June 12, 2023

Mark Ghaly, MD
Chair, Health Care Affordability Board
1215 O St.
Sacramento, CA 95814

SUBJECT: Comments on the May 23, 2023, Health Care Affordability Board Meeting

Dear Dr. Ghaly:

Just like the Health Care Affordability Board, California's hospitals are dedicated to ensuring patients receive high-quality, timely, equitable, and affordable health care. The California Hospital Association (CHA), on behalf of its more than 400 hospital and health system members, appreciates the opportunity to engage with the governing board and staff of the Office of Health Care Affordability and offers comments on the presentations and proceedings of the May 23, 2023, Health Care Affordability Board meeting.

Advisory Committee Structure and Appointments

CHA Appreciates the Appointment of Hospital Experts but Is Concerned About Potential Changes to the Committee's Composition. Close engagement with health care stakeholders is essential in order for the office to fulfill its multifaceted mission. The establishment of a carefully crafted advisory committee is vital to this purpose. The May board meeting included thoughtful deliberation about the construction of the advisory committee and the appointments of most of its members. CHA appreciates that hospital voices will be able to provide their input and expertise on the committee. We further recognize that a delicate balance was struck in appointing members with different experiences and backgrounds. However, we find it troubling that changes are under consideration that would disturb this balance. We urge the board to consider how any further changes to the composition of the committee must be balanced by additional appointments, including an appointee who adds expertise on statewide hospital finance, operations, and policy issues.

It Is Essential to Distinguish Between Health Care Workers and the Political Organizations That Represent Some of Them. CHA recognizes that the representation of organized labor on the advisory committee is both warranted and consistent with the intent of the authorizing legislation. However, during the advisory committee discussion, it gave us pause to hear remarks that conflated the roles and expertise of frontline health care workers and union representatives, which we regard as distinct. In selecting payer and provider representatives on the committee, the board clearly sought to obtain *on-the-ground* expertise from members working directly for payers and providers. Selecting political

organizations to represent health care workers would be inconsonant with this approach. Accordingly, in considering the outstanding appointments, we urge the board to draw a clear distinction between frontline health care workers and the political organizations that represent a portion of them at the state level.

The Limits of Payer Reporting

We understand that getting data in quickly is critical for the office to meet its statutory timelines. However, tight timelines do not absolve the office from thoughtful and transparent deliberation over key data collection approaches. Overall, we agree with the office that collecting health care cost data from payers is a reasonable approach to gathering the information needed to set and monitor compliance with the health care targets. Nevertheless, it is critical for the office to recognize and address the major shortcomings of this approach to data collection.

Where Is the Strategy for Analyzing Cost Drivers? We understand that payer data will show where costs are growing but will provide little to no information on the drivers of health care cost growth. When asked by a board member how the office would evaluate administrative cost shifts from payers to providers, the office's response fell short of demonstrating a commitment to carefully considering this important issue. This raises further questions about whether the office is adequately preparing to develop a strategy to thoughtfully analyze cost drivers and incorporate this analysis into its overall policy approach. For the office to be successful in supporting a high-value health care system — rather than a low-cost, low-quality, and low-access one — it must develop and release for public consideration a strategy to thoughtfully analyze the underlying drivers of health care cost growth, including those associated with payer policies that shift and hide the true costs of providing health care.

External Validation of Payer Data is a Necessity. Early indications reveal that payer-reported data will be the spine supporting most of the office's oversight and enforcement activities. Bad or politicized data would seriously undermine the office's credibility and mission. For this reason, external checks on the validity of payer-reported data will be critical. Here, Maryland can serve as a model for the office, where the state and provider community work together to ensure the reliability of the data underpinning its health care affordability programs. We recommend the office begin public deliberations now on data transparency and approaches for ensuring the validity of payer-reported data.

