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Health Care Affordability Board
June 20, 2023
Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox.

Date	Name	Written Comment
6/29/2023	Gerald Rogan	Old History: During 1995-1998 my family and urgent care group practice of 7 FTE physicians in Walnut Creek was destroyed by its hostile takeover by a local hospital that bought most of the local primary care physician practices to establish the Muir Medical Group, whose operations were subsidized by the hospital through its medical foundation. The cost to establsihed the Medical Group was $56 million. Each selling physician was paid about $250,000 and joined the Medical Group. Our practice, of 7 FTE physicians was open every days for 18 years> Operating like a "medical home" today, we served about 10,000 patients at affordable prices- about twice the cost of a haircut at a beauty shop for an office visit. For urgent care, our average fee for a typical encounter, including tests and x-rays, was $65.00 or about 1/5th of the fees charged across the street in Emergency Department for the same services. Often we could avoid tests such as an ankle x-ray for an ankle sprain because we offered follow-up. In 1997, after joining Medicare administration, I explained how the vertical integration process works to CMS in Baltimore, then, at its request to the OIG HHS Office of General Counsel, Industry Analysis Group. My presentation is "The effect of Vertical Integration on the Medicare Trust Fund."You can fnd it here. Resources – Rogan Consulting During the 1990s, hospitals were buying physician practices to take control of testing

		referrals. In California, the process started with the Palo Alto Foundation, Next was Sutter with its "clinic without walls". Muir followed as did a hospital system in SF. The hospitals' profits were driven by redirecting referrals from independent physician offices to the hospital's outpatient facility where a facility fee applies. Examples include mammograms and treadmill tests. Hospitals also secured inpatient referrals and put some urgent care clinics out of business. One forced to close was in San Ramon. This change in referrals constituted payment for referrals. CMS/DOJ stopped the vertical integration process for about 10 years beginning around 1998. Established intetrated practices were not dissolved, except for Salick Cancer Centers, one of which was in Walnut Creek. The business plan was to buy an oncology practice, change it to a hospital outpatient infusion facility, and charge facility fees which were not payable when the same space was a physician's office. All Salick centers did was change the name on the door of the office and run up the bill. At the time, in 1995 the MBC knew about the vertical integration and approved it. Its justification was section 1206(l) of the California Health and Safety Code and acceptance of the controversy about who owned the patient's medical records. I attended a meeting about this at the time, sponsored by the Medical Board. I was the only practicing physician at the meeting. At the time, the CMA leasdership supported vertical integration even though its official policy disapproved it. Your data suggests the problem of "runnoing up the bill" remains, 28 years later. What you can do now is look at the fees paid for hospital outpatient facilities for the same services provided in a physician's office. Also, by owning the physician practices, a hospital can negotiate higher fees for service and hospital rates with insurers. However, it is more difficult for a physician to have an independent practice today then in

		1995, due to technology costs and other factors. Integration of medical groups with a hospital is actually a good thing because of a combined medical records and specialty resources. KPMG and KFHs are a good example. Anyway, I hope you enjoy the story about how all of this came to be. Good luck improving value!
6/20/2023	Monterey County	See Attachment #1.
7/20/2023	Health Access CA	See Attachment #2.
8/14/2023	CA Hospital Association	See Attachment #3.

	Annual Premiums	Deductible	OPM
Plans with the three County Hospitals **In-network**			
PPO 25 Single Family	11,700 30,320	650	4,000
PPO 40 Single Family	10,600 26,070	1,500	6,350
Three County Hospital are **Out-of-Network** for below (CHOMP, Salinas Valley Health, Natividad)			
PPO Select Single Family	7,070 18,290	1,000	6,350

OUR STORY MONTEREY COUNTY

- **Regional/ Sector Considerations**
- **Analyzing and controlling "spending growth"**
- **Monterey County already exceeds "spending targets" when compared with other regions**

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HEALTH ACCESS CALIFORNIA

July 20, 2023

The Honorable Mark Ghaly, M.D., Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Department of Health Care Affordability and Information

Vishaal Pegany, Deputy Director
Department of Health Care Affordability and Information
Office of Health Care Affordability

Re: June 2023 Health Care Affordability Board: Comments

Dear Dr. Ghaly, Ms. Landsberg, Mr. Pegany,

Health Access California, the statewide health care consumer advocacy coalition committed to quality, affordable care for all Californians, offers comments on the materials presented at the June 2023 Health Care Affordability Board meeting.

