patient care, but would likely raise health care costs and decrease access to care. As we discuss below,

- First, the antitrust laws permit health care collaborations that do not harm consumers. As the FTC and its staff have consistently explained, many competitor collaborations – including health care provider collaborations and mergers – can be efficient and procompetitive, and are therefore lawful.

- Second, because the antitrust laws already permit procompetitive health care collaborations, the Bill's purported "immunization" provision would foster anticompetitive mergers, collective negotiations, and other conduct that would *not* pass muster under the antitrust laws. Hence, the antitrust immunity contemplated by the Bill would likely increase health care costs,

diminish incentives to improve quality, and decrease access to health care services for Alabama consumers.

I. Interest and Experience of the Federal Trade Commission

Congress has charged the Federal Trade Commission ("FTC" or "Commission") with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] The FTC also enforces Section 7 of the Clayton Act, which prohibits transactions that may substantially lessen competition or tend to create a monopoly.[5] Competition is at the core of America's economy,[6] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality goods and services, greater access to goods and services, and innovation.[7] Pursuant to its statutory mandate, the FTC seeks to identify business practices and governmental laws and regulations that may impede competition without also providing countervailing benefits to consumers.

Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,[8] research,[9] and advocacy.[10] Of particular relevance, the Commission and its staff have long advocated against federal and state legislative proposals that seek to create antitrust exemptions for collective negotiations by health care providers because such exemptions are likely to harm consumers.[11]

II. Alabama House Bill 241 / Senate Bill 243

The Bill "would authorize public universities operating schools of medicine to form a new type of public corporation to be called an authority."[12] The Bill would grant numerous corporate powers, in addition to those generally assigned under Alabama corporate law, to such authorities. These corporations and their affiliates might extend well beyond what are traditionally thought of as academic medical centers, both geographically and in terms of the services they provide. For example, such a corporation would have the power

> [t]o acquire, construct, equip, and operate those health care facilities it considers necessary or desirable,[13] . . . [to] create, establish, acquire, operate, or support subsidiaries and affiliates, either for-profit or nonprofit, to assist an authority in fulfilling its purposes,[14] . . . [and to] participate as a shareholder in a corporation, as a joint venturer in a joint venture, as a general or limited partner in a general or limited partnership, as a member of a nonprofit corporation, or as a member of any other lawful form of business organization, that provides health care *or engages in activities related thereto*.[15]

Once established, an authority could accept grants or gifts from any source,[16] and "[t]he state, any university, any governmental entity, and any public corporation [would be] authorized to give, transfer, convey, or sell to any authority . . . with or without

consideration: (1) Any of its health care facilities and other properties, real or personal, and any funds and assets, tangible or intangible, relative to the ownership or operation of any such health care facilities," among other assets.[17] In addition, the Bill would vest the power of eminent domain in authorities.[18]

There appears to be no requirement that all facilities owned or operated by authorities, their subsidiaries, or their affiliates participate directly in medical education, research, or training, or that all such facilities engage directly in the provision of health care to Alabama citizens. Under the terms of the Bill, even the determination of what counts as a "health care facility" would be left to the authority's discretion.[19]

As noted above, the Bill purports to insulate these many and diverse entities, and their conduct, against the safeguards and consumer protections provided by the antitrust laws.[20]

III. The Bill Is Unnecessary Because the Antitrust Laws Already Permit Efficient Health Care Collaborations

The Bill appears to assume that antitrust laws prohibit efficient health care mergers, acquisitions, and collaborations to the detriment of health care and consumers in Alabama. That assumption is wrong.

Cooperation among competing health care providers, including academic medical centers, often can benefit competition and health care consumers. Many of the Bill's stated goals—e.g., the promotion of public health and the potential contributions of academic medical centers to it[21]—are not objectionable and frequently result from robust provider competition. Consequently, seeking to immunize the Bill's proposed corporate authorities, their affiliates, and their subsidiaries from any potential antitrust liability seems unnecessary, and as explained in Part IV below, also likely harmful.

The antitrust laws already recognize that competitor collaborations can be procompetitive. As the FTC and the U.S. Department of Justice (collectively, "the Antitrust Agencies") have repeatedly explained,[22] this position extends to collaborations among competing health care providers. For example, the Antitrust Agencies have stated that "[n]ew arrangements and variations on existing arrangements involving joint activity by health care providers continue to emerge to meet consumers', purchasers', and payors' desire for more efficient delivery of high quality health care services."[23] More recently, FTC officials have emphasized that

> [t]he FTC supports the key aims of health care reform, and . . . recognize[s] that collaborative and innovative arrangements among providers can reduce costs, improve quality, and benefit consumers. But these goals are best achieved when there is healthy competition in provider markets fostering the sort of dynamic, high-quality, and innovative health care that practitioners seek and patients deserve.[24]

Turning specifically to mergers, the Horizontal Merger Guidelines issued jointly by the Antitrust Agencies recognize that merger-generated efficiencies "may result in lower prices, improved quality, enhanced service, or new products."[25] Those efficiencies are routinely assessed in merger investigations as part of an evaluation of the potential anticompetitive harm stemming from a merger or acquisition. For those reasons, and because many mergers do not threaten competition, the Antitrust Agencies have challenged few of the thousands of health care provider mergers, joint ventures, and other types of collaborations that have occurred in recent years, and have "brought those challenges only after rigorous analysis of market conditions showed that the acquisition was likely to substantially lessen competition."[26] These outcomes confirm that the antitrust laws already consider likely benefits, as well as competitive harms, and therefore already accomplish many of the Bill's objectives.

Moreover, the goals of antitrust law are consistent with the policy goals of fostering the coordination and integration of health care delivery via collaboration among health care providers through, for example, the formation of Accountable Care Organizations.[27] Despite what some health care industry participants have claimed, the antitrust laws do not prohibit the kinds of collaboration necessary to achieve the health care reforms contemplated by the Affordable Care Act and other policy initiatives.[28] Specifically, antitrust does not impede Alabama health care providers from forming procompetitive collaborative arrangements that are likely to reduce costs and benefit health care consumers through increased efficiency and improved coordination of care.[29]

IV. The Purported Antitrust Exemption Poses a Substantial Risk of Consumer Harm

FTC staff understand that Alabama may take particular interest in fostering its academic medical centers. Still, because antitrust law already allows efficient collaborations among health care providers that benefit consumers, the Bill's exemption provisions would encourage mergers and conduct that likely would *not* pass muster under the antitrust laws because they would tend to reduce competition, raise prices, diminish incentives to improve quality, and provide little or no benefits to consumers.

Even though an "authority" can only be established by a public university that operates a school of medicine, the Bill does not require that the authority be limited to that school of medicine, its academic medical center, or the university community. To the contrary, as noted above, the Bill expressly contemplates that authorities will "collaborate with all types of health care providers," and that they may "create, establish, acquire, operate, or support subsidiaries and affiliates, either for-profit or nonprofit, to assist an authority in fulfilling its purposes."[30] In fact, the Bill contemplates that a university may incorporate more than one authority,[31] even if it operates only one academic medical center. Hence, any competitive harm inflicted by such agreements might originate from the loss of competition between two or more *other* hospitals, or other health care providers, and the effects might originate or spread well beyond a teaching hospital and its surrounding community. Any effort to shield such harmful conduct from antitrust

enforcement—including attempts to confer state action immunity—is likely to harm Alabama's health care consumers, including patients as well as both public and private third-party payors.

In its 2007 report, the congressionally established, bipartisan Antitrust Modernization Commission[32] succinctly stated a widely recognized proposition: "[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality and reduced innovation."[33]

Yet, in the face of this proposition, health care providers repeatedly have sought antitrust immunity for various forms of joint conduct, including agreements on the prices they will accept from payors, asserting that immunity for joint bargaining is necessary to "level the playing field" so that providers can create and exercise countervailing market power.[34]

Here, at least with respect to antitrust treatment of health care providers, we disagree with the Bill's assertion that "academic medical centers often are at a competitive disadvantage as a result of limitations on their ability to form networks and delivery systems and otherwise collaborate with other health care providers to form joint ventures or other entities with shared ownership." No such competitive disadvantage is imposed by the federal antitrust laws. If the legislature finds that Alabama's corporate law, or its university charters, unduly burden the state's academic medical centers, we respectfully suggest that you seek more targeted, and less competitively harmful, ways to reform those provisions.[35]

V. Antitrust Exemptions Deprive Consumers of the Substantial Benefits That Competition Provides in Health Care

The U.S. Supreme Court recently reiterated its long-standing position that, "given the antitrust laws' values of free enterprise and economic competition, 'state-action immunity is disfavored.'"[36] As the Court recognized, this general principle applies with full force in the health care industry, where consumers benefit from vigorous competition, and where anticompetitive conduct can cause significant harm.[37] As discussed above, antitrust law permits many forms of procompetitive collaborations among health care providers, and seeks only to protect health care consumers from anticompetitive forms of joint conduct that are likely to harm them. To confer antitrust immunity on provider collaborations, regardless of whether they are procompetitive or anticompetitive, thus would be overbroad and likely to harm consumers.

Empirical evidence on competition in health care markets generally has demonstrated that consumers benefit from lower prices when provider markets are more competitive.[38] Retrospective studies of the effects of provider consolidation by FTC staff and independent scholars suggest that, "increases in hospital market concentration lead to

increases in the price of hospital care."[39] Moreover, additional empirical evidence suggests that, "[a]t least for some procedures, hospital concentration reduces quality."[40]

For example, recent research indicates that "health spending on the privately insured varies by more than a factor of three across the 306 hospital referral regions (HRRs) in the US."[41] For individual procedures, hospital prices can vary even more. The same study found that, "[h]ospitals' negotiated transaction prices routinely vary by over a factor of eight or more across the nation and by a factor of three within HRRs."[42] Different factors may contribute to this variation but "hospital market structure stands out as one of the most important factors associated with higher prices, even after controlling for costs and clinical quality."[43]

Academic medical centers are no less responsive than other health care providers to changes in market structure and conditions, and therefore may respond to changes in market concentration in ways that harm consumers. For example, a retrospective study of a merger involving an academic medical center found that "four of the five commercial insurers experienced large and statistically significant price increases at the merged hospital."[44] Moreover, those insurers "were forced to raise their prices by at least 10 percentage points more at the merged hospital relative to other Chicago area hospitals."[45] Furthermore, the study found that the relative price increase could not be explained by changes in case mix, patients' severity of illness, payer mix, or teaching intensity.[46]

Empirical evidence also suggests that greater competition incentivizes providers to become more efficient and innovative. A recent study shows that hospitals faced with a more competitive environment have better management practices.[47] In sum, ample evidence exists that competition can and does work in health care markets.[48]

The FTC has engaged in significant enforcement efforts to prevent anticompetitive behavior in health care provider markets precisely because consumers benefit from competition and, conversely, are harmed by anticompetitive mergers and conduct.[49]

VI. Conclusion

Competitor collaborations, mergers, and acquisitions can be procompetitive, benefitting patients and payors alike. Interest in such collaboration among health care providers is understandable and, indeed, important. As we have explained both in this comment and in numerous and detailed guidance documents, however, the antitrust laws already permit efficient, pro-consumer collaborations among competing health care providers, and already permit efficient and pro-consumer mergers. The Bill's apparent attempt to confer antitrust immunity is therefore unnecessary for collaborations that would benefit Alabama's citizens. If such immunity were conferred, it would prevent antitrust authorities from scrutinizing, moderating, or preventing anticompetitive mergers and conduct that would seriously harm Alabama consumers. In some cases, it also could encourage groups of private health care providers to engage in blatantly anticompetitive conduct.

We appreciate your consideration of these issues.

Respectfully submitted,

Marina Lao, Director
Office of Policy Planning

Ginger Jin, Director
Bureau of Economics

Deborah Feinstein, Director
Bureau of Competition

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[1] Letter from the Hon. Larry C. Stutts, Alabama State Senate, to the Hon. Edith Ramirez, Chairwoman, Fed. Trade Comm'n (March 10, 2016).

[2] Alabama House Bill 241 / Senate Bill 243, proposed § 3(b)(2) (the companion bills will be cited hereinafter as Senate Bill 243).

[3] *Id.*

[4] Federal Trade Commission Act, 15 U.S.C. § 45.

[5] Clayton Act, 15 U.S.C. § 18.

[6] Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[7] *See* Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 695 (1978) (The antitrust laws reflect "a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[8] *See generally* Fed. Trade Comm'n, An Overview of FTC Antitrust Actions In Health Care Services and Products (Mar. 2013), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/hcupdaterev.pdf; *see also* Fed. Trade Comm'n, Competition in the Health Care Marketplace: Formal Commission Actions, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care.

[9] *See, e.g.,* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE ("DOJ"), IMPROVING HEALTH CARE:

A DOSE OF COMPETITION (2004), http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf [hereinafter FTC & DOJ, IMPROVING HEALTH CARE]. The report was based on, among other things, 27 days of formal hearings on competitive issues in health care, an FTC-sponsored workshop, independent research, and the Agencies' enforcement experience.

[10] FTC and staff advocacy may take the form of letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. *See, e.g.*, FTC Staff Letter to the Honorable Theresa W. Conroy, Connecticut House of Representatives, Concerning the Likely Competitive Impact of Connecticut House Bill 6391 on Advance Practice Registered Nurses ("APRNs") (Mar. 2013), https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice (competitive impact of statutorily required "collaborative practice agreements" for nurse practitioners); FTC and DOJ Written Testimony Before the Illinois Task Force on Health Planning Reform Concerning Illinois Certificate of Need Laws (Sept. 2008), http://www.ftc.gov/os/2008/09/V080018illconlaws.pdf; Brief of the Fed. Trade Comm'n as Amicus Curiae, St. Joseph Abbey, et al. v. Castille, 712 F.3d 215 (5th Cir. 2013) (No. 11-30756) (refuting argument that the policies of FTC funeral rule support restrictions of sort challenged by petitioner); FTC & DOJ, IMPROVING HEALTH CARE, *supra* note 9.

[11] *See, e.g.*, FTC Staff Comment Regarding Oregon Senate Bill 231A, Which Includes Language Intended To Provide Federal Antitrust Immunity To Conversations, Information Exchanges, and Agreements Among Participants (Including Competitors) In Oregon's Health Care Markets (May 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-oregon-senate-bill-231a-which-includes-language-intended-provide-federal/150519oregonstaffletter.pdf; FTC Staff Comment to New York State Senator Ranzenhofer and New York State Assemblyman Abinanti Concerning SB 2647 and AB 2888 Authorizing Certain Agreements for the Creation and Operation of a Health Care Delivery System Network (June 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-new-york-state-senator-ranzenhofer-new-york-state-assemblyman-abinanti-concerning/150605nypublichealthletter.pdf; FTC Staff Comment to the Tennessee Department of Health Regarding the Implementation of Laws Relative to Cooperative Agreements and the Granting of Certificates of Public Advantage (Sept. 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-tennessee-department-health-regarding-implementation-laws-relative-cooperative/151015tennesseedoh.pdf; FTC Staff Comment Before the Connecticut General Assembly Labor and Employees Committee Regarding Connecticut House Bill 6431 Concerning Joint Negotiations by Competing Physicians in Cooperative Health Care Arrangements (June 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-connecticut-general-assembly-labor-and-employees-committee-regarding-connecticut/130605conncoopcomment.pdf; FTC Staff Comment to the Hon. Elliott Naishtat Concerning Texas S.B. 8 to Exempt Certified Health Care Collaboratives From the Antitrust Laws (May 2011), http://www.ftc.gov/os/2011/05/1105texashealthcare.pdf; FTC Staff Comment to Rep. Tom Emmer of the Minnesota House of Representatives Concerning Minnesota H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009), http://www.ftc.gov/opp/advocacy/V090003.pdf; FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008), http://www.ftc.gov/os/2008/02/V080001homecare.pdf; FTC Staff Comment Before the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-

puerto-rico-house-representatives-concerning-s.b.2190-permit-collective-bargaining-health-care-providers/v080003puerto.pdf.

[12] Alabama Senate Bill 243, at Synopsis.

[13] *Id.* § 9(a)(3).

[14] *Id.* § 9(a)(8).

[15] *Id.* § 9(a)(9) (emphasis added).

[16] *Id.* § 9(a)(14).

[17] *Id.* § 18(a).

[18] *Id.* § 10.

[19] *Id.* § 2(6) ("A determination by a board that an asset constitutes a health care facility shall be conclusive, absent manifest error.").

[20] *Id.* § 19(3) ("[T]he collaborative activities expressly authorized by this act, an authority and its university affiliates, as well as the public or private entities and individuals with which they collaborate, shall be immunized from liability under the federal and state antitrust laws.").

[21] *Id.* § 3(a)(1)–(3).

[22] To assist the business community in distinguishing between lawful and potentially harmful forms of competitor collaboration, the Agencies have issued a considerable amount of guidance over the years. Key sources of guidance include the Agencies' general guidelines on collaborations among competitors, as well as joint statements specifically addressing the application of the antitrust laws to the health care industry, including physician network joint ventures and other provider collaborations. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000), https://www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf; U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf (*see, e.g.*, Statement 8 regarding physician network joint ventures, Statement 7 regarding joint purchasing arrangements among providers of health care services, and Statement 6 regarding provider participation in exchanges of price and cost information).

In addition, FTC staff have issued and made public numerous advisory opinion letters containing detailed analyses of specific proposed health care collaborations. These letters have helped the requesting parties avoid potentially unlawful conduct as they seek to devise new ways of responding to the demands of the marketplace. They also have provided further guidance to the health care industry as a whole. *See, e.g.*, Letter from Markus H. Meier, Fed. Trade Comm'n, to Michael E. Joseph, Esq., McAfee & Taft, Re: Norman PHO Advisory Opinion, Feb. 13, 2013, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr_0.pdf; Letter from Markus H. Meier, Fed. Trade Comm'n, to Christi Braun, Ober, Kaler, Grimes & Shriver, Re: TriState Health Partners, Inc. Advisory Opinion, Apr. 13, 2009, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/tristate-health-partners-inc./090413tristateaoletter.pdf; Letter from Markus H. Meier, Fed. Trade Comm'n, to Christi Braun & John J. Miles, Ober, Kaler, Grimes & Shriver, Re: Greater Rochester Independent Practice Association, Inc. Advisory Opinion, Sept. 17, 2007, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/greater-rochester-

independent-practice-association-inc./gripa.pdf.

[23] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 22, at 2.

[24] Edith Ramirez, *Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245 (2014), http://www.nejm.org/doi/pdf/10.1056/NEJMp1408009. *See also* Deborah L. Feinstein, Dir., Bureau of Competition, Remarks at the Fifth National Accountable Care Organization Summit in Washington, DC: Antitrust Enforcement in Health Care: Proscription, not Prescription, 26 (June 19, 2014), https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf ("We continue to hear claims that antitrust principles are at odds with the mandates of the Affordable Care Act. I believe these arguments misunderstand the focus and intent of federal antitrust enforcement. . . . In the final analysis, our actions make clear the important role of antitrust in health care policy. Ultimately, we believe that the imperatives of developing lower cost, higher quality health care can coexist with continued enforcement of the antitrust laws.").

[25] FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, HORIZONTAL MERGER GUIDELINES, § 10 (2010), https://www.ftc.gov/tips-advice/competition-guidance.

[26] Feinstein, *supra* note 24, at 9.

[27] These widely shared policy goals are central to the Accountable Care Organizations contemplated under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022, 14 Stat. 119, 395 ("Affordable Care Act"). Ctrs. Medicare & Medicaid Servs., Fast Facts, All Shared Savings Program and Pioneer ACOs Combined (Apr. 2015) (404 shared savings ACOs and 19 Pioneer ACOs with 7.92 million assigned beneficiaries in 49 states plus Washington, DC and Puerto Rico). The FTC has not challenged any of these 423 ACOs. *See also* Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,822 (Nov. 2, 2011) (codified at 42 C.F.R. pt. 425) ("[T]he intent of the Shared Savings Program and the focus of antitrust enforcement are both aimed at ensuring that collaborations between health care providers result in improved coordination of care, lower costs, and higher quality, including through investment in infrastructure and redesigned care processes for high quality and efficient service delivery.").

[28] FTC Staff Comment to the West Virginia House of Delegates Regarding SB 597 and the Competitive Implications of Provisions regarding "Cooperative Agreements" Between – and Possible Exemptions from the Federal Antitrust Laws for – Health Care Providers (Mar. 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-west-virginia-house-delegates-regarding-sb-597-competitive-implications-provisions/160310westvirginia.pdf; FTC Staff Comment Before the Connecticut General Assembly Labor and Employees Committee Regarding Connecticut House Bill 6431 Concerning Joint Negotiations by Competing Physicians in Cooperative Health Care Arrangements (June 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-connecticut-general-assembly-labor-and-employees-committee-regarding-connecticut/130605conncoopcomment.pdf.

[29] *See id.*; Feinstein, *supra* note 24. As Feinstein points out, antitrust challenges to mergers involving health care providers of complementary – or "vertical" – services are rare. For example, the FTC has not once "challenged a purely vertical merger involving a hospital and a physician practice." Feinstein, *supra* note 24, at 8.

[30] Alabama Senate Bill 243, § 9(a)(8).

[31] *Id.* § 4(b).

[32] The Antitrust Modernization Commission was created pursuant to the Antitrust Modernization Commission Act of 2002, Pub. L. No. 107-273, §§ 11051-60, 116 Stat. 1856.

[33] ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 335 (2007), http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[34] In general, the Supreme Court has flatly rejected the notion that members of the learned professions should be free from antitrust scrutiny: "The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . nor is the public-service aspect of professional practice controlling in determining whether § 1 includes professions." Goldfarb v. Va. State Bar, 421 U.S. 773, 787 (1975); *see also* Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 695 (1978) (Supreme Court rejection of argument that competition itself poses a "potential threat . . . to the public safety"); FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986).

[35] For example, the legislature might consider whether some of the corporate powers the Bill would vest in the authorities—such as the power of eminent domain—would serve not to level the competitive playing field but further distort it, potentially in ways that are both costly and largely unrelated to academic medicine.

[36] FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003, 1010 (2013) (quoting FTC v. Ticor Title Ins. Co., 504 U. S. 621, 636 (1992)); *see also* North Carolina State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1117 (2015) (no state action immunity for dental board that sought to exclude non-dentist competitors in teeth whitening services).

[37] Phoebe Putney, 133 S. Ct. at 1015 (state legislature's objective of improving access to affordable health care does not logically suggest contemplation of anticompetitive means, and "restrictions [imposed upon hospital authorities] should be read to suggest more modest aims."). As the U.S. Court of Appeals for the Fourth Circuit has observed, "[f]orewarned by the [Supreme Court's] decision in *National Society of Professional Engineers* . . . that it is not the function of a group of professionals to decide that competition is not beneficial in their line of work, we are not inclined to condone anticompetitive conduct upon an incantation of 'good medical practice.'" Virginia Acad. of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476, 485 (4th Cir. 1980).

[38] *See, e.g.*, Zack Cooper, Stuart V. Craig, Martin Gaynor, & John Van Reenen, *The Price Ain't Right? Hospital Prices in Health Spending on the Privately Insured*, Nat'l Bureau Econ. Res., NBER Working Paper 21815 (Dec. 2015) (finding tremendous variation in hospital prices, and observing that "hospital prices are positively associated with indicators of hospital market power. Even after conditioning on many demand and cost factors, hospital prices in monopoly markets are 15.3 percent higher than those in markets with four or more hospitals."); Gautam Gowrisankaran, Aviv Nevo & Robert Town, *Mergers When Prices Are Negotiated: Evidence from the Hospital Industry*, 105 AM. ECON. REV. 172 (2015); Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update*, ROBERT WOOD JOHNSON FOUNDATION: THE SYNTHESIS PROJECT (2012) [hereinafter *Impact of Hospital Consolidation*] (synthesizing research on the impact of hospital mergers on prices, cost, and quality and finding that hospital consolidation generally results in higher prices, hospital competition improves quality of care, and physician-hospital consolidation has not led to either improved quality or reduced costs); Martin Gaynor & Robert J. Town, Competition in Health Care Markets (Nat'l Bureau of Econ. Research, Working Paper 17208 (2011) (critical review of empirical and theoretical literature regarding markets in health care services and insurance).

[39] Gaynor & Town, *Impact of Hospital Consolidation*, *supra* note 38, at 1 (citing, e.g., Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 INT'L J. ECON. BUS. 17, 30 (2011) (post-merger review of Agency methods applied to two hospital mergers; data "strongly suggests" that large price increases in challenged merger be attributed to increased market power and bargaining leverage); *see also* Leemore Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52 J. L. & ECON. 523, 544 (2009) ("hospitals increase price by roughly 40 percent following the merger of nearby rivals"); Joseph Farrell et al., *Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals*, 35 REV. INDUS. ORG. 369 (2009) (mergers between not-for-profit hospitals can result in substantial anticompetitive price increases); Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175, 179 (2004) ("Overall, our results do not support the argument that efficiencies from consolidations among competing hospitals lead to lower prices. Instead, they are broadly consistent with the opposing view that consolidations among competing hospitals lead to higher prices.")).

[40] Gaynor & Town, *Impact of Hospital Consolidation*, *supra* note 38, at 3; *see also* Patrick S. Romano & David J. Balan, A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare (Fed. Trade Comm'n Bureau of Econ., Working Paper No. 307, 2010), https://www.ftc.gov/reports/retrospective-analysis-clinical-quality-effects-acquisition-highland-park-hospital-evanston.

[41] Cooper et al., *supra* note 38, at 2.

[42] *Id.* at 33.

[43] *Id.*

[44] Haas-Wilson & Garmon, *supra* note 39, at 27.

[45] *Id.* at 28.

[46] *Id.* at 30.

[47] *See, e.g.*, Nicholas Bloom et al., *The Impact of Competition on Management Quality: Evidence from Public Hospitals*, 82 REV. ECON. STUDIES 457, 457 (2015) ("We find that higher competition results in higher management quality.").

[48] Indeed, similar arguments made by engineers and lawyers in defense of anticompetitive agreements on price—that competition fundamentally does not work in certain markets, and in fact is harmful to public policy goals—have been rejected by the courts, and private restraints on competition have been condemned. *See, e.g.*, FTC v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411, 424 (1990); Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 695 (1978).

[49] *See* note 8 *supra*.

November 1, 2017

FTC Staff Notice of COPA Assessment:
Request for Empirical Research and Public Comments

Summary:

Staff from the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition seek to enhance our ongoing study of the impact of certificates of public advantage ("COPA") on prices, quality, access, and innovation for healthcare services. To complement this continued inquiry, we also seek to better understand the effects of other state-based regulatory approaches intended to control healthcare prices and improve quality ("state-based regulatory approaches"). We encourage empirical research by academics and healthcare industry stakeholders regarding these topics, as well as suggestions regarding potential case studies and data sources. In addition, we invite public comments regarding the benefits or harms that have resulted from COPAs or other state-based regulatory approaches. We anticipate hosting a public workshop in the fall of 2018, to provide an opportunity for invited researchers to present their empirical findings, and to facilitate discussion among researchers, state policymakers, regulators, law enforcers, and industry stakeholders regarding their experiences with COPAs and other state-based regulatory approaches.

Background Information:

Beginning in the 1990s, several states passed COPA laws and regulations intended to allow healthcare providers to enter into cooperative agreements that might otherwise be subject to antitrust scrutiny. Historically, the stated purpose of these laws has been to reduce "unnecessary" duplication of healthcare resources and control healthcare costs. These laws purport to immunize certain activities and transactions under the state action doctrine.[1] COPA laws have been applied to various forms of provider collaboration, and also have been extended to shield provider mergers that might otherwise attract the attention of antitrust enforcers.[2]

[1] In order to obtain antitrust immunity for conduct that might otherwise violate the federal antitrust laws, the state action doctrine requires both a clear articulation of the state's intent to displace competition in favor of regulation and that the state provide active supervision over the regulatory scheme or body. *See* N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101,1114 (2015); FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003, 1013 (2013).

[2] Although a number of state COPA laws extend in theory to cover hospital mergers that otherwise might violate the antitrust laws, in reality few hospital mergers have ever been approved under COPA regulations. To the best of our knowledge, the following hospital mergers have been permitted to proceed pursuant to COPA oversight: HealthSpan Hospital System (Minnesota, 1994); Mission Health System (North Carolina, 1995); Benefis Health System (Montana, 1996); Palmetto Health System (South Carolina, 1998); Cabell Huntington Hospital/St. Mary's Medical Center (West Virginia, 2016); and Mountain States Health Alliance/Wellmont Health System (Tennessee and Virginia, 2017).

In addition, in 1997, United Regional Health Care System was formed when the only two general acute-care hospitals in Wichita Falls, Texas – Wichita General Hospital and Bethania Regional Health Care Center – sought an exemption from the Texas state legislature. However, this transaction does not appear to have involved a COPA regulatory scheme.

In recent years, we have observed a resurgence in the passage and use of COPA laws to immunize provider transactions from antitrust scrutiny.[3] In some situations, we have observed that state legislatures have appeared to pass COPA legislation with the intent of exempting specific proposed hospital mergers from anticipated antitrust challenges. In these and other situations, hospitals have claimed that they need an antitrust exemption because consolidation is the only way to achieve the size, scale, and degree of clinical integration necessary to participate in new delivery and payment models, such as population health initiatives and value-based payment models.

Typically, COPA statutes allow hospitals and other healthcare providers to enter into cooperative agreements if the state determines that the likely benefits outweigh any disadvantages attributable to a reduction in competition.[4] State departments of health – often in consultation with state attorneys general offices – are delegated the responsibility of drafting and implementing COPA regulations, reviewing all submitted COPA applications, approving or denying particular applications, and actively supervising any approved COPAs.

As a condition for COPA approval, states often impose conduct remedies on the COPA recipient, which are intended to mitigate the potential for anticompetitive harms. Such remedies may include rate regulation, prohibitions on certain contracting practices, and commitments to improve quality, or guarantees to return cost savings to the local community. Accountability and enforcement mechanisms may include requiring the COPA recipient to submit annual reports and comply with data audits, as well as termination of the COPA if the state later determines that the benefits no longer outweigh the harms.

In recent years, FTC staff have issued several advocacy comments raising concerns about whether COPA regulations actually achieve the states' intended policy goals; in some situations, FTC staff have explicitly recommended the denial of particular COPA applications.[5] FTC staff

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[3] Three of the seven COPAs granted for hospital mergers occurred in the last two years. *See id.* In addition, the Staten Island Performing Provider System in New York recently received a COPA for certain collaborative activities. *See* https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2016-11-17/docs/copa-sipps_staten_island_pps.pdf.

[4] Benefits may include quality improvements, population health improvements, preserving existing hospital operations, cost efficiencies, and increased access. Disadvantages may include price increases and an inability of health plans to negotiate reasonable contracts with providers, as well as reduced competition, quality, and access.

[5] *See, e.g.*, FTC Staff Submissions Regarding the Proposed Merger and COPA Applications of Mountain States Health Alliance and Wellmont Health System, https://www.ftc.gov/enforcement/cases-proceedings/151-0115/wellmont-healthmountain-states-health; FTC Staff Comment to Hon. Mike Pushkin, West Virginia State Senate, Concerning S.B. 597, Intended to Exempt Health Care Providers Subject to Cooperative Agreements from the Antitrust Laws (Mar. 9, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-west-virginia-house-delegates-regarding-sb-597-competitive-implications-provisions/160310westvirginia.pdf; FTC Bureau of Competition Staff Submission to the West Virginia Health Care Authority Regarding Cooperative Agreement Application of Cabell Huntington Hospital (Apr. 18, 2016), https://www.ftc.gov/system/files/documents/public_statements/945863/160418virginiahealthcare.pdf; FTC Staff Comment to New York State Department of Health, Concerning Certificate of Public Advantage Applications, Intended to Exempt Performing Provider Systems from the Antitrust Laws (Apr. 22, 2015),

have also issued several advocacy comments regarding other types of state action antitrust exemptions for healthcare providers, which in FTC staff's view raise similar concerns as COPA statutes.[6] In these advocacies, FTC staff have acknowledged the potential benefits of procompetitive collaboration among providers. FTC staff have repeatedly taken the position that the antitrust laws do not stand in the way of beneficial collaboration. Rather, the antitrust laws seek only to prohibit activities that would substantially reduce competition and harm consumers, without countervailing benefits sufficient to outweigh the harm. The FTC has issued extensive guidance about the types of provider collaboration and clinical integration that can be achieved without running afoul of the antitrust laws.[7] For these reasons, FTC staff have consistently argued that COPAs and other state action antitrust exemptions for healthcare providers are unnecessary, because they only serve to immunize precisely the types of conduct most likely to cause harm.

A significant volume of empirical literature demonstrates that competition among healthcare providers leads to reduced costs and prices, as well as improved quality and access. FTC staff are not aware of any empirical evidence demonstrating that COPA statutes and regulations produce better results for consumers than market-based competition. We recognize, however, that there is limited empirical research on the impact of COPAs on prices, costs, and quality of healthcare services, patient access to services, or innovations in care delivery models.

Beyond COPA statutes and regulations, some states have pursued other regulatory approaches intended to control healthcare prices and improve quality, including setting reimbursement rates

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https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf.

[6] *See, e.g.*, FTC Staff Comment to Hon. Larry C. Stutts, AL State Senate, Concerning HB 241 and SB 243, Intended to Exempt Collaboration Among Public Universities and Health Care Providers from the Antitrust Laws (May 2, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-alabama-state-senate-regarding-alabama-house-bill-241-senate-bill-243/160504commentalabama.pdf; FTC Staff Comment to Sen. Michael H. Ranzenhofer and Assemblyman Thomas Abinanti, N.Y. State Legislature, Concerning S.B. 2647 and A. 2888, Intended to Exempt Certain Public Health Entities from the Antitrust Laws (June 5, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-new-york-state-senator-ranzenhofer-new-york-state-assemblyman-abinanti-concerning/150605nypublichealthletter.pdf; FTC Staff Comment to Sen. Chip Shields, Or. State Legislature, Concerning S.B. 231-A, Intended to Exempt Certain Collaborations Among Competing Health Care Providers and Payers Participating in a Primary Care Transformation Initiative (May 18, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-oregon-senate-bill-231a-which-includes-language-intended-provide-federal/150519oregonstaffletter.pdf.

[7] HEALTH CARE DIVISION, BUREAU OF COMPETITION, FED. TRADE COMM'N, TOPIC AND YEARLY INDICES OF HEALTH CARE ANTITRUST ADVISORY OPINIONS BY COMMISSION AND STAFF (Apr. 2017), *available at* https://www.ftc.gov/system/files/attachments/competition-policy-guidance/topic_and_yearly_indices_of_health_care_advisory_opinions_april_2017.pdf; FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM, 76 Fed. Reg. 67026 (Oct. 28, 2011); FED. TRADE COMM'N AND U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf; U.S. DEP'T. OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ENFORCEMENT POLICY IN HEALTH CARE (1996), *available at* http://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf.

and implementing quality initiatives.[8] The effects of these state-based regulatory approaches may be analogous to the effects of some of the conduct remedies often imposed with COPAs.

Request for Empirical Research and Public Comments:

This notice is intended to facilitate a rigorous discussion of ways to study the impact of COPAs and other state-based regulatory approaches, including suggestions regarding potential case studies and data sources. FTC staff's goal is to encourage academics and health policy experts to consider these areas for empirical research projects and, ultimately, to share ideas that will lead to the development and execution of useful research that can inform future policy development.

In addition, FTC staff seek information from healthcare providers, payers, consumers, state officials, policy experts, academics, economists, and other interested parties regarding the effects of COPAs and other state-based regulatory approaches. In particular, we invite comment on the following questions and related topics:

- What information is available regarding the effects of COPAs or other state-based regulatory approaches in terms of price, cost, and quality of healthcare services; access to healthcare services; innovations in healthcare delivery models; or other dimensions of healthcare competition?

- What has been done to address the changes that occur over time in healthcare markets subject to COPAs or other state-based regulatory approaches (*e.g.*, changes in the competitive landscape, transformation of delivery and payment models, and healthcare professional shortages), as well as changes in the structure and operation of the providers that are regulated (*e.g.*, expansion by the regulated entity or operational changes that result in higher/lower costs)? Are COPA agreements or other state-based regulatory approaches, including price and quality commitments, modified to address these types of changes? To what extent are healthcare providers, payers, state health departments, state attorneys general, state legislators, or other stakeholders involved in this process?

- What information is available regarding the impact to healthcare markets following the expiration of COPAs or other state-based regulatory approaches, when price and quality commitments are no longer in effect or enforceable?

[8] For example, Maryland has implemented an all-payer hospital rate regulation system that, among other price and cost requirements, commits hospitals to achieving certain quality improvements. CENTERS FOR MEDICARE & MEDICAID SERVICES, https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/. Until recently, West Virginia's Health Care Authority had some ability to establish hospital rates in West Virginia. WEST VIRGINIA HEALTH CARE AUTHORITY, http://www.hca.wv.gov/ratereview/Pages/default.aspx. In addition, some courts and state agencies have entered into consent decrees with merging hospitals that contain some form of post-merger price regulation and other contract term commitments. *See, e.g.*, Butterworth Health Corp. v. FTC, 946 F. Supp. 1285 (W.D. Mich. 1996); Commonwealth of Pennsylvania v. Jameson Health Sys., Inc., No. 15-CV-1706 (W.D. Pa. Mar. 25, 2016), https://www.acms.org/wp-content/uploads/2016/03/signedorder.pdf.

- How much time, and what commitment of resources, is required to fully implement and monitor COPAs or other state-based regulatory approaches? To what extent do healthcare providers, state health departments, state attorneys general, or other stakeholders attempt to measure and quantify these resources? What metrics and methodologies do they use?

- Is competition more or less effective than certain forms of regulation in lowering prices, costs, and health expenditures; improving quality and access; promoting efficient resource allocation; and fostering innovations in care delivery models in healthcare provider markets?

    - Are there any special considerations for assessing competition versus regulation in environments with evolving reimbursement methodologies (*e.g.*, value-based payment models), which may involve more complex contracting practices than traditional fee-for-service payment models? Are rate regulation schemes flexible enough to allow for these more complex contracting practices?

- What existing empirical studies (including working papers) evaluate the effects of COPAs or other state-based regulations?

- How might existing research on conduct remedies, rate regulation, or other regulatory economics inform our understanding of COPAs and other state-based regulatory approaches?

- What additional types of research would be useful? Are there natural experiments that would be particularly relevant to understanding the effects of COPAs? What data are available for this research?

Instructions for Filing Public Comments:

Interested parties are invited to submit written comments on the topics described above to the FTC electronically or in paper form. FTC staff will consider these comments when developing potential research projects or a public workshop agenda, and may use these comments in subsequent reports or policy papers, if any. Comments should refer to "COPA Assessment, Project No. P181200."

Comments filed in electronic form should be submitted using the following web link: https://www.regulations.gov/docket?D=FTC-2019-0016 and following the instructions on the web-based form.

A comment filed in paper form should include the "COPA Assessment, Project No. P181200" reference both in the text and on the envelope, and should be mailed or delivered to the following address: Federal Trade Commission, Office of the Secretary, Room H-113 (Annex X), 600 Pennsylvania Avenue, NW, Washington, DC 20580. Because paper mail addressed to the FTC is subject to delay due to heightened security screening, please consider submitting your comments in electronic form or by courier or overnight service, if possible.

Please note that your comment – including your name and state – will become part of the public record of this project. In addition, comments may eventually be included on a publicly accessible FTC website in connection with a public workshop. Because comments will be made public, they should not include any sensitive personal information, such as an individual's Social Security Number; date of birth; driver's license number or other state identification number, or foreign country equivalent; passport number; financial account number; or credit or debit card number. Comments also should not include any sensitive health information, such as medical records or other individually identifiable health information. In addition, comments should not include "trade secret or any commercial or financial information which is obtained from any person and which is privileged or confidential," as provided in Section 6(f) of the Federal Trade Commission Act ("FTC Act"), 15 U.S.C. § 46(f), and FTC Rule 4.10(a)(2), 16 C.F.R.§ 4.10(a)(2). Comments containing material for which confidential treatment is requested must be filed in paper form, must be clearly labeled "Confidential," and must comply with FTC Rule 4.9(c).[9] For any copyrighted material, please provide authorization (signed by the publisher or author if they retain the copyright) so that the material may be republished on the Agencies' websites.

The FTC Act and other laws that the Commission administers permit the collection of public comments to consider and use in this proceeding as appropriate. The Commission will consider all timely and responsive public comments that it receives, whether filed in paper or electronic form. As a matter of discretion, the FTC makes every effort to remove home contact information for individuals from the public comments it receives before placing those comments on the FTC website. More information, including routine uses permitted by the Privacy Act, may be found in the FTC's privacy policy, available at http://www.ftc.gov/ftc/privacy.htm.

For Further Information Contact:

Stephanie Wilkinson, Attorney Advisor, Office of Policy Planning, Federal Trade Commission, 600 Pennsylvania Avenue, NW, Washington, DC 20580, 202-326-2084, copaassessment@ftc.gov.

Revised March 27, 2019, to reflect new process for submitting public comments.

[9] The comment must be accompanied by an explicit request for confidential treatment, including the factual and legal basis for the request, and must identify the specific portions of the comment to be withheld from the public record. The request will be granted or denied by the Commission's General Counsel, consistent with applicable law and the public interest. *See* FTC Rule 4.9(c), 16 C.F.R. § 4.9(c).

Federal Trade Commission Staff Submission to New York State Health Department Regarding the Certificate of Public Advantage Application of State University of New York Upstate Medical University and Crouse Health System, Inc.

Pursuant to New York Public Health Law Article 29-F and
Rules implemented thereunder at 10 NYCRR Subpart 83-2 *et seq.*

PUBLIC VERSION (REDACTED)
October 7, 2022

Bureau of Competition
Bureau of Economics
Office of Policy Planning

Table of Contents

The staff of the Federal Trade Commission's ("FTC") Bureau of Competition, Bureau of Economics, and Office of Policy Planning (collectively, "FTC staff")[1] respectfully submits this public comment regarding the Certificate of Public Advantage application ("COPA Application") submitted by State University of New York Upstate Medical University ("SUNY Upstate") and Crouse Health System, Inc. ("Crouse") (collectively, the "Parties") to the New York State Department of Health ("NY DOH")[2] pursuant to New York Public Health Law Article 29-F.[3] This comment supplements the information we sent to the NY DOH on August 17, 2022, which included an FTC staff policy paper describing empirical support for the FTC's long-standing concerns with COPA legislation.[4] We appreciate the opportunity to present our views on SUNY Upstate's proposed acquisition of Crouse (also referred to as "proposed merger") in connection with the NY DOH's review of their COPA Application.

I. Executive Summary

FTC staff submits this comment to express our concern that the proposed merger presents substantial risk of serious competitive and consumer harm in the form of higher healthcare costs, lower quality, reduced innovation, reduced access to care, and depressed wages for hospital employees. Applying the standard of the New York COPA Act and Regulations, there is not sufficient evidence to conclude that the potential harms are likely to be outweighed by the potential benefits of the merger. Furthermore, it is doubtful that the regulatory conditions imposed by the NY DOH would effectively mitigate all of the potential anticompetitive harms to patients in the Syracuse area – both in the short term and in the decades to come.

The New York state legislature passed the New York COPA Act allowing collaborations among healthcare providers, including hospital mergers, with an ultimate aim "to promote improved quality and efficiency of, and access to, health care services and to promote improved clinical outcomes to the residents of New York."[5] However, supplanting competition with a COPA regulatory scheme that shields specific hospital transactions from vigorous antitrust enforcement and allows for anticompetitive provider consolidation in highly concentrated markets likely undermines these laudable goals. As discussed below, competition has proven to

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[1] These comments express the views of the FTC's Bureau of Competition, Bureau of Economics, and Office of Policy Planning. These comments do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.
[2] Application for Certificate of Public Advantage Submitted by SUNY Upstate and Crouse to New York State Department of Health (posted Aug. 10, 2022).
[3] New York Public Health Law, Chapter 45, Article 29-F, §§ 2999-aa, 2999-bb, Improved Integration of Health Care and Financing [hereinafter New York COPA Act]. *See also* 10 NYCRR Subpart 83-2 *et seq.*, Certificate of Public Advantage (effective Dec. 17, 2014), https://regs health.ny.gov/content/subpart-83-2-certificate-public-advantage [hereinafter New York COPA Regulations].
[4] *See* Federal Trade Commission, *FTC Policy Perspectives on Certificates of Public Advantage* (Aug. 15, 2022) and *Key COPA Facts*, both available at www.ftc.gov/copa (Attachment A). FTC staff had previously raised concerns with COPA applications submitted to the NY DOH under the Delivery System Reform Incentive Payment program. *See* FTC Staff Comment to New York State Department of Health Regarding DSRIP COPA Applications, https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf (Apr. 22, 2015).
[5] New York COPA Act § 2999-aa.

be a more reliable and effective mechanism for controlling healthcare costs while preserving quality of care.

