



SUPPLEMENTAL REPORT: AN EVALUATION OF THE PROPOSED CHANGE IN CONTROL OF SAINT MARY MEDICAL CENTER

Presented for the consideration of

The Healthcare Rights and Access Section, Public Rights Division,
California Office of the Attorney General

Presented by
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1 Purpose and Intent

The purpose of this document is to update our report, *An Evaluation of the Proposed Change in Control (CiC) of St. Mary Medical Center (SMMC), November 11, 2021*, with additional information received or reviewed after the drafting of the initial report and to provide Appendix F cited in the November report. The sections below include:

- Section 2: A discussion of the stakeholders' (public) response to report.
- Section 3: A discussion of the parties' response to the report and the proposed conditions.
- Section 4: A review of new information regarding Kaiser's affiliation with St. Joseph's Medical Center, Stockton.
- Section 5: A brief analysis of the implications of the possibility that there is no additional staffing at the New Hospital relative to the current SMMC facility.¹
- Section 6: A discussion of implications of the limited provision of reproductive and gender affirming services at SMMC.
- Section 7: The supplemental Appendix F cited in the November 11, 2021 report.

2 Review of Comments by Stakeholders at the Public Meeting

Summary of Findings. The comments at the November 23rd public meeting to discuss the SMMC CiC were largely in favor of the transaction, however, a number of stakeholders had concerns about the loss of a hospital in Apple Valley and, specifically, a loss of an emergency room in Apple Valley. No new information was provided that alters our opinions in our original report of November 11, 2021, *An Evaluation of the Proposed Change in Control of SMMC*.

Meeting summary. On November 23rd the OCAG held a video conference public meeting soliciting public comment on the proposed change in control for SMMC. Below we summarize many of the comments made at this meeting. The public meeting was moderated by OCAG Deputy Attorney General, Lily Weaver and was attended by representatives from Kaiser, SMMC, a representative from Desert Valley Hospital, owned by Prime Healthcare Services, and local area residents including medical professionals and the Mayor of Apple Valley. The

¹ Throughout this document, as in the original report dated November 11, 2021, "An Evaluation of the Proposed Change in Control of St. Mary Medical Center", the term "New Hospital" shall include the general acute care hospital successor to SMMC that will be operated by SMMC LLC. It is understood that the New Hospital will have at least 260 beds and be built on land described in Schedule 1.1(a) to the Contribution Agreement by and between SMMC, SMMC LLC, and their respective parent companies dated May 7, 2021.

summary does not contain a complete verbatim account of the meeting and responses but is intended to capture the different sentiments and opinions expressed by the attendees.

At the opening of the meeting, Kaiser and SMMC representatives provided an overview of the CiC noting that the new hospital will be the focal point of community with an emphasis on outpatient care. They indicated they were exploring options with Apple Valley for the existing site and ways in which it might be able to serve the medical needs of the community. The Kaiser area medical director highlighted that the transaction would “bring inpatient services closer to home” for Kaiser members in the area.

There appeared to be a general consensus in favor of the transaction by those who came to speak. However, a minority of speakers opposed the transaction. Those expressing concerns primarily focused on the loss of a local ER in Apple Valley. While comments were primarily directed at issues of access, we do not interpret that absence of comments on the competitive effects of the transaction as reflecting a lack of concern on this issue. Rather, we believe residents may have lacked awareness of the complex nature of the impact of potential adverse competitive effects and were more focused on the immediate and more tangible aspects of physical access to medical care.

While not a complete list of all the comments at the public meeting, the comments below largely reflect the comments and concerns voiced by those who attended:

- The Mayor of Apple Valley, Curt Emick, acknowledged the clear need for hospital beds but had grave concerns regarding the loss of a local medical center and the only emergency room (ER) in Apple Valley. He stated that he had been having discussions with Providence regarding the re-use of the facility and suggested that the transaction be approved with the condition that the existing site stay open in some capacity as an emergency room in Apple Valley.
- Council Member Scott Nassif supported Mayor Emick’s comment and stressed the fact that the new ER was only 11 miles away but logistics often made it difficult to get to.
- Diane Carloni O’Malley, a former mayor of Hesperia and local attorney, supported approval of the transaction and did not believe Apple Valley would suffer because of the relocation of the hospital. She also felt it would provide better outcomes and population health.
- Ana Sanchez, a physician, was concerned that SMMC was moving out of an area populated by a large vulnerable population for financial reasons and argued that Providence had the resources to retrofit the existing facility.
- Jan Gonzales, of the Victor Elementary School District in Victorville, stated that Kaiser is an insurance option for employees but that there is a hesitancy to choose Kaiser because there are no local hospital options.

- Several local activists, including a church pastor, Paul, supported the partnership. Several cited work with SMMC as evidence that SMMC was committed to the High Desert population.
- Several residents felt that the area needed to keep the existing hospital while building a new one to support the growth in the area. Steve Sobel, a resident of Apple Valley, did not agree that the town would have the same level of service if the current hospital was no longer a general acute care facility, citing the traffic congestion as a major issue for access. Mary Schaffer, a local area resident, felt that they needed a trauma center in area rather than air transport to Loma Linda.
- Fred Ortega, representing the nearby Desert Valley Hospital owned by Prime, offered to extend their support to SMMC with a Foundation contribution to help upgrade SMMC.

3 Review of Comments by the Parties for the Proposed Conditions

This section addresses the parties' responses in their November 23, 2021 document, *Response to Conditions Recommended in SMMC Healthcare Impact Report*. We first offer comments and opinions on the parties' response to selected conditions and then discuss proposed options for alternate conditions, related to profit-sharing, discounts, and price caps.

3.1 Opinions on selected response to recommended conditions

Below we provided comments on selected parties' responses dated November 23rd 2021.² In cases where we don't provide an opinion, we are neither rejecting nor endorsing the parties' response.

- **Time period for the conditions.** Many of the conditions apply for at least ten years or until the New Hospital is operational and admitting patients, and then for a period of ten years or more once the New Hospital opens. The parties object to this condition arguing that the standard term for this condition in transactions approved by the Attorney General is ten years post-closing.

Opinion. The parties are correct that conditions are commonly applied for a period of ten years post-closing, however, this transaction has some uncommon characteristics that make it appropriate to apply conditions for an extended time period. First, rather than having a single facility at a single location that will undergo and CiC at a given point in time, we have a facility at its current location that will undergo the CiC but then be relocated to a new location at some point in the future. It is important that the conditions apply to both facilities. Second, once the new hospital opens, new terms of

² Where we designate a letter and number, e.g. A5, this references the specific response in the parties' document.

the agreement go into effect, most notably, profit-sharing for Kaiser. Therefore, we do not think the proposed time period for applying the conditions are unreasonable. We recognize that regulatory or market conditions may change depending on when the hospital actually opens and the parties have a mechanism for modifying conditions per the California Regulations on Nonprofit Health Facility Transactions, Title 11, Chapter 15, Section 999.5 (h) which address the “Amendment of Consent Terms and Conditions”.

- **Access to pediatric beds (A4).** For at least ten years or until the New Hospital is operational and admitting patients, the current SMMC facility shall maintain or increase the current licensure, types, and/or levels of services for Pediatric services, including a minimum of six licensed pediatric beds.

The parties state that “While access to needed pediatric acute care services will continue at SMMC, SMMC and Kaiser object to the component of this condition that requires SMMC to provide dedicated pediatric beds. For pediatrics, SMMC has an average daily census of one patient. Based on this low volume, requiring SMMC to keep dedicated pediatric beds would result in a waste of SMMC’s resources and would create quality of care issues. Pediatric patients will still have access to SMMC as they do today, but the parties cannot agree to operating a dedicated pediatric unit.”

Opinion. The issue of appropriate access to pediatric beds is an important one that we think deserves careful consideration. Based on the short time frame we had to review the transaction, relative to the complexity of the case and the many issues associated with the CiC, we did not have enough information to allow us to form a well-founded opinion. The OCAg might consider an independent cost benefit analysis of retaining some number of pediatric beds at SMMC. Below, we present some of the facts and observations we’ve gathered to help inform the OCAg on this issue.

- **What is SMMC’s current status?** According to the 2020 Department of Health Care Access and Information (HCAI) data SMMC has eight licensed pediatric beds.³ Currently, SMMC, for the purpose of California Children's Services (CCS), a program serving fragile and often economically disadvantaged children, is a CCS designated (specialty) hospital.⁴ (CCS is a state program for children with certain

³ [Part1] Project Blossom - Response to AG's Request for Information Dated 9-21-21 [10-5-2021] indicate they have a 6-bed pediatric unit. Please describe any plans to expand or reduce lines of services at the new SMMC hospital. The 6-bed pediatric unit will not be offered at the new hospital. The current 6-bed unit has an average daily census of one (1) patient. The unit is closed approximately 40% of the year due to lack of patients, physician specialty and physician subspecialty. Pediatric patients are best served in pediatric hospitals.

⁴ A CCS special Hospital is a hospital licensed as an acute care hospital and meets either one or two below:
1. The hospital has no licensed pediatric beds but has: a) licensed perinatal unit/service and intensive care newborn nursery (ICNN) service and meets the CCS NICU Standards as a Community NICU or an Intermediate NICU, as per CCS Manual of Procedures, Chapter 3.25; or b) licensed under special permit for rehabilitation services and meets CCS Standards as a Rehabilitation Facility.2. The hospital provides services in a specialized area

diseases or health problems and often addresses the health needs of families with low incomes or high medical costs for pediatric care or both.)⁵ We recommend that SMMC retain its status as a CCS hospital so it can continue to treat pediatric patients and not just those age 14-21 because we believe there is a need for local pediatric services based on the information below.⁶

- **What is SMMC's future status?** The parties state that SMMC participates in the CCS program as an approved NICU unit. They will eliminate their pediatric beds but "Access to needed pediatric acute care services will continue at SMMC".⁷ However, is it not clear what this "access" includes. For example, would this include admitting pediatric patients as inpatients if they were diagnosed with acute bronchitis, pneumonia, or asthma? Or would it mean transferring them to Children's Hospital of Orange County or Loma Linda Hospital, which is likely a minimum hour drive and possible two hours one way depending on traffic and time of day?
- **What is the demand for pediatric services?** There appears to be a continuing demand for pediatric care. Between 2015 and 2019 there were more than 15,000 visits for patients ages 1-19 with just a small 3% decrease in total emergency department (ED) visits between the two years.⁸ About 42% of pediatric ED patients from the area go to SMMC's ED, another 40% are split between Desert Valley and Victor Valley hospitals.⁹ Most pediatric patients at SMMC are Medi-Cal patients (82%), a larger proportion than for other age groups at SMMC and likely the least profitable patient category at SMMC.

of medical care and acts as a regional referral center for that specialized type of care, e.g., eye surgery, ear surgery or burn center. While SMMC has licensed pediatric beds, the DHCS website does not appear to designate it as a Pediatric Community Hospital defined as a community-based hospital with licensed pediatric beds that provides services for children from birth up to 21 years of age consistent with the requirements listed in this Section. The length of stay shall not exceed 21 days, with the exception of care provided in a CCS-approved Community or Intermediate Neonatal Intensive Care Unit (NICU), as per CCS Manual of Procedures, Chapter 3.25. (<https://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCName.aspx>)

⁵ Children qualify for CCS if they: 1) are under 21 years old, 2) have a medical condition that is covered by CCS, 3) are a resident of California, 4) and have one of the following: Healthy Families Insurance, designation as a Medi-Cal beneficiary with full benefits, family income of \$40,000 or less, out-of-pocket medical expenses expected to be more than 20 percent of family's adjusted gross income, status as an adopted child with a known health problem that is covered by CCS, or a Medical Therapy Program need.

⁶ For the purpose of California Children's Services (CCS), a General Community Hospital is a community-based hospital without licensed pediatric beds in which care may be provided only for adolescents 14 years up to 21 years of age consistent with the requirements listed in this Section. The length of stay shall not exceed 21 days, with the exception of care provided in a CCS-approved Community or Intermediate Neonatal Intensive Care Unit (NICU), as per CCS Manual of Procedures, Chapter 3.25.

(<https://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCName.aspx>)

⁷ Letter to the OCAG from the parties dated December 10, 2021.

⁸ Data based on a comparison of the HCAI Emergency Department Data pivot profiles for 2015 and 2019.

⁹ OSHPD Patient Discharge Data, 2019.

There has been a steady decline in inpatient admissions for the eight licensed pediatric beds falling from 365 admissions in 2015 to 195 in 2020. Those pediatric patients that need admission are often sent from SMMC to Loma Linda or another children’s hospital. Whether this decline is due to reduced need or administrative direction is uncertain and a closer analysis would be required to understand the reasons for this change. However, there is some evidence that the decline may be attributable to direction from Providence.¹⁰ One would not expect this decline in inpatient utilization based on the ED utilization alone.

- **What is the current environment for pediatric services?** There has been an overall decline in pediatric inpatient units and beds and there has also been consolidation of pediatric care with an increase in the number of inpatient beds at children’s hospitals.¹¹ In fact, Riverside Community Hospital in nearby Riverside County, in November of 2020 decided to close their pediatric unit with 16 beds to “meet the evolving needs of our community”.¹² As a result of this trend, nearly 25% of US children had an increase in distance to their nearest inpatient pediatric unit.¹³ One impetus speculated for this trends is the “structural urbanism” in health care, in which a bias exists toward large population centers. This is based not only on a market orientation, which can require a larger number of customers to generate profit, but also from a public health focus driving preferential funding toward larger population centers. However, as distance to care increases, there is an associated delay in care, as well as an increase in costs, length of stay, and mortality.^{14,15,16} There is evidence

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¹¹ Cushing AB, Bucholz EM, Chien AT, Rauch DA, Michelson KA. Availability of pediatric inpatient services in the United States. *Pediatrics*. 2021;148(1):e2020041723

¹² Riverside Community Hospital Newsroom, August 17, 2020 (<https://riversidecommunityhospital.com/about/newsroom/riverside-community-hospital-announces-pediatric-unit-closure#:~:text=After%20careful%20consideration%2C%20we%20have,over%20the%20past%20few%20years.>)

¹³ Cushing AB, Bucholz EM, Chien AT, Rauch DA, Michelson KA. Availability of pediatric inpatient services in the United States. *Pediatrics*. 2021;148(1):e2020041723

¹⁴ Gattu RK, De Fee AS, Lichenstein R, Teshome G. Consideration of cost of care in pediatric emergency transfer—an opportunity for improvement. *Pediatr Emerg Care*. 2017;33(5): 334–338

¹⁵ Lorch SA, Silber JH, Even-Shoshan O, Millman A. Use of prolonged travel to improve pediatric risk-adjustment models. *Health Serv Res*. 2009; 44(2 pt 1):519–541

¹⁶ Gregory CJ, Nasrollahzadeh F, Dharmar M, Parsapour K, Marcin JP. Comparison of critically ill and injured children transferred from referring hospitals versus in-house admissions. *Pediatrics*. 2008;121(4):e906–e911

that even a small increase in distance to pediatric care can have a large impact on access for patients with few resources and lack of transportation.^{17,18,19} It is probably safe to assume that most working parents, especially ones facing transportation difficulties would have preferred their child to be treated in a community hospital for uncomplicated community-treatable conditions.

- **What are the trade-offs of not having pediatric beds?** It is not clear how a cost benefit analysis might shake out given the financial costs of maintaining designated pediatric beds, the costs of personnel for those pediatric beds given the health care staffing shortages and the benefits to pediatric patients as opposed to other patients who might benefit from those beds.
- **Retention of existing clinics (A6).** For at least ten years (or more) from Closing, SMMC shall retain any existing clinics including the following unless there is documentation supporting their closure:
 - SMMC Medical Center Community Health Center, located at 18077 Outer Highway 18, Suite 100 in Apple Valley;
 - SMMC Community Health Center Hesperia Clinic, located at 17071 Main Street in Hesperia; and
 - SMMC Medical Center Healthy Beginnings Adelanto Clinic, located at 11424 Chamberlain Way, #9 in Adelanto.

The parties state that “SMMC does not operate the clinics listed in this proposed condition. In August of 2020, the assets and operation of these clinics was transferred by SMMC to St. Jude Neighborhood Health Center (“SJNHC”), a federally qualified health center (“FQHC”). Establishment of these clinic operations under an FQHC permitted the provision of a broader array of services to the community available under the Federal health care program. Pursuant to Section 330 of the Public Health Service Act, an FQHC may not be owned, controlled or managed by a third party which would include SMMC and its affiliates. Therefore, as of August 2020, the clinics do not fall under SMMC’s hospital license, are not part of SMMC’s operations or the transaction at issue.

Accordingly, the parties object to this condition and cannot agree for SMMC to maintain clinics that it no longer owns.”

¹⁷ Wolfe MK, McDonald NC, Holmes GM. Transportation barriers to health care in the United States: findings from the National Health Interview survey, 1997–2017. *Am J Public Health.* 2020;110(6):815–822

¹⁸ Syed ST, Gerber BS, Sharp LK. Traveling towards disease: transportation barriers to health care access. *J Community Health.* 2013;38(5):976–993

¹⁹ Upadhyay N, Aparasu R, Rowan PJ, Fleming ML, Balkrishnan R, Chen H. Impact of geographic access to primary care provider on pediatric behavioral health screening [published online ahead of print January 22, 2020]. *Pediatr Blood Cancer.* doi:10.21203/rs.2.21581/v1

Opinion. Much of the data for our report was based on information prior to 2020, however, It appears that SMMC has community health centers at two of the three locations listed above. The SMMC website as of 12/2/2021 lists the following community health centers and programs (<https://www.providence.org/locations/st-mary-medical-center/community-programs>) :

- St Mary Health Centers-Apple Valley, located at 18077 Outer Highway 18 South, Suite 100 in Apple Valley;
- Diabetes Education Center, located at 18077 Outer Highway 18, in Apple Valley;
- Bridges Family Resource Center, located at 18077 Outer Highway 18, Suite 100 in Apple Valley;
- SMMC Health Center Hesperia Clinic, located at 17071 Main Street in Hesperia; and
- St. Mary Health Center- Adelanto, located at 11965 Cactus Road, Suite I,J &K, in Adelanto.

