HCAi Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Health Care Affordability Board
October 14, 2024
Public Comment

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

Date Received	Name	Written Comment
10/11/2024	Salinas Valley Health	See Attachment #1.
11/07/2024	Salinas Valley Health	See Attachment #2.
11/13/2024	Alicia Metters, SEIU 521 Regional Vice President.	See Attachment #3.
11/13/2024	CFT- A Union of Educators and Classified Professionals	See Attachment #4.
11/15/2024	Health Access CA	See Attachment #5.
11/15/2024	California Hospital Association	See Attachment #6.
11/15/2024	Salinas Valley Federation of Teachers	See Attachment #7.
11/18/2024	Monterey Bay Central Labor Council	**Re: Urgent Follow-Up to August 2024 OHCA Board Meeting in Monterey County** Dear Dr. Ghaly, Ms. Johnson, Ms. Landsberg, and Mr. Pegany, We want to extend our sincere gratitude for the Board's recent visit to Monterey County, but we must also emphasize the urgent need to address the affordability crisis afflicting our community. We

Date Received	Name	Written Comment
		respectfully urge the Board to impose a 0.1% sector target for the three hospitals—Community Hospital of the Monterey Peninsula (CHOMP), Salinas Valley Health, and Natividad—without delay. The affordability crisis in Monterey County is reaching alarming levels. While we appreciate the Board's efforts to convene in our region, it is crucial to recognize that the exorbitant hospital prices here are not merely a byproduct of labor costs or payer mix, as the hospitals have suggested, but rather a direct result of severe market concentration. The presentations at the August meeting, coupled with our own claims experience, make it clear that immediate action is needed. We were encouraged by the Board's willingness to engage with local testimonies, reflecting the real struggles faced by residents burdened by high medical costs. However, the time for discussion is running out; we need decisive action. We strongly believe that the three Monterey County hospitals warrant a 0.1% sector target starting in 2026. We hope the additional data analysis mentioned during the meeting can be expedited to avoid further delays in addressing this pressing issue. The hospitals are clearly aware of the OHCA Board's proceedings, as evidenced by their press releases following the August hearing. While we acknowledge CHOMP's commitment to reducing costs, it is simply not enough to alleviate the financial strain on our community. We need sustained, substantive change. Shining a light on the critical need for reform in Monterey County will not only encourage the hospitals to take meaningful steps but will also provide much-needed relief to our residents who are grappling with unprecedented healthcare costs. We deeply appreciate the dedication of the OHCA Board and its staff in championing this cause. The time for action is now- let us work together to make healthcare in Monterey County affordable for all. Sincerely, Francisco Rodriguez Monterey Bay Central Labor Council, AFL-CIO 831-254-4916 secretarytreasurer@mbclc.com

Salinas Valley HEALTH

October 11, 2024

Members of the Health Care Affordability Board
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: **Salinas Valley Health Response to Healthcare Affordability Concerns Raised at August 2024 Board Meeting** (Submitted via Email to Megan Brubaker)

Since 1953, Salinas Valley Health (SVH) has operated as a public district healthcare organization, governed by an elected Board of Directors, to serve Monterey County and surrounding areas. SVH reinvests surplus revenue into infrastructure, technology, and programs to meet the evolving health needs of the community.

For over 70 years, SVH has focused on delivering high-quality healthcare services, ensuring that comprehensive care is accessible to everyone, regardless of financial or insurance status. As healthcare affordability remains a critical issue, SVH is committed to implementing measurable actions to address it. We appreciate the significant work of the Health Care Affordability Board and welcome the opportunity to collaborate in developing solutions.

This document addresses key concerns raised during the August 28, 2024, Office of Health Care Affordability meeting.

SVH Clinic Investment and Professional Services

In response to the critical shortage of primary and specialty care providers in Monterey County, SVH has invested in a California Health and Safety Code 1206(b) clinic system. This system currently supports approximately 200 providers who offer essential primary and specialty care services, including oncology, to patients throughout the Salinas Valley and surrounding communities. We anticipate managing over 600,000 patient encounters through our clinic system in FY25.

Last year, SVH clinics operated at a $50 million deficit, reflecting the financial burden of running a community-focused, inclusive healthcare system. These costs are expected to rise substantially due to the national shortage of healthcare providers, further complicating our ability to meet community healthcare needs.

We do not believe that the cost analysis presented during the OHCA meeting recognized or fully accounted for the expenses associated with these non-hospital healthcare services.

Unfavorable Payer Mix in Monterey County

A major challenge for SVH is the unfavorable payer mix in Monterey County. Currently, 75% to 80% of SVH's patients are government-insured, with Medi-Cal patients (as noted in the OHCA

presentation) comprising 51%, compared to a statewide average of 38%. Only 22% of SVH patients have commercial insurance. This imbalance creates financial strain on our healthcare system as government reimbursements do not fully cover the costs of care for these patients.

Cost-shifting is a common practice where hospitals rely on higher reimbursements from commercial payers to offset lower government reimbursements. This approach is critical for maintaining essential services, especially in rural and underserved communities like Monterey County.

SVH relies on commercial payers to offset the lower reimbursements from government payers. Without this mechanism, many hospitals in the state have struggled to remain operational. We would welcome the opportunity to explore healthcare systems with similar community payer mixes that are financially sustainable under state-average commercial contracts.

Competitive Landscape

The high cost of living in Monterey County, combined with an unfavorable payer mix, adds to the financial strain on SVH. SVH operates in a competitive environment with three other unaffiliated hospitals in Monterey County, providing 24/7 access to care for all community members. Only 18 of California's 56 counties have four or more unaffiliated hospitals, underscoring the unique competitive pressures SVH faces.

Of note, some healthcare organizations entering the market operate closed systems that do not serve the uninsured or government-insured populations.