New York has engaged in statewide initiatives to reduce excess hospital bed capacity, consolidate competing healthcare services, and encourage collaboration and clinical integration among healthcare providers. FTC staff understands that, per the recommendations of the Commission on Health Care Facilities in the 21st Century (also known as the "Berger Commission"), SUNY Upstate and Crouse already entered an Affiliation and Collaborative Agreement, which required joint planning and service sharing under the supervision of the NY DOH.[6] In addition, it is our understanding that SUNY Upstate and Crouse were jointly involved in the Delivery System Reform Incentive Payment ("DSRIP") program, as members of the Central New York Care Collaborative Performing Provider System, which encouraged collaboration among competing healthcare providers under the supervision of the NY DOH to improve New York's Medicaid program.[7] Indeed, the NY DOH appears to have invested substantial time and resources to implement these healthcare delivery reform initiatives, which granted significant public funding for participating healthcare providers, including SUNY Upstate and Crouse.[8] With the Parties already participating in state programs designed to reduce costs and improve quality and accessibility, we question whether a full merger between the Parties under the NY DOH's supervision would confer meaningful benefits that could not already be achieved through these prior initiatives or other less restrictive alternatives that do not permanently eliminate close competition.

FTC staff's concerns detailed in this submission are based on our assessment to date of the proposed merger and the limited information available,[9] applying the analytical framework described in the *Horizontal Merger Guidelines* ("*Merger Guidelines*") that antitrust agencies, state courts, and federal courts use to evaluate mergers.[10] We have conducted preliminary evaluations of both the potential harm to patients and employees from the loss of competition as well as the potential benefits, including clinical quality benefits and cost savings, that the Parties claim they will be able to achieve through the proposed merger. The NY DOH considers these

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[6] *See* New York State Department of Health, REPORT ON THE IMPLEMENTATION OF THE REPORT OF THE COMMISSION ON HEALTH CARE FACILITIES IN THE TWENTY-FIRST CENTURY at 65-66, https://www health.ny.gov/facilities/commission/docs/implementation_of_the_report_of_the_commission.pdf (describing the Affiliation and Collaborative Agreement between SUNY Upstate and Crouse).

[7] *See* New York State Department of Health, *Delivery System Reform Incentive Payment (DSRIP) Program*, https://www health.ny.gov/health_care/medicaid/redesign/dsrip/index.htm.

[8] *See, e.g.*, New York State Department of Health, *Central New York Care Collaborative, Inc.*, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/county/co_cny htm (stating that the CNYCC received total DSRIP award dollars in excess of $323 million from 2015 through 2020); New York State Department of Health, *NYS DSRIP Quarterly Reports* (2014-2020), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/quarterly_reports htm (indicating that the CNYCC may have received total DSRIP related funding in excess of $500 million from 2014 through 2020).

[9] Despite requests from FTC staff to the Parties seeking detailed information typical for evaluating a transaction of this magnitude, the Parties have not supplied any information to the FTC.

[10] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (2010), https://www ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf [hereinafter *Merger Guidelines*]. As discussed further in Section II, if the Commission were to challenge a merger in court, the FTC would follow the legal standard in Section 7 of the Clayton Act.

same factors when reviewing COPA applications. Thus, the goals of our analysis are closely aligned with the analysis that the NY DOH will undertake. For ease of reference, we present our analysis using the specific review factors contained in the New York COPA Regulations. [11]

Competition between SUNY Upstate and Crouse appears to benefit area patients and employers, by enabling health insurers to negotiate lower hospital reimbursement rates (i.e., prices) on behalf of their customers. This competition ultimately reduces the prices that patients must pay in premiums, copayments, deductibles, and other out-of-pocket expenses. Furthermore, competition between the Parties likely improves healthcare quality, as well as the availability of services and new healthcare technologies, as the hospitals compete to attract patients to their respective systems. This competition likely also results in optimal wages and benefits for hospital employees. FTC staff has interviewed numerous market stakeholders who expressed concerns that the proposed merger between SUNY Upstate and Crouse will lead to higher prices and reduced quality of care, reduced access to healthcare services, and worsened working conditions and wages for hospital employees.

FTC staff's quantitative economic analyses confirm that SUNY Upstate competes closely with Crouse, and that the proposed merger will result in high market shares. To measure the degree of lost competition likely to result from the proposed merger, we calculated diversion ratios to estimate the extent to which patients view SUNY Upstate and Crouse as substitutes. The diversion ratios show a high degree of substitutability – i.e., extremely close competition – between SUNY Upstate and Crouse. More than 35% of each hospital's patients view the other merging party as their next best choice. Diversion ratios of this magnitude indicate that the proposed merger would likely lead to significant price increases, as well as reduced business incentives to maintain or improve quality. [12] FTC staff also estimates that post-merger, SUNY Upstate and Crouse would have a combined share of greater than 45% of commercially insured inpatient hospital services in the Primary Service Area ("PSA"), which would increase market concentration to a level that triggers a legal presumption of significant anticompetitive effects. And in Onondaga County, where the effects of the proposed merger likely would be felt most acutely by patients, the Parties would have a combined share of nearly 67% of commercially insured inpatient hospital services. [13]

The Parties assert that the merger would "create a coordinated, highly integrated system with the objective of improving quality of care, increasing access to care, and lowering the costs of health care in the communities served by the Parties." [14] The Parties, however, have not provided sufficient information to substantiate many of these claims, nor have they demonstrated that the claimed benefits and cost savings would offset the merger's substantial harm to competition. Moreover, the proposed merger does not appear necessary to achieve many of these

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[11] NY COPA Regulations § 83-2.5, https://regs.health.ny.gov/content/section-83-25-review-process.
[12] *See* Section V.A.3 for further discussion of diversion ratios.
[13] *See* Section V.A.4 for further discussion of market shares and concentration analyses. In the COPA Application, the Parties refer to a 17-county area as "Central New York" and inaccurately assert that this constitutes the PSA. FTC staff does not believe this broad of an area constitutes either the PSA or a relevant geographic market for antitrust purposes. *See* Section V.A.2 for further discussion of the PSA.
[14] COPA Application at 41.

claimed benefits, which may be realized through arrangements that are less restrictive to competition.

To the extent that the COPA must offer public advantages in order to be approved, the impact of the proposed merger on employee pay and benefits may be relevant to the NY DOH's review.[15] Consider, for example, the likelihood that the proposed merger will depress wage growth for registered nurses and respiratory therapists due to increased employer consolidation. Consolidation of these systems may also leave certain healthcare professionals with fewer employment and training opportunities. Furthermore, any wage depression resulting from the merger may exacerbate the current challenges of recruiting and retaining healthcare professionals in this region.

The Parties propose some conditions that they claim will limit the potential for any unintended negative consequences.[16] These conditions are vague and unenforceable, and appear to be nothing more than aspirational goals that fall short of the types of "conduct remedies" that other state health authorities have attempted as part of COPA oversight.[17] Furthermore, the Parties suggest that filing an Annual Performance Report and developing a framework for measuring progress *after* the COPA is approved will constitute sufficient monitoring and supervision. Such an *ex-post* framework is unlikely to hold the Parties accountable or mitigate the potential disadvantages or anticompetitive effects associated with the proposed merger.

Finally, we note our concern about the lack of transparency surrounding this COPA process.[18] The COPA Application has not yet been made readily available to the public. The FTC has found that it benefits from broad stakeholder input, and has reason to believe the NY DOH would benefit from such input as well. This is particularly true given the significant impact this merger is likely to have on the delivery of healthcare services in the region. Based on the foregoing reasons which are fully supported below, we urge the NY DOH to deny the Parties' COPA Application.

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[15] *See* Section V.C for further discussion of wage effects.

[16] *See* COPA Application at 69.

[17] *See* Section VII for further discussion of the Parties' proposed conditions and conduct remedies more generally. In merger challenges, the FTC prefers "structural remedies" (*i.e.*, an injunction preventing consummation of a merger or a divestiture of assets) rather than "conduct remedies" (*i.e.*, restrictions intended to regulate the conduct of a merged firm).

[18] *See, e.g.*, James Mulder, *SUNY Upstate Hides Huge Amounts of Information About Merger With Crouse*, Syracuse.com (Aug. 25, 2022), https://www.syracuse.com/health/2022/08/suny-upstate-hiding-huge-amounts-of-information-about-merger-with-crouse html; James Mulder, *SUNY Upstate, Crouse Officials Stay Mum on Biggest Hospital Merger in Syracuse History*, Syracuse.com (Aug. 26, 2022), https://www.syracuse.com/health/2022/04/suny-upstate-crouse-officials-stay-mum-on-biggest-hospital-merger-in-syracuse-history html.

II. FTC's Interest and Experience

The FTC's mission includes promoting fair competition in healthcare markets that will benefit patients, hospital employees, and the public at large.[19] To carry out this mission, Congress has charged the FTC with enforcing the Clayton Act, which prohibits mergers and acquisitions that may substantially lessen competition or tend to create a monopoly.[20] In addition, the FTC enforces the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[21] Pursuant to its statutory mandate, the FTC seeks to identify mergers and acquisitions, business practices, laws, and regulations that may lessen competition.

Vigorous competition among healthcare providers in an open marketplace provides patients with the benefits of lower prices, higher quality, greater access, innovation for goods and services, and improved wages and benefits for employees.[22] Anticompetitive mergers and conduct in healthcare markets have long been a focus of FTC law enforcement, research, and advocacy.[23] A critical part of the FTC's role in protecting the public is reviewing proposed mergers and acquisitions in the healthcare industry. The FTC has considerable experience in evaluating proposed hospital, outpatient facility, and physician group mergers, to determine whether they may substantially lessen competition.[24]

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[19] Commissioner Wilson has reservations regarding the use of "fair competition" rather than "competition." Although there may be a future debate regarding the differences between "fair competition" and "unfair methods of competition," the substance of today's comment is not impacted by this distinction.

[20] *See* Clayton Act, 15 U.S.C. § 18; Federal Trade Commission Act, 15 U.S.C. § 45.

[21] *Id*.

[22] *See* Nat'l Soc. of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978) (The antitrust laws reflect "a legislative judgment that, ultimately, competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[23] *See, e.g.*, FED. TRADE COMM'N, *Competition in the Health Care Marketplace*, https://www ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care; FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2022), https://www ftc.gov/system/files/ftc_gov/pdf/2022.04.08%20Overview%20Healthcare%20%28final%29.pdf; Joseph Farrell, Paul A. Pautler & Michael G. Vita, Fed. Trade Comm'n, *Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals,* 35 REV. INDUS. ORG. 369 (2009), http://link.springer.com/content/pdf/10.1007%2Fs11151-009-9231-2.pdf; FED. TRADE COMM'N, *Examining Health Care Competition*, (Mar. 20-21, 2014), https://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition; FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *Examining Health Care Competition*, (Feb. 24-25, 2015), https://www ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition. These workshops focused on the competition implications of various issues that are central to healthcare reform, including the challenges of measuring healthcare quality, as well as evolving healthcare provider and payment models. The workshop record suggests that neither a transition to value-based payment models nor improved population health management require anticompetitive levels of provider consolidation. *See also* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf [hereinafter DOSE OF COMPETITION REPORT].

[24] *See* FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, *supra* note 23, at Section III.

The FTC advocates against the use of COPAs through comments and testimony submitted to state legislators and other stakeholders due to concerns that COPAs may enable activity that would substantially reduce competition.[25] In 2017, the FTC announced a policy project to assess the impact of COPAs on prices, quality, access, and innovation for healthcare services.[26] This project has included empirical research of past COPAs, a public workshop highlighting practical experiences with COPAs and related policy considerations, and an ongoing study of recently approved COPAs.[27]

FTC staff recently released a paper, *FTC Policy Perspectives on Certificates of Public Advantage*, and a brief information sheet, *Key COPA Facts*, which summarize empirical research on COPAs approved in other states and findings from our COPA assessment policy project.[28] In particular, we have learned that COPAs can be difficult to monitor and regulate over a long period, and that COPA oversight regimes are not always successful in mitigating price and quality harms resulting from a loss in competition. Indeed, several COPAs have resulted in substantial price increases for patients, as well as declines in quality of care. Furthermore, when COPA oversight is removed, the risk of price and quality harms increases significantly.

III. FTC Evaluates Healthcare Mergers Similarly to the Approach Outlined in the New York COPA Act and Regulations

The FTC's goal to promote fair competition in healthcare markets for patients, employees, and the public at large is similar to the NY DOH's mission to "protect, improve and promote the health, productivity and wellbeing of all New Yorkers."[29] Likewise, the approach that the NY DOH must use to review a COPA application is similar to the approach FTC staff uses to review hospital mergers.

The New York COPA Act describes a state policy "to encourage, where appropriate, cooperative, collaborative and integrative arrangements including but not limited to, mergers and

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[25] *See, e.g.*, FTC Staff Submissions Regarding the Proposed Merger and COPA Applications of Mountain States Health Alliance and Wellmont Health System, https://www.ftc.gov/enforcement/cases-proceedings/151-0115/wellmont-healthmountain-states-health; FTC Staff Comment to Texas Health and Human Services Commission Regarding Certificate of Public Advantage Applications (Sept. 11, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhsccopacomment.pdf.

[26] *See* FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments (Nov. 1, 2017), https://www ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf.

[27] *See* FTC Public Workshop, *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets* (Jun. 18, 2019), https://www.ftc.gov/news-events/events/2019/06/health-check-copas-assessing-impact-certificates-public-advantage-healthcare-markets [hereinafter FTC COPA Workshop]; FTC Press Release, *FTC to Study the Impact of COPAs* (Oct. 21, 2019), https://www.ftc.gov/news-events/press-releases/2019/10/ftc-study-impact-copas.

[28] *See* Federal Trade Commission, *FTC Policy Perspectives on Certificates of Public Advantage* (Aug. 15, 2022) and *Key COPA Facts*, both available at www.ftc.gov/copa (Attachment A).

[29] New York State Department of Health, *About the New York State Department of Health: Mission, Vision and Values*, https://www health ny.gov/about/ (last accessed Aug. 17, 2022).

acquisitions among health care providers . . . under the active supervision of the [NY DOH] commissioner . . . where the benefits of such active supervision, arrangements and actions of the commissioner outweigh any disadvantages likely to result from a reduction of competition."[30] The NY DOH promulgated regulations to implement the New York COPA Act, which lay out several factors to be considered when reviewing COPA applications, including: the financial condition of the hospitals, the competitive dynamics of the relevant geographic area, the potential benefits and disadvantages of the COPA, and whether there are less restrictive alternatives that would result in a more favorable balance of the potential benefits and disadvantages.[31]

The FTC and U.S. Department of Justice ("DOJ") have jointly issued *Merger Guidelines* that outline the analytical framework used by the antitrust agencies to evaluate the competitive impact of a proposed merger. These guidelines reflect experience in analyzing a wide variety of mergers – including many hospital and other healthcare-related mergers, both proposed and consummated – as well as economic and other relevant research. Federal and state courts routinely rely on the *Merger Guidelines* framework to analyze the likely competitive effects of a proposed hospital merger. Ultimately, as stated in the *Merger Guidelines*, the "Agencies seek to identify and challenge competitively harmful mergers while avoiding unnecessary interference with mergers that are either competitively beneficial or neutral."[32]

When reviewing a proposed hospital merger, FTC staff devotes significant resources to understand the transaction's potential efficiencies and other benefits (e.g., lower costs, improved quality, capacity expansion, entry into new treatment areas), as well as its potential competitive harm (e.g., higher prices, reduced quality, less access to care, and depressed wages). Some hospital mergers, including those that raise competitive concerns, may yield meaningful clinical quality improvements, cost savings, and other benefits that might not be possible without the merger. Taking this into account, FTC staff's merger analysis typically includes a thorough assessment of the potential efficiencies and other benefits, as well as the disadvantages and harms resulting from a reduction in competition.

FTC staff has an ongoing investigation of the proposed merger. As is customary in our investigations of hospital mergers, a team of attorneys, economists, and financial analysts has interviewed market participants and stakeholders, including health insurers, employers, physician practices, trade groups, unions, and other affected entities. We have performed economic analyses using hospital discharge data and a labor market analysis. To the extent we have been able to access relevant information,[33] we have considered the financial condition of the hospitals, as well as some of the potential clinical quality benefits and cost savings that the Parties claim

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[30] New York COPA Act § 2999-aa. *See also* NY COPA Regulations § 83-2.6 (stating that the NY DOH "may issue a Certificate of Public Advantage for the Cooperative Agreement or planning process, if it determines that the benefits likely to result from the Agreement or planning process outweigh the disadvantages.").

[31] *See* New York COPA Regulations § 83-2.5, https://regs.health.ny.gov/content/section-83-25-review-process.

[32] *Merger Guidelines* § 1.

[33] FTC staff has issued Civil Investigative Demands to the Parties and requested information that would allow us to assess the proposed merger and the claims they make in their COPA Application, but they have not been forthcoming with this information to date.

they will be able to achieve through the proposed merger. Although our investigation is ongoing and the FTC is prohibited from disclosing confidential information obtained during an investigation, we are nonetheless able to provide an initial assessment of the proposed merger based on public sources. Our assessment is also supported by non-public data and information that we have obtained and reviewed. It is important to provide this assessment now, even though our investigation is still underway, to meet the NY DOH's public comment period deadline.

With this context in place, we next present FTC staff's assessment of the factors that the NY DOH must consider under the New York COPA Regulations.

IV. Parties Have Not Adequately Shown the COPA Is Necessary to Prevent a Cessation of Operations or Elimination of Services Due to Financial Distress

> ***NY DOH COPA FACTOR (a):*** *The financial condition of the Parties to the Cooperative Agreement, including whether any health care provider party is experiencing financial distress and may be forced to cease operations or eliminate a service in the absence of the Cooperative Agreement*

ASSESSMENT: The Parties have asserted that the proposed merger is necessary to preserve Crouse's assets in the market, and that without the merger, [redacted] the Parties may have to eliminate some services due to financial distress.[34] After reviewing the financial documents provided by the Parties in the COPA and Certificate of Need ("CON") Applications, [redacted], there likely are alternative ways for it to continue operations that would not require a merger with SUNY Upstate. Such a determination would require further documentation and information, as we have described below. Based on the information provided to date, however, the Parties have not made a convincing case that this merger is necessary to prevent a cessation of operations or elimination of services. [redacted]

The FTC's financial analysts rely on a comprehensive approach when assessing an entity's financial condition and viability, which includes a review of standard documentation that is customary for such an analysis, as well as any additional materials that may provide adequate support for assertions made by the Parties. Such documentation typically includes, but is not limited to, audited financial statements for the past several years including all notes and

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[34] *See* [redacted] *See also* Public Community Discussions on the SUNY Upstate/Crouse Acquisition (Aug. 15 and 18, 2022) (comments of Patrick Mannion, Crouse Health Board Chair); James Mulder, *Upstate, Crouse Hospital Officials Reveal Financial Details of Proposed Merger*, SYRACUSE.COM (Aug. 15, 2022) (describing Crouse's financial liabilities and quoting Crouse's Chair: "Crouse's board of directors began talking about finding a merger partner 10 years ago to ensure the hospital could survive over the long term without eliminating some of its specialized services like the neonatal intensive care unit.").

[35] [redacted]

attachments, year-to-date unaudited financial statements, operating and capital budgets/projections, valuation and liquidation analyses, synergy/efficiencies analyses, reorganization/restructuring plans, closure or service reduction plans, loan documents, correspondence with creditors including any applicable covenant compliance certificates and waivers, and all relevant documentation regarding any recent efforts undertaken to divest or sell assets, issue debt and obtain funding from investors, establish strategic partnerships and find alternative (less anti-competitive) purchasers than the proposed merger. Follow-up requests for additional information and meetings or calls to discuss such materials are a typical part of the review process. The FTC often utilizes formal requests such as Civil Investigative Demands to obtain these materials and any additional documentation needed for its investigations.

Based on the FTC staff's review of the materials provided in the COPA Application and CON Application, significantly more information is needed to adequately assess the financial viability of the Parties. To date, the scope of supporting financial documentation that has been provided is quite limited. Audited financial statements for 2018-2020 were provided for Crouse and its affiliates, which includes Crouse Health Hospital, Inc., Crouse Health Network, LLC and Crouse Medical Practice, PLLC.[36] Unaudited financial statements for 2021 were provided for Crouse Health Hospital, Inc. and Crouse Medical Practice, PLLC.[37] Audited financial statements for 2018-2020 and unaudited financial statements for 2021 were provided for the University Hospital ("UH"), an affiliate of SUNY Upstate.[38] Financial statements were not provided for any other SUNY Upstate affiliates.[39]

FTC staff believes that to adequately assess the financial condition and viability of each of the Parties, the following information should be obtained, if available:

- 2021 audited financial statements. In addition to audited financial statements being presented in accordance with U.S. Generally Accepted Accounting Principles ("GAAP"), the notes and attached schedules included with audited financial statements provide

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[36] [redacted] *See* CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Audited Financial Statements December 31, 2020 and 2019 at 6. Unaudited financial statements for 2021 were provided for only Crouse Health Hospital, Inc. and Crouse Medical Practice, PLLC.

[37] COPA Application Attachments 8-10 (CHS audited financial statements for 2018-2020); CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Audited Financial Statements December 31, 2020 and 2019); CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Statistics & Financial Statements December 2021.

[38] COPA Application Attachment 2 (UH audited financial statements for 2018-2020); COPA Application Attachment 5 (UH unaudited financial statements for 2021); CON Application Schedule 9 Attachment, University Hospital Audited Financial Statements December 31, 2020 and 2019; CON Application Schedule 9 Attachment, University Hospital Financial Statements December 31, 2021.

[39] UH is a department of the State University of New York Upstate Medical University ("SUNY Upstate"). SUNY Upstate is a medical campus of The State University of New York. SUNY Upstate operates a single inpatient hospital with two separate campuses: UH and Upstate Community Hospital. *See* COPA Application at 15.

important information that is not included with unaudited financial statements. It is important to understand any new disclosures and significant changes since the 2020 audited statements were provided. For instance, [redacted] It would be useful to understand how that particular liquidity measure may have changed during 2021 based on updated data and in conjunction with 2021 financial statements prepared in accordance with GAAP. And to the extent either Party is claiming financial distress, [redacted] Verification of the existence or absence of such a disclosure in the 2021 audited financial statements would be important. Among other useful disclosures, the notes to the 2021 audited financial statements would also include updated schedules regarding the amount of each company's long-term debt, its pension obligations, and its minimum required debt and pension payments.

- 2022 year-to-date unaudited financial statements. Given the passage of time since the end of fiscal year 2021, it is important to understand the most recent financial details of each company. Monthly and/or quarterly internal financial statements (balance sheets, income statements, cash flow statements) are often generated in the normal course of business, and if so, should be readily available.

- Operating and capital budgets/projections. It is important to understand how each of the Parties expected to operate independently of the proposed merger. Contemporaneous, standalone operating and capital budgets prepared by each of the Parties in the normal course of business should be provided and reviewed to properly make such an assessment. Those documents may also provide a necessary, additional level of detail not typically provided in the financial statements. [redacted] It would be important to identify and understand those expenses when considering the profitability of Crouse.

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[40] [redacted] *See* COPA Application Attachment 10 at 14; CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Audited Financial Statements December 31, 2020 and 2019 at 14.

[41] *See, e.g.*, CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Statistics & Financial Statements December 2021 at 5; CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Audited Financial Statements December 31, 2020 and 2019 at 3; COPA Application Attachment 10 at 3.

- Valuations and liquidation analyses. It is important to understand the market value of any real estate and other significant assets that may be available as a source of funds for each of the Parties. [redacted] it is important to understand the market value of all of the properties Crouse currently holds, which would be facilitated by a review of any available valuation analyses or similar market assessments of such property. It is also important to review any recent enterprise valuations (including any underlying native financial models) or liquidation analyses that may have been conducted for Crouse as an entity, which would be useful in determining the attractiveness of the hospital to other potential acquirers.

- Synergy/efficiencies analyses. Although the Parties provided several presentations that discussed and summarized the expected benefits and synergies expected from the combination, no supporting documentation or underlying native financial models that may have been relied upon were provided. This information is critical in understanding the key inputs, assumptions, and robustness of such analyses. In addition, FTC staff requires sufficient and reasonable support to show whether such benefits are likely cognizable and specific to the proposed merger, which also has not been included in the COPA and CON Applications.

- Reorganization/restructuring plans. It is also important to understand what restructuring and reorganization plans have been contemplated and attempted by reviewing contemporaneous documents that support such claims.

- Closure or service reduction plans. To the extent either of the Parties are claiming that only the proposed merger would prevent a cessation of operations and reduction of service lines, it is important to obtain and review contemporaneous documentation that will support such claims.

- Loan documents. A review of current loan documents and related agreements (e.g., security agreements, promissory notes) is customary to understand the terms, obligations, and the rights of the Parties pursuant to those agreements.

- Correspondence with creditors including any applicable covenant compliance certificates and waivers. It is important to review correspondence from lenders regarding the status of existing obligations, periodic compliance reports, events of default, requests for loan modifications, requests for waivers to loan covenants, and requests for additional

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[42] *See* COPA Application Attachment 14, Asset Purchase Agreement (July 6, 2022), Schedule 1.1.84 (Hospital Real Property); COPA Application Attachment 14, Lease Agreement (July 6, 2022) at 2.
[43] COPA Application at 52; CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Statistics & Financial Statements December 2021 at 5.

funding. [redacted], it is certainly reasonable to explore whether Crouse, independent of the proposed merger, could re-negotiate or replace its current bond debt to obtain debt with more favorable terms.[48]

- Relevant documentation regarding any recent efforts undertaken to divest or sell assets. The COPA Application stated: [redacted] As noted previously, it is important to determine the market value of any remaining significant assets held by Crouse (including the hospital real property) to determine their prospects to generate funds. For instance, it is unclear whether, independent of the proposed merger, the Crouse hospital real property could be sold to a third-party and leased back to Crouse.

- Relevant documentation regarding any recent efforts undertaken to issue debt and obtain funding from investors. As noted above, it is important to explore the prospects of issuing new debt and attracting investors, [redacted].

- Relevant documentation regarding any recent efforts undertaken to establish strategic partnerships and find alternative (less anti-competitive) purchasers than the proposed merger. To determine whether a less anti-competitive alternative may be available, it is important to understand the efforts undertaken to establish any such strategic partnerships and find alternative purchasers. [redacted]

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[44] COPA Application at 52.
[45] [redacted] *See* COPA Application Attachment 4I-5 at 5.
[46] COPA Application Attachment 19 at 8.
[47] COPA Application at 52.
[48] [redacted]. *See* COPA Application Attachment 4I-4 at 13; COPA Application Attachment 4I-5 at 8.
[49] COPA Application at 52-53.

[redacted] Apparently, comments made by Crouse Health Board Chair Patrick Mannion during a public forum during the week of August 15, 2022 indicated that Crouse's board of directors had issued a request for proposal and held conversations with many interested organizations before SUNY Upstate was selected. Similarly, [redacted] No supporting or contemporaneous documentation has been provided to indicate whether such options were viable alternatives to the proposed merger.

V. Competitive Dynamics of the Primary Service Area: The Proposed COPA Is Likely to Result in Significant Disadvantages Due to a Reduction in Competition Between SUNY Upstate and Crouse

NY DOH COPA FACTOR (b): *The dynamics of the relevant primary service area, including the availability of suitable and accessible health care services and the level of competition in the primary service area, the likelihood that other health care providers will enter or exit the primary service area, the health care workforce and the existence of unique challenges such as difficulties in recruiting and retaining health care professionals*

ASSESSMENT: In this section, FTC staff describes our economic analyses of the proposed merger, which includes information about how the merger is likely to affect the availability of healthcare services and the level of competition in the PSA, as well as entry conditions and unique workforce challenges. At the outset, we note that the Parties have asserted a PSA that is much broader than the commonly accepted definition. As we explain in more detail below, the actual PSA includes portions of nine counties – *not* the 17 counties asserted by the Parties.[52] FTC staff has evaluated the competitive dynamics in the PSA as it is defined in the New York COPA Regulations.[53] In addition, FTC staff has evaluated the competitive dynamics in Onondaga County separately from the PSA, as this is the likely locus of the merger's effects.

Our preliminary analyses suggest that the proposed combination of SUNY Upstate and Crouse would eliminate close competition between the hospital systems for patients residing in the combined PSA, and particularly in Onondaga County. SUNY Upstate appears to routinely compete with Crouse on price, quality, innovation, and patient experience for inclusion in health

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[50] COPA Application at 65.
[51] COPA Application Attachment 4I-1 at 3.
[52] *See* COPA Application at 37. In the COPA Application, the Parties refer to a 17-county area as "Central New York" and inaccurately assert that this constitutes the PSA. FTC staff does not believe this broad of an area constitutes either the PSA or a relevant geographic market for antitrust purposes. *See* Section V.B. for further discussion.
[53] FTC staff does not believe the PSA necessarily represents a "relevant geographic market" under the *Merger Guidelines* or antitrust case law, which analyze how insurers (and in turn, their members) would respond to price increases imposed by a hypothetical monopolist.

insurer networks and to attract patients to their respective hospital system for inpatient, outpatient, and physician services. Contrary to the Parties' claims that their service offerings are complementary,[54] SUNY Upstate and Crouse offer similar facility locations, service offerings, and quality of care.[55] Each system operates acute care hospitals that provide inpatient services, as well as outpatient facilities, and they employ physicians across a number of specialties. There is significant geographic overlap between these hospitals' facilities in the areas from which they draw patients.[56] Indeed, SUNY Upstate University Hospital and Crouse Hospital are located across the street from one another and share a medical campus. Consistent with our economic analyses, empirical research indicates that mergers among hospitals in close proximity are likely to result in particularly significant price increases.[57] By eliminating this competition, the proposed merger would substantially increase the combined system's ability to exercise its market power, enabling it to extract higher prices in negotiations with health insurers, which in turn would likely lead to higher healthcare costs for employers and patients. The proposed merger also would reduce the combined system's business incentives to maintain or improve the quality or availability of healthcare services.

Because SUNY Upstate and Crouse also compete as participants in healthcare labor markets, the proposed merger will reduce competition to recruit and retain healthcare employees. The reduction in labor market competition could lead to reduced wages and benefits for healthcare employees.

The Parties list several goals of the COPA, including preserving and enhancing access to care; improved utilization of existing capacity at Crouse facilities, while avoiding a costly facility expansion at SUNY Upstate's facilities; supporting SUNY Upstate's academic and research mission; preserving critical services and jobs; and improving health equity.[58] They claim that "[o]ther than the investments Upstate is committing to make in Crouse facilities and infrastructure, the Parties are not aware of any increased costs or prices that will result from the Transaction."[59] They further claim that they "have not identified any disadvantages to quality, access, or cost, associated with the Transaction,"[60] These statements are not supported by the available evidence. As we discuss in more detail below, the cost savings and efficiencies claimed by the Parties are speculative and unsubstantiated at this point. Indeed, as context, studies show that mergers often do not achieve projected cost savings and efficiencies.[61] Furthermore, [redacted]

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[54] *See* COPA Application at 21-22, 31-32, 57.
[55] *See* Table 6 depicting the vast majority of all patients treated at SUNY Upstate are treated for conditions that are also treated at Crouse, and vice-versa.
[56] *See generally* COPA Application at 37-38. *See also* PSA Analysis and Diversion Ratio Analysis, *infra* Sections V.A.2-3; FTC Map: SUNY Upstate and Crouse Individual and Combined Primary Service Areas (Attachment C).
[57] *See, e.g.*, WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., RESEARCH SYNTHESIS REPORT NO. 9: HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 7 (2006), http://www rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1 ("Mergers among hospitals that are close together geographically generate greater price increases than do mergers among distant hospitals.").
[58] COPA Application at 34-35.
[59] COPA Application at 61.
[60] COPA Application at 65.
[61] *See infra* note 156.

[redacted], so it is difficult to understand how this merger could nevertheless foster the creation of jobs or improve access to healthcare. Finally, contrary to what the Parties claim, there is *substantial* danger of competitive harm from the merger and insufficient evidence to demonstrate it would be outweighed by any potential benefits. Moreover, the commitments offered by the Parties are unlikely to mitigate this harm, or do so in a timely fashion.

The bases for FTC staff's assessment of the competitive effects of the proposed merger are described in the following subsections. Subsection A describes the geographic and services areas in which the Parties currently compete for patients, and characterizes the likely effects of the post-merger reduction in competition for residents of the Parties' combined PSA, as well as Onondaga County. Subsection B describes entry conditions in the relevant geographic area and explains that entry of new healthcare providers is not likely to occur. Subsection C describes the impact the merger could have on wage growth for hospital employees, which could exacerbate any challenges with recruiting and retaining healthcare professionals.

A. Level of Competition in the Primary Service Area and Availability of Healthcare Services

We first describe the generally accepted economic framework for analyzing hospital competition in subsection A.1. We then describe the Parties' PSA in subsection A.2. In subsection A.3, we present the diversion ratio analysis using 2019 patient discharge data from the Statewide Planning and Research Cooperative System ("SPARCS")[62] to assess the competitive effects of the proposed merger. In subsection A.4, we present market share and concentration analysis using the SPARCS data. Finally, in subsection A.5, we present an analysis of service overlaps using the SPARCS data.

1. Economic Framework for Analyzing Hospital Competition

The FTC and healthcare economists use a two-stage framework for analyzing competition in hospital markets. In the first stage, hospitals compete for inclusion in health insurers' networks. Health insurers – on behalf of their customers (employer and individual patients) – use competition between hospitals as leverage to negotiate better reimbursement rates (i.e., prices). This, in turn, results in lower premiums, copayments, deductibles, and other out-of-pocket expenses for (i) employers who purchase health insurance for their employees, (ii) employees who receive health insurance as a benefit, and (iii) consumers who purchase their own health insurance. This first-stage competition benefits all commercially insured individuals as well as plan sponsors (employers and unions) and insurers. In the second stage, hospitals

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[62] *See* New York Department of Health, *Statewide Planning and Research Cooperative System (SPARCS) Overview*, https://www health.ny.gov/statistics/sparcs/. FTC staff includes the following disclaimer from NY DOH: "This publication was produced from raw data purchased from or provided by the New York State Department of Health (NYS DOH). However, the conclusions derived, and views expressed herein are those of the author(s) and do not reflect the conclusions or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here."

compete to attract patients. Competition between hospitals to attract patients and physician referrals leads to increased quality and availability of healthcare services. This second-stage competition benefits all commercially insured patients as well as those covered by Medicare, Medicaid, and other forms of government pay.

Thus, hospital systems compete on both price and quality. When competing hospitals merge, two different kinds of adverse effects may occur: higher prices charged to insurance companies (which are then passed on to employers and patients) and non-price effects such as reduced quality and availability of services.[63] These anticompetitive effects are larger when the merging hospitals are closer (*i.e.*, more intense) competitors, and when non-merging hospitals are less significant competitors.

This framework is consistent with a large and growing body of empirical research finding that mergers between close competitors in concentrated healthcare provider markets are likely to result in substantial consumer harm, without offsetting improvements in quality.[64] For example, one paper discussing several studies of hospital mergers concludes that "the magnitude of price increases when hospitals merge in concentrated markets is typically quite large, most exceeding 20 percent."[65] Notably, this empirical finding holds for both for-profit and not-for-profit hospitals.[66] In other words, non-profit hospitals can and do exercise market power and raise prices, similar to for-profit hospitals.[67] Thus, as most courts have recognized, the non-profit status of merging hospitals does not mitigate the potential for anticompetitive harm.[68]

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[63] *Merger Guidelines* §§ 1, 6.

[64] *See, e.g.*, Zack Cooper, Stuart Craig, Martin Gaynor & John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51 (2019), https://healthcarepricingproject.org/sites/default/files/Updated_the_price_aint_right_qje.pdf; Nancy Beaulieu, Leemore Dafny, Bruce Landon, Jesse Dalton, Ifedayo Kuye & J. Michael McWilliams, *Changes in Quality of Care after Hospital Mergers and Acquisitions*, 382 NEW ENG. J. MED. 51 (Jan. 2, 2020), https://www.nejm.org/doi/pdf/10.1056/NEJMsa1901383?articleTools=true. For surveys of the research literature, *see, e.g.*, MARTIN GAYNOR & ROBERT TOWN, THE IMPACT OF HOSPITAL CONSOLIDATION – UPDATE (Robert Wood Johnson Found., The Synthesis Project, Policy Brief No. 9, 2012), http://www rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Martin Gaynor, Kate Ho & Robert Town, *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LITERATURE 235 (2015), https://www.researchgate net/publication/278676719_The_Industrial_Organization_of_Health-Care_Markets.

[65] GAYNOR & TOWN, *supra* note 64, at 2.

[66] *See, e.g.*, Robert Town, *The Economists' Supreme Court Amicus Brief in the Phoebe Putney Hospital Acquisition Case*, 1 HEALTH MGMT. POL'Y & INNOVATION 60 (2012), http://www hmpi.org/pdf/HMPI-%20Town,%20Phoebe%20Putney.pdf; Gaynor, Ho & Town, *supra* note 64.

[67] *See, e.g.*, Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. INDUS. ECON. 63 (2001), http://onlinelibrary.wiley.com/doi/10.1111/1467-6451.00138/epdf (finding substantial price increases resulting from a merger of non-profit, community-based hospitals, and determining that mergers involving non-profit hospitals are a legitimate focus of antitrust concern); Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction*, 18 INT'L J. ECON. BUS. 65, 79 (2011), http://www.tandfonline.com/doi/full/10.1080/13571516.2011.542956 (finding evidence of post-merger price increases ranging from 28%-44%, and concluding that "[o]ur results demonstrate that nonprofit hospitals may still raise price quite substantially after they merge. This suggests that mergers involving nonprofit hospitals should perhaps attract as much antitrust scrutiny as other hospital mergers.").

[68] *See, e.g.*, Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1081 (N.D. Ill. 2012) ("[T]he evidence in this case reflects that nonprofit hospitals do seek to maximize the reimbursement rates they receive.");

2. Primary Service Area

The NY DOH defines the PSA to be "the lowest number of zip codes from which the party draws at least 75 percent of its patients."[69] In our experience this is the generally accepted definition, and other state health authorities and hospitals define the PSA in the same or similar manner. We calculated the combined 75 percent PSA for the Parties (i.e., the lowest number of zip codes from which SUNY Upstate and Crouse combined draw 75 percent of their patients) using 2019 SPARCS data. Using this definition, the Parties' PSA consists of portions of nine counties in central New York: Onondaga, Oneida, Oswego, Jefferson, Cayuga, Madison, Tompkins, Cortland, and St. Lawrence. It is unclear why the Parties' COPA Application asserts that the PSA includes 17 counties; a larger so-called PSA would of course understate their actual competitive significance in the area that they serve. The geographic extent of the combined PSA is shown in Attachment C and described in Table 1 below.

Table 1: SUNY Upstate-Crouse Combined PSA
(Based on 2019 SPARCS Data)

County	# Zip Codes in PSA	# Discharges in PSA	Parties' Share of Discharges in PSA
Onondaga	33	44,720	62.5%
Oneida	3	12,301	12.3%
Oswego	6	9,257	37.6%
Jefferson	2	5,956	14.6%
Cayuga	1	4,912	23.5%
Madison	4	3,706	39.4%
Tompkins	1	3,248	7.0%
Cortland	1	3,038	23.0%
St. Lawrence	1	1,946	13.7%
Total	52	89,084	42.2%

Fed. Trade Comm'n v. ProMedica, No. 3:11 CV 47, 2011 WL 1219281, at *22 (N.D. Ohio Mar. 29, 2011) (finding that a nonprofit hospital entity "exercises its bargaining leverage to obtain the most favorable reimbursement rates possible from commercial health plans."); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1284-87 (7th Cir. 1990) (rejecting the contention that nonprofit hospitals would not seek to maximize profits by exercising their market power); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1213-14 (11th Cir. 1991) ("[T]he district court's assumption that University Health, as a nonprofit entity, would not act anticompetitively was improper."); Hospital Corp. of America v. Fed. Trade Comm'n, 807 F.2d 1381, 1390-91 (7th Cir. 1986) (rejecting the contention that nonprofit hospitals would not engage in anticompetitive behavior). *See also* DOSE OF COMPETITION REPORT, *supra* note 23, ch. 4, at 29-33 (discussing the significance of nonprofit status in hospital merger cases, and concluding that the best available empirical evidence indicates that nonprofit hospitals exploit market power when given the opportunity and that "the profit/nonprofit status of the merging hospitals should not be considered a factor in predicting whether a hospital merger is likely to be anticompetitive.").

[69] New York COPA Regulations § 83-2.2(i).

While the combined PSA includes patients from 52 zip codes (see Table 1) in nine counties, most of those zip codes are in Onondaga County, and most patients in the PSA reside in Onondaga County. Overall, SUNY Upstate and Crouse account for 42.2% of all patient discharges from zip codes within the combined PSA.

In addition to the combined PSA, we separately calculated the individual PSAs for SUNY Upstate and Crouse. A map of the zip codes included in the combined PSA, in SUNY Upstate's individual PSA, and in Crouse's individual PSA is included as Attachment C to this comment.[70] We find that Crouse's individual PSA is contained almost entirely within SUNY Upstate's PSA. Crouse's individual PSA includes 39 zip codes, 37 of which overlap with the SUNY Upstate PSA. SUNY Upstate's individual PSA is broader, containing 57 zip codes. SUNY Upstate's broader individual PSA reflects the fact that SUNY Upstate offers some services that Crouse does not,[71] and some patients with higher-acuity conditions are willing to travel further to visit SUNY Upstate as a result.

While there are other hospitals located within the area of the Parties' combined PSA, these hospitals are generally smaller, located far away from Syracuse, and do not draw patients from a wide area. As we describe below, patients do not consider these other hospitals to be close substitutes for SUNY Upstate or Crouse, and these hospitals have little or no competitive significance for SUNY Upstate and Crouse. The one exception is St. Joseph's Health Hospital ("St. Joseph's"), which is owned by Trinity Health and also located within Syracuse.

3. Diversion Ratio Analysis Confirms that SUNY Upstate and Crouse Are Close Competitors

To directly measure the degree of competition between the merging hospitals, FTC staff performed a diversion ratio analysis.[72] This analysis calculates what would happen if, hypothetically, one of the merging hospital systems were removed from an insurer's network and was no longer an option for that insurer's patient members. The patients who would have used their preferred hospital system must now use another. The fraction of a hospital's former patients who would now go to another particular hospital is the diversion ratio from the first hospital to

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[70] *See* FTC Map: SUNY Upstate and Crouse Individual and Combined Primary Service Areas (Attachment C).
[71] For example, SUNY Upstate has one of three burn units in New York State to the west of the Hudson River.
[72] To calculate diversion ratios, we estimate a patient choice model using SPARCS data for commercially insured patients covering calendar year 2019. We focus on the hospital choices of commercially insured patients because they determine the negotiated prices between hospitals and insurers. We also focus on general acute care services (mental health and addiction services, for example, may be negotiated separately and also have different market dynamics with different sets of providers). For a discussion of the underlying methodology used to calculate diversion ratios, see Joseph Farrell, David J. Balan, Keith Brand & Brett W. Wendling, *Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets*, 39 Rev. Indus. Org. 271 (2011), http://link.springer.com/content/pdf/10.1007%2Fs11151-011-9320-x.pdf; Devesh Raval, Ted Rosenbaum & Steve Tenn, *A Semiparametric Discrete Choice Model: An Application to Hospital Mergers*, 55 Econ. Inquiry 1919 (2017), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3026754.

the second.[73] The estimated diversion ratio between two hospitals accounts for patients' geographic location (as determined by the 5-digit zip code of the patient), health condition (as determined by the diagnosis-related-group ("DRG") codes used for the patient), and other patient characteristics such as gender and age. All hospitals in the state of New York are included in FTC staff's diversion ratio analysis as possible alternatives for patients. Thus, unlike the market share and concentration estimates described in the next subsection, the diversion ratio calculation reflects the importance of geographic proximity for patients' choices without constraining the analysis to a particular geographic area.

