November 15, 2024

Health Care Affordability Board
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments Ahead of the November 2024 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

The California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, appreciates the opportunity to comment on the November 2024 Health Care Affordability Board meeting. The Office of Health Care Affordability (OHCA) has an historic opportunity to transform health care delivery in California, but it cannot achieve its goals of affordable, high-quality, equitable care delivery without a thorough understanding of how health care delivery and financing is evolving under its purview. This letter offers recommendations for how OHCA should approach measuring impacts on access, quality, and equity; foster investments to expand primary care and behavioral health access; and encourage collaboration across the health care sector to fulfill OHCA's bold mission.

Proposed Approach to Quality and Equity Measurement Has Merit, but Will Not Comprehensively Capture Important Trends in Access, Quality, and Equity

Measuring Quality, Equity, and Access Is Necessary to Protect Against Unintended Consequences. OHCA is statutorily required to ensure that its spending targets do not impair access, quality, or equity. To carry out this purpose, state law requires OHCA to develop and track a set of quality and equity measures. CHA strongly supports OHCA efforts to track overall health care system performance and encourages the board to push for a comprehensive and innovative approach to measuring and protecting against the unintended consequences of OHCA's cost containment efforts.

Using Existing Hospital Measures Has Significant Benefits. OHCA has proposed to use a slate of pre-established quality and equity measures to track overall health care system performance. As part of that proposal, OHCA staff have recommended using the same measures as the Hospital Equity Measures Reporting Program developed by its parent department, the Department of Health Care Access and Information (HCAI), over the past several years. This approach has certain advantages, most notably compliance with the provision in state law that OHCA leverage pre-existing measures used by other regulatory bodies. Furthermore, reliance on existing measurement would minimize administrative complexity for both OHCA and hospitals and reduce the degree to which hospitals are asked to adhere to disjointed sets of quality and equity performance measures. Streamlining these processes would allow hospitals to focus their resources on meaningful improvement on a discrete set of measures.

While hospitals continue to evaluate OHCA's proposed use of this full measure set, CHA encourages OHCA to consider focusing on those measures that are firmly within hospitals' control. Additionally, OHCA and HCAI should continually update these measures as necessary to ensure, where applicable, that they remain consistent with the evolving ways in which other regulators, like the Centers for Medicare & Medicaid Services, measure hospital performance. Finally, OHCA and HCAI should carefully consider how finely performance is stratified by race, ethnicity, gender, sexual orientation, and other demographic characteristics, given that greater specificity often reduces the extent to which statistically significant conclusions can be drawn from the data.

Critical Aspects of Health Care System Performance Would Not Be Tracked Under OHCA's Proposed Approach. While the proposed approach has certain advantages, it would provide only a partial view of health care system performance. The following bullets describe key aspects missing from OHCA's proposal. As proposed elsewhere, OHCA should use existing data collected by government agencies and other organizations to fill these gaps.

- **Access Measures Are Essentially Absent.** By including almost no access measures, the proposed approach to quality and equity measurement would result in a serious lack of insight into many critical measures of health system performance. The OHCA board would have no way of knowing whether:
    - Appointment and emergency department wait times are increasing
    - Patients are forced to travel further for emergency care or labor and delivery services
    - Patients are experiencing greater difficulty obtaining a usual source of care
    - Networks of behavioral health therapists are decreasing
    - High-value – if sometimes high cost – pharmaceuticals and other new health care technologies are growing farther out of reach
    - Patients with rare diseases like hemophilia, cystic fibrosis, or muscular dystrophy are facing greater challenges obtaining the care they need to survive.