Nationally Recognized Quality of Care

At the OHCA hearing, it was suggested that SVH's quality of care does not align with its reimbursement levels. We strongly disagree. SVH is deeply committed to patient safety and quality care, as demonstrated by the numerous prestigious awards we have received, which currently include:

- 5-Star Quality Rating from CMS
- 10 consecutive Hospital Safety "A" grades from Leapfrog
- Magnet® Recognition
- Best Regional Hospitals by U.S. News & World Report
- Healthgrades' Top 5% Patient Safety Excellence Award

Additional Financial Pressures

In addition to underfunded government payer services, SVH faces significant infrastructure challenges, including a State seismic mandate that presents an additional $60 million financial burden to our healthcare system. No funds have been allocated by the State for hospital seismic improvements. Furthermore, our 70-year-old facility requires hundreds of millions of dollars in upgrades to meet our desired modernization standards.

Affordability Initiatives

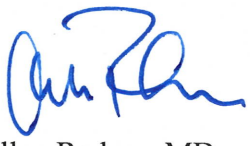
Salinas Valley Health recognizes the burden placed on individuals seeking affordable healthcare in our community and remains committed to finding collective solutions. Ongoing initiatives include:

- Supporting and developing lower-cost sites of care, such as our clinic system, an ambulatory surgery center, an outpatient radiation oncology center, and an outpatient endoscopy center.
- Developing a robust inpatient and outpatient population health division focused on preventive care to reduce high-cost illnesses.
- Increasing commitment to risk-based contracting with financial rewards focused on beneficial outcomes rather than costly utilization.
- Investing in outpatient and inpatient quality measures, as demonstrated by our national recognitions, which have repeatedly shown meaningful outcome improvements and cost savings to patients and payers.
- Providing a significant community investment in well-being initiatives, including a no-cost mobile health clinic (which has provided over 17,000 patient encounters in underserved areas) and leadership in the development of a countywide Blue Zones Project.

Conclusion

Despite the significant financial challenges we face, SVH is dedicated to delivering inclusive, high-quality healthcare services to all community members. We believe that the materials presented at the August 28 OHCA hearing did not fully reflect the complexity of the issues surrounding healthcare affordability, and the conclusions reached were overly simplified. We look forward to collaborating with the Office of Health Care Affordability and other stakeholders to address these challenges and to ensure a sustainable healthcare system for the future.

Sincerely,



Allen Radner, MD
Salinas Valley Health President/CEO

Salinas Valley HEALTH

November 7, 2024

VIA EMAIL
Email to Megan Brubaker

Members of the Office of Health Care Affordability Board
2020 W. El Camino Avenue
Sacramento, CA 95833

Re: Salinas Valley Health Request for Meaningful Dialogue

This follow up letter to the OHCA Board is prompted by another internal discussion today at Salinas Valley Health about the many ways we are addressing the affordability issue and the additional efforts our organization is pursuing to make additional progress in reducing the cost of care in our community.

As previously indicted in our conversation prior to the August 28, 2024 OHCA Board meeting held in Monterey County and also outlined in our October 11, 2024 response to the above-referenced meeting, Salinas Valley Health is eager to engage in meaningful dialogue on the subject of healthcare costs in Monterey County. The importance of this topic to all stakeholders deserves the time of a respectful and in-depth discussion about our mutual concerns and sustainable solutions that support access to quality care in our diverse community.

Specifically, we welcome a conversation with one or more OHCA Board members and/or the analysts contributing to the presentations to better clarify for both parties the financial, geographic, quality, and mission driven elements involved in operations specific to Salinas Valley Health.

We are committed to building on our legacy as a public health care district delivering quality care to everyone and want to collaborate with the OHCA Board to take the next steps in this critical journey.

Sincerely,

Allen Radner, MD
Salinas Valley Health President/CEO

LOCAL 521 SEIU Stronger Together

SERVICE EMPLOYEES INTERNATIONAL UNION CTW-CLC

SAN JOSE H.Q.
2302 Zanker Road
San Jose, CA 95131
Phone: 408-678-3300
Fax: 408-954-1538
Phone: 408-678-3398
(Vendors)

BAKERSFIELD
1001 17th Street
Bakersfield, CA 93301
Phone: 661-321-4160
Fax: 661-325-7814

FRESNO
5228 E. Pine Avenue
Fresno, CA 93727
Phone: 559-447-2560
Fax: 559-261-9308

HANFORD
101 N. Irwin St., Suite 205
Hanford, CA 93230
Phone: 559-587-1521
Fax: 559-582-3510

SALINAS
HOLLISTER
334 Monterey Street
Salinas, CA 93901
Phone: 831-784-2560
Fax: 831-757-1863
Phone: 831-636-3455
Fax: 831-636-0787
(Hollister)

SAN CARLOS
981 Industrial Rd., Suite A
San Carlos, CA 94070
Phone: 650-801-3500
Fax: 650-595-1930

SANTA CRUZ
WATSONVILLE
517B Mission Street
Santa Cruz, CA 95060
Phone: 831-824-9255
Fax: 831-459-0756
Fax: 831-724-9095
(Watsonville)

VISALIA
1811 W. Sunnyside Avenue
Visalia, CA 93277
Phone: 559-635-3720
Fax: 559-733-5006

www.seiu521.org

November 13, 2024

Sent via email to: ohca@hcai.ca.gov

Mark Ghaly M.D., Chair of Health Care Affordability Board
Kim Johnson, Secretary-Designate California Health and Human Services
Board Elizabeth Landsberg, Director Department of Health Care Access and Information
Vishaal Pegany, Deputy Director Office of Health Care Affordability Department of Health Care Access and Information

RE: Follow up to August 2024 OHCA Board Meeting in Monterey County

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

We are very happy that the Board was able to come to our beautiful Monterey County in August 2024 to hear directly from residents about the market concentration caused by the hospitals and not by labor costs or payer mix. Hearing the Board members' discussion about the high hospital prices in the County and their concern about how these impacts on working people was also greatly appreciated. We want to ask that the Board impose a .01% sector target for the three hospitals, Community Hospital of Monterey Peninsula (CHOMP), Salinas Valley Health and Natividad, as soon as possible.

Monterey County residents deserve more affordable healthcare, and the data shared and discussed during the August meeting affirms what our members and residents have been sharing with the Board for the past year about three hospitals, thus supporting that the three Monterey County hospitals merit a .01% sector target beginning in 2026. We are also supportive of a deeper dive into data that was mentioned in the meeting and can happen quickly so as not to delay the adoption of a sector target. While we understand that there are considerable complexities in defining sectors and that the OHCA would be forging new ground as the first state to do so, we hope that the extreme outlier nature of inpatient and outpatient hospital prices in Monterey County is addressed quickly by OHCA.

While CHOMP has committed to reducing costs and prices, this is not enough to address the need for the County and to reign in the prices that the three hospitals are charging for costs, which are the most expensive in the county and the state. Monterey County residents need a real transformative change to affordable healthcare.

We greatly appreciate the hard work the OHCA Board, and its staff, are doing to bring some relief to our members.

Sincerely,

Alicia Metters, Social Worker III
SEIU 521 Regional Vice President
Monterey, Santa Cruz, and San Benito Counties

Cc/ Riko Mendez, SEIU 521 Chief Elected Officer
Governor Gavin Newsom
Senate President pro Tempore Toni Atkins
Assembly Speaker Robert Rivas
Debbie Narvaez, Executive Representative to Riko Mendez
Olivia Martinez, Regional Director

.

CFT A Union of Educators & Classified Professionals

Sacramento Office
1225 H Street
Sacramento, CA 95814

p 916.446.2788
f 916.446.2401

cft.org
CFT
CFTunion

Attachment #4

November 13, 2024

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

Kim Johnson, Secretary-Designate
California Health and Human Services Board

Elizabeth Landsberg, Director
Department of Health Care Access and Information

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

RE: Urgent Follow-Up to August 2024 OHCA Board Meeting in Monterey County

Dear Dr. Ghaly, Ms. Johnson, Ms. Landsberg, and Mr. Pegany:

CFT — A Union of Educators & Classified Professionals, AFT, AFL-CIO, writes to emphasize the urgent need to address the affordability crisis afflicting the Monterey County community. We respectfully urge the Board to impose a 0.1% sector target for the three hospitals—Community Hospital of the Monterey Peninsula (CHOMP), Salinas Valley Health, and Natividad—without delay.

The affordability crisis in Monterey County is reaching alarming levels. While we appreciate the Board's decision to convene in our region, it is crucial to take the next step and recognize that the exorbitant hospital prices here are not merely a byproduct of labor costs or payer mix, as the hospitals have suggested, but rather a direct result of severe market concentration. The presentations at the August meeting, coupled with real claims experience, make it clear that immediate action is needed.

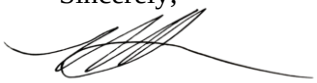
We were encouraged by the Board's willingness to engage with local residents offering heartbreaking testimony, reflecting the real struggles faced by those burdened by high medical costs. However, the time for discussion is running out; we need decisive action. We strongly believe that the three Monterey County hospitals warrant a 0.1% sector target starting in 2026. We hope the additional data analysis mentioned during the meeting can be expedited to avoid further delays in addressing this pressing issue.

The hospitals are clearly aware of the OHCA Board's proceedings, as evidenced by their press releases following the August hearing. While we acknowledge CHOMP's commitment to reducing costs, it is simply not enough to alleviate the financial strain on our community. We need sustained, substantive change.

Shining a light on the critical need for reform in Monterey County will not only encourage the hospitals to take meaningful steps but will also provide much-needed relief to residents grappling with unprecedented healthcare costs.

We deeply appreciate the dedication of the OHCA Board and its staff in championing this cause. The time for action is now; let us work together to make healthcare in Monterey County affordable for all.

Sincerely,



Mitch Steiger
Legislative Representative
MS: ac-opeiu#29 afl-cio

HEALTH ACCESS CALIFORNIA

November 15, 2024

Sandra Hernandez, M.D., Vice Chair
Health Care Affordability Board

Kim Johnson, Member
Health Care Affordability Board
Secretary, California Health and Human Services Agency

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

2020 W. El Camino, Ste 1200
Sacramento, CA 95833

Re: November 20, 2024, Board Meeting

Dear Dr. Hernandez, Ms. Johnson, Ms. Landsberg and Mr. Pegany,

Health Access California, the statewide consumer advocacy coalition committed to quality, affordable health care for all Californians, offers recommendations and comments on the work of the Office of Health Care Affordability as it relates to consumer affordability, sector targets, hospital spending, cost and market impact reviews (CMIRs), the ongoing investigation into Monterey hospitals, and equity/quality measures for hospitals, physician organizations and health plans as well as proposed changes in THCE data collection.

Health Access Recommends:

- OHCA Reports include a broad array of consumer affordability metrics and impacts.
- OHCA work with sister agencies, including DMHC, CDI, CalPERS and Covered California to translate the cost growth targets into affordability for consumers and other purchasers
- OHCA establish sector targets, beginning with high-cost outliers including the hospitals in Monterey, the top 10%-20% of high-cost hospitals and then high-

1127 11th Street, Suite 925, Sacramento, CA 95814 | (916) 497-0923 health-access.org

cost outliers among health plans, physician organizations and other entities subject to the targets.

- OHCA staff continue to refine measures of inpatient and outpatient hospital spending to include significant sources of hospital revenue and measures of complexity of care.
- OHCA adopt equity and quality measures to serve as guardrails against cost cutting at the expense of equity and quality and guides toward the triple aim of lower costs, improved outcomes and greater equity with measures appropriate to different types of entities such as health plans, hospitals, and physician organizations.
- Cost and Market Impact Reviews:
    - Health Access recommends that waivers of CMIR be accompanied by a one or two sentence case summary of the reasons for waiver.
    - OHCA should consider how the focused study on Monterey might benefit from some public discussion of parameters and approaches without compromising the authority or confidentiality of its investigation.
- Total health care expenditure data collection:
    - Health Access asks whether the data collected to date reflect 90%-95% or more of the expected data?
    - Health Access opposes dropping data field on "member responsibility"
    - Health Access supports inclusion of data fields on Alternative Payment Models and Primary Care as consistent with OHCA's mission.
- Finally, Health Access appreciates the suggestions of various entities subject to the targets that other entities reduce their costs.

Consumer Affordability, Rate Review, CalPERS and Covered California

The Health Care Affordability Board and the Office of Health Care Affordability are intended to improve the affordability of health coverage for consumers and other purchasers. The Board has heard numerous presentations from the staff on the lack of consumer affordability and the reality that it continues to get worse. Health Access recommends that the initial public report provide an overview of the lack of affordability for consumers and the damage done because of ever-escalating premiums, deductibles, coinsurance, copays and other out of pocket costs such as out of network behavioral health care. We also recommend that the Office brief the Legislature on the lack of consumer affordability as well as the steps the Office and Board are taking to address that lack of affordability.

1127 11th Street | Suite 925 | Sacramento, CA 95814

We commend staff for working with other state agencies, including the Financial Solvency Standards Board of the Department of Managed Health Care, CalPERS health benefits, and Covered California. Translating the cost growth targets into the reality of more reasonable rate increases for consumers and other purchasers, including those state and local agencies that provide health benefits to their workers and dependents, as well as the many California businesses that provide state-regulated coverage to their workers, requires such coordination among state agencies. For example, CalPERS has signed some health plan contracts to begin to implement the cost growth targets as well as advanced primary care and aligned quality/equity measurement sets but there is more to do there as well.

Sector Targets: Monterey Hospitals, High-Cost Outliers, and More

Health Access again urges that the Health Care Affordability Board take the following steps:

- Set a target of 0.1% for the three Monterey hospitals until 2029.
- Set lower cost growth targets for high-cost outlier hospitals defined as the top 10% or 20% of high-cost hospitals, measured by hospital spending as a percentage of Medicare for commercially insured patients and
- Begin to look at other areas of spending, including health plans and physician organizations, also looking at high-cost outliers and consider setting lower cost growth targets for such high-cost outliers.
- Define and track total medical expenditures (TME) by health systems[1] as well as individual facilities with future consideration of defining sectors by health systems that are high-cost without being high-value, consistent with the statute.

Health Access recognizes that measures of hospital spending are the basis for setting targets for specific, high-cost hospitals, including the most expensive 10% or 20% of hospitals. For this reason, we have worked with staff and consultants on this and now turn to a discussion of the current progress.

Hospital Spending: Inpatient and Outpatient

Hospital Spending: Inpatient Revenues

The Office has convened an informal workgroup that includes numerous hospital representatives, primarily those working in hospital finance, as well as plan representatives, labor, and consumers. Health Access agreed to serve as the consumer representative.

[1] AHRQ has defined health systems: https://www.ahrq.gov/sites/default/files/wysiwyg/chsp/compendium/2022-Compendium-TechDoc.pdf . Various provisions of California law use different definitions of health systems. To arrive at a useful definition of health systems for the purposes of OHCA, the staff may wish to review these varying definitions.

1127 11th Street | Suite 925 | Sacramento, CA 95814

This workgroup fairly readily agreed that for inpatient revenues, annual change in net patient revenue adjusted by case mix index and volume of discharges largely captured inpatient revenues for the purposes of measuring "total medical expenditure" or TME. In addition, in the view of Health Access, total revenues for a hospital or health system will be appropriate for understanding the overall financial capacity of a particular hospital or health system compared to other health systems.

The staff and consultants are continuing to clarify data about some elements of spending such as revenues from the hospital provider tax, known as the Quality Assurance Fee; intergovernmental transfers (IGTs) and certified public expenditures (CPEs). For example, IGTs and CPEs vary greatly by county and are of crucial importance to county hospitals but not other hospitals. The QAF and disproportionate share funding (DSH); and other revenue streams require review and standardization of reporting so that reporting is consistent across hospitals as well as reliably and accurately capturing the full revenue picture. For instance, reporting of the QAF appears to be both voluntary and inconsistent even though the QAF is an important revenue source for many hospitals. Staff have laid out a path to updating HCAI regulations on hospital financial data to improve the consistency and reliability of data reporting. Health Access supports steps to update data reporting on inpatient revenues.

Hospital Spending: Outpatient Revenues and Acuity: Several Dead-Ends and Other Options?

In contrast to measuring inpatient revenues, measuring outpatient revenues has been hindered by outdated reporting and lack of readily available measures to reflect the acuity of care delivered. Spending on hospital outpatient care is now roughly equal to inpatient revenues, something which was not true 50 years ago when the data reporting was initiated by OSHPD.

Several possible approaches have been considered to measure the complexity of care and discarded. Staff are now regrouping on this question.

The first suggestion was to infer from fee-for-service claims the severity of care paid for by managed care. Assuming that the risk mix or service mix of outpatient hospital care can be projected or imputed from fee-for-service claims to managed care does not seem plausible and thus was rejected by the workgroup. Only 5% of Medi-Cal beneficiaries are still enrolled in fee-for-service and the risk profile of this residual population is dramatically different than those enrolled in Medi-Cal managed care. For commercial populations, it is unclear what counts as "fee-for-service" when DMHC regulates 95%-98% of state-regulated coverage, including EPOs

1127 11th Street | Suite 925 | Sacramento, CA 95814

and PPOs as well as HMOs. More than half of Medicare enrollees in California are enrolled in Medicare Advantage plans: sorting out differences in delivery systems and risk profiles is complicated by the dominance of Kaiser in the Medicare Advantage market and its absence in the traditional Medicare market.

The second suggestion was to use Equivalent Case-Mix Adjusted Discharge (E-CMAD) for outpatient care. Creating the data infrastructure to permit the use of this approach does not appear to be feasible in the reasonably foreseeable future.

One possibility that may be worth exploring is the measurement approach used by Medicare for outpatient hospital services (OPPS), which uses an "ambulatory payment classification" (APC) approach. This includes both comprehensive payments (C-APCs) for entire outpatient encounters and carve outs for some high-cost items, such as drugs and biologics over a certain threshold. Some facilities, such as cancer centers and children's hospitals, are treated differently. Health Access has suggested consideration of this approach to staff and consultants. In addition, hospital industry representatives also spoke about how they track the elements of outpatient hospital services and other approaches may be feasible.

Quality and Equity Measures

Quality and equity measures are included in the enabling statute for the Health Care Affordability Board and the Office of Health Care Affordability for several reasons:

- First, to assure that cost cutting is not done at the expense of quality and equity
- Second, as with primary care and behavioral health, to move toward a well-functioning health system with lower costs, improved outcomes, and reduced disparities.

Equity and quality measures serve both as guardrails and as guides to a better functioning health system that works for all Californians.

The law requires the use of "recognized clinical quality, patient experience, patient safety, and utilization measures" for health plans, hospitals, and physician organizations. The law also requires alignment with existing measures, out of the recognition of the plethora of measures developed over the last thirty years. The law importantly requires use of "available means for reliable measure of disparities in health care, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status", sometimes abbreviated as RELD-SOGI (race, ethnicity, language, disability, sexual orientation, and gender identity). Finally, the law requires annual review and updating of the measure set. Health Access appreciates this last provision given some of the gaps in current measure sets identified by staff, particularly the lack of stratification and the evolving capacity to collect data.

1127 11th Street | Suite 925 | Sacramento, CA 95814

Health Access has participated in the development of numerous sets of equity and quality measures, including committees and workgroups at Covered California, the Department of Managed Health Care, and the Department of Health Care Services as well as working on legislation that led to some of the quality measures used by the California Department of Public Health (CDPH) and the Office of Patient Advocate quality report card. Based on that broad experience, we have reviewed the proposed measure set developed by staff.

Health Access comments:

- Sadly, behavioral health measures are few and too often focused on very small subsets of the population with behavioral health needs.
    - Health Access strongly supports using depression screening and follow-up, using a standard screening tool for depression because depression is egregiously underdiagnosed while being comorbid with most of the major chronic conditions such as asthma, cancer, diabetes, and heart disease. Failure to manage depression complicates management of other chronic and acute conditions as well as imposing avoidable misery on people. Failure to screen and treat depression is an omission as grave as failing to screen for cancer or manage hypertension.
    - Depression screening and follow-up is far preferable as a clinical intervention to reporting on depression medication metrics. Using measures based on medications for depression assumes both that those with depression are accurately diagnosed and that drugs are the most appropriate treatment in all instances. Neither is true. This measure is used in part because it is easier to track prescriptions than screening and follow-up.
    - NCQA and other bodies involved in developing standardized measures have failed to develop an array of behavioral health measures comparable to those for other major chronic conditions such as asthma and diabetes. This omission reflects, and perpetuates, the longstanding failure to fully incorporate behavioral health into the health care system and should be rectified.
- Several of the measure sets consulted focus appropriately on prevention and chronic disease management. This goes hand in hand with OHCA's emphasis on primary care as well as the triple aim of lower costs, improved outcomes and greater health equity. But such measure sets tend not to focus on hospital care or other complex care for those most in need.
- Hospital measures:
    - Hospital spending accounts for about 45% of commercial health insurance premiums, the largest single share. It is also almost 40% of overall spending as well as spending by Medicare and Medi-Cal.

1127 11th Street | Suite 925 | Sacramento, CA 95814

    - Because hospital costs are such a large share of total health care expenditures, hospital quality measures are important to include alongside those focused on primary care, prevention, and chronic disease management.
    - Health Access has testified that the measures maintained by CDPH on never events, maternal mortality and more should be reviewed and considered as well as the OPA report card measures.
    - We particularly regret the lack of stratification of the OPA-maintained hospital measures, which reflects in part the lack of diversity of those consulted by OPA in developing its report cards. Both the lack of stratification of measures and the diversity of those consulted should be corrected. Some hospital measures should not vary by race or ethnicity such as health-acquired infections, while others may vary with age, income, and social determinants, such as readmissions.
    - Hospital measures should be updated annually, consistent with the law.
- As with other efforts by OHCA, we view the proposed quality and equity measures as a starting point that may evolve over time.
    - Twenty years ago, stratification by sexual orientation and gender identity was rarely considered.
    - There is still work to do to collect information on race, ethnicity and language as well as disability.
    - In the future, we hope that social determinants of health will be added, and that income and caregiving will be considered variables. There is a substantial literature on each of these variables including SDOH, income and caregiving on the relationship to overall health status, from depression to other chronic conditions.
    - The law on equity and quality measures rightly requires annual review and updating of these measures.

Cost and Market Impact Reviews, Focused Study on Monterey Hospitals

Cost and Market Impact Reviews to Date

Health Access is disappointed with the work to date in this area:

First, we are disappointed that until very recently, every single transaction that has been submitted for review has had review waived. Given the assertions of those entities subject to review that OHCA review obviates the need for any other legislative or administrative action, the waiving of review raises substantial questions about whether the role of CMIRs should be strengthened.

1127 11th Street | Suite 925 | Sacramento, CA 95814

Second, it would be helpful to all interested parties if OHCA provided a sentence or two to describe why in these instances, review was waived. In effect, the Office is building case law in this area. All interested parties, whether consumer advocates or potential parties to transactions, are still learning what the standards for review will be. An abbreviated case summary or description would be helpful.

Third, we are concerned that the Office is only reviewing transactions if the parties present the transaction for review and, as best we can tell, the Office is not seeking out transactions that are likely to meet the standards for review. While some parties may be aware of the new requirements of California law, others may not be. The Office should screen records of transactions, including business media reports, in order to reach those parties, including their law firms, who may be unaware of the new state requirements. The Office may also work with sister state agencies to alert their respective regulated entities of the need to file.

We also note that there are far fewer transactions than some had projected. It may be that the earlier estimates were excessive. It may also be that relatively high interest rates have chilled merger and acquisition activity, as it often does. It may be that other transactions closed early to avoid scrutiny. It may be that the Office is missing transactions that are properly subject to review.

Monterey County Study

Health Access is pleased that the Office is undertaking a focused market review of the Monterey County hospitals. This is consistent with our request that a lower cost growth target be imposed on the three Monterey hospitals, as low as 0.1% for five years. We recognize that the law allows OHCA to collect information confidentially from other parties and observers in the Monterey area. We note that some of the Advisory Committee members have particular experience with Monterey to offer.

A discussion of the broad considerations involved in this study might be helpful to the Office without undermining its investigative authority or might strengthen trust in the process. After all, it is precisely because community members made the effort to bring the problems in Monterey to the attention of the Board that this study was requested. Similarly, the requirements imposed by other bodies of law and regulation may shed light on the reasons for the high costs: in this respect, we point to the time and distance standards imposed by DMHC under the Knox-Keene Act of 15 miles and 30 minutes for hospitals which create the conditions for CHOMP to be a monopoly while Salinas Valley and Natividad constitute a duopoly. Similar geographic factors explain some other high-cost outliers among hospitals. DMHC does

1127 11th Street | Suite 925 | Sacramento, CA 95814

geomapping for the time and distance standards: this may be helpful to those engaged in the study.

"Total" Health Care Expenditures

Health Access appreciates the update on data submission by payers regarding "total" health care expenditures, that subset of health care spending by plans and insurers on covered benefits. Additional information would be helpful: staff reports that 17 of 18 submitters have provided the information.

- Does this reflect the overwhelming majority of submitters?
- And what about covered lives? What proportion of the 37 million Californians with health insurance does this include?
- Does it include self-insured lives?
- Medicare Advantage?
- How does it compare to the data collection under the Health Payments Database? Is there substantial overlap?

We recognize that initial data collection may not result in 100% of the universe but there is a significant difference between collecting information on 25%-30% of the universe, as originally proposed for physician organizations, and collecting information on 90%-95% of THCE.

Staff briefly presented to the Advisory Committee some proposed changes to the Data Submission Guide.

- Based on the experience of Monterey, Health Access opposes the deletion of "Member Responsibility" from the Attributed and Regional files.
    - As we understand it, unlike most California regions where fixed dollar copayments are common, coinsurance is rife in Monterey as a response to high hospital costs.
    - Coinsurance is pernicious for consumers: there is no way to predict what a consumer will owe because it is a percentage of unknowable underlying costs.
    - This is in stark contrast to fixed co-payments in which a consumer knows they will owe $50 for an emergency room visit or a smaller amount for a doctor's visit.
- Health Access supports the addition of data fields on Alternative Payment Models and Primary Care spending as consistent with action already taken by the Board.

Cost Containment Efforts While Improving Outcomes and Equity

Health Access has appreciated the comments and presentations by various stakeholders to the Board about efforts to control cost growth while improving outcomes and equity. We also note

1127 11th Street | Suite 925 | Sacramento, CA 95814

that several written comments from trade associations and entities subject to the targets have offered possible approaches to cost containment, usually focused on entities other than those making the comments. Health Access supports, and has supported, a wide array of cost containment measures from limiting deductibles for small business purchasers to capping prescription drug co-pays to exposing high drug costs through first-in-the-nation reporting on advance notice of price increases to OHCA itself. Health Access is happy to work to ensure that efforts to contain costs in any part of the health care industry are done in a manner that, as with OHCA, assures access, quality, and equity as well as lower cost growth. In our comments to the Board, we have offered a variety of suggestions on how cost growth may be slowed. We will continue to work on these efforts.

Summary

Health Access has made recommendations on:

- Consumer affordability
- Lower cost growth targets for high-cost outliers
- Measures of hospital spending, both inpatient and outpatient as well as total revenues at a facility and system level
- Equity and quality measures
- Cost and market impact reviews, as well as the focused study on Monterey hospitals
- Data on total health care expenditures

We appreciate your consideration of these comments,

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Interim Executive Director

CC: Health Care Affordability Board
Kimberly Chen, Acting Deputy Secretary, Program and Fiscal Affairs, California Health and Human Services Agency
Darci Delgado, PsyD, Assistant Secretary, California Health and Human Services Agency
Mary Watanabe, Director, Department of Managed Health Care
Josephine Figueroa, Deputy Commissioner, Department of Insurance
Assemblymember Robert Rivas, Speaker of the Assembly
Senator Richard Roth, Chair, Senate Health Committee

1127 11th Street | Suite 925 | Sacramento, CA 95814

Assemblymember Mia Bonta, Chair, Assembly Health Committee
Senator Caroline Menjivar, Chair, Senate Budget Subcommittee on Health and Human Services
Assemblymember Akilah Weber, M.D., Chair, Budget Subcommittee on Health

1127 11th Street | Suite 925 | Sacramento, CA 95814

November 15, 2024

Health Care Affordability Board
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments Ahead of the November 2024 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

The California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, appreciates the opportunity to comment on the November 2024 Health Care Affordability Board meeting. The Office of Health Care Affordability (OHCA) has an historic opportunity to transform health care delivery in California, but it cannot achieve its goals of affordable, high-quality, equitable care delivery without a thorough understanding of how health care delivery and financing is evolving under its purview. This letter offers recommendations for how OHCA should approach measuring impacts on access, quality, and equity; foster investments to expand primary care and behavioral health access; and encourage collaboration across the health care sector to fulfill OHCA's bold mission.

Proposed Approach to Quality and Equity Measurement Has Merit, but Will Not Comprehensively Capture Important Trends in Access, Quality, and Equity

Measuring Quality, Equity, and Access Is Necessary to Protect Against Unintended Consequences. OHCA is statutorily required to ensure that its spending targets do not impair access, quality, or equity. To carry out this purpose, state law requires OHCA to develop and track a set of quality and equity measures. CHA strongly supports OHCA efforts to track overall health care system performance and encourages the board to push for a comprehensive and innovative approach to measuring and protecting against the unintended consequences of OHCA's cost containment efforts.

Using Existing Hospital Measures Has Significant Benefits. OHCA has proposed to use a slate of pre-established quality and equity measures to track overall health care system performance. As part of that proposal, OHCA staff have recommended using the same measures as the Hospital Equity Measures Reporting Program developed by its parent department, the Department of Health Care Access and Information (HCAI), over the past several years. This approach has certain advantages, most notably compliance with the provision in state law that OHCA leverage pre-existing measures used by other regulatory bodies. Furthermore, reliance on existing measurement would minimize administrative complexity for both OHCA and hospitals and reduce the degree to which hospitals are asked to adhere to disjointed sets of quality and equity performance measures. Streamlining these processes would allow hospitals to focus their resources on meaningful improvement on a discrete set of measures.

While hospitals continue to evaluate OHCA's proposed use of this full measure set, CHA encourages OHCA to consider focusing on those measures that are firmly within hospitals' control. Additionally, OHCA and HCAI should continually update these measures as necessary to ensure, where applicable, that they remain consistent with the evolving ways in which other regulators, like the Centers for Medicare & Medicaid Services, measure hospital performance. Finally, OHCA and HCAI should carefully consider how finely performance is stratified by race, ethnicity, gender, sexual orientation, and other demographic characteristics, given that greater specificity often reduces the extent to which statistically significant conclusions can be drawn from the data.

Critical Aspects of Health Care System Performance Would Not Be Tracked Under OHCA's Proposed Approach. While the proposed approach has certain advantages, it would provide only a partial view of health care system performance. The following bullets describe key aspects missing from OHCA's proposal. As proposed elsewhere, OHCA should use existing data collected by government agencies and other organizations to fill these gaps.

- **Access Measures Are Essentially Absent.** By including almost no access measures, the proposed approach to quality and equity measurement would result in a serious lack of insight into many critical measures of health system performance. The OHCA board would have no way of knowing whether:
    - Appointment and emergency department wait times are increasing
    - Patients are forced to travel further for emergency care or labor and delivery services
    - Patients are experiencing greater difficulty obtaining a usual source of care
    - Networks of behavioral health therapists are decreasing
    - High-value – if sometimes high cost – pharmaceuticals and other new health care technologies are growing farther out of reach
    - Patients with rare diseases like hemophilia, cystic fibrosis, or muscular dystrophy are facing greater challenges obtaining the care they need to survive.

  Hospitals recommend that the OHCA board direct OHCA staff to develop a supplemental plan for comprehensively measuring access to care, including for patients with chronic and rare diseases, and thereby strive to fulfill its mandate to maintain access to care while reducing spending growth.
- **Quality and Equity Measures Ignore the Outcomes We Want Our Health Care System to Achieve.** California's health care system produces miracles every day, extending and saving lives from diseases and injuries that, one or more decades ago, would have led to certain death or impairment. And yet, OHCA's proposed quality and equity measure set almost entirely ignores performance related to the health care system's primary function: improving people's health. Instead, the vast majority of measures only look at preventive care processes, like whether a patient received a screening or whether just one of several specific kinds of visits occurred (e.g., well-child and prenatal visits). While the proposed measures may reflect sound *process measures*, they don't consider whether health was improved, a disease was reduced in severity or cured, or mortality was avoided. By failing to account for what we fundamentally want from health care — better health — OHCA could be left with the mistaken impression that the system is performing as hoped, even while its most fundamental functions are degrading or no longer improving to their full potential. To address this deficiency, the OHCA board should ask OHCA staff to incorporate outcome measurement into its approach for measuring and reporting on system performance.
- **Creation and Diffusion of New Treatments Deserves Special Attention.** A major risk of OHCA's efforts to reduce spending is slowing the rate of innovation in health care and how

quickly these innovations become available to the patients that need them. This outcome would be tragic, causing untold avoidable disease and death. Recent research in the National Bureau of Economic Research underscores the reality of this risk.[1] The research showed that a 61% reduction in Medicare payments for medical devices led to a 25% decline in new product introductions and a 75% decrease in patent filings, both indicating a slowdown in innovation. New entrants into the manufacturing market fell while outsourcing increased, leading to poorer device quality. As a result, the authors estimate that the price cuts potentially led to losses in the value of foregone innovation far exceeding the amount of Medicare dollars saved. OHCA's spending target aims to reduce total health care spending growth by almost 40% over the next five years, with potential for similar troubling effects as the Medicare medical device rate reductions. Monitoring such unintended consequences is critical for OHCA to meet its mission without damaging the health of 39 million Californians.

Greater Investment in Primary Care and Behavioral Health Is Essential and Should Be Considered in Light of OHCA's Other Targets

Access to primary and behavioral health care is inadequate in California. As a result, thousands of patients turn to emergency departments and hospitals for their health care needs, even though timely preventive primary and behavioral health care could have prevented their need for acute care. To address these challenges, CHA supports OHCA's efforts to encourage greater investment in primary and behavioral health care. OHCA has already set a 15% target for the proportion of total medical spending going to primary care. Now, OHCA is working toward the adoption of a target for behavioral health care. Below are key considerations as OHCA continues this work.

Behavioral Health Investment Goals Must Include the Full Continuum of Behavioral Health Services. Behavioral health care is in crisis, with record numbers of Californians unable to access the care they need. Deficiencies in care availability span the entire continuum of care, from navigation and peer services to therapy, medication-assisted treatment, intensive outpatient services, inpatient psychiatric care, and long-term nursing and supportive care. Investment is needed in all these areas to ensure care is there when people need it and to speed transitions out of emergency departments and hospital beds to more appropriate care settings. In establishing its methodology for measuring behavioral health spending and setting an investment goal, OHCA must recognize the full scope of investment needed and the state resources currently devoted to expanding the full continuum of behavioral health care services across both community- and hospital-based care. In doing so, OHCA's efforts in this area would ultimately be supportive of the critical efforts underway under Behavioral Health Services Act and Behavioral Health Community-Based Networks of Equitable Care and Treatment Demonstration.

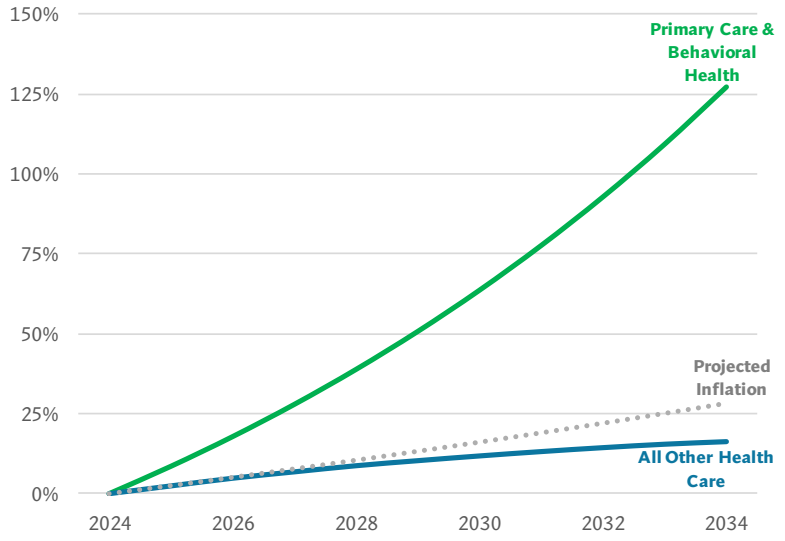
Statewide Spending Target Must Account for OHCA's Investment Goals. OHCA has set a goal of increasing primary care spending from around 9% of total health care spending today to 15% of total spending by 2034. Comments from OHCA leaders indicate that a similar goal could be sought for behavioral health care. These represent audacious but laudable goals. To assure congruity with OHCA's overall spending goals, the board should consider the interaction between its goals for primary and behavioral health care investment and statewide spending growth. As the figure on the next page shows, the risk of dissonance is clear. If the behavioral health target were set at similar levels to the primary care goal, per capita spending in these two service categories would increase by between 100% and 150% over

[1] Yunan Ji and Parker Rogers. "The Long-Run Impacts of Regulated Price Cuts: Evidence from Medicare." NBER Working Paper No. 33083. October 2024. https://www.nber.org/papers/w33083

the next decade. To meet the statewide spending target starting at 3.5% and moving down to 3%, all other health care spending would be limited to growth of around 2% annually over the next five years and decline even further thereafter. This would leave cumulative growth of all other health care spending at between 15% and 20% over the entire decade, over 40% less than projected inflation over this same period. Whether the health care sector could meet such a goal is questionable, as is its desirability given the real cuts to health care spending that it would require.

Primary and Behavioral Health Care Could See Enormous Spending Growth, While All Other Health Care Would Be Subject to Divestment Under OHCA Targets

Cumulative Projected Growth Under Actual and Potential Targets



Projections assume primary and behavioral health care spending each increase from 9% to 15% of total health care expenditures (THCE) between 2024 and 2034, while THCE increases at the statewide spending target through 2029 and 3% annually thereafter. Inflation is projected at 2.5% annually.

Learning Needed Before Moving Toward Sector Targets

The August and October board meetings featured calls to push ahead toward sector targets, contravening clear statutory intent to learn from experience under the statewide spending target before differentiating the state's spending targets by type of health care entities or region. To answer such calls at this point would be premature, coming before OHCA has analyzed even baseline spending data, finalized a multipronged data collection plan, implemented the state's first spending target, or set any rules for enforcement. OHCA has conducted no cross-sector analyses to determine where the sector discussion should be focused, nor heard from the organizations that are being scrutinized in the discussions the board has held. No consideration has been given to how different sector targets for different components of the health care industry would interact. As such, a lower spending target for providers could simply allow payers to retain any resulting savings as higher earnings, rather than being passed along to those who should be the ultimate beneficiaries of OHCA's work —Californians. More learning is needed before moving forward.

Conclusion

OHCA has tremendous authority to transform health care delivery in California. Fulfilling this awesome responsibility will require thoughtful consideration of what Californians want from their health care system and adopting rules and practices that reflect these multifaceted aims. CHA encourages OHCA to proceed reflectively, with due consideration of the impacts its decisions will have for the 39 million Californians who rely on the state's health care delivery system for their health, lives, and livelihoods.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency

Salinas Valley
Federation of Teachers
AFT Local 1020 * AFL-CIO
931 Blanco Circle Salinas, CA 93901 * 831-235-1587

November 14, 2024

Mark Ghaly, M.D., Chair
Health Care Affordability Board
Kim Johnson, Secretary-Designate
California Health and Human Services Board
Elizabeth Landsberg, Director
Department of Health Care Access and Information
Vishaal Pegany, Deputy Director
Office of Health Care Affordability
Department of Health Care Access and Information

By email: ohca@hcai.ca.gov

Re: Urgent Follow-Up to August 2024 OHCA Board Meeting in Monterey County

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

The Salinas Valley Federation of Teachers want to extend our sincere gratitude for the Board's recent visit to Monterey County, but we must also emphasize the urgent need to address the affordability crisis afflicting our community. We respectfully urge the Board to impose a 0.1% sector target for the three hospitals—Community Hospital of the Monterey Peninsula (CHOMP), Salinas Valley Health, and Natividad—without delay.

The affordability crisis in Monterey County is reaching alarming levels. While we appreciate the Board's efforts to convene in our region, it is crucial to recognize that the exorbitant hospital prices here are not merely a byproduct of labor costs or payer mix, as the hospitals have suggested, but rather a direct result of severe market concentration. The presentations at the August meeting, coupled with our own claims experience, make it clear that immediate action is needed.

We were encouraged by the Board's willingness to engage with local testimonies, many of them members of our local, Salinas Valley Federation of Teachers, reflecting the real struggles faced by residents burdened by high medical costs. However, the time for discussion is running out; we need decisive action. We strongly believe that the three Monterey County hospitals warrant a 0.1% sector target starting in 2026. We hope the additional data analysis mentioned during the meeting can be expedited to avoid further delays in addressing this pressing issue.

The hospitals are clearly aware of the OHCA Board's proceedings, as evidenced by their press releases following the August hearing. While we acknowledge CHOMP's commitment to reducing costs, it is simply not enough to alleviate the financial strain on our community. We need sustained, substantive change.

Salinas Valley
Federation of Teachers
AFT Local 1020 * AFL CIO
931 Blanco Circle Salinas, CA 93901 * 831-235-1587

Shining a light on the critical need for reform in Monterey County will not only encourage the hospitals to take meaningful steps but will also provide much-needed relief to our residents who are grappling with unprecedented healthcare costs.

We deeply appreciate the dedication of the OHCA Board and its staff in championing this cause. The time for action is now- let us work together to make healthcare in Monterey County affordable for all.

Sincerely,

Kati Bassler

President

Salinas Valley Federation of Teachers