California Hospital Association

October 18, 2023

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

SUBJECT: Comments on the September 2023 OHCA Board and Advisory Committee Meetings

Dear Dr. Ghaly:

On behalf of our more than 400 hospital and health system members, the California Hospital Association (CHA) appreciates the opportunity to comment on the September 2023 proceedings of the Health Care Affordability Board and Advisory Committee. We share the Office of Health Care Affordability's (OHCA) commitment to improving the affordability of health care for all Californians. We are here to partner with OHCA to promote affordability while addressing longstanding deficiencies in access, quality, and equity.

This letter provides recommendations and considerations in four key areas in which OHCA and the board are currently making or preparing important decisions:

- **Market Oversight.** We thank OHCA for the positive changes included in the revised October 9, 2023, cost and market impact review (CMIR) regulations, in particular for clarifying that ordinary business transactions are not covered and establishing an expedited review process when access is threatened due to provider financial instability. However, we request a large number of additional amendments to sharpen the focus on the most impactful transactions, clarify and speed up review timelines, add reasonable protections around fees, ensure consideration of the benefits of transactions, clearly formulate the criteria for determining whether to conduct a full CMIR, reduce the burden of the regulations' information submission requirements, and protect confidentiality.
- **Spending Targets.** The September board and advisory committee meetings included valuable discussions of the potential design of the spending targets, but certain important perspectives were missing. Board and advisory committee members expressed potential interest in spending targets based on economic indicators such as growth in average wages. However, as we show below, in peer countries such as Australia, Canada, Sweden, and the United Kingdom, per capita health care expenditure growth has far outpaced average wage growth. These consistent trends among peer countries with diverse health care systems indicates that drivers other than health care policy – like population aging, labor market dynamics, and technological evolution– are behind the relatively high growth in health expenditures. Ultimately, this suggests that a target that is not reflective of the underlying drivers of health care cost growth, such as one solely based

on average wages, would result in severe underinvestment in California's health care system and seriously undermine access to quality care.

- **Risk Adjustment.** At the September board meeting, OHCA announced its intention to risk adjust health care entities' spending data only on the basis of age and sex, foregoing clinical risk-adjustment approaches that perform orders of magnitude better than age and sex in explaining variation in health care spending. We remain worried that this will penalize health care entities for treating high-risk patients, thereby exacerbating health inequities. We summarize research that shows the negative impacts failing to account for risk selection can have on vulnerable populations, in this case, Black infants. We recommend that OHCA instead perform both clinical and non-clinical adjustment during initial implementation to test which approach is better suited to achieving OHCA's objectives of promoting affordable, high-quality, and equitable care.
- **Patient Attribution.** We reiterate our request for early engagement with providers to ensure that the patient attribution methodology OHCA adopts is clearly prescribed via regulation, transparent, open to validation by providers, minimizes misattribution, and calibrated to cover only those providers that have a meaningful influence on their patients' utilization patterns and costs.

Market Oversight

Earlier this month, OHCA released revised draft regulations on the CMIR process. The revised version of the regulations contains meaningful positive changes, for which we thank OHCA. However, CHA has a number of significant remaining concerns with the CMIR regulations as currently drafted. We ask for a number of meaningful changes to ensure the regulations accord with OHCA's authorizing statute and prevent avoidable and widespread negative impacts on California's health care providers and their patients.

Further Focus on the Most Impactful Transactions. As drafted, the regulations establish noticing and materiality requirements that would capture a large number of market and operations activities that extend beyond what was intended by the authorizing legislation. We urge OHCA to make additional changes to narrow the draft regulations and focus its efforts on transactions likely to have significant effects on the health care market, reduce the uncertainty around when filing is required by health care entities, and ultimately lighten the burden placed on health care entities—including small and rural entities—seeking business and operational relationships to continue delivering accessible and high-quality care in their communities.

