August 14, 2023

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

SUBJECT: Comments on the June 2023 Health Care Affordability Board and Advisory Committee Meetings

Dear Dr. Ghaly:

California's hospitals share the Office of Health Care Affordability's (OHCA) commitment to making sure patients receive high-quality, timely, equitable, and affordable health care. On behalf of its more than 400 hospital and health system members, the California Hospital Association (CHA) appreciates the opportunity to comment on the June 2023 presentations and proceedings of the Health Care Affordability Board and Advisory Committee.

Market Oversight

Missed Opportunity to Provide a Balanced Perspective on Health Care Partnerships. We were disappointed that the June board and advisory committee meeting presentation neglected to paint a balanced picture of the trends and impacts of consolidation in health care. First, the conclusion that hospital and health system integration leads to higher prices or costs is *not* unilaterally supported by the available research. For example, a recent study from researchers at the University of Southern California found no systematic difference in price growth between California hospitals that are and are not part of larger systems.[1] Second, the presentation focused narrowly on hospital and physician organization consolidation, failing to address the growing challenges stemming from insurance company concentration and their vertical integration with pharmacy benefit managers (PBMs), physician organizations, and management services organizations. Just three health insurance companies control more than 80% of the commercial market in California, tilting the leverage in contracting negotiations decidedly in the insurers' favor. In fact, this figure undersells insurance companies' true market power. That's because, through affiliations with PBMs and management services organizations like CVS and Optum, they exert control over critical inputs to the provision of health care, including pharmaceuticals and the providers hospitals need. Going forward, we encourage the office to present these broader perspectives on health care partnerships.

It's Critical That the Office Consider the Benefits of Partnerships. Pursuant to its authorizing legislation, the office will play an important role in providing information to the public on the potential

[1] John Romley, P., Moonkyung Kate Choi, P., Erin Trish, P., & Darius Lakdawalla, P. (2022). Price Changes Varied Widely Across California Hospital Systems from 2012 through 2018. *Healthpolicy.usc.edu*. https://doi.org/10.25549/sxzq-3s27

impacts of certain significant health care market transactions. To ensure balance, state statute requires the office to consider not only the potential downsides of market transactions under its review, but also their myriad benefits, including increased access, higher quality, and more efficient care delivery. We urge the office to faithfully pursue this dual mandate as it crafts the rules governing it and subsequently implements the cost and market impact review process. Specifically, we encourage the office to keep in mind the following major benefits of health care partnerships:

- **Lifeline for Distressed Hospitals.** The devastating closure of Madera Community Hospital earlier this year is a stark reminder of what can happen when a potential partnership for a financially distressed hospital falls through. With dozens of additional hospitals on the financial brink following years of stagnant reimbursement and explosive and uncontrollable cost growth, it is critical that the office recognizes the essential lifeline that partnerships provide to hospitals at risk of closure. Delaying and, in some cases, preventing these potential partnerships through drawn-out regulatory processes, the imposition of unreasonable conditions on approved transactions, and transaction denials can mean the difference between a community keeping or losing its hospital and the vital health care resources that come with it.
- **Economies of Scale.** Partnerships allow health care entities, and ultimately their patients, to benefit from the efficiencies created by economies of scale. As health care entities grow and integrate, they can spread their fixed administrative and other costs over a wider patient population. For example, installing a new electronic medical record (EMR) system at a hospital comes with a price tag in the tens of millions of dollars. Kern Medical Center's 2019 EMR replacement cost around $30 million, 9% of the hospital's total net patient revenues that year. For independent physicians, EMR adoption costs — estimated to be as high as $70,000 per provider — can be prohibitively expensive absent the ability to partner with other physicians and health systems. In addition, larger health care entities can often negotiate better prices for critical health care necessities like pharmaceuticals and medical supplies, generating savings that are passed along to patients and payers in the form of lower costs.[2]
- **Opportunities for Clinical Integration and Care Coordination.** Patients who obtain care through health systems benefit from integration in many ways: improved information sharing facilitated by common EMR platforms, the availability of multi-specialty care teams that are capable of treating the full range of their patients' medical needs, and the avoidance of closed-loop referrals and duplicative screenings. The result: reduced risk for hospital admissions and readmissions, shorter lengths of hospital stays, improved control of chronic conditions like diabetes, and greater patient satisfaction.[3,4] Health care partnerships provide a vital pathway toward clinical integration, a feature that the office and board should carefully consider in their market oversight functions.
- **Ability to Accept Risk.** The office is tasked with promoting the shift of reimbursement from arrangements that reward volume to those that reward value. To do so, the office will be setting benchmarks for encouraging greater adoption of alternative payment methodologies (APMs). Often, APMs will shift the financial risk from payers to providers, internalizing the risk associated with a person's health status among the providers responsible for their care. Such risk-based arrangements require scale — small, independent providers typically do not have the ability to