Patient Attribution Policies Merit Scrutiny. During the board meeting, patient attribution was portrayed as a relatively straightforward and noncontroversial component of state health care affordability programs. We would challenge this portrayal. Maryland, which has led the nation in implementing a global payment system for hospital services and operates under total cost of care targets, has spent years trying — with mixed success — to develop and implement a rational patient attribution process. Its chosen approaches have proven controversial to this day as hospitals regularly report not having seen patients who are attributed to them, and vice versa.

While the misattribution of patients might be of small consequences for low-cost patients at large health care entities, a single high-cost patient (who might incur millions of dollars in expenses in a single year) misattributed to even a medium-sized health care entity could be the difference between whether that entity makes or misses its cost target. We recommend that the office and board carefully consider this scenario in the development of a reasonable patient attribution policy.

Furthermore, letting payers select their own patient attribution methodologies has serious potential to introduce unreliable, incommensurable, and potentially manipulated data into the cost target program. We recommend the office set clear and consistent standards for patient attribution, including ways to facilitate external validation of the associated data.

Cost Target Adjustments

We appreciated the overview of required and potential adjustments to the cost targets at the May board meeting. This is a complex area, both in terms of the requirements under state law and the technicalities of how to appropriately implement the adjustments. While significant further deliberation of these adjustments clearly is warranted, we would raise three initial issues for consideration:

Regulations Must Strike a Balance Between Flexibility and Rigidity. The success of California's cost target program depends on the ability to strike an appropriate balance between flexibility and rigidity in the setting and enforcement of the cost targets. Flexibilities that must be considered include opportunities to modify targets or their enforcement based on economic and public health trends and shocks, policy changes that affect the cost of care, and other difficult-to-control inputs and drivers of underlying costs. On the other hand, clearly defined processes and rules are necessary to avoid arbitrary and capricious penalization of health care entities that do everything to meet the spirit but not the letter of the authorizing law. We look forward to engaging with the office on an ongoing basis on how to strike this delicate balance.

A Glide Path Is Essential. The diffusion of new policies and practices to improve the value of care will be necessary to achieve the office's multipronged mission. The fruits of these innovations will take time to germinate. For this reason, it is critical that the office create a glide path that gives the health care system time to adapt to the new equilibrium that will exist under office oversight. As the May board meeting presentation showed, other states recognized the importance of not shocking the system with cost targets that are significantly at odds with prior spending trajectories.

Urge Greater Public Involvement and Deliberation Before Arriving at Even Preliminary Decisions, Including Risk Adjustment. Risk adjustment is a critically important component of the cost targets that is intended to ensure that the targets do not inappropriately penalize health care entities for factors beyond their control. Moreover, it is a complex area that is subject to active and ongoing academic and policy debates. We question the prudence of staking even a provisional position on risk adjustment at the very first public meeting on the topic, without releasing any detailed assessment of the benefits *and tradeoffs* of the preferred approach, and without gathering input from stakeholders. Specifically, when it comes to risk adjustment, the office stated a preference for only risk adjusting based on age and sex, a form of risk adjustment that explains a paltry 1% of the variance in health care spending across patients.[1] Adopting this approach could cause health care entities to think twice about caring for the most vulnerable patients, such as those with mental illness and other chronic diseases, when doing so could raise their costs over time and limit their ability to meet their cost target. A more holistic approach to risk adjustment has the potential to address this shortcoming, albeit while introducing other tradeoffs that should also be considered. Ultimately, the discussion revealed a troubling lack of public engagement

[1] Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman. 1999. "Risk Adjustment and Medicare." *The Commonwealth Fund.* https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_1997_apr_risk_adjustment_and_medicare_newhouse_riskadj_revised_232_pdf.pdf

and transparent assessment of key decisions that the office is already arriving at, even if preliminarily. Going forward, we urge the office to demonstrate more diligence in involving the public prior to arriving at important policy decisions such as this.

Sincerely,

Ben Johnson
Vice President, Policy

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board