- **We Applaud the Exemption of Transactions in the Ordinary Course of Business.** The former version of the draft regulations would have required routine changes in business operations to go through the CMIR process. For example, basic activities like a hospital contracting with a health plan to be an in-network provider, updating an electronic medical record system, securing a loan, or leasing new medical office space would have been covered. The revised regulations by-and-large address this flaw by categorically exempting transactions in the usual and regular course of business from the definition of a transaction. We thank the office for this critically needed change. We ask OHCA to clarify that this exemption extends to "ordinary and customary *financing* transactions" to avoid notices relating to the ordinary financing of a providers' operations, such as taking out a loan to purchase a large piece of medical equipment or bond financing a capital improvement project.

  Conform to the Materiality Requirements in Statute. State statute requires a notice of a material change only when a health care entity transfers "*a material amount* of its assets to one or more entities" or transfers control, responsibility, or governance of "*a material amount* of the

assets or operations to one or more entities." In other words, each circumstance requiring a filing must include a threshold dollar amount of assets and/or a threshold measure of control *that is being transferred*. Several of the conditions requiring notice of a material change under the regulations fail to comply with this statutory imperative. They instead mention a dollar amount or percentage for a resulting revenue increase, resulting new revenue, or a new form of ownership. The regulations conflate a "material transfer" with "material resulting revenue." We recommend various amendments to conform the regulations to statute and ensure filings are required only when a material amount of assets or control is transferred.

- **Establish Reasonable Asset Transfer Materiality Thresholds Pegged to Inflation**. We maintain that the $25 million threshold for providing notice is much too low, neither recognizing the size of California nor the 30% inflation that has occurred since Massachusetts set the precedent for this threshold. To prevent ever smaller transactions (in real dollar terms) from falling under the review process, CHA recommends that any adopted threshold be updated regularly to account for inflation. To address both these concerns we recommend adopting the Federal Trade Commission benchmark. If OHCA does not adopt this benchmark, we recommend applying a standalone inflation adjustment to whatever dollar thresholds are adopted.
- **Conform With Generally Accepted Definition of "Control."** The draft regulations now define a change in control as a transaction that transfers more than 25% of the control of a health care entity. This threshold is still far too low. A person or corporation with a 25% interest in a health care entity does not control the health care entity. Moreover, the threshold belies substantial legal precedent as to the meaning of "control." Both the California Corporations Code and the Federal Trade Commission set a 50% threshold for defining control. As a rule of statutory construction, the Legislature is presumed to know existing law when enacting new laws. As such, they undoubtedly knew the definition of "control" and chose to use that term in the governing statute. We recommend the 50% threshold be adopted.

Establish Clear and Speedy Timelines for CMIR. We thank OHCA for proposing an expedited review process for transactions intended to save financially distressed providers and prevent losses in access. However, we remain concerned that the CMIR process would take a minimum of 250 days for transactions subject to full review—over two months longer than Oregon's comparable deadline. This would add hundreds of thousands of dollars to the cost of transactions and produce a chilling effect on prospective collaborations, regardless of how beneficial the arrangement would be to California patients and communities. We again urge OHCA to expedite and clarify its timelines for the CMIR process. Specifically, we request several practical changes to deadlines to reduce the timeline to 200 days—comparable to that in other states. We further ask OHCA to clarify OHCA's missing deadline for publishing preliminary reviews, establish reasonable protections against overly long and potentially unrestricted tolling against OHCA's deadlines, and adopt additional reasonable rules that hold OHCA accountable to achieving its deadlines.

Establish Reasonable Fees for CMIR Activities. Existing governmental reviews of arrangements among health care entities regularly entail hundreds of thousands of dollars in costs to reimburse government agencies for their use of outside consultants and experts. Because government agencies simply pass along these costs to regulated entities, the fees charged by consultants to government agencies often greatly exceed the amounts these same consultants charge directly to health care entities for similar work. For this reason, and to comply with statutory requirements, it is critical for OHCA to put in place reasonable protections regarding the fees that will be charged to health care entities under the CMIR process. We again ask OHCA to amend the regulations to ensure that fees charged are reasonable and accord with the economical costs of conducting a review.

Ensure Benefits of Proposed Transactions Are Given Appropriate Consideration. OHCA's authorizing statute requires that the benefits of proposed transactions be considered in the CMIR process. However, the revised regulations remain silent on whether and how OHCA will consider these benefits. The regulations must be revised to affirm and enumerate OHCA's responsibilities to give the benefits of proposed transactions their proper consideration.