[2] 7. Schmitt, M. (2017). Do Hospital Mergers Reduce Costs? Journal of Health Economics, 52: 74-94.
[3] Liljas, A., Brattström, F., Burström, B., Schön, P., & Agerholm, J. (2019). Impact of Integrated Care on Patient-Related Outcomes Among Older People – A Systematic Review. *International Journal of Integrated Care*, *19*(3). https://doi.org/10.5334/ijic.4632
[4] Dorling, G., Fountaine, T., Mckenna, S., & Suresh, B. (2015). *The evidence for integrated care 2*. https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/The%20evidence%20for%20integrated%20care/The%20evidence%20for%20integrated%20care.ashx

withstand the fluctuations in the risk of their small patient panels. Accordingly, to successfully promote the shift to APMs, the office must take care not to discourage the partnerships and growth that are prerequisites to the adoption of a wide variety of APMs.

Principles to Pursue in the Cost and Market Impact Review (CMIR) Process. Statutory deadlines for implementing the CMIR process are fast approaching and rulemaking is starting now. We sincerely thank the office for committing to an extended public process for providing stakeholder feedback on the proposed related regulations and ask the office to continue this practice in future rulemaking. We urge the office to keep the following principles in mind as it drafts and then finalizes the CMIR regulations. (We note that this letter was prepared prior to the July 31 release of the draft regulations.)

- **Clear and Speedy Timelines for CMIRs.** For many years, proposed partnerships among nonprofit and public hospitals have been subject to oversight by the attorney general (AG). Even when relatively small transactions are involved, these reviews regularly take months if not years to complete, adding millions of dollars in costs to these transactions and producing a chilling effect on prospective partnerships, regardless of how beneficial the partnership would be to the entities' patients and communities. Critically, the office's authorizing legislation did not establish a time frame within which the office must complete its transaction reviews, leaving this crucial decision to the regulatory process. To provide basic clarity around how long the CMIR process will take and prevent the discouragement of constructive partnerships, we strongly urge the office to establish clear and speedy timelines for its market transaction reviews.
- **Prevent Duplication of Efforts Between OHCA and Other Regulatory Departments.** The office's market oversight efforts are intended to complement the state's pre-existing related efforts, including those by the AG and Department of Managed Health Care. Referrals to and from the office and the other regulatory agencies are authorized in statute. We are concerned that the presence of multiple regulatory bodies could lead to duplication of efforts and unaligned rules. To prevent such unintended outcomes, we ask the office to work closely with its sister regulatory agencies to establish clear rules around timelines, jurisdiction, and the common reliance on findings from any one of the oversight entities for purposes of completing the respective review processes.
- **Ensure Benefits of Proposed Transactions Are Given Appropriate Consideration.** The office's authorizing statute requires that the benefits of proposed partnerships be considered in the CMIR process. The pending regulations that define and govern the CMIR process must affirm and enumerate the office's responsibilities to give the benefits of proposed transactions their proper consideration.
- **Establish Reasonable Materiality Thresholds to Focus on the Most Impactful Transactions.** State statute establishes a clear intent for the office to *"analyze those transactions likely to have significant effects."* To faithfully operationalize this intent, and allow the office to devote its resources to where it can achieve the greatest impact, it should establish reasonable materiality thresholds (and waiver criteria, as discussed below).
- **Objective Criteria for Obtaining Waivers from Full Cost and Market Impact Review.** State statute allows the office to, following an initial review, provide waivers from the full CMIR process for regulated entities looking to partner. To provide clarity around expectations and prevent arbitrary waiver decisions, we encourage the office to establish clear and objective criteria via regulation for when waivers will be granted.
- **Reasonable Fees on Parties to a Transaction.** The authorizing legislation allows the office to establish "appropriate" fees on health care entities that are party to a proposed and regulated transaction. Given the office's foundational purpose of reducing health care spending, it must take

care to ensure that its own activities do not increase compliance and related costs for regulated entities, costs that ultimately get passed onto California residents. With this in mind, we urge the office to minimize the fees charged to health care entities subject to the CMIR process and aim to simply cover the anticipated and reasonable costs of the reviews.

- **Reasonable Reporting Requirements for Parties to a Transaction.** Overly expansive reporting requirements on parties to a transaction place unnecessary burdens on health care entities, raise compliance costs, and, as described below, risk disclosure of information that should remain confidential. Accordingly, in setting requirements on what information parties to a transaction must report prior to and during the CMIR process, the office must establish clear reporting requirements that gather the minimum kinds and amount of information necessary for it to fulfill its statutory prerogatives.
- **Protect Sensitive Non-Public Information Provided to the Office.** Health care entities maintain large amounts of data to fulfill their patients' clinical needs, sustain their finances and operations, and compete in the health care marketplace. Protecting the confidentiality of these data is critical. While we understand that the office's role under the CMIR process is to provide information and analysis that is of use to the public, it is absolutely essential that protected health information and sensitive business information remain confidential. To the extent the office does collect non-public information per the reporting requirement described above, we ask the office to clearly delineate in regulation the reasonable and appropriate criteria for what information may be collected by the office but not released to the public. Such information would include that related to trade secrets, confidential staffing agreements, and other information beyond what is necessary for the public to be able to understand the major impacts of a proposed partnership as it relates to the benefits and tradeoffs laid out in Article 8 of the office's authorizing legislation.