We recommend that, to the extent that SMMC and Providence have control over these resources, they keep them open for at least ten years. However, we realize the types and location of community resources needed may change and the parties have a mechanism for modifying conditions per the California Regulations on Nonprofit Health Facility Transactions, Title 11, Chapter 15, Section 999.5 (h) which address the “Amendment of Consent Terms and Conditions”.

- **Emergency procedures that may violate ERDs (B4).** At the date at which the New Hospital begins admitting patients, for procedures that are medically indicated, but not allowed to be performed under SMMC’s ERDs (e.g., hysterectomies, gonadectomies), and could not be safely transferred to another institution, Kaiser staff would be allowed to perform the procedure at the New Hospital. Kaiser would in no way be limited in its existing provision of gender affirming procedures at Kaiser facilities.

The parties state that “This condition is objected to on the grounds that it represents a fundamental misunderstanding of SMMC’s current service offerings and how the ERDs apply to SMMC’s operations. SMMC, as a Catholic sponsored facility, does not currently provide any services prohibited by the ERDs and will not agree to a condition that requires SMMC to provide any services that could violate the ERDs and compromise SMMC’s Catholic sponsorship. It is important to note that the ERDs permit certain services to be performed in life saving emergencies, and SMMC must maintain the authority to determine when such exceptions arise. The transaction will not change the ability of any patient in the community to receive certain services where and how they receive those services today (including the reproductive health services that Kaiser

patients currently receive on an outpatient basis and at Kaiser Ontario Medical Center and Kaiser Fontana Medical Center). SMMC has always maintained a process for directing patients to publicly available information about where to find centers of excellence for services not provided by SMMC. This condition would require SMMC to offer new services that could compromise SMMC's Catholic sponsorship, and therefore this condition is not acceptable."

Opinion. It is our opinion that SMMC should allow all physicians, but particularly Kaiser physicians, to perform normally disallowed procedures at SMMC that are medically necessary, if so deemed by the physician, if the patient cannot be safely transferred. For example, when a miscarriage requires immediate intervention to protect the health or life of the pregnant patient.

- **Maintenance of the Mobile Van Services (C3).** For a period of ten years from the Closing Date, SMMC shall maintain Bright Futures Mobile Vans to help low-and moderate-income families access health care for women and children. The New Hospital shall develop a plan to quantify its goals for successfully bringing services to communities with disproportionate unmet health needs. This plan would include an annual report on progress toward those goals. Services may include physical examinations, cancer screenings, immunizations, TB screening, and diabetes screening, among others.

The parties state that: "Similar to the response above concerning A6, SMMC does not operate the Bright Futures Mobile Van program. In August of 2020, the assets and operation of the Bright Futures Mobile Vans program was transferred by SMMC to St. Jude Neighborhood Health Center ("SJNHC"), a federally qualified health center. Establishment of these clinic operations under an FQHC permitted the provision of a broader array of services to the community available under the Federal health care program. Pursuant to Section 330 of the Public Health Service Act, an FQHC may not be owned, controlled or managed by a third party which would include SMMC and its affiliates. Therefore, as of August 2020, the program is not part of SMMC's operations, and has been operated by SJNHC. Accordingly, the parties object to this condition and cannot agree for SMMC to maintain a program that it no longer owns."

Opinion. According to the [SMMC website](#), as of November 2, 2021, the Bright Futures "Mobile Health Services helps families receive vital healthcare right in their neighborhood." We believe this is a valuable service, particularly for a hospital in a more rural area where outlying residents may not have easy access to health care services. Therefore, to the extent the parties have control over mobile van services, it is our opinion that SMMC should pursue the goal of "helping families receive vital healthcare right in their neighborhood" through mobile van services.

- **Improving behavioral health services (C4).** Within one year of the Closing Date, the New Hospital will submit a plan to implement a Behavioral Health Quality Improvement Program (BH-QIP) with measurable outcomes to be reported publicly at one-year intervals over a five-year period.

The parties state that “SMMC and Kaiser object to this condition on the grounds that SMMC does not currently participate in the BH-QIP program nor is SMMC familiar with the BH-QIP program. Any decision to participate in the BH-QIP would require a thorough assessment by the joint-ventured LLC that will own the hospital post-closing.”

Opinion. One of the stated reasons for the transaction is to improve the quality of care for patients in the area. Lack of adequate behavioral health services in the area is well documented and Kaiser is active in quality improvements activities related to behavioral health.²⁰ Teaming with Kaiser to provide appropriate behavioral health services and monitor their effectiveness would help support the stated goals of the transaction.

- **Disallowance of “set aside beds (C8).** Develop a condition that would not allow beds “set aside” for Kaiser’s exclusive use at either the current SMMC facility or the New Hospital regardless of whether there was an immediate need.

The parties state that: “As further addressed in response to D8 below, Kaiser and SMMC agree that, consistent with applicable Federal law, no payor should be afforded designated capacity commitments or exclusive dealing arrangements with SMMC and, accordingly, do not object to this condition but require that it be expanded to prohibit any such arrangement with any third party payor.”

Opinion. We agree with the parties’ response to the extent it acknowledges that Kaiser should not have designated capacity commitments or exclusive dealing arrangements with SMMC.

- **Safeguarding of competitively sensitive information (D3).** Notwithstanding the parties’ general right to discuss the New Hospital strategy and operational decisions, the parties must not provide one another with non-public financial information pertaining to either Providence, SMMC, or Kaiser, nor any strategic plans or other partnerships that these parties may enter into. SMMC must not share patient data with Kaiser that would allow estimates of health care services utilization by payor, health plan, employer group, or other plan sponsors. Notwithstanding this condition, the parties’ may share patient data with one another to the extent necessary for the treatment or care of patients.

²⁰ Microsoft Word - 2020 KP Northern CA HMO Provider Manual_Final.doc (https://info.kaiserpermanente.org/info_assets/cpp_nca/Quality_Assurance_and_Improvement.pdf) and Microsoft Word - 1_2020 KP Northern CA Self-Funded Provider Manual_Final.doc (https://info.kaiserpermanente.org/info_assets/cpp_nca/Quality_Assurance_and_Improvement_QA_I.pdf)

The parties state that “SMMC and Kaiser object to this condition in its entirety because it is overly broad. SMMC and Kaiser will not accept a condition that prohibits SMMC from sharing financial information, strategic plans, partnerships or patient data. As described above, much of this information may be non-competitive and can appropriately be shared with Kaiser’s representatives on the new SMMC board of managers and with Kaiser as a member/owner of the hospital joint venture. For example, patient data will need to be shared for quality review and improvement. SMMC and Kaiser will comply with all applicable laws and adopted antitrust guidelines that govern the sharing of competitively sensitive information but will not accept an overly broad condition that prohibits the appropriate sharing of information for proper purposes.”

Opinion. The parties state that “patient data will need to be shared for quality review and improvement.” However, the condition allows for that by stating: “...the parties’ may share patient data with one another to the extent necessary for the treatment or care of patients.”

- **Feasibility study for a freestanding ED, trauma center or for non-acute mental health services (and any other behavioral health services) that are lacking in the community (A3 A8, B4).** The conditions state that SMMC should explore the use of the existing SMMC hospital site for alternate uses including a freestanding ED, trauma center or for non-acute mental health services (and any other behavioral health services).

The parties state that “The feasibility analysis must remain confidential (non-public)”, that “SMMC, in its sole discretion, will make the ultimate decision...” and that “SMMC and Kaiser would not accept any condition that gives the Attorney General the option or ability to impose future conditions.”

Opinion. Without making the study public and without the authority to impose additional conditions based on the results of the study, there will be no transparency about the validity of the study or whether the best interests of the community are being addressed. At a minimum, the study should be made publicly available.

A discussion of profit-sharing, discounts, and price caps are addressed separately in the next section.

3.2 Comments on Proposed Options for the Terms of Approval for the SMMC CiC: Profit-sharing, Discounts, and Price Caps

The conditions proposed modifying the CiC terms with respect to Kaiser’s discount, profit-sharing and exclusive caps on Kaiser rate increases. In particular the following were proposed:

- Eliminate Kaiser profit-sharing since it is the key factor that insulates Kaiser from increases in commercial rates at SMMC, and aligns the interests of Providence and Kaiser, reducing potential competition.
- Ensure Kaiser's commercial discount does not depend on the level on profit margin achieved at SMMC, i.e., the discount should not automatically increase when profits at SMMC increase above the target range. (In the original terms of CiC, Kaiser's discount increases when profits increase, which means that the rate they would be paying will decrease).
- Remove the Kaiser discount for administrative services only (ASO) contracts.
- If Kaiser's profit-sharing remains, then the Kaiser discount off of commercial payer rates would be reduced.

The parties objected to a condition that eliminates profit-sharing. However, profit-sharing, price caps and discounts are all linked to create incentives for both Kaiser and SMMC. Subsequently, this section is intended to assess the general impact, in terms of direction and magnitude of incentives, of three options for the level of profit-sharing, discounts and price caps as a condition for approval of the CiC. A high-level summary of the three options are in Exhibit 1 below and include:

- Option 1: 0% profit-sharing, which the parties have indicated would necessitate abandoning the transaction;
- Option 2: 30% profit-sharing with no discount; and
- Option 3: 20% profit-sharing with a ■■■% discount.

All options would include both out-of-network and in-network price caps. All options would apply until the New Hospital opens and for five years thereafter. We suggest it would also include the option for the OCAG to require an extension for another five years after the initial five years after the New Hospital opens.

Option 1 was recently proposed by the Office of the California Attorney General and the parties raised significant concerns. For discussion we present Option 2 for comparison, but we believe Option 3 is likely to best address consumer welfare while addressing the parties' concerns related to no profit sharing and its impact on financial viability.

Exhibit 1. Summary of Options Under Consideration

	Profit Sharing	Discounts	Price Caps
Option 1	0%	█%	Yes
Option 2	30%	█%	Yes
Option 3	20%	█%	Yes

Each option is considered relative to its anticipated impact on competition in the area recognizing that competition is not necessarily binary but exists on a continuum ranging from no competition, i.e., a monopoly, to having many competitors in a market. Our goal is to ensure that competition is preserved in the SMMC market as much as possible to benefit market area residents. We consider how much each of these options favor Kaiser relative to its competitors and changes the parties’ incentives to increase prices at the hospital and foreclose on Kaiser’s rivals with downstream adverse effects on the consumers.

We estimate Kaiser’s effective discount on commercial rates under each of these options as summarized in Exhibit 2 below. The “effective discount” accounts for the estimated combined effect of the profit sharing and the discount on Kaiser’s net cost of health care services at SMMC compared to what its competitors would pay per adjusted patient day.²¹ The estimate of effective discount presented below assumes current level of average commercial prices and average operating costs.

Exhibit 2. Estimates of the Effective Discount on Kaiser’s Commercial Rates

Estimation procedure	30% profit share, █% discount (Original terms)	0% profit share, █% discount (Option 1)	30% profit share, 0% discount (Option 2)	20% profit share, █% discount (Option 3)
Average commercial price (\$)	6,000	6,000	6,000	6,000
Kaiser’s rate = price minus discount (\$)	█	█	6,000	█
Profit earned on Kaiser’s patient-day = Kaiser’s rate minus \$2,650 in operating costs	█	█	3,350	█
Kaiser’s share of profit	█	█	1,005	█
Kaiser’s net cost of adj. pat. day	█	█	4,995	█
Kaiser’s effective discount	█	█%	17%	█%

²¹ Note that Exhibit 2 focuses on Kaiser’s competitive advantage without addressing the impact on SMMC or the New Hospital.

Below we evaluate each option and then consider the details and impacts of price caps separately. For each option considered, we assume conditions related to profit sharing and discounts would have a duration of six years after the New Hospital opens, with an option to extend for five years, but with an absolute maximum of 15 years. So, for example, if the New Hospital opened in six years after the transaction closes, after six years of the New Hospital being in operation, the AG could extend the conditions for only three additional years for a total of the maximum number of years, 15.

Option 1: Profit-sharing=0%; Discount=█%; Price Caps. From the parties' perspective profit-sharing is a critical part of the parties' initial agreement that buffers the return on investment for Kaiser given their \$280M-\$300M capital investment in the New Hospital.²² However, we estimate that even in the absence of profit-sharing Kaiser's financial benefits from this transaction will likely exceed its scheduled capital contribution (see Appendix F6). Simply by having SMMC in their network, Kaiser will increase their market share and generate net profits from premiums in 2030 alone that are grossly estimated at \$25M. In addition, Kaiser receives an estimated \$█ million in savings from the reduction in rates at SMMC in the five years prior to New Hospital opening. Importantly though, without profit-sharing, Kaiser is more exposed to price increases at SMMC and may react to a price increase by reducing its patient volume at SMMC (See Appendix F4).

Under this option, Kaiser gets a straightforward █% discount off the average rate that its competitors pay which, while steep, is lower than the effective discount of at least █% that Kaiser would enjoy due to 30% profit-sharing under the original terms of the transaction.

In the short run, the steep █% discount enables Kaiser to lower premiums below other insurers to increase their market share. In the long run they may be able to push out other insurers, create a far less competitive environment, position themselves as the monopoly insurer with the New Hospital and raise premiums for area residents.²³ The presence of a █% discount, in the absence for profit sharing, however, helps to reduce financial incentive for SMMC to foreclose on Kaiser competitors, (e.g., by significantly raising prices for other insurers), since the expected reimbursement to SMMC from Kaiser rivals will be greater than the discounted Kaiser's rates (see Appendix F4).

Given, however, that the parties have asserted that the recommended removal of all profit sharing would likely be a deal breaker, we consider other options.

²² Kaiser Permanente will contribute between approximately \$280M - \$300M in cash in exchange for a minority interest (30%). The remaining balance for construction costs will be debt-financed by the joint venture. (p 363 of the 351881987 document).

²³ The evidence from several methods and data sets suggests that insurer monopoly is the most important predictor of premium levels and growth rates. Health Affairs, August 2018 (<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0054>)

Option 2: Profit-sharing=30%; Discount= 0%; Price Caps. Option 2 achieves the smallest absolute gap between Kaiser and non-Kaiser payers in the net cost of treating patients at SMMC, with Kaiser having an estimated 17% effective discount (derived from the profit-sharing) off of the average commercial price. Under this option Kaiser also has the greatest incentive to minimize its commercial patient volume at SMMC. Lower commercial utilization at SMMC along with higher profit sharing would insulate Kaiser from price increases more than it would be the case under options 1 and 3.²⁴ More importantly, the absence of a discount for Kaiser results in SMMC's preference for higher Kaiser enrollment share, creating incentives to help Kaiser expand its insurance market share.²⁵

Profit-sharing increases Kaiser's financial rewards from this CiC, which are, arguably, already high even in the absence of profit-sharing (profit from increased enrollment and savings on treating current patient volume at SMMC could pay-off this investment by itself by 2035). (See Appendix F6). Including profit-sharing partially "insulates" Kaiser from price increases at SMMC, aligning Kaiser and SMMC interests to price-out Kaiser competitors with rate hikes, although the absence of an additional ■% helps somewhat (see Appendix F5, Exhibit 5.1). If insurers are more likely to exit the market, they would not be able to work innovatively with other area hospitals to develop new competitive products in the health care market and it is quite possible that at least one local hospital option might also leave the market making it less competitive on both the insurer and hospital side.

Sharing profit with Kaiser means that SMMC's own profits will not increase much and can even fall from their current level if prices stay constant. This might put pressure on SMMC to increase prices in order to justify its investment of almost \$700 million. However, the profit-sharing terms might align SMMC and Kaiser's incentives to minimize costs and improve clinical care efficiencies.

The absence of a discount for Kaiser means that SMMC would derive financial benefits from increased Kaiser enrollment in the market and would create financial incentives to foreclose on Kaiser's rivals, resulting in adverse effects on competition.²⁶ The potential incentives of SMMC to push Kaiser rivals from the market by increasing prices could be mitigated by price caps, helping to keep other insurers and subsequently, other hospitals in the market.

However, price caps alone are not enough to ensure a competitive environments. While we can impose a price cap for a given period, over the long term we need ensure that there are market

²⁴ See Appendix F5 and Exhibit F5.1 for the detailed discussion of how profit sharing protects Kaiser from the effects of price increase.

²⁵ See Appendix F4 for the discussion on how SMMC's profits change when Kaiser's market share increases.

²⁶ We estimate that SMMC profit would increase by about \$5 million under the low-medium Kaiser utilization scenario if Kaiser's share in admissions from the SMMC market area increases from the current 34% to 50%. See Appendix F4 for more discussion on the methodology.

incentives to promote a procompetitive health care marketplace. Therefore, price caps need to be combined with other conditions that mitigate anti-competitive concerns.

Option 3: Profit-sharing=20%; Discount=■%; Price Caps. Option 3 is the balance between Options 1 and 2. A ■% discount off the average commercial price (weighted toward largest payers that have lower rate) guarantees that Kaiser will most likely have the lowest rates among payers at SMMC. In combination with profit-sharing that gives Kaiser an effective discount of ■%. The effective discount that results from profit-sharing is less certain than the simple ■% discount of the average commercial rates, as the profit margins depend on costs and prices that could change in response to market conditions, input costs and operational changes in the New Hospital. The price caps help support a competitive environment by reducing the likelihood that other insurers are priced out of the market leaving just Kaiser and SMMC to dominate the insurance and hospital services market.