The diversion ratio is a useful measure of the degree of patient overlap between merging hospitals, and the relative bargaining positions of the hospital systems and insurers. If a significant fraction of the patients "diverted" from SUNY Upstate (Crouse) would choose Crouse (SUNY Upstate), then the two merging parties are considered close competitors and close substitutes for inclusion in an insurer's network. Before the merger, the presence of Crouse (SUNY Upstate) in the insurer's network constrains the reimbursement rate that SUNY Upstate (Crouse) can obtain in negotiations with the insurer. The merger would remove this competitive constraint on negotiated prices, and likely cause prices to rise. The degree of the price increase depends on the diversion ratio – a higher diversion ratio likely means a larger anticompetitive price increase post-merger. FTC staff's diversion ratio analysis is presented in Table 2.

Table 2: Diversion Ratio Analysis in Combined PSA
(Based on 2019 SPARCS Data)

	Diversion Ratios	
Hospital / Health System	**Remove Upstate**	**Remove Crouse**
SUNY Upstate	N/A	35.4%
Crouse	38.4%	N/A
St. Joseph's	43.8%	53.1%
Mohawk Valley Health System	1.7%	1.2%
Auburn Community Hospital	3.8%	1.3%
Samaritan Health	0.8%	0.4%
Oswego Health	3.2%	3.1%
Oneida Health	1.7%	1.0%
Guthrie	1.7%	0.8%
Rome Health	0.7%	0.4%
University of Rochester Medical Center	1.1%	1.2%
Cayuga Health System	0.4%	0.3%
Other Hospitals and Systems	2.6%	1.8%
Total	**100.0%**	**100.0%**

[73] *See Merger Guidelines* § 6.1 ("Diversion ratios between products sold by one merging firm and products sold by the other merging firm can be very informative for assessing unilateral price effects, with higher diversion ratios indicating a greater likelihood of such effects."). Unilateral price effects refer to the ability of a merged firm to raise prices on its own, without colluding with other competitors.

The diversion analysis confirms that SUNY Upstate and Crouse are close substitutes from the perspective of patients and payers. FTC staff calculates that if SUNY Upstate were no longer an option for area residents, 38% of the patients who currently use SUNY Upstate would seek care at Crouse. Conversely, if Crouse were no longer an option for area residents, 35% of the patients who currently use Crouse would seek care at SUNY Upstate.[74] These high diversion ratios are not surprising, given that SUNY Upstate and Crouse serve patients from a similar geographic area with similar health conditions, and there are very few nearby third-party hospitals. These diversion ratios indicate that a merger between SUNY Upstate and Crouse would eliminate direct head-to-head competition and likely lead to significant price increases, as well as reduced business incentives to maintain or improve quality. These diversion ratios equal or exceed many recent hospital merger cases where courts found the proposed mergers to be anticompetitive.[75]

The same analysis also confirms that only one other hospital, St. Joseph's in Onondaga County, closely competes with SUNY Upstate and Crouse. That is, if SUNY Upstate (Crouse) were no longer an option, nearly all of the patients who currently use SUNY Upstate (Crouse) and would *not* seek care at Crouse (SUNY Upstate) would instead seek care at St. Joseph's. The estimated diversion of SUNY and Crouse patients to any other particular hospital system in New York State is less than 4%. These diversion ratios strongly indicate that a merger between SUNY Upstate and Crouse would reduce the number of options available for most of their patients from three to two. It is also worth noting that the presence of St. Joseph's as a close competitor to SUNY Upstate and Crouse does not mitigate concerns about the proposed acquisition. After the acquisition, health insurers would have only two hospital options to include in a provider network for Syracuse area patients, and those patients would only have two local hospital systems providing general acute care ("GAC") inpatient services.

4. High Market Shares and Concentration Levels Confirm that the Proposed COPA Is Likely to Result in Significant Disadvantages

General principles of antitrust law and economics indicate that mergers between close competitors in highly concentrated hospital markets are likely to result in significant harm to

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[74] These diversion ratios are estimated using the observed choices of patients within the combined PSA. The same analysis can be performed using a wider geographic area. We have estimated the same statistical model on the Parties' combined 90 percent service area and find very similar diversion ratios. In other words, the calculated diversion ratios are not particularly sensitive to the geographic area used to estimate the model.

[75] *See, e.g.*, Complaint in the Matter of Advocate Health Care Network, Advocate Health and Hospitals Corporation, and NorthShore University HealthSystem ¶ 41, Docket No. 9369 (Dec. 18, 2015) https://www ftc.gov/system/files/documents/cases/151218ahc-pt3cmpt.pdf (diversion ratios were 20-25%); Complaint in the Matter of Penn State Hershey Medical Center and PinnacleHealth System ¶ 46, Docket No. 9368 (Dec. 14, 2015) https://www ftc.gov/system/files/documents/cases/160408pinnacleamendcmplt.pdf (diversion ratios were 30-40%); Fed. Trade. Comm'n Proposed Findings of Fact and Conclusions of Law in the Matter of Hackensack Meridian Health and Englewood Healthcare Foundation ¶ 100, Civil Action No. 2:20-cv-18140-JMV-JBC (D.N.J. Jun. 4, 2021) (diversion rations were 17-45%), https://www ftc.gov/system/files/documents/cases/337_2021.06.04_ftc_fof_redacted.pdf.

competition, resulting in higher prices, lower quality care, or reduced wages for hospital staff.[76] For this reason, market shares and concentration are also important tools for assessing the potential for adverse competitive effects resulting from a merger. Consistent with the diversion ratio analysis discussed above, the proposed merger would create a system with a high market share and lead to a highly concentrated market, likely resulting in substantial harm to patients due to lost competition.

Courts and antitrust agencies use a standard measure, the Herfindahl-Hirschman Index ("HHI"), to gauge a merger's effect on market concentration.[77] Under the *Merger Guideline*s and relevant case law, mergers resulting in a post-merger HHI above 2,500 and an increase in HHI of more than 200 points are presumed likely to enhance the merged firm's market power and to be anticompetitive.[78]

The concentration analysis is most appropriate when applied to a properly defined relevant antitrust market. The generally accepted definition of a "relevant antitrust market" is a set of substitute products over which a hypothetical monopolist could exercise market power by negotiating a small but significant non-transitory increase in price. This test for whether a set of substitute products constitutes a relevant antitrust market is sometimes called the "hypothetical monopolist test."[79] The geographic boundaries of a relevant antitrust market for the analysis of hospital competition are not necessarily the same as those of a PSA.

In merger investigations, defining the relevant antitrust market is a fact-intensive exercise involving interviews with market participants and reviewing confidential documents, in addition to data analyses. While we have not formally defined a relevant antitrust market in this comment, the diversion analysis, which shows that SUNY Upstate, Crouse, and St. Joseph's are close

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[76] *See, e.g.*, *Merger Guidelines* §§ 5-6; United States v. Phil. Nat'l Bank, 374 U.S. 321, 363-66 (1963) ("Specifically, we think that a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects.").

[77] HHI measures are calculated by summing the squares of the individual firms' market shares. For hospital mergers, they are based on the market shares of all hospitals (or systems) deemed to be in the market.

[78] *Merger Guidelines* § 5.3. Courts accept this presumption of illegality when evaluating hospital mergers. *See, e.g.*, ProMedica Health Sys., Inc. v. Fed. Trade Comm'n, 749 F.3d 559, 570 (6th Cir. 2014) ("[T]he Commission is entitled to take seriously the alarm sounded by a merger's HHI data."); *id.* ("These two aspects of this case – the strong correlation between market share and price, and the degree to which this merger would further concentrate markets that are already highly concentrated – converge in a manner that fully supports the Commission's application of a presumption of illegality."); Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1079 (N.D. Ill. 2012) ("High levels of concentration raise anticompetitive concerns, and the HHI calculation provides one way to identify mergers that are likely to invoke these concerns."); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1211 n.12 (11th Cir. 1991) ("The most prominent method of measuring market concentration is the Herfindahl-Hirschman Index (HHI)."); *id*. at 1218 n.24 ("Significant market concentration makes it easier for firms in the market to collude, expressly or tacitly, and thereby force price above or farther above the competitive level.") (quotation marks omitted); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) ("The defendants' immense shares in a reasonably defined market create a presumption of illegality.").

[79] *See Merger Guidelines* § 4.2.1. Agencies typically consider a "small but significant price increase" to be five percent. *Id.*

substitutes for one another (while no other hospitals are), suggests that Onondaga County likely constitutes a relevant antitrust market. [redacted]

Below, we report the results of our concentration analysis for the combined PSA as well as for the set of GAC hospitals within Onondaga County. We also report the results of our concentration analysis for all patient discharges as well as limited to discharges of commercially insured GAC patients. Because commercial hospital rates are negotiated with insurance companies, a merger's effect on hospital prices for commercially insured patients is often a helpful proxy for the degree of competition between the merging hospitals. Of course, the benefits of hospital competition, including improved patient experience and investment in innovation, accrue to all patients, not only the commercially insured.

Table 3 contains the results of our concentration analysis for hospitals serving patients residing in the combined PSA. The post-merger HHI for all discharges is 2,457 and the increase in HHI is 836. The combined SUNY Upstate-Crouse hospital system would have a share of 42.2% of inpatient hospital services for patients living in the combined PSA.[82] These metrics are even higher when looking specifically at commercially insured GAC patients, with a post-merger HHI of 2,769, an increase in HHI of 1,034, and a combined share for SUNY Upstate and Crouse of 45.5%. The combined share and HHI calculations exceed the thresholds that would create a presumption of illegality under the *Merger Guidelines* and the relevant case law,[83] and also exceed some of the levels in past hospital mergers that courts have found to be anticompetitive and blocked.[84] As with the diversion ratio analysis, all hospitals in the state of New York are included in the shares and concentration analysis for patients residing in the combined PSA.

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[80] COPA Application Attachment 4I-6 at 17.
[81] COPA Application Attachment 4I-1 at 14.
[82] Crouse has affiliations with three hospitals smaller hospitals in rural areas in central and Northern New York: Claxton-Hepburn Medical Center in Ogdensburg (the 11th row in Table 3), Carthage Area Hospital in Carthage, and Community Memorial Hospital in Ithaca. *See* https://www.crouse.org/north-country-hospitals-affiliation. For the purposes of the share analysis, these are considered separate hospitals. If they were included as part of Crouse, the Parties' combined share and the increase in HHI would be even greater.
[83] *See supra* note 78. The concentration levels in the Syracuse area had already increased in recent years, including from SUNY Upstate's 2011 purchase of Community General Hospital. *See, e.g.*, Katie Keith, Sabrina Corlette & Olivia Hoppe, Assessing Responses to Increased Provider Consolidation in Three Markets: Detroit, Syracuse, and Northern Virginia; Case Study Analysis: The Syracuse Health Care Market, Center on Health Insurance Reforms at 6 (Nov. 2018), https://georgetown.app.box.com/s/38whcvigzyytlzznecxz0oq9qklsaitq ("Syracuse's provider market has become increasingly concentrated over the last several years.").
[84] *See* Table B1: Market Shares and HHIs in Prior Healthcare Merger Cases (Attachment B).

Table 3: Shares and Concentration Analysis
Hospitals Serving Patients Residing in the Combined PSA
(Based on 2019 SPARCS Data)

Hospital / System	Share of All Discharges	Share of Commercially Insured GAC Discharges
SUNY Upstate	26.4%	23.9%
St. Joseph's	22.8%	24.3%
Crouse	15.8%	21.7%
Mohawk Valley Health System	9.0%	7.8%
Samaritan Health	4.3%	2.8%
Oswego Health	4.0%	2.1%
Auburn Community Hospital	3.5%	2.7%
Cayuga Health System	3.2%	3.5%
Rome Health	2.4%	1.9%
Guthrie	2.0%	1.6%
Claxton-Hepburn Medical Center	1.4%	1.9%
Oneida Health	1.3%	2.0%
All Others (<1.0% of All Discharges)	*3.9%*	*3.9%*
Combined SUNY Upstate - Crouse Share	42.2%	45.5%
Pre-merger HHI	1,621	1,735
Post-merger HHI	2,457	2,769
Change in HHI	836	1,034

FTC staff has assessed concentration using the combined PSA because this is the geographic area specifically referenced in the New York COPA Regulations. As we explained above, this area is likely broader than a market properly defined for antitrust purposes, meaning the shares listed in Table 3 likely overstate the competitive significance of hospitals outside of Syracuse and understate the likely anticompetitive impact of the proposed merger. In Table 4 below we report the results of the concentration analysis for Onondaga County. As we explained above, this potential relevant antitrust market definition likely satisfies the hypothetical monopolist test.

Table 4: Shares and Concentration Analysis
Hospitals Located in Onondaga County
(Based on 2019 SPARCS Data)

Hospital	Share of All Discharges	Share of Commercially Insured GAC Discharges
SUNY Upstate	43.6%	36.9%
St. Joseph's	33.2%	33.3%
Crouse	23.2%	29.7%
Combined SUNY Upstate - Crouse Share	66.8%	66.7%
Pre-merger HHI	3,541	3,359
Post-merger HHI	5,564	5,556
Change in HHI	2,024	2,197

The results for all discharges and GAC services for commercially insured patients are very similar. For commercially insured GAC discharges, the post-merger HHI is 5,556 and the increase in HHI is 2,197. The combined SUNY Upstate-Crouse hospital system would have a share of 66.7% of GAC inpatient hospital services for commercially insured patients seeking care in Onondaga County.

Finally, we performed the same share and concentration analysis for all patients residing in Onondaga County, regardless of which hospital they chose (as opposed to all hospitals located in Onondaga County, regardless of the origin of the patients, as shown above in Table 4). The results of this analysis are shown in Table 5 below and are broadly similar to the results of the concentration analysis in Table 4. For patients residing in Onondaga County (which is where most patients in the PSA reside), the proposed merger would reduce the number of available hospitals from three to two for nearly all patients.

Table 5: Shares and Concentration Analysis
Hospitals Serving Patients Residing in Onondaga County
(Based on 2019 SPARCS Data)

Hospital	Share of All Discharges	Share of Commercially Insured GAC Discharges
SUNY Upstate	37.1%	31.6%
St. Joseph's	34.6%	33.2%
Crouse	25.4%	31.9%
All Others (<1.0% of All Discharges)	*2.9%*	*3.3%*
Combined SUNY Upstate - Crouse Share	62.5%	63.5%
Pre-merger HHI	3,218	3,123
Post-merger HHI	5,101	5,141
Change in HHI	1,883	2,019

5. Analysis of Service Overlaps Confirms that SUNY Upstate and Crouse Are Close Competitors

In addition to the diversion ratio and concentration analyses described above, FTC staff also performed an analysis of the 2019 SPARCS inpatient discharge data to evaluate the overlap in the Parties' services. We find that, contrary to the Parties' claims that their service offerings are complementary,[85] the patient conditions they treat (and hence the services they provide) are very similar.

Using the 2019 SPARCS inpatient discharge data, FTC staff measured service overlaps as the DRG codes that are common to both hospitals.[86] DRG codes are used to classify patients according to diagnosis and medical complexity and are a common way to classify sets of services offered by hospitals. Any DRG code that appears in the data for both hospitals for at least X inpatient events is included in the overlap set, where X is equal to 1, 3, or 5 patients. Table 6 reports the number of DRG codes in each overlap set along with the percentage of all patients treated at both SUNY Upstate and Crouse that are in the overlap set.

[85] *See* COPA Application at 21-22, 31-32, 57.
[86] *See* CMS Guidance, *Design and development of the Diagnosis Related Group* (DRG), https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf.

Table 6: SUNY Upstate and Crouse Patients with Overlapping DRGs (Based on 2019 SPARCS Data)

DRG Overlap Set	DRG Codes in Overlap Set	Patients in Overlap Set	
		Upstate	Crouse
>=1	562	94.5%	99.3%
>=3	421	89.6%	95.6%
>=5	341	85.2%	93.4%

Table 6 shows that the vast majority of all patients treated at SUNY Upstate are treated for conditions that are also treated at Crouse, and vice-versa. For example, the 421 DRGs for which both SUNY Upstate and Crouse treated at least three patients account for 90% of all Upstate patients and 96% of all Crouse patients. The 341 DRGs for which both SUNY Upstate and Crouse treated at least five patients account for 85% of all SUNY Upstate patients and 93% of all Crouse patients.[87] In other words, SUNY Upstate and Crouse treat similar types of patients with similar health conditions.[88] This suggests that most patients view SUNY Upstate and Crouse as competing options for the treatment of their health conditions. The proposed merger would leave those patients with one fewer competing option.

B. Entry of Other Healthcare Providers Would Not Be Timely, Likely, or Sufficient to Replace the Competition Lost as a Result of the Merger

Another factor that the NY DOH must consider when evaluating the COPA Application is the likelihood that other healthcare providers will enter or exit the PSA.[89] Under the *Merger Guidelines* framework, the FTC considers whether entry by a new competitor would be timely, likely, and sufficient to alleviate the harm to competition caused by the proposed merger.[90] FTC staff acknowledges that such entry – if it would be timely, likely, and sufficient – could offset or reduce concerns in years to come from the elimination of competition between SUNY Upstate and Crouse.

The evidence obtained to date shows, however, that new entry would not be timely, likely, or sufficient to offset the competitive harm of the proposed merger. Construction and

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[87] In principle, any threshold number of patient visits for each DRG can be used to define the "overlap set," and there is no reason to prefer "at least 3" to "at least 5," or vice-versa. Any threshold risks understating the degree of overlap in the services provided by SUNY Upstate and Crouse, because one hospital system may fall just above the threshold while the other falls just below the threshold due only to chance. For example, a DRG that is treated 6 times at SUNY Upstate and 4 times at Crouse would not be included in the "at least 5" overlap set, despite the fact that both hospitals treat patients who received the same diagnosis code.

[88] FTC staff also evaluated the degree of overlap in Major Diagnostic Categories ("MDCs") treated by each hospital. SUNY Upstate and Crouse both treat patients with conditions that fall within each MDC, with one exception: SUNY Upstate has the only burn unit in the central New York region, so Crouse (along with all other hospitals in this region) must send burn patients to SUNY Upstate or Strong Memorial in Rochester (which is not located in this region).

[89] New York COPA Regulations § 83-2.5(b).

[90] *Merger Guidelines* § 9.

operation of new acute care hospitals involve significant capital investment and take many years from the initial planning stage to opening. Furthermore, new entry or expansion by acute care hospitals would have to meet the requirements of New York's CON program, which is overseen by the NY DOH and the Public Health and Health Planning Council.[91] It is unlikely that any firm could overcome the entry barriers necessary to build a new acute care hospital in the Syracuse area in the foreseeable future. Unsurprisingly, FTC staff's investigation to date has revealed no such plans for new entry by acute care hospitals.

C. Merger Likely Would Depress Wage Growth for Hospital Employees and Exacerbate Challenges with Recruiting and Retaining Healthcare Professionals

In evaluating the dynamics of the healthcare workforce in the PSA, the NY DOH should consider the impact of the proposed merger on healthcare employee wages, and how that could exacerbate the current challenges with recruiting and retaining employees that the Parties have claimed.[92] Indeed, it is part of the NY DOH's vision to consider the "wellbeing of all New Yorkers."[93] SUNY Upstate and Crouse assert that the COVID-19 pandemic created unprecedented challenges, particularly staffing shortages.[94] The FTC agrees that it is critically important to preserve access to healthcare services during the COVID-19 pandemic, and has issued statements clarifying the role of antitrust enforcement during this difficult time.[95]

The impact of hospital consolidation on competition in labor markets has garnered particular attention during recent FTC merger reviews and is relevant to the NY DOH's analysis, as this can affect employee pay and community access to healthcare services.[96] A recent academic study found that hospital mergers generating large increases in employer concentration have meaningful and statistically significant effects on employee wages.[97] Depression of wage

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[91] *See* New York State Department of Health, *CON Review Types as Determined by Facility Type*, https://www.health.ny.gov/facilities/cons/more_information/review_process.htm.

[92] COPA Application at 43, 64 (describing higher attrition rate of clinical and administrative staff due to alternative higher-wage employment opportunities, health care worker burnout, and early retirement, as well as the difficulties of recruiting providers that have not already trained in the central New York area).

[93] New York State Department of Health, *About the New York State Department of Health: Mission, Vision and Values*, https://www health ny.gov/about/ (last accessed Aug. 17, 2022).

[94] COPA Application at 43.

[95] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, JOINT ANTITRUST STATEMENT REGARDING COVID-19, https://www.ftc.gov/system/files/documents/public_statements/1569593/statement_on_coronavirus_ftc-doj-3-24-20.pdf (Mar. 24, 2020).

[96] *See e.g.,* FTC COPA Workshop Transcript: Session 2 (Afternoon) at 29 (Jun. 18, 2019), https://www ftc.gov/system/files/documents/public_events/1508753/session2_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 2] (remarks by Elena Prager describing how labor market effects are a relevant consideration for states who are evaluating COPAs, and may care about constituent pay and community access, among other policy goals; for states that have a broad public interest mandate and want to take these issues into account, there is sufficient evidence of "substantial and detectable effect on worker pay").

[97] *See* Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, American Economic Review (2021), https://www.aeaweb.org/articles?id=10.1257/aer.20190690 [hereinafter Prager & Schmitt Study]. *See also* David Arnold, *Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes*, Working Paper (2020), https://darnold199.github.io/jmp.pdf;Elena Prager Presentation at FTC COPA

growth could dissuade qualified hospital employees (already in short supply in many parts of the country) from seeking employment, which could create or exacerbate a shortage of qualified workers and undermine the quality of patient care and access to services.[98] Lower income levels for hospital employees may also worsen population health in local communities where hospitals are leading employers.[99] According to the Parties, SUNY Upstate is currently the largest employer in the central New York region and Crouse is among the ten largest.[100] According to data from Onondaga County, SUNY Upstate is by far the largest employer in the county and Crouse is the fifth largest.[101] Likewise, a 2018 study of the Syracuse healthcare market by the Center for Health Insurance Reform found that the healthcare sector is a key economic driver for the region, and "many residents [are] employed by one of the three health systems."[102] FTC staff is not aware that this proposed COPA, or any COPA for that matter, has imposed conditions or incorporated provisions that would mitigate the merger's potentially negative impact on hospital employee wages.

FTC staff conducted a preliminary analysis of the likely competitive effects of the proposed merger in healthcare labor markets using 2020 American Hospital Association ("AHA") data on employment of registered nurses and respiratory therapists.[103] FTC staff

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Workshop, *Effects of Hospital Mergers on Employee Pay* (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/slides-copa-jun_19.pdf at 109 (describing the study and methodology).

[98] *See, e.g.*, David Card, *Who Set **Your** Wage?*, Annual Meeting of the American Economic Association (Jan. 2022), https://davidcard.berkeley.edu/papers/Card-presidential-address.pdf; Vicky Lovell, SOLVING THE NURSING SHORTAGE THROUGH HIGHER WAGES, Institute for Women's Policy Research (2006), http://people.umass.edu/econ340/rn_shortage_iwpr.pdf.

[99] *See* FTC COPA Workshop Transcript: Session 2, *supra* note 96, Christopher Garmon remarks at 30-31 (discussing the impact of the Prager & Schmitt Study as applied to COPAs). *See also* Mikael Lindahl, *Estimating the Effect of Income on Health and Mortality Using Lottery Prizes as an Exogenous Source of Variation in Income*, 40 J. HUM. RESOUR. 144 (2005), http://jhr.uwpress.org/content/XL/1/144 (finding higher income generates better health); J. Paul Leigh & Juan Du, *Effects of Minimum Wages on Population Health*, HEALTH AFFAIRS HEALTH POLICY BRIEF (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180622.107025/ (suggesting higher income is correlated to improved population health).

[100] *See* COPA Application at 43; Crouse Health, *Upstate Medical University Seeks Approval to Acquire Crouse Health* (Apr. 14, 2022), https://www.crouse.org/news/upstate-medical-university-seeks-approval-to-acquire-crouse-health/.

[101] *See* Onondaga County Website, *Major Employers*, http://www.ongov.net/about/majorEmployers.html.

[102] Katie Keith, Sabrina Corlette & Olivia Hoppe, ASSESSING RESPONSES TO INCREASED PROVIDER CONSOLIDATION IN THREE MARKETS: DETROIT, SYRACUSE, AND NORTHERN VIRGINIA; CASE STUDY ANALYSIS: THE SYRACUSE HEALTH CARE MARKET, Center on Health Insurance Reforms at 3 (Nov. 2018), https://georgetown.app.box.com/s/38whcvigzyytlzznecxz0oq9qklsaitq.

[103] *See* AHA Data Solutions, https://www.aha.org/data-insights/aha-data-products (representing information provided by nearly 6,300 hospitals and more than 400 health care systems). While the AHA data report on several different categories of employees, respiratory therapists and registered nurses may be most relevant because a majority of them are employed in hospitals. *See* Mayo Clinic College of Medicine and Science, *Explore Health Care Careers: Respiratory Therapist*, https://college mayo.edu/academics/explore-health-care-careers/careers-a-z/respiratory-therapist/ (last accessed Oct. 3, 2022); U.S. Bureau of Labor Statistics, *Occupational Workplace Handbook: Registered Nurses*, https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-3 (last accessed Oct. 3, 2022). Moreover, registered nurses make up more than 30% of hospital employment. *See* U.S. Bureau of Labor Statistics: The Economics Daily, *Registered nurses made up 30 percent of hospital employment in May 2019* (Apr. 27, 2020), https://www.bls.gov/opub/ted/2020/registered-nurses-made-up-30-percent-of-hospital-employment-in-may-2019 htm.

evaluated labor concentration in the commuting zone for nursing labor, as developed by the U.S. Department of Agriculture. [104] For the proposed merger, this commuting zone consists of the following six counties: Cayuga, Cortland, Madison, Onondaga, Oswego, and Tompkins. While this commuting zone may not necessarily represent a relevant antitrust market, it is consistent with other empirical research on the effects of concentration in hospital labor markets. FTC staff used these data to calculate the number and share of employees working at all hospital facilities in this commuting zone, as well as pre- and post-merger HHIs for the proposed merger.

FTC staff found that the labor markets for both registered nurses and respiratory therapists will be highly concentrated after the proposed merger, and that the merger would increase concentration significantly. Using the AHA data, Table 7 shows that SUNY Upstate and Crouse have a combined share in the commuting zone of 50.1% for registered nurses and 45.0% for respiratory therapists. The post-merger HHIs are 3,093 and 2,734, respectively, and the increases in HHI are 949 and 874, respectively. The post-merger HHIs and changes in HHIs suggest that the proposed merger may cause harm to competition for registered nurses and respiratory therapists. [105]

Using the exact data and methodology employed in the Prager and Schmitt study of concentration in hospital labor markets cited above, FTC staff also calculated employment shares using total hospital employment as reported to the Centers for Medicare & Medicaid Services ("CMS") in hospitals' annual cost reports. [106] Using the CMS data, Table 7 also shows that SUNY Upstate and Crouse would account for nearly 50% of total hospital employment within the commuting zone, and that the combination of their shares would lead to a post-merger HHI of 3,015 and an increase in HHI of 1,027. This analysis suggests that harm to competition for labor as an input caused by the proposed merger will not be limited to registered nurses and respiratory therapists. [107]

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[104] The U.S. Department of Agriculture developed commuting zones using 2000 census data on commuting patterns. FTC staff's definition of the labor market for registered nurses follows much of the recent literature, which shows that around 80% of job applications on career websites are submitted by residents living within the commuting zone. *See, e.g.*, Prager & Schmitt Study; José Azar, Ioana Marinescu & Marshall I. Steinbaum, *Labor Market Concentration*, NBER Working Paper No. 24147 (2019), https://www.nber.org/papers/w24147; Ioana Marinescu & Roland Rathelot, *Mismatch Unemployment and the Geography of Job Search*, 10 AM. ECON. J. MACROECON. 42 (2018), https://www.aeaweb.org/articles?id=10.1257/mac.20160312.

[105] For context, these increases in HHI are very close to the 75th percentile among hospital mergers calculated in the Prager and Schmitt study, which found negative effects on hospital employee wage growth for mergers causing an increase in concentration above the 75th percentile.

[106] *See* CMS, *Hospital Cost Report Public Use File*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Cost-Report/HospitalCostPUF (last accessed Oct. 3, 2022). FTC staff used data from 2018, the most recent year available.

[107] Only hospitals that report data to both AHA and CMS are included in the labor concentration analysis. This includes non-GAC hospitals such as psychiatric centers and long-term care facilities and excludes Veterans Affairs hospitals.

Table 7: Hospital Employment Shares in SUNY Upstate-Crouse Commuting Zone (Based on 2020 AHA Data and 2018 CMS Data)

		Registered Nurses		Respiratory Therapists		Hospital Employees	
Hospital / System	**County**	**FTE**	**Share**	**FTE**	**Share**	**FTE**	**Share**
SUNY Upstate	Onondaga	1,587	37.4%	74	30.8%	5,591	35.2%
St. Joseph's	Onondaga	843	19.9%	52	21.7%	3,107	19.5%
Crouse	Onondaga	538	12.7%	34	14.2%	2,322	14.6%
Cayuga Medical Center	Tompkins	434	10.2%	25	10.4%	1,203	7.6%
Oswego Health	Oswego	263	6.2%	18	7.5%	854	5.4%
Auburn Community Hospital	Cayuga	178	4.2%	9	3.8%	702	4.4%
Oneida Health	Madison	162	3.8%	17	7.1%	703	4.4%
Guthrie Cortland Medical Center	Cortland	122	2.9%	6	2.5%	612	3.8%
Community Memorial Hospital	Madison	72	1.7%	5	2.1%	218	1.4%
Richard H. Hutchings Psychiatric Center	Onondaga	42	1.0%	0	0.0%	585	3.7%
Combined SUNY Upstate - Crouse Share:		50.1%		45.0%		49.8%	
Pre-merger HHI:		2,144		1,860		1,988	
Post-merger HHI:		3,093		2,734		3,015	
Change in HHI:		949		874		1,027	

In addition to significantly increasing concentration in the labor markets for registered nurses and respiratory therapists, the merger would combine two significant nursing schools. SUNY Upstate is the largest provider of training for healthcare professionals in the central New York region, and its proposed acquisition of Crouse's nursing school would further strengthen its position. [redacted]

VI. Benefits of the COPA Are Unlikely to Outweigh the Disadvantages Resulting from a Reduction in Competition and Less Restrictive Arrangements May be Available

In conjunction with our standard analysis under the *Merger Guidelines*, FTC staff evaluated the proposed merger applying the benefits and disadvantages factors that the NY DOH must consider when reviewing the COPA Application. [109] Based on the information we have obtained to date, we do not have reason to believe the Parties' claimed benefits of the COPA are likely to outweigh the significant disadvantages that would result from a reduction in competition between SUNY Upstate and Crouse. Furthermore, we have considered "the availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition." [110] Under this factor, we believe there may be less restrictive alternative arrangements available.

[108] COPA Attachment 4I-1 at 14.
[109] New York COPA Regulation 83-2.5 (c)-(d).
[110] New York COPA Regulation 83-2.5 (e).

Under the New York COPA Act and Regulations, the NY DOH must consider whether the proposed COPA is likely to generate sufficient public benefits to offset the likely harm to consumers. This inquiry is similar to the analysis that courts and antitrust agencies perform when assessing the competitive impact of mergers. [111] As noted above, the *Merger Guidelines* reflect the combined experience of the antitrust agencies when assessing mergers. In addition to considering competitive harm, that assessment also explicitly includes consideration of the potential benefits resulting from the proposed merger.

For cost savings and quality benefits to be recognized as cognizable efficiencies under the *Merger Guidelines*, they must be sufficiently substantiated by the merging hospitals so that courts and antitrust agencies "can verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific." [112] Rigorous substantiation of efficiency claims is critical because efficiencies are difficult to verify and quantify, in part because much of the information is in the hands of the Parties, and because efficiencies may not be realized. [113] Efficiency claims also must be "merger-specific" – meaning they can only be achieved by this particular merger and not through other means having the same or lesser anticompetitive effects.

Any cost savings and quality benefits that are substantiated and merger-specific must then be balanced against the likely competitive harm. Under the *Merger Guidelines*, the greater the potential anticompetitive effects from a merger, the greater the efficiencies need to be to outweigh the anticipated harm from the merger, and the more certain it must be that any efficiencies would be passed through to consumers. Where the proposed merger is likely to result in substantial harm to competition, the *Merger Guidelines* require a showing of extraordinary efficiencies to overcome that harm. [114] Experience has shown that "[e]fficiencies almost never justify a merger to monopoly or near-monopoly." [115]

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[111] *See Merger Guidelines* § 10; Fed. Trade Comm'n v. ProMedica, No. 3:11 CV 47, 2011 WL 1219281, at *57 (N.D. Ohio Mar. 29, 2011) (finding that the defendant's efficiencies claims did not rebut a presumption of anticompetitive effects); Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1088-89 (N.D. Ill. 2012) (recognizing the *Merger Guidelines* approach for evaluating efficiencies); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1222 (11th Cir. 1991) (recognizing that efficiencies are an important consideration in predicting whether a transaction would substantially lessen competition).

[112] *Merger Guidelines* § 10.

[113] Indeed, legal cases indicate that efficiency claims based on "speculation and promises about post-merger behavior" are not sufficient. United States v. H&R Block, Inc., 833 F. Supp. 2d 36, 89 (D.D.C. 2011) (quoting Fed. Trade Comm'n v. H.J. Heinz, 246 F.3d 708, 720-721 (D.C. Cir. 2001)).

[114] *Merger Guidelines* § 10. *See also ProMedica*, 2011 WL 1219281, at *57 ("Efficiencies must be 'extraordinary' to overcome high concentration levels") (quoting Fed. Trade Comm'n v. H.J. Heinz, 246 F.3d 708, 721 (D.C. Cir. 2001)); *OSF Healthcare Sys*., 852 F. Supp. 2d at 1089 ("'[h]igh market concentration levels require proof of extraordinary efficiencies'") (quoting *H&R Block*, 833 F. Supp. 2d at 89).

[115] *Merger Guidelines* § 10.

A. Proposed Merger Likely Would Have a Substantial Adverse Impact on the Quality and Price of Health Care Services in the Syracuse Area

NY DOH COPA BENEFIT FACTOR (c)(3): *Enhancement of the quality of health care provided by the Parties to the Cooperative Agreement*

NY DOH COPA DISADVANTAGE FACTOR (d)(1): *Increased costs or prices of health care in the primary service area resulting from the Cooperative Agreement, after taking into consideration improvements in quality and outcomes*

NY DOH COPA DISADVANTAGE FACTOR (d)(2): *Diminished quality, availability, and efficiency of health care services*

ASSESSMENT: As described above, our analysis indicates that SUNY Upstate and Crouse are close competitors and that the geographic service area is highly concentrated. As a result, the proposed merger would give the combined hospital system increased bargaining leverage with insurers to negotiate significantly higher reimbursement rates, because insurers would no longer be able to play two competitors off of each other during negotiations. These price increases typically are passed through from insurers to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses. [116] Thus, contrary to the statements by the Parties that they "are not aware of any increased costs or prices that will result from the Transaction," [117] the proposed merger likely would have a substantial adverse impact on patients with respect to the price of healthcare services. [redacted] As described in Section VII, the Parties have not proposed any enforceable terms or conditions that would mitigate this harm.

The elimination of competition between SUNY Upstate and Crouse would also significantly diminish the Parties' business incentives to maintain or improve current levels of quality, patient experience, and access to services and innovative technology, because the combined hospital system would no longer risk losing patients to its pre-merger rival. These non-price dimensions of competition greatly benefit patients and are among the factors by which employers and consumers evaluate the desirability of a provider network. Today, these hospitals know that patients can choose to seek care at, and physicians can send their referrals to, another system if they are not satisfied with the quality, patient experience, or services offered by one of the hospital systems. That threat of losing patients and physician referrals to a rival system incentivizes each system to provide the best possible quality and patient experience, to add new services and technology, and to enhance the availability and convenience of care. Thus, the

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[116] *See infra* Section VI.D, for further discussion of this dynamic.
[117] COPA Application at 61.
[118] [redacted]

proposed merger could reduce the quality of care, all other things equal. Importantly, a reduction in quality of care can have an adverse effect on patient outcomes such as mortality, readmissions, and length of stay. Reduced availability of services may result in decreased patient access, increased travel time to receive services, increased emergency room wait times, and other negative consequences.

In the COPA Application, the Parties argue that the merger generally would lead to improved availability and quality of care, as well as enhanced clinical coordination throughout the merged entity. [119] Assessing potential quality improvements has long been a central element of FTC hospital merger investigations because we recognize that a hospital merger could improve patient health outcomes under certain circumstances. We often analyze the clinical quality effects likely to occur as a result of consolidation with guidance from leading academic and policy experts in healthcare quality. We also evaluate how the merger affects the hospitals' business incentives to deliver higher quality care, and whether changes brought about by the merger would enable the combined hospitals to provide higher quality care more cheaply or efficiently than they could achieve individually.

Empirical literature evaluating the relationship between competition and various measures of hospital quality of care does not support the conclusion that hospital consolidation generally improves clinical quality of healthcare services. To the contrary, studies demonstrate the net effect of mergers of competing hospitals on quality is often negative, and increased competition is associated with better quality. [120] Based on the available evidence, we cannot presume that any given hospital merger is likely to improve quality or reduce costs by enough to offset a price increase.

As we have stated previously, FTC staff needs more information to fully assess the Parties' claims and the Parties have not supplied this information to date. Based on FTC staff's deep experience in evaluating these types of quality justifications, however, it appears that many of the Parties' claims about the likely quality benefits from the merger are unsubstantiated or the benefits appear modest in scope. Furthermore, it appears that many of the claimed quality

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[119] *See, e.g.*, COPA Application at 39-41 (describing how the proposed merger will lead to "improvements in cancer screening, prevention, and treatment services, retention of vital cardiac services, better care coordination for newborns, and integration of behavioral health services;" clinical synergies, such as nurse navigators providing services across the care continuum at the combined organization, "through which best practices and service line offerings of each institution can be adopted for the combined enterprise as a whole;" and reduced wait times and improved patient access and experience).

[120] *See* Romano & Balan, *supra* note 128; Gaynor, Ho & Town, *supra* note 64; GAYNOR & TOWN, *supra* note 64; Beaulieu, Dafny, Landon, Dalton, Kuye & McWilliams, *supra* note 64, at 56 (finding "no evidence of quality improvement attributable to changes in ownership. Our findings corroborate and expand on previous research on hospital mergers and acquisitions in the 1990s and early 2000s and are consistent with a recent finding that increased concentration of the hospital market has been associated with worsening patient experiences."); Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, Medical Care Research and Review 1-18, at 14 (2019), https://journals.sagepub.com/doi/pdf/10.1177/1077558719828938 (finding "increased hospital market concentration is strongly associated with reduced quality across multiple measures. With this result in mind, regulators should continue to focus scrutiny on proposed hospital mergers, take steps to maintain competition, and reduce counterproductive barriers to entry.").

enhancements may be achieved through less restrictive alternatives that would not eliminate the valuable competition between the Parties – either by the Parties independently, through another form of collaboration between the Parties, or through an alternative merger or affiliation with a different partner that would not meaningfully reduce competition.

1. Consolidation of Clinical Services Is Uncertain and Could Reduce Patient Access

Although the Parties contend that they [redacted] as a result of the proposed merger, the COPA Application includes numerous examples of planned consolidation of clinical services. The Parties acknowledge that "[w]ith respect to those services that are currently offered by both Parties, the Transaction will enable the Parties to consolidate those service lines which can reduce duplicative costs and administrative burden." [122] Duplicative service lines that appear to be targeted for consolidation include: neurology, neurosurgery, and stroke care; labor and delivery services; cardiac surgery services; surgical oncology services; and emergency department services. [123] In addition, several service lines that the Parties describe as complementary appear to be targeted for consolidation, including: cardiology and cardiac surgery; pediatric specialty care and NICU services; and inpatient and outpatient behavioral health services and addiction treatment services. [124] This proposed consolidation of clinical services likely would require considerable effort, money, and time. The Parties have not provided sufficiently detailed information in the COPA Application, so it remains unclear whether the merged entity could successfully consolidate clinical services so as to improve patient outcomes, or when the merging hospitals might expect to realize any purported quality benefits.

Moreover, although the Parties claim they are pursuing the COPA "to proactively preserve critical services and workforce," [125] it is entirely possible that consolidation could reduce the availability of, and patient access to, healthcare services – for example, due to the closure of hospital facilities or a reduction in hospital staff. If this were to occur, then the consolidation of clinical services could be more harmful to patients than beneficial.

The Parties suggest that a post-merger consolidation of the cardiac surgery programs is necessary to maintain sufficient volumes of procedures "to ensure the longevity of the cardiac surgery program and to meet the corresponding minimum requirements for the structure heart program," and that without this consolidation, SUNY Upstate's program is at risk of closing. [126] The Parties claim that over the last two years, both hospitals' cardiac surgical volumes have

[121] COPA Application at 64.
[122] COPA Application at 57.
[123] COPA Application at 42, 45-49, 57, 59-61.
[124] COPA Application at 41-42, 45-49, 63.
[125] COPA Application at 35.
[126] COPA Application at 42.

fallen below minimum requirements. [127] While FTC staff would need more information to fully assess these claims, the research literature shows that a "volume/outcome" relationship only exists for a limited set of procedures and services, including trauma and certain other complex procedures. [128] Any quality benefits from the Parties' proposed clinical consolidation would, therefore, be confined to those services for which there is a demonstrated volume/outcome relationship.

The Parties also suggest that shifting SUNY Upstate's low-acuity services to Crouse, thereby opening up beds for higher-acuity and more specialized care at the main Upstate Hospital, will improve utilization and grow several priority service lines, including: neurosciences, cardiac services, hematology and oncology, behavioral health, pediatrics/labor and delivery, primary care, and physician medicine and rehabilitation. [129] However, repurposing acute care beds and consolidating co-located facilities are unlikely to have a volume/outcome relationship. As a result, although these other types of consolidation could result in some cost savings, they would be unlikely to significantly improve quality.

Moreover, even for procedures where there is a volume/outcome relationship, consolidation that might improve clinical quality outcomes would only be merger-specific if it would enable the merged hospital system to surpass certain volume thresholds that the hospitals could not otherwise meet independently. Further, even if the merging hospital systems were able to obtain substantiated, merger-specific volume/outcome related improvements in clinical outcomes by consolidating services, those benefits must be weighed against any potential disadvantages that could result from the consolidation. [130] For example, if closing some facilities would be necessary to consolidate volume at a more limited number of facilities, the increased travel time to these consolidated facilities could have an adverse impact on some patients.

Finally, to consolidate clinical services, the Parties must be able to integrate successfully and this involves achieving sufficient cultural compatibility. Indeed, the difficulty of unifying organizational cultures has been identified as a significant challenge to integrating facilities and a primary reason that anticipated benefits of hospital mergers may fail to materialize. [131] [redacted]

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[127] The Parties state that according to CMS, structural heart programs must perform at least 1,000 cath lab procedures and 400 percutaneous coronary intervention ("PCI") procedures. Over the last two years, SUNY Upstate claims to have performed 981 and 993 cath lab procedures and 323 and 292 PCIs, respectively. Crouse claims to have performed 390 cath lab and 763 PCI procedures during this time frame. COPA Application at 42.

[128] *See* Patrick Romano & David Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Hospital*, 18 INT'L J. ECON. BUS. 45 (2011), http://www.tandfonline.com/doi/abs/10.1080/13571516.2011.542955.

[129] COPA Application at 42-43.

[130] *See* Kenneth Kizer, Independent Assessment of the Proposed Merger between Mountain States Health Alliance and Wellmont Health System 17-19 (Nov. 21, 2016), https://www.vdh.virginia.gov/content/uploads/sites/96/2016/11/Kennith-KIZER-INDEPENDENT-ASSESSMENT-MSHA-WHS-MERGER.pdf.

[131] *See id.* at 24-25 ("Notwithstanding that the VA Healthcare System is completely administratively and financially integrated, and has a longstanding well-defined mission, there were significant challenges in merging facilities under common management primarily because of the often disparate local cultures prevalent at individual facilities – even when in some instances they were geographically separated by only a few miles and served much the same population.").