  Hospitals recommend that the OHCA board direct OHCA staff to develop a supplemental plan for comprehensively measuring access to care, including for patients with chronic and rare diseases, and thereby strive to fulfill its mandate to maintain access to care while reducing spending growth.
- **Quality and Equity Measures Ignore the Outcomes We Want Our Health Care System to Achieve.** California's health care system produces miracles every day, extending and saving lives from diseases and injuries that, one or more decades ago, would have led to certain death or impairment. And yet, OHCA's proposed quality and equity measure set almost entirely ignores performance related to the health care system's primary function: improving people's health. Instead, the vast majority of measures only look at preventive care processes, like whether a patient received a screening or whether just one of several specific kinds of visits occurred (e.g., well-child and prenatal visits). While the proposed measures may reflect sound *process measures*, they don't consider whether health was improved, a disease was reduced in severity or cured, or mortality was avoided. By failing to account for what we fundamentally want from health care — better health — OHCA could be left with the mistaken impression that the system is performing as hoped, even while its most fundamental functions are degrading or no longer improving to their full potential. To address this deficiency, the OHCA board should ask OHCA staff to incorporate outcome measurement into its approach for measuring and reporting on system performance.
- **Creation and Diffusion of New Treatments Deserves Special Attention.** A major risk of OHCA's efforts to reduce spending is slowing the rate of innovation in health care and how

quickly these innovations become available to the patients that need them. This outcome would be tragic, causing untold avoidable disease and death. Recent research in the National Bureau of Economic Research underscores the reality of this risk.[1] The research showed that a 61% reduction in Medicare payments for medical devices led to a 25% decline in new product introductions and a 75% decrease in patent filings, both indicating a slowdown in innovation. New entrants into the manufacturing market fell while outsourcing increased, leading to poorer device quality. As a result, the authors estimate that the price cuts potentially led to losses in the value of foregone innovation far exceeding the amount of Medicare dollars saved. OHCA's spending target aims to reduce total health care spending growth by almost 40% over the next five years, with potential for similar troubling effects as the Medicare medical device rate reductions. Monitoring such unintended consequences is critical for OHCA to meet its mission without damaging the health of 39 million Californians.

Greater Investment in Primary Care and Behavioral Health Is Essential and Should Be Considered in Light of OHCA's Other Targets

Access to primary and behavioral health care is inadequate in California. As a result, thousands of patients turn to emergency departments and hospitals for their health care needs, even though timely preventive primary and behavioral health care could have prevented their need for acute care. To address these challenges, CHA supports OHCA's efforts to encourage greater investment in primary and behavioral health care. OHCA has already set a 15% target for the proportion of total medical spending going to primary care. Now, OHCA is working toward the adoption of a target for behavioral health care. Below are key considerations as OHCA continues this work.

Behavioral Health Investment Goals Must Include the Full Continuum of Behavioral Health Services. Behavioral health care is in crisis, with record numbers of Californians unable to access the care they need. Deficiencies in care availability span the entire continuum of care, from navigation and peer services to therapy, medication-assisted treatment, intensive outpatient services, inpatient psychiatric care, and long-term nursing and supportive care. Investment is needed in all these areas to ensure care is there when people need it and to speed transitions out of emergency departments and hospital beds to more appropriate care settings. In establishing its methodology for measuring behavioral health spending and setting an investment goal, OHCA must recognize the full scope of investment needed and the state resources currently devoted to expanding the full continuum of behavioral health care services across both community- and hospital-based care. In doing so, OHCA's efforts in this area would ultimately be supportive of the critical efforts underway under Behavioral Health Services Act and Behavioral Health Community-Based Networks of Equitable Care and Treatment Demonstration.