Summary of Recommendations:

- Cost and Market Reviews: Not just Transactions, Not Just Consolidation
  - Health Access recommends that as the law provides, OHCA engage not just in transaction reviews, but also cost and market impact reviews to investigate market power and market failures in addition to transactions and consolidation.
  - Health Access recommends that OHCA view its reviews as complementary to those done by the Attorney General, DMHC and CDI. The reviews currently done by the Attorney General for non-profit hospitals and DMHC for health plans are not market reviews looking at competition and cost impacts. For example, the AG health impact analyses are focused on the availability of services in the geographic area.
  - Health Access also recommends that transaction notices include non-health care entities that continue to enter the health care space.
  - Health Access also recommends that the cumulative impact of even smaller acquisitions over moderately brief periods be tracked.
  - OHCA should plan for public forums for community input on major transactions.

        - Primary Care, Behavioral Health and Alternative Payment Models:
            - Health Access recommends prompt action on primary care but understands the need for a longer time horizon on both alternative payment models and behavioral health.
        - Primary care: The need to shift the system to greater reliance on primary care is well-established so that work should begin as quickly as possible.
        - Behavioral health: The need is as clear, but the mechanisms and measures may take more time to develop.
    - We recommend a longer time horizon on alternative payment models for several reasons:
        - First, these approaches have had mixed success at best. This approach is an experiment that may take a decade or more to pay off.
        - Second, Health Access strongly believes that alternative payment models that involve anything more than the most minimal risk taking require adequate financial solvency requirements and regulation. We base this on our long experience with the reality that risk without regulation has repeatedly resulted in calamity in California, including provider bankruptcies and disruption of care for consumers.
- Adjustment to "Total" Health Care Expenditures:
    - Again, Health Access supports either limiting risk adjustment to age and sex or no risk adjustment at all.
    - We recommend skepticism and a high bar to determine whether there are low-cost, high-quality providers who do not achieve that result by worsening equity or avoiding high risk patients.
    - We oppose truncation of high-cost patient "outliers" without further examination, especially with excessively low truncation points.
- Consumer Affordability: It's the Point. Health Access recommends that OHCA track measures of:
    - Affordability of premiums
    - Affordability of access to care including deductibles, copays, coinsurance
    - Collateral damage from the lack of affordability: care skipped or delayed, medical debt, inability to afford other needs from housing and food to education and retirement.
- Medicare and Medi-Cal Considerations. Health Access recommends that the Office reviews the available academic literature on a "cost shift" regarding Medicaid and Medicare payments, such as: Hospitals Don't Shift Costs From Medicare or Medicaid to Private Insurers | Health Care Economics, Insurance, Payment | JAMA Forum Archive | JAMA Network

Cost and Market Impact Reviews: Not Just Consolidation

Overview of Consolidation in California Health Care Markets Likely Understates Impacts

At the June 2023 meeting, the Office and Board received a very good presentation on the impact of consolidation on health care markets. If anything, the presentation likely understates the current level of consolidation since several of the studies date to 2017. Consolidation has continued, if not accelerated since then. Also, in the verbal presentation, Dr. Gudiksen noted that in many markets in California, consolidation has now reached such high levels that market reviews of proposed transactions may not prevent the ill effects of consolidation in terms of cost and quality.

Cost and Market Impacts Review: Market Power, Market Failures, Not Just Transactions and Consolidation

Wisely, the law recognizes that market power and market failures may have already occurred and where prior review of transactions alone is not sufficient. Monterey County, about which the Board has already heard much, appears to be such a situation—and so is Santa Barbara. Both are examples of geographic areas with very high costs. Specifically, Health and Safety Code 127502.5 says in (g):

> (g) If data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures, the director may, at any point, require that a cost and market impact review be performed on a health care entity, consistent with Section 127507.2.

