



# AN EVALUATION OF THE PROPOSED CHANGE IN CONTROL OF ST 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 A Summary of the Transaction and Our Findings

## 1.1 Scope of the Report

To ensure the protection of consumer welfare and, in particular, to ensure that the residents of the High Desert area in San Bernardino have the benefits of health care competition, we were retained by the Office of the California Attorney General (OCAG) to assess the potential impact of the proposed Change in Control (CiC) between St. Mary Medical Center (SMMC) Providence St. Joseph Health and Kaiser in St. Mary Medical Center (SMMC), LLC.<sup>1</sup> We have been asked to analyze whether the transaction may create a significant effect on the availability or accessibility of health care services to the affected community and whether the effect of the transaction may be substantially to lessen competition or tend to create a monopoly.<sup>2</sup> Relatedly, we have been asked to provide our opinion, based on our findings from these two assessments, on whether the transaction should be approved, denied or approved with conditions.

## 1.2 Terms of the Transaction

In January of 2020, SMMC, a nonprofit public benefit corporation provided notice of the creation and affiliation of St. Mary Medical Center, LLC (LLC), a California limited liability corporation. The parties originally provided notice pursuant to Corporations Code section 5920, subdivision (e), because the transaction would occur between SMMC and its affiliate, the new LLC meaning that SMMC is only required to give the Attorney General 20-days advance notice of a transaction with an affiliate, i.e., a corporation that is “directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control” with SMMC. Review by the OCAG, however, found that the notice of the transaction would need to be submitted under Corporations Code section 5920, subdivision (a) and reviewed pursuant to subdivision (a) as a transaction that transferred “control, responsibility, or governance of a material amount of the assets or [health facility] operations of the nonprofit corporation to another nonprofit corporation or entity” and not as an affiliate transaction under Corporations Code section 5920, subdivision (e).<sup>3</sup> Under notice provided under subdivision (a), the Attorney General has 90-days to determine whether to consent or to conditionally consent to the transaction based on its impact on the public interest and to access the parties’ full range of transaction documents associated with full notice.

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<sup>1</sup> The analysis was contracted with Maiuro Health Care Consulting. Primary staff for this project included Lisa Maiuro, PhD, Katya Fonkych, PhD and James Pacci, JD.

<sup>2</sup> These requests are consistent with Corporations Code section 5920 and California Code of Regulations, title 11, section 999.5. Subdivision (f) sets forth factors that the Attorney General shall consider in determining whether to consent to a proposed transaction between a nonprofit corporation and a nonprofit corporation or entity

<sup>3</sup> Ms. Velasco, California Deputy Attorney General, April 19, 2021, Letter to Mr. Owen, regarding Notice of Affiliate Transaction – St. Mary Medical Center

The transaction will be created by SMMC transferring substantially all of the assets and operations comprising SMMC to the new LLC, in which SMMC would have a 70 percent ownership stake, while Kaiser Foundation Hospitals (Kaiser) would have the other 30 percent ownership stake. The LLC will also ultimately own and operate a new hospital in Victorville (the “New Hospital”) intended to replace the existing hospital in nearby Apple Valley and continue to serve residents of the High Desert community in San Bernardino County, California.<sup>4</sup> For context, the “High Desert”, reference throughout the report, is not a consistently defined geographic area but the SMMC market area, defined later, largely overlaps what is often referred to as the High Desert.

Many residents in the High Desert community, including its Kaiser Permanente members, will be able to access the New Hospital, which is expected to open in 2026. Both SMMC medical staff, including St. Mary High Desert Medical Group, and Kaiser Permanente physicians will deliver care at the new facility. SMMC will serve as the employer and operating manager of the hospital.

Changes in control at a hospital, as in this case, where there is a change in control from SMMC to joint control by both SMMC and Kaiser can change the objectives, information, or bargaining skills and incentives of the parties’ negotiating price. Those changes can result in post-transaction price increases regardless of whether the parties are involved in a horizontal transaction and offer the same services such as with a hospital merger or are involved in vertical transaction and offer mutually dependent services such as an integration between and hospital and health insurer. CiC concerns are consistent with evidence we will present that show a risk for the CiC to lead to SMMC to increase its price to area insurers and for Kaiser to dramatically expand its insurance market share with the potential to exercise significant market power and create a risk of foreclose on competitors.

### **1.3 Our Approach and Methodology**

To assess, understand, and evaluate the delivery and landscape for healthcare in the SMMC community we based our analysis on data from secondary data sources, e.g., administrative data, and primary data sources, e.g., stakeholders, who could be affected by the transaction. To evaluate what services are provided by SMMC and determine where it is important to ensure access and availability, we relied primarily on data from the Department of Healthcare Access and Information (HCAI) (formerly the Office of Statewide Health Planning and Development) that included information about availability and utilization of services for SMMC and other area hospitals. This was supplemented by data from the parties and interviews with other area

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<sup>4</sup> San Bernadino County is part of the Inland Empire which is generally interpreted as consisting of both Riverside and San Bernardino counties.



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insurers and providers. These data also helped frame and provide context for the competitive effects analyses.

The competitive effects analyses also relied heavily on HCAI patient discharge data, hospital utilization data, and emergency department data that were supplemented by data from the parties and from other California regulatory agencies. The competitive effects analysis traditionally begins with defining the relevant market and includes two components: the product market and the geographic market. The relevant product market is defined as the cluster of inpatient GAC services which is standard for cases involving community hospitals. The relevant geographic market that was determined was consistent with the “area in which a potential buyer may rationally look for the goods or services he seeks”, and with the hypothetical monopolist test (“HMT”) that is frequently applied by the courts to establish a relevant geographic market. The SMMC market area, located in San Bernardino, is comprised of 16 zip codes across the communities of Adelanto, Apple Valley, Helendale, Hesperia, Lucerne Valley, Oro Grande and Victorville. This area largely overlaps with the non-discrete boundaries of the High Desert area often referenced by insurers in our interviews.<sup>5</sup>

We evaluate how the terms of this CiC affect the abilities and incentives of the parties to exercise their market power, as they relate to several theories of harm (i.e., mechanisms) established in the economic literature. In particular, the following theories of harm are relevant in this context:

**Input foreclosure or raising rivals’ costs.** We focus primarily on the potential impact the CiC would have in imposing higher costs on non-Kaiser insurers in the market, and the prospect that both insurers and hospitals could potentially exit the market due to this adverse impact on competition.

**Customer foreclosure.** In a traditional merger between a dominant hospital and dominant insurer, the merged company could refuse to include rival hospitals in the merged insurer’s network. Subsequently, other market area hospitals would be foreclosed from accessing enrollees of the dominant insurer, driving those patients to seek care from the merged hospital (as it would be the only hospital in the dominant insurer’s market). In this case, Kaiser already is the dominant insurer and, as a closed system, it does not contract with other area hospitals. However, Kaiser enrollment expansion effectively turns former patients of the competing hospitals into Kaiser’s members who don’t have an in-network access to other local hospitals besides SMMC, which reduces patient flows to competing hospitals.

**Reduced likelihood of entry by competitors.** There are relatively few commercially insured patients in the SMMC market area. Given Kaiser’s dominance in the commercial insurance market, the CiC could discourage new companies from entering the provider or insurance

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<sup>5</sup> Throughout the report we may reference reports or conversations that refer to the High Desert area. In our analysis, when we reference the SMMC market area, we are looking at the 16 zip codes specifically.

markets because, to compete successfully post-merger, the entrant may need to enter at multiple levels e.g., with an integration of hospitals and insurance or insurance and physicians, to compete successfully.

**Information sharing.** There are concerns that in this CiC that Kaiser could access competitively sensitive information about rival hospitals and insurers from SMMC, which would give both Kaiser and SMMC unfair competitive advantages against rivals.

## 1.4 Summary of Opinions

Based on our review and analysis of the available evidence and considering the theories of harm described above, we believe that there are risks associated with the loss of access and availability of essential medical services related to this CiC and also risks of anticompetitive effects. The conditions listed in Section 12 of this report could potentially mitigate the impact of anticompetitive effects and ensure that access to medical services important to the community is preserved. We recognize that this transaction has the potential to provide a new state of the art facility to a population that is largely insured by public payers. Additionally, area residents may also benefit from the partnership with Kaiser who may be able to facilitate improved quality of patient care for a vulnerable patient population at a hospital that has received poor CMS quality ratings in the past. However, we have no evidence that indicates these are cognizable benefits that are specific to this transaction and could not be achieved in other, more pro-competitive ways that could benefit SMMC market residents. A summary of our findings and the conditions for approval that we believe should be considered by the OCAg are listed below.<sup>6</sup>

### *Access and Availability of Services*

- SMMC offers some services and departments that are not offered at Desert Valley Medical Center or Victor Valley Medical Center, including electrophysiology, a primary stroke receiving center, a Level 3 neonatal intensive care, a hospital-based laborist program for expectant mothers, and an obstetric emergency department. The CiC could affect the availability of these services or departments.
- Patients living in the SMMC area, many vulnerable and depending on public programs, rely heavily on SMMC for emergency care and maternity/obstetrics care. The CiC could affect the availability of services to this population through changes in the supply of beds or demand from new patient populations. Mental health and substance abuse services appears to be an inadequately met need in the area based on the limited evidence reviewed.

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<sup>6</sup> Opinions are based on data received as of 10/1/2021. Due to the time constraints for producing this report, data received after that date may or may not be included. We reserve the right to change our opinions based on new data.

- Reproductive health services and gender affirming health care services appear to be available through a variety of health care providers in the area. However, Kaiser has indicated that it will continue requiring its members to go to Fontana for these services when they are prohibited by the Ethical and Religious Directives (ERDs). It will be important to the community that Kaiser physicians are not restricted by this CiC in providing reproductive and gender affirming services or that Kaiser’s patients are not barred from receiving these services within the High Desert area where they live.<sup>7</sup> Kaiser is a key provider of gender-affirming procedures in Southern California and the CiC could hinder Kaiser’s ability to provide these services, given SMMC’s operating policies.<sup>8</sup>

### *Competitive Effects*

A vertical integration between a dominant local hospital and a dominant insurer resulting from this transaction raises a risk of adverse competitive effects, including competitive harms of foreclosure and raising rivals costs. This CiC enhances SMMC’s market power to raise prices on competing insurers, some of whom may find it preferable to simply exit the market given the small share of commercial patients remaining as Kaiser enrollment grows. Also, there is a risk that as Kaiser gains dominance in the market due to favorable CiC conditions, they could crowd out their competitors and then exercise their market power to raise premiums, leaving employers with few insurance options and residents with high health care costs.

Our findings include the following:

- SMMC by all accounts is already a “must-have” hospital for all insurers in the area. The CiC will make it even more critical to include SMMC in any insurer’s network that is trying to compete with Kaiser, as soon as Kaiser also has SMMC in their network. Consequently, SMMC gains additional market power in negotiating with local insurers, enhancing its ability to raise prices, creating a risk that this CiC could cause competitive harm by raising rival insurer costs. Ultimately, this impact could result in the foreclosure of both hospital and insurer rivals and their exit from the market.
- The profit-sharing provision of this CiC helps align the financial interests of SMMC and Kaiser benefitting both parties if the New Hospital increases costs for Kaiser’s rivals in the commercial, Medicare and Medi-Cal markets. Both parties profit from an increase in contracted rates for rival Medicare and Medi-Cal plans, since [REDACTED] and both parties share in the New Hospital’s profits. Profit-sharing also minimizes Kaiser costs resulting from commercial price increases, making cost pressures from price hikes disproportionately fall on Kaiser’s rivals.

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<sup>7</sup> While Kaiser states in a document to the OCAG, KP AG Question #29 (October 26 2021), that these services will be preserved, this assurance should be made legally binding between the parties.

<sup>8</sup> While Kaiser states in a document to the OCAG, KP AG Question #29 (October 26 2021), that these services will be preserved, this assurance should be made legally binding between the parties.

- As Kaiser’s market share grows and its members use the New Hospital for outpatient and inpatient services, there may be a shortage in capacity at the current SMMC facility or the New Hospital, and there will likely be a strong incentive for SMMC to restrict or limit access to Medi-Cal managed care plans in an attempt to make room for higher margin Kaiser’s patients, by dropping Medi-Cal managed care contracts, by increasing their rates sharply or otherwise creating mechanisms to restrict their access to patients with lower reimbursement rates. This could disadvantage Kaiser rivals in the Medi-Cal market, as well as create access issues for this vulnerable population.
- The share of the SMMC market area population with commercial insurance is relatively small, with approximately one in five admissions covered by commercial insurers. However, Kaiser currently has a dominant presence in the SMMC commercial insurance market covering 52% of enrollees. With SMMC becoming Kaiser’s local in-network facility, we expect Kaiser’s share of the commercial market to reach about 70% by 2035. Not all of this projected increase is due to its affiliation with SMMC, however, as Kaiser is also expanding its outpatient service offerings in the area.
- Kaiser enrollment growth could be fueled by an unfair competitive advantage owing to the CiC provisions that [REDACTED].
- There is a risk that this CiC could cause competitive harm by reducing the likelihood of entry by both hospital and insurance competitors. SMMC is already the dominant hospital and Kaiser the dominant commercial insurer for a relatively small commercially insured population for which there is the greatest competition, since their net patient revenue per patient day is more than [REDACTED] as for Medicare patients and more than [REDACTED] as for Medi-Cal patients.<sup>9</sup> Entering a market where most commercial patients and their preferred providers are captured by the Kaiser network is a considerable barrier for a new insurer seeking to attract patients with lower rates and a quality network.
- Specifically, as Kaiser’s commercial market share grows, there will likely be far fewer non-Kaiser commercial patients left in the area to be treated by non-Kaiser physicians, potentially leading to the exit of the most attractive doctors who rely on the higher-paying commercial patient group for revenue. Lack of non-Kaiser physicians in the area could also make it more difficult for other insurers to offer attractive insurance products and for other hospitals to provide adequate staffing for their services and departments, resulting in barriers to entry in both insurance and hospital market.

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<sup>9</sup> Approximately one in five admissions is commercially insured. Net patient revenue per patient day is based on data from the parties and it is unclear whether this takes into account supplemental disproportionate share payments or funds from the Hospital Quality Assurance Fee Program (HQAF) which can be sizeable supplements to revenue from Medicaid.

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- The parties did not point to any cognizable efficiencies created by the CiC that could be “credited” against anticompetitive risks.

The nature of this CiC involves several factors that have potential to constrain some of the anti-competitive effects or reduce their risk:

- Unlike in a full merger, where incentives among partners are completely aligned, Kaiser is likely to transfer or shift Kaiser’s patients to its own hospitals if it costs more for Kaiser to have them treated at SMMC. These incentives mean that Kaiser and SMMC are in a way competing over the treatment of Kaiser’s members, which limits SMMC’s ability to increase commercial prices without losing volume, since Kaiser’s SMMC prices are tied to [REDACTED]. However, profit-sharing and discount provisions of the CiC weaken these market forces by reducing Kaiser exposure to price increases.
- Unlike in a full merger where incentives are aligned, SMMC does not appear to have strong incentives to help Kaiser expand its market share. Due to the discount that Kaiser receives per terms of this CiC, financial benefits from Kaiser’s expansion are likely to be negligible and can even turn negative if Kaiser utilization of SMMC is lower than expected (although SMMC would benefit from Kaiser expansion if there is no discount for Kaiser). In addition, SMMC may have strategic concerns about Kaiser’s expansion that could lead to a smaller commercial market share for Providence’s own physician groups. SMMC may also prefer to minimize risks related to over-reliance on Kaiser patient volume should Kaiser decide to exit the CiC in the future.

Although we believe there is a risk of anticompetitive effects on both hospitals and insurers in the market, this risk could be mitigated if various conditions are imposed on the approval of this CiC. A complete list of conditions is in Section 12, however, in brief, we recommend that the OCAG consider the following conditions:

- Impose absolute price caps as a percent of DRG rates on Medi-Cal and Medicare plans to protect access for these groups of patients, as well as limit potential price increase on Kaiser rivals in these markets
- Impose commercial price caps on SMMC thereby restricting the amount by which SMMC’s prices can increase each year, significantly reducing anticompetitive concerns associated with the change in control.
- Remove caps on commercial Kaiser rates that under current CiC terms [REDACTED], or by requiring that the same price increase caps apply to negotiated prices with other commercial payers.
- Impose caps on out-of-network rates charged for emergency utilization such that insurers can drop SMMC without paying exorbitant emergency rates. Given that most of the area’s admissions come through the ED this would be critical to facilitating a competitive environment.

- Set conditions of the contract between Kaiser and SMMC to strip Kaiser of control over the negotiation of contracts with other insurers. For example, Kaiser should not be allowed to veto potential SMMC contracts.<sup>10</sup>
- Prohibit SMMC from requiring exclusive contracting (exclusive dealing) by insurers with SMMC so that insurers have an opportunity to create competitive products with other area hospitals. For example, SMMC would be prohibited from making the exclusion of other hospitals from an insurer's network a condition of the insurer's contracting with SMMC.
- Prohibit anti-tiering and anti-steering provisions and exclusivity provisions in SMMC contracts with other payers so that insurers have an opportunity to develop cost-saving products that minimize SMMC utilization should SMMC raise their rates. This could make patient volume more responsive to price changes, reduce SMMC profit gains from price increases.
- Eliminate Kaiser profit-sharing as it is the key factor that aligns Kaiser and SMMC incentives to raise rival's costs.
- If profit-sharing provision remains, then modify commercial discount terms: 1) Reduce the discount that Kaiser receives on commercial rates; 2) Make it conditional on Kaiser utilization proportion (i.e., no discount unless Kaiser has a certain percent of their commercial patients using SMMC).<sup>11</sup> [REDACTED]
- Do not allow [REDACTED]
- Develop safeguards against the sharing of competitively sensitive information.
- Keep the option to impose conditions at a later time related to mitigating the impact of physician consolidation. Time constraints and limited data available to us did not allow us to assess the risk of competitive effects for the physician market. Should the collaboration move beyond SMMC or the New Hospital with the potential to have broader anticompetitive effects, e.g., if Kaiser and Providence start dividing up the market for specialty physicians services such that each would only provide certain services and they agreed not to compete, effectively engaging in market allocation, this would be worthy of a deeper investigation.

The duration, detail of terms, combination, and enforcement of these conditions would be critical to mitigating the risk of anticompetitive effects in this transaction.

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<sup>10</sup> There may be exceptions to this. For example, if the contract had set-aside beds that were reserved for the insurer and were not available to other patients on a first come first serve basis.

<sup>11</sup> To justify a commercial discount, Kaiser must send a higher proportion of patients to SMMC than other commercial insurers do, which is about 30% on average. This would ensure that Kaiser doesn't get a windfall gain in the period prior to New Hospital opening when Kaiser's share at the existing facility stays low due to capacity constraints. The threshold for a discount could be set higher than [REDACTED]%, but its exact level is related to how other terms of this CiC would be adjusted.

## 2 Introduction & Purpose

### 2.1 The Terms of the Transaction

The new entity resulting from the CiC is an LLC which is majority owned (70%) by SMMC and minority owned (30%) by Kaiser Foundation Hospitals, based on the percentage investment in the initial capital contribution.

The LLC is planning to replace the existing SMMC hospital with a new acute care hospital, the New Hospital, to be located in the area of Southern California commonly referred to as the High Desert, in close proximity to the existing SMMC. The LLC may rely on the services of SMMC and its staff to provide experience, skills, supervision and personnel in the management and operation of the existing or the New Hospital, however, the ultimate authority and control of the operation of the existing or New Hospital is retained by the LLC and subject to their terms and conditions.

The terms of the transaction include: (1) Kaiser's investment on a minority basis, (2) ensuring SMMC maintains governance control and operational oversight over the Hospital, (3) ensuring the New Hospital remains part of the Providence system, (4) ensuring that the New Hospital continues to operate in furtherance of its nonprofit mission and charitable purposes; and (5) ensuring that the employment status and benefits of any individual who currently provides services on behalf of the New Hospital does not change as a result of the transaction.

In this context, the CiC refers to an arrangement between companies that is short of a merger or acquisition given that the parties combine some assets, operations, or business functions but continue to operate as separate entities. More detail on the material terms of the transaction are in Appendix A: Key Terms of the Transaction, but include:

- SMMC and Kaiser will engage in a CiC to collaborate financially to build a replacement hospital.
- SMMC will contribute hospital assets and business (other than existing facility) land to build the New Hospital.
- The New Hospital and approximately \$600 million cash in exchange for a majority control (70%).
- Kaiser will make an initial contribution between approximately \$280 million- \$300 million in cash in exchange for a minority interest (30%). The remaining balance for construction costs will be debt-financed by the transaction.
- Until the New Hospital facility is operational, all results of operations will be solely for Providence Saint Joseph Health (PSJH).

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- Kaiser's participation in “upside/downside” or profit sharing begins when the New Hospital is operational, which is expected to be in 2026.
- The New Hospital will be Catholic-sponsored and operated in compliance with the Ethical and Religious Directives (ERDs).
- PSJH will occupy seven of ten board seats and all operations, staffing, and leadership will be provided by PSJH.
- There will be a Quality Committee that will review and address issues related to quality of services provided at SMMC Hospital.
- SMMC will continue to utilize PSJH payer contracts.
- Simultaneous with LLC formation, SMMC and Kaiser will enter into a non-exclusive agreement for the provision of health care services at a discounted rate to Kaiser’s members.
- The CiC will agree to be bound by a Care Model Agreement to ensure the quality of care and continuity of care of Kaiser’s members of the New Hospital.
- The joint ownership will allow senior Kaiser and Providence St. Joseph executives to have joint approval for key operations of the LLC that could impact both access to services and the competitive environment. There are actions requiring super-majority approval by the Board where “Supermajority Board Approval” means “the approval of a majority of the Managers present and represented by proxy (if any), provided that such approval includes the approval of at least two (2) Kaiser Managers.<sup>12</sup> For example, a Supermajority approval is required for approval or authorization of any exclusive contract binding the Company or any of the Company’s assets “that is reasonably likely to lead to material reductions in capacity or access for Kaiser’s members at any hospital owned by the Company”.<sup>13</sup>

## 2.2 Background and Description of the Transaction

The purpose of this report is to examine the impact of a transaction between St. Mary Medical Center (SMMC), Apple Valley, a general acute care (GAC) hospital that is part of the Providence St Joseph Health System (Providence or PSJH), a nonprofit public benefit corporation and Kaiser Foundation Hospitals (KFH), also a California nonprofit public benefit corporation. Our analysis is intended to address the potential healthcare impact of the CiC on the availability and accessibility of healthcare services to the communities served by SMMC and Kaiser in the High Desert Region

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<sup>12</sup> Notice of Proposed Submission and Request for Consent by: ST. MARY MEDICAL CENTER In Connection with its Contribution Agreement with ST. MARY MEDICAL CENTER, LLC Prepared for the Office of the Attorney General California Department of Justice Charitable Trusts Division  
June 7, 2021

<sup>13</sup> Notice of Proposed Submission and Request for Consent by: ST. MARY MEDICAL CENTER In Connection with its Contribution Agreement with ST. MARY MEDICAL CENTER, LLC Prepared for the Office of the Attorney General California Department of Justice Charitable Trusts Division  
June 7, 2021



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and the potential impact on healthcare competition when SMMC is rebuilt and relocated to nearby Victorville, California about a 14-26 minute drive, depending on traffic conditions, west of the current location in Apple Valley.<sup>14</sup> The planned completion date of the New Hospital, jointly owned by both Kaiser and Providence, is 2026.

SMMC intends to transfer substantially all of the assets and operations comprising SMMC to the new LLC in which SMMC intends to take a 70% ownership stake in the new LLC, while Kaiser Foundation Hospitals (Kaiser) takes the other 30% ownership stake. The new LLC will also ultimately own and operate a new Hospital intended to replace the existing Hospital which currently does not meet California seismic safety standards.

SMMC owns and operates the acute care hospital located at 18300 Highway 18, Apple Valley, California 92307, an area in San Bernardino County that is part of California's Inland Empire. SMMC is part of Providence St. Joseph Health ("Providence"), a Catholic-sponsored nonprofit integrated healthcare system that provides a comprehensive range of health care services across California, Alaska, Montana, New Mexico, Oregon, Texas, and Washington. The Hospital operates within Providence's Southern California health network.

KFH, with a minority share in the CiC, is part of Kaiser Permanente, which is recognized as one of the nation's leading health care providers and comprised of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan and Kaiser Permanente Medical Group, their physicians. (Note we refer to "Kaiser" throughout unless specifically referring to Kaiser Insurance, Kaiser Hospitals or Kaiser Medical Group. We also refer to the current SMMC hospital as "SMMC" and, interchangeably, the newly constructed SMMC as either "SMMC" or the "New Hospital". A summary of the terms of the agreement is in Appendix A: Key Terms of the Transaction.

In preparation of this report, Maiuro Health Care Consulting (MHCC) performed the following:

- A review of the Notice to the Office of the California Attorney General (OCAG) under California Corporations Code Section 5920 (this "Notice") in accordance with the requirements of Section 999.5(a) at the request of the OCAG, submitted by SMMC in addition to other public and confidential documents submitted by Providence and Kaiser.
- A review of press releases and news articles related to the proposed combination and other hospital transactions;
- A review of related academic literature relevant to the transaction;
- Interviews with health plan representatives, local medical groups, [REDACTED], [REDACTED], and others who potentially could have an interest in the transaction;

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<sup>14</sup> Time is based on Google Maps for 11/12/2021 at 5pm and 11/12/2021 at 10am PDT. Time to the New Hospital for any given resident may be slightly more or less depending on their zip code.

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- An analysis of financial, utilization, and service information provided by the management of Providence, SMMC, Kaiser, California Department of Managed Care, [REDACTED], and the California Department of Health Care Access and Information (HCAI) (formerly California Office of Statewide Health Planning and Development (OSHPD)); and
- An analysis of publicly available data and reports regarding Providence, SMMC, and Kaiser health care services and service areas including:
  - Demographic characteristics and trends;
  - Health care quality indicators
  - Hospital utilization rates and trends;
  - Health status indicators; and
  - Other data

Our analysis is based on current conditions in the health care environment and does not consider the potential long term impact of COVID, potential future medical staffing issues or other changes that could affect the delivery of health care or health care markets in California or nationally.

### **2.3 Reasons for the Transaction**

The SMMC Board cites the following rationale for wanting to establish a CiC with Kaiser, including<sup>15</sup>:

- The current campus is not seismic compliant.
- The High Desert Community has significant health needs.
- SMMC is highly dependent on Medicaid and supplemental payments from the government while Kaiser has 80% of commercial memberships.
- The High Desert is a challenging environment for physician recruitment.
- The new location will improve access.

As stated in the copy of the written notice submitted to the OCAG, the key purpose of the proposed transaction is to establish an affiliation between SMMC and KFH (through their respective investments in the LLC) to capitalize the construction of a new seismically compliant, state-of-the-art replacement facility for the Hospital in Victorville, California. Currently SMMC has four buildings that are rated SPC-2, six rated SPC-4, and seven rated SPC-5.<sup>16</sup> A hospital

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<sup>15</sup> Community Ministry Board, St Mary Medical Center, Oct 28, 2020 (35188987 -p 359)

<sup>16</sup> Seismic compliance and safety. HCAI. (2021, March 12). <https://HCAI.ca.gov/construction-finance/seismic-compliance-and-safety/#structural-performance-category-spc-ratings>.

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facility meets the California 2030 requirements for seismic safety if all the buildings on campus are either SPC 3, 4 or 5.<sup>17</sup>

As stated by the parties, the New Hospital facility, built to seismic safety standards, is intended to focus on enhancing patient access, improving quality of care, and meeting the growing needs of patients in the California High Desert community. In support of this goal, the transaction involves SMMC contributing to the LLC substantially all of the assets and operations of the Hospital (the “Hospital Business”) as well as the land in Victorville on which the LLC will develop the new replacement facility.<sup>18</sup>

In 2007, SMMC purchased 98 acres in Victorville, California to build a seismically compliant, state-of-the art replacement facility for the Hospital. The estimated cost to build the replacement facility, which will contain approximately 260 acute care beds, is over \$900 million. The target date for completing the development of the New Hospital is 2026. Given SMMC’s current financial position, SMMC determined that it needed to seek a financial partner to assist with building the New Hospital. SMMC also determined that, without a financial partner to develop the New Hospital facility, SMMC could be faced with the decision to divest the SMMC altogether. Consequently, SMMC stated that finding a financial partner was necessary to secure the New Hospital’s future.<sup>19</sup>

## **2.4 Selection of Kaiser as a Partner**

According to the Notice submitted to the OCAg, in 2019, SMMC began discussing the proposed transaction for a replacement facility with Kaiser Permanente.<sup>20</sup> SMMC determined that Kaiser Permanente would be a strong partner for the Hospital based on a variety of factors, including, without limitation: (1) Kaiser Permanente’s nonprofit status, (2) outstanding reputation for clinical quality and value-based care models, (3) shared goals and vision for caring for the poor and vulnerable members of the community; and (4) dedication to providing high-quality, affordable and innovative health care services to the patients it serves. Additionally, Kaiser Permanente does not operate an acute care hospital in the High Desert region. A new hospital in this area would mean that approximately 100,000 High Desert community Kaiser

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<sup>17</sup> All general acute care hospital buildings are assigned a structural performance category (SPC). SPC ratings range from 1 to 5 with SPC-1 assigned to buildings that may be at risk of collapse during a strong earthquake and SPC 5 assigned to buildings reasonably capable of providing services to the public following a strong earthquake. State law requires all SPC-1 buildings to be removed from providing general acute care services by 2020 and all SPC-2 buildings to be removed from providing general acute care services by 2030. Therefore, a hospital facility that may be comprised of a number of hospital buildings meets the 2020 requirements if there are no SPC 1 buildings on campus. A hospital facility meets the 2030 requirements if all the buildings on campus are either SPC 3, 4 or 5. <https://HCAI.ca.gov/construction-finance/seismic-compliance-and-safety/#structural-performance-category-spc-ratings>

<sup>18</sup> Notice of Affiliate Transaction – St. Mary Medical Center, at p. 4 (April 7, 2021) (on file with OCAg).

<sup>19</sup> Notice of Affiliate Transaction – SMMC, at p 295 (April 7, 2021) (on file with the OCAg).

<sup>20</sup> Notice of Affiliate Transaction – SMMC, at pg. 2 (April 7, 2021) (on file with OCAg).

Permanente members would not have to travel over 40 miles for acute care at a Kaiser hospital, but instead would contribute to the commercial and Medicare patient volume at SMMC.

## 2.5 Data Sources

Our analysis relied on a variety of public and non-public data sources, relying heavily on documents from Kaiser and Providence and data from HCAI. Our objective was to evaluate the impact of the transaction on future use and cost of health care services. We chose to rely primarily on 2019 data for many analyses given that COVID-19 in 2020 disrupted the normal operations of most hospitals and we believe that as vaccination rates increase routine hospital operations will resume. It is important to note that HCAI provides a wealth of data on hospitals and patient utilization in California. For some data sets, the data are based on a calendar year and others a fiscal year. Additionally, the HCAI Patient Discharge data includes utilization data as does the HCAI Annual Financial Disclosure Report and HCAI Annual Utilization Data. Consequently, due to variations in timing in data submission or reporting period, there may be small variations in the metrics reported across data tables and figures reported, however, unless otherwise noted, these small discrepancies do not change the story.

## 3 Profile of Kaiser

### 3.1 Overview of the System

Kaiser Permanente, founded in 1945, is one of the nation's largest not-for-profit health plans, serving 12.5 million members.<sup>21</sup> Kaiser Permanente headquartered in Oakland, California, comprises:

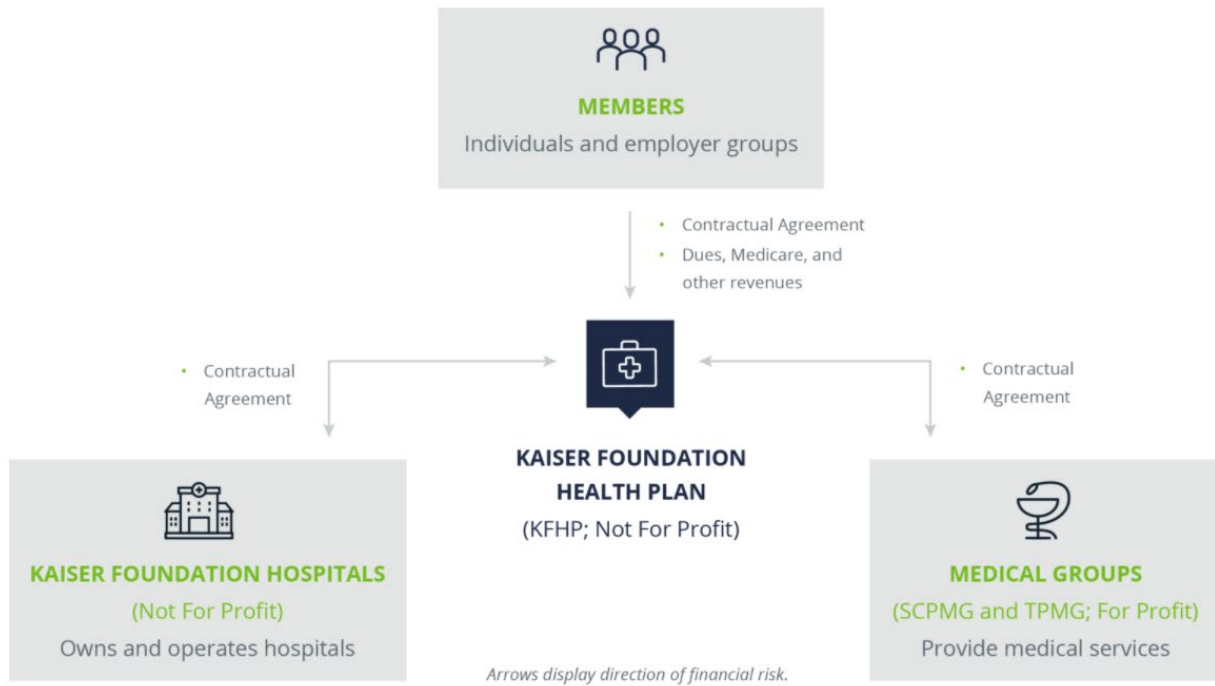
- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals and its subsidiaries
- The Permanente Medical Groups

Exhibit # 1 shows the Kaiser Integrated System organizational structure and financial risk associated with the various components of the system. A core tenet reflected by this graphic is the alignment of financial incentives between multispecialty medical groups, Kaiser Foundation hospital and Kaiser Foundation Health Plan. Since Kaiser receives fixed prepaid premiums for most members, there are incentives to deliver care in the most cost-effective manner: Kaiser is incented to invest in preventative care to reduce high-cost emergency department visits and hospitalizations.

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<sup>21</sup> Kaiser Permanente, Fast Facts (Source: <https://about.kaiserpermanente.org/who-we-are/fast-facts> : Accessed 7/5/2021)

Exhibit 1 Kaiser's Integrated System



(Source: <https://www.brookings.edu/wp-content/uploads/2015/04/050415EmerMedCaseStudyKaiser.pdf>)

Kaiser has 39 hospitals, more than 700 medical offices, more than 20 thousand physicians, and more than 60 thousand nurses along with 216 thousand technical, administrative, and clerical employees and caregivers. Annual operating revenue has increased steadily from \$48 billion in 2011 to \$89 billion in 2020.<sup>22</sup>

Observers of the Kaiser system have cited four notable operation aspects as an integrated healthcare model.<sup>23</sup>

- **Horizontal and Vertical Integration:** There is horizontal integration, between components of the system of the same type, e.g., between Kaiser Hospitals and vertical integration between components not of the same type, e.g., hospitals and insurers. Various components within the Kaiser system are integrated, from the health plan to departments, hospitals, and medical groups. This creates a closed loop system for both outpatient and inpatient care.
- **Prepaid Revenue:** Incentives between the organization and members are aligned with more than 90% of Kaiser's revenue coming through prepaid premiums. With fewer

<sup>22</sup> Kaiser Permanente, Fast Facts (Source: <https://about.kaiserpermanente.org/who-we-are/fast-facts> : Accessed 7/5/2021)

<sup>23</sup> Haslam, Suzanne, Integrated Care: The Kaiser Healthcare Model. Woodruff Sawyer, April 22, 2019  
Ha<https://woodruff Sawyer.com/employee-benefits/integrated-care-kaiser-healthcare-model/>

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concerns of reimbursement, overhead may be lower, and Kaiser can use mobile technologies for payment.

- **Comprehensive Electronic Health Record (EHR):** Patient points of contact have an electronic health record. Kaiser invested in electronic EHR systems over 20 years ago and this accessibility lowers costs by reducing unnecessary testing and improving physician communication.
- **Physician Integration and Leadership:** Kaiser has two associated Permanente Medical Groups in Northern and Southern California. A large percentage of Kaiser Physicians participate in Permanente Medical Group's Leadership Institute in an effort to create healthcare that is driven by health providers rather than exclusively by administrators.

The Northern California, Kaiser headquarters are in Oakland. Operations in the northern California markets include 4.5 million members, 21 hospitals, 262 medical offices, more than 9,500 physicians and more than 80 thousand technical, administrative, and clerical employees and caregivers. The northern markets include:

Northern California

- Central Valley
- Diablo
- East Bay
- Fresno
- Greater San Francisco
- Greater Southern Alameda
- Marin/Sonoma
- Napa/Solano
- Redwood City
- Roseville
- Sacramento
- San Jose
- Santa Clara
- Santa Cruz
- South Sacramento

In Southern California, Kaiser Headquarters are in Pasadena. In the southern CA there are 4.7 million members, 15 hospitals, 235 medical offices, more than 7,800 physicians and more than 75 thousand technical, administrative, and clerical employees and caregivers. The southern markets include:

Southern California

- Coachella Valley

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- Kern County
- Inland Empire
- Metro Los Angeles/West Los Angeles
- Orange County
- San Diego County
- Tri-Central Area
- West Ventura/Valleys

The closest Kaiser hospitals to SMMC are<sup>24</sup>:

- Kaiser – Fontana/Ontario, California in San Bernardino, California, two nearby Kaiser sites with a combination of about 626 licensed beds and an approximate drive of an hour south of Apple Valley depending on traffic and conditions. (Kaiser Ontario and Kaiser Fontana are close to each other and report their patient discharge data in a consolidated format to HCAI.)
- Kaiser - Moreno, California located in Riverside California, a hospital of about 94 licensed beds and a drive of about an hour and fifteen minutes south of Apple Valley,
- Kaiser - Baldwin Park, California, located in the central San Gabriel Valley region of Los Angeles County, a hospital of about 257 licensed beds and a drive of about an hour and fifteen minutes southwest of Apple Valley,
- Kaiser – Riverside, California located in Riverside, California a hospital of about 226 licensed beds a drive of about an hour and twenty minutes south of Apple Valley.

### 3.2 Programs and Services

Kaiser as a fully integrated system offers a comprehensive range of health care services including pediatric services, services for stroke care through their stroke center, primary care, specialty care, tertiary care including a cancer program and bone marrow transplants, maternity and women’s health, prevention and wellness and more.<sup>25</sup> The Los Angeles Medical Center has 23 tertiary care services and 40 Centers of Excellence, i.e. medical facilities where physician specialists apply technology and research, create medical teams and techniques to optimize health outcomes.<sup>26</sup> Some examples of these Centers of Excellence, include a Center

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<sup>24</sup> Distances based on Google maps drive times. (Source: <https://www.google.com/maps/dir>). Licensed beds are based on HCAI 2019 Hospital Annual Financial Disclosure reports. The four Kaiser hospitals are classified as “General” or general acute care hospitals.

<sup>25</sup> Los Angeles health Care services: Kaiser Permanente. Los Angeles. (n.d.). <https://thrive.kaiserpermanente.org/care-near-you/southern-california/los-angeles/health-care-services/>.

<sup>26</sup> Centers of EXCELLENCE: Los Angeles: Kaiser Permanente. Los Angeles. (n.d.). <https://thrive.kaiserpermanente.org/care-near-you/southern-california/los-angeles/health-care-services/tertiary-care-centers-of-excellence/>.

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that specializes in transgender and nonbinary care, chronic pain management, cardiac care, and neurosurgery.<sup>27</sup>

In December 2020, Kaiser opened a new facility in Hesperia, about 20 min southeast of SMMC. It is touted as a state-of-the-art three-story, 54,000 square foot building with 30 provider offices and an array of services designed for Kaiser Permanente members in the High Desert area. It is located just a few miles away from the Kaiser Permanente Victorville Medical Offices and will expand primary care services available to Kaiser Permanente members in the High Desert. Medical services offered at the new Hesperia Medical Office Building include Family Medicine, Internal Medicine, Pediatrics, Obstetrics, Cardiology, Orthopedics and Podiatry, General Surgery and Physical Therapy. Additional onsite services at the Hesperia Medical Office Building include a Nurse Clinic, Pharmacy, Lab, Diagnostic Imaging, Optometry and Optical Dispensing, and a Conference Center.<sup>28</sup>

The San Bernardino County Service Area includes the Kaiser Foundation Hospitals in Fontana and Ontario, and medical offices in Fontana, Ontario, Rancho Cucamonga, Colton, Claremont, Montclair, Chino, San Bernardino, Hesperia, Victorville, Redlands and Upland.<sup>29</sup>

Kaiser Fontana is a GAC with 450 licensed beds located in Fontana California, about an hour drive south of SMMC. It offers emergency services and urgent care services. Kaiser Fontana is by far the largest hospital of the four. It is one of 13 statewide that is a “level one” trauma center. They have a broad array of programs and services that include behavioral health, cardiology, OB/GYN and more.<sup>30</sup> About <sup>31</sup>one-fifth of discharges are related to labor and delivery. The facility states that the plans accepted include<sup>32</sup>: Exclusive Provider Organization (EPO) HMO, Medi-Cal Managed Care, Point-of-Service (POS) and Senior Advantage. Kaiser Ontario, a 146 bed GAC hospital is located about 20 min southwest of Kaiser Fontana.<sup>33</sup>

### 3.3 Key Statistics

The four Kaiser hospitals in the Inland Empire that are within an approximately hour or less drive time from SMMC, depending on traffic, include: Kaiser Fontana, Kaiser Ontario, Kaiser Riverside and Kaiser Moreno. Selected key statistics for these four facilities are below in Exhibit

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<sup>27</sup> Kaiser Permanente, Los Angeles, 2021 (<https://thrive.kaiserpermanente.org/care-near-you/southern-california/los-angeles/health-care-services/tertiary-care-centers-of-excellence/>)

<sup>28</sup> Kaiser Permanente opens new Hesperia Medical Office Building, December 8, 2020, Kaiser Permanente press release.