Spending Targets

Importance of Data-Driven and Careful Decision-Making. We appreciate the engagement and discussions at the board and advisory committee meetings aimed at laying the groundwork for establishing the spending targets and setting rules on how they will be adjusted and enforced. These decisions will be the most impactful and weighty that the board and office will make — with the potential to meaningfully improve the value of every dollar Californians spend on health care. But, if done without care, foresight, and analytical rigor, the decisions have the potential to undermine access to health care and jeopardize the health of Californians. Ultimately, the board will effectively be deciding *how much should health care spending grow* over the coming years. There is no easy answer to this question. To be answered rigorously and credibly, the board and office must incorporate macro and microanalysis of historical spending trends, strong models of the true underlying cost drivers, projections of future headwinds and tailwinds, and a normative assessment of the value of health care. For example, while deliberation over critical details around spending target adjustment methodologies is absolutely essential, we encourage the board to provide space for these higher-level discussions as well.

Applaud the Consideration Given to Spending Target Adjustments. We appreciate the office and board's willingness to seriously grapple with the thorny issue of how to ensure good actors are not punished by the spending target program for factors beyond their control. We believe the implementation of adjustments of the kinds the board and office are currently considering is necessary to achieve this shared goal. Confidence testing to protect against random variation in annual costs, truncation to prevent outliers from biasing the data, and risk adjustment to control for differences in patient populations are all important. These are mutually reinforcing tools that are available at the office's disposal to ensure faith and confidence in the spending target program.

We Remain Concerned With the Office's Aversion to Clinical Risk Adjustment. As noted in previous comments to the board, we remain concerned by the office's stated preference to forego risk adjustment based on clinical factors, which research shows performs orders of magnitude worse in explaining the variance in health care spending compared to clinical risk adjustment.[5] This is not merely a theoretical concern. Employing a risk-adjustment methodology without substantial predictive power opens the door to health care entities being punished for caring for high-risk, high-cost patients. Health care entities would face an incentive to avoid patients with chronic conditions. For example, individuals with early onset mental illness could have trouble with access to care as they could reasonably be predicted to bring higher expenditures without any recognition within the entity's cost target. This raises serious equity concerns, and ultimately is in direct conflict with the office's concurrent goals of improving equitable access to care and protecting Californian's most vulnerable residents. We ask the office to more clearly explain its thinking behind its aversion to clinical risk adjustment, including the analysis it has performed to rule out all the various risk-adjustment tools available.

Data Collection

Prioritize Careful Consideration of Health Care Cost Drivers. The office's authorizing statute requires that the spending target methodology review an array of enumerated factors, including but not limited to the historical health care spending trends; projections of economic and demographic indicators; labor cost trends; and the costs of federal, state, and local mandates; We are concerned that the office has not clearly articulated how it will analyze and allow for public deliberation over these and other factors before setting and establishing mechanisms to enforce the state's spending targets. The intent behind these statutory requirements is to ensure the spending targets are data-driven and informed by the historical and anticipated future drivers of health care cost growth. We encourage the office to prioritize providing a clearly articulated plan for how it will consider these drivers of health care cost growth in the spending target program. To this end, we endorse a suggestion made by an advisory committee member that the office release a report on the critical pieces of information that will be missing from the spending data collected from payers but that should inform the spending target development process. Then, the office and board, in consultation with the advisory committee and interested parties, could begin to develop a plan for collecting and analyzing this necessary information, with the ultimate goal of ensuring the spending targets are aimed squarely at improving the value of the health care system, not just cutting its cost.

Transparency of Payer-Reported Data. Finally, as shared in prior comments, we urge the office to ensure transparency around the data submitted by payers, which we believe are vitally necessary for protecting the credibility of the office's reporting on health care entity performance against the spending target program.

Thank you for the opportunity to comment on the June board and advisory committee proceedings.

Sincerely,

Ben Johnson
Vice President, Policy

[5] Hughes, J. S., Averill, R. F., Eisenhandler, J., Goldfield, N. I., Muldoon, J., Neff, J. M., & Gay, J. C. (2004). Clinical Risk Groups (CRGs). Medical Care, 42(1), 81–90. https://doi.org/10.1097/01.mlr.0000102367.93252.70