This option, compared to Option 2, reduces the incentives for SMMC to support Kaiser's efforts to increase its market share and therefore helps promote a more procompetitive environment. Additionally, these incentives are also tempered by strategic considerations that include concerns that Kaiser may take patients from Providence's own medical groups and reduce SMMC's bargaining leverage as the number of payers remaining in the market decline.²⁷

SMMC's ability to increase prices could be addressed with price caps that should be in effect at least 5 years after the New Hospital opens. Price caps need to be flexible enough to reflect changing costs in the hospital and in the market and changing market dynamics (payers having more versus fewer patients at SMMC), as well as accommodate the new plans and insurance product options that are likely to emerge in a 10-year span. In addition, out-of-network price caps could limit SMMC market power by ensuring that plans would still have competitive rates at SMMC for emergency services in case they remove SMMC from their network in response to price increase.

Options, like this one, that create some incentive to keep insurance rivals in the market are also more likely to reduce the risk of foreclosure on SMMC hospital rivals. If insurers are more likely to stay in the market they may be able to work innovatively with other area hospitals to develop new competitive products in the health care market.

Price Caps. This section provides a brief discussion of what price caps are, why they are important, and how they are calculated. This is followed by our recommendations. Capping prices for the longer term is challenging because market conditions change over time, as do the details of the contracts and patient volumes that different payers have at the hospital. However, we need to make sure that the rates will not start going up rapidly after the New

²⁷ We estimate that SMMC profit would increase by about \$1.9 million under the low-medium Kaiser utilization scenario if Kaiser's market share for admissions increases from the current 34% to 50%, which is lower than in option 2, but higher than in option 1.

Hospital opens at the end of 2026. Therefore, for in-network commercial and government contracts, the OCAg could consider a cap which is the greater of ten years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or five years from the commencement of operations at the New Hospital, with an option to extend for five years.

Suggested Approach. We suggest two alternative approaches to capping SMMC prices for the contracted plans: an absolute price cap as a percent of Medicare FFS rates or, for the commercial payers and plans that currently contract with SMMC, a limit on commercial price increases tied to increases in the medical cost index. As a result, current prices would automatically grow along with the increase in overall medical cost inflation. SMMC can offer a discount off of capped prices to payers based on the conditions of their contracts, as long as the total price paid for the services does not exceed what Medicare FFS would have paid by a specified percentage (or, alternatively, does not grow above the medical inflation index).

Inputs for the price caps calculation. To estimate current price ratios at SMMC for commercial prices to Medicare FFS, Medicare managed care prices to Medicare FFS, and Medi-Cal managed care prices to Medi-Cal FFS we used net revenues per adjusted patient submitted by SMMC. We cross-checked the net revenues per adjusted day by payer category using OSHPD financial data, finding the reported prices to be consistent. We also used OSHPD discharge data to compare charges per day by payer category and found that HMO charges per day are somewhat higher than the corresponding FFS charges, suggesting that the price caps we are proposing are relatively generous.²⁸ The table below (Exhibit 3) shows net SMMC revenues per adjusted patient day for each payer type as reported by SMMC.

Exhibit 3. Net Revenue per Adjusted Patient Day, CY17-CY20

	CY2017	CY2018	CY2019	CY2020
Commercial (a)	\$5,571	\$5,432	\$5,306	\$5,933
Medicaid FFS (d)	\$1,071	\$1,114	\$1,101	\$1,129
Medicaid HMO e	\$1,142	\$1,154	\$1,162	\$1,217
Medicare FFS (b)	\$2,135	\$2,143	\$2,150	\$2,389
Medicare HMO c	\$2,722	\$2,644	\$2,671	\$2,655

Why cap as the ratio to Medicare FFS or Medi-Cal FFS? First, Medicare managed care prices are by nature tied to Medicare FFS rates, because if a Medicare plan goes out-of-network it pays the current FFS rate for the emergency services provided to its patients (in accordance to current regulations). As a result, contracted Medicare managed care rates are only slightly

²⁸ Higher charges within a shorter length of stay mean that HMO patients receive more services per day than FFS patients, so the true ratio of HMO to FFS prices is lower than the estimate based on net revenues per adjusted day. As such, the price cap derived from the ratio of net revenue per day is somewhat above the current ratio of average HMO prices to Medicare FFS.

higher than the standard FFS rates that would apply to a given hospital. At SMMC, the average ratio of Medicare managed care rates to Medicare FFS was 120% during the period 2018-2020 (it was slightly higher in 2017-2019, because SMMC became a disproportionate share (DSH) hospital eligible for a DSH rate adjustment only after 2019). Similar considerations apply to capping Medi-Cal managed care rates.

Second, per the current Health Care Services Agreement (HCSA), Kaiser rates at SMMC [REDACTED] [REDACTED] If we cap the Medicare managed care rates at 125% of FFS that would imply Kaiser has about a [REDACTED] % discount off the highest possible Medicare managed care rate. The price cap of 125% of Medicare FFS rates or below would guarantee that the gap between Kaiser and other Medicare managed care plans would not exceed [REDACTED] %. Similar considerations apply to capping Medi-Cal managed care rates.

However, it is important to define upfront whether the Medicare FFS rate used in the calculation of the caps should include DSH (disproportionate share hospital) adjustment, which could vary over time as the hospital's DSH status and percent change, resulting in fluctuation in Medicare FFS rates at the hospital. It might be better to specify a slightly higher cap that is based on the Medicare rate without DSH adjustment to have a more stable cap that is independent of DSH regulatory and hospital-specific changes. Similarly, for Medi-Cal, it is important to define upfront whether the FFS rate used in the calculation of the caps should include Hospital Quality Assurance Fund (HQAF) revenues.

Medicare managed care price caps. We suggest limiting any Medicare managed care payer's rates to no more than 125% of current Medicare FFS schedule, which is slightly above the current ratio of average Medicare HMO net revenue per adjusted day to Medicare FFS net revenue per adjusted day.²⁹ Given shorter length of stay for HMO patients, the average Medicare HMO patient day at SMMC is more service-intensive than an average FFS patient day at SMMC, which means that the ratio of actual Medicare HMO to FFS prices should be lower than 125% estimated based on net revenue per adjusted day.³⁰ Therefore, we suggest setting a Medicare HMO price cap below 125% (possibly, as low as 110% of Medicare FFS).

Medi-Cal managed care price caps. We suggest limiting any Medi-Cal managed care payer's rates to 110% of current Medi-Cal FFS schedule, which is somewhat above the current ratio of average Medi-Cal managed care net revenue per adjusted day to Medicare FFS net revenue per adjusted day (in 2019 this ratio was 106%). The Medi-Cal price cap addresses not only

²⁹ Ideally, given enough time we would further adjust the current ratio for the intensity of services delivered per adjusted day using charges per adjusted day (which we did in the past, and found that managed care has slightly less expensive services delivered per adjusted day as reflected by charges per adjusted day).

³⁰ We estimated that the charges per patient day for HMO patients at SMMC are about 30% higher than the corresponding charges per patient-day for Medicare FFS patients, due to the shorter length of stay for HMO patients and comparable total charges per discharge (based on the data in OSHPD PDD 2019).

competition, but also access concerns that result from CiC: If capacity becomes an issue, SMMC might be tempted to reduce Medi-Cal patient volume to free up space for Kaiser or other commercial patients, since Medi-Cal has the lowest payment rates. SMMC could do that by increasing prices for Medi-Cal payers in attempt to make them abandon the contract, so that their scheduled and maternity patient volume would be diverted to other hospitals. Having price caps would reduce the likelihood of this scenario.

Commercial plan price caps. For commercial payers and plans that currently have a contract with SMMC, price increases in the short and medium term could be limited to medical cost inflation in this geographic region. Alternatively, or for the new payers and insurance products, commercial prices can be also pegged to Medicare FFS rates since Medicare FFS rates are generally intended to reflect the expected costs of hospital services. One option is to cap commercial prices as a percent of Medicare FFS rates using current ratio of commercial prices to Medicare FFS rate, which was on average 250% of Medicare rates during 2018-2020 time period. Comparison of charges per day at SMMC for commercial and Medicare FFS patients shows that those are slightly higher but very close, which means that the ratio of commercial net revenues per adjusted day to Medicare FFS are a good proxy to the ratio of their prices. Pegging commercial price caps to Medicare FFS rates would be consistent with the caps we suggest for Medicare and Med-Cal managed care plans and allow for the most straightforward calculation by the plans as they negotiate their contracts.

We suggest that *for the commercial payers and plans that currently have a contract with SMMC, increases in rates could be limited to increases in medical price inflation in the area.* The structure of the commercial in-network price cap would apply the greater of ten years from the Closing Date of the Affiliation Agreement while the existing Hospital continues to operate or five years from the commencement of operations at the New Hospital, with an option to extend for five years.

Out-of-network commercial price cap. We suggest setting an out-of-network price cap at 10% above the average in-network commercial price to incentivize plans to contract with SMMC, while at the same time protecting their ability to go out-of-network in response to unfavorable contract conditions at SMMC. Based on the evidence presented by the parties, currently commercial payers on average pay approximately 250% of Medicare FFS, which would result in out-of-network commercial cap at 275% Medicare FFS rates, which is 250% plus 25% where 10% of 250% equals 25% plus 250% (or 275%). The out of network commercial price caps help limit the market power exercised by SMMC by pressuring downward the amount SMMC can negotiate for in-network payment rates with private insurers, while also limiting so-called surprise medical bills from balance-billing for out-of-network costs.

4 Review of New Information: Kaiser Affiliation with St. Joseph's Medical Center

Summary of Findings. The Kaiser affiliation agreement with St. Joseph's Medical Center in Stockton, CA (a member of the Dignity Health hospital system) that went into effect in 2016 as "Port City Operating Company, LLC" carries striking similarities to the proposed transaction with SMMC.³¹ First, Kaiser provided capital to expand St. Joseph's facilities in exchange for a 20% share in the New Company, getting a corresponding █% share in profits from the hospital. Second, per the terms of this deal, Kaiser also received █ on the rates payable for its patients at the hospital. We review the probable consequences of this transaction and argue that the potential impact of the CiC transaction with SMMC is likely to be similar and result in a rapid expansion of Kaiser enrollment in the Stockton market area (although we cannot prove the causal effect with certainty).

In 2015, the share of Kaiser commercial patients among all commercial managed care admissions coming from the zip-codes in 15-mile radius around the Kaiser hospital was 35%, but just 4 years later in 2019 it increased to 49%. The 2015 share in St. Joseph's market is almost exactly equal to current Kaiser admission-based market share in SMMC's market area. Our previous projection that Kaiser's commercial admission share in SMMC's market area will reach about 50% after 2030 (given that the New Hospital opens in 2026) matches the expansion in Kaiser's share of commercial admissions in Stockton area in the four years post transaction.

St Joseph's Medical Center, like SMMC, had a low share of commercial patients. The transaction increased commercial patient volume at St. Joseph's hospital due to the inflow of Kaiser commercial patients, which improved its financial performance and market share based on two alternative definitions of the market. Additionally, Kaiser Manteca, Kaiser's own hospital option in the St. Joseph's area, is at least a 30 minute drive from St. Joseph's as is Kaiser Ontario/Fontana in the SMMC area. (Kaiser Ontario/Fontana is somewhat farther from SMMC.)

1. KAISER DISCOUNT FOR █

- Per terms of the "Port City" affiliation agreement, Kaiser received a █ rate at the St. Joseph's hospital for its fully-insured commercial patients, with an inpatient base case rate of █ being █ the corresponding Medicare FFS case rate.³² These rates are likely to be much █ than the rates that would have

³¹ Details on Kaiser affiliation agreement with St. Joseph's Medical Center (Dignity) came from Kaiser's party response titled "KP_Response_-_Item_5_CONSOLIDATED" received on November 4th.

³² Kaiser's commercial rates at St. Joseph's for 2016-2017 are described in Exhibit 3-A-1 of the affiliation agreement. Medicare base rate of \$8,409 is calculated for the St. Joseph's Medical Center using data from Medicare IPPS final rule for 2016 (without accounting for Medicare DSH payments).

resulted from █% discount off the non-Kaiser commercial rate, since commercial payers pay much higher prices than Medicare FFS.

- The rates applicable to patients from Kaiser █ plans were about █% higher than that: from Exhibit 3-A-1 of the St. Joseph’s agreement, Kaiser has a general acute admissions case rate of █ multiplied by the Case Mix Index for the patient’s MS-DRG, while for “Other Payers” it is █. This contrasts with the original SMMC’s transaction terms, where Kaiser █ plans received █ Kaiser fully-insured commercial patients.
- These █ rates are only █% higher than Medicare FFS, so they must be still █ than what non-Kaiser commercial payers are paying in this hospital (for example, at SMMC commercial payers on average pay 115% above Medicare FFS rates).

2. PAYER MIX

- St Joseph’s like SMMC had a low commercial payer portion of revenues prior to the transaction, 15%. This increased to 22% in 2019 after the transaction with Kaiser (Exhibit 4).
- At the same time Medi-Cal discharges fell 6% from 40% to 34%.

Exhibit 4. Discharges by Payer for St. Joseph, Stockton, 2015 (pre-transaction) & 2019 (post-transaction)

Year		2019	2015
Total	Admissions	20,811	16,427
	%		
Medicare	Admissions	8,756	7,238
	%	42%	44%
Medi-Cal	Admissions	7,087	6,602
	%	34%	40%
County Indigent	Admissions	49	-
	%	0%	0%
Other 3rd Party	Admissions	4,566	2,517
	%	22%	15%
All Other	Admissions	353	70
	%	2%	0%

Source: OSHPD HAFD, 2015 and 2019

3. FINANCES

- St. Joseph’s financial performance improved considerably after its transaction with Kaiser with net outpatient revenue per visit increasing by more than 50% (Exhibit 5).
- St. Joseph’s operating profit increased from \$44 million to \$61 million.

Exhibit 5. Financial Measures for St. Joseph, Stockton, 2015 (pre-transaction) & 2019 (post-transaction)

	2019	2015
Gross I/P Rev Per Day	\$ 26,265	\$19,872
Gross I/P Rev Per Discharge	117,621	91,185
Gross O/P Rev Per Visit	3,835	1,922
Net I/P Rev Per Day	\$ 4,501	\$4,363
Net I/P Rev Per Discharge	20,158	20,021
Net O/P Rev Per Visit	657	422
Payment Surplus/Shortfall	\$ 61,473,739	\$44,442,749
Adj Pat Days	139,999	110,633

Source: OSHPD HAFD, 2015 and 2019

4. MARKET SHARE

- The market share for St. Joseph’s increased after the transaction by 5-7% depending on how the market area is defined. Using San Joaquin County as the market area, the St. Joseph’s market share increased from 24% to 29%. Using the restricted zip codes in the St. Joseph’s agreement document, it increased from 32% to 39%.
- The market share for Kaiser Manteca hospital increases slightly based on both market area definitions.

This transaction has enough similarities to the SMMC transaction to support our concerns that the transaction will lead to a large increase in Kaiser’s market share, as with this case where Kaiser’s share in local admissions grew from 35% to 50% in just 4 years post transaction. This in turn creates a risk of a much less competitive market that would have adverse effects on consumer welfare in terms of premiums and other benefits associated with healthy competition.

5 Review of New Information on Hospital Staffing

Summary of Findings. A November 9, 2021 interview with [REDACTED] suggests that staffing at the New Hospital may not increase in proportion to the increase in licensed beds at the new facility. This interview has raised our concerns about capacity and access at the New Hospital and provides additional support for our recommendations.

Our report, An Evaluation of the Proposed Change in Control of St. Mary Medical Center, Section 7.8, assesses the CiC’s likely impact on the availability of services for existing SMMC patients. Our model, as shown in Exhibit 19 of the initial report, relied on the assumption that “because the number of available beds would increase by nearly 23% under the CiC (260 beds

[at the New Hospital] versus 212 at the current facility), we estimate that the New Hospital will similarly have the capacity to serve 23% more patient days than the current facility.”

According to the [REDACTED] interviewees, however, SMMC has struggled to staff the current facility adequately since at least 2015, with nurse-to-patient ratios in the ICU frequently failing to meet regulatory requirements.³³ Given these difficulties, the parties may not achieve a 23% increase in staffing at the New Hospital.

If there is no staffing increase under the CiC, the estimated patient day shortage at the New Hospital would grow dramatically, from a shortage of 1,709 patient days to 16,351 patient days in 2026, and a shortage of 14,091 patient days, to shortages of 16,351 patient days (see report, Exhibit 19). The [REDACTED] suggest the current facility may already be over capacity. Our model assumed that the current facility, as of 2019, had neither an excess nor a shortage of capacity. To the extent the [REDACTED] description is accurate, the shortages estimated for both the Report Model and the [REDACTED] Scenario—would worsen. Ultimately, however, the existing facility’s capacity is secondary to the analysis since it only represents the baseline level of access. Both scenarios assessed—continuation of the existing facility and approval of the CiC—would be impacted equally by any change to baseline access levels. In other words, the shortage estimates should be understood as the CiC’s *marginal* impact on availability relative to the status quo.

Ultimately, it would be most beneficial to both the community and the parties if staffing at the New Hospital increases in proportion to the increase in beds, or more, if possible. However, if staffing remains the same at the New Hospital leading to less access than anticipated, the issues cited in our initial report are exacerbated and the need for the recommended conditions to ensure access to more vulnerable populations are increased.

6 Discussion of implications of Ethical Religious Directives (ERDs)

Summary of Findings. The parties’ documents coupled with the proposed conditions ensure that Kaiser will continue to be able to perform procedures they consider appropriate and medically necessary at their own Kaiser hospitals but not necessarily at SMMC. Consequently, the transaction creates the risk of unequal access for Kaiser members given that they will not be able to obtain some services at the co-owned SMMC that would have been available had the hospital been exclusively owned by Kaiser.

In a November 17th letter to the OCAg from the American Civil Liberties Union of Southern California (ACLU SoCal), three lawsuits are cited, related to the application of ERDs, that are

³³ [REDACTED]

challenging Catholic hospitals' refusals to allow doctors to provide health care those doctors had deemed appropriate to address specific patients' medical needs. The ACLU express a strong concern that there is a high likelihood that without explicit protections in place, patients will experience painful and unexpected denials of both reproductive health care and gender-affirming health care at the New Hospital. We believe that this is a strong possibility and our opinion is that Kaiser should make provisions to give equal access to High Desert Kaiser members to the same services as other Kaiser members have who have a local Kaiser owned hospital in their area.