Other market failures may not be geographically based. For example, the ample literature on market failures associated with surprise medical bills pointed to emergency room care as well as care provided by facility-based specialists such as anesthesiologists, pathologists, radiologists, neonatologists, and hospitalists as case studies of market failures that resulted in costs as high as 900% of Medicare. While changes in state and federal law have largely addressed surprise medical bills, other market failures or examples of undue market power will emerge as the literature develops and OHCA does its work.

The law does not limit "data" to "spending target data". As indicated throughout the law, the drafters intended "data" to be any data available to the Office and the Department, particularly data that already exists such as the forthcoming HPD data which will date back to 2017 and the long-standing hospital financial data which dates back to 1982. Further, the director has broad authority to commission studies and reports. Just as the Attorney General contracts for health impact analyses, the Department may wish to consider, at least initially, contracting for CMIR reviews.

Health Access recommends the following:

- The overview slide that presents the key components of OHCA should be revised to say "assess market power" rather than "assess market consolidation" to better reflect the task ahead of OHCA.

- CMIR is not statutorily limited to transaction reviews but also includes reviews of market failures and need not wait for spending target data but may use other existing data from both the Department and other sources.

Coordination with Merger Review Authority of Attorney General, Department of Managed Health Care and Department of Insurance.

In our view, the CMIR reviews are complementary to the merger oversight work of the Attorney General with respect to non-profit health facility mergers and the role of DMHC and CDI with respect to plans and insurers respectively.

Attorney General Review of Non-Profit Health Facility Mergers

The Attorney General has longstanding authority to approve, deny or approve with conditions transactions involving non-profit health facilities in which there is a change of control or a material amount of charitable assets. Health Access, which sponsored much of the legislation creating and framing this authority, released a policy paper on thirty years of AG oversight of non-profit hospital transactions, linked on our Health Access website here. We hope Board members and staff find it helpful.

The health impact analyses done for the Department of Justice look at the availability of services in the "community," defined as geographically proximate areas to the hospitals subject to the transaction. These reviews, now quite standardized, look at services such as emergency room care, labor and delivery, cardiac care and other specific hospital services as well as reproductive services and LGBTQ care, including transgender care. But the health impact analyses do not look at market competitiveness or consolidation impacts beyond loss of services.

The AG reviews are not market competition reviews and do not look at the impacts of consolidation. When California innovated by adding "health impact analyses" to oversight of non-profit hospital mergers in the 1990s, the focus was not on consolidation—and anti-trust litigation was moribund. This is very different from the policy perspective that has infused the development of the Office.

The Attorney General also holds public meetings to receive community input on the impact of such transactions. Some of these are lively and well-attended, others much less so. These may serve a function similar to the community review board in Oregon.

In recent years, as a result of the Sutter litigation and comments offered by Health Access California, the California Labor Federation, and others, the AG also imposes conditions related to price impacts. The first such merger conditions, for the Cedars-Huntington merger, led to litigation by the American Hospital Association and the California Hospital Association, which was later settled. Similar conditions on price and anti-competitive

practices are now routine. Even though such conditions are now routine, looking at the larger market impacts is not.

Finally, we know from the AG's Office that they are looking forward to the Office of Health Care Affordability's analysis to strengthen their oversight of hospital mergers and anti-competitive practices in health care.

Health Access recommends:

- OHCA should collaborated closely with the Attorney General to use CMIR transaction reviews and market impact analyses to complement the health impact analyses done for DOJ.

DMHC Merger Review:

In the past, DMHC has not looked deeply at market implications in terms of cross-market and vertical consolidation. In part, mergers of health plans are infrequent and the enhanced DMHC authority is relatively recent. For the series of mergers of health plans with pharmacy benefit managers (PBMs), DMHC did not anticipate or impose conditions related to the pattern of behavior that has emerged to the detriment of consumers and purchasers with respect to costs. Again, reviews by DMHC would be much strengthened if they had the benefit of CMIR reviews.