<sup>29</sup> Kaiser Permanente opens new Hesperia Medical Office Building, December 8, 2020, Kaiser Permanente press release.

<sup>30</sup> Fontana medical Center. Fontana Medical Center | Kaiser Permanente. (n.d.). <https://healthy.kaiserpermanente.org/southern-california/facilities/Fontana-Medical-Center-100127>.

<sup>31</sup> HCAI 2018 Hospital Utilization Data pivot profile.

<sup>32</sup> Fontana medical Center. Fontana Medical Center | Kaiser Permanente. (n.d.). <https://healthy.kaiserpermanente.org/southern-california/facilities/Fontana-Medical-Center-100127>.

<sup>33</sup> Kaiser Fontana and Kaiser Ontario hospitals are consolidated for purposes of reporting to HCAI with Kaiser Fontana being the parent facility.



# 2 Inland Empire Kaiser Hospitals). The largest and closest hospital is Kaiser Fontana, about an hour drive south of SMMC. All four facilities have a basic emergency room services, a level of emergency medical care in a hospital where an emergency medical services (EMS) physician is on staff 24 hours a day, year-around. (See Title 22, Division 5, Sections 70413-70419, California Code of Regulations, for details.) Most emergency departments are licensed at this level.

Exhibit 2 Inland Empire Kaiser Hospitals, 2019

HOSPITAL DETAILS	KAISER FONTANA	KAISER MORENO VALLEY	KAISER RIVERSIDE	KAISER ONTARIO
HCAI ID	106361223	106334048	106334025	106364265
Licensed Beds	450	94	226	176
Patient Days	85,413	13,848	41,890	40,687
Discharges	19,628	4,399	10,005	10,983
ALOS	4.4	3.1	4.1	3.7
Occupancy (%)	52	40	59	63
Live Births	4,249	1,418	3,279	2,888
ED Level	Basic	Basic	Basic	Basic
Approximate average drive time from SMMC*	55 min	1 hour 12 min	1 hours 3 min	55 min

Source: 2019 HCAI Annual Utilization report  
 \* Totals are for general acute care  
 \*\* Drive time based on Google Maps, 7/15/2021

### 3.4 Quality Indicators and Performance Ratings

Kaiser generally performs well on various quality and performance ratings. There are several rating systems to assess health insurance plan quality based on member experience, medical care, and health plan administration to provide consumers with an objective way to compare plans and select the option that may work best for them. Below we look at several of the more widely respected and used plan ratings. These ratings paint a generally positive view of Kaiser as a system that offers quality medical care and Kaiser’s members tend to be satisfied with the care they receive.

The California Office of the Patient Advocate produces a Report Card that shows the quality of health care for millions of Californians who get their care through Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). The 10 largest HMOs and 6 largest PPOs in the state are included in this Report Card. Kaiser Permanente HMO Southern California received an “excellent”, i.e., five out five stars, on medical care and a “very good”,

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i.e., four out of five stars, on patients' rating of their overall experience.<sup>34</sup> It was only one of two plans out of 16 listed with a total of 9 stars.<sup>35</sup>

In 2019, more than 1000 health plans were rated by the National Committee for Quality Assurance (NCQA), an independent, widely recognized 501 nonprofit organization in the United States dedicated to quality improvement through evidence based research.

Kaiser, Southern California received a rating of 4.5 for private members (in contrast to Medicare or Medicaid members) on a scale of one to five where five is the highest performance.<sup>36</sup> The overall rating is the weighted average of all measures. (There were no health plan ratings in 2020.) On the three NCQA composite measures they received a 2.5 for consumer satisfaction, 5.0 for prevention and 4.5 for treatment.

For Medicare they received an overall rating of 5.0 for on a scale of one to five where five is the highest performance. The overall rating is the weighted average of all measures. (There were no health plan ratings in 2020.) On the three NCQA composite measures they received a 3.5 for consumer satisfaction, 5.0 for prevention and 4.5 for treatment. There was no Medi-Cal rating.

Leapfrog Hospital Safety Grades, a widely recognized assessment of patient safety, are assigned to over 2,700 general acute-care hospitals across the nation twice annually.<sup>37</sup> The Leapfrog Hospital Safety Grade uses up to 27 national performance measures from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey and information from other supplemental data sources. In aggregate, the performance measures produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors.

Among the 36 hospitals in California rated by Leapfrog 28 received a rating of A with 7 receiving a B and one a C (Exhibit #3 Leapfrog Safety Ratings, 2019- 2020). The Kaiser hospitals closest to SMMC received three "A's" and a B.

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<sup>34</sup> State of California, Office of the Patient Advocate, Reports Cards, HMO and PPO Quality Ratings Summary 2020-2021 Edition, [https://reportcard.opa.ca.gov/rc/HMO\\_PPOCombined.aspx](https://reportcard.opa.ca.gov/rc/HMO_PPOCombined.aspx) Accessed 8/18/2021

<sup>35</sup> State of California, Office of the Patient Advocate. HMO and PPO Quality Ratings Summary 2020-21 Edition. (Source: [https://reportcard.opa.ca.gov/rc/HMO\\_PPOCombined.aspx](https://reportcard.opa.ca.gov/rc/HMO_PPOCombined.aspx) : Accessed 7/12/2021)

<sup>36</sup> NCQA Health Insurance Plan Ratings 2019-2020 Summary Report (Source: <https://healthinsuranceratings.ncqa.org/2019/search/Medicare/CA/kaiser%20foundation> : Accessed 7/7/2021)

<sup>37</sup> Leapfrog Hospital Safety Guide. (Source: <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/about-the-grade> : Accessed 7/7/2021)

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Exhibit 3 Leapfrog Safety Ratings, 2019-2020

Kaiser Hospitals	# of Hospitals	Grade A	Grade B	Grade C
<b>ALL CALIFORNIA KAISER HOSPITALS</b>	36	28	7	1
<b>Four Kaiser Hospitals Closest to SMMC</b>				
<b>KAISER FONTANA</b>	1	1		
<b>KAISER MORENO VALLEY</b>	1			
<b>KAISER RIVERSIDE</b>	1		1	
<b>KAISER ONTARIO</b>	1	1		

Source: Leapfrog Safety Ratings, 2019-20

Hospital Compare is a consumer-oriented federal website operated by the Centers for Medicare and Medicaid and provides information on how well hospitals provide recommended care to their patients.<sup>38</sup> Kaiser, Fontana, the Kaiser hospital most commonly used in SMMC market area, performed well with four out of five stars on both the overall rating and patient survey rating (Exhibit # 4 Leapfrog Comparisons Ratings, 2019-2020).

Exhibit 4 Leapfrog Comparisons Ratings, 2019-2020

Four Kaiser Hospitals Closest to SMMC	Overall Star Rating	Patient Survey Rating
<b>KAISER FONTANA</b>	4 of 5	4 of 5
<b>KAISER MORENO VALLEY</b>	3 of 5	3 of 5
<b>KAISER RIVERSIDE</b>	3 of 5	3 of 5
<b>KAISER ONTARIO</b>	3 of 5	3 of 5

Source: Leapfrog Comparison Ratings, 2019-20

### 3.5 Payer Mix

Since Kaiser is an integrated health plan most of the Kaiser’s members who are not covered by federal programs are covered by the Kaiser Health insurance plan, a type of commercial insurance. However, federal programs, namely Medicare and Medi-Cal, cover many Kaiser’s members. The four Kaiser hospitals in the Inland Empire areas have about 11 in a 100 of their inpatient discharges covered by Medi-Cal and about 33 of 100 covered by Medicare.<sup>39</sup> Most of

<sup>38</sup> Medicare.gov, Hospital Compare Ratings, Updated 7/21/2021 (<https://www.medicare.gov/care-compare/details/hospital/050300?id=c6b582a9-3a80-45c7-aeec-364ebe17c9b5&state=CA>, Accessed 8/10/2021)

<sup>39</sup> HCAI 2019 Patient Discharge Data (Excludes normal newborns.)

these patients are covered under either Medi-Cal or Medicare (Medicare Advantage) managed care plans in contrast to traditional fee-for-service reimbursement.

## 4 Profile of Providence

### 4.1 Overview of the System

Providence St. Joseph Health (Providence) is a not-for-profit Catholic health system across seven Western states – Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington (Exhibit 5 Map of Providence System Locations). The system is comprised of acute and ambulatory care for inpatient and outpatient services including 51 hospitals, and nearly 1,000 clinics. There are also 29 long-term care facilities, 16 supportive housing facilities, over 8,000 directly employed providers, and more than 25,000 affiliated providers, a health plan, senior care, financial assistance programs, community health investments, and educational ministries that include a high school and university.

Providence serves as the parent and corporate member of Providence Health and Services (PH&S) and St. Joseph Health System (SJHS) and was created in connection with the combination of the multi-state health care systems of PH&S and the SJHS, which was effective on July 1, 2016. Providence is exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code. Prior to the combination, the sole corporate member of PH&S was Providence Ministries, which acted through its sponsors, who are five individuals appointed by the Provincial Superior of the Sisters of Providence, Mother Joseph Providence. Like PH&S the only corporate member of SJHS was St. Joseph Health Ministry, a California non-profit public benefit corporation. Providence Ministries and St. Joseph Health Ministry are each a public juridic person under Canon law, responsible for assuring the Catholic identity and fidelity to the Mission of their respective systems.<sup>40</sup> This is relevant for discussions later in this report related to the United States Council of Catholic Bishops' (USCCB) "Ethical and Religious Directives for Health Care Services," or ERDs.

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<sup>40</sup> 'Public Juridic Person (PJP) is the term the Church uses for an entity established by canon (Church) law to perform a specific function. The most common PJPs are dioceses, parishes and Religious Institutes (e.g., Religious Orders).

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Exhibit 5 Map of Providence System Locations



In the Northern California region, the system serves the North Coast, Humboldt, Napa, and Sonoma communities with five hospitals, ambulatory surgery centers, urgent care centers, wellness centers, physician offices, home health, hospice, and rehabilitation sites. The acute care hospitals, in Northern California, had 37% of the inpatient market share in their service areas in 2019, as reported by HCAI. St. Joseph Heritage Healthcare (now Providence Medical Foundation) operates clinics in the region with its contracted physician partners.

The Southern California region includes 13 acute care hospitals in Los Angeles, Orange, and San Bernardino Counties, and the High Desert, with a total inpatient market share of 24% in their service areas in 2019, as reported by HCAI. Providence Medical Foundation operates over 50 practice locations in the market, including the Facey, PMI, and Providence St. John's medical foundations. In addition, the System includes seven acute care facilities within Orange and San Bernardino counties: Apple Valley, Fullerton, Mission Viejo, Laguna Beach, Newport Beach, Irvine, and Orange. Mission Hospital is located on two campuses in Mission Viejo and Laguna Beach, and maintains the region's level II trauma center, as well as a women's center. Hoag Hospital, which also is composed of two campuses, in Newport Beach and Irvine, also includes Hoag Orthopedic Institute. St. Joseph Heritage Healthcare, a medical foundation, operates clinics in the region with its contracted physician partners.

Providence's finances appear to be relatively strong. In the spring of 2020 Providence received more than \$500 million in government funds, one of many wealthy beneficiaries of a federal

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program that is supposed to prevent health care providers from capsizing during the coronavirus pandemic.<sup>41</sup> The hospital network has nearly \$12 billion in cash reserves. It has invested that money in hedge funds, private equity firms and real estate ventures.<sup>42</sup>

Additionally, it oversees two venture capital funds that manage about \$300 million on behalf of the health care chain. The venture funds do deals alongside some of the country's highest-profile investment firms, including Kleiner Perkins and Carlyle.<sup>43</sup> Last year, Providence's portfolio of investments generated about \$1.3 billion in profits, far exceeding the profits from its hospital operations.<sup>44</sup>

Providence also has a number of affiliates including<sup>45</sup>:

- Covenant Health in West Texas
- Facey Medical Foundation in Los Angeles, California
- Hoag Memorial Hospital Presbyterian in Orange County, California
- Kadlec in Southeast Washington
- Pacific Medical Centers in Seattle, Washington
- Swedish Health Services in Seattle, Washington

## 4.2 Programs and Services

The Providence health system reports offering a comprehensive range of health and social services, including inpatient and outpatient care, through its 52 hospitals and 1085 clinics. and numerous other health sites and health promotion programs primarily on the west coast, Alaska, Washington, Oregon, and California, but also in Montana, New Mexico, and Texas.<sup>46</sup>

Providence reports 25,000 physicians and 36,000 nurses along with 120,000 caregivers who offer expertise in family medicine, internal medicine, pediatrics, obstetrics/gynecology, dermatology and other specialties.<sup>47</sup> They provide transitional care, home and hospice

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<sup>41</sup> Drucker, J., Silver-greenberg, J., & Kliff, S. (2020, May 25). Wealthiest hospitals got billions in bailout for Struggling health providers. The New York Times. <https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html>.

<sup>42</sup> Drucker, J., Silver-greenberg, J., & Kliff, S. (2020, May 25). Wealthiest hospitals got billions in bailout for Struggling health providers. The New York Times. <https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html>.

<sup>43</sup> Drucker, J., Silver-greenberg, J., & Kliff, S. (2020, May 25). Wealthiest hospitals got billions in bailout for Struggling health providers. The New York Times. <https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html>.

<sup>44</sup> Drucker, J., Silver-greenberg, J., & Kliff, S. (2020, May 25). Wealthiest hospitals got billions in bailout for Struggling health providers. The New York Times. <https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html>.

<sup>45</sup> Providence Website <https://www.providence.org/about> Accessed 8/20/2021

<sup>46</sup> Providence Website <https://www.providence.org/about> Accessed 8/20/2021

<sup>47</sup> Providence Website <https://www.providence.org/about> Accessed 8/20/2021

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care, substance abuse programs, mental health treatment, prevention and wellness programs, long-term care, and assisted living and housing.

In addition to the standard array of medical care services, Providence engages in partnerships and initiatives in various areas of the country to increase access to a variety of programs and services that address a range of issues including mental health, substance abuse, health access, and more. A few of these cited on Providence's website include<sup>48</sup>:

- **Focusing on Youth Mental Health:** Providence St. Patrick Hospital in Missoula, Mont. doubled capacity for youth inpatient mental health treatment and resources in 2020.
- **Work2BeWell:** The Work2BeWell program empowers students to become advocates for mental health among school peers and their communities.
- **Covenant Health Community Counseling Center:** This community-based counseling center provides individual, couple and family counseling to low-income individuals and families in Lubbock, Texas.
- **Perinatal Substance Use Disorders:** In California's Humboldt County, Humboldt RISE (Resilience and Inclusion through Support and Empowerment) diagnoses and treats pregnant women suffering from substance use disorders, while offering tools for support and recovery.
- **Public Benefit and Assistance Programs:** The Providence Community Health Insurance Program connects community members with a team of bilingual community health workers who advise and support them in enrolling in public health programs.
- **Providing Care at Shelters:** Everett Gospel Mission and Providence Regional Medical Center in Everett, Wash. partner to ensure sick or injured men staying at the shelter receive safe and quality respite care. Read how this partnership adapted in 2020.
- **Arena Box Office turned Clinic:** In 2020, Providence Health & Services Alaska diverted staff, resources and equipment to create a temporary clinic in Anchorage's Sullivan Arena. Discover how caregivers used a box office to help vulnerable community members receive needed care.
- **Reducing medication costs:** Providence is a founding member of Civica Rx. Civica was created to reduce and prevent drug shortages and help stabilize the cost of medications. Its mission is to make quality generic medicines accessible and affordable to everyone. Providence advocates to improve access to generic medication and lower drug costs to serve our Mission of caring for all, especially the poor and vulnerable.

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<sup>48</sup> Providence Website <https://www.providence.org/about/annual-report/removing-barriers-to-care#tabcontent-10-pane-3> Accessed 8/20/2021

### 4.3 Key Statistics

Key statistics for the Providence Health & Services-Southern California hospitals include the following:

- The Southern California region includes 13 acute care hospitals in Los Angeles, Orange and San Bernardino counties, and the High Desert, with a total inpatient market share of 25% in their service areas in 2018, as reported by the Office of Statewide Health Planning and Development.<sup>49</sup>
- In Los Angeles County, the System includes six acute care facilities. The largest hospital, Providence St. Joseph Medical Center, is in Burbank. The System also includes hospitals in Mission Hills, San Pedro, Tarzana, Torrance and Santa Monica.<sup>50</sup>
- Providence Medical Foundation (“PMF”) operates over 50 practice locations in the market, offering more than 20 types of specialty care. PMF includes the Facey, PMI and Providence St. John’s medical foundations.<sup>51</sup>
- The System includes seven acute care facilities within Orange and San Bernardino counties: Apple Valley, Fullerton, Mission Viejo, Laguna Beach, Newport Beach, Irvine and Orange. Mission Hospital is located on two campuses in Mission Viejo and Laguna Beach, and maintains the region’s level II trauma center, as well as a women’s center. Hoag Hospital, which also is composed of two campuses, in Newport Beach and Irvine, also includes Hoag Orthopedic Institute.
- St. Joseph Heritage Healthcare, a medical foundation, operates clinics in the region with its contracted physician partners.
- The Southern California ministries, including secular affiliates and some representing other faiths, have approximately 31,000 employees – called caregivers – and nearly 5,200 physicians on staff.<sup>52</sup>
- Providence Southern California is part of Providence, formerly Providence St. Joseph Health, a health system of 111,000 caregivers serving in 52 hospitals, 829 clinics and a comprehensive range of services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington.<sup>53</sup>
- The key financial indicators for Providence (not exclusively Southern California) show a general improvement in profitability between 2018 and 2019 (Exhibit # 6 Providence Systems Operation Summary). The company cites higher patient volumes, higher acuity, and higher labor productivity and rates, in addition to improved medical supply

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<sup>49</sup> Notice of Affiliate Transaction – SMMC, at pg. 986 (April 7, 2021) (on file with OCAG).

<sup>50</sup> Notice of Affiliate Transaction – SMMC, at pg. 986 (April 7, 2021) (on file with OCAG).

<sup>51</sup> Notice of Affiliate Transaction – SMMC, at pg. 986 (April 7, 2021) (on file with OCAG).

<sup>52</sup> Notice of Affiliate Transaction – SMMC, at pg. 964 (April 7, 2021) (on file with OCAG).

<sup>53</sup> Notice of Affiliate Transaction – SMMC, at pg. 964 (April 7, 2021) (on file with OCAG).



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management due to key modernization initiatives as factors driving the improved financial performance.

Exhibit 6 Providence Systems Operation Summary, 2018-2019

Operations Summary (\$ Presented in Millions)	As Reported		Pro forma*	
	12/31/2018	12/31/2019	12/31/2018	12/31/2019
Operating Income	\$3	\$214	\$165	\$373
Operating Margin %	0.0	0.9	0.7	1.5
Operating EBIDA	1,363	1,559	1,525	1,718
Net Service Revenue/Case Mix Adjusted Admits	12,066	12,099	12,066	12,099
Total Community Benefits	\$1,595	\$1,515	-	-

Source: Notice of Affiliate Transaction – SMMC, at p.989 (April 7, 2021) (on file with California Attorney General).  
\* Pro forma normalizes for restructuring costs in 2019 and 2018

#### 4.4 Quality Indicators and Performance Ratings

As a system, Providence has shown distinction based on several measures of quality and performance including:

- Ten Providence Southern California hospitals and affiliated partners in Los Angeles and Orange counties earned recognition in July 2020 from U.S. News & World Report, honors that included national and state rankings as top hospitals. With approximately 415 acute care hospitals in California, the 10 hospitals were rated among California’s 45 best and named as Best Regional Hospitals.<sup>54</sup>
- In March 2021, Newsweek listed the World’s Best Hospitals for 2021, Among the more than 330 U.S. hospitals recognized, Providence Mission, in Mission Viejo and Laguna Beach, was No. 1 in Orange County and Providence St. Jude, Fullerton, No. 4. Providence affiliate Hoag, Newport Beach was ranked No. 2.<sup>55</sup>
- CMS updated its Overall Hospital Quality Star Ratings for 2021, giving 455 hospitals a rating of five stars. CMS assigned star ratings to hospitals nationwide based on their

<sup>54</sup> Providence Website <https://www.providence.org/news/uf/626795843> Accessed 8/20/2021

<sup>55</sup> Providence Website <https://www.providenceoc.org/news/two-providence-oc-hospitals-among-newsweeks-best-in-world-list> Accessed 8/20/2021

performance across five quality categories. Several Providence hospitals had five stars including Providence St. Jude Medical Center (Fullerton).<sup>56</sup>

## 4.5 Payer Mix

Overall, the Providence System relies on commercial payers for about half its operating revenue (Exhibit # 7 Providence Operating Revenues by Payer). Medicare is about 32% and Medi-Cal 13% with other smaller payers comprising about 2% of revenue. However, it is important to remember that this distribution varies by site of care, e.g., hospital, clinics, etc. and locations of these sites.

Exhibit 7 Providence Operating Revenues by Payer, 2019-2020

Operating Revenues By Payor* (\$ Presented in Millions)	Fiscal Year Ended	
	12/31/2019	12/31/2020
Commercial	\$11,918	\$11,331
Medicare	8,017	8,021
Medicaid	3,441	3,517
Self-pay and Other	397	251
Total Revenues from Contracts with Customers	23,773	23,120
Other Revenues**	1,252	2,555
Total Operating Revenues	\$25,025	\$25,675

Source: Notice of Affiliate Transaction – St. Mary Medical Center, at p.989 (April 7, 2021) (on file with California Attorney General).  
\* Represents total payor net patient service revenues received, including premium and capitation revenues in accordance with ASC 606, Revenue from Contracts with Customers.  
\*\* Includes \$957 million in grants recognized in revenue from the federal CARES Act in 2020

## 5 Inland Empire Area Overview

### 5.1 Demographic Summary

SMCC Medical Center (SMCC) is located in the Inland Empire, a two-county region in southern California, with more than 4.5 million people located primarily in southwestern San Bernardino County and northwestern Riverside County bordering Los Angeles and Orange Counties west of Arizona and east of Nevada. The area tends to be poorer and less well educated than California on average.<sup>57</sup> Some of the lowest levels of hospital market concentration in California are in the

<sup>56</sup> Bean, Mackenzie and Masson, Gabrielle, 455 Hospitals with 5 Stars from CMS:20201, Becker's Hospital Review, April 30, 2021 <https://www.beckershospitalreview.com/rankings-and-ratings/455-hospitals-with-5-stars-from-cms-2021.html> Accessed 8/20/2021

<sup>57</sup> Inland Actions Website, January 2021 (<https://www.inlandaction.com/the-inland-empire/> Accessed 8/15/2021)

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Inland Empire, although county-wide measures can mask the extent of hospital concentration, as some hospitals are dominant in their local submarkets.<sup>58</sup>

Overall, health insurance coverage in the broader region is dominated by two players: Inland Empire Health Plans (IEHPs), which cover about one-fourth of the region's population through the Medi-Cal program, and Kaiser Permanente, which cover an additional quarter of the population, primarily in the commercial and Medicare markets.<sup>9</sup> Most coverage for Medi-Cal enrollees is provided under the Two-Plan Model, with care provided by one public plan and one private plan. IEHP, the public plan created by Riverside and San Bernardino Counties, covers 89% of managed care enrollees (about 1.3 million people); Molina Healthcare, the private plan, covers the remaining 11% of enrollees.<sup>59</sup> Expanded Medi-Cal eligibility has resulted in increased enrollment in both plans. Most Inland Empire Medicare beneficiaries are enrolled in generally lower-cost Medicare Advantage (MA) plans. Statewide, MA accounts for 44% of Medicare beneficiaries, while nearly 59% of Inland Empire beneficiaries opt for MA. Kaiser covers 31% of MA enrollees, with United Healthcare (19%), and SCAN Health Plan (12%) also accounting for a significant market share.<sup>60</sup> Kaiser health plan plays a large role in the region, effectively competing for patients and new providers in the two counties.

The Inland Empire is largely Hispanic, with recent gains in measures of economic and educational progress, based on results from the 2019 American Community Survey (ACS) Data.<sup>61,62</sup> In 2019, Hispanics comprised the largest portion of the Inland Empire's population. Specifically, Hispanics comprised 50% of Riverside County's population, and 54.4% of San Bernardino County's population. The respective shares of Whites were 33.9% and 27.1%, followed by Asians at 7% and 7.5%, while Blacks were 6.1% and 7.7%. The large Hispanic population is ranked fifth nationally, after Houston and is higher than Chicago.

ACS survey results show, in 2010, the share of San Bernardino County's households living in poverty was 18%; by 2019 this had fallen to just 13.3%. In Riverside County, the share fell from 16.3% in 2010 to 11.3% in 2019. By comparison, about 12% of Californians lived below the poverty line in 2019. The downward trend in poverty among Inland Empire residents was due, in part to the rapid growth of the economy which added 390,400 jobs in the region from 2010-2019, up 33.5%. While limited education, (e.g., as indicated by the share of the adult population who stopped their educations at high school or less), restricted work opportunities, the share of

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<sup>58</sup> Inland Empire, Increasing Medi-Cal Coverage Spurs Safety Net Growth, CA Health Care Almanac, Ca Health Care Foundation (CHCF), December 2020

<sup>59</sup> Inland Empire, Increasing Medi-Cal Coverage Spurs Safety Net Growth, CA Health Care Almanac, Ca Health Care Foundation (CHCF), December 2020

<sup>60</sup> Inland Empire, Increasing Medi-Cal Coverage Spurs Safety Net Growth, CA Health Care Almanac, Ca Health Care Foundation (CHCF), December 2020

<sup>61</sup> At the time this report was being drafted, this was the most recent ACS data available. New data were scheduled to be released mid October 2021.

<sup>62</sup> United State Census Bureau, American Community Survey 2019 <https://www.census.gov/programs-surveys/acs> Accessed 8/10/201

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adults with associate or more advanced degrees in this area rose from 27.1% in 2010 to 31.2% in 2019.

This increase in education correlated with increases in median incomes. In 2010, the median household income in the Inland Empire was \$53,548. In 2019, it was up to \$70,757, a 32.1% increase. Inflation from 2010-2019 was 17.2% suggesting that the gains were not tied to inflation only but the actual purchasing power of an average household in 2019 was about 15% higher than in 2010.

## 5.2 Market Challenges

A recent analysis of the Inland Empire market identified three primary health challenges for the region.<sup>63</sup>

- IT and Data Sharing
- Behavioral Health
- Clinician Shortages

We discuss each one below.

- **IT and Data Sharing:** As in other regions across the state, providers in the Inland Empire struggle to integrate EHR systems, leading to a fragmented care-delivery system that challenges efforts at coordinating. According to one recent analysis, this obstacle is even greater in the High Desert, where the IPAs and medical groups in operation are smaller, and where clinicians are more likely to operate as sole practitioners.<sup>64</sup>
- **Behavioral Health:** Behavioral health care, including both mental health and substance use disorder services, were cited as a very important issue throughout the region. In 2018, more Inland Empire residents reported experiencing frequent mental distress compared with Californians generally, and more Inland Empire residents needed but did not receive mental health treatment.<sup>65</sup> These behavioral health challenges are further highlighted by the fact that the Inland Empire is home to only eight psychiatrists per 100,000 residents, the second-lowest ratio across a seven study market analysis by the California Health Care Foundation.<sup>66</sup>
- **Clinician Shortages:** Access to care has been hampered as the region struggles to recruit primary care clinicians and specialists, as well as other health care professionals, consistent with reports of physician shortages across the state. Among all the California

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<sup>63</sup> Inland Empire, Increasing Medi-Cal Coverage Spurs Safety Net Growth, CA Health Care Almanac, Ca Health Care Foundation (CHCF), December 2020

<sup>64</sup> Inland Empire, Increasing Medi-Cal Coverage Spurs Safety Net Growth, CA Health Care Almanac, Ca Health Care Foundation (CHCF), December 2020

<sup>65</sup> 2018 data from AskCHIS, UCLA Center for Health Policy Research

<sup>66</sup> Inland Empire, Increasing Medi-Cal Coverage Spurs Safety Net Growth, CA Health Care Almanac, Ca Health Care Foundation (CHCF), December 2020

regions, the Inland Empire had the lowest numbers of primary care and specialty physicians per 100,000 residents.<sup>67</sup>

The federal government’s Council on Graduate Medical Education recommends 60 to 80 primary care doctors per 100,000 residents. In the Inland Empire, this ratio has fallen to 35 per 100,000, lower than the statewide average of 50 per 100,000 residents, according to a 2019 report from the Future Health Workforce Commission.<sup>68</sup> Another study has the number of primary care physicians per 100,000 residents slightly higher but supports the finding that the Inland Empire’s ratio is much lower than the statewide ratio (Exhibit # 8 Physician: Inland Empire vs. California & Recommendations).<sup>69</sup>

*Exhibit 8 Physicians: Inland Empire vs. California & Recommendations, 2020*

	Inland Empire	California	Recommended Supply*
<b>Physicians per 100,000 population†</b>	<b>125</b>	<b>191</b>	-
Primary care	42	60	60-80
Specialists	83	131	85-105
† Psychiatrists (subset of Specialists)	8	12	-
<b>% of population in HPSA (2018)</b>	<b>29.6%</b>	<b>28.4%</b>	-

\* The Council on Graduate Medical Education (COGME), part of the US Department of Health and Human Services, studies physician workforce trends and needs. COGME ratios include doctors of osteopathic medicine (DOs) and are shown as ranges above.

† Physicians with active California licenses who practice in California and provide 20 or more hours of patient care per week. Psychiatrists are a subset of specialists.

Sources: Healthforce Center at UCSF analysis of Survey of Licensees (private tabulation), Medical Board of California, January 2020; and Health Professional Shortage Area (HPSA) data from *Shortchanged: Health Workforce Gaps in California*, California Health Care Foundation, July 15, 2020.

While there may be many factors that contribute to recruitment difficulties competition with more geographically attractive neighboring regions, such as Los Angeles, Orange, and San Diego Counties with their greater access to the beach, cultural amenities, and educational and employment opportunities, explains some of the difficulty. The Inland Empire’s sprawling

<sup>67</sup> California Physician Supply and Distribution Headed for a Drought? , California Health Care Foundation, June 2018

<sup>68</sup> Aguilera, Elizabeth, Paging more doctors: California’s worsening physician shortage, CalMatters, Updates February 13, 2020 (Source: <https://calmatters.org/projects/californias-worsening-physician-shortage-doctors/> : Accessed 7/12/2021)

<sup>69</sup> The Council on Graduate Medical Education (COGME), part of the US Department of Health and Human Services, studies physician workforce trends and needs. COGME ratios include Doctor of Osteopathic Medicine (DOs) and are shown as ranges above.† Physicians with active California licenses who practice in California and provide 20 or more hours of patient care per week. Psychiatrists are a subset of specialists. Sources: Healthforce Center at UCSF analysis of Survey of Licensees (private tabulation), Medical Board of California, January 2020; and Health Professional Shortage Area (HPSA) data from *Shortchanged: Health Workforce Gaps in California*, California Health Care Foundation, July 15, 2020.

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geography may also exacerbate the access challenges caused by lower numbers of clinicians and may explain longer patient travel times for care, especially specialist visits.<sup>70</sup>

Some of the access issues may be mitigated in the future with several new medical schools opening in or close to the region that may help to expand the Inland Empire physician pipeline (e.g., University of California, Riverside (UCR) School of Medicine and Kaiser Permanente Bernard J. Tyson School of Medicine).

## 6 General Profile of SMMC

### 6.1 Overview of the Hospital

Providence SMMC was founded in 1956 and is located at 18300 Highway 18 in Apple Valley, California. The facility has 212 licensed beds and a campus approximately 32 acres in size. In 2016 St. Joseph Health, which owned SMMC, merged with Providence Health, a nonprofit health system based in Renton, Washington, to create Providence Saint Joseph Health (Providence). SMMC currently has a staff of more than 1,700 caregivers with more than 300 local physicians.<sup>71</sup>

SMMC is currently contracted with all major insurance plans in the market and is seen as the provider of choice in the High Desert area.<sup>72</sup> Without SMMC as a contracted provider, insurance plans would have a difficult time selling their product since members prefer the hospital to other area alternatives.<sup>73</sup>

Major programs and services include: a 24-hour emergency room, comprehensive cardiac and stroke services, outpatient surgery pavilion, pediatric care, physical, occupational and speech therapy, community clinics and mobile health services serving the poor, chest pain emergency center, open heart surgery program, Level II neonatal intensive care, diagnostic imaging services, diabetes education services, physical referral services, robotic-assisted surgery program, and wound care and hyperbaric medicine.

### 6.2 Programs and Services, Key Statistics

SMMC's 212 licensed beds are used exclusively for GAC, based on 2019 data reported to HCAI (Exhibit # 9 SMMC Licensed Medical Bed Capacity & Utilization, 2019). There are no reported

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<sup>70</sup> Inland Empire, Increasing Medi-Cal Coverage Spurs Safety Net Growth, CA Health Care Almanac, Ca Health Care Foundation (CHCF), December 2020

<sup>71</sup> SMMC Community Benefit Plan submitted to HCAI

<sup>72</sup> This High Desert is sometimes referenced as an area that is smaller than the Inland Empire and includes the towns of Victorville and Hesperia. <https://inlandempire.us/what-is-the-inland-empire/>

<sup>73</sup> This was substantiated in all the interviews we had with insurers.

licensed beds in 2019 for psychiatric care, rehabilitation, long-term care (LTC) or chemical dependency. Available bed occupancy is relatively high, at 85%; the average available bed occupancy rate across the state among GAC hospitals in a similar size range (200 – 299 beds) is just 57%. The average length of stay is slightly fewer than five days, about the same as other comparable GAC hospitals that do not offer LTC.

*Exhibit 9 SMMC Licensed Medical Bed Capacity & Utilization, 2019*

Measurement	Total
Available Beds	212
Patient Days (excluding nursery)	65,958
Average Length of Stay (est.)	4.58

Source: OSHPD 2019 Hospital Annual Financial Disclosure Report and OSHPD 2019 Hospital Annual Utilization Report

SMMC offers a broad range of services:

- **Obstetrics and related care** - The hospital’s OB/GYN program saw 1,753 live births in 2019, about average for similarly sized GAC hospitals in California.<sup>74</sup> SMMC also offers the only Level III Neonatal Intensive Care Unit in the area; this Unit provides care for infants born with health complications. In addition to labor and delivery, SMMC offers post-partum care, educational services, and its Healthy Beginnings/New Avenues programs, which provides prenatal care during the first trimester of pregnancy.
- **Cardiac Care** - SMMC is an active cardiac care provider, with services including full-service diagnostic and treatment programs; cardiac catheterization; open heart and vascular surgery; cardiac rehabilitation; and STEMI Receiving Center services. In 2019, the facility’s physicians performed 69 cardiac surgeries and provided 3,288 cardiac catheterization procedures (e.g., pacemaker implantation).
  - SMMC is designated as a STEMI Receiving Center. STEMI hospitals are those with the expertise, equipment, facilities and other resources to administer percutaneous coronary intervention (PCI), a mechanical means of treating heart attack patients.
- **Emergency Department Services** - For emergency services, the facility houses a 24-hour “basic” emergency department (ED) with 44 emergency treatment stations that provide medical examination and stabilization for patients in need of emergency care. In 2019, there were roughly 77,000 ED visits. Of these, roughly 11,000 patients (14%) were

<sup>74</sup> HCAI 2019 Hospital Annual Utilization Data

admitted as inpatients—an ED admission rate consistent with national averages.<sup>75</sup> The median per-patient time spent in the ED, however, was 227 minutes, a duration somewhat longer than the California average of 189 minutes (The national average is lower than California).<sup>76</sup> The hospital does not have its own trauma center.

- **Imaging** - SMMC offers a variety of imaging services, including mammography, stereotactic breast biopsy, X-ray, CT, MRI, angiography, ultrasound, vascular ultrasound, and nuclear medicine.
- **Outpatient Rehabilitation Services** - The hospital's outpatient rehabilitation services include speech therapy, physical therapy, and occupational therapy for orthopedic, sports injury, prosthetics, geriatric rehabilitation, neurological rehabilitation, and Lymphedema.<sup>77</sup>
- **Orthopedics** - SMMC provides some orthopedic care, generally for conditions that may be present from birth or that often occur as a result of injury or age-related wear and tear (e.g., back pain, or anterior cruciate ligament tears). However, treatment of diseases and disorders of the musculoskeletal system and connective tissue that generally include orthopedic care comprise just a small percentage, about 6% of discharges, of the care delivered. For care delivered to the small percentage of patients who are not admitted through the ED, it is the second largest category of care provided after childbirth.
- **Wellness and Prevention** - SMMC also provides a variety of wellness and prevention programs such as diabetes education.

Exhibit # 10 SMMC Patient Utilization Trends and Service Volumes, FY 2015 to 2019, provides summary utilization statistics for SMMC. While total hospital discharges fell nearly 7% over the four-year period between 2015 and 2019, total patient days nevertheless increased 5%, with the average length of inpatient stay increasing from 4.0 to 4.5 days per stay. SMMC's Neonatal Intensive Care Unit served nearly 50% more patient days in 2019 than 2015; this unit's average length of stay also increased substantially, from 8.0 to 11.9 days.

Utilization of the hospital's ED in 2019 was just 5% higher than 2015 with some variation in the intervening years and a decline of about 4,000 visits between its peak in 2017 and 2019. The

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<sup>75</sup> Capp, R., Sun, B., Boatright, D., & Gross, C. (2017, January 3). ED observation units and admission rates. *Journal of Hospital Medicine*. <https://www.journalofhospitalmedicine.com/jhospmmed/article/126813/ed-observation-units-and-admission-rates#:~:text=The%20average%20ED%20risk%E2%80%90standardized,2.3%25%20was%20not%20statistically%20s,ignificant>.

<sup>76</sup> SMMC Review. Medicare.gov. (n.d.). <https://www.medicare.gov/care-compare/details/hospital/050300?id=c6b582a9-3a80-45c7-aeec-364ebe17c9b5&state=CA&measure=hospital-timely-and-effective-care#ProviderDetailsDetailsContainer>.

<sup>77</sup> SMMC. Providence. (n.d.). <https://www.providence.org/locations/st-mary-medical-center>.



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hospital continues to take on an increasing load of cardiac catheterization procedures; this service grew over 68% between 2015 and 2019. The hospital further saw a 16% increase in inpatient surgeries performed over this period.