Clearly Formulate Criteria for Determining Whether to Conduct a Full CMIR. While the draft regulations list the factors OHCA will consider when determining whether to conduct or waive a full CMIR, they continue to provide no clarity about how OHCA will evaluate those factors. In fact, the draft regulations allow OHCA to make arbitrary decisions about which transactions will be subject to a CMIR based entirely on lax speculation. As a result, health care entities would have little to no ability to anticipate whether an intended transaction would receive a waiver within 60 days or be delayed by 250 or more days. We strongly encourage OHCA to conform these criteria with the statutory imperative requiring OHCA to review transactions likely to have significant effects on the market.

Reasonable Information Submission Requirements for Parties to a Transaction. We remain concerned that the information submission requirements on parties to a transaction place unnecessary burdens on health care entities, increase compliance costs, and exacerbate the risk that sensitive and confidential information will be released into the public domain. Accordingly, the information submission requirements — as currently drafted — should be scaled back to balance OHCA's need for information with the negative impacts that overly onerous reporting requirements would have on health care entities' basic market activities. In addition to several other requested changes, we recommend OHCA limit the submission requirements accompanying an initial notice of a material change to those of Massachusetts and Oregon, as well as California state agencies, including the Department of Justice. Additional information necessary to inform a full CMIR should be collected only when OHCA elects to conduct a full review following a waiver decision (or, at minimum, after OHCA elects not to grant a request for an expedited review). Finally, we ask for technical changes to the definition of revenues for information submission purposes.

Protect Sensitive Non-Public Information Provided to OHCA. We appreciate that OHCA has the difficult task of balancing public transparency with the parties' rights to keep sensitive proprietary information confidential. CHA recommends that Hart-Scott-Rodino filings, competitively sensitive information, and contact information for individuals other than the designated public contact be deemed confidential. In addition, we request that OHCA provide an opportunity for the submitter to appeal the denial before OHCA makes the information public.