[redacted]

2. Hospitals Can Pursue Clinical Standardization without the COPA

The Parties claim the COPA "is anticipated to result in substantial benefits for the combined organizations, for patients, and the community at large," and that "a central objective of this Transaction is to utilize existing resources in a more efficient manner, reducing duplication of operational efforts currently in place, and to more closely coordinate the manner in which care is delivered across the sites of care within the combined organization." [133] Yet beyond such general statements regarding various service lines, the Parties do not identify any specific areas targeted for quality improvement or detailed plans for achieving improvements. A hospital merger may generate overall quality improvements when the merging hospitals have very different clinical quality levels if the merger allows the clinically inferior hospital to come under the management, and adopt the practices, of the clinically superior hospital, thereby improving quality at the inferior hospital. Based on the information FTC staff has obtained to date, neither hospital appears to suffer from low quality levels, meaning the potential for overall quality improvements may be limited. FTC staff will continue to assess this issue in its ongoing investigation.

Having said that, if SUNY Upstate and Crouse want to engage in greater efforts to coordinate care with one another and improve health outcomes for patients, they have other options without having to merge. Although standardizing clinical policies and procedures may lead to quality improvements, the Parties can achieve these either on their own, through some collaboration short of a merger, or through mergers or affiliations with alternative partners that raise fewer competitive concerns. As the antitrust agencies have consistently made clear, the antitrust laws are not an impediment to legitimate, procompetitive collaboration that would benefit consumers. Indeed, the FTC has issued extensive guidance to healthcare providers about ways that they can collaborate without running afoul of the antitrust laws. [134] Generally, most of the benefits from the merger may be achieved through alternatives that are less restrictive to competition and achieve comparable benefits or a more favorable balance of benefits over disadvantages. [135]

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[132] COPA Application Attachment 4I-3 at 14.
[133] COPA Application at 57.
[134] *See, e.g.*, U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), https://www ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf (see specifically Statement 6 regarding provider participation in exchanges of price and cost information, Statement 7 regarding joint purchasing arrangements among providers of health care services, and Statement 8 regarding physician network joint ventures); Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Fed. Trade Comm'n & U.S. Dep't of Justice Oct. 28, 2011), http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf.
[135] This assumes that benefits would be achieved as a result of the merger. FTC staff believes that any benefits resulting from the merger that are substantiated and merger-specific are likely to be modest.

Indeed, the Parties have collaborated in numerous ways over the last fifteen years pursuant to the Berger Commission recommendations and the DSRIP program. Such efforts include a Clinical Affiliation Agreement, an AAMC Uniform Clinical Training Affiliation Agreement, and several additional clinical or operational agreements intended "to take advantage of the proximity between the hospitals and avoid unnecessary duplicative capital expenditure." [136] These statewide initiatives were implemented and supervised by the NY DOH, and appear to have required substantial resources and public funding. [redacted] Furthermore, they claim that other than the proposed merger, there are "no other available arrangements that would have a less restrictive impact on competition in the primary service area and achieve the same benefits, including that preserve Crouse as a safety-net hospital in the community for the long term, or that could achieve a more favorable balance of benefits." [137] Despite the FTC's requests for more information from the Parties about these arrangements, the Parties have not supplied the documents and information that would be necessary to evaluate their claims. As we noted previously, if the Parties were unable to achieve the purported goals of these prior state initiatives – namely, to reduce costs and improve quality and accessibility – then we question whether they can now achieve these goals through the proposed merger.

Furthermore, it appears that [redacted]. It is possible, therefore, that there were other partners Crouse could have selected that may have raised fewer antitrust concerns. [redacted], the FTC has no way of evaluating this claim without more detailed information. Indeed, as we described previously, it appears that Crouse had conversations with several interested organizations, [redacted] FTC staff encourages the NY DOH to request additional documents and information about prior collaborative arrangements between the Parties and Crouse's partner search, to determine whether the Parties' claims in the COPA Application are accurate.

3. COPA Is Unnecessary for Population Health Improvement

The Parties claim that the COPA will "enhance Upstate's ability to provide care to under-served populations" and "align two health systems already committed to health equity, but who, when combined, will be able to achieve greater advances in health equity." [139] They suggest that combining Upstate's Global Health and Crouse's Population Health capabilities will enable them to enhance access to care across central New York. [140]

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[136] COPA Application at 36. *See* COPA Application Attachment 14 for complete list of contractual relationships between the Parties. *See also* Berger Commission Report, *supra* note 6; DSRIP Program Overview, *supra* note 7.
[137] COPA Application at 65.
[138] *See* discussion of Crouse's partner search, *supra* at 13.
[139] COPA Application at 44.
[140] COPA Application at 44.

However, both Parties appear to *already* engage in extensive population health initiatives. For example, SUNY Upstate and Crouse both participated in the development of the Onondaga County Community Health Assessment and Improvement Plan, along with many other providers and community stakeholders. [141] And the COPA Application lists numerous population health initiatives that both hospitals have engaged in to prevent chronic disease; promote a healthy and safe environment; promote healthy women, infants, and children; promote well-being and prevent mental and substance abuse disorders; prevent communicable diseases; and address health equity. [142] It is unclear why the proposed merger is necessary for any of these population health management initiatives. The relevant question is whether SUNY Upstate and Crouse would be more likely to participate in such initiatives, or participate more effectively, with this merger than they would without it. The Parties present no evidence that this is the case. It appears that the region can continue to benefit from these initiatives without incurring the disadvantages associated with the proposed merger. Antitrust laws do not prevent these hospitals from pursuing population health initiatives in the absence of the merger. Furthermore, there does not appear to be any enforceable commitment requiring the combined hospital system to achieve these goals post-merger.

4. Implementation of Uniform EMR System Is Unnecessary to Improve Quality of Care

According the Parties, [redacted]. [143] Instead, SUNY Upstate has agreed to install its EMR system, EPIC, at Crouse as part of the proposed merger. [144] Without more detailed information from the Parties, FTC staff has been unable to verify any of these details and [redacted]. Nevertheless, FTC staff has attempted to evaluate the Parties' claim that bringing patient medical records onto a unified EMR will enable them to better coordinate care for patients.

For several reasons, the Parties' claims regarding a uniform EMR system may be overstated. First, they have not demonstrated that the incremental benefit of a common IT platform would be of sufficient magnitude to significantly improve patient health outcomes. Patients who will only use facilities in one of the current hospital systems are not likely to benefit from the combination of the EMR platforms. There are ways for hospitals to effectively share information with each other, even with separate EMR systems, further limiting the benefits of a common system. Moreover, it is possible that federal legislation regarding EMR

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[141] COPA Application at 41. *See also* Onondaga County Community Health Assessment and Improvement Plan 2019-2021, http://www.ongov.net/health/documents/OnondagaCountyCHA-CHIP.pdf.
[142] COPA Application at 53-56.
[143] COPA Application at 49-50.
[144] COPA Application at 41, 46.

interoperability may reduce or obviate the need for a common EMR platform between the Parties. [145]

Second, any benefit of a common EMR system would have to be compared to its costs. Converting to a common EMR system can be extremely expensive and time consuming, [146] and the conversion process can delay access to critical patient information. [redacted] All told, the time, difficulties, and expense of converting to a common EMR system may outweigh the potential benefit.

Third, a Health Information Exchange ("HIE") already exists in central New York, which enables secure access to patient information across the continuum of care, thereby improving patient health outcomes. [149] HealtheConnections appears to have been available since 2011, and both SUNY Upstate and Crouse appear to be participants. The Parties have not adequately explained the incremental benefit of the information accessible on a combined EMR system versus that available on the existing HIE. Furthermore, under the Affiliation and Collaborative Agreement, the Parties received a $5.1 million HEAL4 grant in 2007 from the NY DOH for information technology updates at SUNY Upstate, so that both hospitals could share electronic information. [150] The Parties have not adequately explained how this money was used and why they now need a combined EMR system.

In summary of Section VI.A, the proposed merger appears to eliminate direct head-to-head competition between SUNY Upstate and Crouse, and will likely lead to significantly higher

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[145] *See* Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), which requires widespread exchange of health information through interoperable certified EMR technology among healthcare providers. Absent the merger, the Parties are already required to achieve EMR interoperability. This undermines the Parties' argument that a merger is necessary to achieve a common EMR platform, so that the hospitals can exchange health information. *See also* CMS, *Promoting Interoperability Programs*, https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms?redirect=/ehrincentiveprograms (last accessed Oct. 3, 2022); CMS, *Certified EHR Technology*, https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification (last accessed Oct. 3, 2022); CMS, *2022 Medicare Promoting Interoperability Program: Certified Electronic Health Record Technology Fact Sheet*, https://www.cms.gov/files/document/2022-cehrt-fact-sheet.pdf (last accessed Oct. 3, 2022).

[146] *See* Akanksha Jayanthi & Ayla Ellison, *8 Hospitals' Finances Hurt by EHR Costs*, BECKER'S HOSPITAL CFO (May 23, 2016), http://www.beckershospitalreview.com/finance/8-hospitals-finances-hurt-by-ehr-costs.html; Akanksha Jayanthi, *8 Epic EHR Implementations with the Biggest Price Tags in 2015*, BECKER'S HEALTH IT & CIO REVIEW (Jul. 1, 2015), http://www.beckershospitalreview.com/healthcare-information-technology/8-epic-ehr-implementations-with-the-biggest-price-tags-in-2015 html.

[147] COPA Application at 49.

[redacted]

[149] Healthe Connections, *About Us*, https://www healtheconnections.org/about-us/ (listing SUNY Upstate, Crouse, and St. Joseph's as hospital participants in Onondaga County). *See also*, Health IT Connections, *Central New York's Health Information Exchange Connects Four Area Hospitals, Lab To Improve Patient Care And Continues Its Expansion Across CNY* (May 3, 2011), https://www healthitoutcomes.com/doc/central-new-yorks-health-information-0001.

[150] *See* New York State Department of Health, REPORT ON THE IMPLEMENTATION OF THE REPORT OF THE COMMISSION ON HEALTH CARE FACILITIES IN THE TWENTY-FIRST CENTURY at 66, *supra* note 6.

prices and reduced business incentives to maintain or improve quality and access to care. Importantly, the benefits of competition among healthcare providers are not confined to those patients covered by commercial insurance plans. Competition benefits *all* patients, including those who are covered by government insurance programs (*i.e.*, Medicare and Medicaid) or are uninsured. By far, the most important such benefit is improved quality of care. As noted above, competition-reducing mergers often reduce quality. Those quality reductions could affect all of the hospitals' patients, not just those with commercial insurance. Competition may also indirectly restrain the prices or premiums paid by patients covered by a government insurance program or who are uninsured. [151]

B. Proposed Merger Likely Would Reduce Patient Access to Healthcare Services in the Syracuse Area

NY DOH COPA BENEFIT FACTOR (c)(1): *Preservation of needed health care services in the relevant primary service area that would be at risk of elimination in the absence of a Cooperative Agreement*

NY DOH COPA BENEFIT FACTOR (c)(2): *Improvement in the nature or distribution of health care services in the primary service area, including expansion of needed health care services or elimination of unnecessary health care services*

NY DOH COPA BENEFIT FACTOR (c)(4): *Expansion of access to care by medically-underserved populations*

ASSESSMENT: The Parties claim they must consolidate certain clinical services in order to preserve them and that integration, along with the use of a single EMR system, will generally improve coordination of care and offer enhanced access to vulnerable patient populations. [152] However, as FTC staff has already noted, consolidation of services could just as likely lead to a reduction in access to care. For example, the Parties cite concerns about changing demographics and the financial pressures and capacity constraints they will face as utilization

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[151] Many Medicare patients are covered by Medicare Advantage (MA) plans rather than by traditional Medicare. MA hospital prices are negotiated rather than fixed and, as such, vary from traditional Medicare hospital prices. *See* Robert A. Berenson, Jonathan H. Sunshine, David Helms & Emily Lawton, *Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices*, 34 HEALTH AFFAIRS 1289 (Aug. 2015), http://content.healthaffairs.org/content/34/8/1289.abstract; Laurence Baker, M. Kate Bundorf, Aileen Devlin & Daniel Kessler, *Medicare Advantage Plans Pay Hospitals Less Than Traditional Medicare Pays*, 35 HEALTH AFFAIRS 1444 (Aug. 2016), http://content healthaffairs.org/content/35/8/1444.abstract. A competition-reducing merger may to some extent increase MA prices, and those increases will be passed through to Medicare beneficiaries in the form of higher MA premiums or reduced benefits. In addition, under the Patient Protection and Affordable Care Act, prices that non-profit hospitals charge to uninsured, self-pay patients eligible for financial assistance can be no more than "amounts generally billed to insured patients." *See* Sara Rosenblum, *Additional Requirements For Charitable Hospitals: Final Rules On Community Health Needs Assessments And Financial Assistance*, HEALTH AFFAIRS BLOG (Jan. 23, 2015), http://healthaffairs.org/blog/2015/01/23/additional-requirements-for-charitable-hospitals-final-rules-on-community-health-needs-assessments-and-financial-assistance/. The calculation of these "amounts generally billed" includes commercial insurance prices, which means that increases in commercial prices also increase the prices that hospitals are permitted to charge to uninsured patients.

[152] *See, e.g.*, COPA Application at 41-42.

increases from a growing 65-and-older population, and claim the proposed merger is necessary to alleviate these concerns and preserve access to healthcare services. [153] However, the Parties have not presented sufficient evidence that they lack the financial resources to continue operating independently and to maintain quality and access to healthcare services. We urge the NY DOH to consider whether any challenges the Parties face in response to the changing delivery and payment landscape can be addressed in less restrictive ways than the proposed merger, without reducing valuable competition in this region.

Notably, the Parties have made no firm commitments to keep open or maintain current service levels at hospitals and other facilities. Indeed, they would likely need to consolidate facilities and services to achieve projected cost savings and efficiencies, which would likely lead to a reduction in access to healthcare services, including potentially urgent care. The Parties have identified some general service areas in which they expect to consolidate volume at one hospital or the other following the merger, including: neurology, neurosurgery, and stroke care; labor and delivery services; cardiology and cardiac surgery services; surgical oncology services; emergency department services; pediatric specialty care and NICU services; and inpatient and outpatient behavioral health services and addiction treatment services. We encourage NY DOH to weigh carefully the potential benefits of consolidating volume against the potential harms, including reduced capacity and increased patient drive times.

The Parties' efficiencies claims also raise concerns about reduced capacity and access for healthcare. For example, the Parties claim that absent the proposed merger, SUNY Upstate would have to build additional inpatient space [redacted] to meet increasing inpatient demands. SUNY Upstate claims to be severely capacity constrained and Crouse claims to consistently have excess capacity, [redacted]. Following the proposed merger, SUNY Upstate intends to utilize all of Crouse's existing beds and does not expect to request any additional beds from the NY DOH in the near future. The Parties claim that this plan will make 134 beds available to the system, immediately alleviating SUNY Upstate's capacity constraints and avoiding the "costly" inpatient bed tower expansion. [154] Without more detailed information from the Parties, FTC staff is unable to verify the accuracy of these claims. To be clear, this plan does not mean that bed capacity in the Syracuse area will actually increase under the merger. In fact, rather than constructing new facilities as SUNY Upstate had considered prior to proposing the merger, the Parties now plan to use the available capacity at Crouse to alleviate capacity constraints. Thus, the merger will likely lead to a reduction in capacity in the Syracuse area, which could result in less patient access to healthcare facilities and services.

Furthermore, SUNY Upstate can already refer patients to Crouse if it is capacity constrained at any given time. As previously discussed, there is significant overlap between SUNY Upstate and Crouse in terms of the health conditions of the patients they treat. Therefore, absent the merger, Crouse is already a good alternative for potential transfers from SUNY Upstate for the vast majority of patients treated there. At best, the Parties' claims are limited to

[153] COPA Application at 38-39.
[154] COPA Application at 34-35, 46.

the extent that they can leverage higher acuity service offerings and physician coverage capabilities available only at SUNY Upstate, and not Crouse. However, the Parties do not quantify the impact of this claim, nor do they assess the likely number of patients who would be transferred from Crouse to SUNY Upstate post-merger who could not be transferred pre-merger.

C. Claims of Cost Savings, Efficiencies, and Improvements in Resource Utilization Are Unsubstantiated, Not Merger-Specific, and Insufficient to Overcome the Likely Competitive Harm

NY DOH COPA BENEFIT FACTOR (c)(5): *Lower costs and improved efficiency of delivering health care services, including reductions in administrative and capital costs and improvements in the utilization of health care provider resources and equipment*

ASSESSMENT: The Parties claim that the merger will generate substantial cost savings and efficiencies through avoidance of capital expenditures, consolidation of clinical services, elimination of redundancies, reductions in labor expenses, and reductions in purchasing and other non-labor expenses. [155] For the reasons below, the purported gains in cost savings may be overstated and may not outweigh the lost competition. Furthermore, experience and evidence demonstrate that many hospital mergers do not result in significant efficiencies, despite company projections that they will. [156]

FTC staff recognizes that mergers have the potential to achieve cost savings and efficiencies, and we consider this as part of our analysis. Here, however, the Parties have not provided sufficient detail to evaluate the credibility and magnitude of their claims. For example, the Parties have not identified the specific steps necessary to achieve any savings, the expenditures involved, and a sufficient breakdown of the estimated annual cost savings for each category of claimed efficiencies in their COPA Application. Without this information, the likelihood and magnitude of cost savings claims cannot be verified, which is necessary for the NY DOH to determine whether any claimed efficiencies would offset the significant disadvantages of the proposed merger. Furthermore, even assuming the Parties could achieve

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[155] *See* COPA Application at 45-49, 57, 59-61, 64, 67; COPA Application Attachment 19.

[156] *See* Hannah Neprash & J. Michael McWilliams, *Provider Consolidation and Potential Efficiency Gains: A Review of Theory and Evidence*, 82 ANTITRUST L.J. 551, 553 (2019) ("In total, the literature suggests that consolidation among health care providers – whether horizontal or vertical – does not, on average, result in welfare-enhancing efficiencies. While our findings do not preclude the existence of merger-specific efficiencies in specific transactions, they do suggest that antitrust enforcers and policymakers should apply considerable scrutiny to claims of such efficiencies."). *See also* BRUCE BLONIGEN & JUSTIN PIERCE, EVIDENCE FOR THE EFFECTS OF MERGERS ON MARKET POWER AND EFFICIENCY (Board of Governors of the Federal Reserve System, Finance and Economics Discussion Series 2016-082, 2016), https://www.federalreserve.gov/econresdata/feds/2016/files/2016082pap.pdf at 5 ("In summary, we find evidence that M&As increase markups on average across U.S. manufacturing industries, but find little evidence for channels often mentioned as potential sources of productivity and efficiency gains."); Scott A. Christofferson, Robert S. McNish, and Diane L. Sias, *Where mergers go wrong*, 10 McKinsey on Finance 1 (Winter 2004), http://www mckinsey.com/client_service/corporate_finance/latest_thinking/mckinsey_on_finance/~/media/mckinsey/dotcom/client_service/corporate%20finance/mof/pdf%20issues/mof_issue_10_winter%2004.ashx ("Most companies routinely overestimate the value of synergies they can capture from acquisitions.").

some cost savings, it is unclear how much would be passed through to healthcare consumers in the form of lower prices.

In addition, many of the claimed savings are the type that likely are achievable without the proposed merger. The Parties have not shown that all of the claimed benefits are both merger-specific and incremental to the benefits the Parties would have achieved without the merger. The Parties pledge to use cost savings derived from the merger to invest in quality and healthcare initiatives, including population health improvement initiatives. However, it is unclear what portion of the savings is truly incremental compared to the current or future investments that the hospitals would have made independently, absent the merger. SUNY Upstate and Crouse already make significant investments in quality and healthcare initiatives, and likely would continue to do so without the merger.

There do not appear to be any enforceable commitments to achieve cost savings or efficiencies, or to use these savings to fund quality and access improvements. Even if the Parties were able to reduce their costs by eliminating competing clinical services, that is not an unqualified benefit. Those cost savings may be derived from a reduction in staff or closure of facilities, thereby reducing patient access to healthcare services and forcing some patients to travel further to receive care or wait longer for appointments, which may reduce quality of care and patient satisfaction. The Parties claim that "Upstate not only intends to preserve the jobs at Crouse, it will grow the employee population, contributing high-value jobs to the community."[157] However, the COPA Application also acknowledges that [redacted] Notably, much of the efficiencies section of the COPA Application is redacted so the public has no way of evaluating the Parties' plans to consolidate or eliminate services to achieve cost savings. Any detrimental impact this consolidation would have on the quality of patient care should receive appropriate consideration.

The Parties claim the proposed merger will enable them to utilize resources in a more efficient manner and reduce duplicative costs and administrative burden.[159] Yet, although they describe plans to avoid future capital expenditures, they have not identified any specific past expenditures that they believe to have been unnecessary or duplicative. To the contrary, [redacted]

[157] COPA Application at 43.
[158] *See, e.g.*, [redacted]
[159] COPA Application at 45-49, 57, [redacted].

[redacted]

Economic research indicates that hospital competition leads to lower costs, more effective resource utilization, and improved patient health outcomes, as compared to highly concentrated markets with less competition. [161] Competition between hospitals often leads to investments that improve patient care and access to healthcare services. Thus, to the extent that hospital competition results in facility expansions and new equipment purchases that improve access and quality, competition is good for consumers, not unnecessary or wasteful. Eliminating this competition could lead to a less productive allocation of resources and thereby deny consumers these benefits. [162] For example, although new equipment can be costly, the quality benefits associated with technology advances may justify these expenditures. [163] Investments in facilities, technology, and equipment can result in shorter wait times, more convenient service options for physicians and patients, and the continued availability of services when a piece of equipment fails, all of which are far from wasteful, but quite beneficial. In contrast, to the extent that the combined system's future plans include the consolidation of clinical services, including reduced facility and equipment investments, this could result in reduced patient choice and

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[160] [redacted]. The SUNY Master Capital Plan for 2021-22 lists approximately $50 million for projects under design at SUNY Upstate's University Hospital, $208.8 million for projects under construction, including building a new Health and Wellness Center on the SUNY Upstate campus, and $15.2 million in seven Capital Plan Projects for SUNY Upstate. *See* SUNY Master Capital Plan Report, State-Operated Campuses, Fiscal Year 2021-22, at 79-82. [redacted]

[161] *See* Dan P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q. J. ECON. 577 (2000), http://qje.oxfordjournals.org/content/115/2/577 full.pdf+html (finding that hospital competition unambiguously improves social welfare: competition leads to substantially lower costs and lower levels of resource use, as well as lower rates of adverse patient health outcomes); Martin Gaynor, Rodrigo Moreno-Serra & Carol Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service*, 5 AM. ECON. J.: ECON. POL'Y 134 (2013), https://www.aeaweb.org/atypon.php?doi=10.1257/pol.5.4.134 (finding that hospital competition leads to improved quality and resource utilization).

[162] At the FTC COPA Workshop, participants discussed the impact of state regulatory approaches for reducing duplication of healthcare services. Robert Fromberg from Kaufman Hall, an organization that represents health systems, emphasized the importance of reducing duplicative or underused clinical services, and the role of COPAs as a mechanism for health systems to accomplish this goal. FTC COPA Workshop Transcript: Session 2, *supra* note 96, Robert Fromberg remarks at 31-33. *See also* Kaufman Hall Submission to the FTC (Jun. 4, 2019), https://www regulations.gov/document?D=FTC-2019-0016-0010. Professor Thomas Stratmann then presented his economic research on the effects of CON laws. While CON laws are distinct from COPA laws, they both have the effect of restricting competition among healthcare providers in order to rationalize certain services. The policy goals of CON and COPA laws are also similar – to achieve cost savings by reducing duplicative or underused services, to improve quality of care, and to improve access for services. Thus, CON research may be relevant for considering the impact of COPA laws and regulations. Professor Stratmann's research indicates that states with CON laws have reduced access to care and reduced quality, as compared to states without CON laws. *See also* Vivian Ho Submission to the FTC (Jun. 5, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0012 (describing empirical research that demonstrates "[w]ell-intentioned state CON regulations have not improved patient outcomes or lowered costs for patients. Healthy market competition amongst hospitals is a better strategy for improving patient welfare.").

[163] *See* David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, 20 HEALTH AFFAIRS 11 (Sept. 2001), http://content.healthaffairs.org/content/20/5/11.full.pdf+html ("When costs and benefits are weighed together, technological advances have proved to be worth far more than their costs.").

access to healthcare services. For example, as discussed above, the Parties' plans to forego an expansion of SUNY Upstate's inpatient facility appears to be a reduction of capacity that could reduce patient access.

D. Merger Would Make It More Difficult for Health Care Payers to Negotiate Reasonable Payment and Service Arrangements with the Combined Hospital Entity, Likely Resulting in Higher Prices for Patients and Employers

NY DOH COPA DISADVANTAGE FACTOR (d)(3): *Inability of health care payers or health care providers to negotiate reasonable payment and service arrangements*

NY DOH COPA BENEFIT FACTOR (c)(6): *Implementation of payment methodologies that control excess utilization and costs, while improving outcomes*

ASSESSMENT: The New York COPA Regulations require the NY DOH to consider whether the proposed merger would have an adverse impact on the ability of health insurers to negotiate payment and service arrangements with healthcare providers. Ultimately, this is an important indicator of how the merger is likely to impact consumers because health insurers negotiate on behalf of their customers – area residents and employers. When hospitals obtain greater bargaining leverage, they are able to negotiate higher reimbursement rates (i.e., prices) with insurers. Insurers typically pass on these higher prices to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses. This affects fully insured employers who offer coverage to their employees, self-insured employers who pay their employees' healthcare claims, employees who pay some portion of their health insurance benefits, and individuals who purchase health insurance directly. [164] Furthermore, employers facing higher costs may reduce insurance coverage for their employees or eliminate insurance coverage altogether. Higher healthcare costs can also be passed through to employees in the form of lower wages and total compensation. [165] Because the FTC is concerned about the impact that

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[164] *See* Erin E. Trish & Bradley J. Herring, *How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?*, 42 J. HEALTH ECON. 104 (2015), http://www.sciencedirect.com/science/article/pii/S0167629615000375.

[165] *See, e.g.*, Gaynor, Ho & Town, *supra* note 64, at 236 (stating that employers pass through higher health care costs dollar for dollar to workers, either by reducing wages or fringe benefits, or even dropping health insurance coverage entirely); GAYNOR & TOWN, *supra* note 64, at 1 ("Ultimately, increases in health care costs (which are generally paid directly by insurers or self-insured employers) are passed on to health care consumers in the form of higher premiums, lower benefits and lower wages[.]"); Daniel Arnold & Christopher Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*, (2021 working paper), https://www.ehealthecon.org/pdfs/Whaley.pdf; Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LAB. ECON. 609 (2006), https://www hks harvard.edu/fs/achandr/JLE_LaborMktEffectsRisingHealthInsurancePremiums_2006.pdf (finding that increased health insurance costs lead to reduced wages and employment); Priyanka Anand, *Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey*, 26 Health Econ. 1601 (2017), https://onlinelibrary.wiley.com/doi/10.1002/hec.3452 (finding that as health insurance costs increase, employers that offer health insurance reduce total employee compensation); Jay Bhattacharya & M. Kate Bundorf, *The Incidence of the Healthcare Costs of Obesity*, 28 J. HEALTH ECON. 649 (2009),

healthcare mergers will have on consumers, we take seriously the impact that a hospital merger will have on the ability of insurers to negotiate competitive prices and other contractual terms on consumers' behalf.

Currently, prices for inpatient, outpatient, and physician services provided by SUNY Upstate and Crouse are set via negotiations between each hospital system and insurers. We focus our discussion below on inpatient hospital services, but the same analysis applies to outpatient and physician services. Each side in these negotiations has some bargaining power. The insurer's bargaining power stems from the fact that the hospital wants access to the insurer's patient members, and the hospital's bargaining power stems from the fact that its inclusion in the insurer's network will make that network more attractive to potential patient members. The prices that result from these negotiations are a function of the *relative* bargaining leverage of the two sides in the negotiations, which will depend on how each side would fare if no agreement were reached. Generally, the less one side has to lose from failure to reach an agreement, relative to the other side, the more favorable prices and other contractual terms it will be able to negotiate. Mergers of competing hospitals give hospitals more relative bargaining leverage because, after the merger, insurers now have more to lose from failing to reach agreement with the merged system.

Today, SUNY Upstate and Crouse independently have substantial bargaining leverage in negotiations with health insurers. An insurer network that lacks the hospitals of either system is less attractive to employers and consumers than a network that includes the hospitals of both systems, and this gives each system significant bargaining power today relative to insurers. However, the bargaining leverage of each hospital system is limited by the availability of the *other* system (as well as St. Joseph's) as an alternative. That is, an insurer could still offer a fairly attractive network if it included only two of these three Syracuse area hospital systems, especially because that more limited network would likely be offered at a discount. [166] After the proposed merger, an insurer would have to agree to SUNY Upstate's rates or offer a health plan consisting of just one Syracuse area health system. Moreover, there is some indication from a recent study that SUNY Upstate raised rates at Community General after it acquired the independent hospital system in 2011:

> SUNY Upstate was reportedly aggressive after its 2011 merger with Community General in increasing prices and refusing, for instance, to phase in cost increases over time. As one insurer respondent noted, "my most expensive hospital took over my cheapest

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http://www.sciencedirect.com/science/article/pii/S0167629609000113 (finding that increased health insurance costs can be passed to employees in the form of lower wages); and Jonathan Gruber, *The Incidence of Mandated Maternity Benefits*, 84 AM. ECON. REV. 622 (1994), http://economics.mit.edu/files/6484 (finding that increased health insurance costs can be passed to employees in the form of lower wages).

[166] It is important to note that, even in this case, both the hospital system and the insurer still benefit from reaching an agreement, and so agreement is usually reached. But the *terms* on which agreement is reached depend on the relative bargaining power of the hospital system and the insurer, which in turn will depend on the degree of hospital competition.

> hospital so the pricing of my cheapest hospital is now the same as my most expensive hospital." [167]

Despite the Parties' vague assurance that they "do not anticipate an *immediate* change in commercial reimbursement rates," (emphasis added) [168] the proposed merger would give the combined hospital system the ability to extract substantially higher reimbursement rates from health insurers during contract negotiations, whether or not it occurs immediately. [redacted]

The Parties also assert the proposed merger would facilitate the expansion of value-based payment arrangements with government and commercial payers. [171] However, it is unclear exactly how the merger would affect the combined hospital system's business incentives to enter into value-based payment models. It is possible that the COPA, by increasing the combined hospital system's bargaining leverage, could diminish its willingness to cooperate with payers' attempts to lower costs through value-based and risk-based contracting models, if adopting such an approach would prove less profitable than traditional fee-for-service models. Thus, with its substantial post-merger market power, the combined hospital system may be able to resist certain efforts to negotiate beneficial value-based or risk-based contracts that make it worse off than fee-for-service contracts because insurers will have no viable alternatives than to contract with the combined hospital system. Supporting this conclusion, recent empirical research suggests that consolidation among healthcare providers has not facilitated the increased use of value-based payment models, and that providers in concentrated markets may be able to resist such initiatives. [172] On a related note, recent literature suggests that health systems with increased

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[167] Katie Keith, Sabrina Corlette & Olivia Hoppe, ASSESSING RESPONSES TO INCREASED PROVIDER CONSOLIDATION IN THREE MARKETS: DETROIT, SYRACUSE, AND NORTHERN VIRGINIA; CASE STUDY ANALYSIS: THE SYRACUSE HEALTH CARE MARKET, Center on Health Insurance Reforms at 6 (Nov. 2018), https://georgetown.app.box.com/s/38whcvigzyytlzznecxz0oq9qklsaitq.

[168] COPA Application at 59.

[169] COPA Application Attachment 4I-1 at 16.

[170] COPA Application Attachment 4I-4 at 10 [redacted].

[171] COPA Application at 60-61.

[172] *See* Hannah Neprash, Michael Chernew & J. Michael McWilliams, *Little Evidence Exists to Support the Expectation that Providers Would Consolidate to Enter New Payment Models*, 36 HEALTH AFFAIRS 346, 353 (2017), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0840 ("These findings suggest that new payment models may have triggered some consolidation as a defensive reaction to the threat these models could pose, rather than as a way to achieve efficiencies in response to the new incentives. Hospitals and specialists in particular might consolidate both horizontally and vertically to achieve sufficient market share to resist payer pressure to enter risk contracts or weaken ACOs' ability to exploit competition in hospital and specialty markets, and compel reductions in prices and service volume. . . . Specifically, our study supports skepticism of claims by providers that they are consolidating primarily to engage in risk contracts and achieve efficiencies."); Cooper, Craig, Gaynor & Reenen, *supra* note 64, at 104 ("Finally, there is widespread agreement that payment reform (shifting to contracts where providers bear more risk) is crucial to increasing hospital productivity (McClellan et al. 2017). Our analysis suggests that providers who have fewer potential competitors will be more able to resist attempts at such payment reform.").

scale are not more likely to engage in or be more successful at value-based contracting. [173]

Furthermore, the shift to value-based initiatives is already occurring among many hospital systems and insurers nationwide, and is mandated by CMS in some circumstances. [174] [redacted] In keeping with this trend, SUNY Upstate and Crouse likely would continue to transition to value-based initiatives independently. Crouse admits that it "maintains four value-based payment arrangements with government and commercial payors, and intends to expand those arrangements following the Transaction." [176] [redacted] By pairing Crouse's primary care base and population health infrastructure with SUNY Upstate's specialists, the Parties contend the proposed merger would "greatly accelerate Upstate's ability to participate in value-based arrangements and enhance Crouse's current capabilities." [177] Without more detailed information from the Parties, FTC staff is unable to verify the accuracy of these claims. However, to the extent these hospitals have already transitioned to value-based initiatives and would have continued to expand value-based initiatives independently, this cannot be considered a merger-specific benefit. [178]

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[173] *See, e.g.,* Anil Kaul, K.R. Prabha & Suman Katragadda, *Size Should Matter: Five Ways to Help Healthcare Systems Realize the Benefits of Scale*, PWC STRATEGY& (2016), http://www.strategyand.pwc.com/reports/size-should-matter (finding that greater size has not led to lower costs or better quality outcomes for consolidated health systems); David Muhlestein, Robert Saunders & Mark McClellan, *Medical Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues*, HEALTH AFFAIRS BLOG (Sept. 9, 2016), http://healthaffairs.org/blog/2016/09/09/medicare-accountable-care-organization-results-for-2015-the-journey-to-better-quality-and-lower-costs-continues/ ("Also consistent with last year, large, consolidated ACOs did not necessarily achieve the best performance. In fact, we found that the opposite was often true, as smaller, physician-led ACOs were more likely to improve quality and lower cost enough to earn shared savings. **This result is a cautionary note given the trend toward mergers and consolidations among health systems; consolidation and larger size do not necessarily lead to the functional integration and efficiency needed to succeed under alternative payment models.**") (emphasis added).

[174] *See* CMS, *Value-Based Programs*, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs (last accessed Oct. 3, 2022); U.S. Dep't of Health & Human Servs., *Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements From Volume to Value* (Jan. 26, 2015).

[175] COPA Attachment 4I-1 at 16.

[176] COPA Application at 60.

[177] COPA Application at 61.

[178] *See* Fed. Trade Comm'n v. Penn State Hershey Med. Ctr., 838 F.3d 327, 350-51 (3d Cir. 2016) (suggesting that the ability to engage in risk-based contracting cannot be considered a cognizable, merger-specific benefit when both of the merging hospitals are already capable of doing this independently).

E. Merger Likely Would Substantially Reduce Competition for Physician Services and Ancillary Healthcare Services

NY DOH COPA DISADVANTAGE FACTOR (d)(4): *Reduced competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, health care providers and the potential for adverse health system quality, accessibility and cost consequences*

ASSESSMENT: The framework to evaluate outpatient providers and physician services mergers is essentially the same as that described above for inpatient hospitals. Like hospitals, providers of outpatient services and physician services compete for inclusion in health plan networks and to attract patients. These providers negotiate reimbursement rates with insurers, and the rates negotiated depend on their relative bargaining leverage. When there are adequate alternatives to a particular provider, an insurer has a greater ability to resist demands for higher rates by a particular outpatient provider and physician-services provider.

Based on the information FTC staff has obtained to date, SUNY Upstate and Crouse appear to be close competitors for outpatient and physician services. The systems operate competing outpatient centers that serve the Syracuse area, and each system employs physicians across numerous specialties. The systems compete for inclusion in insurer networks and negotiate with insurers to establish rates for outpatient and physician services. The proposed merger would eliminate the competition between the systems for outpatient and physician services and would further consolidate those markets. Post-merger, the combined system's negotiating leverage is likely to increase substantially, which is likely to lead to higher prices and reduced quality and availability of physician and outpatient services to the serious detriment of area residents and employers.

In summary of Section VI, it appears that the proposed merger is likely to result in serious disadvantages resulting from the loss of competition, while any benefits are likely to be modest and may be largely achievable by other means that are less restrictive to competition. Again, FTC staff notes that to fully assess these issues during our ongoing investigation, we need more detailed information that the Parties have not yet provided. In the following section, we assess whether regulatory terms and conditions could mitigate the likely disadvantages of the COPA.

VII. Possible Terms and Conditions Imposed Under Active Supervision Are Unlikely to Mitigate the Disadvantages Resulting from Loss of Competition

NY DOH COPA FACTOR (g): *The extent to which active supervision is likely to mitigate the disadvantages*

ASSESSMENT: The Parties do not appear to offer any enforceable commitments to mitigate the potential anticompetitive harms resulting from the merger. Instead, the Parties offer the following vague conditions they claim will limit the potential for unintended negative

impacts following the merger – most of which are merely aspirational promises to continue what they are already doing or would have to do under current laws, regardless of the COPA.

- Continuing to operate and provide a full range of essential health care services at Crouse;
- Maintaining or enhancing essential health care services in all counties Upstate serves;
- Bringing a Comprehensive Heart Institute to the region;
- Treating Medicare and Medicaid patients at all inpatient and outpatient locations;
- Publicly reporting quality information and other key metrics through reporting;
- Committing to good faith negotiations with all payors; and
- Reporting changes in prices on negotiated rates consistent with price transparency laws – this will allow the Department to monitor changes in prices on negotiated rates. [179]

A. Parties' Proposed Conditions and Monitoring Plan Are Insufficient

The Parties claim their proposed conditions and monitoring approach "will mitigate any potential disadvantages of a Cooperative Agreement by ensuring that the proposed goals and benefits of the Cooperative Agreement are tracked, measured and achieved." [180] FTC staff strenuously disagrees with this characterization. To the contrary, the proposed conditions fail to define exactly what would be required of the Parties, provide no objective assurance that any of these conditions will actually be achieved, and lack any mechanism for holding the combined hospital system accountable if it does not fulfill the conditions. The Parties' proposal for monitoring the impact of the COPA consists of little more than an offer to file an Annual Performance Report that will include a written narrative describing the benefits achieved under the COPA. The quality metrics the Parties propose to track their progress are quite limited, [181] and although the Parties offer to provide supporting "data and metrics" in their annual reports, they do not specify which data and metrics will be used. Instead, the Parties suggest that *after* the COPA is approved, they would work collaboratively with the NY DOH to jointly develop targets that would measure progress towards program goals. [182] This kind of post-transaction determination of performance metrics does not allow for public evaluation of active state supervision. It also, critically, delays measuring or monitoring of those metrics by the state.

While FTC staff has raised concerns about COPA conditions attempted in other states, the Parties' proposed conditions fall short of what we have observed elsewhere. In particular, although price regulation is not a substitute for market competition, in this case, there does not even appear to be any mechanism for the NY DOH to regulate prices for healthcare services. Unenforceable commitments to negotiate with payers in good faith and comply with price

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[179] COPA Application at 70.
[180] COPA Application at 71.
[181] *See* COPA Application Attachment 22 [redacted].
[182] *See* COPA Application at 69-70.

transparency law reporting requirements will do nothing to prevent anticompetitive price increases that are likely to occur as a result of the merger.

Furthermore, measuring healthcare quality can be challenging and the NY COPA Regulations do not specify objective, quantitative quality of care benchmarks by which claimed benefits can be evaluated, much less weighed against the disadvantages likely to result from the COPA. It is unclear how the NY DOH could objectively determine whether the hospital attestations regarding quality benefits are accurate, and thus whether the combined hospital entity is complying with the requirements of the COPA. [183] Critically, there appear to be no meaningful enforcement mechanisms if the hospital fails to achieve its promises regarding quality improvements, other than revoking the COPA. And it should be noted that revoking the COPA does not really punish the Parties for failing to achieve quality improvements. Indeed, the Parties may consider this outcome desirable because it would leave them unconstrained in their ability to exercise market power to the detriment of Syracuse area patients.

The Parties propose that in the event the NY DOH determines there are any material deviations from the COPA terms and conditions, that the hospital system would have 30 days to adopt a remediation plan intended to correct any deficiencies. [184] However, no further details are specified as to what would be required in a remediation plan and it is unclear what happens if a remediation plan proves inadequate for resolving a problem with the COPA.

Finally, the Parties suggest that the NY DOH implement a monitoring plan similar to what was used for COPAs approved under the DSRIP program. [185] FTC staff is aware of only one Performing Provider System ("PPS") that received COPA approval under the DSRIP program in 2015 – Staten Island PPS. [186] However, it is unclear exactly what the NY DOH did to monitor this COPA, which expired when the DSRIP program ended in 2020. Some of the NY DOH's quarterly DSRIP reports reference plans to monitor the Staten Island PPS COPA. [187] We have not been able to confirm that the NY DOH accomplished these plans or how the NY DOH assessed any information it may have obtained. Without greater transparency into the specific details of the NY DOH's active supervision for this COPA, we cannot say whether it would be sufficient for monitoring the proposed hospital merger to mitigate the potential for anticompetitive harms and disadvantages. However, we note that monitoring a fully merged hospital system in perpetuity presumably would be quite different than monitoring a DSRIP provider collaboration for a limited duration as part of a broader statewide initiative aimed only at the Medicaid program.

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[183] *See* New York COPA Regulations § 83-2.9 (requesting that COPA recipients address several factors in their annual performance reports, but not specifying any objective data or metrics that must be provided).
[184] *See* COPA Application at 69.
[185] *See* COPA Application at 71.
[186] *See* New York State Department of Health Public Health and Health Planning Council, *Executive Summary for the Staten Island PPS COPA Application*, https://www health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2016-11-17/docs/copa-sipps_staten_island_pps.pdf.
[187] *See* New York State Department of Health, *NYS DSRIP Quarterly Reports* (2014-2020), https://www health.ny.gov/health_care/medicaid/redesign/dsrip/quarterly_reports htm.

B. Possibility of Voluntary Termination Poses Serious Concerns and Revocation of COPA Is Unlikely to be an Effective Remedy

Under the New York COPA Regulations, the hospital can voluntarily terminate its COPA by giving 30 days' notice after the COPA has been in effect for a minimum of two years. [188] This means that once all of the hospital assets are combined, the hospital could terminate the COPA and therefore no longer be constrained by any meaningful competition or state regulation of potentially anticompetitive conduct. At this point, antitrust enforcement would not be a likely remedy. Indeed, as we discuss below, we have significant concerns about the difficulty and feasibility of separating a hospital system after assets have been integrated.

The New York COPA Regulations require the NY DOH to review periodic reports submitted by the hospitals and allow the NY DOH to revoke the COPA if it investigates the hospital's activities and determines that the hospital is not complying with the terms of the COPA or the benefits of the merger no longer outweigh the disadvantages attributable to a reduction in competition. [189] Unfortunately, there is no certainty that this provision would protect the public if the COPA does not fulfill its promised benefits.

Even if the NY DOH attempted to order a divestiture of assets as part of the revocation of a COPA, this is unlikely to return the hospital systems to their pre-merger status and fully restore the lost competition once the merger has already been consummated. Hospital mergers can involve a significant degree of integration. For example, the combined entity could consolidate or close hospitals; consolidate and transfer service lines; reorganize physician and other staffing at hospitals (with some physicians potentially leaving the area); negotiate new, consolidated contracts with health insurers; integrate EHR and other IT systems; integrate accounting and other financial systems; eliminate management and other staff; consolidate administrative services and vendors; and change many aspects of daily operations at these hospitals. These changes likely would alter patient travel patterns and facility preferences, as well. Reversing all of this integration and these changes through revocation of the COPA would be highly disruptive, and quite likely impossible. [190]

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[188] New York COPA Regulations § 83-2.14.

[189] New York COPA Regulations § 83-2.10.