Exhibit 10 SMMC Patient Utilization Trends and Service Volumes, FY 2015 to 2019

Patient Days	2015	2016	2017	2018	2019
<b>Total Patient Days</b>	<b>59,011</b>	<b>62,277</b>	<b>63,813</b>	<b>63,842</b>	<b>61,920</b>
Medical / Surgical	45,063	47,394	48,794	48,159	46,625
Obstetrics	3,945	3,747	3,662	4,555	4,343
Pediatric Acute	883	832	716	621	603
Intensive Care	6,619	6,732	6,696	6,628	6,624
Neonatal Intensive Care	2,501	3,572	3,945	3,879	3,725
Discharges	2015	2016	2017	2018	2019
<b>Total Discharges</b>	<b>14,753</b>	<b>14,759</b>	<b>14,689</b>	<b>13,969</b>	<b>13,743</b>
Medical / Surgical	11,259	11,341	11,362	10,789	10,678
Obstetrics	2,316	2,291	2,175	2,094	1,918
Pediatric Acute	369	370	348	318	296
Intensive Care	498	457	489	461	539
Neonatal Intensive Care	311	300	315	307	312
Average Length of Stay	2015	2016	2017	2018	2019
<b>Overall Average Length of Stay</b>	<b>4.0</b>	<b>4.2</b>	<b>4.3</b>	<b>4.6</b>	<b>4.5</b>
Medical / Surgical	4.0	4.2	4.3	4.5	4.4
Obstetrics	1.7	1.6	1.7	2.2	2.3
Pediatric Acute	2.4	2.2	2.1	2.0	2.0
Intensive Care	13.3	14.7	13.7	14.4	12.3
Neonatal Intensive Care	8.0	11.9	12.5	12.6	11.9
Average Daily Census	2015	2016	2017	2018	2019
Medical / Surgical	123.5	129.8	133.7	131.9	127.7
Obstetrics	10.8	10.3	10.0	12.5	11.9
Pediatric Acute	2.4	2.3	2.0	1.7	1.7
Intensive Care	18.1	18.4	18.3	18.2	18.1
Neonatal Intensive Care	6.9	9.8	10.8	10.6	10.2
Services Provided	2015	2016	2017	2018	2019
Inpatient Surgeries	3,287	4,167	3,950	4,046	3,815
Outpatient Surgeries	4,494	5,507	5,019	4,970	4,540
ED Visits	73,247	78,451	80,819	77,625	76,909
Cardiac Catheterization Procedures	2,025	2,093	2,272	2,246	3,409
Obstetric Deliveries	2,448	2,308	2,174	1,963	1,753
Outpatient Visits	145,743	142,168	157,953	118,371	121,834

Source: OSHPD Utilization Pivot, 2015-2019

In addition to its inpatient care services, SMMC Community Health Clinics provide health services including primary care visits, nutrition/diabetes education and pre and post-natal care

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to the underserved residents of the Inland Empire at several locations including: SMMC Health Center Apple Valley; SMMC Health Center Hesperia.<sup>78</sup>

SMMC also has a Foundation that provides financial support through philanthropy and raises funds through charitable donations, planned gifts, and appreciated securities in order to fund advances in medical technology and facilities. The foundation website reports funds raised by the SMMC Foundation for a variety of purposes included \$300,000 for cardiac monitors and \$100,000 for COVID-19 relief.<sup>79</sup>

### **6.3 Accreditations, Quality Measures, and Performance Ratings**

A 2016 report prepared for the OACG indicated that SMMC has had historically questionable quality measures. For example, overall, the St Joseph hospital system, which included SMMC before the St Joseph Providence merger, had hospital readmission rates lower than California's average of 19.4%, with only SMMC reporting a higher readmission rate of 20.4%.<sup>80</sup> Additionally, the majority of the St Joseph hospitals reported higher overall patient experience scores than California's score of 68.0%, with the exception of St. Joseph Hospital-Eureka (57.0%), and SMMC Medical Center (63.0%).

The most recent Medicare ratings published on Medicare.gov in 2021, suggest the hospital quality continues to be poor with an overall rating of 1 star out of 5, and a patient survey rating of 1 star out of 5.<sup>81</sup> Additionally, SMMC had a poor safety grade of D in the spring of 2021 based on the Leapfrog Hospital Safety Grade Rating.<sup>82</sup> This rating indicated the hospital had below average scores on safety measures that included minimizing patient Methicillin-resistant Staphylococcus aureus (MRSA) infections, adopting practices to reduce errors and minimizing dangerous bed sores. Safety grades given twice a year, have been historically poor, with five D's and one C for the three years 2018-2020. However, all the payers interviewed regarding

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<sup>78</sup> Community health center Apple Valley. Providence. (n.d.). <https://www.providence.org/locations/st-mary-medical-center/community-health-center-apple-valley>.

<sup>79</sup> Inland Empire Charity: SMMC Medical Foundation. SMMC Foundation. (2021, January 21). <https://supportstmaryfoundation.org/about-us/>.

<sup>80</sup> Effect of the Proposed Change in Control and Governance of St. Joseph Health System and Providence Health & Services on the Availability and Accessibility of Healthcare Services to the Communities Served by SMMC Medical Services, Prepared for the Office of the Attorney General, March 28, 2016.

<sup>81</sup> Medicare.gov, Hospital Compare Ratings, Updated 7/21/2021 (<https://www.medicare.gov/care-compare/details/hospital/050300?id=c6b582a9-3a80-45c7-aeec-364ebe17c9b5&state=CA>, Accessed 8/10/2021) SMMC had an overall rating of 1 star out of 5, where 5 is highest quality. The overall star rating is based on how well a hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates, and safety of care. Just 6% of hospitals nationally had a one star rating. SMMC had a patient survey rating of 1 star out of 5, where 5 is highest quality. The patient survey rating measures patients' experiences of their hospital care. Recently discharged patients were asked about important topics like how well nurses and doctors communicated, how responsive hospital staff were to their needs, and the cleanliness and quietness of the hospital environment.

<sup>82</sup> Leapfrog Hospital Safety Grade, Spring 20201. (<https://www.hospitalsafetygrade.org/h/st-mary-medical-center-apple-valley-ca?findBy=city&city=Apple+Valley&state=prov=CA&rPos=67&rSort=distance> Accessed 8/26/2021)

SMMC’s quality of care, did not have any issues and felt that this was the preferred hospital by their members in the area.

## 6.4 Seismic Issues

To ensure that patients are physically safe from earthquake dangers, California hospitals must comply with the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act (Health & Safety Code, § 129675-130070). Using the Hazus seismic criteria, SMMC structures subject to seismic compliance have been classified according to the California Senate Bill 1953 Seismic Safety Act for the Structural Performance Category (SPC) and the Non-Structural Performance Category (NPC), as shown below (Exhibit #11 SMMC Seismic Safety Performance Rating, 2020).<sup>83</sup> These classifications require that SMMC structures undergo construction to comply with the California Office of Statewide Health Planning and Development’s seismic safety standards.

Buildings with a SPC-2 rating are those in compliance with the pre-1973 *California Building Standards Code* or other applicable standards, but not in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act. These buildings do not significantly jeopardize life but may not be repairable or functional following strong ground motion and need to be brought into compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act, its regulations or its retrofit provisions by January 1, 2030, or be removed from acute care service.<sup>84</sup>

Exhibit 11 SMMC Seismic Safety Performance Ratings, 2020

Building	SPC Compliance Status	NPC Compliance Status
1) Original Hospital & ER	SPC-2	NPC-2
3) Boiler Building	SPC-2	NPC-2
5) Surgery Addition	SPC-4	NPC-2
7) East Wing	SPC-4	NPC-2

Source: L <https://oshpd.ca.gov/construction-finance/facility-detail/#10695>

The cost of addressing these structural issues related to ensuring seismic safety is one of the key reasons cited for the CiC and building the new facility.

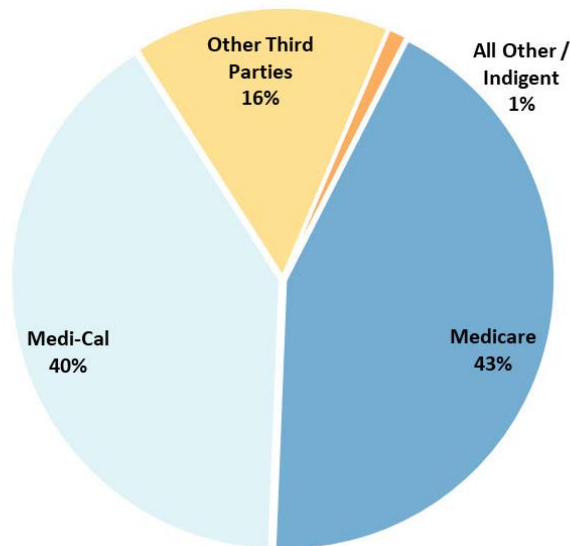
<sup>83</sup> Hazus is a geographic information system-based natural hazard analysis tool developed and freely distributed by the Federal Emergency Management Agency (FEMA). It includes state-of-the-art review of earthquake loss estimation methods,

<sup>84</sup> Seismic Performance Ratings. HCAI. (2020, January 23). <https://HCAI.ca.gov/construction-finance/seismic-compliance-and-safety/seismic-performance-ratings/>.

## 6.5 Payer Mix

Government payers account for an overwhelming majority of SMMC services and patient revenues. In the fiscal year ending June 2019, Medicare beneficiaries accounted for about 43% of SMMC discharges; of these patients, 57% were served under traditional Medicare contracts, with the remainder under managed care (Exhibit # 12 Payer Mix SMMC, 2019). Medi-Cal enrollees accounted for an additional 40% of all discharges—over 80% under managed care. Fewer than 2 of every 10 hospital discharges were covered by other third-party, typically commercial, payers. All other payers, including county indigent and other indigent programs, accounted for the remaining 1% of patients.<sup>85</sup>

*Exhibit 12 Payer Mix SMMC, 2019*



Source: OSHPD Financial Pivot, 2019

SMMC payer mix is similar to that of San Bernardino County average (Exhibit # 13 Payer Mix Comparison, SMMC, San Bernardino & California, 2019). The hospital serves a somewhat higher share of Medicare patients (43.1% versus 34.6%) than the countywide average, with slightly smaller shares to Medi-Cal and other third-party payers. Both SMMC and San Bernardino serve a higher proportion of government insured (Medicare and Medi-Cal) patients than the state on average.

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<sup>85</sup> Other Payers includes self-pay, workers' compensation, other government, and other payers

Exhibit 13 Payer Mix Comparison, SMMC, San Bernardino &amp; California, 2019

Payer Type	SMMC		San Bernardino County		California	
	Discharges	% of Total	Discharges	% of Total	Discharges	% of Total
<b>Medicare</b>	<b>6,205</b>	<b>43.1%</b>	<b>56,741</b>	<b>34.6%</b>	<b>1,168,804</b>	<b>40.6%</b>
Traditional	3,527	24.5%	28,202	17.2%	808,978	28.1%
Managed Care	2,678	18.6%	28,539	17.4%	359,826	12.5%
<b>Medi-Cal</b>	<b>5,802</b>	<b>40.3%</b>	<b>75,966</b>	<b>46.3%</b>	<b>1,010,653</b>	<b>35.1%</b>
Traditional	1,116	7.8%	30,126	18.4%	378,849	13.1%
Managed Care	4,686	32.6%	45,840	27.9%	631,804	21.9%
<b>Other Third Parties</b>	<b>2,221</b>	<b>15.4%</b>	<b>28,316</b>	<b>17.3%</b>	<b>643,631</b>	<b>22.3%</b>
Traditional	239	1.7%	9,878	6.0%	94,083	3.3%
Managed Care	1,982	13.8%	18,438	11.2%	549,548	19.1%
<b>All Other / Indigent</b>	<b>158</b>	<b>1.1%</b>	<b>3,099</b>	<b>1.9%</b>	<b>59,158</b>	<b>2.1%</b>
County Indigent Programs	0	0.0%	0	0.0%	9,701	0.3%
Other Indigent	26	0.2%	673	0.4%	15,114	0.5%
All Other Payers	132	0.9%	2,426	1.5%	44,044	1.5%
<b>TOTAL</b>	<b>14,386</b>		<b>164,122</b>		<b>2,882,246</b>	

Source: OSHPD Financial Pivot, 2019

It is worth noting the importance of Medi-Cal to the region for ensuring care to a large economically disadvantaged population. In the Inland Empire, San Bernardino and Riverside counties operate a Two-Plan Model Medi-Cal model offering enrollees the option of either a publicly-run “Local Initiative Plan,” IEHP, or a commercial alternative, Molina Healthcare. IEHP accounts for roughly 90% of total Medi-Cal managed care enrollment in the region. SMMC contracts with both plans.<sup>86</sup>

Across all San Bernardino County GAC hospitals, Medi-Cal managed care accounted for over one-quarter of all patient discharges in 2019. In the Inland Empire, SMMC is the most significant provider of inpatient care to Medi-Cal enrollees: of the three GAC hospitals in the High Desert, SMMC accounted for 47% of all Medi-Cal managed care inpatient discharges and 51% of patient days.<sup>87</sup> SMMC was also a large safety net provider of outpatient care, with nearly 50,000 Medi-Cal visits in 2019.

<sup>86</sup> Twelve million Medi-Cal enrollees in California receive services under one of six models of managed care: County Organized Health Systems (COHS), the Two-Plan Model, Geographic Managed Care (GMC), the Regional Model, the Imperial Model, and the San Benito Model.

<sup>87</sup> HCAI 2019 Hospital Finance Pivot.

## 6.6 Medical Staff

SMMC contracts with two medical groups for the provision of physician services.<sup>88</sup> SMMC offers 46 physicians in the area, 29 of whom offer primary care services, according to the group's website.<sup>89</sup> Premiere Healthcare IPA, with 10 primary care physicians and 16 specialists, also serves SMMC.<sup>90</sup>

Ratings on the SMMC High Desert Medical Group provided by the Office of the Patient Advocate, a California government agency, show good to very good ratings for the group (Exhibit # 14 SMMC High Desert Medical Group Medical Care Ratings, 2019).<sup>91</sup>

Exhibit 14 SMMC High Desert Medical Group Medical Care Ratings, 2019



The California Office of the Patient Advocate compared medical group performance results in 2019 to a set of national standards for quality of care to make sure that medical groups are offering quality preventive care and service to members. Data show 26 medical groups serving San Bernardino County Medicare Advantage (Medicare managed care) plan members. Premiere Healthcare, SMMC High Desert Medical Group, and Kaiser Permanente Medical Group have

<sup>88</sup> SMMC. Providence. (n.d.). <https://www.providence.org/locations/st-mary-medical-center>.

<sup>89</sup> Providence: Find a doctor. Health for a Better World. (n.d.). <https://www.providence.org/doctors/search>.

<sup>90</sup> Premier Healthcare IPA, An Affiliate of St Joseph. Premier healthcare IPA, an affiliate of St Joseph - Inter Valley Health Plan. (n.d.). <https://portal1.ivhp.com/ProviderSearch/MedicalGroupInformation?IPA=117>.

<sup>91</sup> State of California Office of the Patient Advocate, SMMC High Desert Medical Group 2020-2021 Edition. [https://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=MEDICAL\\_GROUP&Entity=1051407](https://reportcard.opa.ca.gov/rc/profile.aspx?EntityType=MEDICAL_GROUP&Entity=1051407) Accessed 8/16/2021

high quality of medical care ratings with all four groups rated at 4.5 stars, indicating very good performance. (Appendix B: Appendix State of California - Health Care Quality Report Card MA).<sup>92</sup> Similarly, data from the California Office of the Patient Advocate on 27 medical groups serving San Bernardino County commercial HMO plan members, provide ratings on three factors: quality of medical care, patients' overall experience, and total cost of care and show SMMC High Desert Medical Group rated as Good (3 out of 5 stars) on both quality of care and patient experience and "Lower Payment" (4 out of 5 stars) on cost of care (Appendix C: State of California - Health Care Quality Report Card Commercial).<sup>93</sup> Premier offers a lower average payment but has lower care and patient experience ratings while Kaiser Permanente Medical Group is rated as having a higher payment but very good care and patient experience ratings.<sup>94</sup>

## **6.7 Financial Profile & Cost of Hospital Services**

Over the 2015 – 2019 period, SMMC's financial performance markedly improved, although the hospital's operating margin has swung wildly from year-to-year based on reporting to Office of Statewide Health Planning and Development (HCAI) (Exhibit # 15 SMMC Financial Profile, 2015 - 2019). In 2015, the hospital's operating margin was -12.4%, but in 2019, it had risen to 25.4%, with a total margin of 27.6% reflecting a performance far above the statewide averages of 4.0% and 7.2%, respectively, for GAC hospitals. In part this may have to do with the timing of the recognition of revenue, e.g., from the Hospital Quality Assurance Fee (HQAF) program and the fact that the Providence fiscal year is the calendar year rather than HCAI's reporting period, from July 1st to June 30th. While 2019 appeared to be an outlier, the hospital's average operating margin from 2016 to 2019 was nearly 15%, also well above statewide averages.

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<sup>92</sup> State of California Office of the Patient Advocate, Health Care Quality Report Cards 2020-2021 Edition. [https://reportcard.opa.ca.gov/rc2021/MedicareMGRating.aspx?county=SAN\\_BERNARDINO](https://reportcard.opa.ca.gov/rc2021/MedicareMGRating.aspx?county=SAN_BERNARDINO) Accessed 8/16/2021

<sup>93</sup> State of California Office of the Patient Advocate, Health Care Quality Report Cards 2020-2021 Edition. [https://reportcard.opa.ca.gov/rc/medicalgroup-rating.aspx?county=SAN\\_BERNARDINO](https://reportcard.opa.ca.gov/rc/medicalgroup-rating.aspx?county=SAN_BERNARDINO) Accessed 8/16/2021

<sup>94</sup> State of California Office of the Patient Advocate, Health Care Quality Report Cards 2020-2021 Edition. [https://reportcard.opa.ca.gov/rc/medicalgroup-rating.aspx?county=SAN\\_BERNARDINO](https://reportcard.opa.ca.gov/rc/medicalgroup-rating.aspx?county=SAN_BERNARDINO) Accessed 8/16/2021

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Exhibit 15 SMMC Financial Profile, 2015-2019

Measurement	2015	2016	2017	2018	2019
<b>INCOME</b>					
Net Income	\$38,076,559	\$51,794,236	\$54,304,435	\$27,454,059	\$110,697,040
Operating Margin	-12.4%	15.0%	14.6%	4.2%	25.4%
<b>REVENUE</b>					
Net Patient Revenue	\$325,275,062	\$338,321,698	\$337,617,840	\$314,295,664	\$393,685,540
Net I/P Rev Per Day	\$3,259	\$3,245	\$3,048	\$2,767	\$3,330
Net I/P Rev Per Discharge	\$13,056	\$13,673	\$13,250	\$12,525	\$15,266
Net O/P Rev Per Visit	\$849	\$947	\$871	\$1,121	\$1,429
Non-Operating Revenue	\$2,735,216	\$2,026,721	\$10,696,649	\$15,460,898	\$10,183,509
<b>EXPENSES</b>					
Operating Expenses	(\$292,921,431)	(\$288,263,709)	(\$288,195,180)	(\$301,133,738)	(\$291,870,163)
Non-Operating Expenses	(\$749,009)	(\$1,050,480)	(\$5,814,874)	(\$1,168,765)	(\$1,301,846)
<b>UTILIZATION</b>					
Patient Days	61,844	62,775	65,609	65,627	65,958
Discharges	15,437	14,899	15,093	14,500	14,386
Visits	145,743	142,168	157,953	118,371	121,834

Source: OSHPD Financial Pivot, 2019

Growth in total income at SMMC is due to a variety of factors. First, while service volumes have remained roughly flat, per unit prices have increased, driving an overall increase in net patient revenue. Outpatient care, which accounted for 44% of total gross patient revenue in 2019, in fact declined over the five year period over 16%, as measured by annual visits,<sup>95</sup> but net patient revenue per outpatient visit increased 68%. On the inpatient side, patient days and discharges were similarly flat, but net revenue per discharge increased nearly 17%. Despite this price inflation, SMMC was able to lower total operating expenses 0.4%.

Internal documents from SMMC, although not identical to HCAI financial data, also paint a picture of strong profitability. [REDACTED]

[REDACTED].<sup>96</sup> More recent data submitted in the Notice, reported as of January 2021, [REDACTED]

[REDACTED].<sup>97</sup>

SMMC also benefits from SMMC Foundation, which provides philanthropic support. SMMC Medical Center Foundation raises funds through charitable donations, planned gifts, and appreciated securities in order to fund advances in medical technology and facilities. The

<sup>95</sup> HCAI Hospital Annual Financial Data Pivot, 2019

<sup>96</sup> [REDACTED]

<sup>97</sup> [REDACTED]



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Foundation website reports funds raised by SMMC Medical Center Foundation for a variety of purposes, including \$300,000 for cardiac monitors and \$100,000 for COVID-19 relief.<sup>98</sup>

## **6.8 Charity Care & Community Benefit Services**

In FY 2019, SMMC invested a total of \$16M million in Community Benefit dollars that included Financial Assistance at cost, and other cost of care, in addition to strategic community investment addressing community need, but excluding Medicare shortfalls.<sup>99</sup> The FY 2019 community benefit report states that each year, SMMC allocates 10% of its net income (net unrealized gains and losses) to the St. Joseph Health (SJH) Community Partnership Fund. And 75% of these contributions are used to support local hospital care for low-income and underserved populations. In addition, 17.5% is used to support SJH Community Partnership Fund grant initiatives. The remaining 7.5% is designated toward reserves, which helps ensure the Fund's ability to sustain programs into the future that assist low-income and underserved populations.<sup>100</sup>

Working with findings from the community assessment process, SMMC has chosen to address three priority areas as part of its FY 2018-FY 2020 CB Plan/Implementation Strategy Report:

- Access to Resources (clinical care)
- Mental Health and Substance Abuse (health outcome)
- Obesity (health behavior)

Regarding the first priority, the hospital's 2017 Community Health Needs Assessment (CHNA) reports access concerns by 41.5% of respondents, an increase over 38.4% reported in the 2014 CHNA. The hospital's 2017 CHNA revealed the Total Service Area (TSA) served is slightly worse in uninsured, 20.3% of adults, versus 19.3% for the State of California, with slightly lower rates of prenatal care in the first trimester as well: 79.0% in TSA vs. 83.8% for the state.

To address this disparity, the Community Benefit plan cites the use of three fixed clinics and these community clinics that use mobile health clinics to serve rural neighborhoods. Known as the Bright Futures Mobile Van, services include physical examinations, immunizations, diabetes screening and management, cancer screenings and chronic disease management. Towards the goal of increased access, the Community Benefit Plan cites several accomplishments:

- Accomplishment -The Bright Futures Mobile Van has a weekly presence at four sites. The community clinic department also runs three fixed clinic sites where prenatal and

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<sup>98</sup>Inland Empire Charity: SMMC Medical Foundation. SMMC Foundation. (2021, January 21). <https://supportstmaryfoundation.org/about-us/>.

<sup>99</sup> The hospital received more Medicaid revenue than the expense it incurred in FY19 (for a 2017-2019 period), due to the Medicaid Hospital Quality Assurance Fee (HQAF) program. Thus, there was \$0 net benefit for Medicaid. SMMC Community Benefit Plan submitted to HCAI. Note that in the parties Notice to the OCA, p 379, they report \$15,736,191 in community benefit.

<sup>100</sup> SMMC Community Benefit Plan submitted to HCAI.

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primary care services are provided by certified nurse midwives and nurse practitioners to those who are uninsured and underinsured (Medi-Cal).

- Accomplishment - The community clinic provided a total of 29,253 clinical encounters; 5,599 encounters were provided through the Bright Futures mobile van - one out of every five total clinical encounters served rural populations with limited access, similar to FY18 results.
- Accomplishment - Awarded a one-time \$500,000 restricted grant to Borrego Health Federally Qualified Health Center (FQHC) for purchase of a dental van to provide free dental care to High Desert residents, further increasing access to resources for this community.

Regarding the second priority, the lack of mental health resources was a frequent theme from focus groups and forums in the hospital's 2017 needs assessment. Consequently, SMMC identified goals to improve therapy at clinics and partners; advocate for additional services with the County of San Bernardino, Department of Behavioral Health; collaborate with partners to improve services; create awareness addressing stigma; and collaborate to understand root cause issues to mental health and crime.

The Community Benefit report cites several accomplishments toward improving mental health services, including a total of 2,666 mental health clinical encounters in FY 2019, and 1,402 short-term counseling visits for individuals, couples and family provided by community clinics' Bridges for Families Resource Center. They note that they continue to discuss better ways to provide mental health services for children and adolescents due to the lack of facilities in the High Desert. The closest facility, Loma Linda University Children's Hospital, is 50 miles away, about a one-hour drive.

Regarding the third priority, in the 2014 needs assessment, adult overweight and adult obesity rates had the highest recorded percent increase from its 2007 baseline; increasing 6.6%, to 37% overweight adults and a 6.1%, increase to 33% obese adults. Both these figures were greater than adult state averages which in 2014 were 36% overweight and 24% obese. The 2017 needs assessment showed an increase in adult obesity with a rate of 37% in the hospital's service area compared to 26% for the state. Teens also fared worse off at 38% compared to the state's 33%.

The Community Benefit Plan cites several accomplishments related to this goal including multiple partnerships to teach Healthy Eating Active Living (H.E.A.L.) a Department of Public Health approved nutrition curriculum in multiple cities in the service area. Additionally, free physical education classes were provided in low income neighborhoods in Adelanto, Apple Valley, Hesperia and Victorville, where many participants report not having enough money for a gym membership and no transportation. In total 7,281 physical activity encounters were recorded.

Charity care reported to HCAI has steadily increased over the three-year period from 2017-2019, rising from \$12.2M in 2017 to \$25M in 2018 and \$41M in 2019.<sup>101</sup> This trend reflects the difference between gross patient revenue (based on full established charges) for services rendered to patients who are unable to pay for all or part of the services provided, and the amount paid by or on behalf of the patient.

The 2019 reported charity care was considerably higher than other California non-profit hospitals in the same bed size range (200-299). SMMC's charity care was 2.4% of gross revenue, and 14% of operating expenses compared to other similarly sized non-profits who had .76% and 3%, respectively.<sup>102</sup>

In the Notice to the Attorney General, following the CiC, the parties state they will make "periodic reports to the Board of Managers of Company regarding the Hospital's community benefit and financial assistance and emergency medical care activities, including, without limitation, the number of FAP-eligible individuals provided services at the Hospital and the nature of ongoing efforts by SMMC to ensure the Hospital's compliance with IRC §501(r)".<sup>103</sup>

## 6.9 The New SMMC Site

The proposed New Hospital would be located in Victorville about 11 miles away from its current location in Apple Valley. The 103-acre site, owned by St. Joseph Heath, for the New Hospital sits immediately adjacent to the 15 Interstate Highway, at the southern edge of the City of Victorville. The site is zoned as a Planned Unit Development (PUD), and the surrounding area is zoned for single family and multi-family residential. From the south, the site is most easily accessible by taking Main Street exit 143 from I-15. From the north, visitors to the site can exit Bear Valley Rd. and travel southbound on Amargosa Rd.

The New Hospital is expected to have 260 beds—an increase of 48 beds, or roughly 23% of current capacity, over the existing facility. The parties expect that all services currently offered at SMMC will continue to be available at the new hospital, with SMMC High Desert Medical Group doctors offering care alongside Kaiser-affiliated physicians.<sup>104</sup> A June 2021 memo states that both Providence SMMC medical staff, including SMMC High Desert Medical Group, and Kaiser Permanente medical teams will deliver care at the new facility.<sup>105</sup>

Neither recent reports nor the parties' notice offer significant detail on the new facility, other than its overall size and the general description as a new, modern facility with new private rooms

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<sup>101</sup> HCAI Hospital Annual Financial Disclosure Reports, 2017-2019 (Pivot tables)

<sup>102</sup> HCAI Hospital Annual Financial Disclosure Reports, 2019 (Pivot tables)

<sup>103</sup> Notice of Affiliate Transaction – SMMC, at pg. 118 (April 7, 2021) (on file with OCAG).

<sup>104</sup> Notice of Affiliate Transaction – SMMC, at pg. 963 (April 7, 2021) (on file with OCAG).

<sup>105</sup> Notice of Affiliate Transaction – SMMC, at pg. 965 (April 7, 2021) (on file with OCAG).

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and state-of-the-art technology available for diagnostic and treatment services.<sup>106</sup> One published news article, relying on an interview of Providence – South’s president of Operations and Strategy, reports that “the property will likely include the hospital, a medical office building and possibly other ambulatory services,” and that “the hospital may expand some of the ‘more high- end acuity level types of care’ due to the partnership with Kaiser.” The report further notes it is unknown whether the new facility will include a trauma center.

Kaiser, in response to information requests from the OCAG states that inpatient services to be provided and staffed by Permanente at the new SMMC hospital include:<sup>107</sup>

- Hospitalists
- Obstetrics
- General Surgery
- Orthopedics
- Pulmonology/Intensivists
- GI
- Cardiology

## **7 Assessment of Potential Issues Associated with the Availability or Accessibility of Healthcare Services**

### **7.1 Importance of the Hospital to the Community**

St. Mary Medical Center is an central hospital provider of healthcare services in the High Desert region and is known for providing essential services to the uninsured and under-served populations. This is supported both by public data submitted to California state agencies and by interviews. While there are two other hospitals located in St. Mary Medical Center’s service area, St. Mary Medical Center is the market share leader. Medi-Cal and Medicare payers represent about eight of ten of St. Mary Medical Center’s patient population. Some of the programs and services that referenced in the interviews as particularly important include:

- Emergency services
- Obstetrics and Level II Neonatal Intensive Care Unit services
- Intensive care services
- Cardiac care
- Community clinic services, including primary care and prenatal care
- Counseling services

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<sup>106</sup> SMMC - Response to OCAG Supplemental Request for Information [07.30.2021]

<sup>107</sup> Kaiser Permanente - Response Letter to AG Regarding Transferee Requests Received 9-21-21 CONFIDENTIALITY REQUEST (9-27 FINAL) pg. 4.

Community representatives felt it was important that St. Mary Medical Center retain the services that it currently offers, especially its emergency and obstetrics services. It's clear that if St. Mary Medical Center did not maintain its current level of healthcare services, accessibility and availability issues would be created for the underinsured and uninsured residents. In the near term, SMMC will continue as a GAC Hospital in Apple Valley. However, some local residents are concerned about the facility's move to the new location. SMMC is the town's largest employer and has been around since 1956. While the New Hospital would be only about 11 miles away in Victorville, it would be the city's third hospital, while Apple Valley would be left without a hospital.

Some articles suggest that part of the concern is that there has been a historical investment in the facility.

*"We worked so hard to have that hospital. The original developers of Apple Valley donated the land for it. Residents have financially supported it, and all of a sudden, 'Poof — thank you, but we're moving,'" said Nassif. "Everybody is still a little bit in shock."<sup>108</sup>*

The hospital, however, is clearly important to the community and a major provider of services to a large population that is covered by public payers who tend to be more medically vulnerable.

## 7.2 Summary of Interviews with Insurers: Impact of the CiC on Access and Availability

[REDACTED], we participated in a series of videoconferences and phone interviews with insurers and other interested parties to gauge their concerns and perceptions about the CiC's impact on the area. [REDACTED]

[REDACTED]

[REDACTED]. Organizations interviewed included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

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108 Wolfson, Bernard, Providence Kaiser team up to attract patients in California's growing High Desert region, Modern Healthcare, August 5, 2021 (<https://www.modernhealthcare.com/mergers-acquisitions/providence-kaiser-team-up-attract-patients-californias-growing-high-desert> Accessed 8/26/2021)

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- [REDACTED]

Below we provide a summary of our interviews as they relate to access and availability of services.

According to all who were interviewed, SMMC is in-network (i.e., a hospital available to their insured members), and essential to their network. While all insurers acknowledged that Victor Valley, owned by KPC, and Desert Valley, owned by Prime, are also in the area and alternatives to SMMC, all the insurers agreed that their network could not be competitive without SMMC.

None of the insurers mentioned challenges with access to inpatient care or specific services. When pressed, several insurers mentioned that SMMC may be particularly important for cardiac care. No one cited emergency service bed capacity constraints or long wait times for admission as concerns. [REDACTED] noted that accessing physician specialists was often a challenge, however, this is a problem that plagues [REDACTED] generally.<sup>109</sup>

All insurers interviewed agreed that few people from outside the area come into the area for care, and people generally did not leave the area for care unless it was for trauma care or tertiary care services (e.g., neurosurgery or transplants). For this kind of care, St Bernadine or Loma Linda, located south of SMMC in San Bernardino, tended to be used most frequently, but these types of services are relatively rare events.

[REDACTED]

Generally, all the insurers interviewed believed that increased bed capacity would be good for the area. They did not appear to know of many details of the transaction, other than that it involved Kaiser and Providence, and the construction of a new, larger, state of the art facility. But, based on the very limited information they had, they did not seem to have any concerns as long as they would continue to have access to the New Hospital.

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109 Coffman, J and Fix, M, Physician Participation in Medi-Cal: Is Supply Meeting Demand? California Health Care Foundation, June 28,2017 (<https://www.chcf.org/publication/physician-participation-in-medi-cal-is-supply-meeting-demand/> Accessed 8/25/2021)

### 7.3 Ensuring Access to ED Services

Apple Valley residents are particularly concerned about the loss of their local ED.<sup>110</sup> The High Desert region is not without its challenges, with several impoverished and marginalized communities that see the ED as their primary care provider. This is reflected by SMMC's ED utilization, with nearly 77,000 total ED visits in 2019.<sup>111</sup> By comparison, the 69 GAC hospitals in California within the same bed range as SMMC averaged about 49,000 ED visits that year.<sup>112</sup> Nearly 75% of SMMC's ED visits were classified as severe acuity, meaning that there was a threat to the patient's life or, at a minimum, that they required an urgent evaluation.<sup>113</sup> Despite the large volume, only 1% of people coming in for a visit left without being treated.<sup>114</sup> This was less than the cohort of similarly sized hospitals, which had 2% of their patients leave without being treated.<sup>115</sup> Among the total ED visits, 13% resulted in an admission to SMMC.

In 2017, the San Bernardino County Grand Jury issued a report critical of emergency care in the High Desert suggesting the county build a new trauma center in the region, but it was widely recognized that this would be very costly.

Arguably, facilitating improved access to primary care physicians and services could solve some of the ED capacity problems. As of early 2021, it was not clear whether the New Hospital would offer a trauma center as part of the new full-service, acute care facility.<sup>116,117</sup> However, ensuring the availability of an ED with the same or preferably greater capacity is likely to be critical to the health of the area residents. Given the financial resources of both the CiC parties, a trauma center would be of added value so patients do not have to go to Arrowhead Regional Medical Center or Loma Linda University Medical Center for trauma care, which could be a 90 minute or more drive depending on location and travel conditions.

Some states offer freestanding emergency rooms but California indirectly barred freestanding EDs by statute in its hospital regulations. Consequently, it is not an immediate option for SMMC to convert the Apple Valley location to a freestanding ED. However, it is worth noting that Adventist Health was recently allowed a special permit through SB 156, signed by Governor

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<sup>110</sup> Wolfson, Bernard, Providence Kaiser team up to attract patients in California's growing High Desert region, Modern Healthcare, August 5, 2021 (<https://www.modernhealthcare.com/mergers-acquisitions/providence-kaiser-team-up-attract-patients-californias-growing-high-desert> Accessed 8/26/2021)

<sup>111</sup> 2019 HCAI Hospital Utilization Data (Pivot table)

<sup>112</sup> 2019 HCAI Hospital Utilization Data (Pivot table)

<sup>113</sup> These were classified as ED Visit Type Severe with Threat (CPT 99285) and ED Visit Type Severe Without Threat (CPT 99284)

<sup>114</sup> 2019 HCAI Hospital Utilization Data (Pivot table)

<sup>115</sup> 2019 HCAI Hospital Utilization Data (Pivot table)

<sup>116</sup> Rene Ray De La Cruz, Providence, Kaiser Permanente announce new Victorville hospital that will replace SMMC, Victorville Daily Press 6/3/2021 (<https://www.vvdailynews.com/story/news/2021/06/03/providence-kaiser-announce-new-victorville-hospital-replace-st-mary-medical-center/7519507002/>. Accessed 9/20/21)

<sup>117</sup> Subsequent documents provided by the parties indicate a trauma center is not planned per [Part1] Project Blossom - Response to AG's Request for Information Dated 9-21-21 [10-5-2021]

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Newsom in 2019, to explore the option of providing stand-alone ED services in Paradise, California, and they are committed to developing an ED feasibility study.

A recent New England Journal of Medicine (NEJM) article proposed that the cause of ED crowding is misaligned health care economics that pressures hospitals to maintain inefficient high inpatient census levels, often referencing high-margin patients.<sup>118</sup> They argue that it isn't a matter of expanding ED capacity but addressing the economically driven root causes of ED crowding, i.e., the need to achieve minimal financial hospital margins.<sup>119</sup>

A sustainable solution would be tied to a realignment of financial drivers that require very high inpatient census and financially incentivized preferential queuing of revenue-generating patients over admissions from the ED. It would be tied to addressing shortages in health system capacity in primary care, after-hours outpatient services, specialty referrals, and lack of post-acute care facilities, all of which contribute to hospital crowding. The authors argue that the realignment of incentives though is not simple and would likely require engagement by not only hospital executives but, more broadly, those in the payer and regulatory segments of the health care system. This would presumably require commitment among all parties over a sustained period to effect meaningful change.

### **7.3.1 Potential Conditions for Transaction Approval by the OCAG Related to ED**

To minimize potential negative healthcare impacts that might result from the transaction related to access to ED services, we propose that the OCAG consider the following conditions to ensure access to emergency care. Where applicable, we recommend the OCAG consider applying conditions for a period of at least ten years or until the New Hospital is operational and admitting patients.<sup>120</sup> Further, once the New Hospital is operational and admitting patients these conditions would apply to the New Hospital for ten years or more. These conditions include:

- **Exploration of making Apple Valley SMMC site a free standing ED.** Within one year of Closing, the parties shall develop a plan, to be made available to the public, to explore the option of obtaining a special permit to establish a freestanding ED in Apple Valley at the existing SMMC site. (The Paradise, California permit for a freestanding ED may be a guide for the parties.<sup>121</sup>)

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<sup>118</sup> Kelen, G. et al, Emergency Department Crowding: The Canary in the Health Care System, New England Journal of Medicine Catalyst, September 28, 2021 (<https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217> Accessed 10/1/2021)

<sup>119</sup> Kelen, G. et al, Emergency Department Crowding: The Canary in the Health Care System, New England Journal of Medicine Catalyst, September 28, 2021 (<https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217> Accessed 10/1/2021)

<sup>120</sup> This may not be applicable for example where a study is recommended,

<sup>121</sup> Lanski, A., An Emergency Room Will be Opening in Paradise, Action News Now, 10/18/2019 (<https://www.actionnewsnow.com/content/after-the-fire-content/An-Emergency-Room-is-opening-in-Paradise-563334391.html>)



- **Posting of Patient Rights.** Prior to the Closing Date, the parties will enter into Trademark License Agreements that will permit the New Hospital LLC to incorporate the name and trademarks of SMMC, KFH and their respective affiliates into the future branding and marketing of the New Hospital. To ensure that non-Kaiser’s patients understand that they will enjoy access to the ED at the New Hospital (notwithstanding any Kaiser branding), we propose the OCAG consider requiring the facility to post the California Patient Rights on their website and in their emergency room.<sup>122</sup>
- **Develop a feasibility study or cite an existing feasibility study for the creation of a SMMC Trauma Center.** Access to a more local trauma center could serve a need in the community, exacerbated by the demands placed on hospitals by COVID-19, for a place to treat major traumatic injuries such as falls, motor vehicle collisions, or gunshot wounds. Both Kaiser and Providence bring considerable resources to the table and unless there is a compelling reason not to support a trauma center, this may be an efficiency that is created by the two parties working together and would be difficult to achieve independently. We did not have access to a cost-benefit analysis, return on investment analysis, or other feasibility analysis associated with having SMMC designated as a trauma center. However, the OCAG might consider requesting such an analysis within one year of Closing with the option to require other conditions based on the findings in the analysis.
- **Improve access to primary care with mobile van services.** In a 2016 report to the OCAG on the St Joseph and Providence transaction, one of the recommendations was to continue the Bright Future Mobile Van program.<sup>123</sup> This program was designed to help families receive vital healthcare in their neighborhood with eligibility based on financial screening. Presumably greater access to primary care with mobile van services will not eliminate inappropriate use of EDs but it has the potential to reduce it.

The U.S. Department of Health & Human Services’ National Library of Medicine reports that mobile health clinics have the ability to provide cost-saving benefits to the U.S. healthcare system by encouraging patient care early, which can improve an individual’s self-management of their medical conditions.<sup>124</sup> The result can be a reduction in ED visits and hospital admissions, while improving long-term patient health. We propose the OCAG consider requiring the New Hospital to not only continue to offer this service currently provided by SMMC for a period of at least ten years from the Closing Date, but also develop an annual public report that includes statistics on the locations of services provided, the types of services provided, and the number

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<sup>122</sup> The California Patient’s Guide, Chapter IV, Your Right to Emergency Care <http://calpatientguide.org/iv.html>

<sup>123</sup> Effect of the Proposed Change in Control and Governance of St. Joseph Health System and Providence Health & Services on the Availability and Accessibility of Healthcare Services to the Communities Served by SMMC. Prepared by MDS for the California Attorney General, March 28, 2016.

<sup>124</sup> Yu, Stephanie, et al, The scope and impact of mobile health clinics in the United States: a literature review, In J Equity Health, 2017:16: 178 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5629787/> Accessed 8/26/2021)

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of people served. We believe the transparency of the data on the program would facilitate improvements and greater effectiveness of the program over time.

#### **7.4 Ensuring Access to Reproductive Services**

Reproductive services refers to a range of services related to the reproductive system and can include services to improve women’s health from menarche through menopause.<sup>125</sup> Ensuring access to these services is consistent with the CDC statements that reproductive health is a high priority for the United States Center for Disease Control (CDC) and that protecting one’s reproductive system includes having control over it.<sup>126</sup> Reproductive and sexual health services are often necessary and access to these services, including contraceptive care (both emergency and non-emergency), abortion, sterilization and assisted reproduction, sexually transmitted infection (STI) prevention and treatment, obstetrical care, and abortion services, have a profound impact on women’s lives.<sup>127</sup> As such, we address two questions regarding these services as they relate to the CiC :

- What is the current availability and accessibility of reproductive services in the market area?
- Will the current availability and accessibility of reproductive services in the market area be diminished with the CiC ?

California provides legal protections for reproductive health care access and coverage. With the expansion of Medi-Cal through the ACA, California increased health insurance coverage for its low-income populations that includes these services through the state’s Family Planning Access Care and Treatment (FPACT) program. FPACT ensures coverage for family planning services to uninsured women earning up to 200% of the federal poverty level (FPL). California requires that Medicaid and private insurance plans cover abortion.<sup>128</sup> However, these coverage protections do not necessarily guarantee equal access in all parts of the state.

In addition to a simple lack of availability of providers of reproductive services, access may be limited by hospitals that prohibit women’s reproductive health services, including abortions and tubal ligations, based on the Ethical and Religious Directives (ERDs) for Catholic Health Care Services (the Ethical and Religious Directives).

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<sup>125</sup> Women’s Reproductive Health, Centers for Disease Control, April 28, 2020 (<https://www.cdc.gov/reproductivehealth/womensrh/index.htm> Accessed 11/6/2021)

<sup>126</sup> Women’s Reproductive Health, Centers for Disease Control, April 28, 2020 (<https://www.cdc.gov/reproductivehealth/womensrh/index.htm> Accessed 11/6/2021)

<sup>127</sup> Ranji, Usha, et al., Beyond the Numbers: Access to Reproductive Health Care for Low Income Women in Five Communities, Kaiser Family Foundation, November 14, 2019 (<https://www.kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-executive-summary/> Accessed 8/28/2021)

<sup>128</sup> U.S. News & World Report. (2021, June 7). With restrictions tightening elsewhere, California moves to make abortion cheaper. U.S. News & World Report. <https://www.usnews.com/news/best-states/articles/2021-06-07/with-restrictions-tightening-elsewhere-california-moves-to-make-abortion-cheaper>.

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As a Catholic-sponsored entity, SMMC has stated that its activities will align with the moral and social teachings of the Roman Catholic Church and the guidance of the United States Conference of Catholic Bishops. They state that their “activities will be consistent with the ERDs for Catholic Health Care Services (as such term is defined in the Definitive Documents) as interpreted and applied by the Bishop of San Bernardino, and nothing set forth in this Agreement shall affect or limit SMMC’s full compliance with the Catholic identity standards set forth in SMMC’s Operating Agreement as such may be amended from time to time.”

The ERDs prohibit a wide range of common reproductive health services, including all birth control methods, sterilization, abortion, some miscarriage management techniques, the least invasive treatments for ectopic pregnancies, and infertility treatments such as in vitro fertilization (IVF). The ERDs also limit the treatment options to prevent pregnancy resulting from sexual assault, such as oral emergency contraception pills.

There have been previous instances of health care affiliations where a secular partner in has been allowed to continue providing reproductive health services. There have also been some instances where health systems have created “hospitals within hospitals” as a way to wall off a secular space within a hospital, where otherwise prohibited services can be provided.<sup>129</sup> This arrangement can involve the broader hospital’s continuation in compliance with the ERDs post-merger, while the separately walled off “hospital within a hospital” is allowed to provide some reproductive health services in a separately area.<sup>130</sup>

We do not have the bulk of information on reproductive services provided by SMMC or Kaiser since many reproductive related services are often provided at clinics or in physician offices, e.g., contraception, and we lacked complete data for these sites of care. However, we do know that Kaiser is a committed and active provider of these types of services and SMMC is not. We base this on the following:

- SMMC states in documents provided to the OCAG that it evaluates care decisions on a case-by-case basis considering the medical situation of each patient. However, in general, they do not permit certain procedures to be performed, including abortion, permanent sterilization, and physician-assisted suicide.<sup>131</sup> They note that most

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<sup>129</sup> Penan, Hayley and Chen, Amy, *The Ethical & Religious Directives: What the 2018 Update Means for Catholic Hospital Mergers*, January 2, 2019.

<sup>130</sup> For example, in Troy, New York, a secular hospital—Samaritan Hospital—was merging with the St. Peter’s Health System and becoming Catholic. However, the hospital systems reached an arrangement whereby a section of the second floor of the hospital would become the Burdett Care Center, a separately incorporated hospital with its own finances, staff, and board. All maternity services from Samaritan and another nearby Catholic hospital in the system were moved to this center, where post-partum sterilizations and other services were permitted. Source: *Merger Creates St. Peter’s Health Partners; Region’s Most Comprehensive Health Care Provider*, ST. PETER’S HEALTH PARTNERS (Oct. 3, 2011), <http://news.sphp.com/news/merger-creates-st-peters-health-partners-regionsmost-comprehensive-health-care-provider>.

<sup>131</sup> [Part1] Project Blossom - Response to AG’s Request for Information Dated 9-21-21 [10-5-2021]

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reproductive health services (including abortions) are performed in a clinic on an outpatient basis, not in hospitals.

- Kaiser makes a committed statement to offering reproductive care and currently offers surgical abortion, sterilization of men and women, and IVF procedures.<sup>132</sup> Specifically, Kaiser Permanente offers all options of family planning, such as birth control medication (pills, implants, intrauterine devices), male and female sterilization and abortion care.<sup>133</sup> They also partner with local clinics for certain abortions and offer reproductive health services at all of their medical offices and partner with a specialized fertility surgical/lab suite. Female sterilization procedures are done 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.

Additionally, other area providers also offer a range of reproductive health related services. Below (Exhibit # 16 Select Inpatient Reproductive Health Services at SMMC, Victor Valley, Desert Valley and Surrounding Hospitals, 2019) is a table showing selected inpatient abortion and sterilization services provided in 2019 at SMMC and other area hospitals. This includes all discharges with an ICD10 code associated with the following Diagnosis Related Groups (DRG):

- 770-Abortion w D&C Aspiration Curettage or Hysterectomy
- 779-Abortion w/o D&C
- 796-VAGINAL DELIVERY WITH STERILIZATION/D&C WITH MCC
- 797-VAGINAL DELIVERY WITH STERILIZATION/D&C WITH CC
- 798-VAGINAL DELIVERY WITH STERILIZATION/D&C WITHOUT CC/ MCC

The list of ICD10s may not be exhaustive but it does give insight into what hospitals provide these types of services.

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<sup>132</sup> St. Mary Medical Center - Response to AG Supplemental Request for Information [08.10.2021]

<sup>133</sup> KP AG Question #29 (October 26 2021)

Hospital Name	City	County	Total Discharges
LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL	Loma Linda	San Bernardino	125
ARROWHEAD REGIONAL MEDICAL CENTER	Colton	San Bernardino	113
KAISER FOUNDATION HOSPITAL - FONTANA/ONTARIO	Fontana	San Bernardino	112
COMMUNITY HOSPITAL OF SAN BERNARDINO	San Bernardino	San Bernardino	60
REDLANDS COMMUNITY HOSPITAL	Redlands	San Bernardino	23
<b>VICTOR VALLEY GLOBAL MEDICAL CENTER</b>	<b>Victorville</b>	<b>San Bernardino</b>	<b>19</b>
<b>SMMC</b>	<b>Apple Valley</b>	<b>San Bernardino</b>	<b>16</b>
BARSTOW COMMUNITY HOSPITAL	Barstow	San Bernardino	13
LOMA LINDA UNIVERSITY MEDICAL CENTER	Loma Linda	San Bernardino	9
<b>DESERT VALLEY HOSPITAL</b>	<b>Victorville</b>	<b>San Bernardino</b>	<b>8</b>
<b>TOTAL DISCHARGES</b>			<b>498</b>
Source: OSHPD Patient Discharge Data, 2019			
*Includes all discharges with an ICD 10 code associated with the following Diagnosis Related Groups (DRG):			
(1) 770-Abortion w D&C Aspiration Curettage or Hysterectomy			
(2) 779-Abortion w/o D&C			
(3) 796-VAGINAL DELIVERY WITH STERILIZATION/D&C WITH MCC			
(4) 797-VAGINAL DELIVERY WITH STERILIZATION/D&C WITH CC			
(5) 798-VAGINAL DELIVERY WITH STERILIZATION/D&C WITHOUT CC/ MCC			

The top three hospitals based on number of discharges are all in San Bernardino and include: 1) Loma Linda, 2) Arrowhead Regional and 3) Kaiser Fontana. Loma Linda, as a large academic medical center operating six hospitals offers a range of reproductive health services including invitro fertilization (IVF) services, family planning and contraceptive services.<sup>134</sup>

SMMC reports 16 discharges for the selected ICD10 codes for inpatient abortion and sterilization services and the nearby hospitals Victor Valley and Desert Valley report 19 and 8 discharges, respectively. So, while these hospitals are not the most frequent providers of the selected services, it appears they do provide some abortion and sterilization related services.

Additionally, there were 28 ambulatory surgery sites in Riverside and San Bernardino reporting the provision of contraception services, based on ICD10 codes from the Family Planning National Training Centers (FPNTC), for residents in Riverside and San Bernardino. A complete list of ICD10s is at the FPNTC website, however, this includes services such as tubal ligations, sterilizations, and IUD insertion and removal. Victor Valley Global Medical Center, Riverside Community Hospital and Kaiser Fontana accounted for 40% of all encounters.<sup>135</sup>

<sup>134</sup> Loma Linda University Health System website, 2021 (<https://lluh.org/about-us> Accessed 10/3/2021)

<sup>135</sup> HCAI Ambulatory Surgery Center Data, 2019. Contraception codes were based on the data from Family Planning National Training Centers: "Frequently Used Codes: Commonly Used ICD-10 Codes in Reproductive Healthcare", December 19, 2017.

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Inland Empire Women’s Center is another resource that offers gynecology services including Family Planning and Birth Control and obstetrics and their list of procedures and services includes Cervical Biopsy, Colposcopy, Curettage Genetic, IUD Insertion and Diaphragm Fitting, Procedure Ultrasound.<sup>136</sup> The Center states that they accepted many common area insurance plans including IEHP, Alpha Care, Molina, Aetna, Blue Shield, Blue Cross and other insurers and have multiple locations (Exhibit # 17 Inland Empire Women’s Center Locations).

*Exhibit 16 Area Clinics Offering Reproductive Health Services, 2019*

Western Avenue Office 1800 N. Western Ave Suite 204 San Bernardino, CA 92411
Waterman Avenue Office 1364 N. Waterman Ave San Bernardino, CA 92404
Fontana Office 16465 Sierra Lakes Parkway Suite 245 Fontana, CA 92336

Additionally, there was one community clinic, Planned Parenthood of Orange and San Bernardino Counties in Victorville, within 30 miles of the current SMMC facility and the New Hospital zip code open in 2019. Planned Parenthood of Orange and San Bernardino is about a 35 minute drive from Apple Valley, where SMMC is located. This site provides a relatively high volume of reproductive health services and reported more than 2,000 family planning and contraceptive management encounters.<sup>137</sup> The several Planned Parenthood offices in the Inland Empire area, which includes Riverside and San Bernardino, report the availability of abortion, birth control, HIV Services, LGBTQ services, STD testing, and more.<sup>138</sup> Other clinics

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<sup>136</sup> Contact: Inland Empire Women's Center: San Bernardino, CA. Inland Empire Women's Center. (2021, February 4). <https://inlandempirewomenscenter.com/contact-inland-empire-womens-center/>.

<sup>137</sup> These data are based on 2019 clinic information collected by HCAI where Family Planning “Z” ICD10 codes and Contraceptive Management codes, reflect services related to the provision of different types of contraception and are captured by CPT codes 11976, 11980, 55250, 55300, 55400, 57170, 58300 - 58301, 58600, 58605, 58611, 58615.

<sup>138</sup> Parenthood, P. (n.d.). Birth control, STD Testing & Abortion - San Bernardino, CA. Planned Parenthood. [https://www.plannedparenthood.org/health-center/california/san-bernardino/92408/san-bernardino-health-center-2282-90160?utm\\_campaign=san-bernardino-health-center&utm\\_medium=organic&utm\\_source=local-listing](https://www.plannedparenthood.org/health-center/california/san-bernardino/92408/san-bernardino-health-center-2282-90160?utm_campaign=san-bernardino-health-center&utm_medium=organic&utm_source=local-listing). and Parenthood, P. (n.d.). Birth control, STD Testing & Abortion - Riverside, CA. Planned Parenthood. [https://www.plannedparenthood.org/health-center/california/riverside/92506/riverside-flaster-family-health-center-2187-90110?utm\\_campaign=riverside-family-planning-center&utm\\_medium=organic&utm\\_source=local-listing](https://www.plannedparenthood.org/health-center/california/riverside/92506/riverside-flaster-family-health-center-2187-90110?utm_campaign=riverside-family-planning-center&utm_medium=organic&utm_source=local-listing).

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besides the Victorville clinic were available but much farther away requiring an hour's drive or more.

Assuming the landscape of reproductive health services provided through a network of providers, clinics and hospital remains stable, we may be able to assume adequate access but it is difficult to know with any certainty since we do not know the need for services. It is worth noting that community benefit plans and the San Bernardino Community Vital Signs Initiative also do not point to a lack of access to reproductive health services or identify it as a priority or high need for the community.<sup>139</sup>

The uncertainty around the enforcement of the ERDs in this CiC may be consistent with other transactions involving Catholic hospitals. A 2020 study on the growth of Catholic Health Systems stated: Our 2020 study of Catholic hospitals and health systems uncovered examples of partnerships with non-Catholic systems that have become increasingly complex and opaque. The result has been to increase the likelihood that health consumers will be unaware of religiously-based restrictions on care, as would employers evaluating health insurer provider networks in choosing employee health plans<sup>140</sup>

This uncertainty is exacerbated by recent litigation. For example, Hoag Hospital is in litigation with Providence on several issues, including restrictions on reproductive care they say Providence illegally imposes on them through its adherence to the ERDs.<sup>141</sup> Additionally, in October of 2020, a letter was sent to the OCAG alleging that Providence frequently declined to authorize contraceptive treatments, such as intrauterine devices and tubal ligations, in breach of the conditions imposed by Becerra's predecessor, Kamala Harris, when she approved the original affiliation with St. Joseph in 2013.<sup>142</sup> Another court case, however, has strengthened the message that discrimination is not acceptable. In November 2021 the Supreme Court let an appellate court ruling stand against a California hospital accused of denying a transgender patient care.<sup>143</sup> This has implications for a similar case against a St. Joseph Hospital but also points to the need for clear conditions that support nondiscrimination in medical settings.

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<sup>139</sup> Priority area: Access to health and Wellness. Priority Area: Access to Health and Wellness – Community Vital Signs Initiative. (n.d.). <https://communityvitalsigns.org/priority-area-access-to-health-and-wellness/>.

<sup>140</sup> Solomon, Tess et al, Bigger and Bigger, The Growth of Catholic Health Systems, Community Catalyst, 2020. (<https://www.communitycatalyst.org/resources/publications/document/2020-Cath-Hosp-Report-2020-31.pdf> Accessed 8/28/2021)

<sup>141</sup> Kaiser Health News, Orange County Health System Seeks Divorce from Large Catholic Health System, US News, April 9, 2021 <https://www.usnews.com/news/health-news/articles/2021-04-09/california-hospital-seeks-divorce-from-large-catholic-health-system>

<sup>142</sup> Kaiser Health News, Orange County Health System Seeks Divorce from Large Catholic Health System, US News, April 9, 2021 <https://www.usnews.com/news/health-news/articles/2021-04-09/california-hospital-seeks-divorce-from-large-catholic-health-system>

<sup>143</sup> Guilfoil, J., Attorney: Supreme Court decision 'good news' for local transgender discrimination case against St. Joseph Hospital, Times Standard 11/2/2021 (<https://www.times-standard.com/2021/11/02/attorney-supreme-court-decision-good-news-for-local-transgender-discrimination-case-against-st-joseph-hospital/>)

Kaiser has made it clear that Kaiser’s 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’s members across the Southern California Region and that this will not change as a result of this transaction. However, patients will need to continue to travel to obtain care for some of these services, e.g. tubal ligations, abortions, and permanent sterilization, which are offered at the Kaiser Fontana and Kaiser Ontario locations, an approximate 45-90 min drive from Victorville depending on traffic conditions.<sup>144</sup> Kaiser emphasized its commitment to ensuring equitable access, regardless of the zip code of a member’s residence and provided a long list of reproductive and fertility care that their physicians offer including family planning, such as birth control medication (pills, implants, intrauterine devices), male and female sterilization and abortion care noting that they also partner with local clinics for certain abortions. Although Kaiser’s patients will continue to have access to these services, they will not be able to obtain some of them at the New Hospital.

Answering the questions we posed earlier, it appears that there is currently availability and accessibility of reproductive services in the SMMC market. Kaiser has indicated their services would not be diminished with the CiC but based on the current contract and Providence’s commitment to the ERDs, it is not clear what constraints may be put on Kaiser doctors in what settings. Consequently, we propose conditions of approval for consideration by the OCAG if they approve the proposed transaction.

#### **7.4.1 Potential Conditions for Transaction Approval by the OCAG Related to Reproductive Services**

In order to minimize any potential negative healthcare impact that might result from the transaction, we propose that the OCAG consider the following conditions related to ensuring access to range of reproductive health services. We recommend the OCAG consider applying conditions for a period of at least ten years or until the New Hospital is operational and admitting patients.<sup>145</sup> Further, once the New Hospital is operational and admitting patients these conditions would apply to the New Hospital for ten years or more. These conditions include:

- **Allow Kaiser Physicians to practice as they would at Kaiser Hospitals.** Consistent with the 2019 Dignity Health merger with Catholic Health Initiatives to form Common Spirit, where the OCAG approved the merger under the condition that existing reproductive health services at the group of historically non-Catholic Dignity system hospitals be maintained for ten years, Kaiser physicians would be allowed to continue to provide

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<sup>144</sup> KP AG Question #29 (October 26 2021). This document lists the Kaiser hospitals where specific services are offered.

<sup>145</sup> This may not be applicable for example where a study is recommended,



reproductive health services at SMMC for a designated period, e.g., 10 years or throughout the period of the CiC.

- This is consistent with SMMC’s response #31 and #32 in [Part1] Project Blossom - Response to AG's Request for Information Dated 9-21-21 [10-5-2021] (1): “Providence, SMMC and NewCo do not expect any impact on Kaiser or Permanente’s patients from the applicability of the ERDs, Statement of Common Values, or any other restrictions to Kaiser or Permanente.”
- This is consistent with the University of California (UC) guideline: Evidenced-based care proposed by the University of California. “Agreements will expressly provide that UC personnel working or training at any clinical site — whether at UC facilities or elsewhere — will (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 health care options; (iii) prescribe any interventions that are medically necessary and appropriate; and (iv) transfer or refer patients to other facilities when the care they need is not available where they are being seen.”<sup>146</sup>
- Improving or preserving access to reproductive health services could also be achieved by designating a separate part of the facility for such services, as in the case involving the merger of the secular Samaritan Hospital with the St. Peter’s Health System.<sup>147</sup>
- **Allow normally disallowed procedures if the patient could not be safely transferred.** 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, termination of ectopic pregnancies), and could not be safely transferred to another institution, Kaiser staff would be allowed to perform the procedure at the hospital. (Note: This would not be necessary if Kaiser staff are allowed to perform procedures they decide are clinically necessary and would otherwise perform at Kaiser facilities.)
- **Notify the OACG prior to eliminating reproductive health services.** If requirements to continue to provide certain services under the approval of the CiC are subject to a

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<sup>146</sup> University of California, Irvine. (2020, January 28). Working Group on Comprehensive Access Chair’s Report of Findings and Recommendations with Responses from Working Group Members and UC Legal. Irvine.

<sup>147</sup> In Troy, New York, a secular hospital—Samaritan Hospital—was merging with the St. Peter’s Health System and becoming Catholic. However, the hospital systems reached an arrangement whereby a section of the second floor of the hospital would become the Burdett Care Center, a separately incorporated hospital with its own finances, staff, and board. All maternity services from Samaritan and another nearby Catholic hospital in the system were moved to this center, where post-partum sterilizations and other services were permitted. Source: Merger Creates St. Peter’s Health Partners; Region’s Most Comprehensive Health Care Provider, ST. PETER’S HEALTH PARTNERS (Oct. 3, 2011), <http://news.sphp.com/news/merger-creates-st-peters-health-partners-regionsmost-comprehensive-health-care-provider>.

duration limit (e.g., 10 years from the Closing Date), then as with the conditions imposed in connection with the 2019 Dignity Health merger, Providence must notify the Attorney General at least one year prior to eliminating any reproductive health services.

- **Provide a contact or liaison for any concerns related to the provision of services.** Prior to the Closing Date, the parties must ensure that Kaiser personnel have a point of contact at Kaiser for reporting any incidents of New Hospital management impeding Kaiser personnel's ability to provide care in a manner consistent with personnel's professional judgment.

## 7.5 Ensuring Access to the LGBTQ Community

Kaiser is an active provider of LGBTQ services and has indicated this will not change after the transaction.<sup>148</sup> Ensuring these services will be an important step to reducing discrimination in the LGBTQ community. A large national lesbian, gay, bisexual and transgender (LGBTQ) health survey conducted detailed transgender patients' experiences of discrimination in health care.<sup>149</sup> Seventy percent of transgender respondents reported having one or more of the following experiences: Health care providers refusing to touch them or using excessive precautions; Health care providers using harsh or abusive language; Health care providers being physically rough or abusive; health care providers blaming them for their health status. In addition, nearly 27% of transgender survey respondents reported being denied needed care outright because of their transgender status.

As part of our analysis related to access and availability of services for the SMMC market area residents, the OCAg asked us to look at whether area residents received gender-affirming healthcare services, and where they received those services. Appendix D: Availability of Gender-Affirming Healthcare Services, 2019 provides detail on our methodology and findings. However, in brief, we find that residents in Riverside and San Bernardino Counties rely on heavily on Kaiser Facilities in these counties for gender-affirming healthcare services.

Hospitals that provide equitable and inclusive policies and practices ensure compliance with §1557 of the ACA, The Joint Commission and (in some areas) state and local law. Equitable and inclusive policies and practices also have many benefits financial and otherwise for the hospitals. They can reduce the risk of complaints and litigation, maximize patient satisfaction, maximize safety and quality of care, and reduce the costs associated with complications that

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<sup>148</sup> KP AG Question #29 (October 26 2021)

<sup>149</sup> Lambda Legal, When Health Care Isn't Caring: Survey On Discrimination Against LGBT People and People Living with HIV, 5-6 (2010), [http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert\\_transgender-and-gender-nonconforming-people.pdf](http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_transgender-and-gender-nonconforming-people.pdf). This study also found that transgender and gender-nonconforming respondents reported the highest rates of discrimination and barriers to care, having experienced such discrimination up to two to three times more frequently than lesbian, gay, or bisexual respondents.

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arise when transgender patients are denied or delay medical treatment due to discrimination.<sup>150</sup>

Kaiser states explicitly that 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. This will not change as a result of this transaction. Kaiser Permanente is committed to ensuring equitable access, regardless of the zip code of a member’s residence, and this is certainly true for our members in the High Desert”.<sup>151</sup>

Kaiser facilities across the state offer a broad range of services including:<sup>152</sup>

- 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. In San Bernardino county, SMMC’s county for both the current and New Hospital, Kaiser offers the following:<sup>153</sup>

- Six Kaiser endocrinologists in San Bernardino, all with expertise to care for transgender patients, and all who deliver this specialized medical care.
- The option for in-person or virtual video/telephone visits including the initial consultation and follow-up appointments for endocrinology care.
- The option to obtain related LGBTQ medications and have blood draws in the High Desert along with receiving injections in the High Desert.
- The ability to have follow-up appointment virtually so that patients are not required to travel for medical management appointments.
- The ability to obtain hormone therapies, that aren’t provided as clinic administered medications, from Kaiser pharmacies in Victorville and Hesperia, or delivered to the patient directly by Kaiser’s mail order pharmacy.

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<sup>150</sup> CREATING EQUAL ACCESS TO QUALITY HEALTH CARE FOR TRANSGENDER PATIENTS, May 26, 2016, Published by Lambda Legal, New York City Bar, Hogan Lovells, and Human Rights Campaign Foundation.

([https://www.lambdalegal.org/sites/default/files/publications/downloads/hospital-policies-2016\\_5-26-16.pdf](https://www.lambdalegal.org/sites/default/files/publications/downloads/hospital-policies-2016_5-26-16.pdf))

<sup>151</sup> KP AG Question #29 (October 26 2021)

<sup>152</sup> KP AG Question #29 (October 26 2021)

<sup>153</sup> OCAG personal communication with Kaiser, November 5, 2021.

However, Kaiser's patients may not have access to this care at the New Hospital and will still need to travel outside the High Desert region in many cases, including going as far as Kaiser's Fontana or Ontario locations. Conditions could thus establish and confirm Kaiser's intent and assurance to provide care to its patients.

### **7.5.1 Potential Conditions for Transaction Approval by the OACG Related to LGBTQ Services**

To minimize potential negative healthcare impacts that might result from the transaction related to access to discrimination broadly and against the LGBTQ population specifically, we propose that the OACG consider the conditions below to reduce the risk of discrimination. We recommend the OACG consider applying the conditions for a period of at least ten years or until the New Hospital is operational and admitting patients. Further, once the New Hospital is operational and admitting patients these conditions would apply to the New Hospital for ten years or more. These conditions include:

- **Post non-discrimination policies.** From the point of closing, the New Hospital will adopt policies that prohibit discrimination based on gender identity and gender expression and that are consistent with the policies outlined in the Transgender Affirming Hospital Policies Document.<sup>154</sup> Policies prohibiting discrimination based on gender identity and gender expression are summarized briefly below and more detail on Hospital Non-discrimination Policies can be found at the link provided in the footnote.<sup>155</sup>
- **Adopt hospital policies that prohibit discrimination based on gender identity, gender expression and other protected personal characteristics.** The New Hospital shall prohibit discrimination based on any protected personal characteristic identified in state and federal civil rights laws, including section 51 of the California Civil Code and title 42, section 18116 of the United States Code. Categories of protected personal characteristics include:
  - Gender, including sex, gender, gender identity, and gender expression;
  - Intimate relationships, including sexual orientation and marital status;
  - Ethnicity, including race, color, ancestry, national origin, citizenship, primary language, and immigration status;
  - Religion;
  - Age; and

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<sup>154</sup> Creating Equal Access to Quality Health Care for Transgender Patients, Lambda Legal, May 2016 (<https://www.thehrcfoundation.org/professional-resources/transgender-affirming-hospital-policies> Accessed 9/15/2021)

<sup>155</sup> Creating Equal Access to Quality Health Care for Transgender Patients, Lambda Legal, May 2016 ([https://www.lambdalegal.org/sites/default/files/publications/downloads/hospital-policies-2016\\_5-26-16.pdf](https://www.lambdalegal.org/sites/default/files/publications/downloads/hospital-policies-2016_5-26-16.pdf) Accessed 9/15/2021)

- Disability, including disability, protected medical condition, and protected genetic information.
- The New Hospital will post non-discrimination policies on both its website and in the ED. Language comparable to that posted by the University of California San Francisco Hospital would be appropriate.<sup>156</sup>

## 7.6 Ensuring Access to Mental Health Services

There are several sources that suggest residents in the Inland Empire may lack adequate access to mental health services. A recent California Health Care Foundation (CHCF) analysis of the Inland Empire found that more people in this area report experiencing frequent mental distress compared with Californians generally, and more reported needing mental health treatment but not receiving care.<sup>157</sup> They note that the Inland Empire is home to only eight psychiatrists per 100,000 residents, the second-lowest ratio across the seven study markets the Foundation investigated.

The challenge accessing mental health services is further supported by the fact that SMMC's geographic market area is located in a designated mental health shortage area.<sup>158</sup> The Federal Health Resources and Services Administration (HRSA) defines Health Professional Shortage Areas (HPSA) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Additionally, SMMC acknowledges that in the hospital's service area, mental health providers are limited with only two to three psychiatrists operating locally.<sup>159</sup>

San Bernardino County Department of Behavioral Health (DBH) is the area's largest provider of mental health services. While new outpatient and crisis services are available in the High Desert, none of the local hospitals offer inpatient psychiatric services. As a result, patients in crisis can be stabilized or transported 40 miles to inpatient care provided by urban hospitals, including Loma Linda (Redlands, CA) Common Spirit (San Bernardino, CA) Canyon Ridge (Chino, CA) and Arrowhead Regional Medical Center (Colton, CA). The Notice indicates that Kaiser Permanente has started outpatient mental health programs to serve its members. However, while Kaiser Permanente claims it has gone a long way toward improving its mental health care and regulators at California's Department of Managed Health Care report that Kaiser is meeting the benchmarks laid out in a 2017 settlement agreement, it is not clear that these are more

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<sup>156</sup> UCSF Health: Hospital Policies, (<https://www.ucsfhealth.org/your-hospital-stay/hospital-policies>)

<sup>157</sup> California Health Care Almanac, Inland Empire: Increasing Medi-Cal Coverage Spurs Safety-Net Growth, California Health Care Foundation, December 2020.

<sup>158</sup> Health Resources and Services Administration, Health Professional Shortage Area (HPSA) <https://data.hrsa.gov/tools/shortage-area/hpsa-find> Accessed 8/17/2021

<sup>159</sup> Notice of Affiliate Transaction – SMMC, at pg. 392 (April 7, 2021) (on file with OCAg).

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than superficial gains and patients still struggle to access ongoing treatment, e.g., often waiting two months between therapy sessions.<sup>160</sup>

Some headway has been made for the Medi-Cal population with IEHP's efforts to improve behavioral health care integration, including complex care management teams to aid patients with physical, behavioral, social, and environmental needs. One such effort is the Behavioral Health Integration Complex Care Initiative (BHICCI), a partnership between 30 local health centers, clinic sites, and IEHP, with a goal of improving Medi-Cal enrollees' health outcomes by providing care management and care coordination for physical and behavioral health needs across multiple providers and health care systems.<sup>161</sup>

Nonetheless, mental health was the number one health priority identified by community stakeholders and residents in San Bernardino based on a community health assessment conducted by Community Vital Signs along with the Department of Public Health.<sup>162</sup>

While Kaiser Permanente has started outpatient mental health programs to serve its members including intensive outpatient programs serving adults and youth, it is not clear how and to what extent other area residents will benefit from enhanced mental health programs and services as a result of the CiC.<sup>163</sup>

The SMMC Community Health Needs Assessment includes as one of its top priorities "Creating awareness and education regarding mental health and substance use, particularly amongst the Latino population, and ultimately bringing resources that address these in a meaningful and dignified way." The Needs Assessment acknowledges that people living with mental health challenges need to be connected to resources in a timely manner, just as with any other medical emergency.

### **7.6.1 Potential Conditions of Approval Related to Mental Health Services**

To improve access to mental health care for the community following the CiC, we propose that the OCAG consider the following conditions:

- **Implement a Behavioral Health Quality Improvement Program (BH-QIP).** We recommend that within one year of the Closing date of the CiC Kaiser and the new Hospital submit a plan to implement a Behavioral Health Quality Improvement Program

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<sup>160</sup> Gold, Jenny, Despite Quick Fixes, Kaiser Permanente Mental Health Care Still Lags, California Healthline 12/17/2019  
<https://californiahealthline.org/news/despite-quick-fixes-kaiser-permanente-mental-health-care-still-lags/>  
Accessed 8/17/2021

<sup>161</sup> California Health Care Almanac, Inland Empire: Increasing Medi-Cal Coverage Spurs Safety-Net Growth, California Health Care Foundation, December 2020.

<sup>162</sup> San Bernardino Department of Public Health website, Stakeholder Feedback, Copyright 2021  
<https://healthstat.dph.sbcounty.gov/stories/s/CHA-Engagement-Priorities/g67s-angf> Accessed 8/18/2021

<sup>163</sup> Notice of Affiliate Transaction – SMMC, at pg. 20 (April 7, 2021) (on file with OCAG).

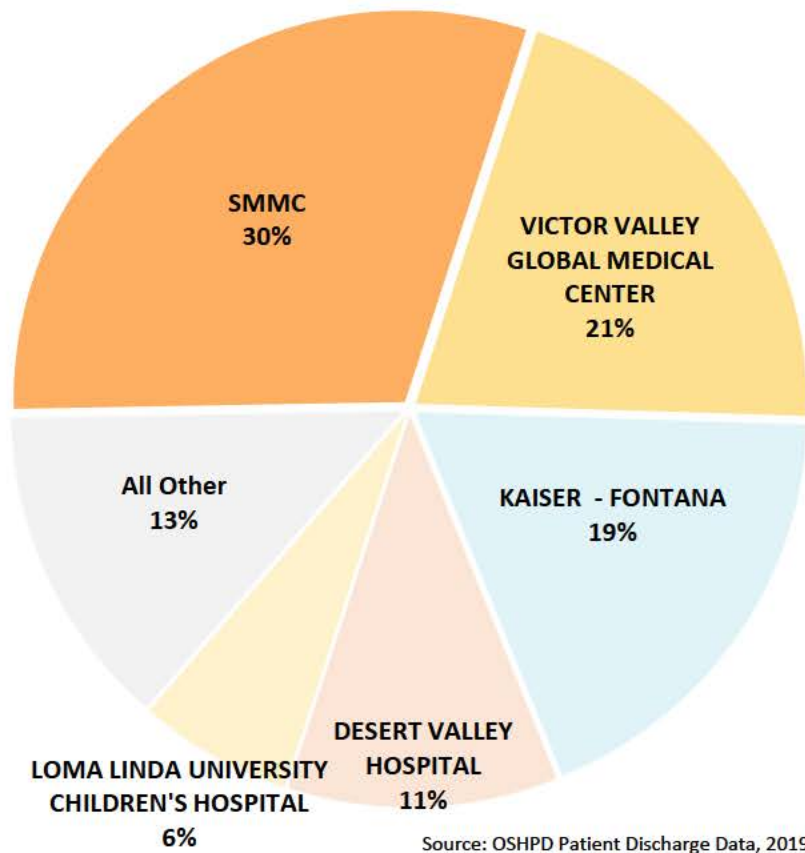
(BH-QIP) with measurable outcomes to be reported publicly at one year intervals over a five year period.

- **Evaluate the use of the Apple Valley site for mental health services.** Within one year of the Closing Date, the New Hospital will evaluate the use of the Apple Valley site for non-acute mental health services and any other behavioral health services that are lacking in the community.

## 7.7 Ensuring Access to Maternity and Obstetrics Services

SMMC is the primary provider for local area residents for maternity services, accounting for 30% of the births in the market area (Exhibit # 18 Live Births within SMMC’s Market Area, 2019). Victor Valley is the second leading hospital handling deliveries in the area.

*Exhibit 17 Live Births within SMMC’s Market Area, 2019*



A reduction in the type and/or level of obstetrics services or number of licensed obstetrics beds provided at SMMC would have an adverse effect on the availability and accessibility of these key services to members of the surrounding communities. Additionally, SMMC is a very

important provider of obstetrics services to low-income patients, as shown by the fact that approximately 7 out of 10 deliveries are of newborns to Medi-Cal patients.

### **7.7.1 Potential Conditions of Approval Related to Obstetrics**

To minimize potential negative healthcare impacts that might result from the transaction related to access to reduced access to obstetrics, we propose that the OACG consider the following condition. We recommend the OACG consider applying this condition for a period of at least ten years or until the New Hospital is operational and admitting patients. Further, once the New Hospital is operational and admitting patients this condition would apply to the New Hospital for ten years or more.

- **Maintain obstetric services.** For at least ten years from closing, SMMC shall maintain the obstetrics at the current or higher level of service at the new location, giving both SMMC and Kaiser Physicians the opportunity to perform deliveries at the hospitals. This service level includes a minimum of 16 obstetrics beds, two intensive care newborn nursery beds, and the maintenance of the hospital designation as a Level III Neonatal Intensive Care Unit.<sup>164</sup>

## **7.8 Ensuring Access to Vulnerable Populations Including Medi-Cal Members**

There has been considerable growth in Medi-Cal since the Affordable Care Act (ACA) and the program now covers more than 13 million Californians, primarily children, adults, and seniors with low incomes as well as people with disabilities. These are the state's more vulnerable populations and ensuring health care access is critical to not only their health but the public health of all Californians. Adult Medi-Cal enrollees are less likely to forego care due to cost but have more difficulty getting timely care compared to those covered by other insurance.<sup>165</sup> This is in large part because Medi-Cal rates are among the lowest physician reimbursement rates in

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<sup>164</sup> The American Academy of Pediatrics (AAP) developed standards for NICU designations to outline the type of care newborns can receive in a facility. Level 1 and 2 NICUs are designed to provide basic care for newborns with conditions that are expected to resolve without need for subspecialty care. To be designated a level 3 NICU, the unit must offer prompt and readily available access to a full range of pediatric medical subspecialties. A level 3 NICU cares for babies born before 32 weeks gestation, weigh less than 3 pounds, 5 ounces, have medical conditions or need surgery. Level 3 NICUs also provide a full range of respiratory support and have available subspecialists include neonatologists and staff and equipment to provide life support as long as necessary. Some babies may need more complex care available at the highest level of NICU — level 4.

<sup>165</sup> Perrone, C, California Lawmakers Asked CHCF How to Improve access to Care in Medi-Cal California Health Care Foundation, Feb 8, 2018 (<https://www.chcf.org/blog/chcf-testifies-access-care-medi-cal-assembly-select-committee/> Accessed 8/27/2020)



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the country with only two states having lower rates.<sup>166</sup> Consequently, it is important that access for this population is not further restricted.

Whether the proposed CiC could adversely affect Medi-Cal enrollees' access to care depends on:

- Continuation of Medi-Cal contracting: Will the New Hospital continue its contracts for Medi-Cal patients and engage in new ones if the current ones are terminated?
- Equal access and availability for Medi-Cal patients: Will Medi-Cal patients have equal access to the New Hospital; and
- Will the access for Medi-Cal patients be sufficient: Will the New Hospital's added capacity be sufficient to satisfy an increase in demand for services from Kaiser enrollees without compromising access for Medi-Cal patients?

The parties' submissions indicates that Medi-Cal enrollees will be given equal priority for service at the New Hospital, but these agreements do not explicitly establish that SMMC will maintain existing contracts for Medi-Cal or contract with Medi-Cal at some specified volume following the opening of the New Hospital. With respect to New Hospital capacity, our analysis of inpatient demand for services shows that, due simply to regional population growth, the current facility will be inadequate to fully serve inpatient demand by 2026, and that by 2035 its shortage of beds would result in an inability to serve over 11,000 patient days per year. If the New Hospital is constructed, we project there will also be a shortage of capacity by 2026, though this gap would be smaller than under the current facility scenario. By 2035, however, if Kaiser is able to capture significant market share, the shortage of beds at the New Hospital may exceed the predicted shortage at the current facility for that year. Given the disparities in payer rates between Medi-Cal and commercial plans, it is possible that Medi-Cal enrollee access to care would be particularly harmed.

As to outpatient capacity, the conclusion is less clear. While the parties' decision not to expand ED capacity is concerning—given that, according to SMMC, its ED is already stretched thin—the parties provide plausible explanations as to how utilization of ED services could decrease even as the number of patients choosing the New Hospital's ED increases. In the sub-sections below, we provide detail supporting these findings.

### **7.8.1 Continuation of Medi-Cal Contracting Will be Important to Area Residents**

While several provisions of the agreement between SMMC, the LLC, and Kaiser suggest that Medi-Cal patient care will remain part of SMMC's mission at the New Hospital, it is not clear

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<sup>166</sup> Beitsch, R. Are Medicaid's Payment Rates So Low They're Discriminatory? Pew Stateline, 9/22/2017 (<https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/09/22/are-medicoids-payment-rates-so-low-theyre-discriminatory> Accessed 10/13/2021)

that the New Hospital will continue to maintain its level of commitment to serve patients of Medi-Cal, Medicare, or other vulnerable populations. The Management Services Agreement entered into between SMMC and the LLC requires that all clinical personnel at the New Hospital “be a participating provider, in good standing, in the Medicare and Medicaid programs and those health plans with which Company contracts, except as otherwise permitted in such personnel contracts.”<sup>167</sup> Thus, while it appears that New Hospital physicians are expected to serve Medi-Cal patients, it is not guaranteed that any particular volume of Medi-Cal patients will be seen or any specific contracts will be honored.

There is some uncertainty regarding the extent of Kaiser’s influence on the New Hospital’s agreements with Medi-Cal plans. Under Article IV of the Affiliation Agreement between SMMC, the LLC, and Kaiser, SMMC is “solely responsible for . . . negotiating all third party payer and government program payer [e.g., Medi-Cal or Medicare] contracts at the Hospitals, including rates and other terms.” Kaiser personnel are barred from “access[ing] payer contract information” and will have no “input into SMMC . . . decision making relating to third party payer contracting.”<sup>168</sup>

Under the Operating Agreement, however, a supermajority of the Board of Directors (i.e., a majority of the overall Board that includes two of the three Kaiser-appointed Directors) is required to approve any “exclusive contract” with another insurer or third party “for dedicated capacity” or that is “likely to lead to material reductions in capacity or access” for Kaiser’s members.<sup>169</sup> However, the parties do not further define “exclusive” in this context and conceivably the terms of the agreement could provide Kaiser veto power over certain contracts that might increase or preserve access for Medi-Cal enrollees to the possible detriment of Kaiser’s members or other plans’ enrollees. Additionally, in a March 17<sup>th</sup> letter to the OCAG, SMMC states: “Given the reimbursement agreements (i.e., the Health Care Services Agreements) Kaiser has agreed to enter into in connection with its minority investment in Newco, an important issue for Kaiser was for its appointees on the Newco Board of Managers to have the ability to approve a Hospital contract that is likely to adversely affect access or capacity for Kaiser’s patients at the Hospital.” Conceivably, Medi-Cal utilization could adversely affect capacity for Kaiser’s patients.

### **7.8.2 Access for Medi-Cal Patients Appears to be Available for Contracted Members**

Where there is a Medi-Cal contract in place with IEHP, the predominant Medi-Cal insurer, and other Medi-Cal insurers, it appears that Medi-Cal patients, in the event of any capacity shortage, are guaranteed access privileges equal to Kaiser’s members. The Care Model Agreement between SMMC and Kaiser outlines SMMC’s responsibilities to provide sufficient

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<sup>167</sup> Notice of Affiliate Transaction – SMMC, at pg. 123 (April 7, 2021) (on file with OCAG).

<sup>168</sup> Notice of Affiliate Transaction – SMMC, at pg. 245 (April 7, 2021) (on file with OCAG).

<sup>169</sup> Notice of Affiliate Transaction – SMMC, at pg. 66 (April 7, 2021) (on file with OCAG).

hospital capacity for Kaiser’s members and other patients, along with various performance metrics that SMMC must meet in providing access to care. These provisions also apply to non-Kaiser’s members, however, and are therefore, we assume, relevant to Medi-Cal enrollee access.<sup>170</sup> The Agreement provides all potential New Hospital patients the same priority, stating that “the New Hospital shall assign beds for such Services to Member patients in the same manner as beds are assigned to all other patients seeking admission at the New Hospital.[Clinicians are to] provide equal access to the New Hospital to any person regardless of payment rates applicable.”<sup>171</sup>

### **7.8.3 Access for Medi-Cal Patients May Not be Sufficient at the New Hospital**

The final question related to Medi-Cal patient access is whether the proposed capacity at the New Hospital is sufficient to serve all existing SMMC patients, including Medi-Cal enrollees, in addition to any new service demand from Kaiser’s members. In this section we model the capacity of the New Hospital to accommodate Medi-Cal enrollees given various assumptions about Kaiser utilization and population growth.

Under the Care Model Agreement, the parties do not appear to contemplate any shortages in capacity resulting from an influx of Kaiser’s patients. The clauses relating to accessibility and capacity note that, in the event the New Hospital is unable to meet the “expected and fluctuating needs of Members,” the parties will attempt first to staff all available beds, and then, if necessary, and “in SMMC’s discretion (and at its sole cost), provide additional capacity through the addition of licensed beds or other major undertakings.”<sup>172</sup>

While SMMC has noted in its responses to the OACG that its current ED is overburdened and that the High Desert region more broadly lacks sufficient inpatient capacity, for purposes of this analysis, the primary focus is to assess whether the CiC, independent of other demographic or market factors, would improve or harm access *relative to* the status quo alternative.<sup>173</sup> In other words, to the extent that the current facility may be inadequate given the volume of services required by Medi-Cal patients (either now or in future years, as the region’s population grows), our analysis is primarily intended to demonstrate only whether the CiC would mitigate or exacerbate this insufficiency.

### **Modeled estimate of inpatient access at the New Hospital**

Exhibit # 19, Sensitivity Analysis of New Hospital Capacity, Patient Days shown below, provides three separate capacity and access scenarios. Each scenario projects a total excess or shortage of capacity in 2026 and 2035, and each scenario adopts [REDACTED]

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<sup>170</sup> Notice of Affiliate Transaction – SMMC, at pg. 184 (April 7, 2021) (on file with OACG).

<sup>171</sup> Notice of Affiliate Transaction – SMMC, at pg. 204 (April 7, 2021) (on file with OACG).

<sup>172</sup> Notice of Affiliate Transaction – SMMC, at pg. 206 (April 7, 2021) (on file with OACG).

<sup>173</sup> SMMC Response to OACG, pg. 22 – 23.

[REDACTED] that the region's population grows at a 1% compound annual growth rate (CAGR).<sup>174</sup>

First, the *Current Facility* scenario establishes baseline capacity levels and assumes that SMMC serves the community without any other new hospital entries into the market. We assume that the current facility is already at full capacity, given that its occupancy rate, at 85%, is among the highest in the region. We further assume that in 2026 and 2035, the current facility's capacity remains the same (i.e., there is no increase in the number of staffed beds, and no ability to further increase the occupancy rate). Our model shows that by 2026, due to population growth, SMMC is unable to provide care for an estimated 4,665 patient days per year<sup>175</sup> This shortage increases to an estimated 11,161 patient days by 2035. Given the average length of stay at SMMC (4.6 days), these estimates imply that roughly 1,000 in 2026, and 2,400 patients in 2035, could be deprived adequate care.

We cannot say for certain which patients would not receive care in these scenarios, however, Given that net patient revenue per patient day from commercial payers is more than [REDACTED] [REDACTED] from Medicare, and almost [REDACTED] [REDACTED] Medi-Cal rates, there would at the least be a financial incentive for SMMC to reduce access for Medi-Cal patients.<sup>176 177</sup>

Second, the scenarios *New Hospital – Report Model* and *New Hospital – Kaiser Model* show two separate estimates of the demand for services relative to the New Hospital capacity. The *New Hospital – Report Model* scenario is based on our estimate of increases in demand, while the *New Hospital – Kaiser Model* scenario is based on [REDACTED] [REDACTED].<sup>178</sup> Increases in demand for inpatient services derives from three effects:

- New demand from Kaiser's members, who will now be using the hospital routinely for inpatient services.

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<sup>174</sup> See [REDACTED] We use 2026 and 2035 as our model years. 2026 is the first year that the New Hospital would operate.

[REDACTED] Compound annual growth rate (CAGR) is the mean annual growth rate over a specified period of time longer than one year.

<sup>175</sup> We express capacity in terms of patient days served. The use of discharges or admissions to measure inpatient capacity fails to reflect that some types of patients are admitted for longer periods. As a result, the use of discharges would fail to capture how changes in the composition of payers or patient demographics over time would influence demand for inpatient service.

<sup>176</sup> [REDACTED]

<sup>177</sup> Rate information is based on documents from the parties, however it is unclear whether this takes into account Disproportional Share Funds or fund from the Hospital Quality Assurance Fee Program which can be sizeable sources of revenue for hospitals.

<sup>178</sup> [REDACTED]

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- New demand from *future* Kaiser’s members, as Kaiser is expected to capture an increased share of the SMMC market.
- New demand resulting from population growth in the region.

Exhibit 19 Sensitivity Analysis of New Hospital Capacity, Patient Days. 2019, 2026 & 2035

Patient Day Capacity*	Current Facility			New Hospital - Modeled		2035
	2019	2026	2035	2026	2035	
Patient Days (Capacity)	64,671	64,671	64,671	79,313	79,313	
Total Patient Days Served (Demand)	64,671	69,336	75,832	81,032	93,404	
Kaiser (All Payers^^)	1,008	1,081	1,182	15,161	25,335	
SMMC Medi-cal	24,450	26,214	28,670	25,921	28,350	
SMMC Medicare	30,564	32,769	35,839	31,532	32,055	
SMMC Commercial / Other	8,649	9,272	10,141	8,409	7,664	
Capacity Excess (Shortage)		(4,665)	(11,161)	(1,709)	(14,091)	
Excess (Shortage) - % of Capacity		-7.2%	-17.3%	-2.2%	-17.8%	

\*Discharge capacity at the current facility is based on assumption that all available beds could be staffed (currently, just 195 of the 212 licensed beds, or 92%, are staffed, according to OSHPD's 2019 Financial Pivot data). At the new facility, the increase in discharge capacity is proportional to the increase in available beds.

Note: If the current facility is not able to increase its staffing percentage above 92%, the capacity shortage would expand to 1,133 beds. If at the New Hospital, the same percentage of available beds are staffed as at the current facility, there would be a shortage of 451 beds under Baseline Demand, a shortage of 1,369 beds under Very High Demand, and a shortage of 3,044 beds under the 30% Set-Aside scenario.

\*\*Includes Kaiser's commercial and Medicare Advantage members.

^^ For Kaiser members, we show combined patient days across commercial, Medicare Advantage, and Medi-Cal plans.

If the CiC is approved, determining whether Medi-Cal patients will continue to have adequate access requires estimating whether (a) the increase in capacity at the New Hospital is greater or lesser than (b) the increase in demand for services, as Kaiser’s patients begin using the New Hospital for its ED, maternity care, and other scheduled admissions and as the population grows. In other words, if estimated demand were to exceed estimated supply, one would conclude that the New Hospital would lack capacity sufficient to serve its patients, including Medi-Cal enrollees which could be disproportionately affected given the disparity in reimbursement discussed above.

Estimation of the increase in capacity of the New Hospital is straightforward: because the number of available beds would increase by nearly 23% under the CiC (260 beds 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.

To estimate the change in demand (applicable only to the *New Hospital - Report Model* scenario), two separate analyses were required. First, we estimated Kaiser’s future market shares (of commercial, Medicare Advantage, and Medi-Cal patients) in the SMMC market area

if the CiC were approved. Second, given data showing patient discharges by zip code at each hospital across San Bernardino County,<sup>179</sup> we estimated the share of Kaiser demand from within the SMMC market area that would shift from another Kaiser location (predominantly Kaiser Fontana/Ontario) to the New Hospital, given that, within the SMMC market area, the New Hospital will be closer to the patient’s residence than any other Kaiser location. A detailed account of this analysis is provided in Appendix E: Details on Medi-Cal capacity analysis.

As shown, under the *New Hospital - Report Model* scenario, the New Hospital would have a shortage of 1,709 patient days in 2026. By 2035, due to regional population growth and Kaiser’s capture of additional market share, demand increases considerably, and we estimate that the New Hospital would then face a shortage of 14,091 patient days. (This is greater than the Current Facility 2035 scenario since more Kaiser’s members are using the facility.) As with the *Current Facility* scenario, our *New Hospital - Report Model* scenario assumes that there is no change in average lengths of stay per hospital admission for any of the payers. While the projected shortage at the New Hospital exceeds the projected shortage at the current facility, if expressed as a *percentage* of total capacity, the shortages are roughly equivalent (17.3% of patient days at the current facility versus 17.8% at the New Hospital).

[REDACTED]

This assumes of a lower average length of stay; however, it is not clear what the basis is for this assumption.

Appendix E details on Medi-Cal Capacity Analysis provides further detail on differences between these two models.

#### ED and other outpatient access at the New Hospital

Estimating Medi-Cal outpatient access is more challenging, as the data available on outpatient services provided in the SMMC market area is not as comprehensive as for inpatient care because we have detailed inpatient data but not complete outpatient data. Moreover, whereas the reported number of available beds at the New Hospital allows an estimate of the increase in inpatient capacity, the parties provide limited information on outpatient capacity changes.

As to ED capacity specifically, it is unclear whether the New Hospital’s ED stations will be sufficient meet added demand from Kaiser’s patients.<sup>181</sup> SMMC asserts that its current ED,

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<sup>179</sup> HCAI Patient Discharge Data. 2019

<sup>180</sup> [REDACTED]

<sup>181</sup> While the ED is the primary source of inpatient admissions, analysis of ED capacity is separate from the analysis of inpatient capacity. The latter assesses whether the hospital has sufficient staffed beds to serve patients that

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which saw nearly 77,000 visits in 2019, is already overburdened, a problem that is worsened the County's policy of not allowing hospitals to go on diversion status<sup>182</sup>.<sup>183</sup> Yet the parties have not planned to expand the ED at the New Hospital.<sup>184</sup> Thus, it would at least appear that, if the current facility has no spare ED capacity, any ED demand added by Kaiser enrollees would deprive Medi-Cal patients access to emergency care.

In 2019, Kaiser Fontana / Ontario saw nearly 94,000 ED visits—a slightly larger service load than provided by SMMC. The hospital's admission rate suggests that SMMC market area residents may account for well over 10,000 of these visits.<sup>185</sup> Even a small shift of this demand towards the New Hospital could significantly overstretch capacity.

Despite this apparent challenge, [REDACTED]

[REDACTED]<sup>186</sup>  
This projection appears based on two assumptions. First, the parties expect that SMMC patient misutilization of the ED will decline over time: "SMMC's urgent care center sees approximately 2,000 cases per month. Providence estimates this number to increase by 50% per month when factoring in the 20% of patient misutilization of the Emergency Room." In other words, correcting for misutilization would convert 1,000 ED visits per month—or 12,000 per year—to SMMC's urgent care facility. Second, the New Hospital will have 22 observation beds, with eight dedicated to Kaiser's members.<sup>187</sup> This addition should allow the parties to divert demand from its ED stations. [REDACTED]

[REDACTED] Because there is no data to provide a basis for converting observation days to ED visits, it is unknown to what extent the addition of an observation unit will decrease stress on ED stations.

Given these assumptions, however, it is at least plausible that ED capacity at the New Hospital will be adequate, though it requires that SMMC actually resolve its patients' misutilization of ED resources. With respect to non-emergency outpatient services, the CiC is unlikely to impair Medi-Cal outpatient access. First, while hospitals are the sole providers of inpatient care, they are only one among many providers of outpatient services. Second, because Kaiser opened a new facility in Hesperia in 2020, Kaiser's High Desert members already enjoy access to

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require admission (either through the ED or scheduled), while the former assesses whether the hospital's ED stations are sufficient to serve all ED visits, including the majority of visits that do not lead to admission.

<sup>182</sup> HCAI Utilization Pivot, 2019

<sup>183</sup> California Healthcare Foundation, Reducing Ambulance Diversion in California, Strategies and Best Practices, issue brief 2009.

<sup>184</sup> [Part1] Project Blossom - Response to AG's Request for Information Dated 9-21-21 [10-5-2021]

<sup>185</sup> Kaiser Fontana's admission rate in 2019 was 10.4% (i.e., for every 10 ED visits, roughly one resulted in admission). PDD shows that the SMMC market area residents accounted for nearly 1,300 admissions through the ED, suggesting that roughly 13,000 SMMC market area residents would have visited the ED that year.

<sup>186</sup> [REDACTED]

<sup>187</sup> Notice of Affiliate Transaction – SMMC, at pg. 205 (April 7, 2021) (on file with OCAG).

outpatient services in the area and are therefore less likely to add to the demand for outpatient services at the New Hospital.

#### **7.8.4 Access for Pediatric Patients Would be Restricted**

The parties indicate that they will not be offering the pediatric unit at the New Hospital, stating in a 2021 document that the current six-bed unit has an average daily census of only one patient and that “pediatric patients are best served in pediatric hospitals”.<sup>188</sup> In 2019, SMMC reported eight pediatric acute care beds that had occupancy rate of just 21% and an average daily census of under two patients.<sup>189</sup>

Other data sources suggest that increasingly GAC hospitals are reducing or eliminating access to pediatric inpatient services and they are becoming more concentrated in children’s hospitals.<sup>190</sup> Generally, because pediatric beds are disproportionately occupied by Medicaid patients, pediatric inpatient units may be less profitable for hospitals and are therefore an attractive target for budget cuts. Moreover, the cost of maintaining a pediatric unit may be prohibitive, given that pediatric units require specialized providers who are often already in short supply in rural and underserved areas.<sup>191</sup>

However, Children’s hospitals are not always local which can often mean long drive times. Loma Linda Children’s Hospital is about an hour and a half from Victorville, and as transfer distance grows, the costs and delays associated with transfers will increase—an outcome that may result in longer lengths of stay and increased mortality, in part because longer transfers increase the risk of transport-related adverse events.<sup>192</sup> Additionally, the importance of pediatric care at SMMC was observed in an earlier report addressing SMMC services: “Because of limited alternatives and the distance for families to travel if a child needed to be admitted, it was important to have local pediatric services available for those patients that did not need tertiary care.”<sup>193</sup> Additionally, many patients in the High Desert are lower-income, and these patients may not have ready access to transportation; even small increases in the distance to pediatric services can have a large impacts on health. Consequently, it would be valuable to the community if the New Hospital were required to hold a small number of pediatric beds.

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<sup>188</sup> Project Blossom Part 1, Response to AG’s Request for Supplemental information 9-21-21

<sup>189</sup> HCAI Annual Utilization Data, 2019

<sup>190</sup> Cushing, Anna, et al, Availability of Pediatric Inpatient Services in the United States, Pediatrics originally published online June 14, 2021.

<sup>191</sup> Cushing, Anna, et al, Availability of Pediatric Inpatient Services in the United States, Pediatrics originally published online June 14, 2021.

<sup>192</sup> This assumes a departure time of 5pm from Victorville on a Monday per Google maps.

<sup>193</sup> Effect of the Change in Control and Governance of t. Joseph Health System and Providence Health & Services on the Availability and Accessibility of Healthcare Services to the Communities Served by St. Mary Medical Center, Prepared for the Office of the California Attorney General, March 28, 2016



### **7.8.5 Potential Conditions of Approval Related to Medi-Cal Access and Vulnerable Populations**

Given the possibility that capacity at the New Hospital may be insufficient to serve both existing Medi-Cal patients and the High Desert's Kaiser's members if Kaiser's patients are prioritized at the expense of Medi-Cal patients, we suggest the OACG consider the following conditions. We recommend the OACG consider applying conditions for a period of at least ten years or until the New Hospital is operational and admitting patients. Further, once the New Hospital is operational and admitting patients these conditions would apply to the New Hospital for ten years or more. These conditions include:

- For at least ten years from the Closing Date, the New Hospital shall provide the same types and/or levels of emergency and non-emergency services to Medi-Cal Managed Care and traditional Medi-Cal beneficiaries, on the same terms and conditions as other similarly situated hospitals offering substantially the same services, without any loss, interruption of service, or decrease of quality, or gap in contracted hospital coverage, including continuation of the contracts with IEHP, Molina and other existing contracts covering the Medi-Cal population.<sup>194</sup>
- For at least ten years from the Closing Date, the Hospital shall maintain its current city/county contracts for the programs listed below subject to the request and agreement of the appropriate city/county.
- Additionally, given that the Medicare members tend to be a medically fragile population, for at least ten years from the Closing Date, the Hospital shall maintain its participation in the Medicare program, by maintaining a Medicare Provider Number and providing the same types and/or levels of emergency and non-emergency services to Medicare beneficiaries, on the same terms and conditions as other similarly situated hospitals.
- For at least ten years from Closing, SMMC shall continue to operate as a general acute care (GAC) hospital.
- For at least ten years from Closing, SMMC shall maintain 24-hour emergency services at no less than current licensure and designation with the same types and/or levels of services, including a minimum of 44 emergency treatment stations.
- Within at least one year of Closing, SMMC shall present options for a SMMC trauma center and a plan for opening the trauma center or a compelling analysis as to why a trauma center is either not feasible or not an asset to the community.
- For at least ten years from Closing, SMMC shall maintain or increase the current licensure, types, and/or levels of services for the following services:
  - Pediatric services, including a minimum of 6 licensed pediatric beds;

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<sup>194</sup> <https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-031914-122357>

- Cardiology services, including a minimum of 2 cardiac catheterization labs and the designation as a STEMI Receiving Center;
  - Critical care services, including a minimum of 20 intensive care beds;
  - Obstetrics services, including a minimum of 16 obstetrics beds; and
  - Neonatal intensive care services, including a minimum of 8 neonatal intensive care beds and designation as a Level II Neonatal Intensive Care Unit.
- For at least ten years from Closing, SMMC shall maintain the following services as committed to in Exhibit 8.13 of the Health System Combination Agreement:
  - Diabetes care services;
  - Imaging/radiology services;
  - Laboratory services;
  - Rehabilitation services;
  - Surgical services;
  - Women's services; and
  - Wound care services.
- For a period of ten years from the Closing Date, the New Hospital 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.

## **7.9 Preserving Community Benefit and Charity Care**

SMMC currently operates and will continue to operate as a nonprofit organization and, as such, is exempt from most federal, state, and local taxes. In addition to tax exemptions, nonprofit status allows hospitals to benefit from tax-exempt bond financing and to receive charitable contributions that are tax-deductible to the donors. This favored tax status is intended to be an acknowledgement of the "community benefit" provided by SMMC and other non-profit hospitals.

Throughout California, community benefit which includes charity care continues to play a critical role in the health care safety net, both for those who do not have coverage and those who have coverage that is unaffordable because of cost sharing or premiums that are even more difficult for many because of the economic impact of COVID-19. With their combined financial resources, the New Hospital can continue working with their communities and community partners to support and create programs that improve the overall health of their communities by addressing health disparities that impact communities of color, low-income communities, and other underserved populations such as LGBTQ populations.

### **7.9.1 Potential Conditions of Approval Related to Charity Care and Community Benefits**

To minimize potential negative healthcare impacts that might result from the transaction related to access to reduced community benefits, we propose that the OCAG consider the conditions below. We recommend the OCAG consider applying these conditions for a period of at least ten years or until the New Hospital is operational and admitting patients. Further, once the New Hospital is operational and admitting patients these conditions would apply to the New Hospital for ten years or more. These conditions include:

- **Maintain charity care levels.** For at least ten years from closing, SMMC shall maintain a charity care policy that is no less favorable than SMMC's current charity care policy and in compliance with California and Federal law. SMMC shall provide an annual amount of charity care equal to or greater than the amount consistent with the historic level of charity care provided by SMMC as calculated based on the average hospital charity care expenditure during the most recent three (3) years prior to the Closing Date for which data are available and determined in accordance with HCAI standards. The definition and methodology for calculating "charity care" and the methodology for calculating "cost" based on the charges reported shall be the same as that used by HCAI for annual hospital reporting purposes. The Charity Care required annually will be increased on an annual basis by the rate of inflation as measured by the Consumer Price Index for Riverside-San Bernardino-Ontario, California.
- **Maintain community benefit services.** For at least ten years (or more) from closing, SMMC shall continue to expend an amount equal to or greater than the amount consistent with the historic level of community benefits provided by SMMC as calculated based on the average hospital community benefits expenditure during the most recent three (3) years prior to the Closing Date for which data are available and determined in accordance with HCAI standards. The community benefits required annually will be increased on an annual basis by the rate of inflation as measured by the Consumer Price Index for Riverside-San Bernardino-Ontario, California or another index as determined by the OCAG. Additionally, per the FY2019 community benefit report, the parties shall continue to allocate 10% of the New Hospital's net income (net unrealized gains and losses) to the St. Joseph Health Community Partnership Fund to support low-income and underserved populations in the market area.

## **8 Relevant Literature**

To inform our analysis of the transaction we sought to identify insights from relevant health care literature. While the CiC contract states that this is a horizontal transaction between two hospital organizations (Kaiser Foundation Hospitals (KFH) and SMMC), Kaiser is an integrated and closed system with a well-established insurance product and therefore our concerns are

centered more on the vertical effects of the transaction between insurer and hospital. However, with both parties having their own physicians groups in the market there are also aspects of horizontal competition. Vertical consolidation in health care markets (consolidation between health care firms operating in different, but related, product markets, such as insurers and physicians, insurers and hospitals, or hospitals and physicians) can be structured in a variety of ways, can have both procompetitive and anticompetitive impacts, and can have important implications for health care consumers. While many of the basic tenets of competition are applicable across all industries, the health care industry, has several characteristics that complicate antitrust analysis and therefore analyses specific to health care is most relevant. For example, because of insurance, most healthcare end-customers do not pay the full prices of the healthcare services they receive and most end-customers rely on their physician as an agent since they do not possess the information required to choose the care they need. This creates incentives, specific to health care that vary throughout the supply chain, from hospitals on one end, to payers on the other, with physicians in the middle.<sup>195</sup>

## 8.1 Limited Evidence in the Literature

While there is ample evidence that suggest hospital mergers are often detrimental to competition, e.g., hospital mergers lead to significant price increases (exceeding 20%) when the mergers occurred in concentrated markets, there is far less evidence related to CiCs.<sup>196,197,198,199</sup> Literature related specifically to a vertical integration where both parties are not equally and fully invested is even more sparse. The literature that does exist paints a mixed picture that, to date, provides a less-than-optimistic view of integrated delivery systems' ability to systematically deliver on the promise of cost-effective, high-quality healthcare.<sup>200</sup> This literature is supported by a recent case involving Pittsburgh health giants Highmark, a dominant insurer, and UPMC, a dominant provider. Their contract raised antitrust concerns of collusion to limit competition in the Western Pennsylvania market by favoring UPMC hospitals with higher

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<sup>195</sup> Capps, C. et al, Stacking the Blocks: Vertical Integration and Antitrust in the Healthcare Industry, CPI ANTITRUST CHRONICLE, May 2021

<sup>196</sup> Scheffler, R, Arnold, D, and Whaley, Chris. Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices Health Aff (Millwood). 2018;37(9)  
<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0472>

<sup>197</sup> Fulton BD. Health care market concentration trends in the United States: evidence and policy responses. Health Aff (Millwood). 2017;36(9):1530–8

<sup>198</sup> Post B, Buchmueller T, Ryan AM. Vertical integration of hospitals and physicians: economic theory and empirical evidence on spending and quality. Med Care Res Rev. 2018;75(4):399–433.

<sup>199</sup> Gaynor M, Town R., "The impact of hospital consolidation: Update", Robert Wood Johnson Foundation (June 2012). Available at: [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261).

<sup>200</sup> Capps, C. et al, Stacking the Blocks: Vertical Integration and Antitrust in the Healthcare Industry, CPI ANTITRUST CHRONICLE, May 2021

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payments for medical services than other hospitals were paid and by freezing competing health insurers out of the market so Highmark could keep premiums high.<sup>201</sup>

The claimed societal benefits of vertical mergers include providing better coordinated care leading to improved quality and lower cost. These improvements are said to derive from eliminating duplicative tests and reducing unnecessary care, as well as coordinating care across the continuum. Capps et al, acknowledge that while the theoretical benefits and potential antitrust issues surrounding integrated delivery systems are relatively clear, empirical literature that can inform antitrust policy is less developed.<sup>202</sup> This is due in part to the absence of robust public data on integrated delivery system performance, especially outside of Medicare ACOs. Beck and Morton review recent empirical literature on the impact of vertical integration and find that taken as a whole, the empirical evidence as to the change in welfare that is due to vertical mergers is mixed and should certainly not be used as a basis for a presumption that most vertical mergers are procompetitive or harmless.<sup>203</sup> They look at a variety of transaction in various industries, however. While a section of their publication addresses health care transactions, the only reference to integration between hospitals and insurers specifically is based on hospital-insurer transactions in Chile during 2013–2016 pointing to the fact it takes a bit of reach to cite research on this topic.

There is literature, however, that supports our contention that SMMC will further enhance its market position after the CiC and gain additional bargaining leverage beyond the fact that it may be a state of the art facility. A recent paper by Ho and Lee analyzed the indirect competition between Kaiser as an integrated system and non-Kaiser hospitals in the market and found that horizontal competition effects are not straightforward when non-Kaiser providers are located in the same market as Kaiser system in the area.<sup>204</sup> They developed and tested a theory showing that proximity to Kaiser hospital has a positive effect on prices for the most attractive hospitals but a negative effect for other hospitals in the market. Their argument is as follows:

“If a very attractive hospital (e.g., a “center of excellence”) is dropped from BS’s network when Kaiser is not present, a large number of consumers may switch from BS to another insurer with a contract with that hospital in order to access it. Adding Kaiser to the market may not harm the attractive hospital’s outside option: most of its patients might still switch to the alternative insurer if it is dropped, rather than to Kaiser, perhaps viewing Kaiser hospitals as a poor substitute for the center of excellence. However, the remaining marginal BS enrollees, who would otherwise have stayed with the plan after losing the

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<sup>201</sup> Mamula, C. Special master recommends unsealing Highmark, UPMC court records, Pittsburgh Post-Gazette, August 2, 2019

<sup>202</sup> Capps, C. et al, Stacking the Blocks: Vertical Integration and Antitrust in the Healthcare Industry, CPI ANTITRUST CHRONICLE, May 2021

<sup>203</sup> Beck, M and Morton, F.Ss, Evaluating the Evidence on Vertical Mergers Review of Industrial Organization (2021) 59:273–302.

<sup>204</sup> Ho, Kate and Lee, Robin S, Insurer Competition in Health Care Markets, *Econometrica* Vol. 85, No. 2 (March 2017), pp. 379-417 (<https://www.jstor.org/stable/44955124> Accessed 8/15/2021).

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attractive hospital, may now switch to Kaiser, thereby harming BS's outside option. This would lead to a positive impact of Kaiser on negotiated prices for the attractive hospital. However, Kaiser may adversely affect a less attractive hospital's outside option as consumers who would have switched to other insurers in order to maintain access to this dropped hospital may now instead choose to switch to Kaiser. Furthermore, there may be fewer consumers who are willing to switch from BS to Kaiser upon BS losing the less attractive hospital. Both of these effects would make the impact on prices less positive or potentially negative."<sup>205</sup>

To apply this argument in the context of this CiC, we determined that while SMMC does not qualify as a "center of excellence" it is likely to be a preferred local hospital in SMMC market. This means that SMMC does not necessarily have pressure to reduce its prices when Kaiser hospital is nearby, unlike other less preferable hospitals, so it is not in a price-based competition with Kaiser. However, while the authors provide a useful framework for analyzing indirect horizontal effects when Kaiser is involved, it is not enough to analyze the effects of Kaiser as a payer including SMMC in its network under the conditions of this CiC.

Kaiser Permanente, along with Geisinger, and Health Partners were some of the earliest and most prominent health insurance companies formed by provider organizations that have been able to offer comprehensive advantages from a limited network of providers at competitive prices. With incentives under the ACA and other trends in their local markets, health systems in the United States have formed dozens of new health insurance companies or acquired existing health plans through joint venture or other arrangement since 2010. An analysis of these plans indicted that most of the plans experienced heavy financial losses and exited the market.<sup>206</sup>

## 9 Overview of the Market of the Proposed Transaction

Below we set the stage for describing the competitive landscape for SMMC's market area based on hospitals, insurers, patients, and the types of services most commonly used by these patients. The following topics are covered below:

- Definition of the SMMC market area
- Description of hospitals in the SMMC's market area.
- Examination of the market for ED, maternity and scheduled services.
- Examination of the role of Kaiser and other health insurers in insurance-based competition in the SMMC market area.
- Examination of the commercial payer market and price competition among hospitals in the SMMC market area.

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<sup>205</sup> Ho, Kate and Lee, Robin S, Insurer Competition in Health Care Markets, *Econometrica* Vol. 85, No. 2 (March 2017), pp. 379-417 (<https://www.jstor.org/stable/44955124> Accessed 8/15/2021).

<sup>206</sup> Baumgarten, Allen, Analysis of Integrated Delivery Systems and New Provider Sponsored Health Plans, Robert Wood Johnson Foundation, June 2017 <https://www.rwjf.org/en/library/research/2017/06/analysis-of-integrated-delivery-systems-and-new-provider-sponsor.html>

## 9.1 Overview of the Geographic Market

SMMC currently serves an urban cluster in the High Desert area that consists of Victorville, Apple Valley, Hesperia, and the nearby rural communities. This service area is separated from other densely populated areas by deserts and the San Bernardino Mountains, and therefore is straightforward to define.

To define a relevant market for purposes of examining competitive effects we need to define a product and geographic market. As with most transactions involving community hospitals, we focus on a product market of GAC services.<sup>207</sup> This is consistent with the *Merger Guidelines*' framework for defining the relevant product market for hospital services. The product market has typically been defined as a broad group of medical and surgical diagnostic and treatment services for acute medical conditions where the patient must remain in a health care facility for at least 24 hours for recovery or observation.<sup>208</sup>

To define the geographic market, we start by focusing on where SMMC draws its patients and which other hospitals are principal "direct competitors" to SMMC and serve many of the same patients. This is based on an analysis of patient flow data showing where SMMC patients are located, based on zip code, and what other hospitals people in these zip codes use. Direct competition is said to exist when the merging hospitals compete in the same market with health plans and individual patients viewing the merging hospitals as potential substitutes to each other.<sup>209</sup> Given that SMMC will be relocating to nearby Victorville with a planned opening in 2026, one of the more challenging aspects of assessing this CiC is evaluating the market area of a hospital that has not yet been built. While the New Hospital will be located at a different site, given the sites' proximity to one another and the fact that the provision of medical services will be similar, we consider a single relevant market area for both the new and current facilities.<sup>210</sup>

To determine the boundaries of this comprehensive service area based on the current SMMC location in Apple Valley, we analyzed the locations of patients discharged from area hospitals in

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<sup>207</sup> *In American Medical International, Inc. and Hospital Corp. of America*, the FTC defined the relevant product market as a group of general acute care hospital services. Am. Med. Int'l, 104 F.T.C. 1, 107 (1984); *In re Hosp. Corp. Am.*, 106 F.T.C. 361 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986).

<sup>208</sup> U.S. Dep't of Justice & Federal Trade Comm'n, Horizontal Merger Guidelines (1992 rev. 1997, efficiencies section only), (<http://www.ftc.gov/bc/docs/horizmer.htm> Accessed 7/26/2021)

<sup>209</sup> Vistnes, G., "Hospitals, Mergers, and Two-Stage Competition," *Antitrust Law Journal*, 2000 (hereafter "Vistnes (2000)") for a more detailed discussion of how hospitals compete, and the importance of distinguishing between "first-stage competition" in which hospitals directly compete for inclusion in a health plan's provider network and "second-stage competition" in which hospitals compete for individual patients. That article discusses how patient preferences affect health plan preferences, and thus how first-and second-stage competition are related but not the same. We consider the closest Kaiser hospitals as indirect competitors but not direct competitors to SMMC.

<sup>210</sup> Arguably, a case could be made for two separate market areas based on the Apple Valley site and the nearby New Hospital site, however, given our legal time constraints for producing this report, the fact that this is not an urban hub so the selection of GAC hospitals in the area are limited, and there is no patient data to define the future New Hospital market, we chose to focus our analysis on a single market area.

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HCAI's 2018 and 2019 Patient Discharge Data. These datasets provide patient discharges by zip code and diagnosis,<sup>211</sup> providing data on a) where patients live; b) what hospitals they use and where those hospitals are located; and c) what conditions they are being treated for and what procedures they are receiving.

Additionally, although not standard practice in antitrust or competitive effects analysis, we confirmed that our market area is also appropriate based on ED visit utilization since approximately 80% of admissions come through the ED and about half of SMMC revenues come from outpatient services, of which ED visits is the largest proportion.<sup>212</sup>

The following criteria were used to select zip codes for the definition of the SMMC service area, based on the current Apple Valley location of SMMC. Any zip code meeting one or more of the following conditions was included:

- ***Zip codes that contribute the largest number of patients until they cumulatively reach at least 75% of SMMC's admissions.*** This captures all the zip codes that are the most important sources of patients for SMMC. In addition, we confirmed that SMMC is an important provider of hospital care for people in these zip codes: 23% to 48% of inpatient admissions from these zip codes go to SMMC, and from 30% to 68% of ED visits coming from this area use SMMC.
- ***Less-populous zip codes where a large share of patients use SMMC.***<sup>213</sup> This adds the nearby rural communities that have few people but rely on SMMC for a large portion of their hospital services. Among patients in these zip codes, SMMC accounts for at least 43% of ED visits and at least 37% of inpatient admissions.
- ***Additional less populated contiguous zip codes in Hesperia and Victorville that are surrounded by other market area zip codes for geographic continuity.***

To account for the future SMMC (New Hospital) location, the service area was expanded with the zip codes based on the following criteria:

- Zip codes for which the New Hospital would be the closest hospital, based on estimated drive time from the patient zip code to the New Hospital location.

The New Hospital is about a 14-26 minute drive, depending on traffic, to the southwest of the current SMMC location.<sup>214</sup> The core market area (Apple Valley/ Hesperia /Victorville and Adelanto) will likely stay the same for the New Hospital location, since current driving distance

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<sup>211</sup> This excludes newborn born so as not to count both the mother and baby at the point of discharge.

<sup>212</sup> Outpatient ED utilization is estimated based on HCAI Emergency Department Data, 2019

<sup>213</sup> The cut-off is at least 1% of SMMC volume and at least 30% use of SMMC although these small zip codes do not have a material effect on the analysis.

<sup>214</sup> Travel time by car under minimal traffic conditions



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will remain under 40 minutes for any zip code included in the initial set of zip codes selected. To account for the shift to the new location, we added zip codes where the New Hospital location would be the closest hospital or, if there was another hospital in the area, the difference in drive time from the patient zip code centroid to the New Hospital and the other nearby hospital was less than 5 minutes.<sup>215</sup> For the rural northern and eastern zip codes (92356, 92368 and 92342) it is not clear at what point an increased driving distances will be sufficient to discourage patients from driving farther to access SMMC instead of choosing Victor Valley Hospital or Desert Valley Hospital, which will be closer options. Ultimately, we retained these zip codes for the purposes of defining a comprehensive market that covers both current and potential admission patterns in the market.

The final SMMC market area consists of 16 zip codes that comprise 90% of SMMC's inpatient admissions<sup>216</sup> and 93% of its outpatient ED visits (Exhibit # 20 SMMC Geographic Market Area).

This definition of the SMMC's market area is consistent with SMMC's definition of their service area in their community needs assessment as it includes the cities of Adelanto, Apple Valley, Helendale, Hesperia, Lucerne Valley, Oro Grande and Victorville.<sup>217</sup> Throughout the report we refer to the SMMC market or service area which is the geographic region captured by those 16 zip codes. However, in many places where we are citing literature or statistics we may refer to the High Desert area, which largely overlaps the SMMC market area but is not identical to it, or San Bernardino County, the southern California county in which both the SMMC market area and the High Desert area are located, or the Inland Empire which generally includes both Riverside and San Bernardino counties.

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<sup>215</sup> For example, patients in a Phelan zip code have 2 hospitals nearby. Desert Valley hospital is approximately a 20 minute drive and the New Hospital is approximately a 14-26 minutes' drive. We don't know which one is closer to any given patient since we are using center or zip-code and do not have the patient address but we include this zip code in the market.

<sup>216</sup> Several additional small zip codes (Barstow, Wrightwood) were considered for inclusion, but retained only for sensitivity analysis since their current utilization of SMMC is minimal and will likely be even lower with the New Hospital moving further away.

<sup>217</sup> It is also consistent with another report provided to the California Attorney General, Effect of the Proposed Change in Control and Governance of St. Joseph Health System m and Providence Health & Services on the Availability and Accessibility of Healthcare Services to the Communities Served by St. Mary Medical Center, March 28, 2016 Prepared by MDS and Vizient with the exception of one single zip code 92311, a zip code in Barstow which is located 67 miles north of San Bernardino. The methodologies for defining the area were not similar but produced very similar results.

Exhibit 18 SMMC Geographic Market Area

ZIP	City/Town	Share of ED visits from ZIP that go to SMMC	Share in SMMC ED visits	Share of IP admits from ZIP that go to SM	Share in SMMC IP admits	Drive time to current SMMC	Drive time to new SMMC	Current closest hospital	Drive time to closest
<b>Core zipcodes that constitute 81% of SM s business</b>									
92307	Apple Valley	68%	17.1%	48.4%	15%	9	28	SM	9
92345	Hesperia	30%	13.0%	22.7%	14%	24	21	DV	10
92308	Apple Valley	61%	14.1%	41.8%	14%	15	29	DV	15
92395	Victorville	32%	10.7%	28.8%	11%	17	13	DV	12
92392	Victorville	33%	11.1%	25.1%	10%	12	13	VV	7
92301	Adelanto	37%	9.8%	32.8%	9%	31	36	VV	29
92394	Victorville	37%	8.3%	29.6%	7%	19	26	VV	17
<b>Small rural zipcodes with high share of admissions and visits to SM</b>									
92356	Lucerne Valley	62%	2.3%	46.8%	3%	30	48	SM	30
92368	Oro Grande	50%	0.3%	40.5%	0%	48	54	VV	45
92342	Helendale	43%	1.2%	37.0%	2%	38	45	VV	36
<b>Supplementary zipcodes, added for market continuity also close to new location</b>									
92344	Hesperia	24%	2.0%	17.3%	2%	20	14	DV	14
92340	Hesperia	22%	0.1%	9.0%	0%	23	27	DV	13
92393	Victorville	26%	0.3%	23.1%	0%	15	13	DV	4
<b>New market zipcodes for which new SM will be the closest hospital</b>									
92371	Phelan	29%	1.5%	20.9%	2%	42	39	VV	39
92372	Pinon Hills	23%	0.4%	15.3%	1%	46	36	DV	38
92329	Phelan	22%	0.4%	9.4%	0%	45	36	DV	36

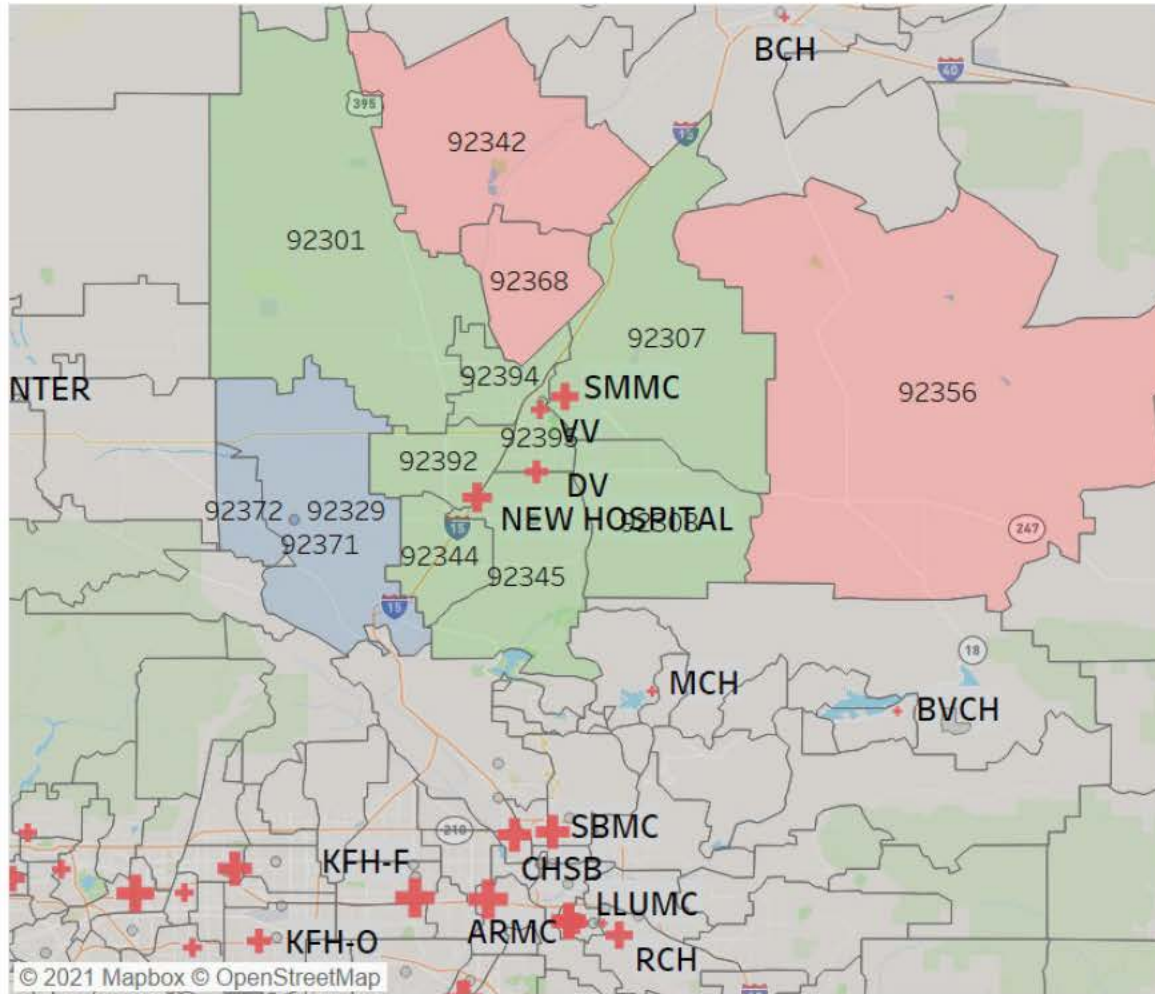
Source: Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data, 2018 and 2019

A map of the SMMC market area below shows the communities it covers and the locations of the hospitals serving this area. SMMC's market area includes the communities of Apple Valley, Hesperia, Victorville, Adelanto, Lucerne Valley, Helendale, Phelan, Pinon Hills, and Oro Grande, which together have a population of about 380,000 (Exhibit # 21 SMMC Geographic Market Area: Map).<sup>218</sup> This area is anticipated to experience a compound annual growth rate (CAGR) of about 1.1% between 2020 and 2030.<sup>219</sup>

<sup>218</sup> Note we did not include Barstow since this city was further north, used SMMC less frequently than 25% of admissions, and we felt it was too distant to be included in the New Hospital market area.

<sup>219</sup> Sources: Claritas, California Department of Finance (DOF). Note: To project 2030 and 2035 SA populations, Claritas 2020–2025 zip code growth patterns were extrapolated forward, with the resulting distribution applied to California DOF 2030 and 2035 county-level projections. CAGR is compound annual growth rate, defined by taking a final value amount as input, along with a time frame and starting amount. (this estimate is based on parties Response to AG's Request for Supplemental Information, dated 9-21-21.

Exhibit 19 SMMC Geographic Market Area: Map



Abbreviation Reference:			
ARMC	Arrowhead Regional Mesial Center	LLUMC	Loma Linda University Medical Center
BCH	Barstow Community Hospital	MCH	Mountain Community Hospital
BVCH	Bear Valley Community Hospital	New Hospital	New St. Mary's Facility Location
CHSB	Community Hospital of San Bernardino	RCH	Redlands Community Hospital
DV	Desert Valley Hospital	SSMC	St. Mary's Medical Center
KFH-F	Kaiser Foundation Hospital- Fontana	VV	Victor Valley Global Medical Center
KFH-O	Kaiser Foundation Hospital-Ontario		

## 9.2 Hospital Competitors in the Market Area

Having defined the market area, in this section we further describe SMMC's market area and discuss:

- Hospitals competing in this area,
- How SMMC compares to the other area hospital competitors,
- Hospital options outside the market area,
- Inpatient hospital care service lines in the market area, and
- Where market area Kaiser's patients receive care

### 9.2.1 *There are Three Principal Local Community Hospitals*

In addition to SMMC, there are two other hospitals located within SMMC market area and serving the same population: Desert Valley Hospital, part of the Prime hospital system, and Victor Valley Hospital, KPC, another for-profit hospital system. We label them "local" hospitals, and those constitute the main local hospital competitors in the market area (Exhibit # 22 Distribution of Patient Admissions from SMMC Market Area for Kaiser and Non-Kaiser's members).

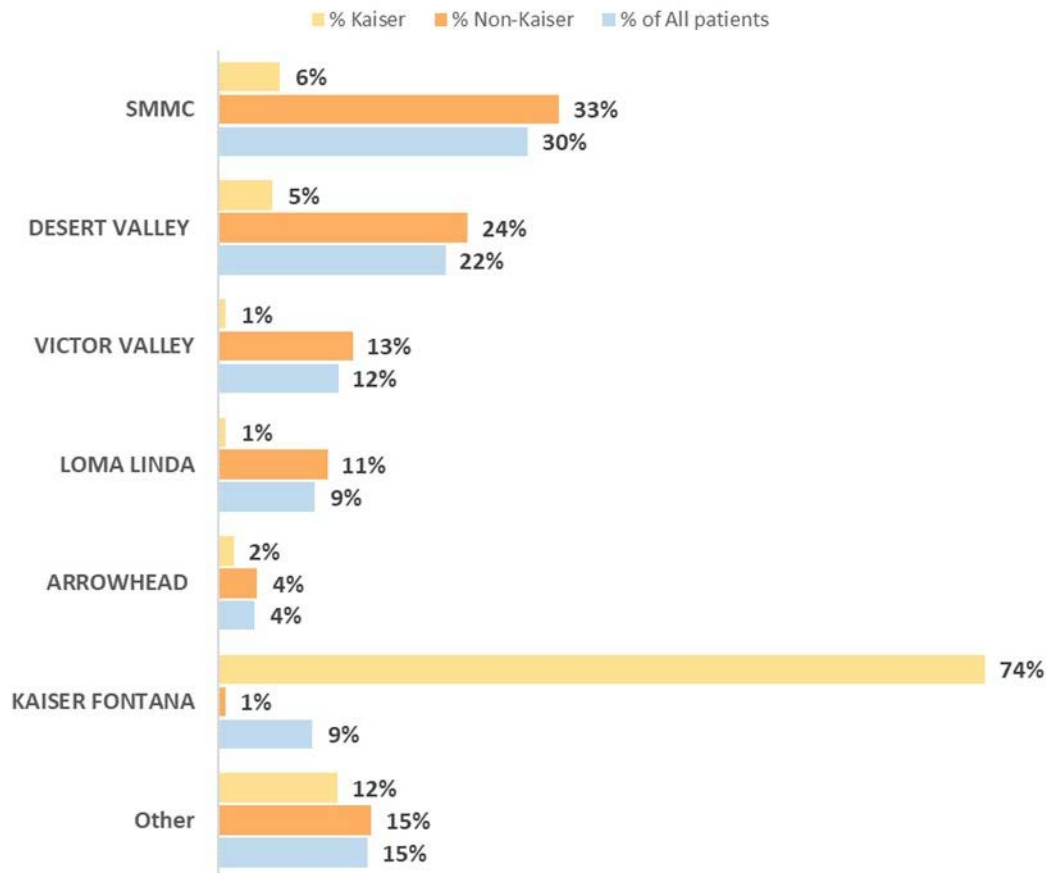
Patients from the SMMC market area access hospital services primarily through the emergency room. Of all admissions coming from this area, 75% of patients were admitted through the emergency room.<sup>220</sup> While patients have a strong preference for nearby hospitals for most GAC services, location is even more critical for emergency services. Given the high proportion of emergency services in the SMMC market area, hospitals' patient volumes as well as payer mix are very dependent on its proximity to the most populated areas and to more versus less affluent areas. Therefore, a change in SMMC hospital location is likely to redistribute patient flows going to all three local hospitals, as it becomes closer to patients in Hesperia and southern part of Victorville, and further away from Apple Valley.

Desert Valley Hospital is 12 minutes to the north and Victor Valley Community Hospital is 5 minutes to the west of current SMMC location. Both are located in Victorville, in the 92395 zip code. The market area of these local hospitals overlaps with SMMC's market area: Desert Valley hospital gets 91% of its inpatient admissions from SMMC market area as we defined it, and Victor Valley hospital gets 87%. Together with SMMC these local area hospitals account for 64% of all admissions (but 70% of non-Kaiser admissions) coming from the market area.

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<sup>220</sup> Some maternity patients are also admitted through the emergency room. Further, we analyze all maternity as a separate category, regardless of the route for their admission, while separating non-maternity emergency admissions as another category.

Exhibit 20 Distribution of Patient Admissions from SMMC Market Area for Kaiser and Non-Kaiser’s members, 2019



Source: OSHPD Patient Discharge Data, 2019

SMMC has the largest share of inpatient admissions for residents in their market area, accounting for 30% of total inpatient admissions, or 33% of non-Kaiser admissions.

Additionally, SMMC accounts for 41% of the market area outpatient ED visits (data not shown). Desert Valley and Victor Valley are the second and third-most frequently used hospitals within SMMC’s market area for ED visits.

Just a small portion of all admissions in the area are insured by Kaiser but Kaiser and non-Kaiser’s members who live in SMMC’s market area show very different admission patterns across the hospitals, with Kaiser’s members using primarily Kaiser hospitals for both scheduled and emergency care.

The closest Kaiser hospitals are the distant Kaiser Fontana, a 450 bed licensed hospital in Fontana, California, and its nearby companion, Kaiser Ontario, with 176 licensed beds.<sup>221</sup> These

<sup>221</sup> Note that the 2019 HCAI Patient Discharge Data report the consolidated information for these two facilities under a single HCAI identification number. The two hospitals are approximately 13 miles apart.

facilities are both about a 50 to 60 minute drive time from the current SMMC location and are outside the normal driving distance preferred by patients for most of inpatient hospital services. Kaiser Fontana/Ontario is used as the primary hospital by Kaiser’s members from the SMMC market area, with 74% of Kaiser’s members from the area receiving inpatient care from this facility, while non-Kaiser’s members only rarely use it for emergencies. The Kaiser Fontana/Ontario hospitals are closer to St. Bernadine and Arrowhead (also not within the SMMC designated market area). Kaiser hospitals are often excluded from markets for purposes of analyzing competitive effects because they are not considered direct competitors.<sup>222</sup>

### 9.2.2 SMMC Stands Out Compared to its Local Competitors

SMMC is the largest of the three community hospitals in the market area, with 215 licensed beds, of which 195 were staffed in 2019. SMMC’s case mix index, a measure reflecting the diversity, complexity, and severity of patient illnesses treated, is comparable to Desert Valley Hospital’s. The smaller Victor Valley hospital has a much lower case mix index, reflecting services that are for less complex and severe patient conditions (Exhibit # 23 Characteristics of SMMC, its Local Competitors and Kaiser Fontana).

*Exhibit 21 Characteristics of SMMC, its Local Competitors and Kaiser Fontana, 2019*

Hospital	System	Available beds	Staffed beds	Occupancy rate	All payer acute CMI*	Average Length of stay*	OP ED visits per IP day	Minutes from new hospital**
<b>In Market Area</b>								
St. Mary's MC	Providence	212	195	85%	1.54	4.4	1.2	20
Desert Valley	Prime	148	122	75%	1.58	4.0	1.0	10
Victor Valley	KPC Health	101	63	57%	1.3	3.7	1.9	15
<b>Outside Market Area</b>								
Kaiser Fontana	Kaiser	626	377	55%	1.6	4.0	1.2	45

Source: OSHPD Patient Discharge Data, 2019  
 \*Calculated from OSHPD PDD 2019 for all acute admissions, excluding newborns born in the hospital  
 \*\*Rounded travel time by car under minimal traffic conditions

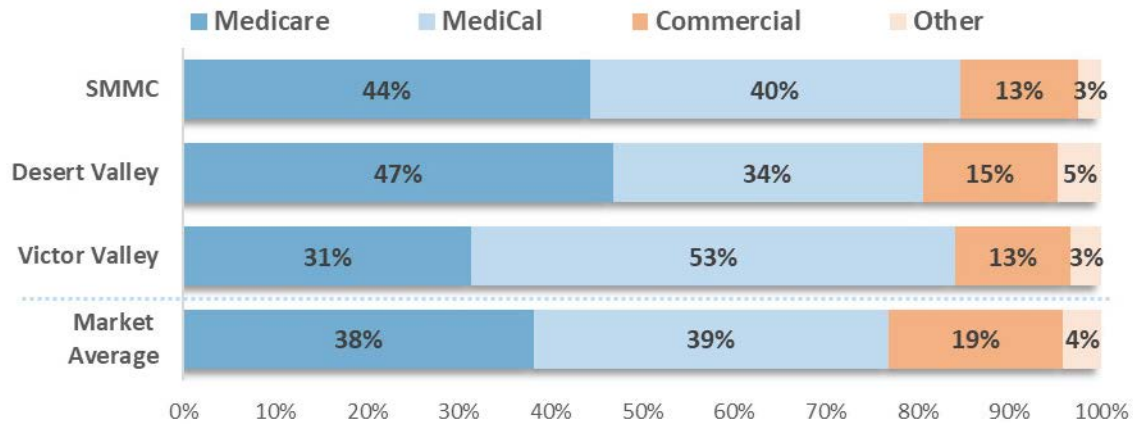
### 9.2.3 Hospital Payer Categories in the Market Area: Public Payers Dominate

The payer mix for SMMC specifically is reflective of the overall payer mix in the market area, which heavily relies on public payers: 88% of SMMC admissions come from Medicare and Medi-Cal patients, with only 13% of patients covered by commercial payers (Exhibit # 24 Payer-mix for Inpatient Admissions by Hospital). There is a slightly lower share of commercial patients at SMMC relative to the commercial share of the market area, in part because Kaiser’s commercial

<sup>222</sup> A December 2020 to the CA AG analyzing the Cedars Sinai – Huntington Memorial transaction excludes Kaiser on the basis that providers do not compete with non-Kaiser providers because commercial payers cannot substitute Kaiser providers into their networks in place of non-Kaiser providers who seek to raise price.

patients currently travel out of the market area to access Kaiser Hospitals. SMMC’s local competitors have similar payer mix, although a larger share of Victor Valley’s patients are covered by Medi-Cal – the lowest-paying of all payers, while Desert Valley has the most favorable mix of payers.

Exhibit 22 Payer-mix for Inpatient Admissions by Hospital, 2019



Source: OSHPD Patient Discharge Data, 2019

#### 9.2.4 There are Several Hospital Options Outside the Market Area

Aside from the Kaiser hospitals, there are several other hospitals, not within the market area, that are less frequently used by patients in the area for not GAC services, e.g., tertiary care, specialty care, trauma care and children’s services. The largest and most important providers for High Desert residents are St. Bernardine Medical Center and Loma Linda University Medical Center & Children’s Hospital, in San Bernardino and Arrowhead Regional Medical Center (ARMC). Both are located outside and south of the market area and are within a 45-50 mile radius of the current SMMC location. St Bernadine is a 342-bed GAC, owned by Dignity Health. Loma Linda includes both a children’s hospital and a sprawling academic medical center with more than 500 beds and a Level 1 trauma center, providing the highest level of surgical care, of levels I-V, for trauma patients.<sup>223</sup> ARMC is a large 456 bed teaching hospital located in Colton, California. ARMC is owned and operated by the County of San Bernardino and has a Level II trauma center. North of SMMC is Barstow Community Hospital, a very small hospital of 30 licensed beds in the city of Barstow, zip code 92311. Patients from SMMC market area do not regularly travel to Barstow hospital for care.

<sup>223</sup> “Level I trauma center” is a comprehensive regional resource that is a tertiary care facility central to the trauma system. A Level I trauma center is capable of providing total care for every aspect of an injury – from prevention through rehabilitation)

### **9.2.5 Market Area Definition – SSNIP Test**

Market definition is a critical component of any case evaluating the competitive effects and the impact on consumers of a healthcare consolidation whether a merger, joint venture or some other affiliation. To define the relevant market, we apply a hypothetical monopolist test that asks whether a hypothetical profit-maximizing firm that was the only present and future seller of a product (or set of products) in a candidate market (the “hypothetical monopolist”) could profitably impose a small but significant and non-transitory increase in price (“SSNIP”) on consumers.<sup>224</sup> If yes, then that set of products would be identified as the relevant product market. If not, then the set of products is expanded to include the next closest substitutes, and the test is repeated until it identifies the smallest universe of products over which the hypothetical monopolist could profitably raise its price to consumers. We argue that the hospital market area as we defined it is appropriate for this specific transaction and that it passes a SSNIP test.

If patients were directly paying for hospital care and choosing which hospital to go to based on their price-quality combination, one could argue that there are separate markets for each of the hospital service lines: ED visits, maternity and each of the services in the scheduled category. However, the insurer first negotiates with the hospital for price levels covering all service lines together. Once a network is constructed, patients choose where they get their care with network status, i.e., whether a hospital is in-network or out-of-network, having a major influence on their decisions where to get maternity and scheduled care, since the out-of-network hospitals are more expensive. The network status has less of an impact in emergency situations where the patient often has little or no choice and they are taken to the closest facility.

Arguably, the overwhelming majority of non-Kaiser admissions in the area (either total, commercial or all managed care) are for time-sensitive services – emergency and maternity. If there was a hypothetical hospital service monopolist in SMMC area, this monopolist could impose 5-10% price increase without a significant impact on its contracts with insurers and resulting patient volumes. The hospitals outside the SMMC market are not appropriate substitutes for the local hospitals because they are located too far to be acceptable by most patients, and because being tertiary care providers carry a much higher price tag for common inpatient services that a regular community hospital can provide.

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<sup>224</sup> See *FTC v. Penn State Hershey Medical Center*, 838 F.3d 327, 342 (3d Cir. 2016) (“A common method employed by courts and the FTC to determine the relevant geographic market is the hypothetical monopolist test”—“if a hypothetical monopolist could impose a small but significant non-transitory increase in price (“SSNIP”) in the proposed market, the market is properly defined); *St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.*, 778 F.3d 775, 784 n.10 (9th Cir. 2015) (affirming geographic market based on application of the hypothetical monopolist test)



For example, consider a commercial health plan that is contracting with local hospitals, such as Blue Shield. If in response to 5-10% price increase this plan drops all local hospitals from the network and instead contracts with other GAC hospitals an hour or more away, it would 1) lose customers that currently prefer having local in-network hospital options, and 2) for remaining members plan would start paying much higher prices, as those patients still use local hospitals for emergency and maternity. If this plan instead passes this 5-10% price onto its customers, its effect on the premiums for final consumer will be negligible for the following reasons:

- Hospital care constitutes less than 50% of medical costs.
- Medical expenses and quality improvement activities constitute about 80% of insurance premium.<sup>225</sup>
- In-market admissions are 70%, while 30% are treated at non-local hospitals (for non-Kaiser's members).

So, if health plan passes overall price increase directly on its plan members from the SMMC area, the overall impact of 5-10% price increase in the market would result in 1.4% to 2.8% increase in premiums ( $0.5 \times 0.8 \times 0.7 \times 0.1 = 0.028$  for 10% increase). Most likely, however, the actual impact on the consumers would be even smaller, since price increase in inputs can be passed to the consumers only by a monopolist insurer, while insurance market in High Desert isn't a monopoly. In non-monopoly markets, costs increases are likely to be split between consumer and the health plan, making the effects of 5-10% price increase in hospital costs virtually unnoticeable to the consumers (if price increase is split 50/50 between plan and its customers, the effect on premiums is 0.7%-1.4%). Finally, premium rates are usually calculated for the areas much larger than SMMC service area (i.e., San Bernardino and Riverside counties), so the increase in premiums would be spread over larger population, further diluting the impact of price increase on the consumers. Therefore, it is unlikely that in response to the 5-10% price increase plan will drop a hypothetical monopolist (local hospital) from its network, or that final consumers will switch plans to out-of-the-area Kaiser because their premiums increased by less than 1-2%. It is also unlikely that consumers will respond to 5-10% price increase through cost-sharing, due to lack of price transparency, emergency nature of most admissions, and the fact that most hospital admissions cost above deductible and out-of-pocket maximums set in the plans. As such, a hypothetical monopolist in SMMC market area can profitably impose a 5-10% price increase, and the market is well-defined.

### **9.2.6 There are Three Key Service Categories within GAC Services in the Market**

To examine the market shares of SMMC and its competitors in the GAC product market, we divided inpatient services into three mutually exclusive inpatient care categories. Each has a

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<sup>225</sup> Rate Review & the 80/20 Rule, Healthcare.gov website. (<https://www.healthcare.gov/health-care-law-protections/rate-review/> Accessed 11/11/2021)

unique demand pattern and degree to which patients have an opportunity to “choose” the hospital rather than simply be transported to the nearest hospital. These include:<sup>226</sup>

- Maternity admissions – 19% of the market <sup>227</sup>
- Emergency admissions, with exception of maternity – 61% of the market
- Scheduled admissions, with exception of maternity – 19% of the market

Emergency admissions are separated because the proximity of hospital is of the highest importance for these services, and in-network status is least likely to play a role in hospital selection. A patient transported by an ambulance does not choose their hospital, and in other emergency situations proximity of the hospital is of the higher importance than other characteristics. Usually, maternity patients choose their hospital in advance, but the travel distance is also important for such services due to unpredictable timing. In addition, most maternity patients prefer to get regular prenatal services from the local doctor, who is most likely to deliver at a local hospital. Therefore, most mothers place a high value on distance and predominantly choose local hospitals for their delivery, or risk emergency admission to a nearby hospital. Scheduled admissions, on the other hand, involve the most choice and planning on the part of patients or their doctors, where value for the patient is relatively more important than the travel distance.

The market shares for each of these services are derived separately for Kaiser and non-Kaiser’s members, since Kaiser’s members are limited in their choice of hospital. The analysis of SMMC market power primarily relies on the shares of market for non-Kaiser’s members, since in most cases Kaiser’s members do not have SMMC hospital in their choice set.

### ***9.2.7 Inpatient Maternity Care is a Critical Service in the Market Area***

Maternity admissions are 19% of the overall patient market in SMMC service area, but for commercial and Medi-Cal patients those constitute about 25% of the admissions (newborns excluded to avoid double-counting). In the majority of cases, mothers choose a hospital for delivering their babies beforehand, but unplanned emergency admissions are also possible. If women use out-of-network hospital for their birth and access it through the emergency room during active labor, the insurance has to cover it. (For example, women insured by Kaiser will be covered by Kaiser if they deliver at a local non-Kaiser hospital). Therefore, we group all maternity admissions together regardless of whether they came through emergency room route.

Given a choice, maternity patients overwhelmingly prefer to go to one of the three local hospitals for deliveries: 74% of non-Kaiser maternity admissions originating from the SMMC

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<sup>226</sup> Rounding of the numbers results in 99% rather than 100%.

<sup>227</sup> Obstetric services for birth and pregnancy-related conditions (major diagnostic category 14)

market area were to local area hospitals. SMMC was the main provider of maternity services in the area (36%), while Victor Valley had 25%, and Desert Valley had 13% of maternity admissions among non-Kaiser’s members (Exhibit # 25 Hospital Distribution of Maternity Non-Kaiser Admissions from the Service Area).

SMMC has an even higher share of non-Kaiser commercial deliveries with 41% of maternity market, while Victor Valley hospital only 20% and Desert Valley has just 8% of deliveries.<sup>228</sup> The most important out-of-the-area maternity option for non-Kaiser’s members is Loma Linda, which is almost an hour away but offers Level-4 NICU and other specialized care for complex maternity cases.

*Exhibit 25 Hospital Distribution of Maternity Non-Kaiser Admissions from the Service Area*

	Medicare	Medicaid	Commercial	Total
<b>SMMC Market Hospitals</b>				
<b>SMMC</b>	29%	35%	41%	36%
<b>Desert Valley Hospital</b>	4%	15%	8%	13%
<b>Non SMMC Market Hospitals</b>				
<b>Other</b>	14%	9%	18%	11%
<b>Arrowhead Regional MC</b>	0%	3%	1%	3%
<b>-</b>				
<b>St. Bernardine MC</b>	0%	1%	1%	1%

Source: OSHPD financial pivot data 2019; OSHPD PDD 2019

Kaiser maternity patients mostly travel out of the area to deliver their babies, with 86% delivering at Kaiser Fontana/Ontario. Nevertheless, Kaiser maternity patients also used local area hospitals, with 6% going to SMMC, and 1% going to Desert Valley.

**9.2.8 Emergency (Non-Maternity) Admissions Constitute the Bulk of Admissions in the Area**

Emergency non-maternity admissions constitute the bulk of admissions from the SMMC market accounting for at least 61% of all patients from the area. The share of this category in total admissions varies dramatically across payers, as well as for Kaiser and non-Kaiser’s members. Among non-Kaiser’s members, 85% of Medicare patients are admitted through ED, while among commercial non-Kaiser’s patients the share of non-maternity ED admissions is 57%, and for Medi-Cal it is 60%.

<sup>228</sup> HCAI Patient Discharge Data, 2019

For market area residents who are not Kaiser’s members, SMMC is the largest provider of inpatient care through ED (36%), followed closely by Desert Valley, with 32% of the ED admission market (Exhibit # 26 Hospital Distribution of Emergency Admissions from the Service Area, 2019).

*Exhibit 26 Hospital Distribution of Emergency Admissions from the Service Area, 2019*

	Medicare	Medicaid	Commercial	Total
<b>SMMC Market Area Hospitals</b>				
<b>SMMC</b>	40%	36%	28%	36%
<b>Victor Valley MC</b>	12%	16%	12%	14%
<b>Non SMMC Market Hospitals</b>				
<b>Other</b>	6%	8%	12%	8%
<b>Arrowhead Regional MC</b>	3%	6%	3%	4%
<b>Kaiser -Fontana/Ontario</b>	0%	0%	1%	0%

**9.2.9 Scheduled (Non-Maternity) Admissions Are Only a Small Share of Total SMMC Admissions**

Scheduled admissions, for example, for hip replacement or hysterectomy, are those admissions where the patient may have greater choice in selection of the facility than, for example, emergency admissions. These admissions constitute only 15% of inpatient care admissions from the SMMC service area for non-Kaiser’s members and 19% for all patients from this market. This category also includes admissions transferred directly from another hospital’s emergency rooms, which constitute 4% for all patients in the area.<sup>229</sup> Excluding these transfers, overall, only 15% of admissions are scheduled by all market area patients in advance, which even fewer for non-Kaiser’s members. In contrast to ED care, travel distance is less critical for scheduled services and patients are more likely to coordinate with their doctor to actively choose a hospital.

Patients from the SMMC market area may need to travel to Loma Linda and other tertiary out-of-area hospitals for more complex scheduled services, either because services or specialist are not available locally, e.g., children’s services or related or because there are capacity issues in the area. For example, half of the Loma Linda volume from the area are services delivered at specialized Loma Linda Children’s’ Hospital. Nevertheless, among in-area hospitals, SMMC still has the highest share of scheduled admissions, with 17% of the total, while Desert Valley has

<sup>229</sup> Most of these transfer cases are Kaiser’s patients who are being transferred from the local hospital emergency rooms to Kaiser hospitals.

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only 2% (Exhibit # 27 Hospital Distribution of Non-Kaiser Scheduled Admissions from the SMMC Market Area, 2019).

*Exhibit 23 Hospital Distribution of Non-Kaiser Scheduled Admissions from the SMMC Market Area, 2019*

	Medicare	Medicaid	Commercial*	Total
<b>SMMC Market Area Hospitals</b>				
<b>SMMC</b>	28%	12%	13%	17%
<b>Victor Valley MC</b>	1%	1%	0%	1%
<b>Non SMMC Market Hospitals</b>				
<b>Other</b>	44%	25%	54%	38%
<b>St. Bernardine MC</b>	4%	4%	2%	4%
<b>Kaiser -Fontana/Ontario</b>	1%	2%	1%	1%

Non-maternity scheduled services includes multiple service lines, each with a different set of hospital choices for the patients given specialized nature of most scheduled services. Orthopedic services is the most common type of services among non-maternity scheduled admissions in SMMC area, representing 21% of scheduled or 4% of total admissions.<sup>230</sup> SMMC is the top provider of these services for the patients from its service area taking 28% of scheduled orthopedic admissions, while Loma Linda has 22% share. Neither Desert Valley nor Victor Valley are significant providers of scheduled orthopedic services. Cardiac services represent 13% of scheduled non-maternity admissions, and SMMC provides 22% of those – almost as many as Loma Linda medical center (25%).<sup>231</sup> Desert Valley is another local hospital that offers inpatient scheduled cardiac services taking 6% of the market. Another diagnostic category among scheduled admissions where SMMC has significant share is neonatal services.<sup>232</sup> Among newborns that were admitted (versus born) in the hospital, SMMC has 38% share, which primarily includes NICU transfers from other local hospitals in the area. None of the other local hospitals is a significant provider of neonatal services (unless born in that hospital).

<sup>230</sup> To simplify the discussion, we are using label “orthopedic services” for major diagnostic category 8 – “Musculoskeletal and connective tissue diseases”

<sup>231</sup> To simplify the discussion, we are using label “cardiac services” for major diagnostic category 5 – “Circulatory system diseases”

<sup>232</sup> To simplify the discussion, we are using label “complex neonatal” for major diagnostic category 15 – “Newborns and other neonates”. Note that for the purposes of market share calculation we excluded newborns born in the hospital, so the remaining neonates include mostly NICU transfers from other hospitals.

**9.2.10 SMMC is a Dominant Provider of Inpatient Services in its Market**

Overall, SMMC captures about one-third of the market for inpatient services provided to non-Kaiser's members from SMMC area, while Desert Valley hospital has 24% and Victor Valley has 13%. If we exclude emergency admissions, SMMC's share for all scheduled and maternity services provided to non-Kaiser's members is 25%, Victor Valley's share is 12%, Desert Valley's share is 7%. Arguably, SMMC is the only community hospital in the area that provides significant amount of non-emergency general acute care inpatient services. Loma Linda Medical Center is a major competitor for scheduled and complex maternity services, however being a tertiary care provider and a teaching hospitals means having higher costs and prices than a regular community hospital. Therefore, from an insurer's perspective Loma Linda's hospitals (Children's and AMC) are not close substitutes for the general acute care services provided by a local community hospital.

Mirroring the distribution of admissions in the market area as discussed above, at SMMC, ED and maternity care are the most frequently provided services and account for 91% of the hospital's discharges. Non-maternity scheduled admissions account for just 9% of admissions.

Specific services tied to ED emergency and maternity services that make SMMC an attractive hospital in local insurers' networks are its designation as a ST-Elevation Myocardial Infarction (STEMI) receiving center, being a designated primary stroke center and a Level 3 NICU.

Assuming these designations would remain in place following the relocation, SMMC will retain its strong competitive bargaining position after the CiC is established.<sup>233</sup>

As a Primary Stroke Center, St. Mary has an acute stroke team and neurologist accessible 24/7 with designated stroke beds, which can expedite diagnosis and treatment of stroke improving the outcomes. St. Mary is the only local hospital in High desert designated as a primary stroke center. Other primary stroke centers just outside primary market area includes St. Bernardine medical center and Kaiser Fontana/Ontario hospitals.

The STEMI receiving center designation is particularly important. A STEMI, more commonly known as an acute heart attack caused by clotting in one or more arteries, usually requires aggressive treatment promptly to prevent permanent heart damage. Working in coordination with emergency medical responders, the physicians and staff at STEMI receiving centers can expedite the diagnosis and treatment of cardiac episodes.

Within San Bernardino County, there are six STEMI Receiving Centers that administer percutaneous coronary intervention for patients experiencing an acute heart attack: SMMC, Desert Valley Hospital, Loma Linda University Medical Center, Pomona Valley Hospital Medical

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<sup>233</sup> As of early September 2021, we did not have access to information on details regarding what services the New Hospital would offer or in what capacity they would offer those services.

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Center, San Antonio Regional Hospital, and St. Bernardine Medical Center.<sup>234</sup> This means that ambulances will bring most local stroke and heart attack patients to SMMC, regardless of whether this hospital is in patient's network.

SMMC and Victor Valley are the only two hospitals within the service area to provide neonatal intensive care beds, however the level and capacity of NICU is higher at SMMC (Level III vs level I). There were ten neonatal beds within the service area, with SMMC providing eight that operated at over 100% occupancy, while Victor Valley's beds operated two at an average occupancy of just 16%.<sup>235</sup> Other hospitals with NICUs just outside the SMMC market include St Bernardine Medical Center in San Bernardino, and Kaiser Riverside Community Hospital in Riverside. SMMC is likely to receive time-sensitive NICU transfers from other local hospitals regardless of the patient's insurance and in-network status (30% of NICU transfers from the service area go to SMMC).

In conclusion, due to its capacity and service lines provided, SMMC is the most attractive community hospital to have in-network for the insurers that serve SMMC market area. Given that all local hospitals are currently in-network for all major insurers in the market, the fact that SMMC has the highest share of patients in each of the main service categories is indicative of its dominant status in the area that it serves. The planned change in location that will bring SMMC closer to more populated areas will likely increase its dominance in the market.

#### ***9.2.11 Kaiser's members in the SMMC Market Do Not Have a Local Kaiser Hospital Option***

Despite a much longer travel time, Kaiser's patients in the SMMC market area primarily use Kaiser Hospitals, i.e., Kaiser Fontana/Ontario and other Kaiser Hospitals, for all types of admissions, including emergency (Exhibit # 28 Proportion of Hospital Admissions for Non-Kaiser Patients from SMMC's Market Area, by Type of Service, 2019).

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<sup>234</sup> San Bernardino Inland Counties Emergency Medical Agency website  
[https://www.sbcounty.gov/icema/main/stemi\\_ctr.aspx](https://www.sbcounty.gov/icema/main/stemi_ctr.aspx) (Accessed 9/5/2021)

<sup>235</sup> HCAI Annual Hospital Utilization Data, 2019

Exhibit 24 Proportion of Hospital Admissions for Non-Kaiser patients from SMMC's Market Area, by Type of Service, 2019

Hospital	ED admissions (exclusive of maternity)	Maternity admissions	All Other Scheduled Admissions	Total Share of All Market Area Admissions
<b>SMMC</b>	35%	48%	17%	33%
<b>DESERT VALLEY</b>	30%	10%	2%	24%
<b>VICTOR VALLEY</b>	17%	1%	1%	13%
<b>LOMA LINDA</b>	5%	17%	35%	11%
<b>All Other</b>	13%	25%	45%	19%
<b>Total</b>	100%	100%	100%	100%

Source: OSHPD Patient Discharge Data, 2019

SMMC and other in-area non-Kaiser hospital are utilized by Kaiser's members almost exclusively for emergency admissions, with SMMC providing 10% of emergency admission services to Kaiser's members from the market area, about as many as Desert Valley. In the absence of local in-network option, about half of Kaiser's patients use three local hospitals for outpatient ED visits, and SMMC is the largest provider of those visits (60% of Kaiser ED visits to local hospitals are at SMMC). When admission is necessary, Kaiser either transfers its patients to Kaiser Hospitals directly from the emergency room, or they are admitted, treated and about 38% of those Kaiser admits to the local hospitals are eventually transferred to Kaiser Hospitals for further treatment. As such, admissions at Kaiser Fontana are not always reflecting patient choices, as many of those patients might be transfers from the local area hospitals (Exhibit # 29 Proportion of Hospital Admissions for Kaiser's patients from SMMC's Market Area, by Type of Service).

Exhibit 29 Proportion of Hospital Admissions for Kaiser's patients from SMMC's Market Area, by Type of Service, 2019

Hospital	ED admissions (exclusive of maternity)	Maternity admissions	All Other Scheduled Admissions	Total Share of All Market Area Admissions
<b>Kaiser Fontana</b>	63%	91%	78%	74%
<b>Other Kaiser</b>	4%	6%	11%	7%
<b>SMMC</b>	12%	2%	0%	6%
<b>Desert Valley</b>	11%	1%	0%	5%
<b>All Other</b>	10%	1%	11%	8%
<b>Total</b>	100%	100%	100%	100%

Source: OSHPD Patient Discharge Data, 2019

### 9.3 Insurers in the Market Area

According to SMMC's 2019 community need assessment document, about 90% of the population in its service area has insurance. SMMC's community needs assessment service area has



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a large share of low-income population with 46% living below 200% FPL, which is higher than in San Bernardino county and much higher than in California. Due to lower income levels and the employment situation in the High Desert region, the majority of non-Medicare residents are insured through Medicaid program.

This pattern is reflected in the payer distribution of admissions from the area, where for every commercial admission there are two Medicaid admissions:

- Medi-Cal patients are 39% of admissions, and nearly 60% of ED visits.
- Medicare patients are 38% of admissions, and about 20% of ED visits.
- Commercial patients are 19% admissions, and about 16% of ED visits.
- Other payers account for the 4% of ED visits and admissions.

### ***9.3.1 The Medi-Cal is a Dominant Insurer in the SMMC Area***

Medi-Cal patients in the market area are mostly covered by Medi-Cal managed care plans, reflected in 80% of Medi-Cal admissions being covered by a managed care plan. Inland Empire Health Plan (IEHP) is the dominant insurer for Medi-Cal managed care, with roughly 90% of all managed care enrollees across the two-county Inland Empire region. IEHP is one of the top 10 largest Medicaid health plans and the largest not-for-profit Medicare-Medicaid plan in the country. With a network of more than 6,400 providers and more than 2,000 employees, IEHP serves more than 1.3 million residents in Riverside and San Bernardino counties who are enrolled in Medicaid or Cal-Medi Connect Plan (Medicare-Medicaid Plan).

IEHP is also a top payer for Medi-Cal managed care admissions in SMMC area, covering 86% of those. The next closest plan is Molina, covering 6.5% of Medi-Cal managed care admissions. Kaiser covers only 3.3% of Medi-Cal managed care admissions. Actual share of Kaiser Medi-Cal enrollment is likely to be higher as Kaiser may have a lower admission rate than other payers. According to DMHC data, Kaiser has about 12 thousand Medi-Cal HMO enrollees in the SMMC market area. According to Kaiser, Medi-Cal plans are responsible for 12% of its members in this market area.

### ***9.3.2 Commercial Insurers Cover Only a Small Portion of Admissions in the SMMC Area***

Commercial insurance, while covering only a small portion of the market area admissions, about 19%, is almost all managed care: 66% of the commercially insured admissions are California HMO patients, and 28% use PPO, EPO and other non-Knox-Keene plans.

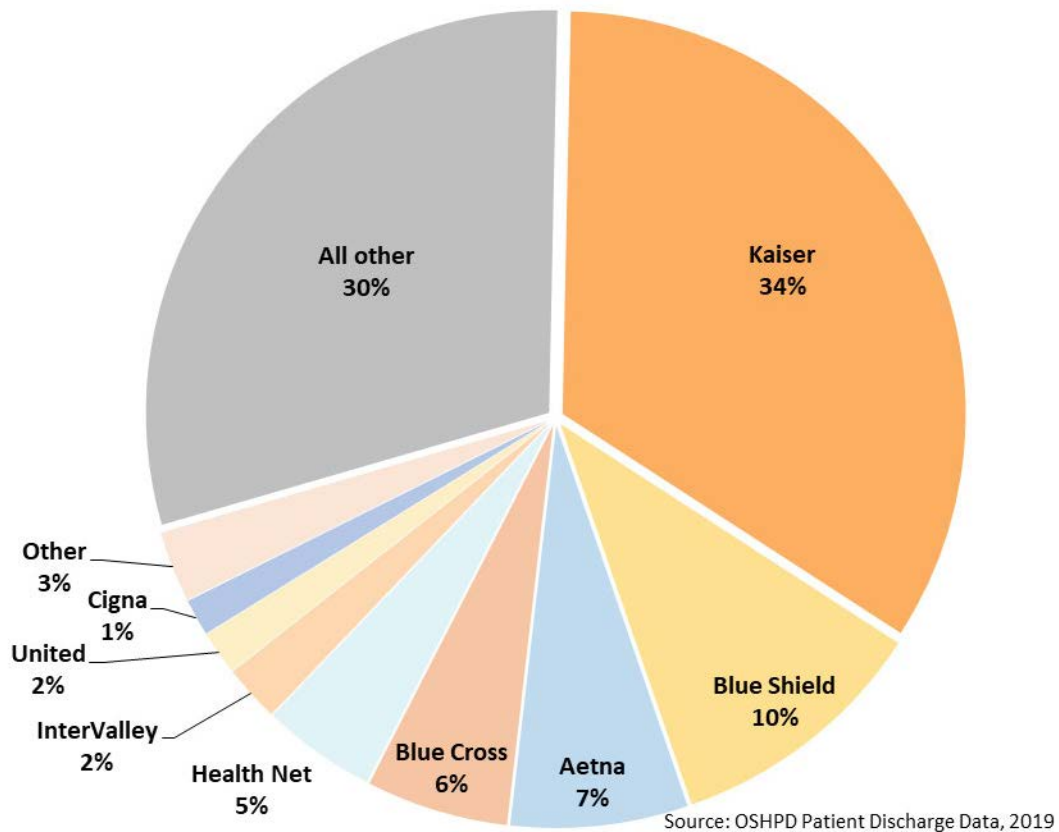
Among commercial insurers, Kaiser is the dominant insurer in the market area, with about one-third (34%) of all commercial admissions (and 50% of all HMO-insured admissions) covered by Kaiser Health Plan (Exhibit # 30 Commercial Managed Care Dissensions in SMMC Area by Plan).

Kaiser Health Plan competes for its plan members (and consequently patients for its hospitals) with other payers in the High Desert area. Kaiser's main competitors in the commercial HMO

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market are Blue Shield, running a distant second, with just 10% of admissions, and Aetna, Blue Cross and Health Net plans, all with 5 – 7% of total commercial admissions.

*Exhibit 25 Commercial Managed Care Dissensions in SMMC Area by Plan, 2019*



Because many non-Kaiser insurers offer non-HMO plans as well (for example, PPO, POS etc.), their total share of the market for managed care is higher than what is shown by HMO plan membership data alone (HCAI discharge data does not report non-HMO plans separately). “Other managed care” bucket is 30% of the commercial managed care market and contains non-HMO plans offered by the same payers that have HMO plans, such as Blue Shield, Blue Cross or Aetna. Unfortunately, HCAI discharge data does not provide payer plan information for the “other managed care” bucket and many of the patients in this category are covered under products provided by the other insurers listed in Exhibit # 30 Commercial Managed Care Admissions in the SMMC Market by Plan. So, the “other managed care” bucket in the exhibit would include PPO products from payers like Blue Shield and Aetna Blue Shield and Aetna PPOs, and subsequently the insurer’s total share in the managed care market is underestimated when only their HMO share is considered. Blue Shield, for example, has only one-third of its

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total commercial enrollees in HMO products statewide,<sup>236</sup> while two-thirds are PPO and POS. If the same proportion held true in SMMC's market, total Blue Shield share in the commercial market, including all managed care products, would be three times higher at about 30% of the market rather than 10%, which is close to Kaiser's share of 34% which already reflects all their managed care products. Therefore, Kaiser might have a close competitor in the market, but we lack the complete data to capture that.

While looking at admissions by payer using HCAI data it is important to understand that the percent of the population who is admitted to a hospital by plan is not necessarily proportional to the percent of the population insured by that plan. Subsequently, we requested data from the Department of Managed Health Care (DMHC) to determine the number of commercially insured in the SMMC market area by plan, e.g., Aetna, Kaiser, etc. However, while these data include all those covered by a fully-insured commercial HMO plans, they do not cover all commercially insured that may be under some other type of product, e.g., some PPOs and all self-insured plans are not regulated the DMHC.<sup>237</sup>

Our 2020 special data request from the DMHC shows Kaiser with 65% of the insured commercial population in the SMMC market among DMHC-regulated plans. This likely overstates Kaiser's share since the DMHC data do not capture the complete number of commercially insured in the market and so the denominator is too low making Kaiser's share higher. To get a more accurate denominator for commercially insured in the SMMC market we used the 2019 American Community Survey (ACS) Data to obtain an estimate of the share residents insured by a private plan who live in or around Victorville-Apple Valley-Hesperia urban cluster. To get total commercially-insured population the estimate of the share was multiplied by total population in the market area obtained from 2020 Census. Given that Kaiser is an HMO and the DMHC captures all HMO members enrolled, we believe the *number* of Kaiser insured is accurate and we were able to re-estimate the Kaiser's share in the SMMC market with a more accurate ACS denominator for the commercially insured. This led us to a 2020 estimate for Kaiser HMO of 52% of all the commercially insured members in the SMMC market. This market share estimate does not include enrollees served by Kaiser administrative services only (ASO) plans covering population in the area, so Kaiser total market share might be even higher than 52%.

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<sup>236</sup> Derived based on the CA enrollment data 2020 reported in <https://www.chcf.org/publication/2020-edition-california-health-insurance-enrollment/#related-links-and-downloads>

<sup>237</sup> The majority of California's health plans are regulated by either the California Department of Insurance (CDI) or the California Department of Managed Health Care (DMHC). The CDI regulates point-of-service health plans and certain Preferred Provider Organization (PPO) health plans underwritten by health insurance companies licensed by the CDI. The CDI does not regulate Health Maintenance Organizations (HMOs) or certain PPOs, which fall under the Knox-Keene Act (i.e., Blue Cross of California or Blue Shield of California). Self-insured ERISA plans where payer like Kaiser or Blue Shield provide administrative services only (ASO) are not regulated by either agency.

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We could not estimate other commercial payers since we had total commercially insured but did not have data on what products may be missing from each plan and regulated by another state agency.

Kaiser's share in commercial admissions from the SMMC market area is comparable to the California average across all zip codes that are within 15 miles from a Kaiser hospital, despite the fact that all the zip codes in the SMMC market are located much further than 15 miles away from the nearest Kaiser hospital Kaiser Fontana/Ontario.<sup>238</sup> The share of Kaiser's patients in SMMC market area is thus considerably higher than one would expect, given the distant location of its hospitals. Kaiser popularity among commercial patients might reflect the fact that Kaiser has strong outpatient care access for members in the area, and that access to inpatient care is of lesser importance for this population. However, we also believe this signals an opportunity for much greater Kaiser's membership growth with a closer Kaiser Hospital option in the SMMC market. We will discuss this in much greater detail in the competitive effects section that follows.

### ***9.3.3 Kaiser is a Key Insurer for The Medicare Members in the SMMC Area***

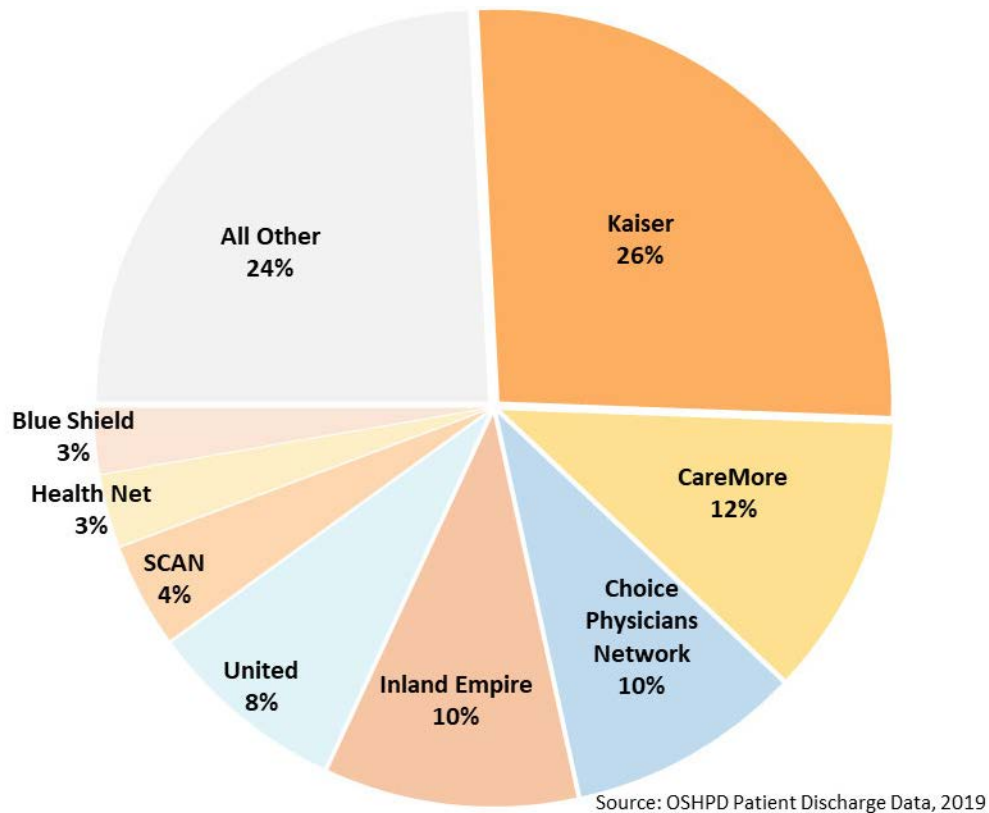
Medicare managed care plans are responsible for only 43% of Medicare admissions in SMMC. Since Medicare managed care plans typically cover somewhat healthier population and have lower admission rates than traditional Medicare, the share of managed care among Medicare enrollees might be a bit higher than reflected in their admission shares.

Kaiser is also the largest insurer for the Medicare managed care population in the area, with 26% of the Medicare managed care admissions in the market (Exhibit # 31 Medicare Admissions in the SMMC Market Area by Plan, 2019). According to DMHC data, Kaiser has about 11 thousand Medicare HMO enrollees in the SMMC market area.

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<sup>238</sup>Proportion of Kaiser insurance in patients within 20 Distance to nearest Kaiser hospital was estimated using HCAI discharge date on patient location, payer plan and hospital used.

Exhibit 31 Medicare admissions in the SMMC market area by plan, 2019



The next largest Medicare managed plan is CareMore – a subsidiary of Anthem. Blue Shield – the closest Kaiser competitor in the commercial market – covers only 3% of Medicare inpatient admissions. Statewide, Kaiser has 49% of total Medicare managed care admissions in the zip codes located within 15 miles of a Kaiser hospital.<sup>239</sup> The absence of a nearby Kaiser hospital in the SMMC market area deters many elderly patients who would otherwise consider a Medicare Advantage plan with Kaiser. It is likely that Medicare managed patients that enroll in Kaiser despite the absence of nearby hospital are healthier than the rest of Medicare population, and their chance of admission is a lot lower. Consequently, the share of Kaiser in Medicare managed care enrollment is much higher than we could estimate based on admissions, just like in commercial market. We expect that once Kaiser network includes a local inpatient option, then more Medicare members would consider Kaiser coverage.

### 9.3.4 Kaiser’s Role in the SMMC Market

Currently, employers and other consumers have two major types of commercial insurance products in the SM market to choose from:

<sup>239</sup> HCAI PDD 2019 data.

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- Regular HMO or PPO plans (e.g., Blue Shield), which contract with all hospitals in the market area and thus provide in-network hospital access within 30 minutes for over 90% of patients in the market. These plans also offer a selection of primary care and specialist physicians that is potentially broader than Kaiser's network.
- Kaiser HMO, which is an integrated system that limits access only to Kaiser Physicians and hospitals, with the exception of emergency care. Although Kaiser is expanding its local outpatient options, the nearest Kaiser inpatient facilities are over 50 minutes away for most patients in SM market area.

According to DMHC data, about 90% of commercial Kaiser enrollment in the area are large group employer-sponsored plans. Little is known about the exact premiums rates that Kaiser charges for its large group plans in the area and how they compare to other options. According to the interviews with some of the employers in the market and the data they provided, Kaiser offers competitive rates, which is a major draw for their employees. In the market for individual and small group insurance, e.g., Covered California, Kaiser premiums are about the same or even higher than similar non-Kaiser plans in the rate region covering San Bernardino and Riverside counties.

Despite a lack of access to local hospitals, currently about 52% of commercial population in the SMMC market are insured by Kaiser.<sup>240</sup> The next closest payer is Blue Shield HMO, with about 10% of admissions, and additional PPO product share – which is at least as high as HMO. Kaiser, despite only having a presence outside the SMMC market area, is the dominant commercial insurer, with almost half of the commercial HMO market (Exhibit # 32 Share of Kaiser Insured Inpatient Admissions in the Market Area).

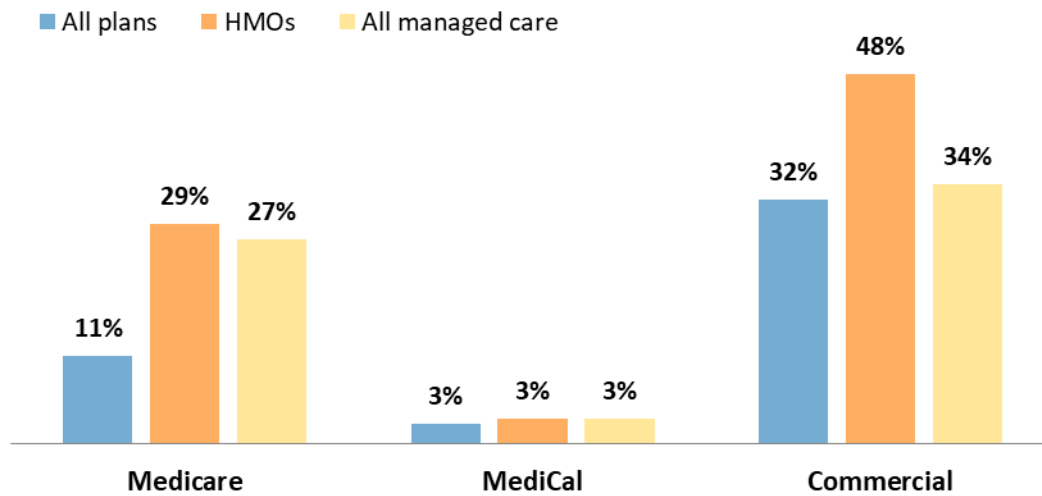
Kaiser also has urgent care centers in the area, as well as a recently completed new outpatient center in Hesperia that opened in 2020. The main factor limiting its further expansion, especially in the Medicare market, is that its nearest in-network hospital is located 40 to 70 minutes away from patients' homes.

Community hospitals in the market including SMMC depend on commercial patients for their profitability, since this group of patients is reimbursed at much higher rates than Medicare and Medicaid patients. However, this market has a very small share of commercial admissions amounting to 19% of the market, a third of which are Kaiser's patients that mostly use Kaiser Hospitals for their care. Consequently, local hospitals depend on a very small pool of commercial patients for their profits.

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<sup>240</sup> This is based on data for the insured populations in the SMMC markets area provided by the Dept of Managed Care for 2019 is an approximate estimate. Kaiser covers 34 to 37% (with newborns) of commercial admissions from the area, which translate into higher enrollment due to typically lower admission rate for Kaiser's patients.

Exhibit 26 Share of Kaiser insured Inpatient admissions in the market, 2019



Source: OSHPD Patient Discharge Data, 2019

Note: All plans include both managed care and traditional payers. All managed care includes HMOs and other managed care plans, e.g., PPOS.

## 10 Analysis of the Competitive Effects of the Proposed Transaction

This CiC is between a dominant insurer in the market and a dominant hospital, which we believe creates a risk of reduced competition in both the insurance and hospital markets. We apply vertical merger theory to examine competitive effects with a focus first on the insurance market and then on the hospital market. The two are clearly intertwined, however, they are separate products and therefore have separate discussions. Our goal in both discussions is to better understand whether theories of competitive harm which can ultimately adversely affect SMMC area residents, are supported by evidence. These theories include both input foreclosure or raising rivals' costs, customer foreclosure, and reduced likelihood of entry by competitors.

After our discussion on the competitive effects of the insurance and hospital markets, we also address the potential anticompetitive effects associated with sharing competitively sensitive information across organizations. Following this we provide conditions for approval that would mitigate anticompetitive effects associated with this CiC.

These topics are covered in the following sections:

- Analysis and Approach: Our approach to the analysis of the CiC (10.1)
- The Insurance Market: Findings as they relate to the insurance market (10.2)

- The Hospital Market: Findings as they relate to the hospital market (10.3)
- Sharing Information: Findings on the potential impact of sharing sensitive information between the parties (10.4)
- Conditions: Conditions for approval for consideration to mitigate the risk of anticompetitive effects (10.5)

**In summary we find that the transaction causes the following anti-competitive effects:**

- There is the risk that Kaiser enrollment growth could reduce viable competition in the commercial managed care market which, along with barriers to entry, creates a risk that Kaiser could exercise its monopoly power to eventually increase the premiums and reduce quality.
- Kaiser enrollment growth could be fueled by unfair competitive advantage based on the CiC provisions, which, in their current form, result in Kaiser getting rates much lower than its competitors. Profit-sharing provision partially insulates Kaiser from price increases imposed by SMMC on other commercial plans, which results in price increases disproportionately affecting Kaiser competitors.
- Profit-sharing provision aligns financial interests of SMMC-Providence and Kaiser to increase costs for Kaiser rivals. Both parties benefit from an increase in contracted rates for rival Medicare and Medi-Cal plans, since corresponding Kaiser rates are independent of them. It also minimizes Kaiser costs resulting from commercial price increase, making cost pressures from a price hike fall disproportionately on its rivals.
- As Kaiser admissions grow and create capacity issues at the current SMMC facility or the New Hospital, there will be a strong incentives for SMMC to reduce access or utilization for Medi-Cal or Medicare managed care plans in an attempt to make room for higher margin Kaiser's patients.
- SMMC market power would be bolstered as a result of this CiC, as Kaiser rivals will find that keeping the best local hospital in their network is indispensable in competing with Kaiser once they have SMMC in their network.
- An increase in Kaiser's market share would reduce commercial patient volume at other local hospitals (already low in this market), making it more difficult for them to stay profitable in the long run, increasing the risk of local hospitals exiting the market.

**The following factors have a potential to constrain anti-competitive concerns:**

- Unlike in a full merger, **SMMC will have strategic concerns about the growing Kaiser's share** in the market because it reduces patient volumes treated by Providence physician groups and could create an over-reliance on Kaiser's volume thereby exposing SMMC to risks if Kaiser decides to exit the CiC. Under the current terms of the affiliation that involve a rate discount for Kaiser, SMMC's total profits get a negligible boost from an increase in Kaiser's membership, making strategic concerns take priority for SMMC.



- Unlike in a full merger, Kaiser's priority of its own profits will incentivize them to shift Kaiser's patients to its own hospitals if it costs a lot more to treat them at SMMC. These incentives mean that SMMC-Providence is, in a way, competing with Kaiser's own hospital for treating Kaiser's members at a lower cost. This limits SMMC's ability to increase commercial prices without causing an increase in cost for Kaiser and resulting in a drop in Kaiser patient volume at the New Hospital.

**Conditions could be put in place that mitigate anti-competitive effects or leverage market forces in constraining anticompetitive behavior**

- Modifying the CiC terms with respect to Kaiser's discount, profit-sharing and exclusive caps on Kaiser rate increases could potentially eliminate Kaiser's unfair competitive advantages in commercial market, as well as reduce SMMC market power to increase rates on other commercial payers
- **Anti-tiering, anti-steering and exclusivity clauses** can be prohibited from SMMC contracts with other payers to ensure other payers' ability to shift volume to less expensive hospitals in the event of price increase making it easier to compete with Kaiser on costs and facilitate competition in the hospital market.
- **Limiting SMMC's ability to increase prices for Kaiser's rivals**, including price caps on Medi-Cal and Medi-Care managed care rates, and caps on price increase for commercial payers, as well as caps on out-of-network services (in case the Surprise Billing Act doesn't work as intended).
- Modifying the CiC terms to **strike out Kaiser's power to veto a new payer contract** (unless it clearly gives its rivals an unfair competitive advantage, such as designated capacity)

**The following factors have the potential to make the transaction less anticompetitive, but there are still risks:**

- Kaiser's access to a local in-network hospital on fair, competitive terms can potentially address the current limitation that Kaiser faces in this market. Fair competition from an efficient integrated system (Kaiser) could create downward pressure on the insurance rates in the area and improve quality-based competition that ultimately serves consumers. However, a potential Kaiser dominance in the market, even if achieved on fair terms, creates barriers to entry for the competitors, forces many of them to exit the market, which ultimately limits consumer choices and creates an opportunity for Kaiser to abuse its power to raise premiums in the absence of competition.
- The increased appeal of the New Hospital might force hospital competitors to upgrade their facilities, improve services and/or lower prices to attract more patient volume in a market where all local hospitals have been enjoying high level of profits without having to considerably improve the scope and quality of their services. The flip-side of this

potential incentive is that it carries a risk of competing hospitals losing too much in profits and eventually exiting the market as their patients switch to Kaiser and their stream of revenue from higher paying commercial patients dries up.

## 10.1 Analytic Approach

Our analysis relies on a vertical merger framework that focuses primarily on the incentives created by the CiC and analysis of the CiC effects on the parties' market share, profits, costs and their ability and incentives to raise prices in the insurance and hospital market, as well as overall competitiveness of the hospital and insurance market in the SMMC market area.<sup>241</sup>

Vertical mergers involve merging companies operating at different levels of the supply chain with the transaction involving the upstream market and the downstream market. In this CiC SMMC is the upstream market and Kaiser as an insurer is the downstream market. Vertical mergers can raise concerns about competitive harm in several ways and we consider some of the relevant theories of harm (i.e., mechanisms) addressed in the economic literature by which the proposed transaction might cause anticompetitive effects. In this CiC, there is a risk of anticompetitive effects in this transaction as they relate to the following theories:

- Input foreclosure or raising rivals' costs.
- Customer foreclosure
- Reduced likelihood of entry by competitors.

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<sup>241</sup> Generally, when looking at health care consolidation in the hospital or health insurance market, for purposes of research or regulation, the analysis relies on a two-stage model of competition, where first an independent payer negotiates with different hospitals and chooses which ones to include in its exclusive or preferred network based on prices, proximity and quality, and second, patients choose which providers they use from the network constructed. The value of a provider to the insurer depends on how important that provider is to the patients. Mergers and affiliations between hospitals, for example, bring up competitive concerns when merging hospitals are close substitutes and can negotiate with the same insurers in the market. A common payer choosing hospitals for its network is the critical part of the hospital competition theory which underlines the willingness-to-pay and diversion ratio models commonly used for horizontal merger analysis. This model is not applicable to this CiC because Kaiser Hospitals and SMMC do not directly compete for a common customer, but rather Kaiser plans compete with non-Kaiser plans based on their premiums and network, which includes hospitals and other providers. An employer or an individual in SMMC market can: 1) choose a Kaiser plan which gives them access to only Kaiser in-network providers, but not to SMMC and other local area hospitals except in emergency, or 2) choose one of the non-Kaiser HMO or PPO plans that currently include SMMC and other local providers in the area. Given the constraints of a chosen plan, Kaiser insured members do not generally use non-Kaiser hospitals for non-emergency services and non-Kaiser's members do not have access to Kaiser Hospitals for non-emergency services. Any horizontal competition between the two parties is indirect: SMMC together with other local community hospitals are constrained by how much they can increase prices given those increases would increase the total costs to the insurers in the market and affect their premiums, which in turn may induce some customers to switch to Kaiser and stop using SMMC for non-emergency services. While the multistage and indirect nature of this competition prevents us from applying standard horizontal competition theory and econometric tools such as WTP, our approach and conclusions are still consistent with a rational analysis related to theories of competitive harm. See The Commonwealth Fund discussion of how federal antitrust tools are inadequate to prevent anticompetitive health care consolidation at: <https://www.commonwealthfund.org/blog/2021/federal-antitrust-tools-are-inadequate-prevent-anticompetitive-health-care-consolidation>.

- Information sharing

**Input foreclosure or raising rivals' costs.** One theory of harm regulatory agencies consider is "input foreclosure or raising rivals' costs" which involves forcing downstream competitors (i.e., rival insurers) to exit the market or raise their prices to end customers, making them less competitive to the merged company's downstream business. In the context of a vertical merger between a hospital and insurer this type of harm could be manifested as:

- Excluding the merged hospital from participating in competing insurers' networks. This could make the rival insurers' health plan networks significantly less attractive to prospective enrollees or make their health plans outright unmarketable.
- Raising the reimbursement rates that rival insurers must pay to include the merged provider in their networks.

For the New Hospital, raising rivals' costs are potentially feasible and profitable and there is a risk of anticompetitive effects that include:

- Forcing downstream competing non-Kaiser insurers (downstream competitors) to exit the market or raise their premiums, making them less competitive to the merged company's downstream business.
- Causing end customers of the non-Kaiser insurers to switch their purchases to the merged company's downstream business which is the New Hospital.
- Allowing the New Hospital to raise its own downstream prices to end customers such as non-Kaiser health plans benefit.

This type of harm is feasible given that the New Hospital as a dominant provider could have the ability and incentive to raise the reimbursement rates for the rival insurers. Area insurers all have indicated that SMMC is the most desirable local provider in their network and they cannot continue to offer attractive health plans to their enrollees without it, which makes their demand for SMMC services relatively inelastic with respect to price. However, Providence, as a majority owner of the New Hospital, does not have an incentive to exclude the competing plans completely, since their reimbursement rates are higher than the reimbursement they would receive from Kaiser, and excluding them would result in a profit reduction that a potential increase in utilization from new Kaiser's members doesn't fully compensate for.

**Customer foreclosure.** There is also the risk that the transaction raises customer foreclosure concerns, i.e., the ability of consolidating company to reduce or cut-off the supply of downstream products to rival firms. In a traditional merger between a hospital and insurer, the merged entity might refuse to include rival hospitals in the merged insurer's network. As a result, rival hospitals would be foreclosed from accessing enrollees of the dominant insurer, driving those patients to seek care from the merged hospital, that is, the only hospital in the

dominant insurer's network.<sup>242</sup> However, this case differs from a traditional merger in that Kaiser's patients generally lack the opportunity to use other hospitals except in emergency, and there are no contracts in place that Kaiser could drop to shift its current patient volume from other competing hospitals (except its own) to SMMC. At the same time, a major expansion in Kaiser enrollment fueled by this CiC reduces the number of non-Kaiser's patients that could go to SMMC competitors by as much as 24% in the commercial market<sup>243</sup>. Also, SMMC could potentially use its market power to ensure that other insurers do not contract with hospitals aside from SMMC or otherwise restrict their contracting options with other hospitals.

**Reduced likelihood of entry by competitors.** A vertical merger might create market conditions that discourage a company from entering the upstream or downstream market because, to compete successfully post-merger, the entrant would need to enter at both the upstream (insurance) and downstream (provider) levels. For example, this transaction creates a risk of customer foreclosure by eliminating the ability of a new hospital entrant to the market to contract with Kaiser which will be the dominant commercial insurer, unless a potential hospital entrant into the market also enters the downstream insurance market to generate a sufficient access to patients. Subsequently, the need to enter both the upstream hospital and downstream insurance markets might delay, discourage, or prevent a new hospital from entering the market. Additionally, this reduced likelihood of entry is compounded by the fact that Kaiser's dominance will result in a less favorable payer-mix, i.e., fewer commercially insured patients, left for non-Kaiser physicians. This in turn may make it more difficult for competitors to enter the market since they have too few attractive non-Kaiser physician options to construct a network.

**Information Sharing and Coordination.** Post CiC information sharing between an insurer and hospital undergoing a merger or CiC is a potential competitive concern. In this case, Kaiser as the merged insurer likely would have competitively sensitive information from and about rival hospitals, and SMMC, the merged hospital likely would have competitively sensitive information from and about rival insurers.

### ***10.1.1 Analyses Related to Theories of Harm***

To analyze this CiC in the context of the theories of harm listed above, we developed a simulation model that allows us to estimate current Kaiser costs spent on hospital services for the SMMC area members, and how these costs will change as a result of this CiC. We also

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<sup>242</sup>Gilman, A and Sheth, A, Antitrust Analysis of Vertical Health Care Mergers. Practical Law, April/May 2020 (<https://www.crowell.com/files/20200401-Antitrust-Analysis-of-Vertical-HC-Mergers.pdf> Accessed 9/11/2021)

<sup>243</sup>Growth in Kaiser admissions share from 34% to 50% of all admissions coming from SMMC service area would reduce non-Kaiser admissions by 24%.

investigate how discounts, profit-sharing and other terms of the CiC will affect Kaiser costs, profits and willingness to use SMMC hospital. We evaluated whether Kaiser and SMMC have matching incentives to increase prices at SMMC and increase Kaiser's market share.

We relied on hospital financial and utilization reports, patient discharge and outpatient emergency visit datasets to estimate patient volumes, profits, net revenues per adjusted days and operating costs per adjusted days for commercial payers, and other financial and utilization metrics<sup>244</sup>. Where available, these input data were supplemented with and cross-checked against the data that the parties provided and found to be consistent. In addition, we used data on insurance enrollment from DMHC (Department of Managed Health Care) and interviews with various stakeholders.

We modelled a range of scenarios, where 50% to 70% of Kaiser's patients coming from SMMC service area are treated in the New Hospital, and where Kaiser's share in commercial admissions from the market ranges from its current share of 34% to 50% of the market. These ranges of utilization percent and market share were constructed based on our analysis of utilization patterns for different services lines, CiC conditions, information found in parties responses, and analysis of Kaiser's market shares in similar markets. The attached appendix provides details on modelling of financial and utilization impact of the transaction on the parties.

## **10.2 The Transaction Will Create a Risk of Increased Market Power for Kaiser**

There are risks of anticompetitive effects in the insurance market. This section examines the competitive effects as they relate primarily to health insurance and Kaiser's role in the SMMC commercial insurance market. While we believe that there are risks of anticompetitive effects on the insurance market in the SMMC market area we cannot quantify the magnitude or exact timing and duration of those effects due to data limitations and theory deficiencies in this area, as well as uncertainties that surround this deal.

### ***10.2.1 The CiC Creates a Risk of Making an Already Concentrated Insurance Market Less Competitive***

Based on the evidence from comparable markets and the state-wide Kaiser expansion trajectory we expect the share of Kaiser inpatient hospital admissions from the SMMC market area to grow by up to 50% for the commercial population reaching 50% of commercial admissions after the CiC. If we look at other markets with Kaiser hospitals, it provides a perspective on the potential for Kaiser insurance growth in the SMMC market once Kaiser's members have a local option. To project potential Kaiser's share of admissions in the market after the CiC we looked at the share of Kaiser's patients coming from zip-codes in a 15-mile

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<sup>244</sup> California Department of Health Care Access and Information (HCAI, formerly Office of Statewide Health Planning and Development (HCAI)) is the source of these datasets.

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radius around existing Kaiser hospitals (since all zip codes in the SMMC service area are within 10 to 15-mile radius around SMMC). We selected several comparable Kaiser hospital areas to serve as an example. In these selected, comparable markets with a Kaiser hospital within 15-miles of area residents, Kaiser admissions were approximately half of all area commercial inpatient admissions. For example, geographically, the closest hospital to SMMC is Kaiser Fontana / Ontario, which currently primarily serves the population living in Fontana, Ontario and surrounding areas, including the small number of Kaiser's patients in the SMMC service area. The share of Kaiser's patients among the commercial admissions coming from a 15-mile area around this hospital was 47% in 2019. In 2008, Kaiser's share among commercial admissions in this area was about 40.5%, expanding by about 7 percentage points since then.

Another appropriate example is Kaiser Moreno Valley hospital in nearby Riverside county, which Kaiser acquired in 2008 (formerly, a 101-bed Moreno Valley Community Hospital) and expanded since then. Moreno hospital is located within 40-minute drive from a more advanced Kaiser Riverside hospital – another similarity with SMMC which will be located within similar distance from a larger Kaiser Fontana medical center. Prior to hospital acquisition by Kaiser, the share of Kaiser among commercially insured admissions from 15-mile area around Moreno hospital was 33% (exactly the same as current Kaiser's share in SMMC area), but by 2019 it grew to 49%. Yet another example, is the Dignity hospital in Stockton (St. Joseph Medical Center), which Kaiser added to its network by acquiring a 20% stake in that hospital in 2016. In 2019, the share of Kaiser's members among commercially insured admissions that come from the 15-mile area surrounding this hospital reached 48%.

We expect Kaiser Medicare admissions from the area to increase by 90% in 2035. There are several reasons to expect that Medicare enrollment growth would be much larger than the commercial growth: 1) current Medicare enrollment in Kaiser has been more constrained by the absence of the local hospital option, since inpatient services are more important for older population, and 2) managed care penetration is relatively low in the Medicare population from SMMC area, having the potential to expand through Kaiser enrollment. We also assume that Medi-Cal Kaiser admissions will grow by 50% in the next 15 years, however the impact of this population on Kaiser hospital admissions is minimal given that Kaiser covers only 3.3% of Medi-Cal managed care admissions.

Given the projected increase in Kaiser insurance market shares, and high SMMC-utilization scenario (up to 70% of Kaiser's patients going to SMMC) we independently derive about the same number of Kaiser discharges going to SMMC in 2035, as does Kaiser in their own projections for Kaiser patient volume at SMMC.<sup>245</sup> Therefore, we believe our projected increase

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<sup>245</sup> Our estimates were based on analyses prior to receiving information on Kaiser growth from the parties.

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in Kaiser's market share and enrollment is consistent with Kaiser's own enrollment targets and projections.

Kaiser's share of admissions in the market translates into much larger Kaiser's shares in managed care enrollment in the area. While share of Kaiser in commercial admissions from SMMC market is 34%, our estimated share of Kaiser enrollment is 52% of the commercial managed care market in 2019, not counting additional enrollment in ASO plans served by Kaiser.<sup>246</sup> The explanation for the discrepancy between admission and enrollment shares is that by virtue of serving mostly large employer group plans, Kaiser plans include more families and younger/ healthier population than other managed care plans in the area, resulting in lower hospitalization rates. In addition, Kaiser attracts the healthiest population in the market that is not discouraged by the absence of local hospital, resulting in self-selection of healthier population into Kaiser. It is also possible that Kaiser makes effective efforts to prevent admissions and re-admissions so that Kaiser population is less likely to need inpatient hospital care overall.

If we assume that Kaiser enrollment will grow proportionally to its admissions from the area, then Kaiser commercial enrollment will grow from current 52% to 76% of the market by 2035. However, additional enrollees that Kaiser will attract with a local in-network hospital are likely to be less healthy than current Kaiser's members and will likely have higher hospitalization rate. Therefore, we reduce the projection of Kaiser enrollment share to approximately 70% of the market, not counting additional enrollment in self-insured plans, where insurance carriers provide administrative services only (ASO plans).<sup>247</sup>

The commercial managed care insurance market in the SMMC market area, which covers about 19% of SMMC market area admissions, is already highly concentrated among a few insurers, with an estimated HHI above 3500 and Kaiser covering at least 52% of enrollees.<sup>248</sup> Other alternatives to Kaiser HMO plans in the market, include CA Physician network (Blue Shield), Blue Cross, HealthNet, as well as PPO plans offered by major insurers like Blue Shield, Anthem and Aetna. Blue Shield is the main Kaiser competitor in a commercial market segment in this

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<sup>246</sup> See section 9.3.2 for the derivation of Kaiser's share of commercial enrollment in SMMC area.

<sup>247</sup> Administrative Services Only (ASO) is a group health self-insurance program for large employers wherein the employer assumes responsibility for all the risk, purchasing only administrative services from the insurer.

<sup>248</sup> To calculate a conservative estimate of HHI we used data on commercial enrollees from DMHC that covers 74% of estimated commercial managed care population in the area. We distributed the remaining 26% equally between Kaiser, and five other top payers known to have PPO or ASO plans, not covered by DMHC data. While hospital market concentration based on the Herfindahl-Hirschman Index (HHI) is a commonly accepted measure of market concentration, it is challenging when including Kaiser since, with the Kaiser model, Kaiser hospitals have a monopoly as their patients are forced to bypass local hospitals and travel to the in-network Kaiser hospital for non-emergency services. Change in HHI is of little meaning when applied to Kaiser affiliation with a local hospital: when Kaiser's patients start using that local hospital, their patient flows would be split between Kaiser and non-Kaiser facilities resulting in a lower HHI estimated from patient distribution, although that doesn't mean that this market suddenly became more competitive.

area, with 13% of commercial HMO enrollment or about 14% of the managed care commercial market.

For simplicity, we look at commercial managed care in its entirety, however, it is worth noting that for some large employers looking for health insurance for their employees, large group HMO products are their focus and are not substitutable with other products. Among fully insured HMO plans Kaiser already has about 70% of the market. In a large group HMO market specifically, Kaiser faces even less competition providing coverage for as many as 80% of enrollees in this market.<sup>249</sup> Total Kaiser enrollment has been growing rapidly at the annual rate of 6.2% per year in the 2014-2019 period, and [REDACTED]

[REDACTED]<sup>250</sup>

In many markets Kaiser has more competitive rates for large group plans.<sup>251</sup> Typically, other HMOs, and particularly PPOs, can successfully compete against Kaiser when they offer more choices or broader provider networks than Kaiser. So far, the main advantage of Kaiser rivals in this market has been in-network access to local hospitals, as well as more choices of specialists and hospitals outside the local market (for example by academic medical centers like Loma Linda MC). On the other hand, High Desert area in general and SMMC market in particular suffer from limited local physician options and insurers are challenged to create an adequate and accessible network, while Kaiser has robust primary care offerings in the area.<sup>252</sup> Kaiser appeals to physicians by offering a work-life balance available through an employment relationship with a guaranteed income.

Kaiser has been pursuing market expansion even in the absence of the CiC as evidenced by the new outpatient center that opened in Hesperia in December 2020, which offers many of the non-emergency outpatient services that a community hospital would typically provide.<sup>253</sup> Outpatient service expansion, such as opening a modern outpatient center in Hesperia is already making Kaiser a more attractive insurance option.

Kaiser's prominence in the market so far has been constrained only by the absence of a local hospital in its network, which Kaiser rivals in the area can offer. Including the most preferable and centrally located SMMC hospital in its network makes Kaiser plans even more attractive and competitive in the SMMC market, especially if Kaiser maintains its current level of premiums relative to other payers.

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<sup>249</sup> Department of Managed Care Data, 2019. (Special data request)

<sup>250</sup> Enrollment in commercial, Medicare and Medi-Cal together.

<sup>251</sup> <https://www.calhealth.net/Blue-Shield-California-versus-Kaiser-comparison-review.htm>

<sup>252</sup> Inland Empire, Increasing Medi-Cal Coverage Spurs Safety Net Growth, CA Health Care Almanac, Ca Health Care Foundation (CHCF), December 2020

<sup>253</sup> This Hesperia Medical Office Building has more than 30 medical offices, including services like family medicine, internal medicine, pediatrics, obstetrics, cardiology, orthopedics and podiatry, general surgery and physical therapy. Additional onsite services at the Hesperia include a nurse clinic, pharmacy, lab, diagnostic imaging, optometry and optical dispensing



**10.2.2 Kaiser's Cost of Providing Care for its Members from the SMMC Area is Likely to Change as a Result of the CiC, Declining Before the Opening of the New Hospital, and Increasing Afterwards**

We analyzed whether CiC terms would result in cost savings for Kaiser compared to the status quo giving it an advantage to lower premiums relative to its rivals and found that it depends on the proportion of Kaiser's patients treated at SMMC. SMMC commercial rates, even with a discount, are likely to be higher than Kaiser marginal costs of at their own hospitals, and these cost differences accumulate as Kaiser treats a larger share of its patients at SMMC.<sup>254</sup>

Currently Kaiser pays ██████████ out-of-network rates at SMMC that are about ██████████ ██████████ the average commercial rates. As a result, we estimate that about \$█████████ million or ██████████% of SMMC operating profits were derived from Kaiser commercial patients, despite Kaiser's patients constituting only 7% of commercial admissions at SMMC, and about 20% of outpatient ED visits.<sup>255</sup>

After the CiC goes into effect and before the New Hospital opens (2022-2026), Kaiser costs spent on inpatient care in the area will go down from their current level as a result of their SMMC discount unless Kaiser dramatically expands the number of patients treated at the current SMMC facility (which is unlikely, due to the lack of capacity in the current hospital).<sup>256</sup> The resulting drop in SMMC profits and corresponding gain for Kaiser is estimated to be around \$12 million in the year 2025, which accounts for the fact that Kaiser will triple its commercial patient volume at the current SMMC facility (from 5% to 15% of Kaiser's patients from the area using SMMC).<sup>257</sup>

If Kaiser passed those cost savings to the consumer that would result in annual premium reduction of about \$160 per enrollee short-run, which would give Kaiser another competitive advantage and further fuel Kaiser enrollment growth.<sup>258</sup> Alternatively, these short-term cost

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<sup>254</sup> SMMC average commercial rate per adjusted day is about \$6,000, while its operating cost at about \$2,700, which means that even with a ██████████% discount and ██████████% profit-sharing, Kaiser pays \$█████████ above the average cost per day. It's most likely that Kaiser's marginal costs at its own facilities aren't higher than average cost at SMMC and might in fact be even lower.

<sup>255</sup> Actual inpatient and estimated outpatient charges for Kaiser commercial patients were multiplied by Kaiser paid-to-charge ratio from their current contract, and then by cost-to-charge ratio to derive SMMC's revenues, costs and incremental profit from Kaiser patient volume. See Appendix F for the details of this calculation.

<sup>256</sup> Discussed in detail in section 10.1 above.

<sup>257</sup> This calculation considers the fact that treating additional Kaiser's patients at SMMC at a discount of commercial prices is more expensive for Kaiser than treating them at Kaiser's own hospitals at cost. See Appendix F for details.

<sup>258</sup> Reduction in cost of premium is calculated as \$12 million in savings divided by 74,000 Kaiser's members from the area.

savings provide protection for Kaiser if SMMC decides to raise its commercial rates prior to opening the New Hospital.

After the New Hospital opens, we expect that 50%-70% of Kaiser's patient volume from the area would be treated at SMMC instead of Kaiser Fontana, which would increase Kaiser's costs.<sup>259</sup> We estimate Kaiser's inpatient costs per member to at least revert back to their current level or slightly increase, given a constant price level, a [REDACTED] % discount and conservative assumptions.<sup>260</sup> This factor could push commercial premiums back to their pre-CiC level or above if Kaiser passes the difference in costs to the consumer.