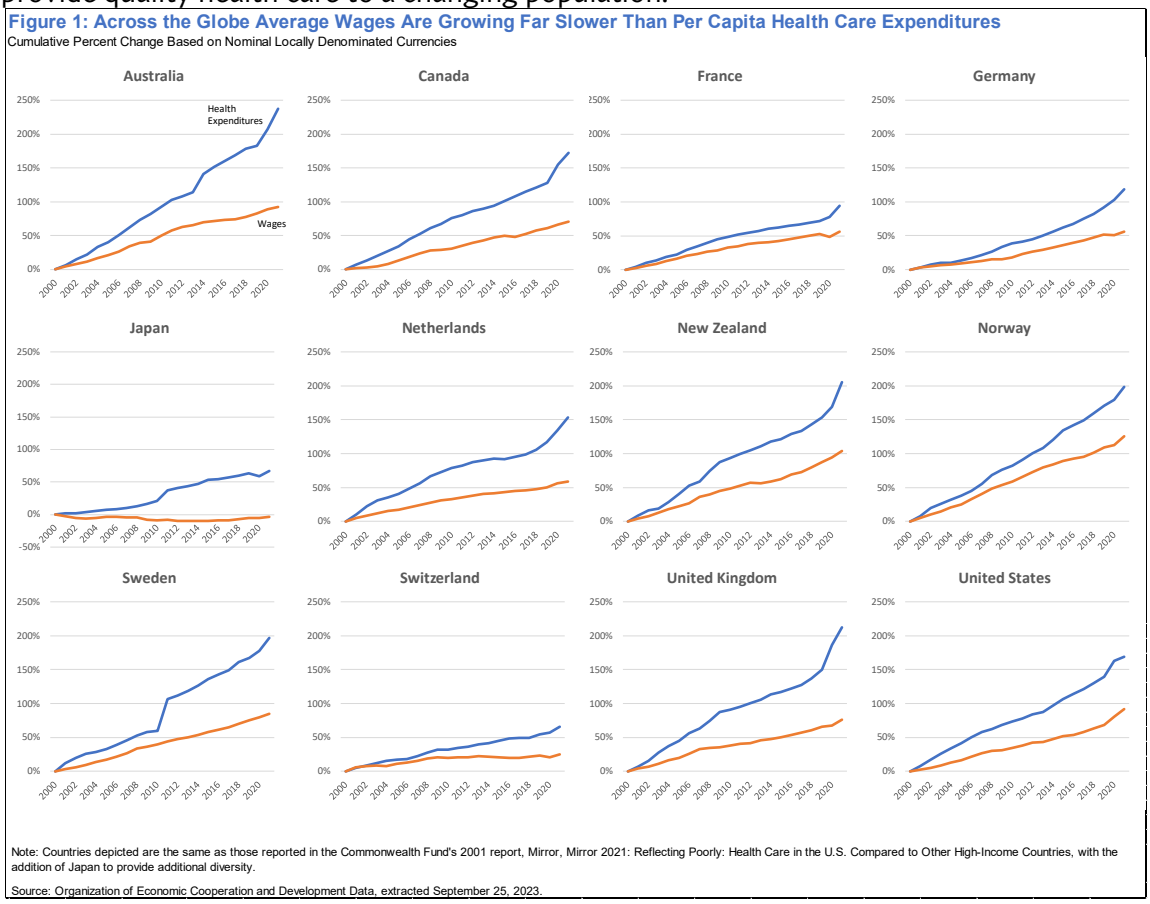
Spending Targets

The September board and advisory committee meetings included the first in-depth discussions of the design of the spending targets. These discussions were extremely valuable. However, certain important perspectives were missing.

We Urge OHCA to Strive for an Affordable *and* High-Performing Health Care System. Unfortunately, the presentation and subsequent discussion on the spending targets focused on only one of OHCA's multipronged objectives—that of affordability While we agree on the importance of considering how the economic experiences of California households relate to economic indicators that could be used as spending targets, we believe this cannot be the only consideration for setting an appropriate and workable spending target. Specifically, it may not be possible to realize a high-performing health-care system under the constraints of a spending target equal to the economic indicators considered during the September discussions.

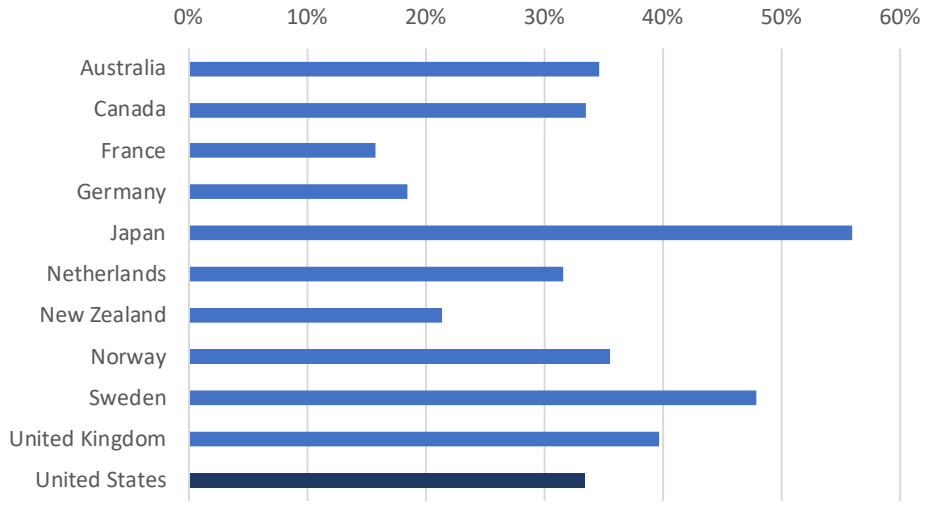
A Spending Target Exclusively Based on Wage or Income Growth Would Bring Serious Downside Risks. Spending targets based on measures of average or median income or wage growth are intended to limit health care spending growth to what individual families can afford. We understand the intuitive appeal of this approach, as voiced by members of the board and advisory committee. However, a deeper look at these measures reveals that they are inconsistent with the underlying realities of supporting even a highly cost-effective health care system.