CDI Merger Review:

In terms of mergers, CDI only has authority over "domestic" carriers—that is, those domiciled in California. Few health insurers regulated by CDI are domiciled in California. Overall, CDI's market share is modest, less than 5% of the state-regulated market. So DOI's merger review authority extends to a subset of less than 5% of the state-regulated market, one that some Insurance Commissioners have used effectively but others have not.

Health Access Recommends:

- OHCA work collaboratively with DMHC and CDI to conduct merger reviews that are complementary to the merger reviews done by DMHC and CDI.

Transaction Threshold

The enabling statute uses language very similar to that used in the Corporations Code for non-profit health transactions overseen by the Attorney General[1]. The focus in this

[1] (c) (1) A health care entity shall provide the office with written notice of agreements or transactions that will occur on or after April 1, 2024, that do either of the following:

language is a "material amount of assets." This is not a majority or even a substantial share of the assets. Instead, it may be a small fraction. More important is the transfer of control or governance which may also occur when only a small fraction of assets is transferred.

Because the threshold is similar to that used by the Attorney General since the early 1990s, which is defined through both longstanding regulation[2] and case law, the experience of the Attorney General as to what constitutes a qualifying transaction should be helpful.

Health Access Recommends:

- OHCA staff should continue to work closely with the Attorney General staff, in both the merger review and anti-trust units, to determine what constitutes a qualifying transaction given the AG's long experience with similar statute and regulation.

Transactions Not Subject to Transaction Threshold

The wide range of affiliations, partnerships, and other collaborative agreements among doctors, doctor organizations, hospitals, health systems, health plans, and various other providers is illuminated by a recent paper, Collaborative Agreements in Health Care: Complexities, Uncertainties, and Considerations for Oversight (chcf.org), which provides a useful framework for market reviews beyond transaction analyses.

The question to be asked about such arrangements is whether the arrangement provides equity or infrastructure such that the provider receiving that investment could not operate their business or succeed in that business without that investment. For example, Vision Services Plan[3] (VSP) has publicly stated that it provides equity investments to numerous "independent" optometrists: while VSP asserts that those optometrists remain competitive with each other and independent of VSP, nothing to assures that continues to be the case. VSP has also publicly stated that these "independent" optometrists are employees of VSP's affiliate and thus under the direction and control of that entity. VSP could engage in market behaviors to set price or quality. At what point does investment offer the opportunity for control?

Health Access Recommends:

(A) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities.
(B) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.

[2] California Regulations on Nonprofit Health Facility Transactions - Title 11, Chapter 15, section 999.5, (a)
[3] Letter on AB 1092 (Wood) on DMHC oversight of health plan transactions. We recognize that vision-only plans are not a focus of OHCA or CMIR: we provide this an illustrative example. The California Medical Association has asserted that equity investments in physician practices are also common.

- As OHCA determines which transactions and cases of market power to review, the staff and Board should ask whether an arrangement allows the opportunity for control through the provision of equity, investment or other things of value without which a physician or other provider cannot run their business.

Cross-Market Reviews, Non-Health Care Entities

Whether it is Amazon's acquisition of One Medical, a company now providing primary care in Los Angeles as well as elsewhere, or other transactions by non-health care entities, the regulations must be capacious enough to capture such transactions.

Private equity provides another timely example of non-health care entities in the health care space and further confirms that reviews of transactions may surface the potential of market failures due to the use of lucrative market niches such as surprise medical bills by facility-based specialists.

Health Access Recommends:

- The standards for transaction review include non-health care entities.
- Reviews of market power look beyond the health care industry to those industries attempting to move into the health care space, especially those that are likely to increase costs without improving value or equity.

Cumulative Look at Acquisitions

OHCA should look at the cumulative impact of acquisitions, whether it is health systems or private equity or other entities growing through accumulation of moderately brief periods of time, as in a few years.