[190] Recent FTC and DOJ statements have indicated that the agencies are willing to seek post-consummation structural relief in appropriate circumstances. *See* ANTITRUST DIV., U.S. DEP'T OF JUSTICE, MERGER REMEDIES MANUAL 19 (2020), https://www.justice.gov/atr/page/file/1312416/download ("If the acquired assets are integrated, crafting an effective divestiture to eliminate the anticompetitive effects may be difficult, but nonetheless necessary to undo the illegal effects of the merger."); Ian Conner, Former Director, Bureau of Competition, FTC, Remarks at GCR Live 9th Annual Antitrust Law Leaders Forum: *Fixer Upper: Using the FTC's Remedial Toolbox to Restore Competition* 4 (Feb. 8, 2020), https://www.ftc.gov/system/files/documents/public_statements/1565915/conner_gcr_live_conduct_remedies_2-8-20.pdf ("For many reasons, it may be hard to resurrect a competitor or form a new player that is able to exert the same competitive intensity that the target would have provided, but for the merger in question. The recent Remedy Study noted that the Commission may face significant challenges in crafting a remedy for a consummated merger, especially if the acquired business has been merged and its assets combined with those of the acquiring firm. . . . Nevertheless, even when it is hard and may require assets and services beyond those acquired, breakup of the merged company to reestablish competition is still the most likely remedy for a consummated merger."); FED.

For that reason, antitrust agencies typically seek to prevent or remedy problematic mergers *before* they are consummated because it is inherently challenging, and rarely feasible, to "unscramble the eggs" and unwind the assets of companies after they have been integrated. [191] Historically, the FTC has faced difficulties in obtaining effective remedial relief after assets have been combined through a merger, including hospital and other healthcare provider mergers. Indeed, even in certain cases where the FTC has proven that such a merger was anticompetitive and resulted in higher prices without offsetting quality improvements or enhanced patient experience, the FTC has been unable to obtain a viable divestiture remedy for these harms. [192] Similarly, if the COPA is approved, and SUNY Upstate is allowed to merge its operations with Crouse, the remedies available if the merger does not yield its promised benefits would be severely limited.

The revocation provision does not guarantee a restoration of pre-consolidation market competition, nor does it guarantee an adequate timeline for restoring pre-consolidation market competition. Based on recent FTC experience, it can take a year or more to finalize divestitures, even when there has not been significant facility, clinical, and other integration between the Parties. [193]

C. General Concerns with Conduct Remedies

Beyond what the Parties offered in the COPA application, the NY DOH has independent discretion to impose terms and conditions on recipients of COPAs in an attempt to mitigate the disadvantages resulting from loss of competition, although we do not know whether this will happen or what possible terms might entail. Other states have imposed various types of terms and conditions on recipients of COPAs, including rate regulation, mechanisms for sharing cost savings and efficiencies with local residents, public reporting of quality metrics, and

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TRADE COMM'N, THE FTC'S MERGER REMEDIES 2006-2012: A REPORT OF THE BUREAUS OF COMPETITION AND ECONOMICS 12, 18-19 (2017), https://www.ftc.gov/system/files/documents/reports/ftcs-merger-remedies-2006-2012-report-bureaus-competition-economics/p143100_ftc_merger_remedies_2006-2012.pdf (describing the significant challenges in crafting a remedy for a consummated merger when assets have been combined)..

[191] *See, e.g.,* Deborah L. Feinstein, Former Director, Bureau of Competition, FTC, Remarks at the Fifth National Accountable Care Organization Summit: Antitrust Enforcement in Health Care: *Proscription, not Prescription* (Jun. 19, 2014), https://www ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf

[192] *See, e.g.*, Opinion of the Commission on Remedy in the Matter of Evanston Northwestern Healthcare Corp. 89-91, Docket No. 9315 (Apr. 28, 2008), https://www ftc.gov/sites/default/files/documents/cases/2008/04/080428commopinionon remedy.pdf; Statement of the Federal Trade Commission in the Matter of Phoebe Putney Health Sys., Inc., Docket No. 9348 (Mar. 31, 2015), https://www ftc.gov/system/files/documents/public_statements/634181/150331phoebeputneycommstmt.pdf (Commission unable to unwind merger of two hospitals merging to a monopoly because of state certificate of need laws and regulations).

[193] *See, e.g.*, Press Release, Fed. Trade Comm'n, FTC Approves ProMedica Health System's Divestiture of former Rival St. Luke's Hospital (Jun. 24, 2016), https://www.ftc.gov/news-events/press-releases/2016/06/ftc-approves-promedica-health-systems-divestiture-former-rival-st (Divestiture of hospital approved in June 2016, four years after Commission ruled that the proposed transaction violated the Clayton Act); Order to Maintain Assets at 1-2, Saint Alphonsus Med. Center-Nampa, Inc. v. St. Luke's Health System, Ltd., No. 1:12-cv-00560-BLW (D. Idaho Dec. 10, 2015) (Order appointing trustee to oversee divestiture of hospital 22 months after district court enjoined the transaction and over two and a half years after Commission filed complaint for permanent injunction).

commitments regarding certain contractual provisions between the hospitals and commercial health insurers. Such terms and conditions are often referred to as "conduct remedies" because they attempt to ameliorate the harm to competition and consumers resulting from a merger by imposing restrictions on the merged entity's conduct. [194]

It is doubtful that conduct remedies can drive meaningful cost savings and quality improvements with as much force as maintaining a competitive environment. Conduct remedies that purport to restrain price increases are unlikely to replicate the pricing dynamics that would have prevailed absent the merger because such a remedy cannot replace the competitive conditions that otherwise would have existed. Rate review cannot simulate the nuanced, iterative responses that competitors make in response to each other during the negotiation process. [195] In addition, a conduct remedy designed to mitigate one type of harm may inadvertently create another type of harm as an unintended consequence. For example, a conduct remedy limiting price increases may result in the unintended reduction in quality of care.

Conduct remedies designed to prevent price increases have several serious deficiencies. First, they are typically temporary. After the conduct remedy expires, the less competitive market structure remains, but any constraint imposed by the remedy will be eliminated, and prices are likely to increase as a result. [196] Second, designing and enforcing price restrictions is a complicated and highly resource-intensive endeavor, in part because such restrictions would need to constrain prices for all current and future services provided by the merged entity during the relevant timeframe, and account for different (or changes in) reimbursement methodologies. [197] In the healthcare industry, in particular, where prices, quality, and costs are difficult to measure, these kinds of regulatory mechanisms often do not achieve their intended purpose, no matter how well-intentioned. [198]

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[194] In contrast to conduct remedies, "structural remedies," which include divestitures and injunctions preventing mergers, restore or maintain competition at the pre-merger level, thereby remedying the source of the anticompetitive harm – the elimination of competition between the merging hospitals. Under a conduct remedy, competition at the pre-merger level is not maintained. Designing a conduct remedy that would counteract the effects of an anticompetitive merger is nearly impossible because the source of the harm is not prevented.

[195] *See* Commonwealth v. Partners Healthcare Sys., No. SUCV2014–02033–BLS2, at 42 (Sup. Ct. of Mass. Jan. 30, 2015), http://www mass.gov/ago/docs/press/2015/partners-memo-of-decision-and-order.pdf ("A conduct remedy, which typically involves regulation of specific conduct over a limited period of time, is more difficult to craft and easier to circumvent. It also does not directly address the problem, which is a loss of competition: indeed, it permits consolidation and then attempts to limit the consequences that flow from that by imposing certain restrictions on the defendant's behavior. . . . [C]onduct remedies 'seek to thwart the natural incentives of the merged entity to behave as a single firm' and thus require constant and costly monitoring.").

[196] *See id.* at 3 (stating that the temporary conduct remedies would be "like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off.").

[197] The purpose of imposing a conduct remedy is to constrain the exercise of market power following the merger. The constraint would not be effective if market power could be exercised by increasing the price of bundles of services containing a mix of constrained and unconstrained services.

[198] *See* Letter from 21 Health Care Economists to The Honorable Janet L. Sanders in the Matter of Commonwealth of Massachusetts v. Partners Healthcare Sys. (July 21, 2014) [hereinafter Partners Economist Letter]; Gregory S. Vistnes, *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health* 11 (Feb. 10, 2011), http://www mountainx.com/files/copareport.pdf ("Economists have long recognized the difficulties of regulating monopolists and how regulation, no matter how

Even assuming that price restrictions could effectively replicate pricing that would prevail were the Parties to continue to compete, the proposed merger would still likely cause a reduction in business incentives to improve or maintain quality. Economic theory and empirical evidence indicate that adverse quality effects of mergers are particularly likely in markets where prices are regulated. [199] For example, studies of the United Kingdom healthcare market, where rate regulation has long been the norm, demonstrate that highly concentrated provider markets have worse patient health outcomes than competitive provider markets. [200]

Designing a conduct remedy to mitigate the harms of lost quality competition would be extremely difficult and resource intensive. Any meaningful remedy would need to both establish an explicit quantitative measure of the level of quality that competition would have produced and require the merged entity to produce at least that level of quality. This is nearly impossible, for several reasons. While objective quality measures exist for specific inpatient hospital services (and may be incorporated into commercial insurance contracts), these measures are not comprehensive and are difficult to establish; moreover, it would be even more difficult to establish those measures for non-inpatient services (*e.g.*, outpatient services) because those quality measures are generally much less developed.

It would be equally challenging to design a compliance mechanism to ensure that the combined hospital system achieved defined quality targets. Due to the complexities of assessing quality, no mechanism exists to impose a conduct remedy sufficient to offset a loss of quality competition. It is difficult to envision how a supervisor of the COPA would be able to effectively force the combined hospital system to achieve a particular quality metric. Even if it were possible to establish a meaningful penalty for failure to perform, the combined health system still would be less likely to reach the quality levels that the hospitals would have achieved independently in a competitive environment.

The federal antitrust agencies have long contended that conduct remedies are inadequate for addressing competitive harms that result from horizontal mergers. Instead, the agencies strongly prefer "structural remedies," which seek to restore pre-merger competitive conditions through an injunction preventing consummation of a merger or a divestiture of assets. [201] Courts

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carefully crafted and implemented, can inadvertently create undesirable incentive problems."); Cory S. Capps, *Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health System* 32 (May 2, 2011) ("Economists generally agree that, with rare exceptions, competition produces better outcomes than regulation."); Comment from Amerigroup Corp. to the Tenn. Dep't of Health 4 (Sept. 21, 2015), https://www.tn.gov/assets/entities/health/attachments/Amerigroup-COPA_Written_Comments.pdf ("regardless of the obligations and restrictions placed on recipients of a COPA, regulations are never an effective substitute for competition").

[199] *See, e.g.*, Gaynor, Ho & Town, *supra* note 64.

[200] *See, e.g.*, Gaynor, Moreno-Serra & Propper, *supra* note 161.

[201] *See* DOJ Merger Remedies Manual, *supra* note 190; FTC Merger Remedies Study, *supra* note 190; Feinstein, *supra* note 191. *See also* Fed. Trade Comm'n, Analysis of Proposed Agreement Containing Consent Order to Aid Public Comment: In the Matter of Phoebe Putney Health System, Inc., et al., Docket No. 9348, at 1 (Aug. 22, 2013), https://www ftc.gov/sites/default/files/documents/cases/2013/08/130822phoebeputneyanal.pdf ("The Commission

generally agree with this position. [202] In 2015, for example, a Massachusetts court rejected a consent agreement that would have allowed multiple hospital systems to merge, provided they agreed to certain conduct remedies. The court found that the proposed conduct remedies – which included price caps, component contracting, a prohibition on joint contracting, and physician and network growth restrictions – would have done little to restore the lost competition or to address the anticompetitive harms. [203] Furthermore, the court expressed serious concerns about its ability to enforce the conduct remedies, which would have required substantial technical expertise and resources to resolve complicated issues relating to healthcare pricing during a time in which healthcare contracting practices were changing enormously. [204] While every geographic area has unique aspects, these challenges would almost certainly arise in the Syracuse area.

In summary, rate regulation and other conduct remedies do not replicate lost competition resulting from mergers, they are challenging and costly to implement, and they require constant supervision to ensure compliance. Adding to this complexity, hospitals subject to rate regulation and other conduct remedies often have strong financial incentives to circumvent the required regulatory commitments. [205] All of these factors would strain the state's ability to determine whether the public policy goals of the COPA are being met and to hold the combined hospital system accountable.

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has declined to seek price cap or other nonstructural relief, as such remedies are typically insufficient to replicate pre-merger competition, often involve monitoring costs, are unlikely to address significant harms from lost quality competition, and may even dampen incentives to maintain and improve healthcare quality.").

[202] *See, e.g.*, United States v. E.I. du Pont de Nemours & Co., 366 U.S. 316, 330-31 (1961) (Supreme Court held that structural remedies to preserve competition are the preferred form of relief for mergers that violate Section 7 of the Clayton Act because they are "simple, relatively easy to administer, and sure.").

[203] *See Partners Healthcare Sys.*, *supra* note 195, at 2. Indeed, several prominent health economists urged the Massachusetts court not to accept the consent agreement, arguing that it would not offset the consumer harm likely to result from the acquisitions. Responding to arguments offered by Partners that the mergers would yield economic and operational efficiencies, as well as quality improvements, that would help to slow the growth rate of healthcare expenditures and benefit consumers, the economists stated that "systematic evidence from hundreds of hospital mergers around the nation provides little empirical support for these assertions." Partners Economist Letter, *supra* note 198, at 2.

[204] *See Partners Healthcare Sys.*, *supra* note 195, at 19 (stating that the methodology for regulating prices "remains a mystery" to the court, and expressing concerns that any monitor would be able to handle the complex task of administering the price caps) ("Even with some expertise in the field, the monitor will have to take into account complex contractual arrangements between Partners and the major payers, each of which have their own unique features and tradeoffs. The prices at issue are not for a homogenous good or a single product but for a complex set of services which can be bundled and redefined from one year to the next.").

[205] *See id.* at 42 ("A conduct remedy, which typically involves regulation of specific conduct over a limited period of time, is more difficult to craft and easier to circumvent. It also does not directly address the problem, which is a loss of competition: indeed, it permits consolidation and then attempts to limit the consequences that flow from that by imposing certain restrictions on the defendant's behavior. . . . [C]onduct remedies 'seek to thwart the natural incentives of the merged entity to behave as a single firm' and thus require constant and costly monitoring."); *id.* at 32 ("Particularly where the product or transaction is complex and enforcement of the remedies is over a long period of time, there are many opportunities for the entity, in pursuit of its own self-interest, to 'crowd' the border of stated rules and create ways to evade them.").

VIII. Conclusion

Existing competition between SUNY Upstate and Crouse benefits patients, employers, and hospital employees in the Syracuse area by constraining prices for inpatient, outpatient, and physician services, which ultimately helps control out-of-pocket healthcare expenses. This competition also has spurred these hospitals to offer a wide breadth of services and to strive to be high-quality providers of those services in order to attract physician referrals and patient admissions.

The proposed merger would eliminate this beneficial competition and give SUNY Upstate the ability to exercise significant market power. This would likely result in higher prices and reduced quality for healthcare services in the Syracuse area. SUNY Upstate has not provided sufficient information regarding its plans for cost savings, efficiencies, and quality improvements to allow us to fully assess these factors. Any cost savings or quality benefits of the merger would need to be extraordinary in order to outweigh the significant competitive harm that is likely to result from the merger, and there is no indication that this is the case. Moreover, many of the claimed benefits likely could be achieved through an alternative arrangement – either independently, through another form of collaboration with each other, or through a merger or affiliation with a different partner – that would be less harmful to competition. It is doubtful that terms and conditions imposed under active supervision could mitigate the likely price effects of this merger, and they could exacerbate reductions in the quality of care or access to care for patients in the Syracuse area. Furthermore, there do not appear to be any enforceable commitments to maintain or improve quality and access.

In summary, FTC staff respectfully encourages the NY DOH to consider the following factors and questions when reviewing the COPA Application submitted by SUNY Upstate and Crouse:

1. Will the proposed merger substantially reduce competition, allowing the combined hospital to negotiate higher prices for healthcare services, and reducing its business incentives to maintain or improve quality of care?

2. Are the claimed benefits (a) credible and verifiable, (b) likely to be achieved and passed through to consumers, (c) achievable only through *this* merger, and (d) of sufficient magnitude to outweigh the proposed merger's significant disadvantages?

3. Have the hospitals substantiated their plans sufficiently to ascertain the steps, timeframe, and costs necessary to (a) consolidate clinical services, (b) surpass volume thresholds that the hospitals are not already capable of achieving independently to improve patient health outcomes, and (c) achieve projected synergies and cost reductions?

4. Will terms and conditions imposed by the NY DOH under active supervision effectively mitigate the competitive harms of the merger, and are they capable of being successfully implemented and objectively monitored, to determine whether the COPA is meeting the stated public policy goals?

5. Is there any meaningful mechanism for the NY DOH to discipline the combined hospital if it fails to meet the COPA requirements?

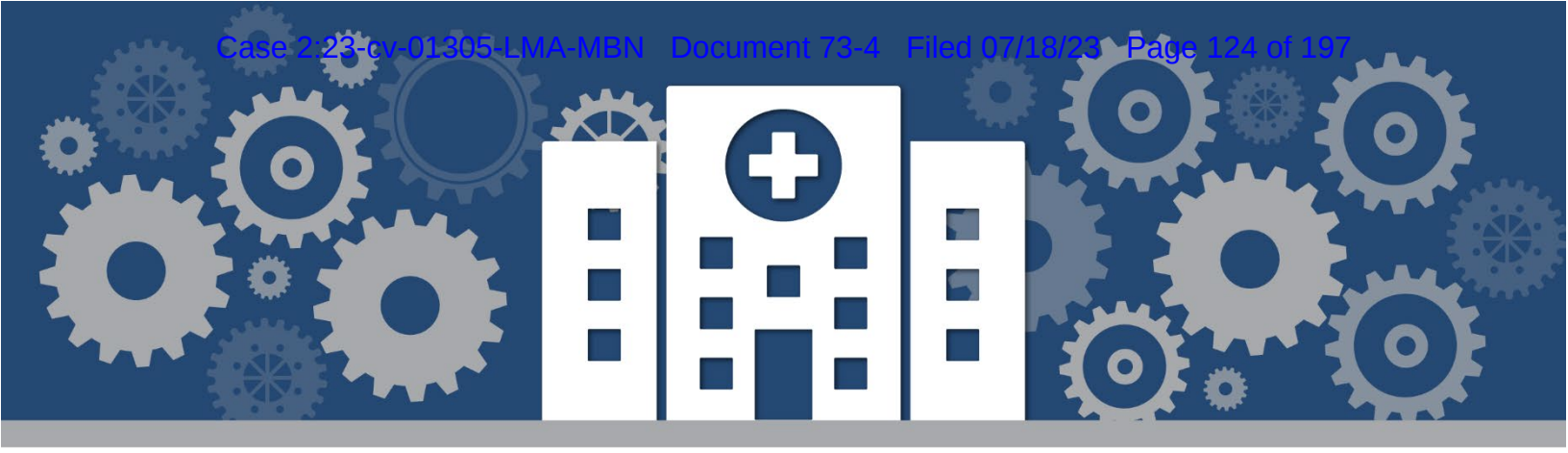
6. How long does the NY DOH intend to provide regulatory oversight of the COPA, and what will happen in the event that the combined hospital voluntarily terminates the COPA or the underlying legislation is repealed or revised to allow the COPA to expire?

In our assessment, there is insufficient evidence that the potential benefits of the COPA outweigh the potential disadvantages of the elimination of competition between SUNY Upstate and Crouse.

We thank you for the opportunity to present our views and hope they will be helpful as you evaluate the COPA Application. We would be happy to provide any additional expertise and information that we are authorized to share in connection with your review.

Please direct all questions regarding this submission to Gustav Chiarello, Attorney, Mergers IV Division, Bureau of Competition, 202-326-2633, gchiarello@ftc.gov; and Stephanie Wilkinson, Attorney Advisor, Office of Policy Planning, 202-326-2084, swilkinson@ftc.gov.

FTC Public Comment
Attachment A



FTC Policy Perspectives on Certificates of Public Advantage

Staff Policy Paper

August 15, 2022

FEDERAL TRADE COMMISSION

Lina M. Khan, Chair
Noah Joshua Phillips, Commissioner
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Questions may be directed to FTC staff at CopaAssessment@ftc.gov.

Introduction

This paper by Federal Trade Commission staff presents information for state lawmakers considering proposed legislation regarding Certificate of Public Advantage ("COPA") laws.[1] The FTC routinely challenges hospital mergers that would substantially lessen competition, and therefore would raise healthcare prices for patients, reduce quality of care, limit access to healthcare services, and depress wage growth for hospital employees. COPA laws attempt to immunize such hospital mergers from the antitrust laws by replacing competition with state oversight and limiting the FTC's ability to challenge them. COPAs thus allow for hospital consolidation that is likely to harm patients and employees. The existing research shows that COPAs' purported benefits are simply unproven, so there are many reasons to be skeptical of their use. Experience and research demonstrate that COPA oversight is an inadequate substitute for competition among hospitals, and a burden on the states that must conduct it. Hospital competition, on the other hand, has proven to result in lower prices and improvements in quality of care, expanded access to healthcare services, and even higher wages for some hospital employees. For these reasons, the FTC advocates against the use of COPAs to shield otherwise illegal hospital mergers.[2] Indeed, both Democratic and Republican administrations and several leading academics have raised concerns about COPAs, cautioning states not to rely on them in the absence of evidence that COPAs produce better results than market-based competition.[3]

FTC staff invites state lawmakers to work collaboratively with competition policy experts to minimize the negative effects of further anticompetitive hospital consolidation and avoid using COPAs. We also urge states that have existing COPA laws to consider repealing those laws if they do not have an active COPA in place. We welcome the opportunity to speak with any state lawmakers who wish to better understand the FTC's hospital merger review process or the COPA studies described in this paper.

What is a COPA and why do hospitals seek them?

COPA laws are enacted to replace competition among healthcare providers with regulatory oversight by state agencies. In states with COPA laws, officials allow hospitals to merge if they determine the likely benefits from a particular merger outweigh any disadvantages from reduced competition and increased consolidation. States often impose various terms and conditions on COPA recipients intended to mitigate harms from a loss of competition, including price controls and rate regulations, mechanisms for sharing cost savings and efficiencies, and commitments about certain contractual provisions between hospitals and commercial health insurers. Once granted, COPAs purport to shield provider mergers and other types of collaborations from federal antitrust enforcement under the state action doctrine.[4] State departments of health – often in consultation with state attorneys general offices – are responsible for implementing COPA regulations, evaluating COPA applications submitted by hospitals, and actively supervising any approved COPAs in perpetuity.

Hospitals that wish to merge seek COPAs when a specific merger would otherwise violate antitrust laws. Indeed, most COPAs that have been approved so far resulted in a single hospital monopoly.[5]

Mergers that lead to lower prices or better health outcomes for patients are unlikely to violate antitrust laws and thus would not require COPAs to mitigate anticompetitive harms.[6]

Why should state lawmakers be concerned about hospital consolidation?

Healthcare experts consistently find that highly concentrated healthcare markets are more likely to have higher prices for consumers (e.g., patients and employers who fund employee health plans), reduced quality of care and patient health outcomes, and reduced access to healthcare services. Most studies show that competition among health systems – not consolidation – results in the lowest prices and optimal quality benefits for patients,[7] as well as optimal wages and benefits for employees.[8]

Hospitals compete for inclusion in insurance plans, and insurers rely on that competition to negotiate better prices and higher quality of care commitments for plan members. When hospitals have substantial market power, their negotiating leverage with health insurers increases and they often are able to demand higher rates (i.e., prices), which are then passed on to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses.[9] Notably, this finding holds true with *both* for-profit and not-for-profit merging hospitals.[10] By eliminating competition among hospitals, a merger can create or exacerbate this market power. When considering a request for a COPA to permit a merger that will eliminate competition, we urge state lawmakers to consult local health insurers regarding the impact that COPA legislation could have on their ability to negotiate competitive rates or implement value-based delivery and payment models, as this could have a big impact on patients and employers. Also, employers facing higher costs may limit insurance coverage for their employees or eliminate insurance coverage altogether. Studies show that rising healthcare costs caused by hospital consolidation are often passed through to employees in the form of lower wages and less generous benefits.[11]

In addition to raising consumer prices, eliminating competition may reduce hospital incentives to maintain or improve quality and patient access to care.[12] Studies demonstrate the net effect of mergers of competing hospitals on quality is often negative, and increased competition is associated with better quality.[13] Based on the available evidence, we cannot presume that any given hospital merger is likely to improve quality or reduce costs by enough to offset a price increase.

Finally, a recent study found that mergers that significantly increase hospital concentration in local labor markets, reducing the number of hospital employers, result in slowed wage growth for workers whose employment prospects are closely linked to hospitals. This study showed that four years after such high-impact mergers occurred, nominal wages were 6.8% lower for nurses and pharmacy workers and 4.0% lower for non-medical skilled workers than they would have been without the merger.[14] State lawmakers and health departments must evaluate whether COPAs are in the best interest of the public and the impact on labor markets is highly relevant to this analysis. This type of wage depression could dissuade qualified hospital employees (already in short supply in many parts of the country) from seeking employment, which could undermine the quality of patient care and access to services.[15]

Lower income levels for hospital employees may also worsen population health in local communities where hospitals are leading employers.[16] FTC staff are not aware of any COPA that has attempted to address a merger's impact on hospital employee wages.

Competition results in better outcomes than consolidation subject to COPAs

Competition has proven to be more reliable and effective than COPAs for controlling healthcare costs while preserving quality of care, including in rural areas facing economic challenges. Competition between hospitals benefits area employers and residents. It enables health insurers to negotiate lower hospital reimbursement rates (i.e., prices) on behalf of customers, which reduces the prices that area employers and residents must pay in premiums, copayments, deductibles, and other out-of-pocket expenses. That competition also incentivizes hospitals to improve healthcare quality and the availability of services and new healthcare technologies, as the hospitals compete to attract patients to their respective systems. As a result, area employers and residents – commercially insured, those covered by Medicare and Medicaid, and the uninsured – have benefited from this competition.

Research demonstrates that COPAs have resulted in significant price increases and contributed to declines in quality of care. Sometimes these adverse effects may occur after the COPAs have expired (often at the hospitals' urging), but they may also manifest while the COPAs are in effect, due to the difficulties inherent in implementation and monitoring. In 2017, the FTC announced a policy project to assess the impact of COPAs on prices, quality, access, and innovation for health care services.[17] This project has included research of past COPAs, a public workshop highlighting practical experiences with COPAs and related policy considerations, and an ongoing study of recently approved COPAs.[18] As discussed in more detail beginning on page 7 below, key findings from specific COPA case studies are:

- **Mission Health COPA Studies:** The first study found substantial increases in commercial inpatient prices during early COPA years (at least 20%). The second study found substantial price increases during later COPA years (an average of 25%) and even greater price increases after the COPA was repealed (at least 38%). Both studies demonstrate that price regulations during the COPA were ineffective, and the second study demonstrates the risk of eventually having an unregulated monopolist.

- **Benefis Health COPA Study:** Substantial increases in commercial inpatient prices after the COPA was repealed (at least 20%), demonstrating the risk of eventually having an unregulated monopolist.

- **MaineHealth COPA Study:** Substantial increases in commercial inpatient prices at an unregulated hospital during the COPA (at least 38%), as well as after the COPA expired at both hospitals – for a total price increase of at least 50% during the COPA and post-COPA period. The study demonstrates the risk of selectively regulating hospitals within a larger system –

MaineHealth exercised its market power by raising prices at the unregulated hospital. It also demonstrates the risk of eventually having an unregulated monopolist. Perhaps more importantly, there was a measurable decline in quality at the acquired hospital after the COPA expired.

The next section describes some of the purported benefits that hospitals often claim as justification for COPAs. We are not aware of any studies showing that these purported benefits are ever actually achieved.

In addition, COPAs can be extremely difficult to implement and monitor, requiring significant state resources over many years, sometimes decades. Regulatory fatigue, staff turnover, and changes in funding priorities at state agencies can lead to less vigorous supervision over time. Also, the hospitals subject to COPAs often lobby for repeal of COPA oversight or fewer COPA conditions, citing costs and difficulties of compliance. When this happens, the practical effect is that the merged healthcare system that was previously subject to state COPA oversight is then able to exercise increased market power (in most cases, monopoly power) unconstrained by either state regulation or antitrust enforcement against merger-related harms.

> *"My bottom line is that COPA regulation is fraught with difficulties. Regulations can become obsolete and less effective over time. State regulators became referees to resolve competitive battles, and the political pressure is considerable. And most significantly, the end game or exit strategy can be a problem and might leave you with a concentrated, but unregulated market power."*
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> *Mark Callister, Monitor for Benefis Health COPA*

Hospital arguments in favor of consolidation subject to COPAs are flawed

Hospitals offer a variety of justifications when lobbying state lawmakers to enact COPA laws, but there are many reasons for lawmakers to be skeptical. Hospitals seeking COPAs commonly claim their proposed mergers would result in cost savings and efficiencies that would allow for improvements in clinical quality outcomes. Experience and evidence demonstrate, however, that many hospital mergers do not result in significant efficiencies, despite hospital projections that they will.[19]

Hospitals seeking COPAs have also cited concerns about low reimbursement rates or future reductions in reimbursement that may occur as a result of declining admissions and healthcare reform efforts. They argue their proposed mergers would improve their financial condition and enable them to meet such challenges. In each of the last four hospital mergers the FTC investigated that received a COPA, and in our experience more broadly, hospitals seeking COPAs have had adequate financial resources to continue operating independently and to maintain quality and access to healthcare services without requiring a merger – contrary to the claims often made by the hospitals. Indeed, if a hospital is truly failing financially and the proposed merger is the only way for it to remain viable, the FTC is unlikely to challenge such a merger and the hospital does not need COPA protection against antitrust enforcement.

Hospitals often claim their proposed mergers would create jobs and ensure local access to healthcare facilities and services. In the FTC's experience, though, hospitals frequently project cost savings premised on facility consolidation, the elimination of services, and job reductions. Therefore, lawmakers should examine these claims carefully and consider how they align with post-merger plans for integration and operations, as cost savings projections may indicate that a merger would reduce employment and patient access to healthcare services in local communities.[20]

Hospitals frequently argue that proposed mergers should proceed subject to COPAs because they would create a larger combined patient base, allowing them to improve population health efforts. Merging hospitals also claim that increasing their patient base would facilitate cost-saving, value-based payment models with health insurers. However, population health initiatives can be (and usually are) pursued by the hospitals independently, so mergers are generally not necessary to gain these benefits. And recent empirical research suggests that consolidation among healthcare providers has *not* facilitated the increased use of value-based payment models. Instead, providers in concentrated markets may be better positioned to resist such initiatives.[21] Related research suggests that health systems with increased scale are not more likely to engage in or be more successful at value-based contracting.[22] Indeed, the shift to value-based initiatives is already occurring among many hospital systems and insurers nationwide, and is mandated by Centers for Medicare & Medicaid Services in some circumstances.[23]

Hospitals also claim their proposed mergers would eliminate unnecessary and duplicative costs associated with competition, sometimes referred to as "wasteful duplication," allowing them to save money by avoiding capital expenditures. But again, it is unclear whether hospitals are really interested in avoiding unnecessary or duplicative expenditures or simply want to avoid the pressures of competition. Many hospital mergers do not result in significant cost savings,[24] and some studies have found that hospital competition leads to improved patient health outcomes with more effective resource utilization, as compared to highly concentrated markets with less competition.[25] Competition can incentivize hospitals to invest in facilities, technology, and equipment that improve access and quality.[26] For example, these types of investments can result in shorter wait times, more convenient service options for physicians and patients, and the continued availability of services when a piece of equipment fails. In this regard, competition is good for patients, not unnecessary or wasteful.

Finally, hospitals argue lawmakers should not be concerned about the negative effects of their proposed merger, because the states can impose various types of regulatory conditions on COPA recipients that would mitigate the harms resulting from consolidation. Common examples include price controls and rate regulation, mechanisms for sharing cost savings and efficiencies with local residents, public reporting of quality metrics, and commitments regarding certain contractual provisions between the hospitals and commercial health insurers. But such conditions do not replicate the benefits of competition; rather, they distort competition. They are also challenging and costly to implement, requiring considerable supervision, as hospitals subject to COPAs often have strong financial incentives to evade the regulatory conditions, thus undermining their efficacy.[27]

FTC efforts to prevent harmful hospital consolidation are undermined by COPAs

The FTC is an independent, bipartisan agency with a dual mission of promoting competition and protecting consumers. Under its statutory mandate, the FTC challenges mergers and acquisitions that are likely to substantially lessen competition and harm consumers.[28] Anticompetitive mergers and conduct in healthcare markets have long been a focus of FTC law enforcement, research, and advocacy.[29] The FTC has considerable experience in evaluating mergers involving hospitals, outpatient facilities, and physician groups to determine whether they are, on balance, likely to benefit or harm consumers.[30]

At the heart of FTC investigations is how healthcare mergers impact patients, employers, and employees in local communities. FTC staff considers a wide range of factors, including the impact on prices charged to patients, wages paid to hospital employees following greater employer concentration, patient health outcomes and quality of care, patient access to healthcare services, and the potential for the merger to result in innovative healthcare delivery and payment models. We often consult physician experts with experience in both clinical and academic research settings, to help us evaluate the hospitals' quality of care and health improvement claims. Staff also speaks to local business and community members, including other healthcare providers, public and private employers, and health insurers, to understand how mergers will impact them. We examine a significant amount of public and non-public information, including business documents and data from the merging hospitals and other market participants. Staff also performs an economic analysis of hospital discharge data, as well as a financial analysis of the merging hospitals. Notably, these factors are similar to those that state health departments are required to consider when evaluating COPAs. However, the FTC has spent several decades and substantial resources to develop expertise evaluating mergers, and state health departments often have different areas of expertise.

There are certainly circumstances where a bona fide regulatory approach that has the side effect of limiting competition may be an appropriate way to implement important public policy goals. Yet, the available evidence shows COPAs do not achieve the purported policy goals of reducing healthcare costs and improving quality. Instead, COPAs shield specific hospital transactions from vigorous antitrust enforcement, to the detriment of those very goals. Antitrust authorities are better positioned to

challenge anticompetitive mergers that are likely to result in higher prices and reduced quality of care for patients when we do not face the litigation obstacles presented by COPAs. We invite state lawmakers to engage with us in addressing the problems associated with anticompetitive hospital consolidation and avoid the use of COPAs.

Case studies: COPAs do not prevent hospitals from exploiting market power

Many states have enacted COPA legislation since the 1990s. FTC staff are aware of nine states that have approved hospital mergers pursuant to such legislation: North Carolina, South Carolina, Montana, Maine, Minnesota, and most recently, West Virginia, Tennessee, Virginia, and Texas.[31] But some of these states have decided to do away with COPAs. North Carolina, Montana, and Minnesota have repealed the underlying legislation so that hospitals in these states are no longer allowed to obtain COPAs. Unfortunately, these legislative changes also eliminated state regulatory oversight of the hospital systems that were allowed to merge under COPAs. Furthermore, antitrust enforcement was no longer practical since the mergers had long been consummated. As a result, these systems can now exercise their substantial market power unconstrained by state oversight or antitrust enforcement against merger-related harms.

FTC staff has evaluated several of these COPAs, and the findings illustrate the significant challenges of trying to regulate a hospital with substantial market power in perpetuity. COPAs can be difficult to implement and monitor over time, and are often unsuccessful in mitigating merger-related price and quality harms. Furthermore, when COPA oversight is removed, which happens frequently, the risk of price and quality harms increases significantly because of the absence either of the preexisting competition or regulation. For these reasons, FTC staff recommends that state lawmakers not enact COPA laws. In states where COPA laws already exist, FTC staff recommends repealing these laws provided there is not an active COPA currently in place. If there is already an active COPA in place, states should not approve any new COPA applications.

> *"Almost all of the COPAs established prior to 2015 have expired or were repealed, leaving the affected communities with unregulated hospital monopolists, higher prices, and likely reduced quality. States considering the use of a COPA to grant antitrust immunity to merging hospitals should carefully weigh this risk of harm against the possibly short-run and limited benefits of the merger."*
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> *Christopher Garmon & Kishan Bhatt*

Mission Health System (North Carolina)

In December 1995, Memorial Mission Hospital and St. Joseph's Hospital, the only two general acute care hospitals in Asheville, North Carolina, entered into an agreement under the state's COPA law for certain collaborative activities. In 1998, the two hospitals merged and amended their agreement with the state to approve the merger subject to certain terms and conditions – including margin, cost, and physician employment caps, as well as quality and contracting commitments. The merged hospital, renamed Mission Health System, operated under these terms for nearly 20 years. In 2015, the North Carolina legislature repealed the state's COPA law after lobbying by Mission Health, and the Mission Health COPA ended in September 2016 – leaving no competitive or regulatory constraint on Mission Health's monopoly power in Asheville. In February 2019, Mission Health was acquired by the for-profit healthcare system HCA Healthcare – despite the fact that the COPA was originally approved, in part, to prevent out-of-state for-profit healthcare systems from acquiring the local hospitals.

Empirical research on the price effects of the Mission Health COPA for inpatient hospital services from 1996 to 2008 shows that Mission Health increased its prices by at least 20% more than peer hospitals during the COPA period, suggesting that despite the margin and cost regulations, state COPA oversight did not prevent Mission Health from raising prices more than similar hospitals.[32] A second study found an average price increase of 25% through 2015, driven by large increases several years into the COPA period. It also found prices increased by another 38% after the COPA was repealed in 2015 and before Mission Health was acquired by HCA Healthcare – indicating the post-COPA price increase likely reflects the removal of the COPA oversight rather than the conversion to a for-profit hospital system.[33] In addition, an attorney from the North Carolina Attorney General's office, responsible for overseeing the Mission Health COPA for nearly 20 years, stated that he does not recommend using COPAs due to the potential for regulatory evasion during the COPA period, and the ability of hospitals to eventually be freed of COPA oversight, which leaves the community with an unregulated monopoly.[34] And a healthcare economist hired to evaluate the Mission Health COPA in 2011 discussed the difficulty of designing a regulatory scheme that prevents evasion *and* is flexible enough to allow for industry changes over the full COPA duration.[35]

Benefis Health System (Montana)

In July 1996, the Montana Department of Justice allowed Columbus Hospital and Montana Deaconess Medical Center – the only two general acute care hospitals in Great Falls, Montana – to merge pursuant to a COPA and form Benefis Health System. COPA conditions included revenue caps, quality commitments, and other cost-saving commitments. In 2007, at Benefis Health's urging, the Montana state legislature passed a bill that effectively terminated the COPA agreement, despite the Montana Attorney General's objections. As a result, Benefis Health has been able to freely exercise its market power in Great Falls with no regulatory or antitrust oversight for merger-related harms since 2009, when the legislation took effect.

Empirical research on the price effects of the Benefis Health COPA for inpatient hospital services from 1992 to 2013 shows that Benefis's prices closely tracked the prices of peer hospitals in duopoly markets during the COPA period, but then increased by at least 20% following the repeal of the COPA.

This suggests that the COPA was effective in constraining prices to the level of peer hospitals, but that the COPA removal led to higher prices consistent with the exercise of market power by an unconstrained hospital monopoly.[36] The CEO of Benefis has stated that, although he did not observe the post-COPA price increases found in this study, he does not believe COPAs adequately address the rising costs of healthcare.[37]

An attorney hired by the Montana Department of Justice to oversee the Benefis Health COPA stated:

> My bottom line is that COPA regulation is fraught with difficulties. Regulations can become obsolete and less effective over time. State regulators become referees to resolve competitive battles, and the political pressure is considerable. And most significantly, the end game or exit strategy can be a problem and might leave you with a concentrated, but unregulated market power.[38]

Also, a policy advisor for the Montana Insurance Commissioner explained that his office proposed legislation in 2019 to repeal Montana's COPA law to enhance competition in provider and insurance markets. His office viewed COPAs as a "regulatory incentive for consolidation" at a time when the research has clearly shown "that hospital consolidation leads to poor outcomes for both quality and costs." [39] He claimed that since the Benefis Health COPA expired, "their market power has played out in several different high-profile circumstances," including dramatic cost increases and most recently, "Benefis was able to be the last holdout of the Montana employee state health plans reference pricing initiative to lower health costs."[40]

Palmetto Health System (South Carolina)

In May 1997, Baptist Healthcare System and Richland Memorial Hospital, two general acute care hospitals in Columbia, South Carolina, merged to form Palmetto Health System. The South Carolina Department of Health and Environmental Control ("DHEC") approved the transaction, subject to terms and conditions of a COPA. During the initial five-year period of the COPA, Palmetto Health was subject to rate and revenue controls, as well as commitments to achieve cost savings and to provide a portion of its revenues to fund public health initiatives and community outreach programs. Several conditions were changed or eliminated in November 2003, although Palmetto Health continued to report annually to DHEC. In November 2017, Palmetto Health merged with Greenville Health System to create the largest health system in South Carolina, now known as Prisma Health System.[41]

Empirical research on the price effects of the Palmetto Health COPA for inpatient hospital services from 1992 to 2008 shows that prices at Palmetto Health did not increase more than prices at other comparable hospitals. This may be due to COPA oversight, but it may also be the result of hospital competition that remained in the area after the merger.[42] Unlike the other COPAs studied that involved mergers to monopolies, Palmetto Health continued to face competition from other hospitals serving the Columbia area, including most notably Providence Health (later acquired by LifePoint Health) and Lexington Medical Center.[43] Indeed, in its COPA application submitted to DHEC, Palmetto Health highlighted this competition as a constraint on its ability to exercise post-merger market power.

In 2020, Prisma Health persuaded DHEC to expand the original COPA to include LifePoint's hospital and emergency room assets in the greater Columbia area. This maneuver potentially would have allowed Prisma Health to acquire these facilities without facing an antitrust challenge.[44] The FTC had significant concerns about this proposed acquisition, as it would have eliminated much of the remaining hospital competition in the area. After a legal challenge from rival hospital Lexington Medical Center, a South Carolina Administrative Court held that DHEC's incorporation of the LifePoint facilities into the original COPA was "outside the scope of the COPA law's purposes."[45] Prisma and LifePoint then announced that they would no longer pursue the proposed acquisition.[46] Since then, the LifePoint assets were acquired by another health system that did not raise anticompetitive concerns. The court's decision is the first known holding that a COPA modification did not pass muster under the state action doctrine, and underscores that there are important and meaningful limitations to using COPAs to shield hospital mergers from antitrust scrutiny.

MaineHealth (Maine)

In March 2009, MaineHealth acquired Southern Maine Medical Center ("SMMC") under a COPA issued by the Maine Department of Health and Human Services. SMMC is located about 20 miles from MaineHealth's flagship general acute care hospital in Portland, Maine Medical Center ("MMC"), and the combined organization has a dominant share of patient discharges in the SMMC service area. The COPA terms required MaineHealth to limit SMMC's operating profit margin and reduce expenses, as well as expand access and maintain quality. But the COPA did not impose any conditions on the other hospitals operated by MaineHealth, including MMC. In accordance with the state COPA law, the MaineHealth COPA expired after six years in May 2015.

Empirical research on the price and quality effects of the MaineHealth COPA for inpatient hospital services from 2003 to 2018 showed varying results for the regulated SMMC hospital and the unregulated MMC hospital. During the COPA period, SMMC's prices increased by about 8% to 13% compared to peer hospitals, but this increase was not statistically significant and the conclusion is that the COPA was largely effective at constraining SMMC's prices during the COPA period. However, SMMC's prices increased by almost 50% following the expiration of the COPA in 2015. At MMC, prices increased by 38% during the COPA period, and by 62% following the expiration of the COPA (for an average of 50% during the entire post-merger period). Furthermore, SMMC's quality declined across most measures following the expiration of the COPA.[47] The study summarizes as follows:

> These results highlight the deficiencies of the MaineHealth COPA, which only placed restrictions on SMMC's price, not that of MMC or any other MaineHealth hospital. The evidence suggests that MaineHealth was able to exercise the market power gained in the SMMC acquisition (and possibly other acquisitions) through a price increase at the unregulated MMC.[48]

Recent COPAs and Developments

Ballad Health System (Tennessee/Virginia) and Cabell Huntington Hospital (West Virginia)

In January 2018, Mountain States Health Alliance and Wellmont Health System – competitors in the geographic region that straddles the border of southwestern Virginia and northeastern Tennessee – merged to form Ballad Health System under COPA approvals from the Tennessee and Virginia Departments of Health.[49] Both states imposed terms and conditions, including a price increase cap, quality of care commitments, a prohibition of certain contractual provisions, and a commitment to return cost savings to the local community. The Tennessee Department of Health has already agreed to amend these conditions on three separate occasions, on July 31, 2019, April 27, 2021, and July 1, 2022.[50] On March 31, 2020, the Tennessee Department of Health and Tennessee Attorney General's Office temporarily suspended several COPA conditions due to the COVID-19 pandemic.[51] Approximately two years later, some of these conditions were resumed on January 1, 2022, and the remaining conditions were set to resume on July 1, 2022.[52] Some concerns have been raised about recent modifications to these conditions, however, most notably Ballad Health resuming the ability to oppose certificate of need applications filed by providers seeking to enter the market.[53]

In May 2018, Cabell Huntington Hospital and St. Mary's Medical Center – both located in Huntington, West Virginia – merged after receiving a COPA approval in 2016 from the West Virginia Health Care Authority ("Authority").[54] COPA conditions include annual reporting, regulatory rate review, the prohibition of certain contracting practices, quality of care and population health commitments, and the maintenance of St. Mary's Medical Center as a free-standing general acute care hospital for a minimum of seven years. The COPA is set to terminate in 2024. Soon after the COPA was approved, the West Virginia legislature made significant changes to the Authority, including eliminating the salaried board of directors (including those who approved the COPA), a 50% reduction in funding, and large staffing reductions (including those who evaluated the COPA). In addition, the Authority's autonomy was eliminated, and it was placed under the direction of the West Virginia Department of Health and Human Resources.[55] The Authority is still responsible for continued oversight of the Cabell COPA, although with substantially fewer resources and a lack of independent authority.

In October 2019, the FTC announced that it would study the Ballad Health and Cabell Huntington COPA effects on prices, quality, access, and innovation of healthcare services, as well as the impact of hospital consolidation on employee wages. The FTC intends to collect information over several years that will help FTC staff to conduct retrospective analyses of the Ballad Health and Cabell COPAs, and we will report these findings publicly when the study is complete.[56]

During a panel discussion on early observations of the Ballad Health COPA, staff from the Tennessee Attorney General's office and the Virginia Department of Health described the lengthy process by the states to approve and monitor the COPAs.[57] A representative for Ballad Health described the COPA implementation as successful.[58] However, representatives from an independent physician group and health insurer raised concerns about the early COPA performance, including reduced access and

pricing issues relating to the rapid closure of outpatient surgical facilities, trauma centers, and NICUs, as well as difficult payer negotiations that they claim have hindered the transition to value-based contracting.[59] And a former member of the Tennessee COPA Local Advisory Council described the significant public concerns with the COPA, primarily relating to facility closures and staffing shortages.[60]

Hendrick Health System and Shannon Health System (Texas)

In October 2020, Hendrick Health System and Shannon Health System – both located in Texas – received COPA approvals from the Texas Health and Human Services Commission for their respective mergers.[61] FTC staff conducted preliminary investigations of these mergers and determined that they were likely to lessen competition substantially and lead to price increases and quality reductions for patients, as well as depressed wages for nurses.[62] In an attempt to mitigate any merger-related harms, the state imposed limited terms and conditions as part of the COPA approvals, primarily consisting of regulatory rate review and reporting requirements. Although it is too early to assess the price and quality effects of these COPAs, we will continue to monitor developments.

Conclusion

To summarize, the weight of the empirical evidence indicates that "[i]n the long run, hospital mergers shielded with COPAs often lead to higher prices and reduced quality from unconstrained provider market power."[63] Despite hospital claims that COPAs will result in lower costs and improved population health outcomes, we are not aware of any proven benefits of COPAs. For these reasons, FTC staff urges state lawmakers to avoid using COPAs to shield otherwise anticompetitive hospital mergers.

Questions may be directed to FTC staff at CopaAssessment@ftc.gov.

Endnote References

[1] This policy paper represents the views of the staff of the Federal Trade Commission. It does not necessarily represent the views of the Commission or of any individual Commissioner. The Commission, however, has voted to authorize staff to issue this policy paper.

[2] *See, e.g.*, FTC Staff Submissions Regarding the Proposed Merger and COPA Applications of Mountain States Health Alliance and Wellmont Health System, https://www.ftc.gov/enforcement/cases-proceedings/151-0115/wellmont-healthmountain-states-health; FTC Staff Comment to Texas Health and Human Services Commission Regarding Certificate of Public Advantage Applications (Sept. 11, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhsccopacomment.pdf.

[3] *See. e.g.,* U.S. DEP'T OF THE TREASURY, THE STATE OF LABOR MARKET COMPETITION 48 (Mar. 7, 2022), https://home.treasury.gov/system/files/136/State-of-Labor-Market-Competition-2022.pdf; U.S. DEP'T OF HEALTH & HUMAN SERVICES, U.S. DEP'T OF THE TREASURY, & U.S. DEP'T OF LABOR, REFORMING AMERICA'S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION 57-59 (Dec. 2018), https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf; Martin Gaynor, WHAT TO DO ABOUT HEALTH-CARE MARKETS? POLICIES TO MAKE HEALTH-CARE MARKETS WORK 22 (Brookings Institution, The Hamilton Project Policy Proposal 2020-10, Mar. 2020), https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf; Liam Bendicksen & Christopher Koller, *The Risk of Repeal: Examining the Use of State-Action Immunity for Hospital Mergers*, HEALTH AFFAIRS FOREFRONT (Aug. 10, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210806.481073/full/. *See also* Executive Order on Promoting Competition in the American Economy (Jul. 9, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/ (discussing the importance of hospital competition).

[4] To obtain antitrust immunity for conduct by private actors that might otherwise violate the federal antitrust laws, the state action doctrine requires both a clear articulation of the state's intent to displace competition in favor of regulation and that the state provide active supervision over the regulatory scheme or body. *See* N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1114 (2015); FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003, 1013 (2013).

[5] Of the ten COPAs that have been approved, seven of them involved mergers between the only two general acute care hospitals serving a local region. Only three COPAs involved situations where any significant competition remained in the local region post-merger, but even these mergers created hospitals with dominant market shares. *See* Case Studies section, *infra* page 7, for further discussion of previously approved COPAs.

[6] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 10 (2010). Antitrust laws are not an impediment to legitimate, procompetitive collaboration that would benefit consumers. Antitrust agencies have provided extensive guidance to healthcare providers seeking ways to collaborate without running afoul of the antitrust laws. *See, e.g.*, U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf; Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Fed. Trade Comm'n & U.S. Dep't of Justice Oct. 28, 2011), http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf.

[7] *See, e.g.*, Zack Cooper, Stuart Craig, Martin Gaynor & John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51 (2019), https://healthcarepricingproject.org/sites/default/files/Updated_the_price_aint_right_qje.pdf; Nancy Beaulieu, Leemore Dafny, Bruce Landon, Jesse Dalton, Ifedayo Kuye & J. Michael McWilliams, *Changes in Quality of Care after Hospital Mergers*

and Acquisitions, 382 NEW ENG. J. MED. 51 (Jan. 2, 2020), https://www.nejm.org/doi/pdf/10.1056/NEJMsa1901383?articleTools=true. For surveys of the research literature, *see, e.g.*, Martin Gaynor & Robert Town, THE IMPACT OF HOSPITAL CONSOLIDATION – UPDATE (Robert Wood Johnson Found., The Synthesis Project, Policy Brief No. 9, 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Martin Gaynor, Kate Ho & Robert Town, *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LITERATURE 235 (2015), https://www.researchgate.net/publication/278676719_The_Industrial_Organization_of_Health-Care_Markets.

[8] *See, e.g.,* Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, 111 AM. ECON. REV. 397 (2021), https://www.aeaweb.org/articles?id=10.1257/aer.20190690 [hereinafter Prager & Schmitt Study]; Daniel Arnold & Christopher Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*, (2021 working paper), https://www.ehealthecon.org/pdfs/Whaley.pdf.

[9] *See* Erin E. Trish & Bradley J. Herring, *How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?*, 42 J. HEALTH ECON. 104 (2015), http://www.sciencedirect.com/science/article/pii/S0167629615000375.

[10] *See, e.g.*, Robert Town, *The Economists' Supreme Court Amicus Brief in the Phoebe Putney Hospital Acquisition Case*, 1 HEALTH MGMT. POL'Y & INNOVATION 60 (2012), http://www.hmpi.org/pdf/HMPI-%20Town,%20Phoebe%20Putney.pdf; Gaynor, Ho & Town, *supra* note 7.

[11] *See, e.g.*, Arnold & Whaley, *supra* note 8; Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LAB. ECON. 609 (2006), https://www.hks.harvard.edu/fs/achandr/JLE_LaborMktEffectsRisingHealthInsurancePremiums_2006.pdf; Priyanka Anand, *Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey*, 26 HEALTH ECON. 1601 (2017), https://onlinelibrary.wiley.com/doi/10.1002/hec.3452; Gaynor, Ho & Town, *supra* note 7, at 236; Gaynor & Town, *supra* note 7, at 1.

[12] *See* Gaynor, Ho & Town, *supra* note 7; Gaynor & Town, *supra* note 7; Beaulieu, Dafny, Landon, Dalton, Kuye & McWilliams, *supra* note 7, at 56; Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, MED. CARE RES. REV. 1-18, at 14 (2019), https://journals.sagepub.com/doi/pdf/10.1177/1077558719828938; Patrick Romano & David Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Hospital*, 18 INT'L J. ECON. BUS. 45 (2011), http://www.tandfonline.com/doi/abs/10.1080/13571516.2011.542955.

[13] *See* Gaynor, Ho & Town, *supra* note 7, at 249; Gaynor & Town, *supra* note 7, at 4.

[14] *See* Prager & Schmitt, *supra* note 8.

[15] *See, e.g.*, David Card, *Who Set **Your** Wage?*, Annual Meeting of the American Economic Association (Jan. 2022), https://davidcard.berkeley.edu/papers/Card-presidential-address.pdf; Vicky Lovell, SOLVING THE NURSING SHORTAGE THROUGH HIGHER WAGES, Institute for Women's Policy Research (2006), http://people.umass.edu/econ340/rn_shortage_iwpr.pdf.

[16] *See* FTC COPA Workshop Transcript: Session 2 (Afternoon) at 30-31 (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session2_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 2] (statement by Christopher Garmon on the impact of the Prager & Schmitt Study as applied to COPAs). *See also* Mikael Lindahl, *Estimating the Effect of Income on Health and Mortality Using Lottery Prizes as an Exogenous Source of Variation in Income*, 40 J. HUM. RESOUR. 144 (2005), http://jhr.uwpress.org/content/XL/1/144 (finding higher income generates better health); J. Paul Leigh & Juan Du, *Effects of Minimum Wages on Population Health*, HEALTH

AFFAIRS HEALTH POLICY BRIEF (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180622.107025/ (suggesting higher income is correlated to improved population health).

[17] *See* FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments (Nov. 1, 2017), https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf.

[18] *See* FTC Public Workshop, *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets* (Jun. 18, 2019), https://www.ftc.gov/news-events/events/2019/06/health-check-copas-assessing-impact-certificates-public-advantage-healthcare-markets [hereinafter FTC COPA Workshop]; FTC Press Release, *FTC to Study the Impact of COPAs* (Oct. 21, 2019), https://www.ftc.gov/news-events/press-releases/2019/10/ftc-study-impact-copas [hereinafter FTC COPA Study].

[19] *See, e.g.*, Hannah Neprash & J. Michael McWilliams, *Provider Consolidation and Potential Efficiency Gains: A Review of Theory and Evidence*, 82 ANTITRUST L.J. 551, 553 (2019), https://www.americanbar.org/digital-asset-abstract.html/content/dam/aba/publishing/antitrust_law_journal/alj-82-2/neprash-mcwilliams-alj-82-2.pdf; Anil Kaul, K.R. Prabha & Suman Katragadda, *Size Should Matter: Five Ways to Help Healthcare Systems Realize the Benefits of Scale*, PwC Strategy& (2016), http://www.strategyand.pwc.com/reports/size-should-matter. Furthermore, in some hospital merger cases courts have found that efficiency claims do not rebut a presumption of anticompetitive effects. *See e.g.*, Fed. Trade Comm'n v. ProMedica, No. 3:11 CV 47, 2011 WL 1219281, at *57 (N.D. Ohio Mar. 29, 2011).

[20] *See* David Arnold, *Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes* (2021 working paper), https://darnold199.github.io/jmp.pdf.

[21] *See, e.g.*, Hannah Neprash, Michael Chernew & J. Michael McWilliams, *Little Evidence Exists to Support the Expectation that Providers Would Consolidate to Enter New Payment Models*, 36 HEALTH AFFAIRS 346, 353 (2017), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0840; Cooper, Craig, Gaynor & Reenen, *supra* note 7, at 104.

[22] *See, e.g.*, David Muhlestein, Robert Saunders & Mark McClellan, *Medical Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues*, HEALTH AFFAIRS BLOG (Sept. 9, 2016), http://healthaffairs.org/blog/2016/09/09/medicare-accountable-care-organization-results-for-2015-the-journey-to-better-quality-and-lower-costs-continues/.

[23] *See* Centers for Medicare & Medicaid Services, *Value-Based Programs*, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs (last accessed Aug. 4, 2022).

[24] *See, e.g.*, Neprash & McWilliams, *supra* note 19; Kaul, Prabha & Katragadda, *supra* note 19.

[25] *See* Dan P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q. J. ECON. 577 (2000), http://qje.oxfordjournals.org/content/115/2/577.full.pdf+html; Martin Gaynor, Rodrigo Moreno-Serra & Carol Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service*, 5 AM. ECON. J.: ECON. POL'Y 134 (2013), https://www.aeaweb.org/atypon.php?doi=10.1257/pol.5.4.134.

[26] *See* David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, 20 HEALTH AFFAIRS 11 (Sept. 2001), http://content.healthaffairs.org/content/20/5/11.full.pdf+html.

[27] *See, e.g.,* Gregory S. Vistnes, *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health* 11 (Feb. 10, 2011), http://www.mountainx.com/files/copareport.pdf; Cory S. Capps, *Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health*

System 32 (May 2, 2011). *See also* FTC COPA Workshop Transcript: Session 2, *supra* note 16, Erin Fuse Brown remarks at 18-20; Erin C. Fuse Brown, *Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage* (Milbank Memorial Fund 2018), https://www.milbank.org/publications/hospital-mergers-and-public-accountability-tennessee-and-virginia-employ-a-certificate-of-public-advantage/; Erin C. Fuse Brown, *To Oversee or Not to Oversee? Lessons from the Repeal of North Carolina's Certificate of Public Advantage Law* (Milbank Memorial Fund 2019), https://www.milbank.org/publications/to-oversee-or-not-to-oversee-lessons-from-the-repeal-of-north-carolinas-certificate-of-public-advantage-law/.

[28] *See* Clayton Act, 15 U.S.C. § 18; Federal Trade Commission Act, 15 U.S.C. § 45.

[29] *See, e.g.*, *Competition in the Health Care Marketplace*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care; FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2022), https://www.ftc.gov/system/files/ftc_gov/pdf/2022.04.08%20Overview%20Healthcare%20%28final%29.pdf.

[30] *See* FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, *supra* note 29, at Section III.

[31] Hospital systems that have been awarded COPAs include: HealthSpan Hospital System (Minnesota, 1994); Mission Health System (North Carolina, 1995); Benefis Health System (Montana, 1996); Palmetto Health System (South Carolina, 1998); MaineHealth (Maine, 2009); Cabell Huntington Hospital (West Virginia, 2016); Ballad Health System (Tennessee and Virginia, 2018); Hendrick Health System (Texas, 2020); Shannon Health System (Texas, 2020). In April 2021, a COPA law was enacted in Indiana to allow for a possible merger between Union Health and Terre Haute Regional Hospital. *See* Howard Greninger, *Talks Focus on Terre Haute Hospitals' Future: New State Law Opens Door to 'Merger' of Trauma Hospitals, Requires Certificate Approval*, TRIBUNE-STAR (Dec. 2, 2021), https://www.tribstar.com/news/indiana_news/talks-focus-on-terre-haute-hospitals-future/article_685467e6-3bba-58c7-bf1b-4966091383b1.html. And in July 2022, State University of New York Upstate Medical University and Crouse Health System announced they would seek a COPA for their proposed merger. *See* Anna Langlois, *Syracuse Hospitals Seek Antitrust Immunity*, GLOBAL COMPETITION REVIEW (Jul. 28, 2022), https://globalcompetitionreview.com/gcr-usa/article/syracuse-hospitals-seek-antitrust-immunity.

[32] Lien Tran & Rena Schwarz Presentation at FTC COPA Workshop, *The Mission Health COPA: Evidence on Price Effects from CMS HCRIS Data* (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/slides-copa-jun_19.pdf at 37.

[33] Christopher Garmon & Kishan Bhatt, *Certificates of Public Advantage and Hospital Mergers* at 19 (Feb. 2022, paper forthcoming in J. Law Econ.).

[34] FTC COPA Workshop Transcript: Session 1 (Morning), Kip Sturgis remarks at 43 (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session1_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 1].

[35] FTC COPA Workshop Transcript: Session 1, *supra* note 34 Cory Capps remarks at 34-35. *See also* Randall R. Bovbjerg & Robert A. Berenson, URBAN INSTITUTE, CERTIFICATES OF PUBLIC ADVANTAGE: CAN THEY ADDRESS PROVIDER MARKET POWER? (2015), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf; Vistnes COPA Study, *supra* note 27; Capps COPA Study, *supra* note 27. In this prior research, health policy experts and economists evaluated certain aspects of the Mission Health COPA, but they were unable to reach conclusions about whether the COPA successfully constrained prices, reduced healthcare costs, or improved quality.

[36] Garmon & Bhatt, *supra* note 33, at 20.

[37] FTC COPA Workshop Transcript: Session 1, *supra* note 34, John Goodnow remarks at 40, 43-44.

[38] FTC COPA Workshop Transcript: Session 1, *supra* note 34, Mark Callister remarks at 38. Mark Callister informed us that the Benefis Health COPA was opposed by medical professionals and citizens of Great Falls, and was supported by the payers. *Id.* at 37.

[39] FTC COPA Workshop Transcript: Session 1, *supra* note 34, Kendall Cotton remarks at 40.

[40] *Id.* at 41.

[41] The Palmetto Health hospitals still operate under the COPA that was originally approved in 1997, although the degree of current active supervision by DHEC is questionable. In 2013, South Carolina cut funding for its Certificate of Need program, which encompasses the COPA program, thereby reducing the level of state monitoring.

[42] *See* Garmon & Bhatt, *supra* note 33, at 20, 42.

[43] At that time, four general acute care hospitals served the Columbia Core-Based Statistical Area in addition to Baptist Healthcare and Richland Memorial: Providence Health in Columbia (later acquired by LifePoint), Lexington Medical Center in West Columbia, Kershaw Health in Camden (later acquired by LifePoint), and Fairfield Memorial Hospital in Winnsboro (closed in 2018). *See* Garmon & Bhatt, *supra* note 33, at 42 ("Baptist and Richland together represented 55 percent of the bed capacity in the Columbia CBSA and treated 66 percent of the commercially insured inpatients.").

[44] *See* South Carolina Department of Health and Environmental Control, Final Staff Decision In Re Prisma Health Midlands COPA (Feb. 28, 2020), https://www.scdhec.gov/sites/default/files/media/document/FINAL-STAFF-DECISION-IN-RE-PRISMA-HEALTH-MIDLANDS-COPA_2-28-2020.pdf; Palmetto Health-USC Medical Group, *Prisma Health to Acquire KershawHealth and Providence Health* (Mar. 5, 2020), https://phuscmg.org/news/prisma-health-to-acquire-kershawhealth-and-provide.

[45] In the Matter of Lexington County Health Services District Inc. v. South Carolina Department of Health and Environmental Control, Prisma Health-Midlands, Providence Hospital, LLC, Order Denying Cross-Motions for Summary Judgment, Docket No. 20-ALJ-07-0108-CC (SC Admin. Law Court, Nov. 2, 2020).

[46] *See* Dave Muoio, *Prisma Health, LifePoint Health Call Off Sale of 3 South Carolina Hospitals*, FIERCE HEALTHCARE (Apr. 13, 2021), https://www.fiercehealthcare.com/hospitals/prisma-health-lifepoint-health-call-off-sale-three-south-carolina-hospitals.

[47] Garmon & Bhatt, *supra* note 33, at 21-22, 34.

[48] *Id.* at 21.

[49] FTC staff investigated the proposed merger of Mountain States and Wellmont for more than two years. FTC staff submitted public comments and testimony to the Virginia and Tennessee state departments of health and offices of Attorneys General recommending denial of the COPA. *See* FTC Staff Submissions Regarding the Proposed Merger and COPA Applications of Mountain States Health Alliance and Wellmont Health System, https://www.ftc.gov/enforcement/cases-proceedings/151-0115/wellmont-healthmountain-states-health.

[50] *See* Tennessee Dep't of Health, *Certificate of Public Advantage (COPA)*, https://www.tn.gov/health/health-program-areas/health-planning/certificate-of-public-advantage.html (last accessed Aug. 4, 2022).

[51] *See* Letter from Tennessee Office of the Attorney General to Ballad Health CEO (Mar. 31, 2020), 2020-03-31 Temporary Suspension-Letter -executed.pdf (tn.gov) (last accessed Aug. 4, 2022); Tennessee Dep't. of Health, List of Suspended

Provisions, https://www.tn.gov/content/dam/tn/health/documents/copa/copa-emergency-declaration-memo.pdf (last accessed Aug. 4, 2022).

[52] *See* Letter from Tennessee Office of the Attorney General to Ballad Health CEO (Dec. 3, 2021), 2021-12-03-AG-and-TDH-Reasonable-Recovery-Letter-to-Ballad.pdf (tn.gov) (last accessed Aug. 4, 2022).

[53] *See* Jeff Keeling & Ashley Sharp, *Changed Ballad COPA Restrictions Draw Docs' Criticism*, WJHL-TV (Jul. 13, 2022), https://www.wjhl.com/news/investigations/changed-ballad-copa-restrictions-draw-docs-criticism/.

[54] In November 2015, the FTC issued an administrative complaint alleging that the proposed merger of Cabell Huntington Hospital and St. Mary's Medical Center violated antitrust laws. In March 2016, while litigation was pending, West Virginia enacted COPA legislation purporting to extend antitrust immunity to certain hospital mergers under the state action doctrine. Subsequently, the West Virginia Health Care Authority approved a COPA application submitted by the hospitals. The FTC opposed the legislation and COPA application. In July 2016, the FTC dismissed its administrative complaint against the proposed merger in light of the COPA approval. *See* Statement of the Federal Trade Commission in the Matter of Cabell Huntington Hospital, Inc., Docket No. 9366 (Jul. 6, 2016), https://www.ftc.gov/system/files/documents/public_statements/969783/160706cabellcommstmt.pdf.

[55] *See* West Virginia Health Care Authority, *About HCA*, https://hca.wv.gov/About/Pages/default.aspx (last accessed Aug. 4, 2022).

[56] *See* FTC COPA Study, *supra* note 18.

[57] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Janet Kleinfelter and Joseph Hilbert remarks at 3-6.

[58] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Richard Cowart remarks at 8-10. *See also* Richard Cowart Submission on behalf of Ballad Health to the FTC (Aug. 2, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0174; Ballad Health Submission to the FTC (Aug. 2, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0173.

[59] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Scott Fowler and John Syer remarks at 11-16.

[60] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Daniel Pohlgeers remarks at 16-17. *See also* numerous submissions to the FTC from concerned citizens, https://www.regulations.gov/docketBrowser?rpp=25&so=DESC&sb=commentDueDate&po=0&dct=PS&D=FTC-2019-0016.

[61] *See* Texas Health and Human Services, *Certificate of Public Advantage*, https://www.hhs.texas.gov/providers/health-care-facilities-regulation/certificate-public-advantage (last accessed Aug. 4, 2022).

[62] FTC staff submitted a comment to the Texas Health and Human Services Commission recommending denial of both COPAs. *See* FTC Staff Comment to Texas Health and Human Services Commission Regarding Certificate of Public Advantage Applications (Sept. 11, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhsccopacomment.pdf.

[63] Garmon & Bhatt, *supra* note 33, at 1. "Overall, COPA regulation, if properly designed, may result in hospital prices that are consistent with the pre-merger market. However, COPA-regulated hospitals have a strong incentive to evade regulation and pursue the removal of the COPA. Almost all of the COPAs established prior to 2015 have expired or were repealed, leaving the affected communities with unregulated hospital monopolists, higher prices, and likely reduced quality. States considering the use of a COPA to grant antitrust immunity to merging hospitals should carefully weigh this risk of harm against the possibly short-run and limited benefits of the merger." *Id.* at 26.

Federal Trade Commission

Key COPA Facts

FTC.gov/COPA

Certificate of Public Advantage ("COPA") laws attempt to immunize hospital mergers from antitrust laws by replacing competition with state oversight. COPAs facilitate hospital consolidation, which is a key driver of higher healthcare costs without improvements in quality of care. Indeed, hospitals only seek COPAs for specific mergers that would otherwise violate antitrust laws and often result in monopolies.

FTC staff urges states to avoid using COPAs and invites state lawmakers to work collaboratively with competition policy experts to minimize the harmful effects of further hospital consolidation on local patients, employers, and hospital employees.

- **Mission Health COPA (NC):** Substantial increases in commercial inpatient prices during early COPA years (at least 20%), during later COPA years (average 25%), and after COPA was repealed (at least 38%). Demonstrates price regulations during COPA were ineffective, as well as the risk of eventually having an unregulated monopolist.
- **Benefis Health COPA (MT):** Substantial increases in commercial inpatient prices after COPA was repealed (at least 20%). Demonstrates the risk of eventually having an unregulated monopolist.

Studies show that several hospital mergers subject to COPAs have resulted in higher prices and reduced quality of care, despite regulatory commitments designed to mitigate these anticompetitive effects.

- **MaineHealth COPA (ME):** Substantial increases in commercial inpatient prices at unregulated hospital during COPA (at least 38%), as well as after COPA expired at both hospitals – for a total price increase of at least 50% during the COPA and post-COPA period. Demonstrates the risk of selectively regulating hospitals within a larger system, as well as the risk of eventually having an unregulated monopolist. Measurable decline in quality at the acquired hospital after the COPA expired.

COPAs rarely work as promised. Here are the reasons to be skeptical:

- **COPAs exacerbate the widespread problem of hospital consolidation.** Studies show various harms can arise from hospital consolidation, including higher prices for patients without improvements in quality of care, reduced patient access to healthcare services, hospital resistance to value-based delivery and payment models intended to help reduce costs, and lower wages for hospital employees as a result of fewer employment options. Antitrust enforcers have successfully challenged anticompetitive hospital mergers likely to cause such harms, and COPAs undermine these efforts.
- **COPAs can reduce hospital employee wage growth.** Hospitals are major employers in most communities. When mergers result in high levels of hospital concentration, local labor markets suffer because fewer hospitals compete for workers. A recent study shows that such mergers can lead to lower wages for workers whose employment prospects are closely linked to hospitals, such as nurses and pharmacy workers. COPAs are sought for hospital mergers involving the highest levels of concentration and therefore can reduce employee wages.

- **COPA monitoring and compliance are difficult.** Effective COPA oversight requires significant state expertise and resources. Over time, regulatory fatigue, staff turnover, and changes in funding priorities at state agencies can lead to less vigorous supervision. Hospitals also must devote significant resources to compliance with COPA conditions, which leads them to eventually lobby for repeal of COPA oversight or fewer COPA conditions – defeating the original purpose of the COPA.
- **COPAs are susceptible to regulatory evasion.** COPA regulation is rarely, if ever, comprehensive enough to address all of the ways hospitals can exercise market power. Competition allows for greater flexibility when responding to market dynamics and has been proven to produce better results for consumers.
- **COPAs are only temporary.** Most COPAs do not last in perpetuity. They are eventually repealed, revoked, or terminated. Once state oversight ends, the community is often left with a hospital monopoly that can exercise its market power without constraint.

Hospitals make several unproven claims when seeking COPAs to form monopolies:

Claim	Fact
This merger will eliminate "wasteful duplication" associated with competition.	**Competition benefits patients, employers, and hospital employees – it is not unnecessary or wasteful. Competition can incentivize hospitals to invest in facilities, technology, and equipment that improve patient access to healthcare services and quality of care.**
This merger will reduce healthcare costs and generate efficiencies.	**Many hospital mergers do not achieve projected cost savings and efficiencies.**
Vulnerable rural hospitals will close without this merger.	**Facilities often close even with a merger. Antitrust enforcers already consider hospital financial conditions when evaluating mergers. If a rural hospital is truly failing financially and the proposed merger is the only way for it to remain viable, then the FTC is unlikely to challenge the merger and antitrust immunity is not necessary.**
This merger will improve quality of patient care and overall population health.	**Studies show that hospital mergers in highly concentrated markets are unlikely to improve quality and instead are associated with quality declines. There are many ways hospitals can achieve these laudable goals without a merger, and the antitrust laws do not prevent hospitals from engaging in initiatives to improve the quality of patient care and population health.**
This merger will enhance access to healthcare facilities and create jobs.	**Many of the cost savings projected by merging hospitals are the direct result of planned facility consolidation, elimination of services, and job reductions.**

FTC Public Comment
Attachment B

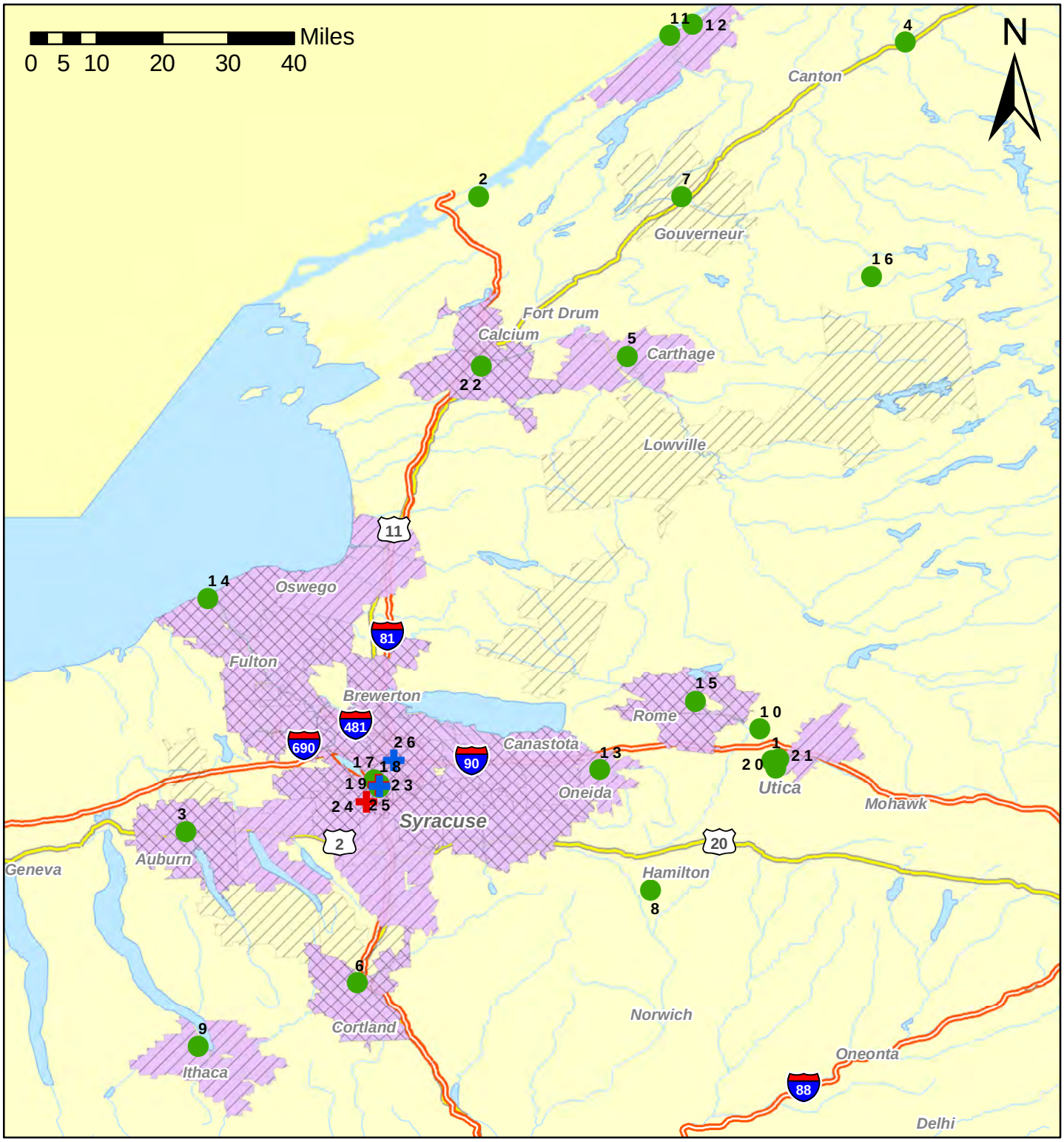
Table B1: Market Shares and HHIs in Prior Healthcare Merger Cases [206]

Case	Combined Share	HHI Increase	Post-Merger HHI	Outcome
University Health (11th Cir. 1991)	43%	630	3,200	Enjoined
ProMedica Health System (6th Cir. 2014)	58%	1,078	4,391	Enjoined
OSF Healthcare (N.D. Ill. 2012)	59%	1,767	5,179	Enjoined
Rockford Memorial (7th Cir. 1990)	68%	2,322	5,111	Enjoined
Advocate Health Care Network (7th Cir. 2016)	60%	1,782	3,943	Enjoined
Penn State Hershey Medical Center (3rd Cir. 2016)	76%	2,582	5,984	Enjoined
Hackensack Meridian Health (3d. Cir. 2022)	47%	841	2,835	Enjoined
SUNY Upstate/Crouse (Commercial Inpatient Services in Onondaga County)	**67%**	**2,197**	**5,556**	**TBD**

[206] For figures provided in Table B1, *see* United States v. Rockford Mem'l Corp., 717 F. Supp. 1251, 1280 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1211 n. 12 (11th Cir. 1991); Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1078-79 (N.D. Ill. 2012); ProMedica Health Sys., Inc. v. Fed. Trade Comm'n, 749 F.3d 559, 568, 570 (6th Cir. 2014); Fed. Trade Comm'n v. Advocate Health Care Network, et al., 841 F.3d 460 (7th Cir. 2016), *on remand*, No. 15-C-11473, 17 (N.D. Ill. 2017); Fed. Trade Comm'n v. Penn State Hershey Medical Center, 838 F.3d 327, 347 (3rd Cir. 2016); Fed. Trade Comm'n v. Hackensack Meridian Health, Inc., 30 F.4th 160, 172 (3d. Cir. 2022).

FTC Public Comment
Attachment C

SUNY Upstate and Crouse Individual and Combined Primary Service Areas



Legend

- Upstate
- Crouse
- 3rd Party
- Upstate PSA
- Crouse PSA
- Combined PSA

Number	Hospital Name	Number	Hospital Name
1	Faxton St. Luke's Healthcare	14	Oswego Hospital
2	River Hospital	15	Rome Memorial Hospital
3	Auburn Community Hospital	16	Clifton-Fine Hospital
4	Canton-Potsdam Hospital	17	St. Joseph's Hospital Health Center
5	Carthage Area Hospital	18	Richard H. Hutchings Psychiatric Center
6	Guthrie Cortland Regional Medical Center	19	Syracuse Veterans Affairs Medical Center
7	Gouverneur Hospital	20	St. Elizabeth Medical Center
8	Community Memorial Hospital	21	Mohawk Valley Psychiatric Center
9	Cayuga Medical Center at Ithaca	22	Samaritan Medical Center
10	Central New York Psychiatric Center	23	Upstate University Hospital
11	Claxton-Hepburn Medical Center	24	SUNY Upstate Community Hospital
12	St. Lawrence Psychiatric Center	25	Crouse Health
13	Oneida Healthcare	26	Crouse Commonwealth Place

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

May 13, 1999

The Honorable Rene O. Oliveira
Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768-2910

Dear Representative Oliveira:

The Bureau of Competition of the Federal Trade Commission is pleased to respond to your request, dated May 5, 1999, for comment on Senate Bill 1468, "An Act Relating to the Regulation of Physician Joint Negotiation" (SB 1468), which currently is being considered by the Texas legislature.(1) The bill would permit competing physicians to jointly negotiate contractual terms with health plans under certain circumstances. Our understanding is that SB 1468 has been adopted by the Texas Senate, and that a vote on a similar measure is expected in the House of Representatives in the very near future. Given the limited time available, we highlight three concerns about the bill, but are not able to provide a complete analysis of all the issues that the bill raises.

The Commission has previously expressed serious concerns about the impact on consumer welfare of a federal proposal to enact an antitrust exemption intended to authorize collective negotiation between health service practitioners and health plans. In testimony before the Committee on the Judiciary of the United States House of Representatives in July 1998, the Commission opposed enactment of H.R. 4277, the "Quality Health-Care Coalition Act of 1998." The Commission stated that the exemption would immunize "a broad range of anticompetitive joint conduct by physicians and other health care professionals that could seriously harm consumers and undermine efforts to promote high-quality, cost-effective health care for consumers." Furthermore, the Commission pointed out, the exemption would impair innovation in health care financing and delivery, and reduce choices among alternative health plans. Finally, the Commission noted that an antitrust exemption is not needed in order to allow physicians collectively to express their concerns about patient care and quality of care issues that may arise from their participation in managed care plans, or to permit them to enter into joint ventures that can offer better alternatives to patients or to health plans. A copy of the Commission's testimony is enclosed for your information.

The bill being considered by the Texas legislature differs from H.R. 4277 in various respects. In contrast to the federal proposal, which would simply provide an antitrust exemption for collective negotiations, SB 1468 requires some oversight of the negotiating process by the Texas Attorney General. In addition, SB 1468 would limit to 10% the proportion of physicians in a geographic area who could negotiate collectively, unless the Attorney General approved inclusion of a larger number in the group. The bill allows collective negotiation of certain types of fee-related issues only where the Attorney General determines that the health plan has substantial market power.

It is not clear, however, to what extent these differences would reduce the potential for anticompetitive effects otherwise likely to arise from the authorization of collective bargaining among competing physicians. For example, the provision in Section 29.09(b) that no joint negotiation shall represent more than 10% of the licensed physicians in a defined geographic area provides no significant limitation on the aggregation of bargaining power by many types of physician groups. For many medical specialities, a group including all the physicians in a particular speciality or subspeciality would constitute less than 10% of all licensed physicians, and their combination in a single bargaining group could give them significant market power over health plans.(2) Although the bill permits the Attorney General to raise or lower the percentage in particular cases, it does not provide any standards to guide the Attorney General's decision. It is unclear, for example, whether the bill's intent is that the Attorney General limit bargaining groups to 10%

of a properly defined antitrust market. Without such a limitation, the 10% cap on the size of physician bargaining groups does not protect against the risk of substantial consumer harm.

Second, it is not clear to what extent the bill's use of a health plan market power screen for some types of collective bargaining would limit potential consumer harm. The bill prohibits collective negotiation on certain specified fee-related issues, unless the Attorney General determines that a health plan with which physicians are negotiating possesses "substantial market power." However, the bill provides no standard for determining when substantial market power will be deemed to exist. We are uncertain whether the intent is to have the Attorney General apply established antitrust principles of market power analysis, or whether the reference in the bill's preamble to "imbalances" in bargaining power suggests some other approach that would compare the bargaining power of a plan to that of an individual physician. In addition, the scope of arrangements to which the market power screen applies is limited. For example, negotiating over formulation and application of physician reimbursement methodology is not subject to the requirement that the health plan have substantial market power, though such matters plainly can have a direct and substantial effect on fee levels. Collective negotiation about other "non-price" issues also can have a substantial effect on the cost of services that the plan covers, as well as limiting the options available to plans to meet consumer demand for high-quality and affordable health insurance.

Third, the bill imposes substantial responsibilities on the Attorney General that could be difficult to carry out given the time frames provided in the bill and the fact-intensive nature of the issues. Moreover, we note that the regulatory scheme established by the bill contains no mechanism for members of the public, or others who stand to be affected by the Attorney General's decision, to offer evidence and views pertaining to the costs and benefits of the proposal or any of the underlying issues. In addition, the bill provides little guidance as to how the discretion granted to the Attorney General is to be exercised. For example, section 29.09(b) of the bill directs the Attorney General to approve a request to enter into joint negotiation or a proposed contract if the applicants demonstrate that "the likely benefits resulting from the joint negotiation or proposed contact outweigh the disadvantages attributable to a reduction in competition" that may result, but it provides no criteria to guide the Attorney General in evaluating benefits or disadvantages, or in weighing one against the other.(3)

We hope you find these comments helpful. Should you have any additional questions concerning this issue, please contact Richard Feinstein at 202-326 3688.

Sincerely yours,

William J. Baer

Enclosure

1. This letter represents the views of the staff of the Bureau of Competition of the Federal Trade Commission and does not necessarily represent the views of the Commission or any individual Commissioner.

2. Physicians differ as to specialities and these individual specialties may constitute different product markets. Moreover, relevant geographic markets may differ as to specialty.

3. The nature of the oversight actually exercised by the Attorney General is important to the question whether private parties acting pursuant to the statute would be exempt from the federal antitrust laws by virtue of the "state action doctrine." The "state action doctrine" allows a state to override the national policy favoring competition where the state legislature clearly articulates a policy to displace competition with regulation, and state officials actively supervise private anticompetitive conduct. See California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980). The active supervision requirement "is designed to ensure that the state action doctrine will shelter only the particular anticompetitive acts of private parties that in the judgment of the State, actually further state regulatory policies." Patrick v. Burget, 486 U.S. 94, 100 (1988). The question to be addressed in any individual case, therefore, is "whether the State has exercised sufficient independent judgment and control so that the details of the

rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." Federal Trade Commission v. Ticor Title Insurance Co., 504 U.S.621, 634-35 (1992). We note in particular that Section 29.09(c) of the bill provides that an approval of the initial filing for authorization to bargain collectively covers all subsequent negotiations between the parties, apparently without regard to whether circumstances have changed such that the subsequent bargaining might no longer qualify for approval.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
Bureau of Economics
Office of Policy Planning

EXHIBIT
8

March 18, 2009

Representative Tom Emmer
Minnesota House of Representatives
301 State Office Building
100 Rev. Dr. Martin Luther King, Jr. Boulevard
Saint Paul, Minnesota 55155

Re: **Minnesota House Bill H.F. No. 120 & Senate Bill S.F. No. 203**

Dear Representative Emmer:

This letter responds to your request for comment on Minnesota House Bill H.F. No. 120 and its companion Senate Bill S.F. No. 203.[1] These bills are intended to exempt from state and federal antitrust law certain anticompetitive activities by health care cooperatives in Minnesota, including illegal price fixing and collective negotiation of terms of dealing with purchasers of health care services. Further, nothing in the bills is likely to prevent the harmful effects that arise from immunizing price fixing. Instead, these bills would deprive health care consumers of the protections of the antitrust laws and the benefits of competition.

If the bills under consideration in Minnesota were to become law, all consumers — patients, employers, insurers, and federal, state, and local health care programs — likely would pay more for medical care. Additionally, the bills are unnecessary: current state and federal antitrust laws already permit doctors and other health care practitioners in many circumstances to cooperate in providing services when that cooperation improves the quality of, or access to, health care services.[2] Finally, it is questionable whether the regulatory scheme the bills

[1] This letter represents the views of the Federal Trade Commission's Bureau of Competition, Bureau of Economics, and Office of Policy Planning. It does not necessarily represent the views of the Commission or any individual Commissioner. The Commission has, however, voted to authorize the staff to submit these comments.

[2] Indeed, the Federal Trade Commission and its staff have provided substantial guidance to the industry regarding how such arrangements can operate and how they will be evaluated under long-standing antitrust law

(continued...)

contemplate would immunize health care cooperatives from liability for conduct that violates the federal antitrust laws.

Because they are likely to harm consumers, the Commission has long opposed federal and state legislative proposals that would create antitrust exemptions for collective bargaining by health care providers.[3] Similarly, the Congressional Budget Office believes that antitrust exemptions for health care providers would increase health care costs.[4] More generally, the bi-partisan Antitrust Modernization Commission observed "[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality, and reduced innovation."[5] That is precisely what the bills under consideration would do, if enacted. By raising health care costs, moreover, the bills would make it more expensive and more difficult to institute health care reform and expand health care coverage.

The bills' main proponent is the Minnesota Rural Health Cooperative (MRHC). As the MRHC has itself disclosed, the Commission staff has been investigating serious allegations that MRHC engaged in collective negotiation of physician, hospital, and pharmacy prices. MRHC representatives have made inaccurate statements at legislative hearings about the views of FTC

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[2](...continued)
principles. *See* FTC website, http://www.ftc.gov/bc/healthcare/industryguide/index.htm.

[3] *E.g.,* Prepared Statement of the Federal Trade Commission Concerning "The Community Pharmacy Fairness Act of 2007," Before the Antitrust Task Force of the Committee on the Judiciary, United States House of Representatives (October 17, 2007) http://www.ftc.gov/os/testimony/P859910pharm.pdf; Prepared Statement of the Federal Trade Commission on Examining Competition in Group Health Care (September 6, 2006) http://ftc.gov/os/testimony/P859910CompetitioninGroupHealthCareTestimonySenate09062006.pdf; Prepared Statement of the Federal Trade Commission Before the Committee on the Judiciary, United States House of Representatives, Concerning H.R. 1304, the "Quality Health-Care Coalition Act of 1999 " (June 22, 1999) http://www.ftc.gov/os/1999/06/healthcaretestimony.htm; FTC Staff Comment Before the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (January 30, 2008) http://www.ftc.gov/os/2008/02/v080003puerto.pdf; FTC Staff Comment to the Honorable Dennis Stapleton Concerning Ohio H.B. 325 to Permit Competing Health Care Providers to Engage in Collective Bargaining With Health Plans (October 16, 2002) http://www.ftc.gov/os/2002/10/ohb325.htm; FTC Staff Comment to the Office of Corporation Counsel, District of Columbia Concerning Bill 13-333, the "Physicians Negotiation Act of 1999 " (October 29, 1999), http://ww.ftc.gov/be/hilites/rigsby.shtm; FTC Staff Comment to the Honorable Rene O. Oliveira Concerning Texas S.B. 1468, "An Act Relating to the Regulation of Physician Joint Negotiation" (May 13, 1999) http://www.ftc.gov/be/v990009.shtm.

[4] *See* Congressional Budget Office Cost Estimate, H.R. 1304, Quality Health-Care Coalition Act of 1999 (March 15, 2000) at 5, available at http://www.cbo.gov.

[5] Antitrust Modernization Commission, Report and Recommendations (April 2007) at 335, available at http://govinfo.library.unt.edu/amc/report_recommendation/toc.htm.

staff regarding both the merits of the bills and their effect on our investigation.[6] This letter is intended to provide you with FTC staff's analysis of the likely impact of these bills on Minnesota consumers and on the extent to which the bills, if enacted into law, will shield health care providers from antitrust scrutiny for otherwise illegal collective bargaining.

The Minnesota Bills

Like the other health care provider collective bargaining bills on which the Commission and Commission staff have commented, the pending bills are intended to confer authority for otherwise competing health care providers to agree on the prices and other terms they will accept from health plans, and to bargain jointly to obtain these collectively determined contract terms.[7] Although the bills state that "establishing a system of review and supervision of health care cooperative contractual negotiations" will assure that "competition is preserved," there is little reason to expect that this will be the case, because the bills' regulatory approach will not eliminate the likelihood of the type of harmful effects that arise from immunizing price fixing.

The bills require health care provider cooperatives to submit to the Minnesota Commissioner of Health all "contracts and business or financial arrangements under 62R.06." The bills then require the Commissioner to "review and authorize" the submitted contracts and business or financial arrangements.

Although the bills set up a scheme for state review, the nature of that review is limited. Indeed, both bills effectively establish a presumption in favor of approval. Unless the Commissioner makes an affirmative disapproval of an application, it will automatically be deemed approved 60 days after initial submission (if no additional information is requested), or 60 days after the submission of any additional information requested by the Commissioner. The Commissioner may not deny an application absent an affirmative determination of harm: "[t]he commissioner shall not deny any application unless the commissioner determines . . . that: (1) the anticompetitive effects of the arrangement on the marketplace exceed the procompetitive effects or efficiencies, or that any price agreements included in the arrangement are not necessary to achieve the efficiencies that are expected to result from the arrangement; or (2) the applicant has not provided complete or sufficient information requested by the commissioner to evaluate the impact of the proposed arrangement on the health care marketplace." Thus, as long

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[6] We have asked the MRHC representatives to notify the relevant legislative committees that their prior representations of FTC staff views were not accurate.

[7] Chapter 62R already purports to exempt at least certain health care cooperative activity from antitrust challenge, but contains no mechanism for state supervision.
2008 Minnesota Statutes, § 62R.06, subd. 3, https://www.revisor.leg.state.mn.us/statutes/?id=62. This absence of state supervision means this provision cannot provide immunity from federal antitrust law. *See infra*. We understand that the bills are substantially similar to one that the Minnesota Legislature passed last year, but that did not become law due to a veto by the Governor of the larger bill within which the legislation was included.

as the applicant provides the information requested by the Commissioner, within a very limited time, the Commissioner must evaluate the potential competitive effects of the application, the potential efficiencies of the application, and determine which of these effects exceeds the other. Unless the Commissioner denies the application within 60 days, the application is approved by default.

Collective Bargaining by Health Care Providers Does Not Serve the Public Interest

Allowing health care professionals to collectively bargain will likely harm consumers. In brief, FTC staff has the following specific concerns:

- An exemption for collective bargaining by health care professionals would allow conduct that would otherwise constitute unlawful price fixing or other serious antitrust violations. The Commission's experience investigating numerous cases of collective bargaining by competing health care providers has shown that an antitrust exemption for such joint negotiations would cause consumers and employers, as well as federal, state, and local governments, to pay higher prices for health care.

- Such an exemption is not necessary to enable health care providers to negotiate collectively with health plans in various circumstances in which competition will be increased and consumers are likely to benefit. The Federal Trade Commission and the Department of Justice have issued health care policy statements that explain how health care providers can organize networks and other joint arrangements to deal collectively with health plans and other purchasers without running afoul of the antitrust laws.[8]

- An antitrust exemption for collective bargaining is not the way to improve health care quality. Immunizing collective bargaining imposes costs without any guarantee that patients' interests in quality care would be served.

We address these points in greater detail below.

The Bills Will Likely Raise Health Care Costs

H.F. No. 120 and S.F. No. 203 would permit health care providers, acting through health care cooperatives, to act collectively to compel purchasers and payers to pay higher prices to those providers in order to offer the providers' services to consumers. Private payers and governmental purchasers necessarily will pass along the cost of those higher prices to customers, employees, and taxpayers. The bill's oversight provision will not protect consumers from price fixing.

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[8] *See* FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (August 1996) *available at* http://www.ftc.gov/ reports/ hlth3s.htm.

Two Commission settlements illustrate the type of harm that can occur. Collective fee demands by pharmacists in the State of New York in the 1980s cost the state an estimated $7 million in increased health benefits expenditures for state employees.[9] Morever, thirty-one anesthesiologists in Rochester, New York, allegedly conspired to increase their fees by negotiating collectively with third-party payers over reimbursement terms, by agreeing to threaten not to participate in certain health plans unless their fee demands were met and by actually de-participating when the payers rejected those demands.[10] We are aware that the anesthesiologists subsequently settled a private class action lawsuit for the same conduct for approximately $940,000, which was distributed to approximately 24,000 patients who allegedly were overcharged as a result of the anesthesiologists' challenged conduct.

A Congressional Budget Office (CBO) analysis of a federal bill to create antitrust exemptions for health care providers noted the bill's likely negative effects on private insurers and businesses, state tax revenues, and premiums for state-sponsored health insurance programs for their employees. The CBO estimated that this exemption would increase state expenditures for Medicaid and the State Children's Health Insurance Program (SCHIP) by $120 million in 2001 and by $2.3 billion over the 2001-2005 period.[11] Proportionally similar effects in Minnesota, albeit at higher levels due to cost increases and inflation since then, can be expected if the pending Minnesota bills are enacted.[12]

The CBO noted that "[b]y increasing costs to private health plans, [the bill] would result in higher private health insurance premiums. In the case of employer-sponsored health plans,

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[9] *Peterson Drug Company*, 115 F.T.C. 492, 540 (1992); *see also Pharmaceutical Society of the State of New York, Inc.*, 113 F.T.C. 661 (1990) (consent order).

[10] *Rochester Anesthesiologists,* 110 F.T.C. 175 (1988) (consent order).

[11] *See* Congressional Budget Office Cost Estimate, H.R. 1304, Quality Health-Care Coalition Act of 1999 (March 15, 2000) at 5, available at http://www.cbo.gov. A study of the possible effects of the same exemption legislation on private payers prepared by Charles River Associates, Inc., on behalf of the Health Insurance Association of America, concluded that, if enacted, the bill could "increase private health insurance premiums by 5 to 13 percent," and "could increase national personal health care expenditures by $29 to $95 billion annually." *See* Charles River Associates, Inc., for Health Insurance Association of America, "Comments on American Medical Association-Sponsored Critique of Charles River Associates Study on Physician Antitrust Waivers" at 1 (April 6, 2000); Charles River Associates, Inc., for Health Insurance Association of America, "Updated National Projections, The Cost of Physician Antitrust Waivers" (March 3, 2000).

[12] In a recent article, Minnesota Governor Pawlenty stated that "[b]etween 2000 and 2006, healthcare spending in Minnesota increased more than 60%, from $19 billion to more than $30 billion." Gov. Tim Pawlenty, "The Minnesota Way," 39 *Modern Healthcare* 20 (January 19, 2009). Referring to Minnesota's 2008 healthcare reform legislation as "a crucial first step in . . . payment reform," and noting that Minnesota "is not immune to the current healthcare system's uneven quality and out-of-control costs," Governor Pawlenty called for a healthcare payment system that rewards value, rather than volume, and that will improve healthcare quality. We believe that the anticompetitive conduct that would be authorized by H.F. No.120 and S.F. No. 203 is inconsistent with Minnesota's health care reform goals.

higher premium contributions charged to employers would be passed on to employees in the form of lower cash wages and other fringe benefits," which in turn, "would lead to lower . . . state tax revenues."[13] Minnesota taxpayers, government, businesses, and employees of those businesses all will bear the burden of the higher prices that the bills will authorize health care cooperatives and their members to demand. Employers are likely to reduce or eliminate coverage for their employees, or to pass on to them more of those costs through higher insurance contribution rates, co-payments, and deductibles, or reduced coverage. Enactment of legislation to authorize certain health care providers to fix prices and artificially raise costs to businesses that provide health care benefits to their employees and to the taxpaying public appears particularly unjustifiable in the current economic environment.

The bills' provisions for state oversight would not ensure that consumers are protected from the significant harm likely to occur as a result of state-sanctioned price fixing. Apart from instances in which a contract application is incomplete or sufficient information to evaluate the application is not submitted to the reviewing official, the reviewing official may deny a contract application only after determining that the contract's anticompetitive effects exceed any procompetitive effects or efficiencies. Such a determination requires extensive factual investigation and analysis. Yet the bills require the investigation and analysis to be completed within a very limited time.[14] Further, it is also likely that an inquiry to determine the net competitive effects of a proposed contract could be done only if the regulator had access to data not likely to be in the hands of either the regulator or the parties to the contract. Absent access to compulsory process, however, the Commissioner is likely to have difficulty obtaining the necessary information from third parties within the short time limits that the bills provide. It is not clear, moreover, that the bills' designated reviewing officials would have the relevant expertise or the capability, including the appropriate resources, to make the kinds of evaluations and determinations regarding competition and market effects that are required if an application is to be denied.

Although the existing statute that the bills seek to amend bars a health care provider cooperative from engaging in acts of "coercion, intimidation, or boycott, or any concerted refusal to deal with, any health plan company seeking to contract with the cooperative on a

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[13] Congressional Budget Office Cost Estimate, H.R. 1304, *supra* note 12, at 1.

[14] The bills' default position, whereby a contract or other proposal would be deemed approved unless affirmatively rejected based on the bills' specified criteria and finding requirements, inverts the current legal standard applicable to such conduct under the antitrust laws. Long-established antitrust standards consider price agreements among competitors to be presumptively anticompetitive and unlawful unless they are shown by the participants to be reasonably necessary to create or further some procompetitive, efficiency-enhancing, joint activity. Even then, the price agreements may still be held unlawful after further analysis, if the participants possess market power and the overall effect of the activity in the market, on balance, is determined to be anticompetitive. *See, e.g., North Texas Specialty Physicians*, 2005-2 Trade Cas. (CCH) ¶ 75,032, *aff'd. sub nom. North Texas Specialty Physicians v. FTC*, 528 F.3d 346 (5th Cir. 2008); *Polygram Holding, Inc.,* 5 Trade Reg. Rep. (CCH) ¶ 15,453 (FTC 2003), *aff'd. sub nom. Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005).

competitive, reasonable, and nonexclusive basis,"[15] such a provision is unlikely to be effective. First, it will be difficult, if not impossible, to enforce. Coercion, intimidation, boycotts, and concerted refusals to deal are beyond the bill's protection only if the health plan offers "competitive" and "reasonable" terms. But it is unclear who decides which offers are "competitive" or "reasonable" or what the criteria are for determining whether the offers meet these tests. Second, even if cooperatives do not resort to overt coercion, their collective bargaining would still present a serious risk of anticompetitive harm. Collective negotiations by their very nature can convey an implicit threat that, if the health plan does not agree to terms acceptable to the physician group, the plan will be unable to obtain agreements with group members.[16] And the bills' immunity for collective bargaining would facilitate extensive communication among providers as to what prices they will accept. That could lead to secret agreements among the providers to refuse to deal except on collectively determined terms that, though not immune, would be difficult to detect and prosecute.

Finally, even if the bills work as intended, they still would lead to higher health care costs. The bills allow providers to agree on the fees that they will accept in their negotiations before they obtain the required approval. Thus, even if a contract were ultimately denied, the providers would have already agreed on acceptable price terms. The risk that such an agreement on fees would spill over into individual negotiations on price terms is substantial.

The Bills Are Not Likely to Improve Quality of, or Access to, Care

Despite the bills' references to improved access, quality, and competition, nothing in the bills would assure that these policy goals would be furthered. Allowing competing physicians and other health care providers to act as a price-fixing cartel through health care cooperatives, would not improve access to those services or increase competition. To the contrary, such higher prices will make it more difficult for consumers to gain access to needed services due to part or all of those costs being passed on to consumers by institutional purchasers and payers. Nor would higher payments to health care provider members of cooperatives provide any assurance of improved quality.

Further, the bills' presumption in favor of approval may allow cooperatives to impose terms and conditions for participation that restrict non-price competition in ways that directly undermine the goals of improved health care quality or access. For example, if the terms and conditions for participation in a cooperative specify doctors' office hours, participating doctors

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[15] Section 62R.08.

[16] *See Michigan State Medical Society*, 101 F.T.C. 191, 296 n. 32 (1983) ("the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained"); *see also Preferred Physicians Inc.*, 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences is inherent in collective negotiations).

could not compete by offering longer hours during the day or on weekends, impeding some patients' access to health care services.[17]

The Bills Are Unnecessary to Promote Arrangements That Will Benefit Consumers

There is no need to authorize price fixing to promote health care cooperative arrangements. Health care cooperatives currently operate in Minnesota, and to the extent that joint activity by health care cooperatives – including joint contracting for efficiency-enhancing, integrated programs – is intended and likely to create efficiencies, improve quality of and access to care, and have an overall procompetitive effect in the market, the antitrust laws already permit such conduct. The Federal Trade Commission and its staff have provided substantial guidance regarding how such arrangements can operate and will be evaluated under long-standing antitrust law principles.[18] The bills' exemption is simply unnecessary to permit that kind of legitimate activity. However, regardless of their stated intent to improve health care quality and access and to control costs, the bills' provisions condone conduct by health care cooperatives and their members that does nothing more than aggregate the participants' market power and use that power to demand higher payments for their services.

The Bills May Not Create State Action Immunity

The antitrust immunity that the bills are intended to confer can only be effective if there is adequate state supervision of the collective bargaining activities authorized by the statute.[19] For a law to exempt private conduct from antitrust laws, the state, among other things, must actively supervise the conduct at issue. Under Supreme Court precedent, this requirement means that purportedly state-approved rates or prices must be "established as a product of deliberate state intervention, not simply by agreement among private parties."[20] Here, it is unclear that the state's review will be sufficient to protect private parties from antitrust liability because (1) the state's review must occur in a limited time, (2) the rates are effective before state approval, and (3) the

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[17] Along with potentially undermining goals of improved health care quality and access, "collective bargaining over other, more clearly 'non-price' issues in a health plan contract can have a substantial effect on the ultimate costs paid by consumers." *See* the Prepared Statement of the Staff of the Bureau of Competition and the Office of Policy and Planning Before the Committee on Labor and Commerce, Alaska House of Representatives: The Threat of Consumer Harm Resulting from Physician Collective Bargaining Under Alaska Senate Bill 37, March 22, 2002, http://www.ftc.gov/be/hilites/cruz020322.shtm.

[18] *See supra* note 2.

[19] *Parker v. Brown,* 317 U.S. 341, 351 (1943).

[20] *Federal Trade Commission v. Ticor Title Insurance Co.,* 504 U.S. 621, 634-35 (1992).

rates are deemed approved even if no decision is made.[21] Thus, even if the legislature passes the bills, health care cooperatives may still be subject to federal antitrust laws.

Finally, we note that state action immunity is not retroactive. Even if there is state supervision sufficient to exempt a health care cooperative's conduct from the application of the federal antitrust laws, immunity would only arise for future supervised conduct. Past conduct that violated the federal antitrust laws would not be immune from prosecution.

* * *

In summary, based on our expertise in analyzing competition in health care markets, we believe the bills, if enacted, would harm Minnesota consumers through higher prices for health care services, higher insurance premiums, lower levels of insurance coverage, and lower wages. All Minnesota taxpayers, moreover, would likely bear the burden of this proposal as state-sponsored insurance programs would have to pay more to provide coverage for the most vulnerable segments of the population.

We hope you find these comments helpful. Should you have any additional questions, please do not hesitate to contact Markus H. Meier, Assistant Director, Health Care Division, at 202-326-3759.

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[21] *Id.* at 634-35 ("prices or rates are set as an initial matter by private parties, subject only to veto if the State chooses to exercise it, the party claiming immunity must show that state officials have undertaken the necessary steps to determine the specifics of the rate setting scheme").

Respectfully submitted,

_____
David P. Wales, Jr.
Acting Director
Bureau of Competition

_____
James C. Cooper
Acting Director
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Bureau of Economics

U.S. Department of Justice

Antitrust Division

EXHIBIT 9

Liberty Square Building
450 5th Street, N.W.
Suite 4000
Washington, D.C. 20530-0001

May 18, 2011

Representative Phillip Johnson
State Representative, 78th Legislative District
104 War Memorial Building
Nashville, Tennessee 37243

RE: Proposed Repeal of State Action Exemption for Public Hospitals

Dear Chairman Johnson:

You have requested that the Antitrust Division comment on a proposed amendment to Tennessee law that would repeal the state's antitrust exemption for "private act metropolitan hospital authorities" (also known as public hospitals) found in Tenn. Code Ann. § 7-57-501 et seq.[1] The Antitrust Division believes that by enabling the antitrust laws to apply to the conduct of public hospitals in Tennessee, this amendment will help promote hospital competition to the benefit of Tennessee consumers.

1. Background

Tenn. Code Ann. § 7-57-501 et seq. grants broad authority to public hospitals in Tennessee. Under this statute, public hospitals may exercise "all powers necessary or convenient to effect any or all the purposes for which [they are] organized,"[2] and they may do so "regardless of the competitive consequences."[3] In 2005, the U.S. Court of Appeals for the Sixth Circuit held that this statute creates an antitrust exemption for public hospitals for a wide range of potentially anticompetitive actions, including exclusive contracts with health insurers. *See Jackson, Tennessee Hosp. Co., LLC v. West*

[1] Letter from Representative Phillip Johnson, Tennessee House of Representatives, to Scott Fitzgerald, Attorney, Litigation I Section, Antitrust Division, U.S. Department of Justice, April 21, 2011.

[2] § 7-57-502(b)(10).

[3] § 7-57-502(c).

Tennessee Healthcare, Inc., 414 F.3d 608, 612 (6th Cir. 2005) ("*Jackson*") (holding that the plain language of the Tennessee statute is "most sensibly read as an [express] authorization to act without regard for the antitrust laws").[4]

Your letter describes the potential impact of the current law on two acute-care hospitals in Jackson, Tennessee. One hospital, Jackson-Madison County General Hospital, is a 635-bed facility chartered as a public hospital; the other, Regional Hospital of Jackson ("Regional Hospital"), is a 154-bed privately owned hospital. Jackson-Madison County General Hospital is part of a larger system of affiliated hospitals operating as West Tennessee Healthcare. Your letter states that Jackson-Madison County General Hospital has "used its organizational structure, size and market presence to demand exclusive insurance contracts with many of the major insurance plans…for the past fifteen years."[5] It is the Antitrust Division's experience that such exclusive contracts can restrict competition between hospitals and harm consumers.

2. Competition in Health Care

Although the Antitrust Division has not investigated hospital competition in the Jackson, Tennessee region, it has analyzed competition in health-care markets for many years. For example, during the Division's extensive health-care hearings with the Federal Trade Commission in 2003, the federal agencies obtained substantial evidence about the role of competition in health care and concluded that vigorous competition among health-care providers—including hospitals—"promotes the delivery of high-quality, cost-effective health care."[6]

The Division has also had extensive experience in analyzing the application of the state action doctrine to health-care providers. Together with the FTC, the Division has long opposed unwarranted extensions of the state action doctrine. Our concerns about extensions of the state action doctrine are informed by the fundamental principle that market forces tend to improve the quality and lower the costs of health-care goods and services.

In our antitrust investigations, we often hear the argument that health care is "different" and that competition principles do not apply to the provision of health-care services. However, this proposition is not supported by the evidence or law.[7] Similar arguments made by engineers and lawyers—that competition does not work and, in fact

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[4] In *Jackson*, the court did not require the defendant to show that its conduct was actively supervised by the state. *Id.* at 612, n.5.

[5] Letter from Rep. Phillip Johnson, *supra* note 1.

[6] Fed. Trade Comm'n and U.S. Dep't of Justice, Improving Health Care: A Dose of Competition (2004), Executive Summary at 4.

[7] *See id.*

is harmful to public policy goals—have been rejected by the courts, and private restraints on health-care competition have long been condemned.

Moreover, just as competition between hospitals can lead to lower prices and higher-quality care, so, too, restraints on competition by hospitals can lead to lower quality and more expensive care. Accordingly, the Antitrust Division has pursued formal investigations and prosecutions across the full range of health-care products and services, including challenges to anticompetitive vertical arrangements between hospitals and health insurers.

Most recently, the Antitrust Division brought an enforcement action challenging *de facto* exclusive contracts with commercial health insurers obtained by United Regional Health Care System, the dominant, not-for-profit hospital in Wichita Falls, Texas.[8] United Regional was formed in October 1997 by the merger of what were then the only two general acute-care hospitals in Wichita Falls. To complete the 1997 merger, the two hospitals sought and obtained an antitrust exemption from the Texas legislature relating to the merger.[9] Shortly after the legislature permitted the merger, a group of doctors began planning for a hospital that would compete with United Regional. United Regional responded to this threat by systematically entering into contracts that contained a significant pricing penalty if an insurer contracted with United Regional's rivals. As a result, United Regional's rivals could not obtain contracts with most insurers.

In February 2011, the United States and the State of Texas filed a complaint that challenged United Regional's contracts, which alleged that by denying United Regional's rivals access to most insurers, United Regional had (1) delayed and prevented the expansion and entry of United Regional's competitors; (2) limited price competition for price-sensitive patients; and (3) reduced quality competition between United Regional and its competitors. The United States and Texas settled the case by entering into a consent decree with United Regional that prohibits United Regional from using exclusive and other types of anticompetitive contracts with insurers.

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[8] *United States and State of Texas v. United Regional Health Care System*, No. 7:11-cv-00030-O (N.D. Tex., Feb. 25, 2011).

[9] In 1997, the Texas Legislature enacted Tex. Health & Safety Code Ann. § 265.037(d), which provides that a county-city hospital board "existing in a county with a population of more than 100,000 and a municipality with a population of more than 75,000 . . . may purchase, construct, receive, lease, or otherwise acquire hospital facilities, including the sublease of one or more hospital facilities, regardless of whether the action might be considered anticompetitive under the antitrust laws of the United States or this state." In an attempt to qualify for the state action antitrust exemption enacted by the legislature, the two hospitals entered into a leasing arrangement that involved the local county-city hospital board.

3. Analysis

The Antitrust Division believes that repealing the state action exemption for public hospitals in Tennessee will likely promote competition and benefit consumers. In the *United Regional* case, the Antitrust Division and Texas challenged United Regional's contracting practices because we did not think that the antitrust exemption under Texas law (that allowed for United Regional's formation) extended to United Regional's contracting practices. By contrast, if a public hospital in Tennessee engaged in similar conduct, under current state law, that conduct would be exempt from an antitrust challenge under *Jackson*.

As explained above, anticompetitive conduct by dominant hospitals—including dominant *public* hospitals—can lead to higher prices and lower quality to Tennessee's health-care consumers. This type of conduct can include exclusive contracting with commercial insurers, as illustrated by the *United Regional* case. It can also include anticompetitive acquisitions, unlawful predatory pricing, certain types of economic credentialing, and even horizontal agreements with competitors. By repealing the antitrust exemption, this type of conduct could be investigated, prosecuted, and deterred—helping protect competition.

Thank you for the opportunity to comment. In conclusion, we urge the Tennessee legislature to adopt the legislation under consideration, which may be expected to bring the salutary benefits of hospital competition to health-care consumers in Tennessee.

Sincerely yours,

Joshua H. Soven

Joshua H. Soven
Chief, Litigation I Section
Antitrust Division

UNITED STATES OF AMERICA

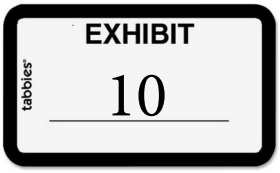
FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

May 18, 2011

Representative Elliott Naishtat
Texas House of Representatives
P.O. Box 2910
Austin, TX 78768-2910



Dear Representative Naishtat:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] are pleased to respond to your request for comments on the antitrust provisions of Texas Senate Bill 8 ("S.B. 8" or "the Bill"). The Bill, among other things, apparently intends to exempt certified "health care collaboratives" from state and federal antitrust laws. The exemption is aimed at immunizing a collaborative's contract negotiations with payors but appears to extend to a broad range of other activities as well. We are concerned that the antitrust provisions of the Bill, if enacted as passed by the Texas State Senate, are likely to lead to dramatically increased costs and decreased access to health care for Texas consumers. The review provisions in the Bill appear unlikely to prevent these harmful effects.

The Bill is not needed to allow procompetitive cooperative activities by health care providers, because antitrust law already permits collaboration that benefits consumers. To the extent that S.B. 8 is designed to authorize conduct not already permitted under the antitrust laws, it threatens to deprive health care consumers of the benefits of competition. In addition, the regulatory regime contemplated by the Bill may be insufficient to meet the rigorous standards required to confer state action immunity from the federal antitrust laws.

Interest and Experience of the Federal Trade Commission

Congress has charged the Federal Trade Commission ("FTC" or "Commission") with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in commerce.[2] Pursuant to its statutory mandate, the FTC seeks to identify business practices and governmental

[1] This letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Federal Trade Commission (Commission) or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] Federal Trade Commission Act, 15 U.S.C. § 45.

regulations that may impede competition without also offering countervailing benefits to consumers.

Health care competition is critically important to the economy and consumer welfare. For this reason, anticompetitive conduct in health care markets has long been a key focus of FTC activity. The agency has brought numerous antitrust enforcement actions involving the health care industry.[3] In addition, the Commission and its staff have given testimony,[4] issued reports[5] and engaged in advocacy to state legislatures regarding various aspects of competition in the health care industry. Of particular relevance, the Commission and its staff have long advocated against federal and state legislative proposals that would create antitrust exemptions for collective negotiations by health care providers when such exemptions are likely to harm consumers.[6]

[3] *See* Federal Trade Commission, Overview of FTC Antitrust Actions in Health Care Services and Products, Sept. 2010, available at: http://www.ftc.gov/bc/110120hcupdate.pdf.

[4] *See* Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Subcomm. On Courts and Competition Policy, On "Antitrust Enforcement in the Health Care Industry," Dec. 1, 2010; Prepared Statement of the Fed. Trade Comm'n Before the Subcomm. On Consumer Protection, Product Safety, and Insurance, Comm. on Commerce, Science & Transportation, On "The Importance of Competition and Antitrust Enforcement to Lower-Cost, Higher-Quality Health Care," July 16, 2009 (all testimonies available at: http://www ftc.gov/ocr/testimony/index.shtml).

[5] *See* FED. TRADE COMM'N, EMERGING HEALTH CARE ISSUES: FOLLOW-ON BIOLOGIC DRUG COMPETITION (Jun. 2009); FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005); FED. TRADE COMM'N AND DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (Jul. 2004) (all reports available at: http://www.ftc.gov/reports/index.shtm).

[6] *See* FTC Staff Comment to Rep. Tom Emmer of the Minnesota House of Representatives Concerning Minnesota H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009); FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008); FTC Staff Comment Before the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008) (all advocacies available at: http://www.ftc.gov/opp/advocacy_date.shtm); *also* Letter to Hon. Rene O. Oliveira, Concerning Texas Physician Collective Bargaining (May 1999) (available at: http://www ftc.gov/be/v990009.shtm); *also* Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Concerning H.R. 1304, the "Quality Health-Care Coalition Act of 1999," June 22, 1999, available at: http://www ftc.gov/os/1999/06/healthcaretestimony htm.

The Texas Bill

S.B. 8 allows establishment of "health care collaboratives" -- organizations that may consist of physicians and other health care providers, including hospitals -- and is apparently intended to provide them with an exemption from the antitrust laws. That immunity would extend to a collaborative's negotiations of all contracts with payors, both governmental and private.[7] According to the Bill's preamble, the antitrust exemption is considered necessary to "explore innovative health care delivery and payment models [and] to give health care providers the flexibility to collaborate and innovate to improve the quality and efficiency of health care."[8] The preamble also states that the Bill is not intended to authorize what would otherwise be per se violations of the antitrust law.[9]

To qualify as a health care collaborative, an organization must be certified by the Commissioner of the Texas Department of Insurance.[10] To be certified, a collaborative must be able to demonstrate that it has processes in place to contain costs and evaluate health care quality. It must also show:

> the willingness and potential ability to ensure that the health care services be provided in a manner that: (i) increases collaboration among health care providers and integrates health care services; (ii) promotes quality-based health care outcomes, patient engagement, and coordination of services; and (iii) reduces the occurrence of potentially preventable events.[11]

[7] S.B. 8, § 1.01(c) (Tex. 2011).

[8] S.B. 8, § 1.01(a)(1) and (3) (Tex. 2011).

[9] S.B. 8, § 1.01(c) (Tex. 2011).

[10] S.B. 8, § 848.054 (Tex. 2011).

[11] S.B. 8, § 848.057 (Tex. 2011).

Under the Bill, the Department of Insurance must approve a health care collaborative upon finding that: (1) it is "not likely to reduce competition in any market for physician, hospital, or ancillary health care services" due either to the size of the health care collaborative or its composition; and (2) it is "not likely to possess market power."[12] Within six months of approval, a health care collaborative must seek renewal of its certification based, among other factors, on a review of financial statements and an evaluation of the quality and cost of its health care services.[13] The Bill appears not to require certification renewals after that point. The Department of Insurance, however, will be authorized to revoke a certification when there have been changes in market conditions or in a collaborative's composition that are likely to reduce competition. The Attorney General must review the adequacy of the Department's findings within 60 days, although the bill provides no standards for conducting the review.[14]

The Likely Effects of S.B. 8

The antitrust exemption in the Bill is unnecessary to promote health care benefits to consumers through collaboratives. This is because the antitrust laws *already* allow procompetitive collaborations among competitors. To the extent that the Bill goes beyond that and would allow coordinated activity among health care competitors beyond that permitted by the antitrust laws, it poses a substantial risk of consumer harm, by increasing costs and decreasing access to health care. Even with some oversight by the Department of Insurance and the Attorney General, that consumer harm may be difficult to prevent once a collaborative is certified.

(a) <u>The Bill Is Unnecessary to Promote Arrangements That Will Benefit Consumers</u>

Federal antitrust law already permits joint activity by health care collaboratives that is reasonably necessary to create efficiencies, improve quality of and access to health care, and have an overall procompetitive effect. Antitrust standards distinguish between effective clinical integration among health care providers that has the potential to achieve cost savings and improve health outcomes and anticompetitive collaboration and price fixing by health care providers, which is likely to increase health care costs. In fact, in order to promote such activity, the FTC and its staff and the Department of Justice ("DOJ") have provided substantial guidance regarding how health care providers can integrate their clinical operations in such a way as to achieve cost savings and improve health care outcomes. [15] We therefore see no need for new legislation to authorize

[12] Id.

[13] S.B. 8, § 848.060 (Tex. 2011).

[14] S.B. 8, § 848.059 (Tex. 2011).

[15] Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy In Health Care* (1996), available at: http://www.ftc.gov/bc/healthcare/industryguide/policy/index htm; TriState Health Partners, Inc., Letter from Markus Meier, FTC to Christi Braun, Ober, Kaler, Grimes & Shriver, April 13, 2009; Greater Rochester Independent Practice Association, Inc., Letter from Markus Meier, FTC to Christi Braun & John J. Miles, Ober, Kaler, Grimes & Shriver, September 17, 2007, letters available at:

collaboratives and collective negotiations.

(b) The Bill Poses a Substantial Risk of Consumer Harm

The Bill as written goes beyond the current law and appears intended to extend broad antitrust immunity to health care collaboratives. Regardless of any stated intent by a collaborative to improve health care quality and control costs, the practical effect of the Bill will be to exempt anticompetitive conduct from antitrust scrutiny. We think this would pose an unnecessary and substantial risk of consumer harm.

It is well-recognized that antitrust exemptions routinely threaten broad consumer harm for the benefit of a few. The bipartisan Antitrust Modernization Committee observed "[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality and reduced innovation."[16] Although the Bill would not exempt conduct that amounts to a "per se" violation of the antitrust laws, the Bill appears intended to shield a broad range of anticompetitive conduct from antitrust challenge. This may cover anticompetitive mergers and acquisitions as well as a range of agreements among competitors that, although not strictly speaking per se illegal, are so inherently likely to injure competition that they are condemned under the rule of reason absent any plausible procompetitive justification.[17]

In addition, it is not likely that the Department of Insurance's consideration of competition concerns and the Attorney General's review will protect consumers from the harmful effects of this legislation, for a number of reasons. The initial review of a health care collaborative is limited in scope, and even the more detailed review that may occur upon certificate renewal may not be sufficient. Further, it is not clear that the Department of Insurance has the necessary expertise to conduct the type of fact-intensive, time-consuming analysis of competition and market power needed to protect consumers. Even if the Department does find a problem, the grounds for revocation are limited. Indeed, if a health care collaborative uses its market power to increase prices for consumers, there is

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http://www ftc.gov/bc/healthcare/industryguide/advisory.htm; *also* Fed. Trade Comm'n & U.S. Dep't of Justice, *Antitrust Guidelines for Collaborations Among Competitors*, April 2000, available at: http://www ftc.gov/os/2000/04/ftcdojguidelines.pdf. Most recently, the FTC and DOJ released a joint statement explaining how the reviewing antitrust agency will enforce U.S. antitrust laws against the new Accountable Care Organizations – groups of health care providers that, if they are likely to lower costs and cause improvements in the availability of health care, will be permitted under the Affordable Care Act of 2010 to operate. (Fed. Trade Comm'n and the Antitrust Division of the Department of Justice: Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating In the Medicare Shared Savings Program, available at: http://www ftc.gov/os/fedreg/2011/03/110331acofrn.pdf.).

[16] Antitrust Modernization Commission, Report and Recommendations (April 2007) at 335, available at: http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[17] Many such agreements are considered to be "inherently suspect" because they are very likely to harm consumers, and thus receive summary condemnation. *See North Texas Specialty Physicians v. FTC*, 528 F.3d 352 (5th Cir. 2008); *Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005);

no provision for remedying this harm. Moreover, there is no mandatory review of a collaborative's status after the first year. Finally, the extent of and time allotted for the Attorney General's review are limited and the standards under which the Attorney General can find a determination inadequate are unclear. Thus, the review provisions are not adequate to protect consumers from the likely harm created by the Bill.

The Bill May Not Create State Action Immunity

The antitrust immunity that the Bill purports to confer on private health care collaboratives is effective only if the State of Texas has clearly articulated an intention to replace competition in this area with a regulatory scheme, and actively supervises this private conduct.[18] The active supervision test seeks to determine "whether the State has exercised sufficient independent judgment and control so that the details [of the restraint] have been established as a product of deliberate state intervention, not simply by agreement among private parties."[19] As explained by the Supreme Court in *Patrick v. Burget*, state officials must "have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy."[20]

Here, the State's review proposed under the Bill does not appear sufficient to protect consumers from the potential anticompetitive effects of collaborations that do not further the goals of the legislation. Notably, the Bill does not appear to mandate *any ongoing* state supervision of health care collaboratives after the initial approval and one-time renewal processes. The State, for example, under the Bill as written, would not require that its officials review contracts and fee arrangements between collaboratives and payors to assess whether they in fact comport with State policy goals, and to remedy situations that may violate those goals. Parties claiming antitrust immunity under the state action doctrine bear the burden of establishing that they are entitled to such immunity. As the Supreme Court has made clear, this is a high bar. The regulatory program proposed by the Bill appears not to meet that bar.

Conclusion

Our analysis of S.B. 8 suggests that its passage poses a significant risk of increased health care costs and decreased access to care for Texas consumers. The antitrust immunity provisions in this legislation are unnecessary and will allow private health care collaboratives to engage in unsupervised anticompetitive conduct. In summary, FTC staff is concerned that this legislation is likely to foster anticompetitive conduct that is inconsistent with federal antitrust law and policy, and that such conduct could work to the detriment of Texas health care consumers.

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[18] *Parker v. Brown*, 317 U.S. 341, 351 (1943); Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

[19] *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S. 621, 634 (1992).

[20] 486 U.S. 94, 101 (1988).

We appreciate your consideration of these issues.

Respectfully submitted,

Susan S. DeSanti, Director
Office of Policy Planning

Joseph Farrell, Director
Bureau of Economics

Richard A. Feinstein, Director
Bureau of Competition

UNITED STATES OF AMERICA

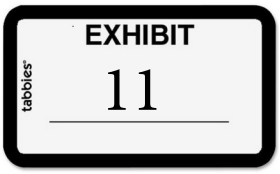
FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

June 8, 2011

Senators Eric D. Coleman and John A. Kissel
Representatives Gerald Fox and John W. Hetherington
Connecticut General Assembly
Room 2500 L.O.B.
300 Capitol Avenue
Hartford, CT 06106-1591



Dear Senators Coleman and Kissel and Representatives Fox and Hetherington:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] are pleased to respond to your request for comments on the antitrust provisions of House Bill No. 6343 ("H.B. 6343" or "the Bill"). The Bill, among other things, intends to exempt health care provider-members of certified "cooperative arrangements" from state and federal antitrust laws.[2] The exemption is aimed at immunizing a cooperative's contract negotiations with managed care organizations, but appears to extend to a broad range of other activities as well. We are very concerned that the antitrust provisions of the Bill, if enacted, are likely to lead to dramatically increased costs and decreased access to health care for Connecticut consumers. The review provisions in the Bill appear unlikely to prevent these harmful effects.

The Bill is not needed to allow procompetitive cooperative activities by health care providers because antitrust law already permits collaborations that benefit consumers. To the extent that H.B. 6343 is designed to authorize conduct not already permitted under the antitrust laws, it threatens to deprive health care consumers of the benefits of competition. In addition, the regulatory regime contemplated by the Bill may be insufficient to meet the rigorous standards required to confer state action immunity from the federal antitrust laws if that is indeed the intent of the Bill.

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[1] This letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Federal Trade Commission (Commission) or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] Although the Bill explicitly grants antitrust immunity only under Connecticut law, for purposes of this letter we assume that the immunity is intended to extend to federal antitrust law as well. *See Town of Hallie v. City of Eau Claire*, 471 US 34, 42 (1985) (state legislature's explicit statement recognizing anticompetitive conduct and expectation of antitrust immunity is not necessary for state action doctrine immunity to apply).

Interest and Experience of the Federal Trade Commission

Congress has charged the Federal Trade Commission ("FTC" or "Commission") with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in commerce.[3] Pursuant to its statutory mandate, the FTC seeks to identify business practices and governmental regulations that may impede competition without also offering countervailing benefits to consumers.

Health care competition is critically important to the economy and consumer welfare. For this reason, anticompetitive conduct in health care markets has long been a key focus of FTC activity. The agency has brought numerous antitrust enforcement actions involving the health care industry.[4] In addition, the Commission and its staff have given testimony,[5] issued reports,[6] and engaged in advocacy to state legislatures regarding various aspects of competition in the health care industry. Of particular relevance, the Commission and its staff have long advocated against federal and state legislative proposals that would create antitrust exemptions for collective negotiations by health care providers when such exemptions are likely to harm consumers.[7]

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[3] Federal Trade Commission Act, 15 U.S.C. § 45.

[4] *See* Federal Trade Commission, Overview of FTC Antitrust Actions in Health Care Services and Products, Sept. 2010, available at: http://www.ftc.gov/bc/110120hcupdate.pdf.

[5] *See* Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Subcomm. On Courts and Competition Policy, On "Antitrust Enforcement in the Health Care Industry," Dec. 1, 2010; Prepared Statement of the Fed. Trade Comm'n Before the Subcomm. On Consumer Protection, Product Safety, and Insurance, Comm. on Commerce, Science & Transportation, On "The Importance of Competition and Antitrust Enforcement to Lower-Cost, Higher-Quality Health Care," July 16, 2009 (all testimonies available at: http://www ftc.gov/ocr/testimony/index.shtml).

[6] *See* FED. TRADE COMM'N, EMERGING HEALTH CARE ISSUES: FOLLOW-ON BIOLOGIC DRUG COMPETITION (Jun. 2009); FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005); FED. TRADE COMM'N AND DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (Jul. 2004) (all reports available at: http://www.ftc.gov/reports/index.shtm).

[7] *See* FTC Staff Comment to the Hon. Elliott Naishtat Concerning Texas S.B. 8 to Exempt Certified Health Care Collaboratives From the Antitrust Laws (May 2011); FTC Staff Comment to Rep. Tom Emmer of the Minnesota House of Representatives Concerning Minnesota H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009); FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008); FTC Staff Comment Before the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008) (all advocacies available at: http://www ftc.gov/opp/advocacy_date.shtm). *See also* Letter to Hon. Rene O. Oliveira, Concerning Texas Physician Collective Bargaining (May 1999) (available at: http://www ftc.gov/be/v990009.shtm); Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Concerning H.R. 1304, the "Quality Health-Care Coalition Act of 1999," June 22, 1999, available at: http://www ftc.gov/os/1999/06/healthcaretestimony htm.

The Connecticut Bill

H.B. 6343 allows the establishment of "cooperative arrangements" – agreements among health care providers – and apparently intends to provide them with an exemption from the antitrust laws upon approval by the Connecticut Attorney General. That immunity would extend to "sharing, allocating or referring patients, personnel, instructional programs, support services or facilities or medical, diagnostic or laboratory facilities or procedures, or negotiating fees, prices or rates with managed care organizations, and includes, but is not limited to, a merger, acquisition or joint venture."[8] The Bill also prohibits managed care organizations from refusing to negotiate "in good faith" with parties in a certified cooperative arrangement. A managed care organization that violates this prohibition is subject to a penalty of up to $25,000 per day.[9]

To qualify as a cooperative arrangement under the Bill, the health care providers must apply for and receive a "certificate of public advantage" from the Connecticut Attorney General.[10] The Attorney General's review of an application must consider the benefits of the arrangement, including "enhancement of the quality of health services to consumers; gains in cost efficiency of providing health services; improvement in utilization of and access to health services and equipment; and avoidance of duplication of health resources."[11] The Attorney General must compare these benefits against any disadvantages, including "the potential reduction in competition; the adverse impact on quality, access or price of health care services to consumers; and the availability of arrangements that achieve the same benefits with less restriction on competition."[12] The Attorney General must then determine whether the "benefits outweigh the disadvantages" and approve or deny the application within ninety days of receiving it.[13]

The Attorney General is also responsible for overseeing the cooperative arrangements by reviewing annual progress reports.[14] If, through this review, the Attorney General determines that the benefits of the cooperative arrangement no longer outweigh the disadvantages, he must hold a hearing to determine whether to revoke or modify the certificate.[15] The Attorney General, however, may not "modify or revoke a certificate of public advantage more than three years after the initial issuance" of the certificate.[16]

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[8] H.B. 6343 § 1(a)(1) (Conn. 2011).

[9] H.B. 6343 § 1(e) (Conn. 2011).

[10] H.B. 6343 § 1(b) (Conn. 2011).

[11] H.B. 6343 § 1(c)(2) (Conn. 2011).

[12] *Id.*

[13] H.B. 6343 § 1(c)(1) (Conn. 2011).

[14] H.B. 6343 § 1(c)(4) (Conn. 2011).

[15] H.B. 6343 § 1(c)(5) (Conn. 2011).

[16] *Id.*

The Likely Effects of H.B. 6343

The antitrust exemption in the Bill is unnecessary to promote health care benefits to consumers through cooperative arrangements. This is because the antitrust laws *already* allow procompetitive collaborations among competitors. The Bill, which is designed to allow coordinated activity among health care competitors beyond that permitted by the antitrust laws, poses a substantial risk of consumer harm by increasing costs, impeding innovation, and decreasing access to health care. Even with oversight by the Attorney General, that consumer harm may be difficult to prevent once a cooperative is certified.

(a) <u>The Bill Is Unnecessary to Promote Arrangements That Will Benefit Consumers</u>

Federal antitrust law already permits joint activity by health care providers that benefits consumers. First, even providers' price agreements are lawful when reasonably necessary to create efficiencies (such as reducing the cost or improving the quality of health care provided to patients), and have an overall procompetitive effect. For example, antitrust standards distinguish between effective clinical integration among health care providers that has the potential to achieve cost savings and improve health outcomes and those provider arrangements that exist merely to give the providers greater bargaining leverage with health plans. Both the FTC and its staff and the U. S. Department of Justice have provided substantial guidance to providers to make clear that the antitrust laws do not prevent health care providers from engaging in beneficial collaborations. [17] The antitrust laws are designed to stop actions that raise prices or inhibit new forms of competition; they do not block activities that benefit consumers. We therefore not only see no need for legislation to authorize collective fee negotiations that would arguably benefit consumers, we are also concerned that any new legislation may instead have the effect of immunizing agreements among providers, and potentially harm consumers.

Second, no antitrust exemption is needed to permit health care providers to

[17] See, e.g., Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy In Health Care* (1996), available at: http://www ftc.gov/bc/healthcare/industryguide/policy/index htm; TriState Health Partners, Inc., Letter from Markus Meier, FTC to Christi Braun, Ober, Kaler, Grimes & Shriver, April 13, 2009; Greater Rochester Independent Practice Association, Inc., Letter from Markus Meier, FTC to Christi Braun & John J. Miles, Ober, Kaler, Grimes & Shriver, September 17, 2007, letters available at: http://www ftc.gov/bc/healthcare/industryguide/advisory.htm. *See also* Fed. Trade Comm'n & U.S. Dep't of Justice, *Antitrust Guidelines for Collaborations Among Competitors*, April 2000, available at: http://www ftc.gov/os/2000/04/ftcdojguidelines.pdf. Most recently, the FTC and DOJ released a joint statement explaining how the reviewing antitrust agency will enforce U.S. antitrust laws against the new Accountable Care Organizations – groups of health care providers that, if they are likely to lower costs and cause improvements in the availability of health care, will be permitted under the Affordable Care Act of 2010 to operate. Fed. Trade Comm'n and the Antitrust Division of the Department of Justice: Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating In the Medicare Shared Savings Program, available at: http://www ftc.gov/os/fedreg/2011/03/110331acofrn.pdf..

discuss their concerns regarding health plan practices, whether among themselves or with health plans. We understand that some supporters of the Bill may be under the impression that any such discussions would violate the antitrust laws. But that is not the case. Health care professionals may, under existing antitrust law, engage in collective advocacy, both to promote the interests of their patients and to express their opinions about other issues, such as payment delays, dispute resolution procedures, and other matters.[18]

(b) The Bill Poses a Substantial Risk of Consumer Harm

The Bill is intended to extend antitrust immunity to a broad range of agreements among health care providers to eliminate competition. Regardless of any stated intent by a health care provider to improve health care quality and control costs, the practical effect of the Bill will be to exempt anticompetitive conduct from antitrust scrutiny. We think this would pose an unnecessary and substantial risk of consumer harm.

It is well-recognized that antitrust exemptions routinely threaten broad consumer harm for the benefit of a few. The bipartisan Antitrust Modernization Committee observed "[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality and reduced innovation."[19] The Bill appears intended to shield a broad range of potentially anticompetitive conduct from antitrust challenge. Such anticompetitive conduct may include cooperative agreements not to compete with regard to patients, procedures, personnel, or support services, agreements on the fees providers will accept from health plans, and agreements that will have the effect of eliminating beneficial competition through merger.

In addition, the Bill's requirement that managed care organizations negotiate with parties to a cooperative agreement – backed up with a potential civil penalty of $25,000 per day for a failure to negotiate "in good faith" – compounds the likely consumer harm.[20] This requirement not only will decrease the incentives of cooperatives to

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[18] The 1996 *Statements of Antitrust Enforcement Policy In Health Care* issued by the Commission and the Department of Justice explain the ways in which antitrust law permits health care providers to collectively provide both fee and non-fee related information to health plans. (Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy In Health Care* (1996), available at: http://www ftc.gov/bc/healthcare/industryguide/policy/index htm) *See also* Letter to Gregory G. Binford (February 6, 2003) (advisory opinion explaining that physicians' proposed formation of advocacy group to collect and disseminate information about health plan policies and procedures, including fees paid to local physicians compared to fees paid in other areas, did not appear likely to have anticompetitive effects). See also American Medical Assn, Model Managed Care Contract (4th Ed. 2005), available at http://www.ama-assn.org/ama1/pub/upload/mm/368/mmcc_4th_ed.pdf.

[19] Antitrust Modernization Commission, Report and Recommendations (April 2007) at 335, available at: http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[20] Antitrust jurisprudence recognizes a party's long-established right to exercise its discretion over with whom it deals. *See United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919).

compete on price and quality, but also threatens the ability of health plans to effectively use selective contracting, a key mechanism for promoting quality and cost-containment goals. Furthermore, the lack of clarity surrounding what constitutes "good faith" negotiation in this context may discourage plans from actively pursuing programs and contract terms that would benefit consumers. Moreover, determining liability based on a failure to negotiate in "good faith" could require courts to assess the reasonableness of prices and other terms of dealing, a role for which they are ill-suited.[21]

It will be difficult, if not impossible, for the Attorney General's review to protect consumers from the harmful effects of this legislation. First, it is not clear that the Attorney General has the necessary funds or available resources to conduct the type of fact-intensive, time-consuming market analysis needed to evaluate the competitive effects of a health care cooperative during the certification process. The time allotted for the Attorney General's review is limited to ninety days and the standards under which the Attorney General may assess the cooperatives are unclear. Second, the Attorney General's ability to remedy the harm caused by an anticompetitive cooperative, once formed, is limited. The Attorney General's oversight relies solely on his or her review of a cooperative's annual "progress report." Moreover, even if the Attorney General finds a cooperative arrangement has caused consumer harm, the power to address such problems is circumscribed by the limited remedy (revocation or modification of certification) as well as the limited grounds for exercising that remedy. Thus, if a cooperative has used its market power to increase prices without countervailing benefit, there is no means to remedy that harm. Third, once three years have passed since a cooperative's certification, the Attorney General has no power to modify or revoke the purported antitrust immunity conveyed by the certification, regardless of the circumstances. Thus, the review provisions will not protect consumers from the likely harm created by the Bill.

The Bill Likely Will Not Create State Action Immunity

The federal antitrust immunity that the Bill apparently purports to confer on cooperative arrangements is effective only if the State of Connecticut has clearly articulated an intention to replace competition in this area with a regulatory scheme, and actively supervises this private conduct.[22] The active supervision test seeks to determine "whether the State has exercised sufficient independent judgment and control so that the details [of the restraint] have been established as a product of deliberate state intervention, not simply by agreement among private parties."[23] As explained by the Supreme Court in *Patrick v. Burget*, state officials must "have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy."[24]

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[21] *Verizon Commc'ns. Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 408 (2004).

[22] *Parker v. Brown,* 317 U.S. 341, 351 (1943); *see also Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

[23] *Federal Trade Commission v. Ticor Title Insurance Co.,* 504 U.S. 621, 634 (1992).

[24] 486 U.S. 94, 101 (1988).

Here, the State's review proposed under the Bill does not appear sufficient to meet the requirements of the state action doctrine. Notwithstanding the requirement that annual progress reports be filed by the health care providers during the initial three-year period, the Bill seemingly would not require State officials to review particular contracts and fee arrangements between groups of providers and payers to assess whether they comport with State policy goals (including but not limited to the goals stated under section 1(c)(2) of the Bill), and to remedy on an ongoing basis situations that may violate those goals. Notably also, the Bill does not appear to mandate *any* state monitoring and review of cooperative arrangements three years after the initial issuance of a certificate. As the Supreme Court has made clear, parties claiming state action immunity face a high bar. The regulatory program proposed by the Bill appears not to clear that bar.

Conclusion

Our analysis of H.B. 6343 suggests that its passage would pose a significant risk of increased health care costs and decreased access to care for Connecticut consumers. The antitrust immunity provisions in this legislation are unnecessary and would allow groups of private health care providers to engage in unsupervised anticompetitive conduct. In summary, FTC staff is concerned that this legislation is likely to foster anticompetitive conduct that is inconsistent with federal antitrust law and policy, and that such conduct could work to the detriment of Connecticut health care consumers.

We appreciate your consideration of these issues.

Respectfully submitted,

Susan S. DeSanti, Director
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Joseph Farrell, Director
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Richard A. Feinstein, Director
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UNITED STATES OF AMERICA

FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

October 20, 2011

Senator John J. Bonacic
New York State Senate
201 Dolson Avenue, Suite F
Middletown, NY 10940

Dear Senator Bonacic:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] are pleased to respond to your request for comment on New York Senate Bill S.3186-A ("S.B. 3186" or "the Bill"), known as the "Health Care Consumer and Provider Protection Act," which would authorize independent health care providers to negotiate collectively a variety of contract provisions with certain health plans, including fees and other non-fee-related matters. We are concerned that the Bill, if enacted, will likely lead to increased costs, reduced innovation, and decreased access to health care for New York consumers, without countervailing benefits. We therefore recommend that the Bill be rejected by the New York State Assembly.

The Federal Trade Commission has consistently opposed legislative proposals to grant antitrust exemptions for collective negotiations among health care providers. Antitrust law already permits collaborations that benefit consumers, so the Bill is not needed to allow truly procompetitive cooperative activities by health care providers. To the extent that S.B. 3186 is designed to authorize conduct not already permitted under the antitrust laws, the Bill threatens to deprive health care consumers of the benefits of competition. The types of collective negotiations permitted by S.B. 3186 will likely raise prices and reduce access for health care services, without ensuring improved quality of care or other consumer benefits. In addition, the regulatory regime contemplated by the Bill may not meet the rigorous standards required to confer state action immunity from the federal antitrust laws to the providers.

Interest and Experience of the Federal Trade Commission

Congress has charged the Federal Trade Commission ("FTC" or "Commission") with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in commerce.[2] Pursuant to its statutory mandate, the FTC seeks to identify business practices and governmental regulations that may impede competition without also offering countervailing benefits to consumers.

Health care competition is critically important to the economy and consumer welfare. For this reason, anticompetitive conduct in health care markets has long been a key focus of FTC activity. The agency has brought numerous antitrust enforcement actions involving the health care industry.[3] In addition, the Commission and its staff have given testimony,[4] issued reports,[5] and engaged in advocacy to state legislatures regarding various aspects of competition in the health care industry. Of particular relevance, the Commission and its staff have long advocated against federal and state legislative proposals that would create antitrust exemptions for collective negotiations by health care providers when such exemptions are likely to harm consumers.[6]

The New York Bill

As we understand it, S.B. 3186 would authorize health care providers to collectively negotiate fee-related contract provisions with any health plan deemed to hold "substantial market share in a business line."[7] In addition, the Bill would allow health care providers to collectively negotiate numerous non-fee-related contract provisions with a health plan operating within the same service area as the health care providers, regardless of whether the plan holds substantial market share.[8] Competing health care providers would be allowed to communicate directly with each other regarding the contractual terms and conditions to be negotiated with a health care plan, including prices and other competitively sensitive information.[9] Actual negotiations with health plans must be accomplished through an authorized representative of the health care providers.[10]

Once competing health care providers establish terms to be negotiated, the health care providers' representative would be required to submit a report to the New York Attorney General identifying the proposed subject matter of anticipated collective negotiations with health plans, as well as any efficiencies or benefits expected to be achieved through the negotiations for health care providers and consumers.[11] With the advice of the Superintendent of Insurance and the Department of the Health Commissioner, the Attorney General must approve or disapprove any proposals for health care providers to engage in collective negotiations within 20 days. If a proposal is rejected, the Attorney General must provide an explanation of the proposal's deficiencies, along with suggestions to remedy these deficiencies.[12] If the Attorney General does not act, however, the report shall be deemed approved and the health care representative can begin negotiations with health plans. In the event that a health plan declines to negotiate, cancels negotiations, or fails to respond to a request for negotiation, the health providers' representative may request intervention by the Attorney General to require the health plan to participate in negotiations.[13] The Attorney General must then oversee a resolution process between the health care providers and the health plan, which may include appointing a mediator and, if necessary, a fact-finding board that would submit its recommendations to the Attorney General for a final decision.[14]

In the event that an agreement is reached between the health care providers and a health plan, the Attorney General would have 60 days to conduct a substantive investigation of the competitive impact of the proposed agreement before approving or

disapproving it.[15] In evaluating the competitive impact of the proposed agreement, the Attorney General would be authorized to collect information from health plans and health care providers operating in the same geographic area as the health care cooperative.[16] Once an agreement has been approved, the Attorney General would be required to monitor the agreement to ensure compliance with the conditions of approval.[17]

The Likely Effects of S.B. 3186

The Bill is designed to allow coordinated activity among competitors beyond what the antitrust laws permit, and therefore poses a substantial risk of consumer harm by increasing costs, impeding innovation, and decreasing access to health care. Indeed, at least ten organizations in New York have submitted memoranda in opposition to this legislation, primarily citing concerns about collective negotiations among health care providers potentially leading to increases in private insurance premiums that, in turn, could lead to an increase in the number of uninsured New York residents.[18] Furthermore, we believe it would be difficult to undo the consumer harm that is likely to occur once competitors have shared sensitive fee- and non-fee-related information in anticipation of collective negotiations, regardless of whether negotiations or agreements are approved under the regulatory scheme described in the Bill.

a) <u>The Bill Is Unnecessary to Promote Arrangements That Will Benefit Consumers</u>

As a preliminary matter, federal antitrust law already permits many joint activities by health care providers when such activities are procompetitive and likely to benefit consumers. Therefore, additional legislation is not necessary to promote the interests of New York health care consumers. We understand that some health care providers are concerned that they have limited leverage when negotiating with large health plans, and therefore would like to collaborate in their dealings with them. Consequently, we can understand why the New York legislature would want to provide a greater level of certainty to health care providers regarding potential antitrust risks. However, we believe that legislation allowing collective negotiations among health care providers, beyond what is permitted by the federal antitrust laws, would result in substantial harm to consumers rather than procompetitive benefits.

First, collective negotiations by providers may be lawful when they are reasonably necessary to create efficiencies, such as reducing the cost or improving the quality of health care services, or fostering innovation in health care delivery. Antitrust enforcement agencies recognize, for example, that effective clinical integration among health care providers may have the potential to achieve cost savings, improve health outcomes, and encourage innovation. The FTC, its staff, and the U.S. Department of Justice have provided substantial guidance to clarify that the antitrust laws do not prevent health care providers from engaging in these types of beneficial collaborations.[19] When in doubt about the potential antitrust risks associated with a proposed collaboration, health care providers may request an advisory opinion from FTC staff.[20]

Second, no antitrust exemption is needed to permit health care providers to discuss their concerns regarding health plan practices, whether among themselves or with health plans. Health care professionals may, under existing antitrust law, engage in collective advocacy to promote the interests of their patients, and also to express their opinions about other issues such as payment delays and dispute resolution procedures.[21]

b) <u>The Bill Poses a Substantial Risk of Consumer Harm</u>

In addition to being unnecessary, the Bill, if enacted, is likely to harm consumers. Regardless of its stated intent to address an imbalance in negotiating leverage between health care providers and health plans, the practical effect of the Bill will be to exempt some anticompetitive conduct from antitrust scrutiny. The underlying assumption of the legislation – that consumers would benefit from collective negotiations among providers – is fundamentally flawed. There is no credible economic theory supporting that notion, and no evidence demonstrating that collective negotiations among providers will do anything other than raise prices for consumers.[22] Indeed, the primary objective of permitting collective negotiations among health care providers is to raise reimbursement rates paid by health plans. These rate increases are inevitably passed on to consumers in the form of higher health insurance premiums or higher out-of-pocket expenses. Ultimately, there is no credible basis to conclude that the regulatory scheme contemplated by the Bill will be better for consumers than the outcomes achieved through competition among health care providers; indeed, evidence shows that such a deviation from the competitive process may only harm consumers.

The Bill is intended to extend antitrust immunity to health care providers that collectively negotiate agreements with health plans, thereby denying consumers the benefits of competition in health care markets. The Commission and its staff have long opposed blanket antitrust exemptions for health care providers. Indeed, for more than thirty years, the Federal Trade Commission has consistently challenged such collective negotiations by independent, competing health care providers because of their harmful effects on competition and consumers.[23] For example, in testimony before Congress regarding a proposed federal antitrust exemption for physician collective bargaining, the Commission detailed the predictable harm to consumers, including higher prices for health insurance coverage, a reduction in benefits as health insurance costs increase, higher out-of-pocket expenses for consumers not covered by insurance, and an increase in the portion of the population that is uninsured.[24]

The Bill further increases the risk of consumer harm because it effectively would require health plans to negotiate with health care providers.[25] This approach would decrease the incentives of health care providers to compete on price and quality, and would make it more difficult for health plans to resist provider pressure for higher fees. It also would threaten the ability of health plans to use selective contracting, a key mechanism for promoting quality and cost-containment goals.[26] As a result, consumers are likely to face significantly increased health care costs.

Furthermore, by immunizing agreements among competing physicians on the fees and other terms they will accept from health plans, the Bill is likely to facilitate other anticompetitive coordinated conduct, such as collusive refusals to deal. For example, while S.B. 3186 would not explicitly authorize providers to strike or boycott health benefit plans,[27] the Commission previously has observed that collective negotiations can convey an implicit threat: if the health plan does not agree to terms acceptable to the physician group as a whole, the plan may be prevented from successfully negotiating agreements with individual members of the group.[28] In the face of antitrust immunity for collective negotiations, this sort of collusive refusal to deal likely would be difficult to detect and prosecute.

c) Market Share Provisions Not Likely To Alleviate Risk of Consumer Harm

S.B. 3186 contains market share provisions purporting to reduce the potential for anticompetitive harm from collective negotiations among competing physicians. It is unlikely, however, that these provisions will be effective in protecting health care consumers.

First, the Bill authorizes health care providers to engage in collective negotiations on fee-related matters only in situations in which a health plan has "substantial market share in a business line."[29] The definition of "substantial market share in a business line" is unclear, however, and therefore will be difficult to implement in practice. Second, although the Bill limits the market share of health care provider negotiating groups, this limit only applies where health plans themselves have a very small share of the market.[30]

With respect to both of these market share provisions, the Bill fails to establish proper antitrust markets from either a legal or economic perspective. A high market share may indicate market power when based upon a properly defined antitrust market, including relevant product and geographic dimensions. Determining proper antitrust markets is among the most difficult issues in antitrust law, and it does not appear to be adequately addressed in the Bill. In addition, although the market share thresholds apparently are designed to offset health plans' market power, the Bill sets market share thresholds much lower than those commonly accepted by courts and others engaged in antitrust analysis. Consequently, the Bill is likely to authorize anticompetitive behavior by health care providers in situations where a health plan does not actually possess market power that would create an imbalance in negotiating leverage.[31]

Furthermore, the Bill would not apply any market power screen to negotiations involving non-fee-related matters. Non-fee matters can have a direct and substantial effect on provider fee levels and the cost of services that the health plan covers.[32] Agreements on non-fee terms also may limit the options available to health plans to meet consumer demand for high-quality and affordable health insurance.

The Bill May Not Create State Action Immunity

The federal antitrust immunity that the Bill purports to confer on collective negotiations by health care providers with health plans is effective only if the State of New York has clearly articulated an intent to replace competition in this area with a regulatory scheme, and then actively supervises this private conduct.[33] The active supervision test seeks to determine "whether the State has exercised sufficient independent judgment and control so that the details [of the restraint] have been established as a product of deliberate state intervention, not simply by agreement among private parties."[34] As explained by the United States Supreme Court in *Patrick v. Burget*, state officials must "have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy."[35] As the Court has made clear, private parties claiming state action immunity face a high bar.

Here, the review scheme contemplated by the Bill may not be sufficient to meet the active supervision prong of the state action doctrine. The health care providers' representative must furnish a copy of all communications related to negotiations, discussions, and offers made by the health care plan,[36] as well as any proposed agreements negotiated pursuant to the Bill.[37] It is unclear, however, to what extent state officials would be allowed to review particular contracts and fee arrangements between groups of providers and health plans to assess whether they comport with state policy goals. Likewise, while the New York Attorney General would be required to monitor agreements approved under this Bill to ensure ongoing compliance and would be allowed to revoke an approval if an agreement violates the goals of the legislation, it is unclear whether the New York Attorney General can fulfill these legislative requirements.

The Bill would impose substantial and ongoing oversight requirements on the New York Attorney General, yet these responsibilities may be difficult for the Attorney General to carry out given the required time frames, fact-intensive nature of the issues, and resources needed for a proper review. The Attorney General would have only 60 days to conduct a substantive competitive review of any agreement arising from collective negotiations.[38] Furthermore, the Bill does not clearly articulate a standard of review or the factors that must be considered by the Attorney General during its review. While the Bill would allow the Attorney General to set fees to cover the cost of administering this legislation, these fees are designated for the New York State Department of Health, *not* the Attorney General's office.[39] Thus, it is unclear whether the Attorney General would have the resources necessary to oversee the regulatory scheme described in the Bill.[40]

Conclusion

Our analysis of S.B. 3186 suggests that its passage would pose a significant risk of increased health care costs and decreased access to care for New York consumers. The antitrust immunity provisions in this legislation are unnecessary and would allow groups of independent health care providers to engage in unsupervised anticompetitive conduct. In summary, FTC staff is concerned that this legislation is likely to foster anticompetitive conduct that is inconsistent with federal antitrust law and policy, and that such conduct could harm New York health care consumers.

We appreciate your consideration of these issues.

Respectfully submitted,

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[1] This letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Federal Trade Commission (Commission) or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] Federal Trade Commission Act, 15 U.S.C. § 45.

[3] *See* Federal Trade Commission, Overview of FTC Antitrust Actions in Health Care Services and Products, March 2011 [hereinafter FTC Health Care Overview], *available at* http://www.ftc.gov/bc/healthcare/antitrust/hcupdate.pdf.

[4] *See* Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Subcomm. On Courts and Competition Policy, *Antitrust Enforcement in the Health Care Industry*, Dec. 1, 2010; Prepared Statement of the Fed. Trade Comm'n Before the Subcomm. On Consumer Protection, Product Safety, and Insurance, Comm. on Commerce, Science & Transportation, *The Importance of Competition and Antitrust Enforcement to Lower-Cost, Higher-Quality Health Care*, July 16, 2009 (all testimonies *available at* http://www.ftc.gov/ocr/testimony/index.shtml).

[5] *See* FED. TRADE COMM'N, EMERGING HEALTH CARE ISSUES: FOLLOW-ON BIOLOGIC DRUG COMPETITION (Jun. 2009); FED. TRADE COMM'N, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES (Aug. 2005); FED. TRADE COMM'N AND U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (Jul. 2004) [hereinafter FTC/DOJ, A DOSE OF COMPETITION] (all reports *available at* http://www.ftc.gov/reports/index.shtm).

[6] *See* FTC Staff Comment to Senators Eric D. Coleman and John A. Kissel and Representatives Gerald Fox and John W. Hetherington of the Connecticut General Assembly Concerning House Bill No. 6343 to Exempt Certified Health Care Cooperatives From the Antitrust Laws (Jun. 2011); FTC Staff Comment to the Hon. Elliott Naishtat Concerning Texas S.B. 8 to Exempt Certified Health Care Collaboratives From the Antitrust Laws (May 2011); FTC Staff Comment to Rep. Tom Emmer of the Minnesota House of Representatives Concerning Minnesota H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009); FTC Staff Comment to Antonio Silva Delgado of the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008); FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008); FTC Staff Comment to the Hon. Lisa Murkowski of the Alaska House of Representatives Concerning Alaska Senate Bill 37 to Permit Collective Bargaining by Health Care Providers (Jan. 2002); FTC Staff Comment to the Hon. Brad Benson of the State of Washington House of Representatives Concerning House Bill 2360 to Permit Collective Bargaining by Health Care Providers (Feb. 2002); FTC Staff Testimony Before the Alaska House of Representatives Concerning Alaska Senate Bill 37 to Permit Collective Bargaining by Health Care Providers (Mar. 2002); FTC Staff Comments to the Hon. Dennis Stapleton of the Ohio House of Representatives Concerning House Bill 325 to Permit Collective Bargaining by Health Care Providers (Oct. 2002); FTC Staff Comment to the Hon. Rene O. Oliveira of the Texas House of Representatives Concerning Senate Bill 1468 to Permit Collective Negotiations by Physicians (May 1999); FTC Staff Comment to Robert R. Rigsby of the District of Columbia Government Concerning Bill No. 13-333 to Permit Collective Bargaining by Physicians (Oct. 1999) (all advocacies *available at* http://www.ftc.gov/opp/advocacy_date.shtm). *See also* Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Concerning H.R. 1304, the "Quality Health-Care Coalition Act of 1999," June 22, 1999, *available at* http://www.ftc.gov/os/1999/06/healthcaretestimony.htm.

[7] S.B. 3186 § 4922 (N.Y. 2011).

[8] S.B. 3186 § 4921 (N.Y. 2011). S.B. 3186 would not authorize strikes of health benefit plans by health care providers. S.B. 3186 § 4925 (N.Y. 2011). The statement of legislative intent clarifies that the Bill is not intended to affect collective bargaining relationships involving health care providers who are employees, or rights relating to collective bargaining arising under applicable federal/state collective bargaining statutes.

[9] S.B. 3186 § 4923.1(a) (N.Y. 2011).

[10] S.B. 3186 § 4923.1(c) (N.Y. 2011).

[11] S.B. 3186 § 4924.2 (N.Y. 2011).

[12] S.B. 3186 § 4924.4 (N.Y. 2011).

[13] S.B. 3186 § 4924.7 (N.Y. 2011).

[14] S.B. 3186 § 4924.8 (N.Y. 2011).

[15] S.B. 3186 § 4924.9 (N.Y. 2011).

[16] S.B. 3186 § 4924.10 (N.Y. 2011).

[17] S.B. 3186 § 4927 (N.Y. 2011).

[18] *See* Memoranda in Opposition to S.3186-A (Hannon)/A. 2474-A (Canestrari) from the National Federation of Independent Business (Jun. 22, 2011), Business Council of New York State (Jun. 22, 2011), Iroquois Health Care Alliance (Jun. 22, 2011), Hinman Straub Attorneys at Law on behalf of Blue Cross and Blue Shield Plans of New York (Feb. 7, Jun. 6, and Jun. 21, 2011), Rochester Business Alliance (Jun. 22, 2011), Unshackle Upstate (Jun. 21, 2011), New York Health Plan Association (Jun. 22, 2011), Employer Alliance for Affordable Health Care (Jun. 2011), Coalition of New York Public Health Plans (Jun. 2011), Center for Medical Consumers and New York Public Interest Research Group (Jun. 2011).

[19] *See, e.g.*, U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy In Health Care* (1996) [hereinafter DOJ/FTC, *1996 Health Care Statements*], *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm; TriState Health Partners, Inc., Letter from Markus Meier, FTC to Christi Braun, Ober, Kaler, Grimes & Shriver, April 13, 2009; Greater Rochester Independent Practice Association, Inc., Letter from Markus Meier, FTC to Christi Braun & John J. Miles, Ober, Kaler, Grimes & Shriver, Sept. 17, 2007, letters *available at* http://www.ftc.gov/bc/healthcare/industryguide/advisory.htm. *See also* Fed. Trade Comm'n & U.S. Dep't of Justice, *Antitrust Guidelines for Collaborations Among Competitors*, April 2000, *available at* http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf. Most recently, the FTC and DOJ Antitrust Division jointly released a proposed statement explaining how the antitrust agencies will apply U.S. antitrust law to the new Medicare Shared Savings Program Accountable Care Organizations created by the Affordable Care Act of 2010. Fed. Trade Comm'n & U.S. Dep't of Justice, *Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating In the Medicare Shared Savings Program*, *available at* http://www.ftc.gov/opp/aco/index.shtml.

[20] For information about the Federal Trade Commission's advisory opinion process, *see Guidance From Staff of the Bureau of Competition's Health Care Division on Requesting and Obtaining an Advisory Opinion, available at* http://www.ftc.gov/bc/healthcare/industryguide/advop-health.pdf.

[21] The 1996 *Statements of Antitrust Enforcement Policy In Health Care* issued by the Commission and the Department of Justice explain the ways in which antitrust law permits health care providers to collectively provide both fee and non-fee related information to health plans. DOJ/FTC, *1996 Health Care Statements*, *supra* note 19. *See also* Letter to Gregory G. Binford (Feb. 6, 2003) (advisory opinion explaining that physicians' proposed formation of advocacy group to collect and disseminate information about health plan policies and procedures, including fees paid to local physicians compared to fees paid in other areas, did not appear likely to have anticompetitive effects); American Medical Assn., Model Managed Care Contract (4th Ed. 2005), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/368/mmcc_4th_ed.pdf.

[22] There are some studies demonstrating that consolidation among health plans may result in lower prices to consumers for healthcare services. *See, e.g.*, Glenn A. Melnick, Yu-Chu Shen & Vivian Yaling Wu, *The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices*, 30 HEALTH AFFAIRS 1728 (2011), *available at* http://content.healthaffairs.org/content/30/9/1728.full.html. There is, however, no reasonable basis for the assertion that consolidation among health care providers (either physicians or hospitals) would benefit consumers in the form of lower prices. *See, e.g.*, Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power,* Center for Studying Health System Change, Research Brief No. 16 (Nov. 2010), *available at* http://www.hschange.com/CONTENT/1162/; Robert A. Berenson, Paul B. Ginsburg & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFFAIRS 699 (2010), *available at* http://content.healthaffairs.org/content/29/4/699.full; William B. Vogt & Robert Town, *How has hospital consolidation affected the price and quality of hospital care?*, Robert Wood Johnson Found. Synthesis Project, Research Synthesis Rep. No. 9 (Feb. 2006), *available at* http://www.rwjf.org/files/research/no9researchreport.pdf; Cory Capps & David Dranove, *Hospital Consolidation & Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175 (2004), *available at* http://content.healthaffairs.org/content/23/2/175.full.

[23] *See* FTC Health Care Overview, *supra* note 3, at 21-52.

[24] Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Concerning H.R. 1304, the "Quality Health-Care Coalition Act of 1999," June 22, 1999, *available at* http://www.ftc.gov/os/1999/06/healthcaretestimony.htm. It is well-recognized that antitrust exemptions routinely threaten broad consumer harm for the benefit of a few. The bipartisan Antitrust Modernization Committee observed "[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality and reduced innovation." ANTITRUST MODERNIZATION COMMISSION, REPORT AND RECOMMENDATIONS (April 2007) at 335, *available at* http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[25] Antitrust jurisprudence recognizes a party's long-established right to exercise discretion over with whom it deals. *See* United States v. Colgate & Co., 250 U.S. 300, 307 (1919).

[26] *See* FTC/DOJ, A DOSE OF COMPETITION, *supra* note 5, at 11-12:

> [Managed Care Organizations, hereinafter MCOs] historically relied on three strategies to control costs and enhance quality of care. One is selective contracting with providers that must meet certain criteria to be included in the MCO's provider network. Selective contracting can intensify price competition and allow MCOs to negotiate volume discounts and choose providers based on a range of discounts. When MCOs and other insurers have a credible threat to exclude providers from their networks and send patients elsewhere, providers have a powerful incentive to bid aggressively to be included in the network. Without such credible threats, providers have less incentive to bid aggressively, and even MCOs with large market shares may have less ability to obtain lower prices.

[27] S.B. 3186§ 4925(1) (N.Y. 2011).

[28] The FTC has taken numerous enforcement actions to address situations in which health care providers collectively negotiated prices and other competitively significant terms with health plans and refused to negotiate individually with health plans. In using these tactics, health care providers often were able to extract higher fees and other favorable terms from health plans, thereby raising the costs of and restricting access to health care services for consumers. *See, e.g.,* Southwest Health Alliances, Inc., Dkt. No. C-4327 (F.T.C. Jul. 15, 2011); Minnesota Rural Health Cooperative, Dkt. No. C-4311 (F.T.C. Dec. 28, 2010); Roaring Fork Valley Physicians IPA, Inc., Dkt. No. C-4288 (F.T.C. April 5, 2010); Michigan State Medical Society, 101 F.T.C. 191, 296 n. 32 (1983) ("the bargaining process itself carries the implication of adverse

consequences if a satisfactory agreement cannot be obtained"); Preferred Physicians Inc., 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences inherent in collective negotiations). For descriptions of all FTC enforcement actions taken prior to March 2011 that relate to agreements on price or price-related terms in the health care industry, as well as docket links, *see* FTC Health Care Overview, *supra* note 3, at 21-52.

[29] S.B. 3186 § 4922 (N.Y. 2011). The Bill states that "substantial market share in a business line" exists if a health care plan's market share of a business line within a service area exceeds either ten percent of the total number of covered lives in that service area or 25,000 lives, or the New York Attorney General determines that the health plan's market share significantly exceeds the countervailing market share of individual health care providers. S.B. 3186 § 4920.5 (N.Y. 2011).

[30] S.B. 3186 § 4923(2) (N.Y. 2011). The Bill limits the size of health care provider negotiating groups to 30 percent in situations where health plans have less than 5 percent of the market.

[31] Proper market definition allows market participants to be identified, which facilitates the calculation of market shares and market concentration levels. These calculations may be informative of the likely competitive effects of a merger, collaboration, or other type of conduct by market participants, especially in situations where market power is thought to exist. *See, e.g.*, U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* § 4 (2010), *available at* http://www.ftc.gov/os/2010/08/100819hmg.pdf.

By setting the thresholds at a 10 percent and 5 percent market share, respectively, the Bill would authorize anticompetitive behavior by health care providers in many situations in which the health plan would not actually possess market power. Although the federal courts have not identified a precise market share figure that constitutes market power, the guidance they have provided strongly suggests that 10 percent is not sufficient. *See, e.g., Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984) (rejecting the possibility that a hospital had market power in spite of the fact that it serviced roughly 30 percent of the relevant market); *United States v. Eastman Kodak Co.*, 63 F.3d 95 (2nd Cir. 1995) (finding that 30 percent share of the relevant market was too small to give rise to inference of market power); *New York v. Anheuser-Busch, Inc.*, 811 F. Supp. 848 (E.D.N.Y. 1993) (finding that 40 percent market share was insufficient to show market power in light of low barriers to entry); *Manufacturer's Supply Co. v. Minnesota Mining & Manufacturing Co.*, 688 F. Supp. 303 (W.D. Mich. 1988) (finding that 25.8 percent market share was insufficient to show market power).

[32] For example, health care providers would be allowed to collectively negotiate a number of non-fee terms, including coverage provisions, health care benefits, benefit maximums/limitations, exclusions of coverage, as well as the formulation and application of health care provider reimbursement procedures. S.B. 3186 § 4921(1) (N.Y. 2011).

[33] *Parker v. Brown,* 317 U.S. 341, 351 (1943); *see also Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

[34] *Federal Trade Commission v. Ticor Title Insurance Co.,* 504 U.S. 621, 634 (1992).

[35] 486 U.S. 94, 101 (1988).

[36] S.B. 3186 § 4924.5 (N.Y. 2011).

[37] S.B 3186 § 4924.9 (N.Y. 2011).

[38] Based on the experience of FTC staff, investigating physician conduct matters is time- and resource-intensive.

[39] S.B. 3186 § 4926 (N.Y. 2011).

[40] In addition, according to the Bill, the Attorney General must monitor any agreements between health care providers and health plans that are approved under the Bill, and "may revoke an approval upon a finding that the agreement is not in substantial compliance with the terms of the application or the conditions of approval." S.B. 3186 § 4927 (N.Y. 2011). The Bill is silent, however, on what actions the Attorney General might take to remedy anticompetitive effects that have *already* resulted from such an agreement.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
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Robert F. Leibenluft
Assistant Director
Health Care Division
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EXHIBIT
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June 28, 1996

Joe Sims, Esquire
Jones, Day, Reavis & Pogue
Metropolitan Square
1450 G Street, N.W.
Washington, D.C. 20005-2088

Re: Columbus Hospital/Montana Deaconess Medical Center;
File No. 951-0117; PMN 96-1804

Dear Mr. Sims :

The Commission has conducted an investigation to determine whether the proposed merger of the only two hospitals in Great Falls, Montana -- Columbus Hospital and Montana Deaconess Medical Center (characterized by the parties as Montana Deaconess acquiring Columbus) -- may have violated § 7 of the Clayton Act, 15 U.S.C. § 18, or § 5 of the Federal Trade Commission Act, 15 U.S.C. § 45. This transaction raises significant antitrust concerns, as it may substantially lessen competition or tend to create a monopoly in the provision of hospital services to the residents of Great Falls and the surrounding area.

Upon review of this matter, however, it now appears that no further action is warranted at this time. Under the state action defense to the antitrust laws, a state must articulate a clear and affirmative policy to allow for anticompetitive conduct, and the state must actively supervise the anticompetitive conduct undertaken by private actors. See, e.g., FTC v. Ticor Title Ins. Co., 504 U.S. 621 (1992). Montana has enacted legislation stating the issuance of a "certificate of public advantage" (COPA) by the Montana Department of Justice signals its "intent" that "supervision and control over the implementation of . . . mergers . . . substitute state regulation . . . for competition . . . and that this regulation have the effect of granting the parties to the . . . mergers . . . state action immunity for actions that might otherwise be considered to be in violation of state or federal . . . antitrust laws." Mont. Code Ann. §§ 50-4-601, 50-4-605 (1995). The Montana Department of Justice ("the Department") issued a COPA for the merger of Montana

Deaconess and Columbus on March 7, 1996.

The Department issued the COPA after it had received public comments on the proposed transaction, and considered an independent analysis of the projected cost savings resulting from the consolidation. The Department rejected several of the grounds asserted by the hospitals in favor of the merger, and attached to the COPA numerous conditions which go beyond the obligations initially offered by the hospitals. These conditions are ongoing, and do not expire after a specified time period.

The conditions include the establishment of a "patient revenue cap" to ensure that the consolidated hospitals do not generate revenues in excess of those sufficient to provide the profit margin approved by the Department. All merger-related cost savings must be passed on to consumers in the form of price reductions, rebates to consumers, or funding for health care related programs as directed by the Department. The Department rejected requests from the hospitals that they be allowed to spend a portion of such savings on consumer benefits selected by the hospitals or to subsidize new services. The Department expects the COPA's requirements to result in price reductions of approximately 18% to 23% during the first four years after the consolidation. The Department will conduct an annual audit to assure proper implementation of this rate regulation.

The COPA also includes conditions relating to the quality of hospital services. Montana's Department of Justice and Department of Public Health and Human Services will oversee quality assurance. The COPA requires that the consolidated hospitals be accredited by the Joint Commission on Accreditation of Health Care Organizations, and that the hospitals have no material decrease in their scores in the Joint Commission's surveys in future years. Conditions are also attached to the number of operating rooms and their staffing. The hospitals must submit annual reports that include data pertaining to various quality indicators: the results of patient and staff surveys, and information about staffing ratios.

To address concerns about the merger's impact on access, the COPA requires that the hospitals must maintain or assist patients in obtaining all existing medical services available at either hospital prior to the merger. In addition, the hospitals must maintain the existing level of charitable programs and services for low-income persons.

Additional conditions are attached to the COPA concerning the hospitals' dealings with health plans, physicians, competitors, and ancillary service providers. The hospitals are prohibited from entering into exclusive provider agreements with managed care plans and physicians in certain specialties, without the prior approval of the Department. The hospitals are prohibited from employing more than 20% of the physicians in Great Falls specializing in certain primary care services. The hospitals must allow independent physicians to provide medical services outside the hospitals, as long as those activities will not interfere with the effective treatment of patients, and the hospitals may not acquire interests in any outpatient surgical

facilities without the approval of the Department. The hospitals must permit physicians to participate in health plans not affiliated with the hospital, and not discriminate against physicians who do so. The hospitals must grant equal access to all qualified physicians, and engage in good faith negotiations with all health plans. Referrals must be made in a non-discriminatory manner, and the hospitals may not oppose certificate-of-need applications without notifying the Department.

The hospitals will establish a Community Health Council composed of community and health care representatives to provide additional oversight in the regulatory scheme, with representatives of consumers and third-party payers appointed by the Attorney General. This entity will set community health goals, critique annual reports and strategic plans, and act on consumer complaints along with a Consumer Ombudsman.

The Department will supervise the COPA's implementation and will have the power to inspect records, interview personnel, and call special meetings of the board of directors. If the merged hospitals fail to correct any violation of the terms and conditions of the COPA, the Department may enforce those conditions by seeking any remedial action, including a court order to compel compliance. The hospitals are liable for all expenses incurred in analyzing progress reports and verifying compliance. If the Department determines that the COPA's terms and conditions are inadequate to effectuate its goals, it may impose further restrictions or modify any of the existing terms. The COPA and its conditions are binding on all successors and assigns.

In reaching the conclusion that a COPA should issue with the attached conditions, the State appears to have played a substantial role in determining the specifics of its regulation of the merged hospitals. Montana has recognized, by its ongoing regulation after the merger is consummated, that the merger is not a singular event in its effects, but a transaction with continuing consequences.

In examining this matter, we have not made a determination that the conditions attached to the COPA sufficiently address the substantial anticompetitive concerns stemming from this transaction. Indeed, there may be many reasons that they do not. Nor have we made a determination that the regulatory scheme devised by Montana is in any way more appropriate than the national policy favoring competition that is articulated in the antitrust laws. But in light of the intent of the statute allowing for the COPA, the comprehensive nature of the price regulations, the other conditions attached to the COPA, the State's substantial role in determining the specifics of the regulatory scheme, the ongoing nature of the regulations, and the State's intent to implement the regulations in their specific details, we do not plan to take further action at this time. Absent future evidence of inadequate active, ongoing supervision of the merged hospitals, no further action regarding this transaction is planned. Accordingly, the investigation is closed.

This action is not to be construed as a determination that a violation may not have occurred, just as the pendency of an investigation should not be construed as a determination that a violation occurred. The Commission reserves the right to take such further action as the public interest may require.

Sincerely,

Robert F. Leibenluft
Assistant Director

UNITED STATES DISTRICT COURT FOR THE

EASTERN DISTRICT OF LOUISIANA

FEDERAL TRADE COMMISSION Plaintiff, v. LOUISIANA CHILDREN'S MEDICAL CENTER and HCA HEALTHCARE, INC. Defendants.	CIVIL ACTION NO. 23-1305 c/w 23-311 c/w 23-890 REF: ALL CASES SECTION I

NOTICE OF SUBMISSION

PLEASE TAKE NOTICE that the Motion for Judgment on the Pleadings, or alternatively, Motion for Summary Judgment filed by the Defendant/Intervenor State of Louisiana, through Attorney General Jeff Landry, is set for submission on the 23rd day of August 2023, at 9:00 a.m., before the Honorable Judge Lance M. Africk, United States District Court for the Eastern District of Louisiana, 500 Poydras Street, Courtroom C427, New Orleans, LA.

Dated: July 18, 2023 Respectfully Submitted,

JEFF LANDRY
LOUISIANA ATTORNEY GENERAL

s/ *Terrence J. Donahue, Jr.*

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