- **Peer Countries Do Not Experience Health Care Cost Growth at Levels Comparable to Wage Growth…** The United States' peer countries include those with a wide array of health care systems and health care cost containment strategies. If a proposed spending growth target such as average wages were readily attainable, we would expect at least one of America's peers countries to have attained it. However, as shown in Figure 1, none of the 11 peer countries analyzed have seen their per capita health expenditures grow below, or even near, average wages. In fact, between 2000 and 2019, the growth rate for per capita health expenditures was roughly double that for average wages. The consistency of these trends across countries with diverse health care systems indicates that this divergence is not simply due to health care policy differences. Otherwise, we would not expect to see similar trends across countries. For example, if different levels of regulation were the key driver, we would expect divergent trends between countries with highly centralized and regulated systems (e.g., Canada and United Kingdom) and countries that are less regulated or more market oriented (e.g., the U.S. and the Netherlands). What this suggests is that underlying economic and demographic factors are key drivers of the higher growth in health expenditures. Therefore, limiting health care cost growth to a measure of wage growth risks seriously undermining the capacity of California's health care system to provide quality health care to a changing population.



- **…Or Even at Gross Domestic Product (GDP) Growth Levels.** Figure 2 shows that health expenditures have increased as a share of GDP in all the peer countries analyzed over roughly the last 20 years. Necessarily, this indicates that health care costs have grown at a faster rate than overall GDP in these countries, raising the question of whether even a GDP-based spending target could bring unintended negative consequences.

Figure 2: Across the Globe Health Expenditures Are Growing as a Share of GDP
Percent Change Between 2000 and 2019



GDP = gross domestic product.

- **Household Consumption Patterns Do Not Remain Fixed Over Time.** Households' and society's consumption patterns change over time as incomes grow, technologies evolve, and labor market dynamics shift. For example, households may spend significantly less of their income on goods subject to significant technological and cost-saving innovation (e.g., televisions). Alternatively, they may shift expenditures toward certain goods and services as their incomes increase. For example, while Americans' incomes have grown in the aggregate by 175% since 2000, their spending on restaurant meals has increased by over 300%, spending on hotels and other accommodations increased by nearly 225%, and spending on internet access increased by over 700%.[1] Two major patterns help explain which types of expenditures are likely to grow faster than income. First, industries that are labor intensive (that is, they employ many people and relatively fewer machines) tend to grow relatively more expensive over time, as they do not benefit as much from cost-saving automation as do more capital-intensive industries. Labor is a major input in the health care sector (as it is for restaurants and hotels),[2] including for hospitals where labor expenses comprise around 60% of total expenses. Second, industries that introduce major new products through technological innovation also tend to grow more rapidly than industries focused

[1] The higher growth in expenditures on these goods and services than in incomes necessarily implies that the share of income that households are spending on these goods and services has increased. For example, the share of income that Americans are spending on restaurant meals has increased by 57% since 2000, an increase that is greater than or comparable to that for health care among the peer countries compared in Figure 2.
[2] Bates, Laurie J., and Rexford E. Santerre. "Does the U.S. Health Care Sector Suffer from Baumol's Cost Disease? Evidence from the 50 States." Journal of Health Economics, vol. 32, no. 2, Mar. 2013, pp. 386–391, https://doi.org/10.1016/j.jhealeco.2012.12.003. Accessed 15 Aug. 2020.

on refining and improving existing products. Health care is a dynamic sector that regularly introduces revolutionary new and often expensive treatments that are then quickly adopted, a dynamic similar to the widespread adoption of internet access since 2000. In addition to these larger economic trends, demographic trends like aging cause a shift in income shares spent on health care. In the European Union, for example, aging alone is expected to increase the share of GDP spent on health care by 1.3 percentage points over the next 40 years.[3] These trends show how tying health care expenditure growth to economic indicators unrelated to the underlying drivers of health care cost growth could lead to harmful underinvestment in the sector.

We encourage the board and OHCA to incorporate these considerations into their future discussions, and ultimately into the spending targets and related methodologies they adopt. Such considerations could be formally incorporated into the targets in multiple ways, such as: the selection of economic and demographic indicators that tie more closely to the underlying drivers of health care costs, aggregating multiple such indicators into a spending target, and through adopting adjustment factors that ultimately result in a reasonable and attainable target.