For example, three or four years ago, during fights over merger legislation, we started hearing complaints from health systems in Orange County that Optum which is owned by United was buying medical groups in Orange County. Now it is apparently impossible to put together a network in San Bernardino for commercial coverage or Medicare Advantage without contracting with Optum. That rapid accumulation through acquisition is precisely the kind of consolidation OHCA should track.

Health Access Recommends:

- OHCA should review transactions looking at cumulative accumulation, and such investigations should be triggered by cumulative accumulation within moderately brief periods of time.

Acquiring Entity Charged with Seeking Review

During the enactment of the legislation, there were complaints that smaller entities could not bear the burden of OHCA review. We expect those complaints to recur when the CMIR

regulations are proposed. The law provides that the acquiring entity, usually the bigger, more sophisticated player, is charged with seeking review in order to avoid burdening small physician groups or other small entities since usually it is the big guy that acquires the little guy.

Health Access recommends:

- As with the enabling the statute, the regulations should provide clarity that the burden of seeking the review for a proposed transaction is on the acquiring entity.

Public Venue for Community Input

We would note that nothing in the OHCA enabling statute prevents OHCA from holding public meetings on a proposed transaction. Indeed, the Office would probably be wise to plan for such input when transactions are controversial or face disruptions of public comment at its Board meetings or meetings of the Advisory Committee.

Health Access Recommends:

- OHCA staff and board should plan for public forums for particularly controversial or notable transactions in order to allow a broad range of stakeholders to provide their views on the impact of a proposed transaction.
- These public forums need not occur for every transaction. One model for determining "major" transactions is offered by the existing law on DMHC merger oversight.

Primary Care, Behavioral Health and Alternative Payment Methods

We look forward to the discussions of the workgroup on primary care, behavioral health and alternative payment models. For those of us who helped to craft the initial proposals that became OHCA, the goal of OHCA was to transform the health system to achieve the California triple aim of lower costs, better outcomes and improved health equity. Greater reliance on primary care and improved access to behavioral health are central to that vision. Achieving both will take time and investment. The need to move forward on primary care and behavioral health is both urgent and well established. Here progress should occur as rapidly as possible.

Alternative Payment Models

As the presentations to the Board, the Advisory Committee and the Investment and Payment Workgroup acknowledge, the record to date on alternative payment models has been mixed at best. We view the work in this area as an experiment. The nature of experiments is that some things work and some things do not work or do not work as well as expected. On this, OHCA needs to be a "learning organization" and to accept that part of learning is not getting everything right the first time.

What is not experimental is that providers taking risk means that providers require reserves and regulation of financial solvency. California in the 1990s experimented with medical groups taking risk without financial solvency requirements: the results were disastrous for consumers and too many physicians. Medical groups failed such basic tests of business acumen as having audited financials. Even groups responsible for the care of several hundred thousand consumers lacked such basic tools for assuring financial solvency. Groups took full financial risk for both professional care and institutional (hospital) care without any capacity to manage that risk or even to track their financial exposure. Groups went bankrupt in large numbers, disrupting the care of consumers and precipitating personal bankruptcy of individual physicians. California law now requires regulation of fiscal solvency of medical groups taking risk. That is fundamental from a consumer perspective.

Based on this bitter experience, Health Access opposed a proposal by the California Hospital Association in SB 714 (Umberg) of 2019 to exempt hospitals from financial solvency requirements for taking risk of as much as 50% of revenues plus 50% of assets plus other risk. This struck us as an absurd amount of risk to allow without financial solvency requirements.

Health Access is not opposed to shifting from fee-for-service to other payment approaches: we are opposed to exposing consumers to risk without commensurate financial solvency requirements and regulation because it endangers the provision of care as well as threatens the financial solvency of providers consumers rely on.

Proposals to shift risk to providers must be accompanied by proposals to assure financial solvency commensurate with risk. The Knox-Keene Act got that right in 1975 after financial scandals involving numerous health plans[4]. California re-learned that lesson in the 1990s during the failures of medical groups. Repeating that lesson a third time seems an avoidable error.