Below we discuss the reproductive, fertility, end of life, and gender affirming care services Kaiser normally provides to its members. We know, based on data and multiple interviews, that these services would be available to Kaiser members had a new High Desert area hospital been exclusively Kaiser owned but given the ERDs imposed by SMMC there are many services that some Kaiser members will still require but will require them to travel considerable distances.

Kaiser's care delivery strategy for their members in the High Desert is to provide these services at a combination of Kaiser Permanente hospitals, Kaiser Permanente medical office buildings, and contract facilities. Their services include:³⁴

- **Reproductive & Fertility Care.** Kaiser indicated its members who reside in the High Desert area will have the same access to reproductive, fertility, end of life, and gender affirming care as Kaiser Permanente members across the Southern California Region and this will not change as a result of this transaction. Specifically, for reproductive and fertility care, Kaiser offers family planning options, such as birth control medication (pills, implants, intrauterine devices), male and female sterilization and abortion care. They also partner with local clinics for certain abortions. Specifically, they offer reproductive health services at all of their medical offices and partner with a specialized fertility surgical/lab suite. This includes invitro fertilization (Intracytoplasmic sperm injection, preimplantation genetic testing), intrauterine insemination, egg and sperm cryopreservation, egg and sperm donor program available. Female sterilization procedures are done in their operating rooms at Fontana and Ontario. Abortion care for first trimester pregnancies is offered at the Ontario and Fontana OB/GYN clinics and in the operating rooms of both locations (Fontana and Ontario). Their infertility clinic is located in the medical offices in Fontana.
- **End-Of-Life.** Kaiser offers a range of services related to palliative care and hospice care, and proactive efforts to ensure that members have advanced health care directives in their electronic health records in advance of when they are urgently needed. Kaiser indicated that after the transaction, as with their reproductive and fertility care, they

³⁴ These services are based on information in the "KP AG Question #29 (October 26 2021)" document provided to us by the OCAg.

will ensure that members in the High Desert area have the same options for end-of-life care as other Kaiser members.

- **Gender Affirming Care.** Kaiser indicated that members residing in the High Desert area have equal access to the full range of gender affirming care services. Kaiser operates a Center of Excellence in West Los Angeles that specializes in transgender and nonbinary care and consists of clinicians from multiple disciplines and departments that work together to find new ways to provide personalized and comprehensive care and support for the transgender and nonbinary members while providing a safe and welcoming environment. In addition, Kaiser has broad range of gender affirming services at all of their Kaiser Permanente medical centers, which make up a comprehensive gender affirming program, and include:
 - Gender-Affirming Surgery
 - Hormone Therapy
 - Gynecologic Services
 - Fertility Preservation
 - Mental Health Services (Adult and Youth)
 - Primary Care (such as ongoing maintenance of hormonal care, pap smears for transgender men, and sexually transmitted infectious screening where appropriate)
 - Endocrinology (including pediatric endocrinology at a multi- disciplinary gender care clinic at Fontana)
 - Care Management

Several types of gender affirming surgeries are done at Riverside and/or Fontana, including for example, mastectomies and facial feminization procedures. Fontana and Riverside also provide fertility preservation services prior to hormone therapy. All of the genital surgeries for Kaiser Permanente members across Southern California are done at Kaiser Permanente's West Los Angeles medical center.

To ensure that area residents who are Kaiser member are not limited in their access as a result of the ERDs at SMMC, it is our opinion that within one (1) year of the Closing Date of the Affiliation Agreement, Kaiser would prepare a plan to ensure full and equal access to healthcare for all Kaiser members in the High Desert region without discrimination by Kaiser physicians, employees, and contractors at SMMC and the New Hospital. The plan would be submitted to the Attorney General in writing and accompanied by a comprehensive study of all feasible alternatives, including but not limited to the following:

- Constructing or designating a separate ambulatory surgery facility under Kaiser's sole control at or in close proximity to the New Hospital to enable Kaiser physicians, employees, and contractors to: (i) make clinical decisions consistent with the standard of care and their independent professional judgment, respecting the needs and wishes

of each individual patient; (ii) inform patients of all of their healthcare options; (iii) prescribe any interventions that are medically necessary and appropriate; (iv) transfer or refer patients to other facilities whenever they determine it is in the patient's interests; and (v) provide any item or service they deem in their professional judgment to be necessary and appropriate in the event of an emergency, without restriction, and without seeking approval from any non-provider, including any items or services where referral or transfer to another facility would, in their sole professional judgment, risk material deterioration to the patient's condition.

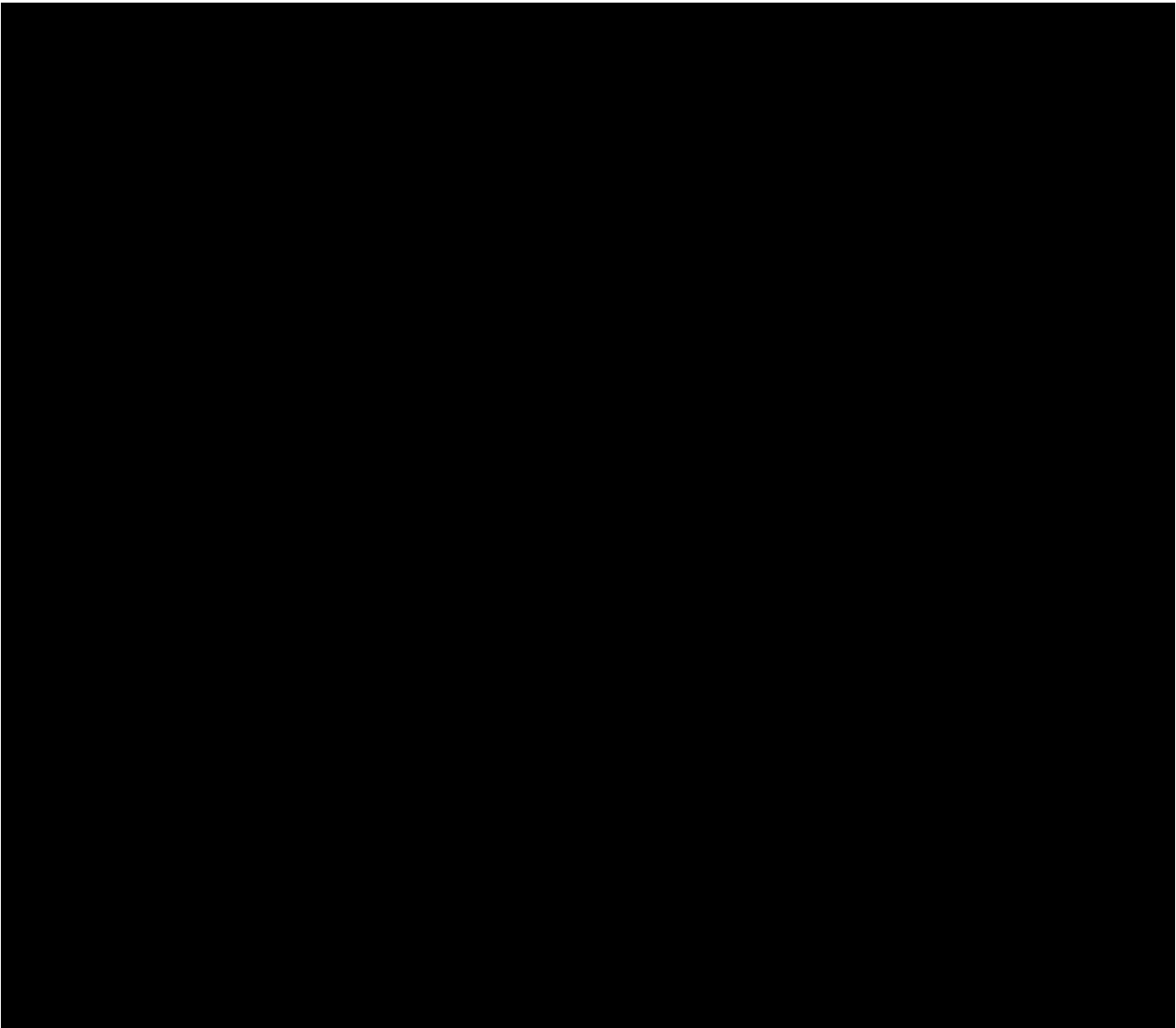
- Obtaining admitting privileges at a nearby non-Kaiser hospital for Kaiser physicians, employees, or contractors to: (i) make clinical decisions consistent with the standard of care and their independent professional judgment, respecting the needs and wishes of each individual patient; (ii) inform patients of all of their healthcare options; (iii) prescribe any interventions that are medically necessary and appropriate; (iv) transfer or refer patients to other facilities whenever they determine it is in the patient's interests; and (v) provide any item or service they deem in their professional judgment to be necessary and appropriate in the event of an emergency, without restriction, and without seeking approval from any non-provider, including any items or services where referral or transfer to another facility would, in their sole professional judgment, risk material deterioration to the patient's condition.
- Directing affected patients to another Kaiser hospital to receive the medically indicated prevention, diagnosis, and treatment without unreasonable delay and establishing a standard and process for compensating affected patients for any resulting harm relating to the transfer.
- Developing a mechanism to proactively inform Kaiser patients of any limitations on services provided at the New Hospital that might otherwise be offered if the patient were at a strictly Kaiser facility and to further inform them of any alternative options.

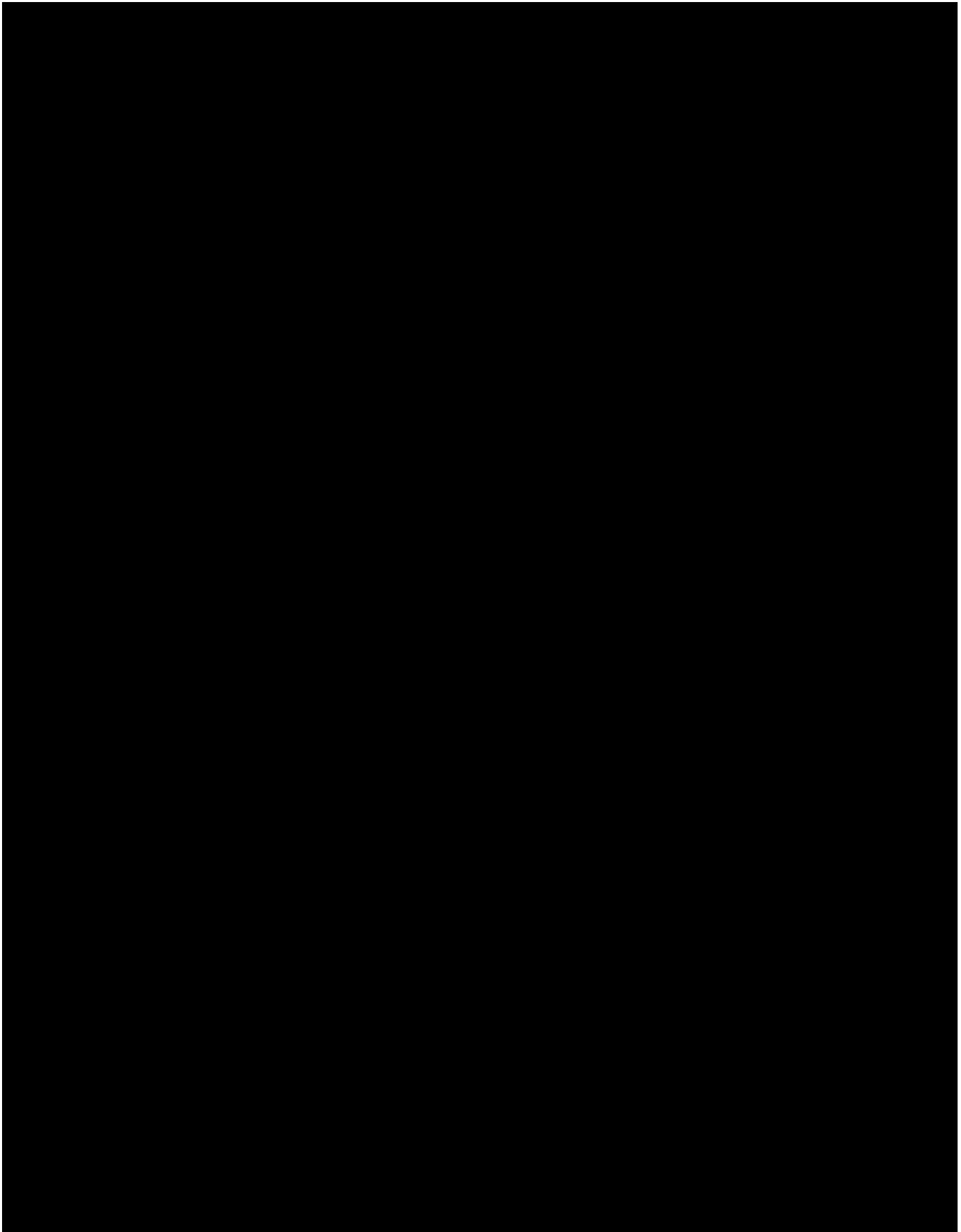
7 Supporting Analysis for Competitive Effects (Appendix F)

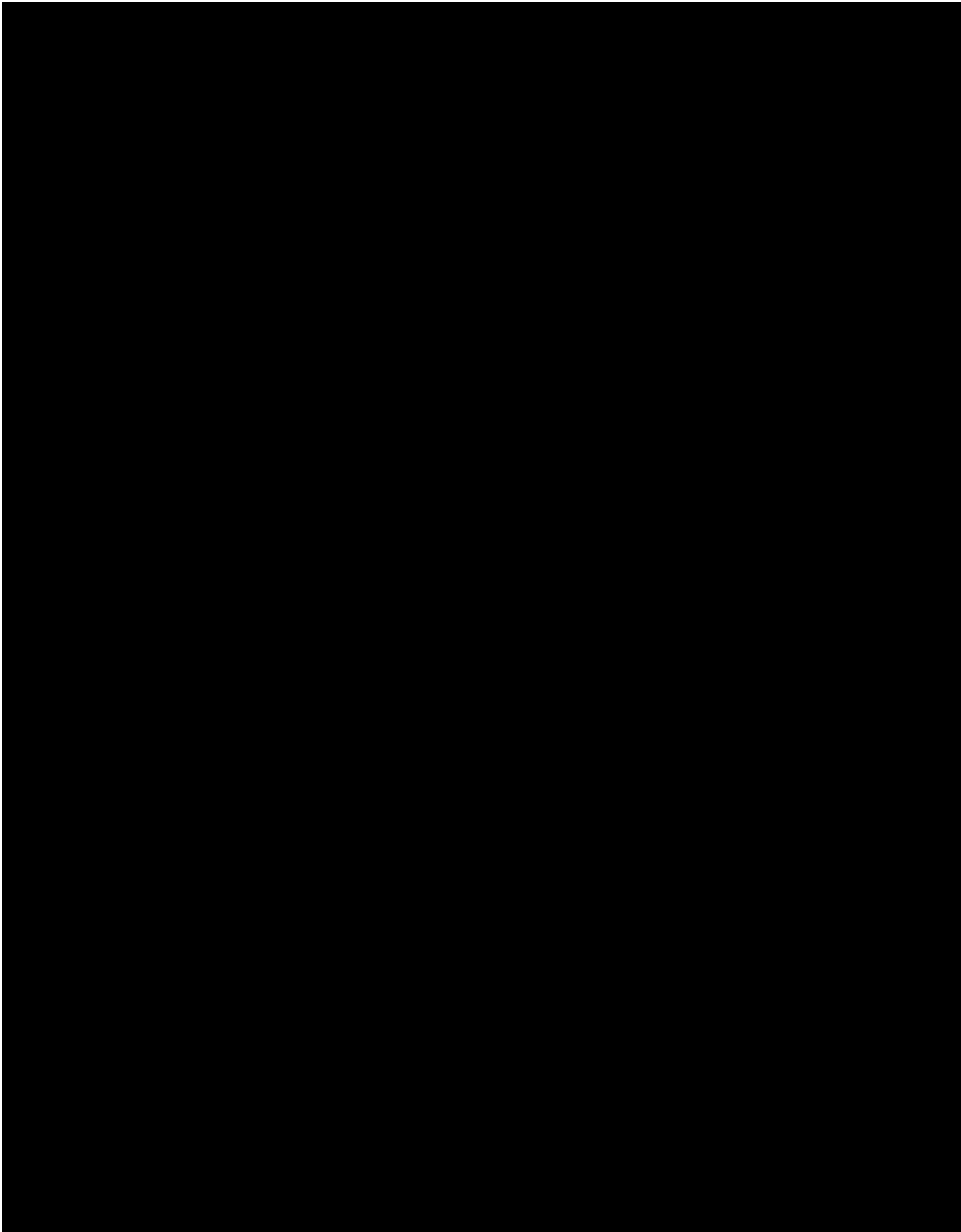
Appendix F is intended as a supplement to the competitive effects analysis in the November 2021 Evaluation of the Proposed Change in Control of St. Mary Medical Center submitted to the OCAG. Appendix F1 summarizes the main assumptions and data inputs used in the modeling of the financial impact of the CiC described in subsequent sections in Appendix F. These numbers are referenced in Appendices F2, F3, F4 and F5 below. For ease of reading of these appendices, we do not repeatedly footnote each number or assumption or calculation but refer the reader to the tables below in Appendix F1. Please note that the estimates presented in these appendices are intended to reflect the direction and magnitude of changes and not intended to be interpreted as exact dollar amounts.

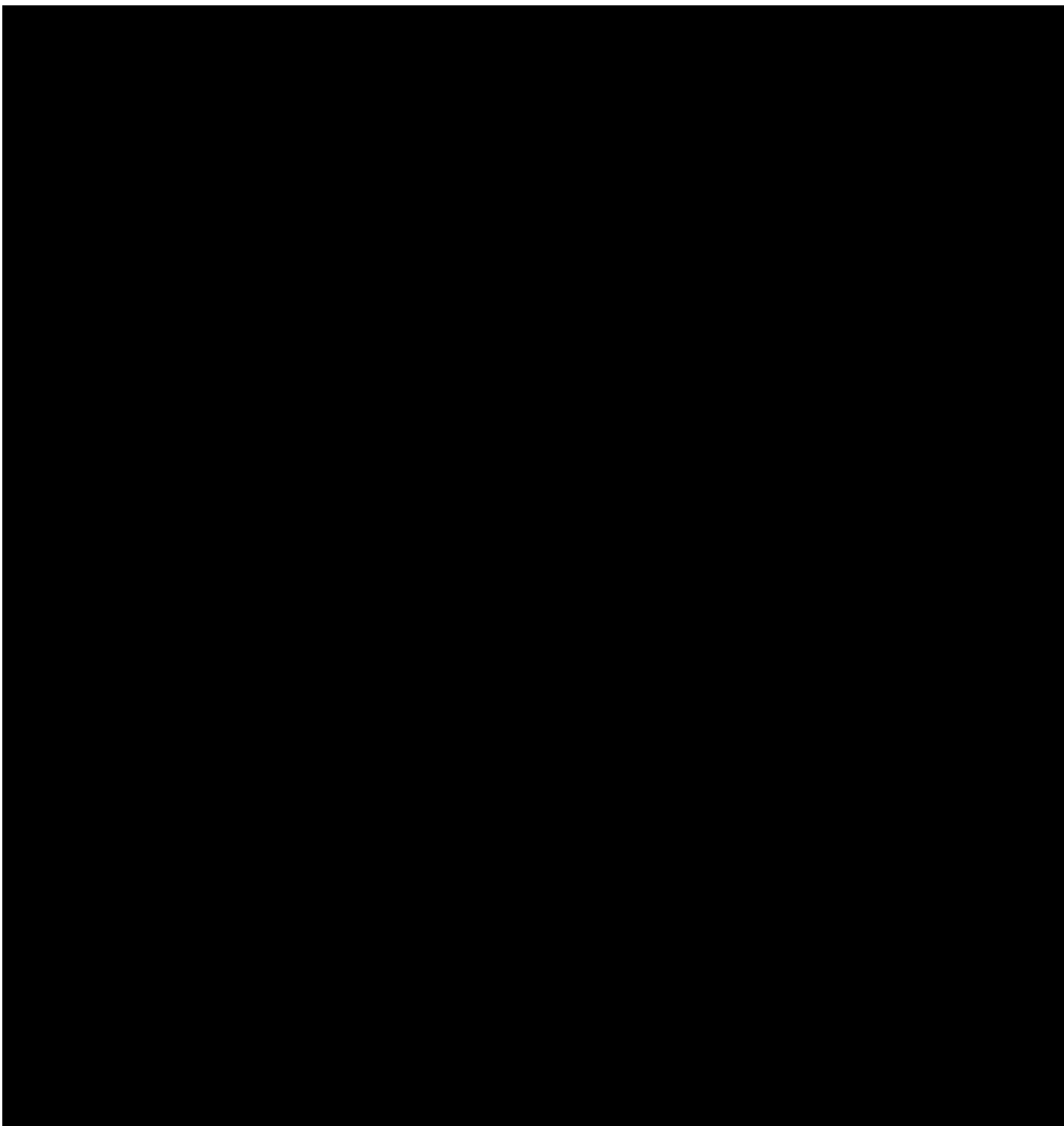
It is important to note that Kaiser will gain financial benefits from this CiC both before the New Hospital opens and after the New Hospital opens. First, as shown in Appendix F3, the reduction in Kaiser's rates at SMMC, reduced from their current out-of-network rate, would result in substantial savings prior to the opening of the New Hospital (although these savings will likely dissipate as Kaiser patient volumes in the New Hospital increase). Second, as shown in Appendix F7 below, Kaiser will also likely get increased premium revenue with an expansion in enrollment as a result of being able to offer a local hospital option for Kaiser members that was not available previously. And third, after the New Hospital opens, Kaiser will also receive a share of the profits generated by the New Hospital.

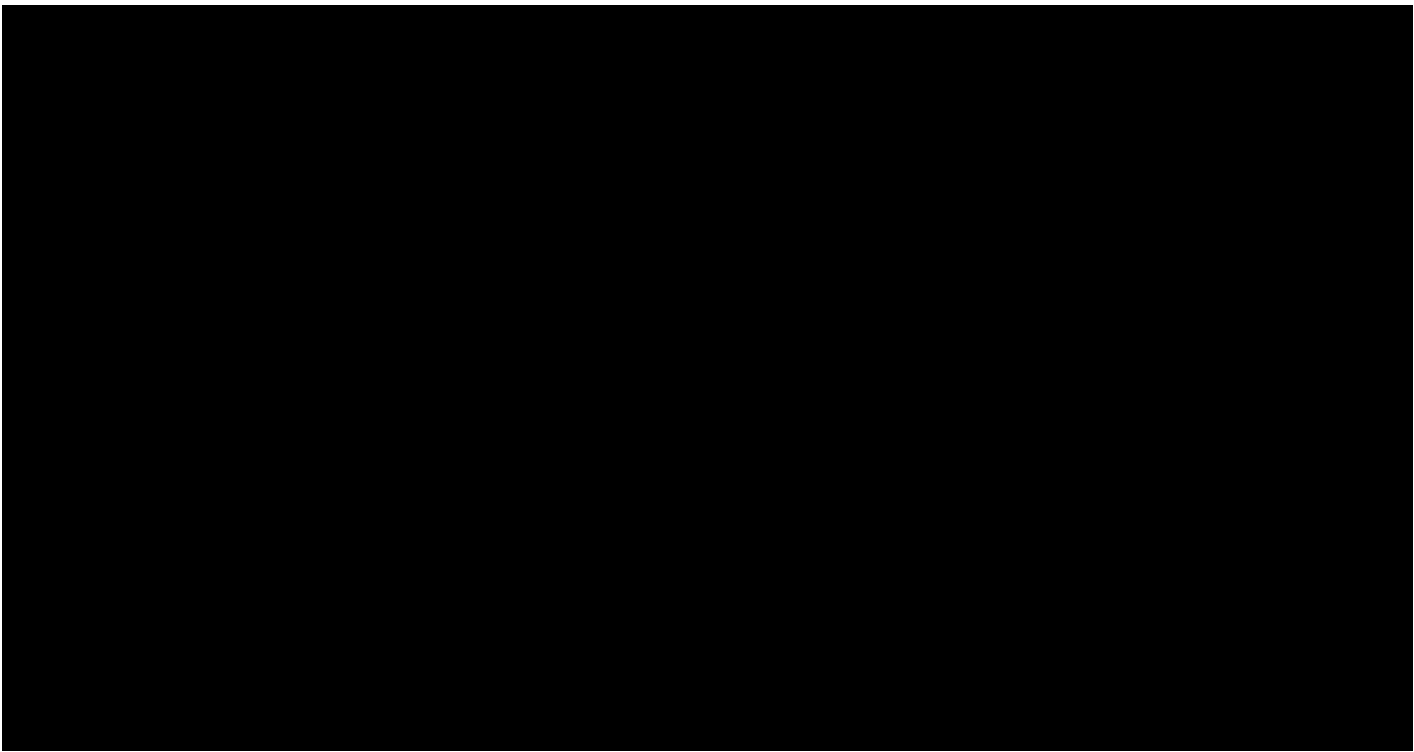
7.1 Appendix F1: Assumptions and inputs used in modeling the financial effects of the CiC



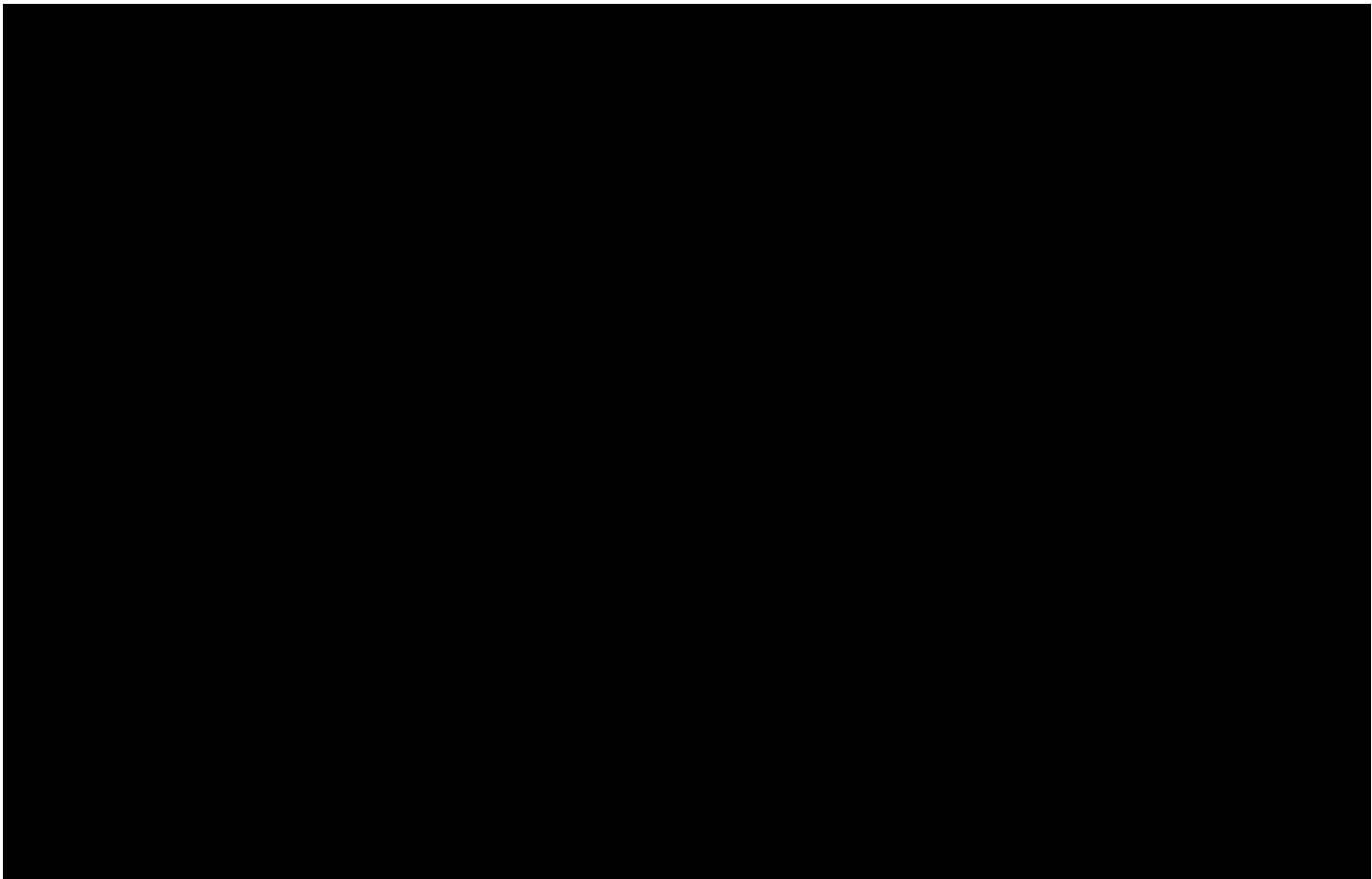


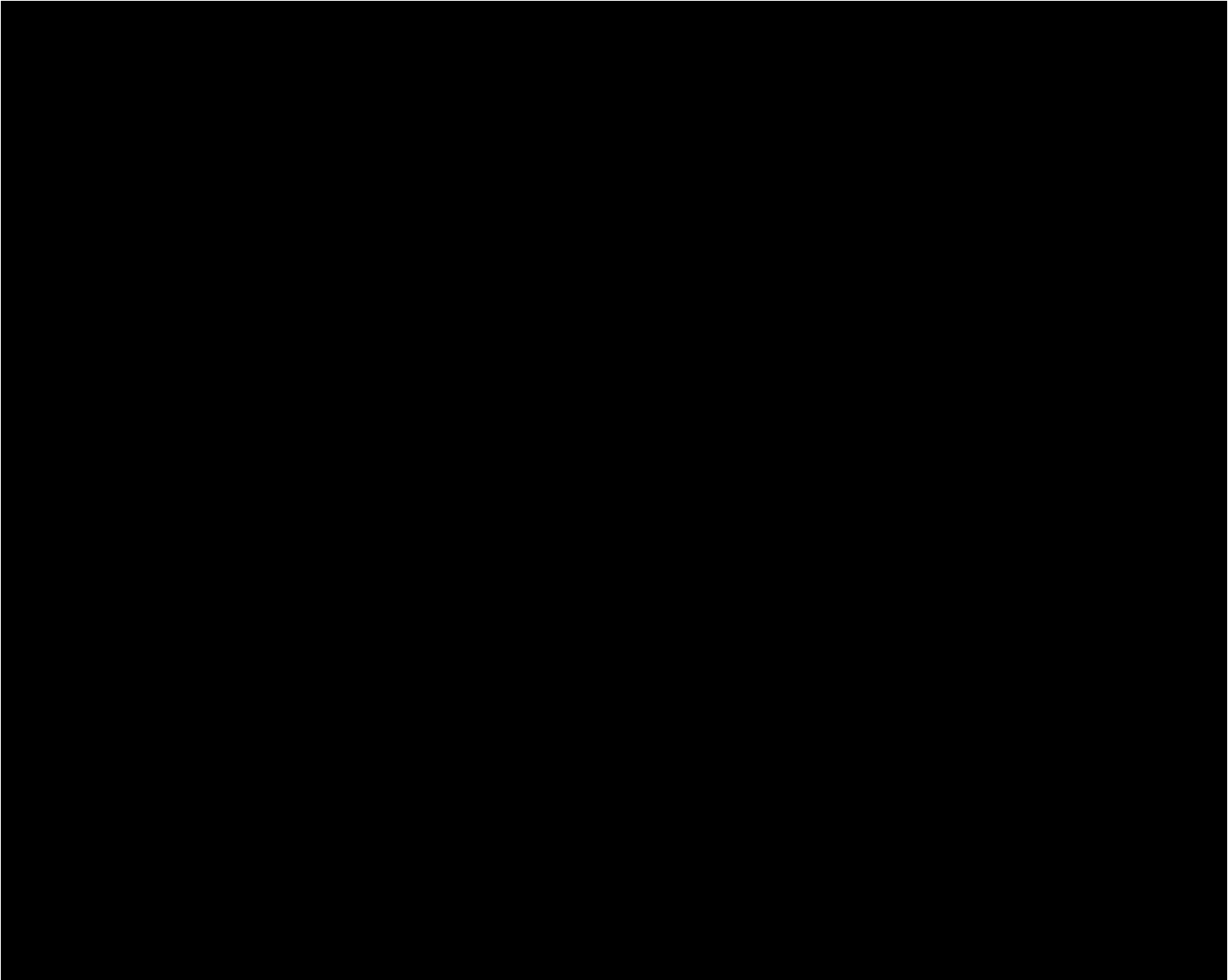


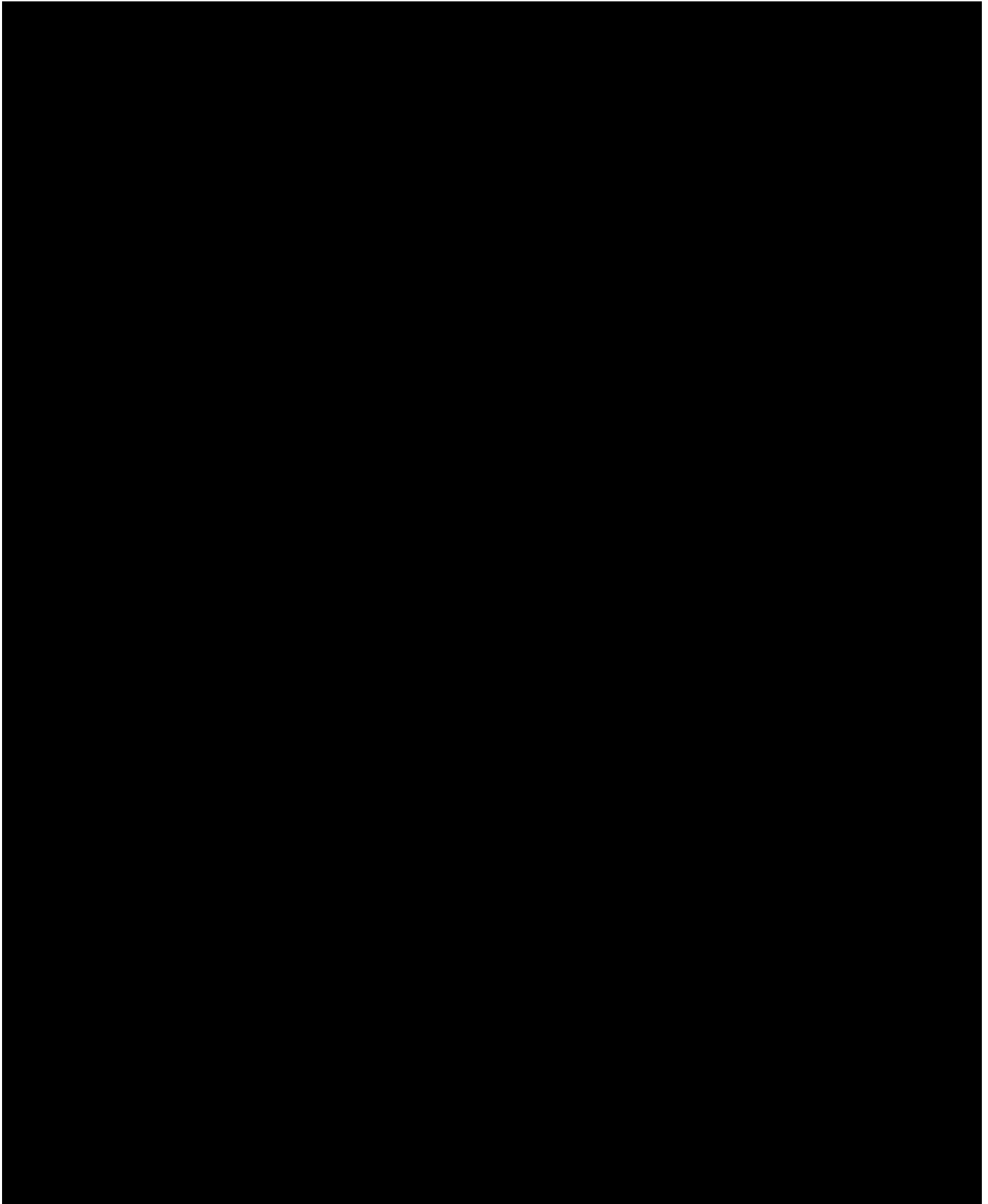


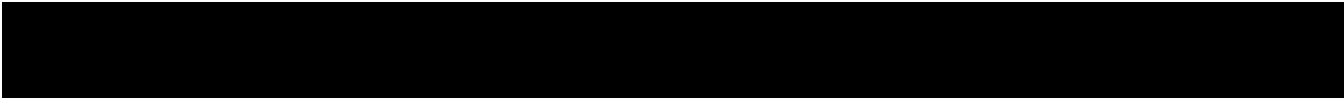


7.2 Appendix F2: The CiC effect on SMMC patient volume and case-mix

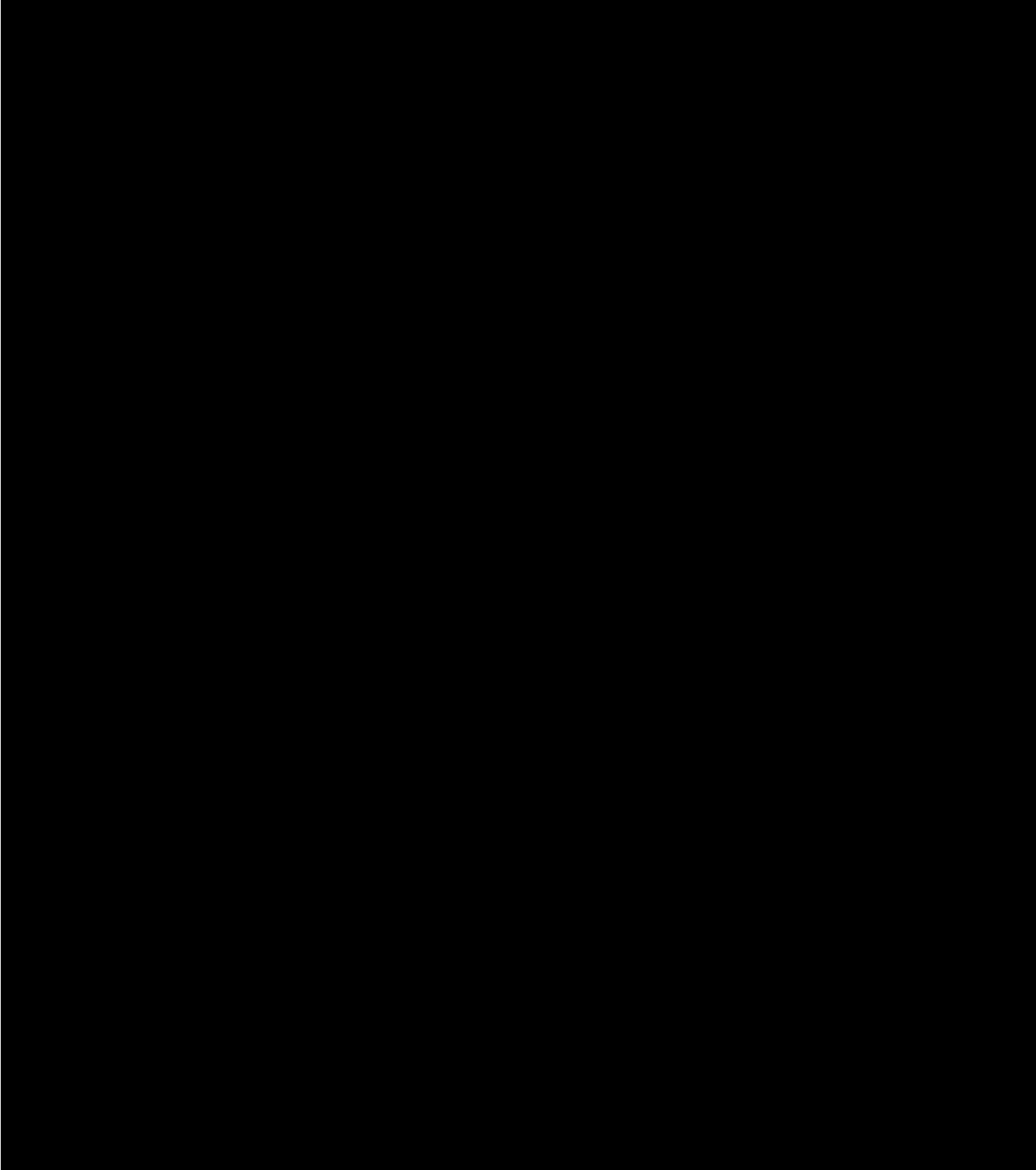


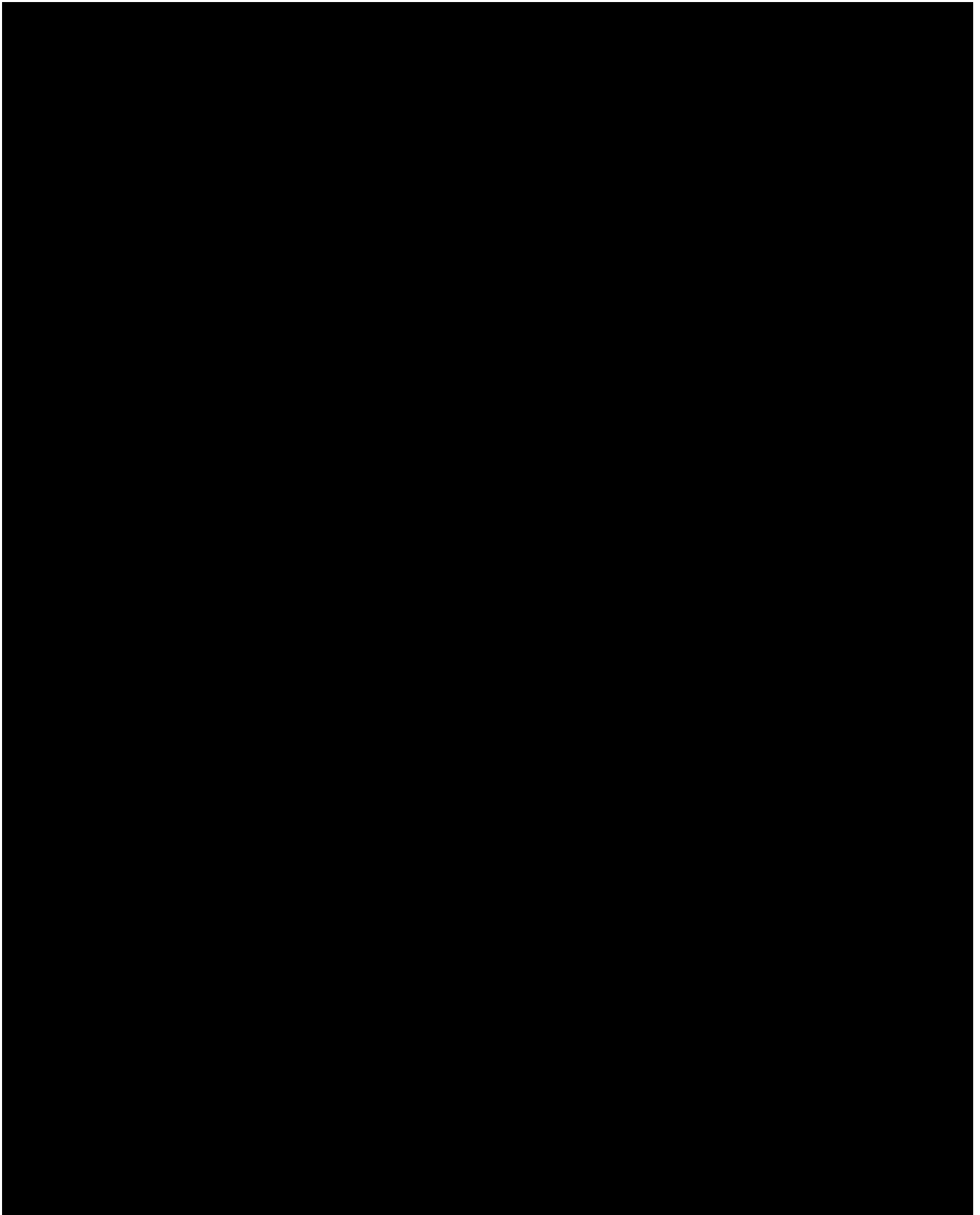


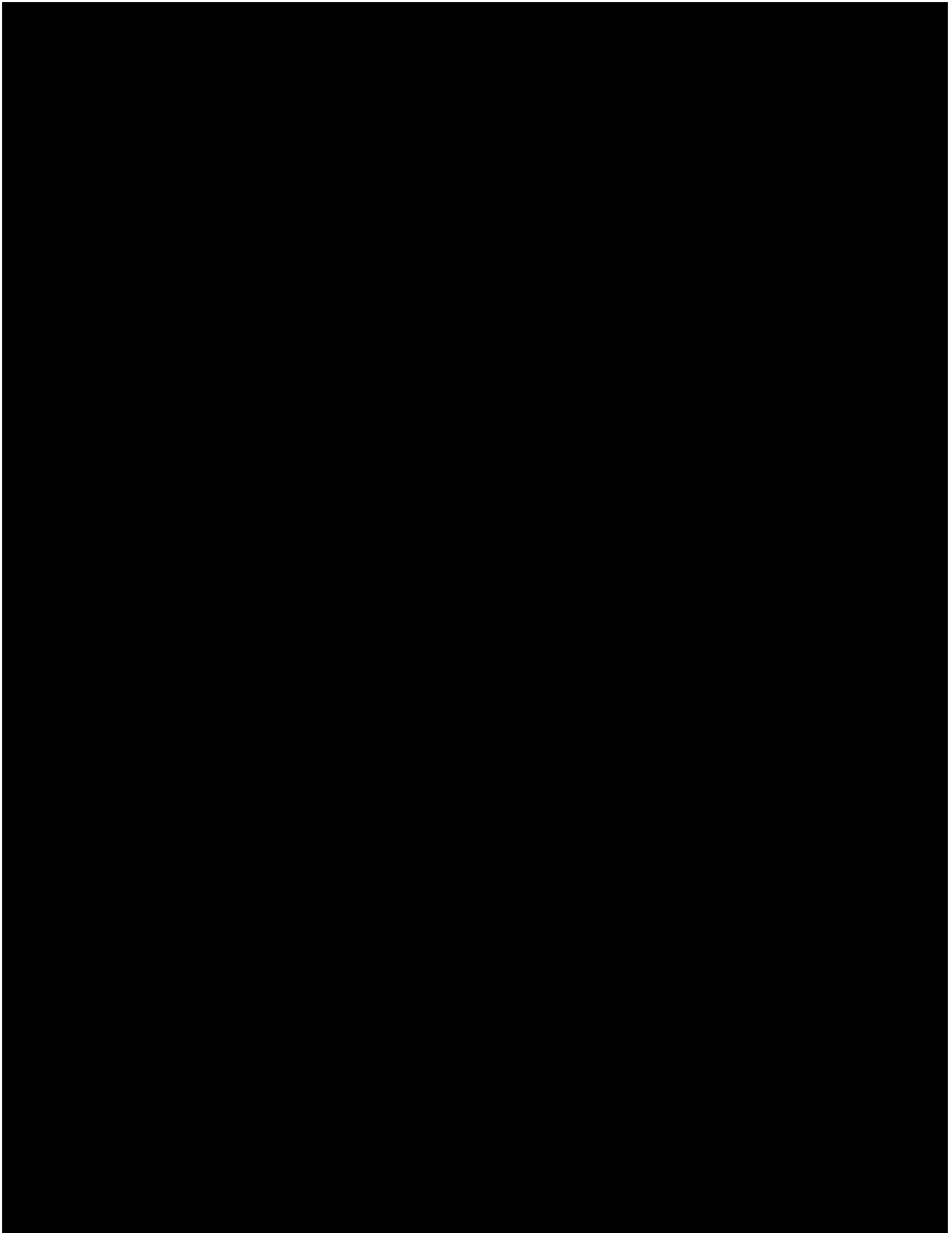


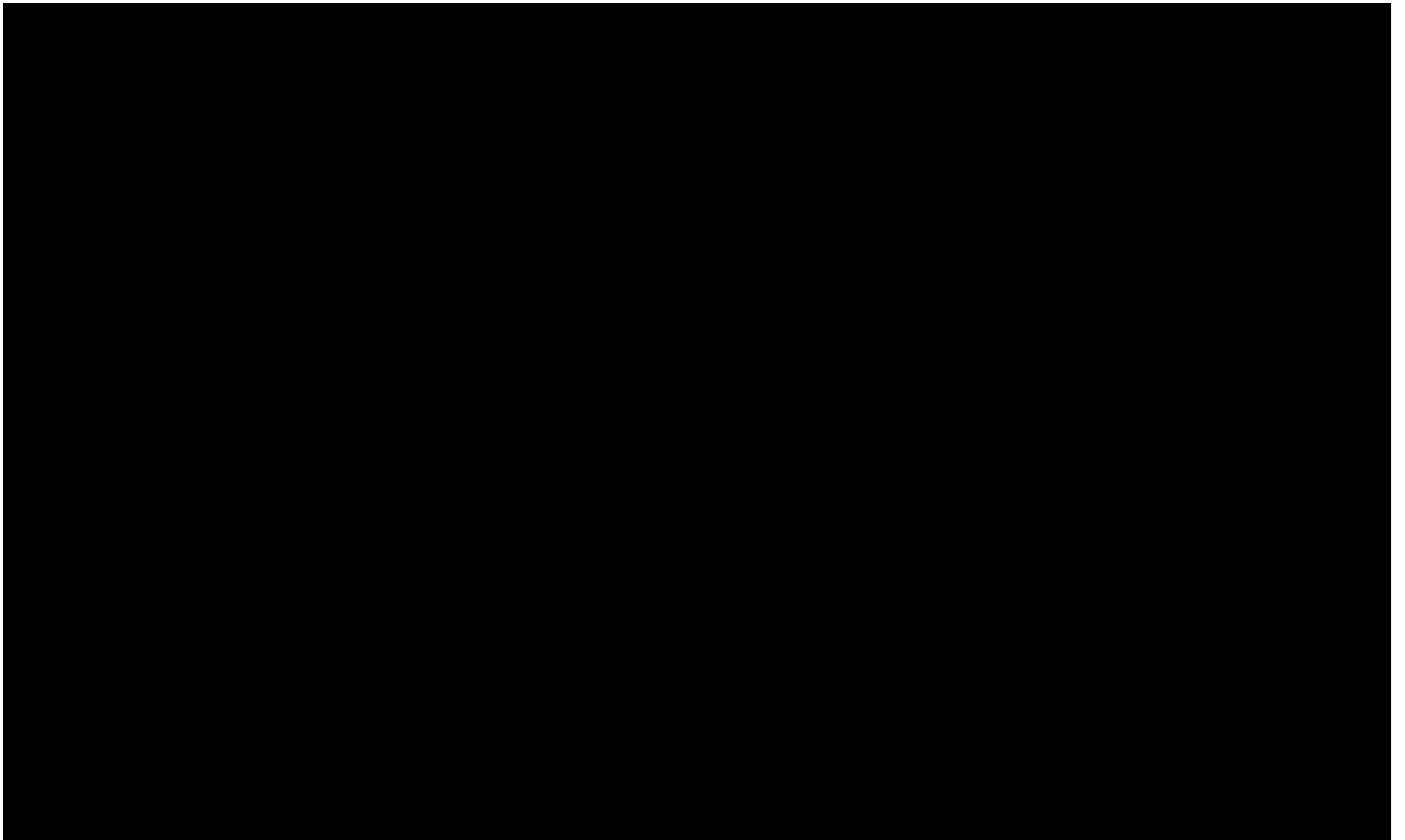


7.3 Appendix F3: The CiC effect on Kaiser’s costs of treating patients at SMMC

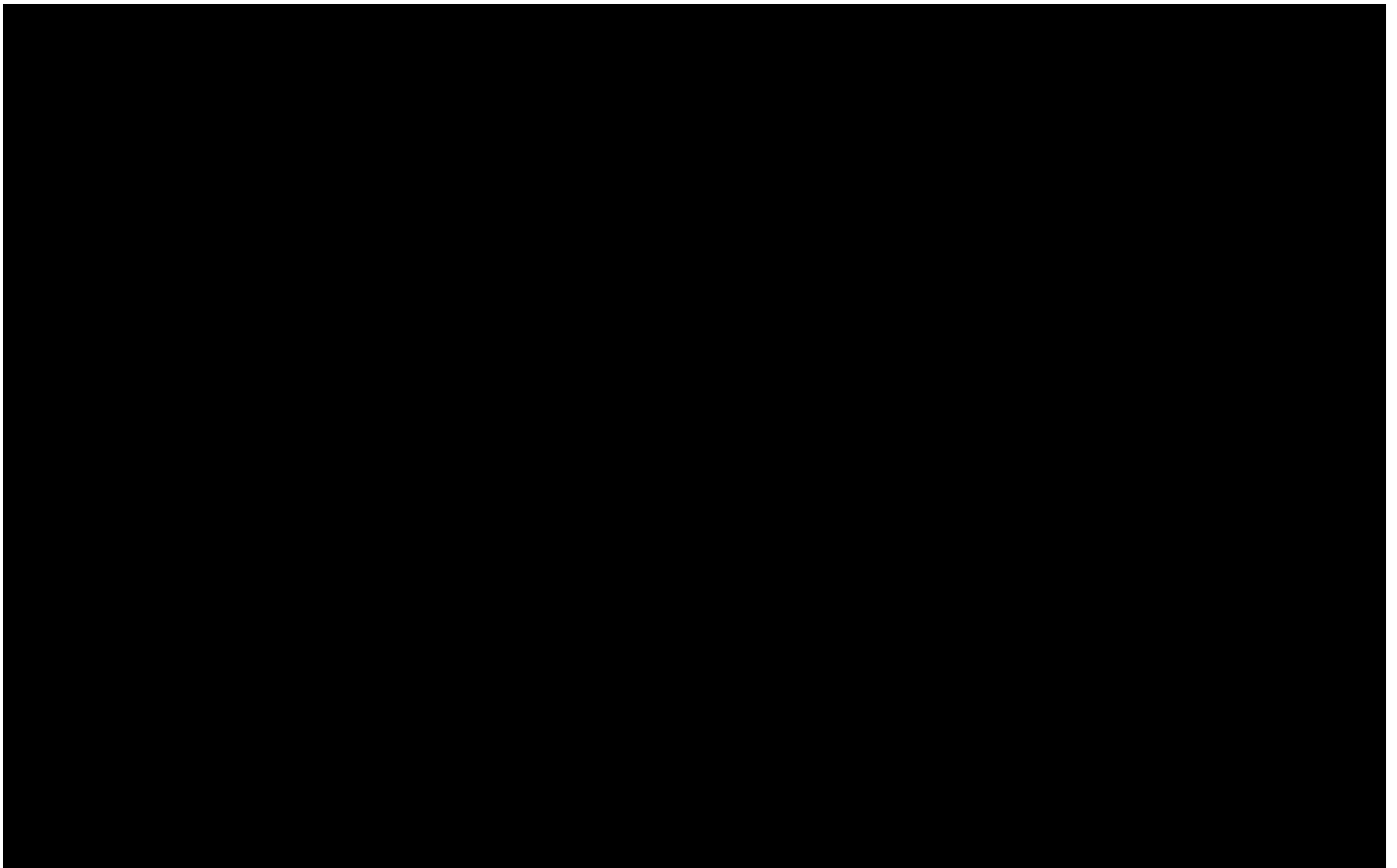


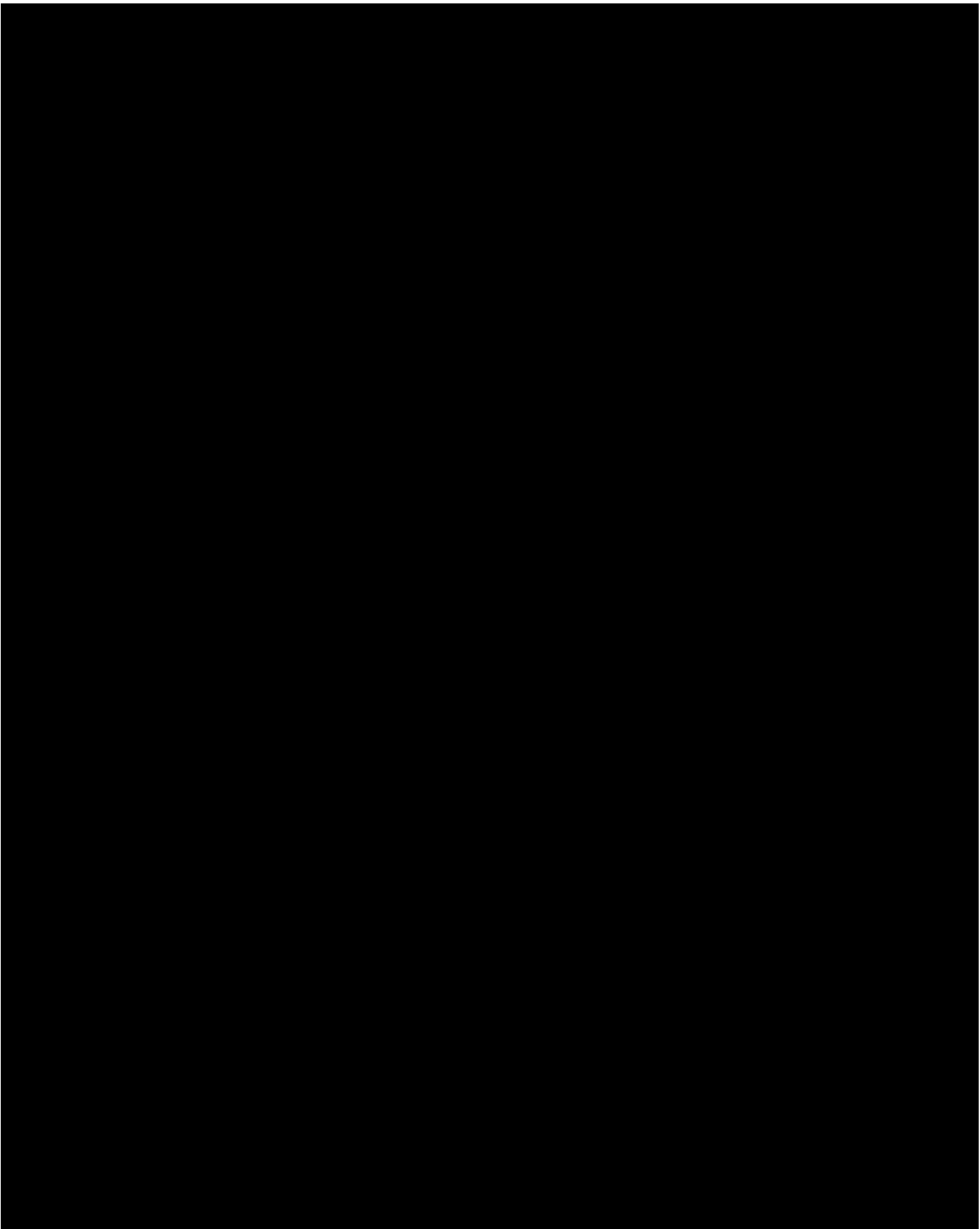


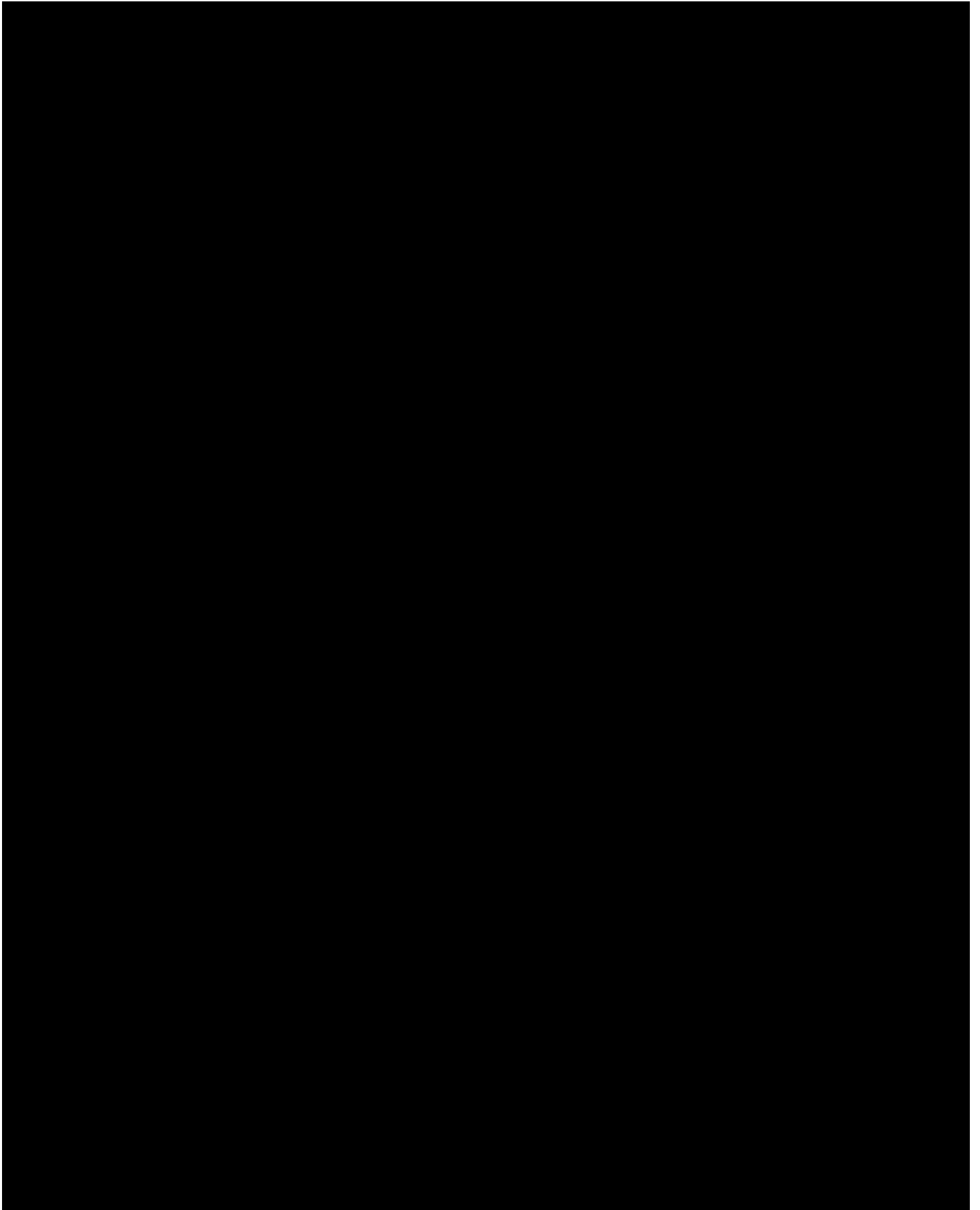


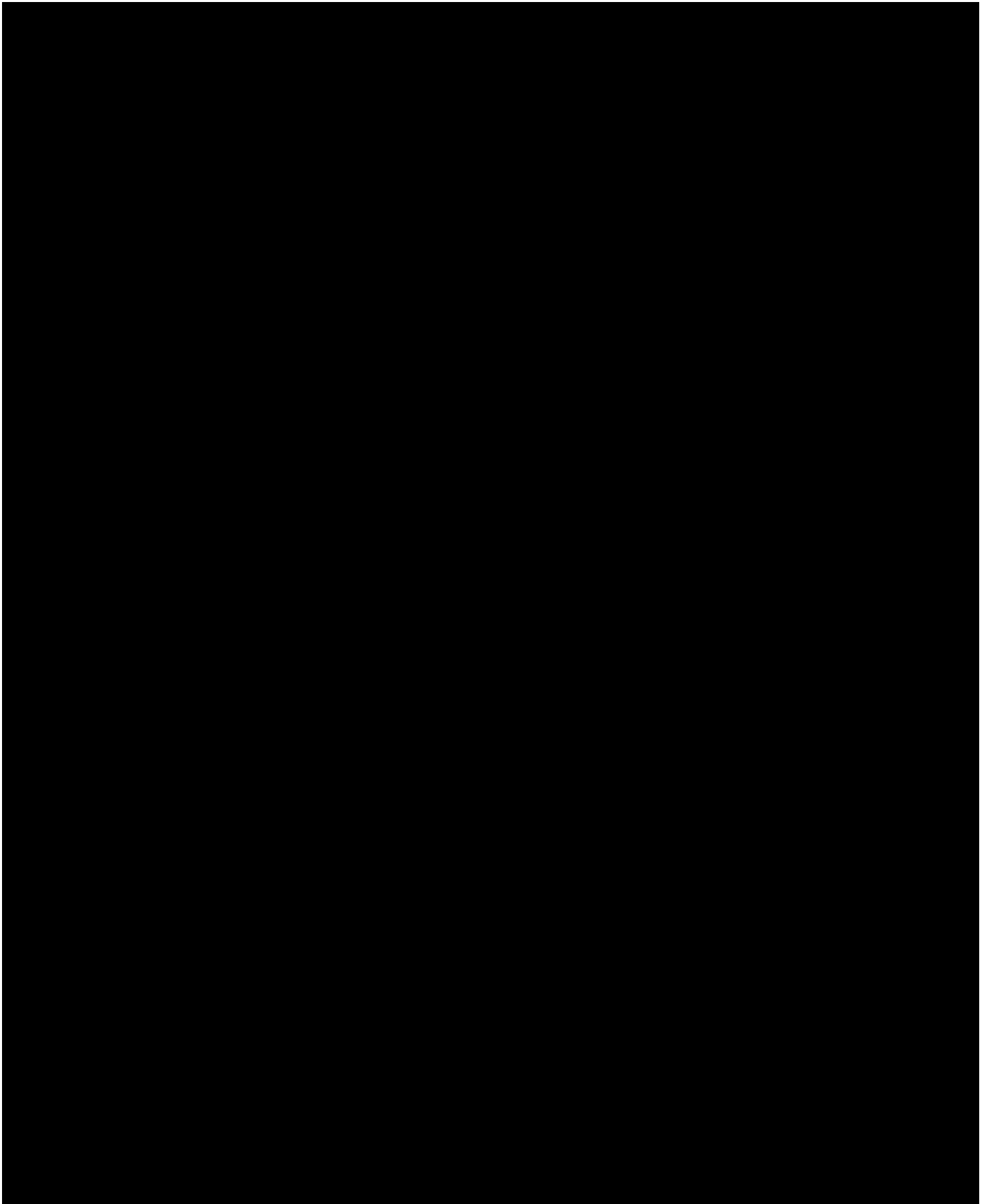


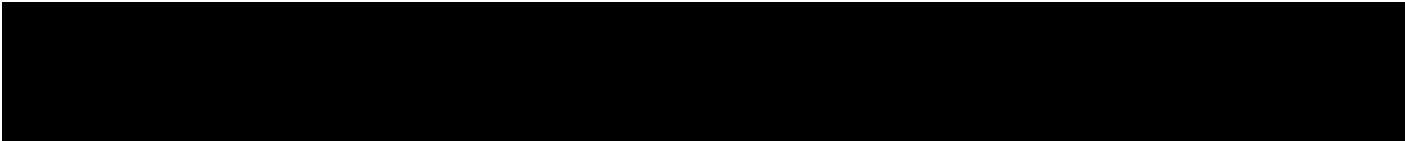
7.4 Appendix F4: The CiC effect on SMMC profit



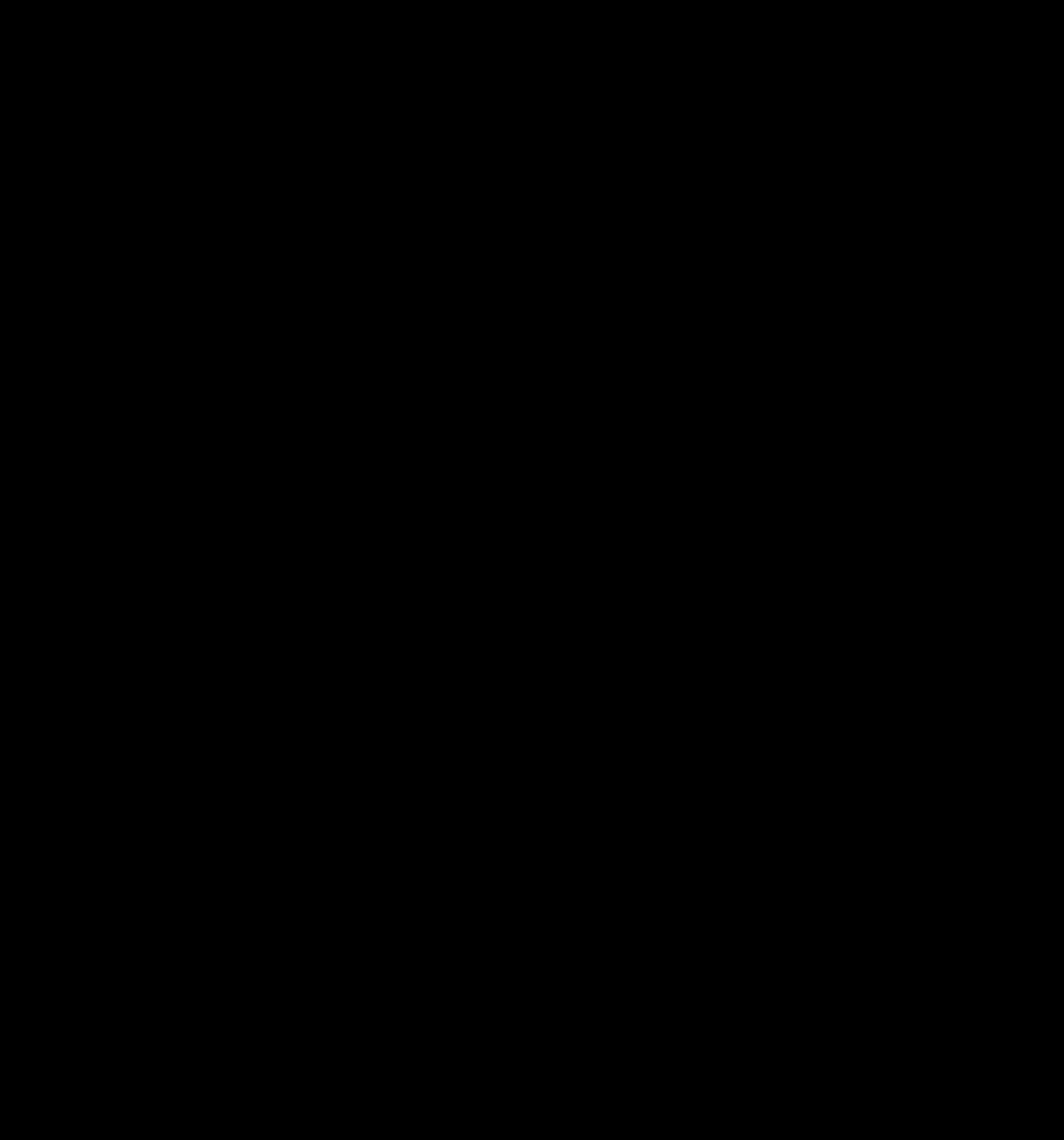


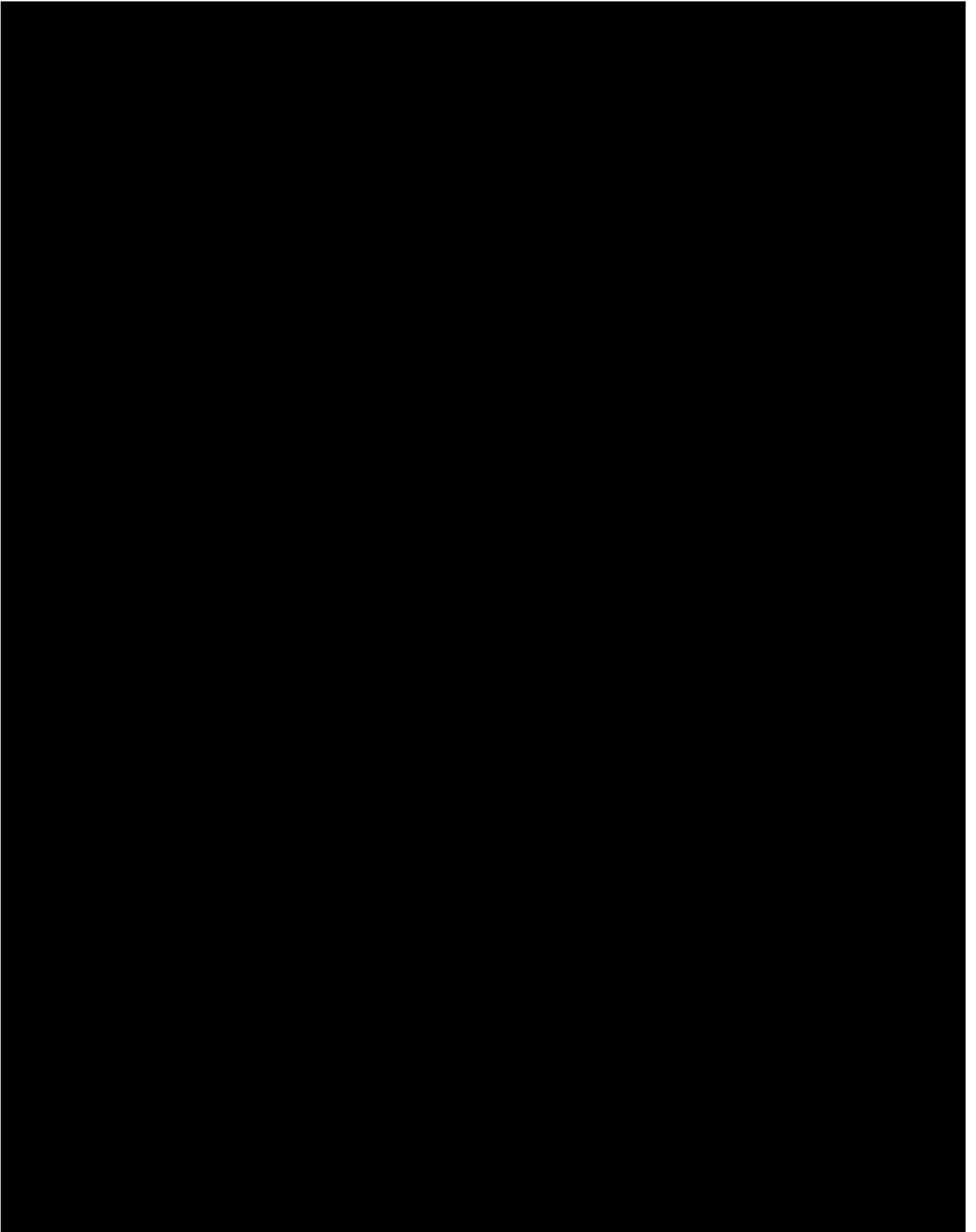


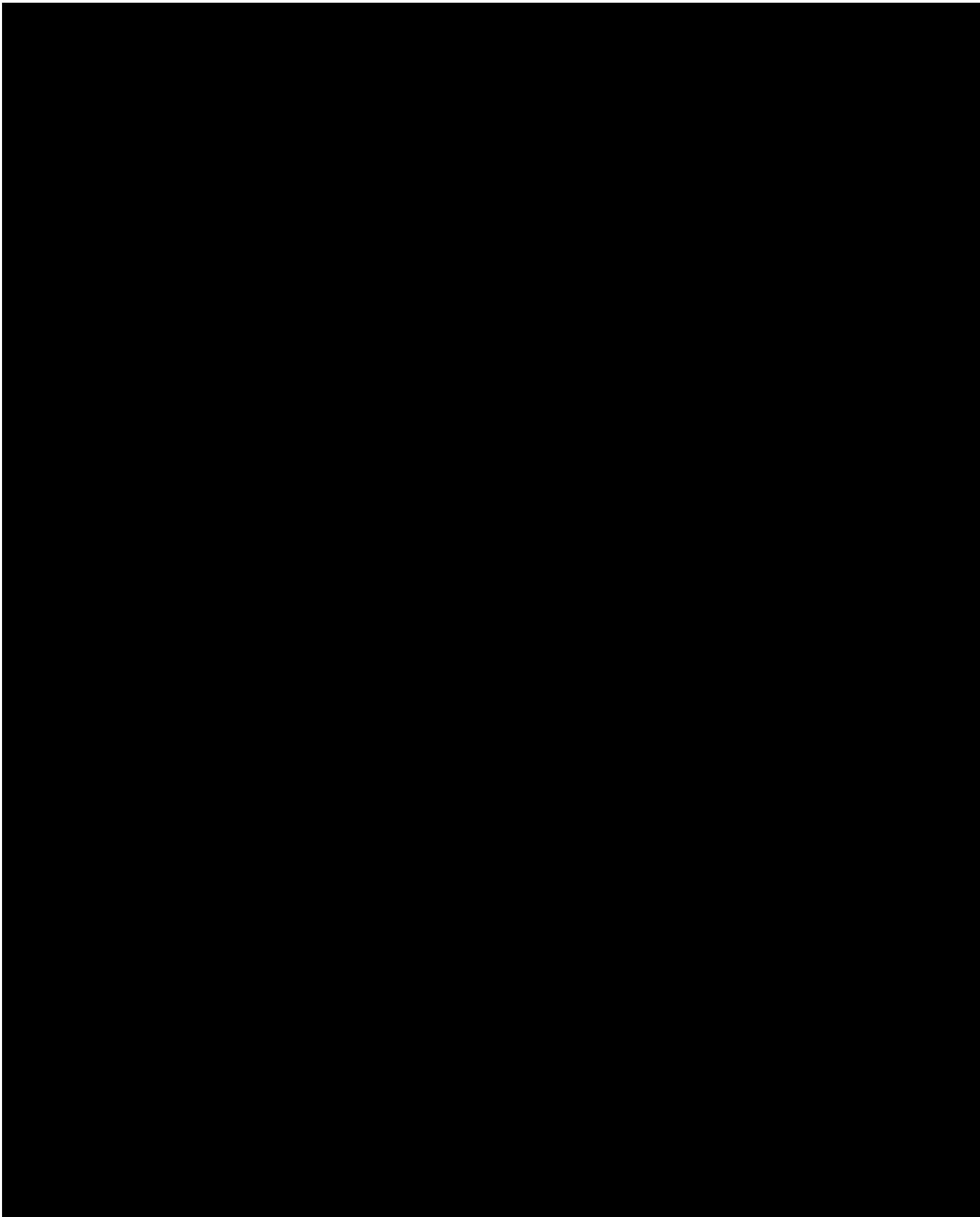




7.5 Appendix F5: Effects of a potential price increase by SMMC on Kaiser's costs

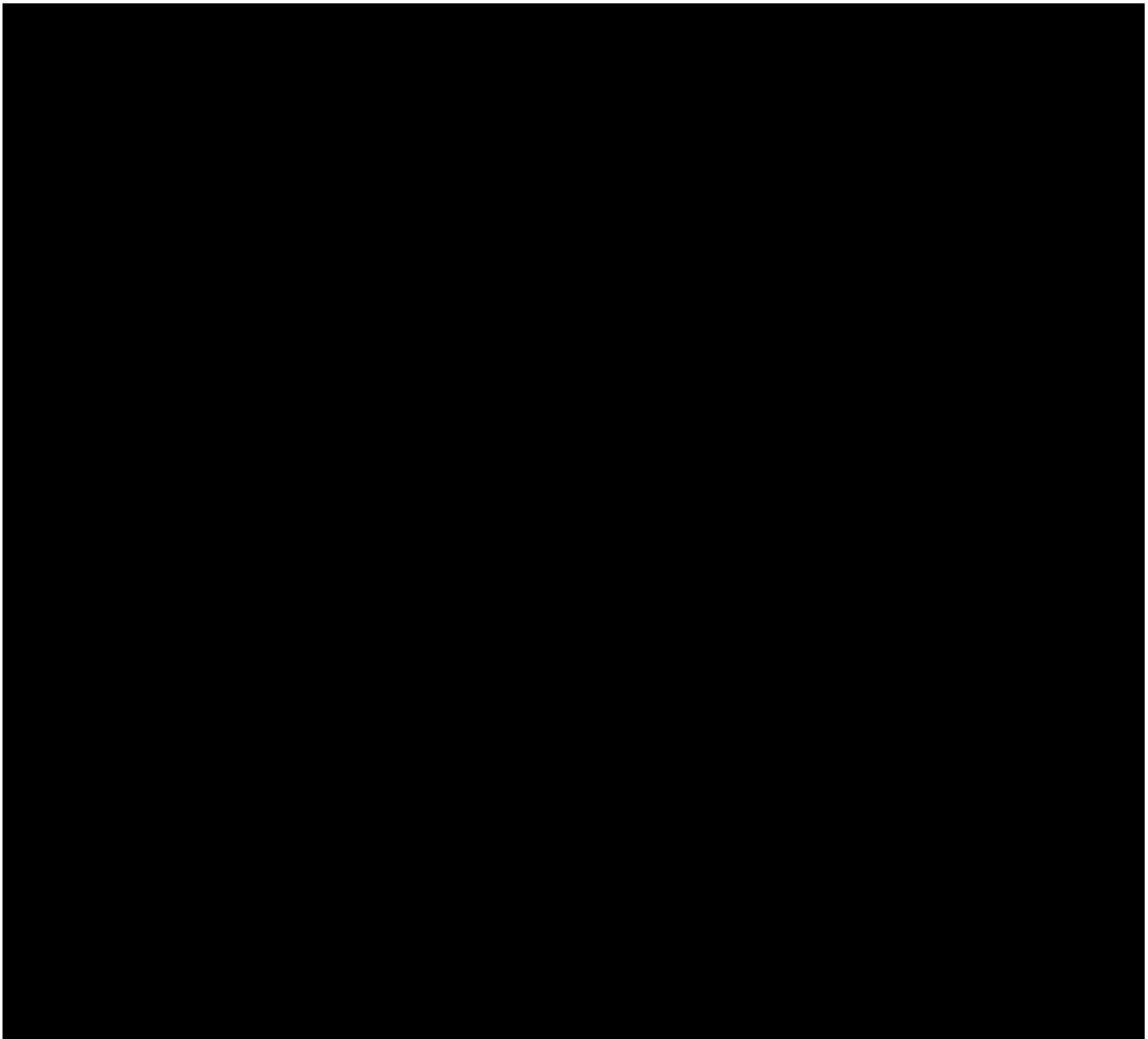


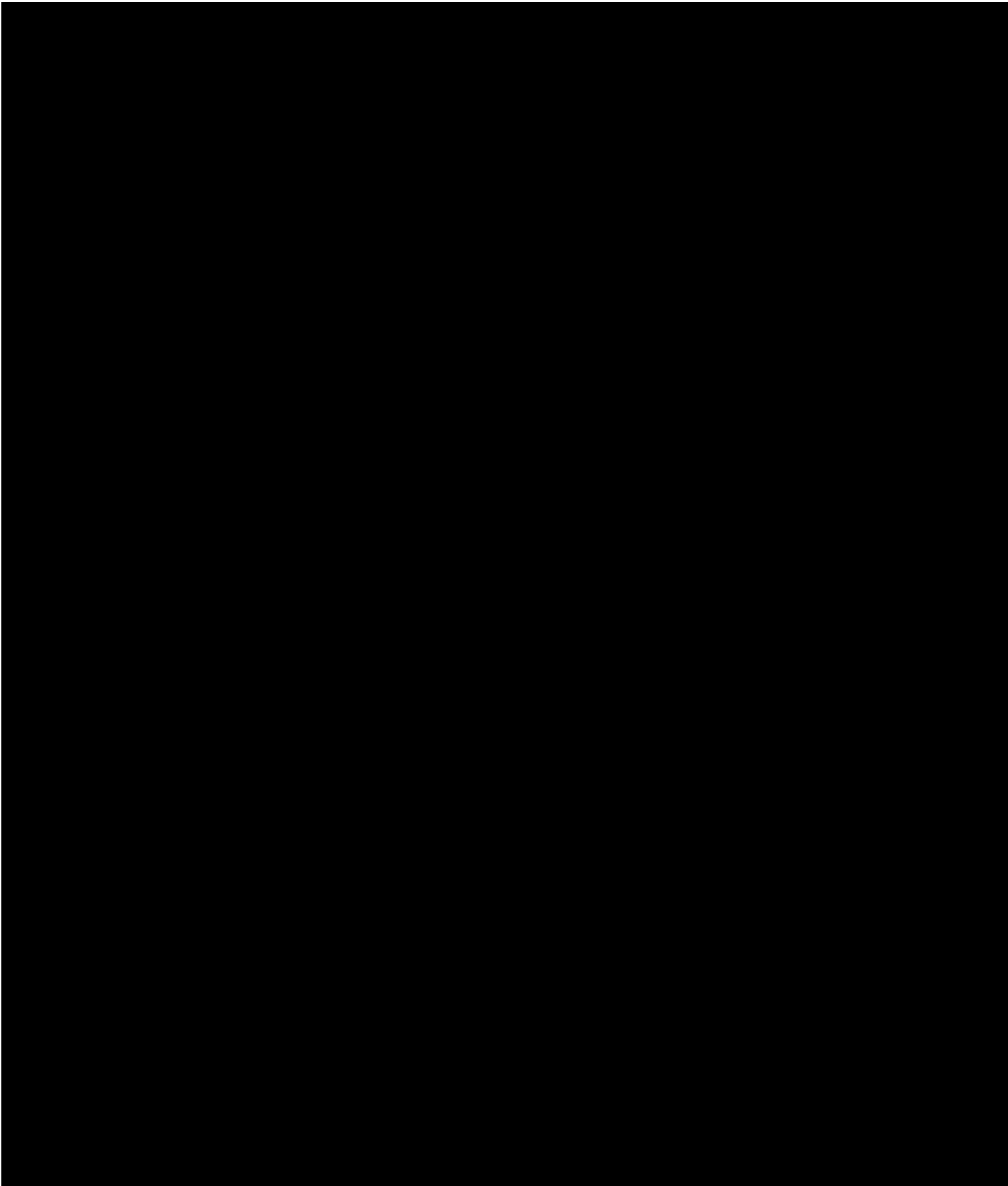


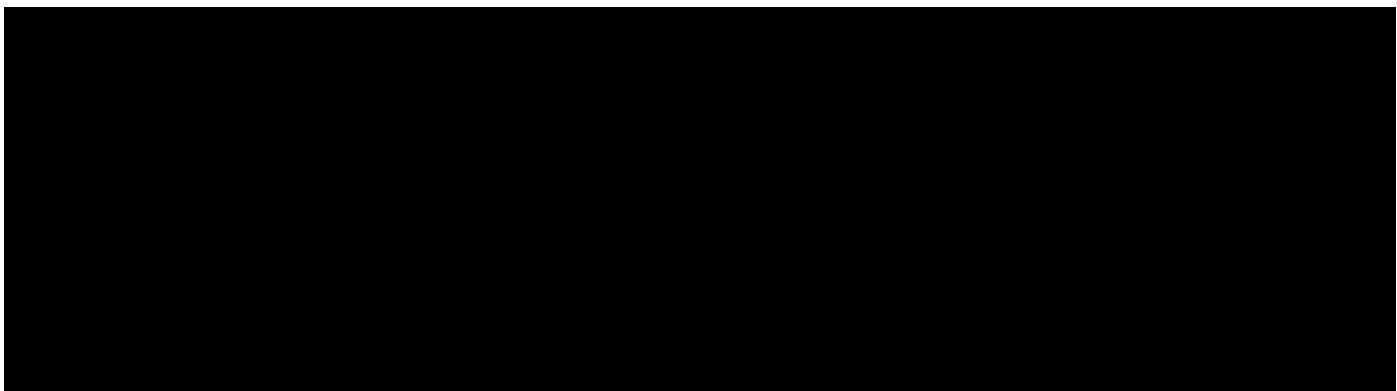




7.6 Appendix F6: Gross Estimates of Kaiser's financial benefits from CiC







8 Acknowledgements

This supplement along with our original report would not have been possible without all the hard work of James Pacci, JD, of Blue Sky Consulting and Dr. Katya Fonkych. Dr. Fonkych in particular worked tirelessly to help tease out the complexities of the financial and competitive implications of this somewhat distinctive transaction.

9 Signature

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct to the best of my knowledge.

Lisa Maiuro, MSPH, PhD

12/17/2021