Risk Adjustment

OHCA's Approach to Risk Adjustment Continues to Raise Concerns. At the September board meeting, OHCA announced its decision to risk adjust health care entities' spending data only on the basis of age and sex. With this decision, OHCA will forego clinical risk-adjustment approaches that perform orders of magnitude better than age and sex in explaining variation in health care spending. We worry that this will expose health care entities to potential enforcement action due to forces beyond their control—in this case, year-to-year fluctuations in the risk profile of their patient populations. In doing so, the spending target program will disincentivize health care entities from serving the highest risk and cost patients, which is inconsistent with supporting an equitable health care system.

Case Study: Risk Selection Hurts Black Infant Health. Several high-quality studies have demonstrated that failing to account for risk differences within payment methodologies can result in worse health outcomes, particularly for vulnerable populations.[4] A notable study of Texas's Medicaid program showed how Black infants — but not Hispanic infants — suffered higher morbidity and mortality rates when the program transitioned from fee for service to managed care, and thereby introduced new opportunities for risk selection.[5] While managed care plans received identical payments for Black and Hispanic infants,

---

[3] Williams, Gemma A., et al. How Will Population Ageing Affect Health Expenditure Growth? Www.ncbi.nlm.nih.gov, European Observatory on Health Systems and Policies, 2019, www.ncbi.nlm.nih.gov/books/NBK550603/.

[4] In addition to the study described in detail in the body, see the following for evidence of the negative impact that unmitigated risk selection can have on vulnerable populations, including high-cost patients generally and cancer patients specifically:

- Wynand P. M. M. van de Ven, Richard C. van Kleef, and Rene C. J. A. van Vliet; Risk Selection Threatens Quality of Care for Certain Patients: Lessons from Europe's Health Insurance Exchanges; Health Affairs 2015 34:10, 1713-1720
- Kreider, Amanda and Layton, Timothy J. and Shepard, Mark and Wallace, Jacob, Adverse Selection and Network Design Under Regulated Plan Prices: Evidence from Medicaid (December 2022). NBER Working Paper No. w30719, Available at SSRN: https://ssrn.com/abstract=4293632

[5] Kuziemko, Ilyana and Meckel, Katherine and Rossin-Slater, Maya, Do Insurers Risk-Select Against Each Other? Evidence from Medicaid and Implications for Health Reform (July 2013). NBER Working Paper No. w19198, Available at SSRN: https://ssrn.com/abstract=2289108

black infants' hospital charges were 80% higher due to their more complicated labor and deliveries. In response to this predictable variation in costs, the authors concluded that the managed care plans had taken actions to enroll and retain more of the relatively lower cost Hispanic enrollees, while doing the opposite for the Black enrollees. Consequently, Black infants suffered even worse health outcomes due to a lack of appropriate preventive care, further widening already unacceptable disparities. Incorporating appropriate models of risk adjustment could have reduced these poor incentives and the resulting damage to Black infant health. However, sex- and age-only risk adjustment could have done nothing to prevent the harm mediated by racial risk differences.

Recommend an Alternative Approach of Testing Multiple Risk Adjustment Models. We appreciate OHCA's stated willingness to reconsider in the future its approach to conducting risk adjustment only on the basis of sex and age. However, without testing and comparing the outcomes of the two distinct approaches to risk adjustment, it is unclear what information OHCA would use as the basis of a future change in approach. Accordingly, we recommend that OHCA simultaneously pilot the two forms of risk adjustment and decide, with information in hand, on the appropriate approach on an ongoing basis.

Patient Attribution

As we have noted in prior letters and testimony, holding providers appropriately accountable against the spending targets will depend on accuracy of the patient attribution methodology. We request early engagement with providers to ensure that the methodology OHCA adopts is clearly prescribed in regulation, transparent, open in practice to validation by providers, designed to minimize cases of misattribution, and calibrated to cover only those providers that have a meaningful influence on their patients' utilization patterns and costs.

Thank you for the opportunity to comment on these important matters currently under consideration by OHCA, the board, and advisory committee.

Sincerely,

Ben Johnson

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:
David M. Carlisle, MD, PhD
Secretary Dr. Mark Ghaly
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan