May 6, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Merrick B. Garland
Attorney General
Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

The Honorable Lina Khan
Commissioner
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

SUBJECT: **Docket No. ATR 102 - Request for Information on Consolidation in Health Care Markets**

Dear Secretary Becerra, Attorney General Garland, and Commissioner Khan:

On behalf of more than 400 member hospitals and health systems, the California Hospital Association (CHA) is pleased to submit comments in response to the joint Department of Health and Human Services (HHS), Department of Justice (DOJ), and Federal Trade Commission (FTC) request for information on consolidation in health care markets.

California's hospitals are struggling financially because of rapidly increasing costs paired with inadequate governmental payment rates. The primary cost driver contributing to hospital financial fragility is the continuing rapid increase in costs for labor, pharmaceuticals, and supplies. These are the three largest expense categories for California hospitals and have grown since 2019 by 22%, 19%, and 18%, respectively, per adjusted discharge[1]. In addition to these direct patient care costs, hospitals face considerable costs related to federal regulation and state regulation. It is estimated a 161-bed hospital annually incurs over $9.7 million[2,3] in costs associated with complying with federal regulatory

[1] https://www.kaufmanhall.com/sites/default/files/2023-04/CHA-Financial-Impact-Report.pdf
[2] www.aha.org/system/files/2018-02/regulatory-overload-report.pdf
[3] Adjusted for inflation using the Produce Price Index for services; https://fred.stlouisfed.org/series/PCUASTDSVASTDSV

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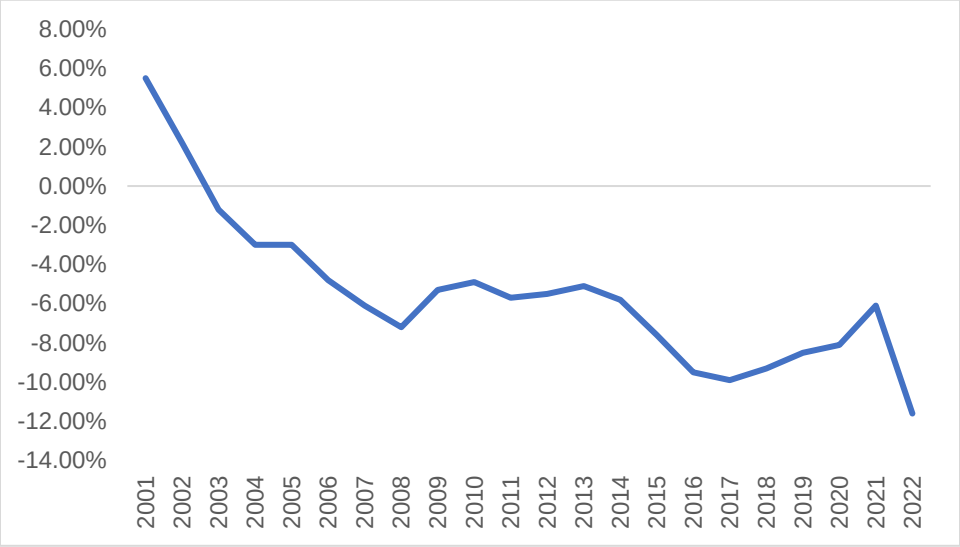
requirements. These costs have grown considerably over time and are in many instances fixed or step-fixed costs which means the per adjusted discharge component will be reduced if they can be spread over a large volume of discharges. State regulatory requirements have also increased (and will continue to increase) hospital operating costs considerably. As examples:

- **Health Care Worker Minimum Wage:** In 2023, the state approved a new $25 health care worker minimum wage, which will be implemented gradually over the next several years. At full implementation, this law is expected to raise health care spending by nearly $8 billion, or 1.5% compared to existing statewide health care spending.

- **Seismic:** California's hospitals have been subject to seismic compliance for **several** years. The next major deadline to meet the state's seismic standards arrives in 2030, requiring hospitals to make around $160 billion in capital improvements over the next six years to comply with the state's rules. Hospitals will borrow to pay for these capital improvements. It is noted that many of California's financially distressed hospitals will lack the balance sheet capacity to borrow the necessary funds to comply with these requirements. Therefore, these distressed hospitals will need to consider alternatives such as integrating with a hospital or health system that has a stronger balance sheet to access capital at affordable rates or potentially risk closing.

Neither Medicare nor Medi-Cal payments cover the cost of providing care to beneficiaries of the programs. Combined they cover approximately 73% of patients in California's hospitals. This means that California's hospitals lose approximately 25 cents for each dollar of cost to provide care to almost three-quarters of their patients. This is not a new trend, as nationally, hospitals' operating margins for Medicare patients have been negative for over 20 years based on data from the Medicare Payment Advisory Commission (MedPAC).

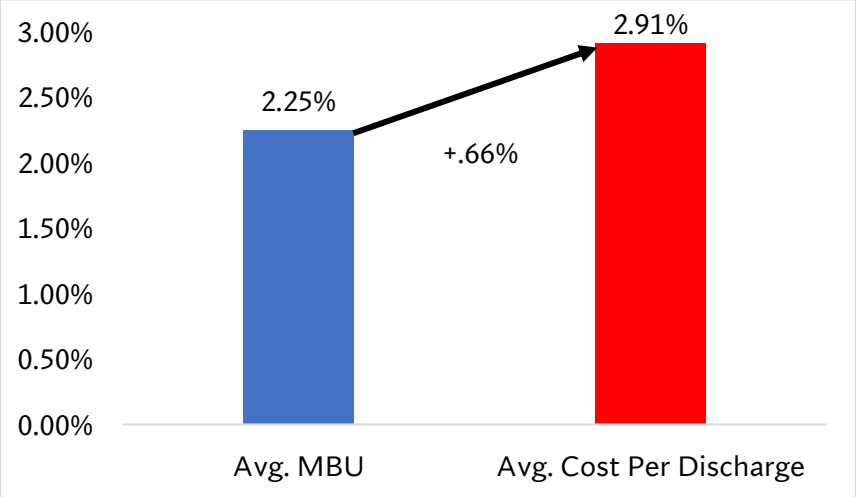
Hospital Operating Margin – Medicare Patients: 2001 to 2022[4,5,6,7]



[4] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch3_SEC.pdf
[5] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch3_sec.pdf
[6] www.medpac.gov/wp-content/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC.pdf
[7] https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-Hospital-payment-adequacy-Jan-2024.pdf

These negative margins are the direct result of input price inflation that has vastly outstripped the growth in Medicare payments as illustrated in the exhibit below. Concern about inadequate Medicare payment rates' destabilizing effect on hospital finances (and therefore access to care) is such that over the last two years[8,9], MedPAC has recommended that Congress significantly increase Medicare base payment rates above current law and provide additional funding to safety-net hospitals. This is the first time the nonpartisan, Congressional advisory body has taken such a step.

Hospital Market Basket Update vs. Per Discharge Cost Growth:
Average 2016 to 2021



Further exacerbating the pressure created by governmental payer underpayment is the highly concentrated nature of California's individual, small group, and large group insurance markets. The Herfindahl-Hirschman Index scores for these markets are 2,570[10], 2,494[11], and 3,121[12], respectively, which far exceed the threshold score of 1,800 the FTC uses to consider a market highly concentrated[13]. This degree of financial concentration allows market-dominant health plans to dictate payment rates to independent hospitals and smaller systems that do not cover the reasonable cost to provide care and the governmental payment shortfall (as evidenced that growth in revenue per adjusted discharge in California is 1.1% lower than the national average)[14].

The increasing financial pressure on California's hospitals is such that nationally renowned consulting firm Kaufman Hall estimates that one in five hospitals are at risk of closure. As evidence of this pressure, in 2023, one California hospital (Madera Community Hospital) closed and another two (Beverly Hospital

[8] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf
[9] https://www.medpac.gov/recommendation/hospital-inpatient-and-outpatient-services-3/
[10] https://www.kff.org/other/state-indicator/individual-insurance-market-competition/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[11] https://www.kff.org/other/state-indicator/small-group-insurance-market-competition/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[12] https://www.kff.org/other/state-indicator/large-group-insurance-market-competition/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22california%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[13] https://www.justice.gov/atr/herfindahl-hirschman-index
[14] CHA Analysis of HCRIS Medicare Cost Report Data (Fields: Net Patient Revenue, Total Operating Expenses)

and Hazel Hawkins Memorial Hospital) declared bankruptcy[15]. Even more concerning, many other hospitals are in severe financial distress and perilously close to reducing services, declaring bankruptcy, or shuttering outright[16].

Following hospital or service line closures, patients are forced to travel farther distances for care in already overcrowded hospitals, resulting in negative outcomes. Research shows that hospital closures disproportionately impact populations at greater risk of inequitable outcomes. After the closure of a rural hospital, inpatient mortality increases by 8.7%, with Medicaid patients (including those who are dually-eligible) and racial minorities bearing the brunt of negative outcomes — 11.3% and 12.6% increases in mortality, respectively[17].

These are not abstract data points. A recent survey to determine the impact of Madera's closure on the Punjabi population and indigenous farm workers in the affected area found that over 60% of respondents will have to find medical centers outside of the community to receive care. Unfortunately, over half of the indigenous farm workers who responded to the survey reported they do not have a reliable mode of transportation to the nearest hospital[18]. This reduced access to care further exacerbates inequitable outcomes for patients who live in socioeconomically disadvantaged areas[19]. Sadly, at least two individuals' deaths have been directly attributed[20] to Madera Community Hospital's closing.

Beyond the impact on patients' lives and access to care, the closure of a hospital like Madera profoundly changes communities for the worse. Prior to closing, the hospital employed an estimated 681 full-time equivalent employees (over 200 registered nurses) or approximately 1.5% of the area's working age population[21]. Given the shortage of health care professionals, many of these individuals will be able to find new jobs. However, it will require them to travel considerably farther as the closest hospital is over 20 miles away[22].

The difference in outcomes for the communities served by Beverly and Hazel Hawkins and Madera are stark and come down to one factor[23]. Beverly and Hazel Hawkins were able to integrate with financially stable health systems and have continued serving their communities; Madera was not. The state imposed onerous conditions on the health system attempting to integrate with Madera to ensure its continued operations. These conditions would have made it impossible for Madera to achieve financial sustainability in the face of rapidly growing costs and inadequate governmental payments[24]. As result, Madera remains closed, and the best-case scenario is that it will reopen this July[25].

[15] https://calmatters.org/health/2023/08/bankrupt-california-hospitals-health-chains/
[16] https://www.latimes.com/california/story/2023-08-25/california-lifeline-17-hospitals
[17] https://www.nber.org/system/files/working_papers/w26182/w26182.pdf
[18] https://a27.asmdc.org/press-releases/20230511-community-organizations-release-survey-effects-madera-hospital-closure
[19] https://www.fresnobee.com/news/local/article272712840.html
[20] https://www.fresnobee.com/news/local/article272712840.html
[21] CHA analysis of California Department of Health Care Access and Information 2022 data
[22] https://fresnoland.org/2023/12/08/madera-hospital-2/
[23] https://calmatters.org/health/2023/08/bankrupt-california-hospitals-health-chains/
[24] https://fresnoland.org/2023/03/01/reimbursements-rates-madera-hospital-closure/
[25] https://calmatters.org/health/2024/02/madera-hospital-reopen/

Health system integration activities, including those financed by private equity[26,27], create value for the communities served by the hospitals involved. Reflexive and ill-conceived efforts to block health system integration activities in general or those financed through certain mechanisms will reduce access to care, increase health insurance premiums for consumers, limit access to advanced services, stymie innovation and quality improvement, and leave communities ill-prepared to respond to the next pandemic. This, in turn, will have a negative impact on consumers, patients, and hospital employees[28]. Below, please find a full discussion of each of these areas.

Access to Care: Beyond the examples discussed above, other recent transactions have preserved and expanded access to care in California. Two transactions in 2020 serve as useful additional case-studies to illustrate the need for integration activity.

- *Petaluma Valley Hospital*: In November 2020, 85% of voters in Sonoma County approved the sale of Petaluma Valley Hospital to Providence St. Joseph Health and the sale was finalized in January 2021. The hospital had struggled for years with limited funding and was in dire need of infrastructure repairs. Without action, the hospital could have faced closure. Now, nearly 400 employees who faced an uncertain future have been provided with stability and job security and millions of dollars required for infrastructure repair (e.g., seismic compliance, a new roof, new boilers, and replacement of other aging equipment) have been secured.

- *St. Francis Medical Center*: Located in South Central Los Angeles — an area where residents have long struggled with inequitable health outcomes — the hospital received a much-needed lifeline when the U.S. Bankruptcy Court for the Central District of California and the California attorney general approved Prime Healthcare's purchase of the hospital on Aug. 14, 2020. Through a focus on local hiring, Prime Healthcare has been able to stabilize jobs for 2,000 St. Francis employees and also support local subcontractors and businesses.

  Beyond St. Francis strengthening the economy in South Central Los Angeles, patients have benefited as well. For example, St. Francis has expanded its behavioral health capacity by 60%[29], enhanced its cardiology and radiation oncology services through new clinical capabilities, and, through new partnerships with the Children's Hospital of Orange County and UC Irvine Health, brought neonatal clinicians to residents of Lynwood and the surrounding neighborhoods, keeping patients closer to home and improving maternal health in the communities St. Francis serves.

Correlation Between Integration and Insurance Premiums: Despite the RFI's assertion, there is no apparent correlation between higher levels of integration and lower levels of affordability for consumers. To the contrary, consumers in more highly integrated states may have more affordable insurance premiums and lower per capita health care expenditures[30].

[26] The use of private equity financing allows hospitals and health systems to expand access to specialty services through joint ventures with groups that have operational and management expertise that are not native in most acute care focused delivery systems.
[27] Many of the "physician enablement" companies supporting independent physician practices' transition to value-based care models like accountable care organizations are funded in part by private equity investments.
[28] https://calhospital.org/wp-content/uploads/2021/10/KH-CHA-Benefits-of-Integration-Report_Final_Revd10-21-2021.pdf
[29] Providing much needed access to mental health care for individuals in crisis and supporting this administration's goals of addressing the mental health crisis.
[30] This discussion defines the most highly integrated states as those in which 80% or more of community hospitals are in a system, including the District of Columbia, Florida, Hawaii, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, and Virginia. The least integrated states are those in which fewer than 40% of community hospitals are in a system, including Alaska, Kansas, Montana, Nebraska, Vermont, and Wyoming.

The Kaiser Family Foundation's 2019 data for the average annual single premium per enrolled employee for employer-sponsored insurance (the main source of individual health plans for consumers) shows that almost 80% (7 of 9) of the most highly integrated states identified by the American Hospital Association data had total annual premiums below the national average of $6,972 (California was also below this average). In comparison, 50% of the least integrated states had total annual premiums above the national average[31,32]. Similarly, the most recent data on per capita health expenditures by state shows that two-thirds (6 of 9) of the most highly integrated states have expenditures below the national average of $8,045 (again, California also is below this average). In contrast, more than 80% (5 of 6) of the least integrated states have expenditures above the national average[33].

These lower premiums are a direct result of the cost efficiencies achieved through integration activities. Integrated systems centralize support functions such as finance, information technology, and human resources, spreading the cost of these functions across a greater number of adjusted patient discharges. A study of hospital integration transactions completed between 2000 and 2010 found "evidence of economically and statistically significant cost reductions at acquired hospitals," with average cost savings between 4% and 7% in the years following the transaction[34].

When an independent hospital integrates with a larger system, it also reduces their cost of capital. This is increasingly important in California as hospitals and smaller health systems will need to access capital markets to renovate existing facilities or build new ones to come into compliance with the state's seismic resilience requirements. Research shows these efficiencies reduce operating costs[35] by 2.3%[36] at facilities recently integrated into health systems. These savings are transmitted to commercial health plans, as revenue per admission at integrated hospitals is reduced by 3.5%. While the data above suggests that some of these savings are passed through to consumers via lower premiums, the agencies should undertake rigorous research to determine if all these savings are passed along to consumers. There is reasonable concern that some of these savings are illegitimately retained by certain health plans that place profits over patients.

Innovation and Quality Improvement: The link between higher volumes and improved clinical outcomes is well established. Hospital and health system integration activity is shown to statistically reduce rates of readmission and mortality[37]. The Leapfrog Group, one of the nation's leading authorities on hospital quality and safety, has listed eight high-risk procedures for which there is a strong volume-outcome relationship[38]. This relates directly to the value of integration as integrated systems that cover a broader population base will also have higher volumes of most medical and surgical procedures. A quality, focused integration strategy often involves the creation of centers of excellence based upon access to a broader patient population.

[31] Kaiser Family Foundation: State Health Facts: Average Annual Single Premium per Enrolled Employee for Employer-Sponsored Insurance, 2019. https://www.kff.org/statedata/.
[32] https://calhospital.org/wp-content/uploads/2021/10/KH-CHA-Benefits-of-Integration-Report_Final.pdf
[33] Centers for Medicare & Medicaid Services: Health Expenditures by State of Residence, 2017. Retrieved April 26, 2021, at http://www.cms.gov/Research-Statistics-Data-and-Systems/ Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/resident-stateestimates.zip
[34] Schmitt, M.: "Do Hospital Mergers Reduce Costs?" Journal of Health Economics, vol. 52 (2017).
[35] www.hfma.org/wp-content/uploads/2022/10/56348.pdf
[36] www.aha.org/system/files/media/file/2019/09/cra-report-merger-benefits-2019-executive-summary-f.pdf
[37] www.aha.org/system/files/media/file/2019/09/cra-report-merger-benefits-2019-executive-summary-f.pdf
[38] The Leapfrog Group website: Complex Adult Surgery https://ratings.leapfroggroup.org/ measure/hospital/complex-adult-surgery

Further, a report on hospital and health system integration transactions over the past five years supports the role of integration in improving the quality of patient care. Using the Leapfrog Safety Grade as a proxy for quality, the report found an overall median change of one full grade (i.e., from "C" to "B") from pre-integration to post-integration, with 71% of the studied transactions achieving improvement of at least one full grade[39].

As a California case example of the improvement in access to specialty care that stems from integration, Cedars-Sinai and Torrance Memorial Medical Center finalized an affiliation in 2018. Patients have benefited from greater access to specialty services and a higher level of care at Torrance Memorial, thus receiving high quality, complex care closer to home. The affiliation has enabled Torrance Memorial to achieve comprehensive stroke center designation, which indicates that it is among the best-equipped hospitals to treat any kind of stroke or stroke complication. The typical patient loses 1.9 million neurons each minute in which stroke is untreated[40]. Given that "time is brain," the ability to provide comprehensive stroke care in the community has undoubtedly improved stroke outcomes.

In addition to advances in neurosciences, Torrance Memorial has also been able to expand capabilities in thoracic surgery, cardiovascular surgery, cancer, and clinical trials. The Medical Center has seen increased volume for these services and Office of Statewide Health Planning and Development (OSHPD) data suggests that since the affiliation, a greater volume of advanced-level patients[41] have been able to stay in their community for services. The number of OSHPD-defined advanced level patients at Torrance Memorial has grown from 1,872 in 2017 to 1,922 in 2019. At the highest level of care (patients with a DRG of 6+), the number of patients has grown from 258 in 2017 to 341 in 2019, a 32% increase.

Similarly, the formation of CommonSpirit in 2019, through the integration of Dignity Health and Catholic Health Initiatives, allowed the combined system to leverage best practices and clinical expertise from hospitals across the country. This resulted in significant improvements in quality and patient safety. For example, the health system has improved from the 65th to the 81st percentile in treatment for sepsis and from the 49th to the 59th percentile in reduction of c. difficile infections.

Pandemic Response: The COVID-19 pandemic has made clear that integrated health systems are vital resources when responding to a public health crisis. Integrated systems were able to efficiently shift resources (both staff and supplies) to harder hit facilities and to designate COVID-19 and non-COVID-19 facilities to segregate infected patient populations from other patients as key advantages they had over independent hospitals in confronting the pandemic.

As an example, a study[42] by researchers at the University of California, San Francisco, found that while there was a relationship between the number of COVID-19 mortalities and a higher burden of COVID-19 patients, that relationship was not significant at larger hospitals with more than 20 COVID-19 admissions, suggesting "that larger hospitals may be more resilient in the face of patient surges."

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[39] Casey, G., Burgdorfer, R., Mathews, L.: Hospital Mergers and Acquisitions—Studying Successful Outcomes. Berkeley Research Group, LLC, 2020.

[40] https://pubmed.ncbi.nlm.nih.gov/16339467/#:~:text=Background%20and%20purpose:%20The%20phrase,evaluation%20and%20therapy%20are%20required.

[41] Advanced level patients are defined as discharges with DRG weight of 3+ or 6+.

[42] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8025591/#:~:text=This%20suggests%20that%20larger%20hospitals%20may%20be,respiratory%20failure%2C%20or%20other%20factors%20is%20uncertain

A separate October 2020 article published in *Health Affairs* noted the survival benefits of regionalization, where acutely ill COVID-19 patients could be transferred to well-equipped hospitals that had high annual volumes of patients requiring mechanical intervention. But where referring and admitting hospitals were not integrated, the familiar barriers of a fragmented health system interfered with patient care[43]. It is worth noting that the authors of this study concluded, "It is time for the policy community to reconsider what has been, in the past two decades, an increasingly hostile posture toward these large complex enterprises and consider what steps can be taken to encourage them to take a broader public health role."

As the HHS, DOJ, and FTC assess integration activities, the agencies must recognize the realities of operating a hospital in the current environment. Systematic underpayment by governmental payers, highly consolidated payers, costly, and ever-increasing regulatory requirements and complex billing requirements have stacked the deck against independent hospitals and health systems that lack economies of scale[44].

Additional restrictions on the ability to integrate (or use the financing mechanism that best achieves the goals of integration) will come with significant losses in access to care, quality improvement, cost efficiency, consumer affordability, innovation, and disaster/pandemic response resilience. CHA appreciates the opportunity to respond to this request for information. If you have any questions, please contact me at cmulvany@calhospital.org.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy

[43] Pollack, H., Kelly, C.: "COVID-19 and Health Disparities: Insights from Key Informant Interviews." *Health Affairs*, Oct. 27, 2020.
[44] Beyond the traditional benefits that scale conveys to health systems (e.g. access to capital at a lower cost, larger purchase volumes that allow for favorable per unit pricing from vendors of medical supplies and pharmaceuticals that have monosomy or monopoly power) health care delivery is fundamentally a knowledge business. On the clinical delivery side, specialized subject matter experts and large data sets are required to continuously improve outcomes and reduce the cost of care delivery. Given regulatory and revenue cycle complexity, specialized subject matter experts are required on the administrative side to ensure compliance with existing laws and that hospitals receive appropriate reimbursement from governmental payers and the contracted amount they are entitled to from commercial payers.