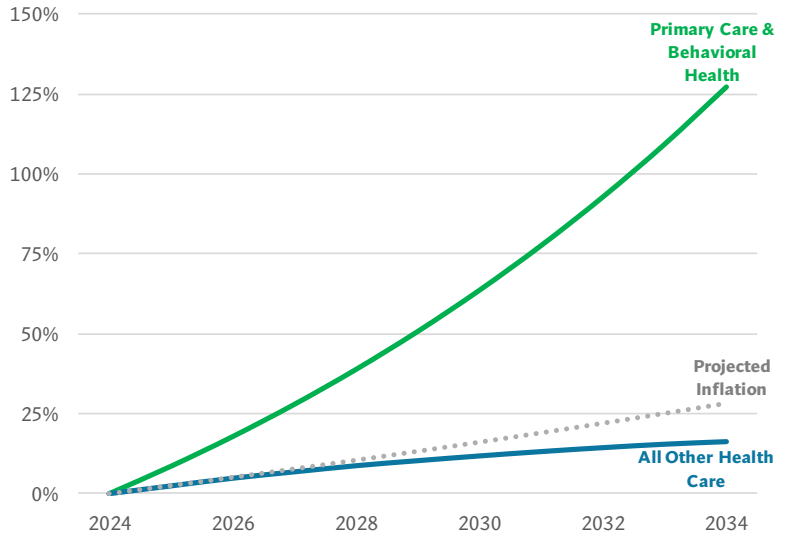
Statewide Spending Target Must Account for OHCA's Investment Goals. OHCA has set a goal of increasing primary care spending from around 9% of total health care spending today to 15% of total spending by 2034. Comments from OHCA leaders indicate that a similar goal could be sought for behavioral health care. These represent audacious but laudable goals. To assure congruity with OHCA's overall spending goals, the board should consider the interaction between its goals for primary and behavioral health care investment and statewide spending growth. As the figure on the next page shows, the risk of dissonance is clear. If the behavioral health target were set at similar levels to the primary care goal, per capita spending in these two service categories would increase by between 100% and 150% over

[1] Yunan Ji and Parker Rogers. "The Long-Run Impacts of Regulated Price Cuts: Evidence from Medicare." NBER Working Paper No. 33083. October 2024. https://www.nber.org/papers/w33083

the next decade. To meet the statewide spending target starting at 3.5% and moving down to 3%, all other health care spending would be limited to growth of around 2% annually over the next five years and decline even further thereafter. This would leave cumulative growth of all other health care spending at between 15% and 20% over the entire decade, over 40% less than projected inflation over this same period. Whether the health care sector could meet such a goal is questionable, as is its desirability given the real cuts to health care spending that it would require.

Primary and Behavioral Health Care Could See Enormous Spending Growth, While All Other Health Care Would Be Subject to Divestment Under OHCA Targets

Cumulative Projected Growth Under Actual and Potential Targets



Projections assume primary and behavioral health care spending each increase from 9% to 15% of total health care expenditures (THCE) between 2024 and 2034, while THCE increases at the statewide spending target through 2029 and 3% annually thereafter. Inflation is projected at 2.5% annually.

Learning Needed Before Moving Toward Sector Targets

The August and October board meetings featured calls to push ahead toward sector targets, contravening clear statutory intent to learn from experience under the statewide spending target before differentiating the state's spending targets by type of health care entities or region. To answer such calls at this point would be premature, coming before OHCA has analyzed even baseline spending data, finalized a multipronged data collection plan, implemented the state's first spending target, or set any rules for enforcement. OHCA has conducted no cross-sector analyses to determine where the sector discussion should be focused, nor heard from the organizations that are being scrutinized in the discussions the board has held. No consideration has been given to how different sector targets for different components of the health care industry would interact. As such, a lower spending target for providers could simply allow payers to retain any resulting savings as higher earnings, rather than being passed along to those who should be the ultimate beneficiaries of OHCA's work —Californians. More learning is needed before moving forward.

Conclusion

OHCA has tremendous authority to transform health care delivery in California. Fulfilling this awesome responsibility will require thoughtful consideration of what Californians want from their health care system and adopting rules and practices that reflect these multifaceted aims. CHA encourages OHCA to proceed reflectively, with due consideration of the impacts its decisions will have for the 39 million Californians who rely on the state's health care delivery system for their health, lives, and livelihoods.

Sincerely,

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