Health Access recommends:

- OCHA should take action on primary care promptly: the literature and conversation on primary care is well developed.
- OCHA should take the time allowed in the statute to develop alternative payment model standards.
- OCHA should coordinate with DMHC on financial solvency requirements for alternative payment models that involve more than minimal amounts of risk.
- Behavioral health is critical but quality measures for behavioral health are sadly lacking: rectifying this will take time and investment.

[4] Health and Safety Code Section 1342 on the intent and purpose of the Legislature: “ensuring the financial stability thereof by means of proper regulatory procedures” and “transferring the financial risk of health care from patients to providers”.

Adjustments to "Total" Health Care Expenditures

Risk Adjustment: Coding Tracks Financial Incentives

Health Access concurs with the observation that in other states, coding has tracked financial incentives for upcoding. We support limiting risk adjustment to age and sex and would potentially support no adjustment at all. We would also support further work in the future on whether it is possible to develop a limited set of clinical factors that is not subject to upcoding or other gaming by a health care entity, as well as factors that are not dependent on access to care in a manner that inequitably works against those most in need of care. Until such time as such a measure set is developed, we support the staff approach, or even the approach taken in other states of no adjustment at all.

Health Access recommends: In the near term, OHCA should limit risk adjustment to age and sex, or not allow risk adjustment.

Quality Adjustments:

Health Access is skeptical that further analysis will reveal high-quality, low-cost providers who do not engage in other kinds of problematic behavior, such as avoiding patients with high needs or locating hospitals or medical practices in affluent areas to avoid serving low-income communities. Once again, we point to an instructive example, the initial implementation of penalties for 30 day all cause readmission which was blind to the health inequities it perpetuated. Initially, this approach penalized large safety net hospitals in the Northeast which served disproportionately low income communities of color while appearing to give credit to for-profit hospitals in the South without emergency rooms which disproportionately served affluent individuals who were not persons of color. HCAI should strive to avoid such results when considering assertions that a hospital or other provider is a "high-quality, low-cost" provider. Something as simple as the percentage of Medi-Cal patients and geo-mapping for medically under-served areas would be instructive.

Health Access recommends: If staff determines that it is appropriate to consider claims that providers are high-quality, low-cost providers, then such scrutiny should include the populations served, as well as the location of providers in affluent areas and other measures of health disparities.

Truncating High-Cost Patient Outliers Without Further Examination

Health Access opposes the proposal to truncate high-cost patient outliers without further examination. We believe this would be limiting to the role envisioned for the Office of Health Care Affordability. While an ACO in Rhode Island, presumably limited to either Medicare or Medicaid enrollees, and thus a subset of the few hundred thousand in each

program in Rhode Island may suffer from the random variation to which small populations are exposed, most insurers and health systems in California are at a much larger scale. Assuming that high-cost patient outliers are a result of random variation without further examination to determine the reasons for the outliers would thwart the purpose of OHCA which is to provide oversight of the entire health care system.

Instead, high-cost patient outliers should be examined to determine if there are clinical reasons such as the emergence of a new condition (long COVID today, AIDS/HIV in the late 1980s, differential maternal mortality) or inappropriate utilization of services being driven by providers as a way to improve revenue. Our prior letter provided the example of diagnoses of kwashiorkor charged as Medicare and Medicaid fraud at a hospital in Redding and Red Bluff as an extreme example of inappropriate utilization and one that was known to California regulators but who failed to take action.

Health Access recommends: OCHA should not truncate outliers without examination of whether the outliers are truly random, rather than indicators of problems.

Per Member Truncation Points

Low member truncation points risk distorting reporting. The Board asked what proportion of "outliers" were excluded at various truncation points. One purchaser estimated that a truncation point as high as $200,000 would exclude almost 20% of the claims for one carrier. Similarly, a major purchaser, the Wonderful Company, at the advisory committee said that with 9,000 employees they had numerous claims over $400,000, a distinct shift from prior years.

Based on our work on attachment points in stop loss and other insurance, we note that low truncation points create a disincentive to manage care of potentially high-cost patients such as patients likely to need dialysis if not carefully managed or care management to avoid organ transplants or limb amputation.

Health Access recommends: OCHA should not use low truncation points used in other states and should do further research on the cost of high-cost outliers if truncation points are used at all.

Consumer Affordability Measures: Coverage, Access to Care, Collateral Damage

The point of the Office of Health Care *Affordability* is to improve the affordability of health care for Californians.

Commercial coverage, whether that provided by an employer or in the individual market, is regressive and unaffordable. While the Affordable Care Act helped those at the low end of the income scale, for anyone making more $25,000 a year and buying individual coverage

they face deductibles of more than $5,000, literally 20% of their income. Even a family making $100,000 a year finds unaffordable a deductible of $5,000 per consumer. Employer coverage is usually more generous than that in the individual market but as the presentations have demonstrated, costs have climbed year after year, worsening regressivity and unaffordability.

Health Access recommends: OCHA should track consumer affordability measures, which come in three categories:

- *Coverage*: Premium or Share of Premium
- *Access to Care*: Deductibles, Copays, Coinsurance
- *Collateral Damage from Lack of Affordability*:
    - Avoiding or delaying necessary care
    - Medical debt
    - Inability to afford other needs, from rent and food to the kids' education and retirement.

Tracking consumer affordability can be done in part through tracking "consumer paid" amounts as part of "total" health care expenditures but it will require other measures as well. It is part of the mandate of OHCA: we again ask the Office to add that work to the workplan. We stand ready to contribute our expertise as well. Fortunately, thanks to the California Health Care Foundation, California has a wealth of data sources on this topic.

Cost Shift from Medicare and Medi-Cal to Commercial Coverage:
Not Substantiated by the Academic Literature

In the advisory committee discussion in June 2023, provider representatives asserted that there is a cost shift from "under-funded" public programs like Medicare and particularly Medi-Cal to commercial coverage. While there is a certain apparent appeal to this argument, there is an entire academic literature in economics which refutes it. A recent summary of this literature is Austin Frakt in JAMA:

Hospitals Don't Shift Costs From Medicare or Medicaid to Private Insurers | Health Care Economics, Insurance, Payment | JAMA Forum Archive | JAMA Network

As Frakt notes, no reputable study in the last 20 years has found evidence of the cost shift. Instead, the literature has demonstrated what can also be observed in California: hospitals like the LA County health system that do the most Medi-Cal and Medicare get paid the least for commercial coverage, averaging about 100% of Medicare[5]. Conversely, the hospitals that get the most for commercial coverage from the Community Hospital of the Monterey Peninsula to John Muir to Huntington Pasadena do the least Medi-Cal. A similar pattern appears to exist for physicians in which those specialties that serve the fewest Medi-Cal

[5] Kronick, R. New analysis of California hospitals shows private insurers pay more than double what Medicare does for similar services - westhealth.org

patients, like adult specialists, make the most while those like pediatricians and other primary care providers, especially in less affluent areas, who have a large proportion of Medi-Cal patients make the least.

A cost structure built on 400% or 500% of Medicare is not a cost-efficient hospital or practice. To quote Uwe Reinhardt and Gerard Anderson decades ago, "It is the Prices, Stupid", a study that was recently updated by Gerard Anderson, Ge Bai et al as "It's Still the Prices, Stupid.[6]" Doctors and hospitals get paid higher commercial prices because there is no countervailing force[7]. OHCA was designed to be that force.

Health Access recommends: On the issue of a cost shift, OCHA should review and take into consideration the well-established economic literature, the Medicare Payment Advisory Committee analyses, and other peer-reviewed academic literature not produced or paid for by health providers who benefit from asserting a cost-shift from public programs to commercial coverage.

On these and other topics, we look forward to continued discussions. Thank you for your work and consideration.

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Anthony Wright
Executive Director

[6] It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt | Health Affairs

[7] If insurers, health plans and TPAs ever played the role of bargaining on cost and quality, they no longer do because of the marker power accrued by doctors, hospitals, and drug companies.

California Hospital Association

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