However, even if Kaiser keeps its insurance rate the same relative to other payers in the market, Kaiser's commercial market share in the area is projected to increase to over 70%.<sup>261</sup> The large group HMO market, a subgroup of the small commercial market, where Kaiser already has about 80% of the market, could effectively become a monopoly. Not all of this projected increase is due to affiliation with SMMC, since Kaiser is also expanding its outpatient services offered in the area, attracting more enrollees.

### ***10.2.3 The Combination of Profit-Sharing and Kaiser Discounts at SMMC Creates a Risk of an Unfair Competitive Advantage for Kaiser Relative to Other Payers***

SMMC, like many other hospitals [REDACTED] [REDACTED].<sup>262</sup> Under plausible utilization scenarios, at least 50% of Kaiser commercial patients from SMMC area will be treated at the New Hospital, which will result in Kaiser's patients occupying at least half of SMMC commercial volume.<sup>263</sup> A typical commercial payer has about 30% of its patients going to SMMC and the rest going to less expensive local hospitals or being treated at out of the area facilities. Therefore, if Kaiser has 50%-60% of its area inpatient care at SMMC, they are more exposed to relatively high SMMC prices than are other payers, so a small discount might be justifiable.

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<sup>259</sup> We present most of the estimates based on medium-utilization scenario (60%) and test our estimates for the sensitivity to this assumption. We estimate Kaiser payments at SMMC for patient care to exceed the costs Kaiser would have spent on treating them at Kaiser own hospitals. For the details see Appendix F.

<sup>260</sup> We assumed that Kaiser marginal cost of treating its commercial patients at Kaiser Fontana are the same as SMMC's operating cost per adjusted day. With Kaiser Fontana operating below capacity, there are reasons to believe that Kaiser actual marginal costs might be lower than average operating costs. If those costs are lower – then Kaiser would lose even more when its commercial patients shift to SMMC, than under our current assumption. Another assumption we use is that Kaiser will have 50% to 60% of its patients from SMMC area treated at SMMC. If this proportion is higher – than Kaiser's costs would be even higher. Therefore, our assumptions are conservative in testing whether Kaiser will cut its current inpatient costs per enrollee as a result of this CiC.

<sup>261</sup> Not counting Kaiser ASO (administrative services only) plan enrollees.

<sup>262</sup> We compared the contract rates at SMMC for the biggest payers and an ACO owned by Providence versus rates for smaller plans.

<sup>263</sup> We measure hospital volume as adjusted days which represent combined inpatient and outpatient volume.

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However, when combined with profit-sharing, a discount of █ % of the average volume-weighted commercial rate paid by the major plans in the market is not small, disadvantaging other competing plans. The fact that the average commercial rate is computed as a volume-weighted measure means that it is weighted towards larger insurers who are already getting a discount at SMMC, making the difference between the rates for Kaiser versus smaller plans a lot bigger than █ %. In addition, Kaiser's nominal discount at SMMC is set to further increase to █ % as soon as the EBIDTA profit margin at the New Hospital is above the target range of █ % to █ %, which is likely under a modest price increase.

The cited discount is amplified by the profit-sharing condition of the CiC, which means that Kaiser gets back █ % of the margin earned on its own patients. Given the current level of prices and average costs spent on Kaiser's patients this effective discount on every additional patient that Kaiser sends to SMMC is at about █ % if both profits and discounts are considered.<sup>264,265</sup> If a formal discount is set to zero, then profit-sharing by itself would result in an effective discount of █ % on every additional Kaiser patient, depending on the marginal cost of Kaiser's patients at SMMC.<sup>266</sup>

Additionally, Kaiser appears to get an unfair advantage in the self-insured (ASO plans) market. Per the CiC provisions, █

█ Employers that have self-insured plans and pay directly for the medical care provided to their employees choose a plan that results in the lowest potential costs, and hospital costs are a large part of the total costs of care. Kaiser has a major advantage vis-a-vis competing insurance providers of █

█ while SMMC is able to negotiate higher rates with other managed care plans<sup>267</sup>. If a Medicare or Medi-Cal plan is out of network with SMMC, it would be paying traditional program rates for emergency visits and admissions, but SMMC scheduled services would be out-of-network for their patients. Per the CiC agreement, █

█ – getting an advantage over its competitors in these markets.

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<sup>264</sup> SMMC operating costs per adjusted patient day on average are about \$2,700.

<sup>265</sup> If marginal costs at SMMC spent on caring for additional Kaiser's patients is lower than average operating costs – then effective Kaiser discount is even higher. For example, marginal cost of \$2,100 would result in another \$600 in profits with Kaiser getting █ ), raising effective discount to █ %. See the preceding section for the details of the calculation.

<sup>266</sup> The range is calculated using average commercial rate of \$6000 and marginal costs ranging from \$2000 to \$2750.

<sup>267</sup> █

#### ***10.2.4 The Transaction Involves a Risk of Raising Rival insurers' Costs and Possibly Foreclosing on Them***

Sharing of profits from the New Hospital is the key provision in this CiC that aligns interests of Kaiser as a payer, and SMMC, as a hospital, making this CiC to some degree similar to a vertical merger. Viewing this case from a vertical merger perspective creates concerns over foreclosure and raising costs on the competitors. In this section we examine whether there is evidence that may support the theory of vertical harm wherein this CiC results in an increase in reimbursement rates that rival insurers must pay to include SMMC in their networks or that results in their inability to compete and so they are foreclosed from (forced to exit) the market.

Kaiser's competitors are the rival insurers that are contracting with SMMC for the hospital services provided to their patients. The foreclosure mechanisms in the context of this CiC means increasing hospital rates for non-Kaiser managed care plans or dropping contracts with them altogether. Consequently, Kaiser should not have a direct power over these decisions per the CiC terms. However, it is not clear if Kaiser could play a role in terminating contracts with other payers, or how much veto power Kaiser has over contracts with potential new payers.<sup>268</sup>

The growth in Kaiser's market share is driven by consumer choice as consumers and their employers are choosing the plan that provides them with the best combination of service and network quality at the lowest price. The fact that Kaiser is becoming a more attractive option in the market would create a downward pressure on premiums offered by all insurers in the market that are trying to compete, which is good for the consumer in the short-run. However, if competing insurers margins turn negative, some may decide to exit the market, reducing competition and choices that consumers have.

##### **10.2.4.1 This CiC Creates a Risk of SMMC Increasing Prices for Kaiser Competitors in Medicare and Medicaid Managed Care Markets.**

Kaiser's rates at SMMC (either New Hospital or current) are independent of what other Medicare or Medi-Cal managed care plans pay at SMMC. So, as long as increasing SMMC rates increases overall hospital's profits, Kaiser directly benefits through profit-sharing. Kaiser as a payer also indirectly benefits from price increase on its competitors because this increases their costs, while Kaiser's costs are unaffected – which gives Kaiser a competitive advantage. Consequently, Kaiser derives double benefits from price increase on Medicare and Medi-Cal

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<sup>268</sup> Operationally, based on the current CiC contract, it appears Kaiser can veto an exclusive contract binding the Company or any of the Company's assets (i) with a health insurer, health plan or other third party payer for dedicated capacity or service ability at the New Hospital, or (ii) that is reasonably likely to lead to material reductions in capacity or access for Kaiser's members at any hospital owned by the Company.

managed care plans: 1) by getting a share of the resulting profits, and 2) by increasing costs on its competitors. According to our estimates, a 10% price increase on all existing Medicare and Medi-Cal managed care volume would bring in \$10-\$12 million in profits for the New Hospital if this volume remains unchanged, ■% of which would accrue to Kaiser. However, the amount would be lower if plans respond to price increases by dropping their contracts with SMMC or using other measures to reduce their volume. This is a possibility, given that once out-of-network they would be paying traditional program rates for their emergency patients at SMMC.

Another issue to consider is that when the New Hospital is near capacity, lowest paying plans (such as Medi-Cal) would be the first ones that SMMC would want to drop by either increasing their rates sharply or not renewing their contracts or otherwise restricting access. If plans agree to price increases, then that would result in higher price for SMMC, but if they don't, they would free up volume for higher margin payers when the hospital is at the capacity. This threat only applies to non-Kaiser Medi-Cal plans, as Kaiser rates and contracts are protected through the CiC conditions.

#### **10.2.4.2 The Combination of a Commercial Rate Discount with Profit-sharing Provisions Partially Insulates Kaiser from Price Increases at SMMC, which would disproportionately raise rival costs**

Similarly, we consider whether SMMC and Kaiser have a common incentive to raise commercial rates which in the theories of harm framework is equivalent to increasing rival costs.

Commercial price increases at SMMC result in *increase in costs* that Kaiser incurs for Kaiser's patients at the average commercial rate minus the Kaiser discount. Before the New Hospital opens, this is the only effect that Kaiser experiences, as any price hike would result in increased costs for Kaiser (relative to the status quo), which would be proportional to an increase in price. Therefore, an increase in commercial prices at the current SMMC facility is not in Kaiser's financial interest before the New Hospital opens and profit-sharing begins. It, might however, suit Kaiser strategic interest because in the period prior to New Hospital opening Kaiser enjoys cost savings due to the combination of its discount and relatively low volume at the current facility, which could compensate Kaiser for an increase in the rates, while its competitors will face increase in their medical costs. In any case, Kaiser as a minority investor does not have the power to stop SMMC from increasing prices other than responding to the price increase with volume reduction at the facility.

After the New Hospital opens, increasing commercial rates has two opposite effects on Kaiser financial gains or losses from the CiC: 1) positive, through profit sharing; and 2) negative, because Kaiser rates are calculated based on average rates paid by non-Kaiser payers. In the section above we discussed in detail the potential effect of price increase at SMMC on Kaiser. Overall conclusion is that the effect of commercial price increase depends on the proportion of Kaiser's patients in SMMC commercial volume – with Kaiser net profits going down and

eventually costs increasing as Kaiser's share at SMMC goes up. When Kaiser proportion in commercial SMMC volume is higher than 36%, Kaiser faces the decline in profits as a result of price hike on other commercial plans, because the increase in costs incurred on its Kaiser's members treated at SMMC would be greater than the increase in profits from all commercial patients<sup>269</sup>. Under the scenario of Kaiser current enrollment level, medium SMMC utilization scenario, and price increase of 10% Kaiser would get extra \$2 million in profits on non-Kaiser commercial patients but lose about \$4 million in net costs increase on its own patients treated at SMMC. On a per adjusted patient-day basis, 10% price increase for an average non-Kaiser commercial payer is \$600, while the net impact on Kaiser is between \$160 and \$230 per adjusted patient-day<sup>270</sup>, if neither Kaiser nor other commercial payers respond to a price hike by reducing their patient volume at the hospital. It is a profit-sharing provision of the CiC that mostly insulates Kaiser from price increase at SMMC: in the absence of it, Kaiser costs would have increased by \$450 per adjusted patient day with 10% increase in price and the █% discount, which is more comparable to the \$600 cost impact on other payers.<sup>271</sup>

Kaiser has an additional protection from price increases at SMMC per terms of the CiC: █  
█  
█. Additionally, a █% discount would reduce Kaiser's costs at SMMC by \$█ per adjusted patient day, saving Kaiser over 4\$ million in inpatient costs depending on how much Kaiser's market share grows. Therefore, if a commercial price increase moves SMMC profits above the target EBIDA range, Kaiser will not lose but will in fact gain from the price increase financially.

In conclusion, the net impact of a commercial price increase on Kaiser is much lower than the impact on Kaiser competitors, because Kaiser gets a discount, while also receiving █% of profits gained from price increase on all the patients (including its owns). The impact of a price increase can even turn into financial gains for Kaiser if the price increase moves SMMC profits above the target range. As a result, other payers face more cost pressure to increase their premiums than Kaiser does, which squeezes their margin and might result in their exit from the market.

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<sup>269</sup> The equilibrium level of Kaiser as a percent of SMMC commercial volume at which Kaiser's net profits from price increase are zero are 36%. See appendix F for the details of the calculation.

<sup>270</sup> The range provided covers current versus maximum Kaiser enrollment scenarios, and medium SMMC utilization (60% of Kaiser's patients treated at SMMC). The key assumption behind this calculation is that commercial payers will not drop their contracts with SMMC in response to 10% price increase.

<sup>271</sup> Given the fact that Kaiser has higher share of its patients at SMMC than do other payers, the same amount of per patient cost increase at SMMC would affect Kaiser more than it affects other payers. For the details of the calculation see Appendix F.

### ***10.2.5 Continuing Kaiser Expansion Creates a Risk of Reduced Likelihood of Entry by the Competitors***

The growth in Kaiser's market share is driven by insurer and consumer choice as consumers and their employers would be choosing the plan that provides them with the best combination of service and network at the lowest price.<sup>272</sup> The fact that Kaiser is becoming a more attractive option in the market would create a downward pressure on premiums offered by all insurers in the market, which is good for the consumer. However, if margins on the competing insurers will turn negative, some may decide to exit the market, reducing competition and choices that consumers have.

Once expansion in Kaiser's market share pushes meaningful competition out of the market, Kaiser could use its monopoly power to increase its premiums, and consumers may not have a choice but to pay them. Normally, if there are no barriers to entry in the market, new entrants or existing competitors can use this opportunity to get the share of Kaiser's market by offering a more competitive premiums and/or more attractive network choice of physicians and hospitals. SMMC should be willing to accept a contract with the new entrant and a potential new entrant might be able to match Kaiser on local hospital access, since SMMC would get more profit from non-Kaiser than from Kaiser commercial patients who are paid at a discount. However, per the CiC agreement, there might be circumstances under which Kaiser can block a competing new contract, which could constitute a barrier to entry.

Another potential competitive concern under the transaction is that with the integration of Kaiser as an insurer with SMMC, a hospital, the integrated entity could increase entry barriers by requiring potential entrants to succeed at two or more levels in the value chain. Since the transaction includes the leading provider system in the area and the leading commercial insurer, entry into the market could be more difficult. The would-be rival insurer may need to enter at both the provider and insurer levels of the supply chain in the SMMC market. That would be costlier and riskier, and therefore less likely to occur, all else equal.<sup>273</sup>

Another critical factor is whether in the aftermath of significant Kaiser expansion there will be enough attractive non-Kaiser physicians left in the market, which a new entrant could potentially recruit to include in its network. Physicians, such as OB-GYNs and primary care doctors, rely on a mix of commercial and public payer patients to get competitive levels of reimbursement. For example, an OB-GYN doctor would have strong incentives to move to a market with more commercial patients, or to become a Kaiser doctor, if a vast majority of its patients are Medi-Cal patients and that results in low average reimbursement. The scarcity of attractive physician options in the area is a plausible reason why a significant share of

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<sup>272</sup> Unlike increase in market share due to merger with a competitor.

<sup>273</sup> Capps, C. et al, Stacking the Blocks: Vertical Integration and Antitrust in the Healthcare Industry, CPI ANTITRUST CHRONICLE, May 2021

commercial maternity patients travel almost an hour to Loma Linda where attractive OB-GYN options are located and admit patients to Loma Linda hospitals. Physician shortage is already a major problem in SMMC market, since average physician reimbursement in High Desert area is lower due to a smaller commercial share of insured population, and at least half of this population is already enrolled in Kaiser. As Kaiser expands its market share, this problem will only exacerbate, leaving fewer and fewer commercial patients that could be treated by local non-Kaiser doctors, in turn making attractive physicians exit this market. As a result, a new entrant might not be able to create an attractive and accessible physician provider network which would appeal to a commercial patient. This constitutes a barrier to entry in the market, which is a potential anticompetitive effect of this CiC.

### **10.3 The Transaction Will Create a Risk of Increased Market Power for SMMC**

In this section we look more closely at the hospital market in the SMMC market area and address the following questions:

1. Will the CiC result in a decline in hospital competition in the SMMC market area?
2. Will the CiC undermine the incentives for SMMC and its hospital rivals to compete on price and quality?

#### ***10.3.1 SMMC is the Dominant Provider of GAC Services in an Already Concentrated Hospital Market***

We calculated an HHI that excluded Kaiser's members and included only the three local hospitals in the market as a weighted sum of HHIs by service line (emergency, maternity and other scheduled).<sup>274</sup> This yielded an HHI of about 3700 for commercial payer market, and 3740 for all payer market. This signals a market for local community hospital services that is highly concentrated. There are alternative ways to calculate the HHI to evaluate current level of competition in the hospital market, and we used several approaches for sensitivity purposes. We also relaxed the market definition and included hospitals within 30-mile radius for emergency and maternity admissions as well hospitals in a 60-mile radius for selected scheduled services that SMMC or a similar community hospital would provide.<sup>275,276</sup> The

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<sup>274</sup> Small size of some zip codes, and small proportion of scheduled services makes the calculation of HHIs both at zip-code and service line level unreliable.

<sup>275</sup> We excluded traumas for emergency admissions, and C-sections with major complications for maternity services. By selecting 30-mile radius we include hospitals where patients could deliberately choose hospitals for urgent services, bypassing the local hospitals to go to Loma Linda or St. Bernardine medical centers. If they went to a hospital that is more than an hour drive away from their residence, it most likely means that patients happen to be in a different area when their emergency happened and didn't have a practical choice to go to their local hospital.

<sup>276</sup> Do define community appropriate admissions we used the list of MS-DRG services developed by Massachusetts Health Policy Commission. We excluded all transfers. We also excluded scheduled pediatric services because SMMC and other local hospitals don't provide those, since they are mostly treated at Loma Linda Children's hospital.



alternative calculations also yield HHIs of around 3000 or above for either commercial or all-payer market, which leads us to conclude that SMMC operates in a concentrated market, regardless of the definition. This HHI is specific to the market of non-Kaiser's patients and is not expected to change much after the CiC.

As an alternative to HHIs, we also looked at the profit margins of the local hospital as another way to evaluate whether hospitals in the market have high market power. SMMC as well as its two local rivals had very high operating profit margins of 15-16% in 2017-2019, which places them in 10-15% of most profitable community hospitals in the state of California.<sup>277</sup> These hospitals continued to have positive margins during COVID-19 pandemic, with SMMC's operating margin getting up to 18% in fiscal year 2020.

The main source of market power for local hospitals in the SMMC market is that local hospitals get most of their admissions through their emergency rooms. SMMC itself has 80% of its admissions coming through emergency room, which includes some maternity admissions. In Victor Valley medical center (a local hospital with the largest Med-Cal share) 98% of admissions are coming through their emergency room, while in Desert Valley this share is at 95%. Health plans don't have the power to substantially reduce ED admissions if they exclude a hospital from their network, as that would result in payers having to cover much higher out-of-network billed charges for their emergency patients.<sup>278,279</sup> The competition for emergency patients among local hospitals by itself isn't a strong enough force to affect patient choice of the hospital and plan choice of the network.

### **10.3.2 Currently SMMC has the Highest Market Power Among its Local Competitors**

SMMC is already a preferred hospital in the High Desert area and enjoys the largest market share in the area with 33% for all non-Kaiser admissions from the area going to SMMC compared to 24% of non-Kaiser admissions going to its closest competitor - Desert Valley. SMMC market share is particularly high in Apple Valley, with SMMC share of outpatient admissions from two Apple Valley zip codes ranging from 42% to 48%, and 61-68% of outpatient ED visits going to SMMC. Interviews with payers have indicated that SMMC is a must-have in-network hospital for a plan to be competitive in the area for both emergency and scheduled services.

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<sup>277</sup> For this calculation both specialty and teaching hospitals were excluded, as well as hospitals providing mostly long-term services.

<sup>278</sup> Melnick, G. A., & Fonkych, K. (2020). An empirical analysis of hospital ED pricing power. *American Journal of Managed Care*. 2020; (26) 3 <https://www.ajmc.com/journals/issue/2020/2020-vol26-n3/an-empirical-analysis-of-hospital-ed-pricing-power>

<sup>279</sup> For example, at SMMC hospital charges are more than double the commercial rates (according to HCAI, average paid-to-charge ratio for third party payers in 2017, 2018 and 2020 was about 42%).

As an emergency care provider, SMMC is a stroke center and STEMI-certified hospital, which means that ambulance will bring the residents to this hospital in the event of a suspected stroke or AMI. In addition, payers' ability to steer patients to other hospital options is limited by the fact that their patients mostly access SMMC through the emergency room.

As a maternity care provider, SMMC is the only local hospital that has level-3 NICU, which is an attractive feature for maternity patients. Our analysis of the HCAI discharge dataset and ambulatory surgery dataset confirmed that SMMC is the only local hospital that provides a significant amount of non-emergency scheduled services. While SMMC heavily relies on emergency room for its patient volume, 20% of its volume are for non-ED scheduled services. Since other local hospitals have negligible scheduled patient volume, SMMC has a near monopoly when patients in its area prefer a local option for maternity, orthopedic, cardiac or other uncomplicated non-tertiary scheduled services. From a health plan perspective, SMMC does not have any real competition in this segment even beyond its local market, since other major providers of scheduled services for the residents of this area are Loma Linda system and Dignity system hospitals, which are priced well above what a community hospital like SMMC is paid and much farther away.<sup>280</sup>

### ***10.3.3 The Transaction Increases SMMC's Market Power***

Building a modern state-of-the-art facility with expanded services is a major factor which, by itself, will make SMMC more attractive to insurers and customers, facilitating SMMC's leverage in negotiations with payers. However, this effect is possible even if SMMC-Providence decides to build an upgraded hospital on their own, without an affiliation with Kaiser. Although it is uncertain if Providence would invest in the new facility in the absence of CiC and how such facility, if built, would compare to the one resulting from CiC.

### ***10.3.4 The Transaction Makes SMMC More Indispensable for Payers' Network to Effectively Compete with Kaiser***

Payers in the area compete for their members by offering the best combination of lower rates and an appealing provider network. In a large group market Kaiser is offering slightly lower rates, robust local outpatient services, but it doesn't have an in-network hospital option, while its rivals do. This allows Kaiser's competitors to attract those patients and employers in the area that value having a local hospital option in-network. Competing plans would lose this advantage as soon as Kaiser offers in-network access to the preferred local hospital and they will be forced to lower their rates as well, or risk losing large part of their enrollees. As discussed in the preceding section, this may not be anti-competitive by itself, but it increases potential risks that Kaiser could increase the rates and lower quality once it dominates the market.

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<sup>280</sup> We used third party revenue per adjusted day as a proxy for commercial prices at Loma Linda Medical Center and Children's hospitals, and St. Bernardine Medical center (Dignity system). Although these price proxies fluctuate year-to-year overall these hospitals are 25%-70% more expensive than SMMC.

Non-Kaiser HMOs, such as Blue Shield, Aetna or Blue Cross, would have a hard time competing against Kaiser in High Desert area if they decide to drop SMMC from their network in response to a potential price increase at SMMC. Once Kaiser is in-market their bargaining power is reduced even further. PPO plans would still be able to attract customers with premier hospital and specialist options for scheduled services outside the local market, but even those will become a harder sell against the Kaiser option if they try to steer patients away from the preferred local hospital – SMMC. This effect has been evaluated in the research of Ho and Lee who found that the presence of a Kaiser hospital in the local area increases the market power of the most preferred non-Kaiser hospital in the market.<sup>281</sup>

As a result, SMMC can demand a higher price in the negotiations with the payers and it would become difficult for the payers to refuse that contract. If payers keep SMMC in-network despite higher prices, they will have their profits squeezed between higher costs and attempts to compete with Kaiser on premiums, which could force some to exit the market. This scenario is particularly likely if Kaiser is insulated from potential price increases with discounts and profit sharing for its commercial or with fixed rates for its Medicare and Medi-Cal patients.

The CiC doesn't directly change the *incentive* that SMMC has to raise prices for Kaiser competitors, as SMMC still cares about the net effect on its own profits (not Kaiser's) and would increase prices to this end with or without the CiC. However, there is a risk that this CiC will increase SMMC's *ability* to increase prices by strengthening its market power. SMMC would be willing to increase price only if it would get more profit from an increase in price than it would lose due to plans going out-of-network or steering their customers away from SMMC<sup>282</sup>. The CiC affects the elasticity of demand for SMMC's services (how much volume it loses due to price increase), as other payers would be trying to keep SMMC in their network to stay competitive vis-a-vis Kaiser who has SMMC as in-network by virtue of the transaction.

### ***10.3.5 The Profit-sharing Condition Adds to SMMC's Incentive to Increase Rates for all Managed Care Payers***

The CiC with a profit-sharing condition creates a different kind of incentive for SMMC to raise prices – namely, to compensate for potential decline in its own profits that result from giving up █% of their profits to Kaiser. As discussed above, an increase in Kaiser volume resulting from the CiC is not likely to be enough to reach even the current level of profits at SMMC once Kaiser receives its share of profits. At the same time, SMMC is making a capital investment of more than \$600 million in this CiC, while it could have made a smaller investment under alternative

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<sup>281</sup> See detailed discussion in the section 8 of the report.

<sup>282</sup>A critical loss ratio would be a relevant calculation here, but we don't have SMMC marginal or average cost for treating Medicare and Med-Cal patients. If we use operating costs instead, we get negative margin for MCAL, and around zero margins for Medicare patients. This doesn't look right and makes critical loss ratio meaningless here.

scenarios, e.g., a seismic modified complete replacement retrofit of approximately \$450 million, achieving similar or higher profits. If SMMC plans to reach and exceed its current level of profits it would be tempted to increase its prices.

### **10.3.6 As Kaiser's Market Share Grows there will be Fewer Commercial Patients in Other Local Hospitals**

As discussed above, we expect that Kaiser's share in hospital admissions will increase from 34% to 40% in 2026-3030 and reach 50% of the market by 2035. As managed care enrollees switch from other payers to Kaiser, the flow of the commercial patients going to other local hospitals in the area will be reduced proportionately by up to a quarter, given that distribution of non-Kaiser's patients among the local hospitals stays constant<sup>283</sup>. A lower volume of commercial non-Kaiser's patients in other local hospitals will reduce their profits (of particular concern for Desert Valley which has the highest commercial share among local hospitals). Change in location of the New Hospital is a separate factor that may redistribute emergency patient flows across the local hospitals. As SMMC moves closer to Desert Valley hospital, and further away from Victor Valley that would potentially increase emergency patient volume in Victor Valley and reduce it in Desert Valley hospital.

A new and updated SMMC facility will be a major draw for the patients in the area, including some of the emergency patients who might be willing to by-pass a closer hospital by 10 to 15 minutes in order to be treated in a better hospital if their condition is not life-threatening. (

If this is reflective of the area's high ED use generally, some ED patients may be willing to drive further to get to SMMC.<sup>284</sup>) Other local hospitals may face an increased pressure to upgrade their facility and improve their quality to attract more patients. Their bargaining leverage with non-Kaiser payers will be reduced as the relative value of SMMC increases. Ho and Lee predict that less preferable hospitals will have less market power and lower prices when there is a local Kaiser hospital in their primary market.<sup>285</sup> As their theory goes, payers need to keep their rates low to compete with Kaiser, so they negotiate aggressively with the less preferable hospitals with whom they share a common threat to lose patients to Kaiser.

Reduction in prices and improvement in services in other local hospitals for the sake of competition is a potentially positive effect, unless this results in consistent losses forcing competing hospitals to exit the market. Currently, relatively high profit margins in these hospitals don't justify this concern, but this could change if there are major changes in the

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<sup>283</sup> Change in non-Kaiser patient population in SMMC market =  $(100\%-50\%)/(100\%-34\%) - 100\% = -24\%$

<sup>284</sup>

<sup>285</sup> Ho, Kate and Lee, Robin S, Insurer Competition in Health Care Markets, *Econometrica* Vol. 85, No. 2 (March 2017), pp. 379-417 (<https://www.jstor.org/stable/44955124> Accessed 8/15/2021).

regulatory environment, such as reduction in Disproportionate Share payments or Hospital Quality Assurance Fee Program payments, that these hospitals depend on.

### ***10.3.7 The Question of Whether There are Risks of Anticompetitive Effects Related to Physician Services Remains Unanswered***

This transaction also includes the collaboration of both Kaiser and SMMC physicians at SMMC. While there is regulatory scrutiny of horizontal mergers among physician practices and among facilities, as well as vertical mergers between physician practices and healthcare facilities, there have been few challenges and little literature since most such acquisitions fall below the Hart Scott Rodino (HSR) thresholds for mandatory reporting.<sup>286</sup> However, some research has shown that physician services markets have become increasingly more concentrated with two thirds of specialist physician markets and almost two-fifths of primary care markets being highly concentrated.<sup>287</sup> There is also evidence that both the quality of care delivered by physicians suffers when physician practices face less competition and physician prices rise.<sup>288</sup> The parties state that SMMC and Kaiser would collaborate in optimizing physician resources to drive quality improvement and availability in an economically sustainable model that "SMMC would provide the majority of acute and ancillary services to Kaiser's patients in the High Desert, requiring SMMC to expand services while precluding Kaiser from duplicating services".<sup>289</sup>

Time constraints and the limited data we received on physicians did not allow us to do an analysis of the impact of the transaction on the physician market. However, after the CiC, the Kaiser and SMMC OB-GYN physicians will certainly have more than 30% of the OB-GYN market in the SMMC market. Should the collaboration move beyond SMMC with the potential to have broader anticompetitive effects, e.g., if Kaiser and Providence start dividing up the market for specialty physicians services such that each would only provide certain services and they agreed not to compete, effectively engaging in market allocation, this would be worthy of a deeper investigation.

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<sup>286</sup> Cory Capps, David Dranove & Chris Ody, "Physician Practice Consolidation Driven by Small Acquisitions, so Antitrust Agencies Have Few Tools to Intervene," *Health Affairs* 36, no. 9 (2017): 1556–1563. The FTC has investigated hospital acquisitions of physician groups, but those have been horizontal merger investigations that came about because a hospital system with an existing physician group had acquired or was seeking to acquire one or more competing physician practices — that is, these were horizontal cases and the vertical aspect was largely incidental.

<sup>287</sup> Fulton, B. D. (2017). Health care market concentration trends in the United States: Evidence and policy responses. *Health Affairs*, 36(9):1530–1538.

<sup>288</sup> Gaynor, M., Examining the Impact of Health Care Consolidation, Statement before the Committee on Energy and Commerce Oversight and Investigations Subcommittee U.S. House of Representatives D.C. February 14, 2018

<sup>289</sup> St. Mary Medical Center - Response to AG Supplemental Request for Information [08.10.2021]

## 10.4 The Transaction Creates a Risk of Anticompetitive Effects Related to Information Sharing

The sharing of competitively sensitive information between the parties could lead to a risk of anticompetitive effects. In this section we address concerns related to potentially competitively sensitive information that may be shared between the parties, CiC agreement safeguards against potential information sharing and possible conditions of approval for consideration.

Critical to assessing any potential anti-competitive effects of the proposed CiC is consideration of the parties' ability to exchange information related to services pricing, costs, or strategic planning. In the vertical merger context, the sharing of information can prove anticompetitive if either the upstream or downstream component of the merged firm is provided "access to its rival[s'] sensitive business information." Within the context of the proposed CiC, Kaiser's potential access to information regarding health plan rivals could affect negotiations with third parties or otherwise alter the parties' overall business strategies in ways that reduce competition. Moreover, as (horizontal) competitors in the provider market, the parties' exchange of information could implicate monopsony concerns. There are three types of information risk posed by the proposed CiC :

- *Payer contract negotiations:* As the parties appear to contemplate throughout the Notice, Kaiser's competition with other health plans in the market area raises concerns over SMMC's ability to negotiate contracts with these payers free of any improper influence from Kaiser officials. To the extent Kaiser is able to access information related to these negotiations, its officials—such as its Managers on the Board of Managers—could in theory attempt to influence the outcome of these negotiations, either formally (through blocking potential contracts<sup>290</sup>) or by exerting more informal pressure on SMMC to demand more favorable terms or foreclose payer contracts altogether.
- *Current payer contracts:* Conceivably, in some circumstances, the consolidated firm can use access to a rival's competitively sensitive information to moderate its competitive response to its rival's competitive actions. For example, this information may allow a firm to preempt or react quickly to a rival's procompetitive business actions. With access to other plans' contracted rates with SMMC, Kaiser could adjust its competitive strategy, withdrawing from some insurance sub-markets or by modifying its product offerings.

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<sup>290</sup> Notice, p. 65 - 66. Under the Operating Agreement, as discussed, a supermajority of the Board of Managers is required for the approval of the New Hospital's strategic plans, as well as any contract for dedicated capacity of hospital services. Even for contracts not requiring supermajority approval, Kaiser's members could conceivably attempt to influence the outcomes of Board votes.

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- *Patient / enrollee information:* Kaiser could access health care utilization data for groups of patients or enrollees of other payors. With this data, Kaiser could better predict the costs of covering certain patients or patient groups, which would strengthen its ability to offer competitive (but profitable) rates when negotiating with employers.
- *Hospital expenses:* Kaiser and SMMC must both negotiate wages and salaries with outside medical groups and other staff, and the parties will presumably purchase similar medical supplies and equipment from outside suppliers. In this context, information shared between the parties could lead to informal agreements that increase the parties' leverage in these negotiations.

In previous health care merger or collaboration contexts, the sharing of confidential information has often been managed by conflict avoidance policies (CAP), which reduce the risk that such information is shared improperly.<sup>291</sup> Broadly, these policies implement technological and physical safeguards against the access of confidential information by counterparties, where both parties may share common data portals or office space.

Accordingly, for purposes of assessing information sharing under the CiC, it is necessary to determine whether the parties' agreements would allow for the sharing of competitively sensitive information, and if so, how these exchanges could be managed by establishing CAPs in connection with the CiC.

#### ***10.4.1 The Parties' Notice Raises Concerns that Sensitive Information May be Shared between Kaiser and SMMC***

In several places, the parties' agreements included in the Notice refer to potentially competitively sensitive information that may be shared between them. First, while SMMC is to manage the New Hospital under the CiC, Kaiser could nevertheless have access to financial data and information underlying strategic decision-making in connection with its appointment of Kaiser officials to the New Hospital's Board of Managers. Under the Operating Agreement, each Manager on the Board of Managers is entitled to "Company books and records and detailed financial and other information reasonably necessary to carry out his or her responsibilities," and upon request, "financial information and audit work papers of the Company that are reasonably necessary for each Member's financial reporting."<sup>292</sup> More broadly, the Board of Managers is charged with overseeing a variety of high-level management responsibilities, some of which may entail sharing information related to SMMC's relationship with competing health plans.<sup>293</sup> The Operating Agreement's provisions on accounting further stipulate that "[e]ach

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<sup>291</sup> See DHCS "MAGELLAN MEDICAID ADMINISTRATION MEDI-CAL Rx PROGRAM CONFLICT AVOIDANCE REPORT AND PLAN" (<https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/MMA-DHCS-CAP-3.pdf>)

<sup>292</sup> Notice of Affiliate Transaction – SMMC, at pg. 68 (April 7, 2021) (on file with OCAG).

<sup>293</sup> Notice of Affiliate Transaction – SMMC, at pg. 65 (April 7, 2021) (on file with OCAG). A supermajority is required for approval of "the strategic plan of the Company," and of any "any exclusive contract binding the Company or

Member shall have the right . . . to audit, examine and make copies of or extracts from the books of account of the Company.”<sup>294</sup>

The parties further acknowledge that through the CiC, they may come to possess various types of “confidential information” belonging to the other party. The Management Services Agreement, for example, notes that each party may come to possess “confidential information and trade secrets of the other Party, including, but not limited to, vendor lists, customer and patient information, financial and accounting information, proprietary policies and procedures, [and] employee information . . .”<sup>295</sup> The Affiliation Agreement similarly contemplates the parties accessing non-public information “including financial information and records; data and data files and formats; business strategies and plans; information regarding relationships with customers, suppliers, employees, independent contractors, health plan subscribers or beneficiaries, and other third parties . . .”<sup>296</sup>

#### ***10.4.2 The Transaction Agreement Safeguards Against Improper Information-Sharing Do Not Appear to Sufficiently Protect Against Anticompetitive Effects***

The parties’ agreements impose several constraints on their information-sharing. Most relevant is the St. Mary Medical Center Anti-Trust Compliance Plan, which provides policy guidance for SMMC and Kaiser and is intended to “reduce the risk of allegations that Company, SMMC and/or KFH have engaged in anticompetitive conduct.”<sup>297</sup> In addition to prohibitions on more overt anti-competitive behavior—including explicit price-fixing, refusals to contract with Kaiser competitors, and allocations of health care services or service areas—the Compliance Plan also stipulates that the parties “should refrain from sharing Competitively-Sensitive Information (defined below) unless otherwise advised by legal counsel that the sharing of such information does not raise concerns under relevant antitrust laws. . . . [Kaiser officials] . . . should only receive [Competitively Sensitive . . . information] that is necessary for the recipient to receive for a legitimate Company purpose.”<sup>298</sup> Included within the category of “Competitively Sensitive” information is any that “relates] to current or future price lists or prices . . . or other competitive terms . . . of third-party payor contracts,” or to “to line-item costs, profits or other financial information, including financial projections,” or to “line-item wages or salaries of professional or nonprofessional staff.”

While the Anti-Trust Compliance Plan may adequately re-state anti-trust law and outline the types of information that cannot be shared without the approval of counsel, it does not lay out

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any of the Company’s assets (i) with a health insurer, health plan or other third party payer for dedicated capacity or service ability at the New Hospital . . .”

<sup>294</sup> Notice of Affiliate Transaction – SMMC, at pg. 87 (April 7, 2021) (on file with OCAG).

<sup>295</sup> Notice of Affiliate Transaction – SMMC, at pg. 133 (April 7, 2021) (on file with OCAG).

<sup>296</sup> Notice of Affiliate Transaction – SMMC, at pg. 249 (April 7, 2021) (on file with OCAG).

<sup>297</sup> Anti-Trust Compliance Plan, p. 1

<sup>298</sup> Anti-Trust Compliance Plan, p. 3



any procedures to ensure compliance or mandate any safeguards to promote information security. Nor does the plan explicitly prohibit any specific interactions between Kaiser and SMMC personnel or information-management practices.

In providing “examples of prohibited allocation agreements” (e.g., agreements to allocate service areas or payor relationships), the plan stipulates that this prohibition would not apply “outside of a legitimate joint venture or collaborative arrangement or control relationship.”<sup>299</sup> Because Kaiser does not further define these terms, however, the circumstances under which these prohibitions would apply is left unclear.

The parties’ Affiliation Agreement, contemplating the need to “avoid even the appearance of anticompetitive conduct,” similarly states that Kaiser personnel will not “have access to payor contract information and shall not have input into SMMC or Company strategic or operational decision making relating to third party payor contracting.”<sup>300</sup> With respect to the confidential information referenced above, the Affiliation Agreement also requires that to the extent that one party accesses the other’s confidential information, further disclosure is only allowed to “directors, officers, employees, agents or consultants who reasonably need access to the Confidential Information to fulfill their duties.”<sup>301</sup>

As with the Anti-Trust Compliance Plan, the Affiliation Agreements’ information-sharing-related provisions lack the specificity needed to ensure that the parties’ officials comply with anti-trust law. In this case, the prohibitions depend to some extent on the definition of “strategic or operational decision-making” and on the considerations that would determine whether personnel would “reasonably need access” to confidential information.

## **10.5 There Are Factors That Can Potentially Constrain Anti-Competitive Effects**

Although the CiC creates a strategic relationship between Kaiser and Providence, the integrated Kaiser system and Providence system remain separate entities each having its own profit and strategic goals, which neither party of the CiC would be willing to sacrifice to achieve the objectives of the other. This is what separates this CiC from a full merger, where a producer and its supplier have aligned interests, and only total profits of the merged entity matter. The economics toolkit that is typically used to evaluate vertical transactions relies on the assumption that a merged entity has the same objective – its combined profit. However, under this CiC, Providence and Kaiser systems remain separate entities, which has a potential to limit price increase when each of them maximizes total profits of their own company.

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<sup>299</sup> Anti-Trust Compliance Plan, p. 3

<sup>300</sup> Notice of Affiliate Transaction – SMMC, at pg. 245 (April 7, 2021) (on file with OCAG).

<sup>301</sup> Notice of Affiliate Transaction – SMMC, at pg. 250 (April 7, 2021) (on file with OCAG).

**10.5.1 The Transaction Does Not Fully Align Financial Incentives for Kaiser and Providence**

This limiting factor would be much stronger if Kaiser was more exposed to commercial price increases, in the absence of profit sharing or/and by means of lower discount.

Kaiser's incentives as an integrated system don't necessarily align with SMMC's profit-maximization goals. Kaiser implicitly treats SMMC and its own hospitals as competitors, looking for the least expensive option to deliver care to its patients. Kaiser has financial incentives to keep maximum number of their non-emergency commercial patients at Kaiser Fontana, where they could be treated at a lower marginal cost than the price Kaiser would pay at SMMC even with a discount and profit-sharing. This incentive is a lot smaller for an average Kaiser Medicare patient, as traditional Medicare rates are lower than commercial price that Kaiser is to pay. Kaiser has an incentive to maximize the share of their Medi-Cal patients going to SMMC as this is often the lowest-paid patient category, and the cost of treating them at Kaiser Fontana isn't likely to be lower than the rate paid at SMMC.

SMMC cannot increase its price on other payers without a resulting price increase for Kaiser, as long as the price Kaiser pays is set as a proportion of average price paid by other insurers. Commercial price increases at SMMC would result in a proportionate increase in costs that Kaiser pays for its commercial patients, and therefore creates an additional reason for Kaiser to reduce its patient volume at SMMC. This means that Kaiser demand for SMMC services could go down in response to a major price increase.

While Kaiser can still respond to price increase at SMMC with volume reductions, current conditions of CiC including discount on commercial rates and profit-sharing are designed to diminish Kaiser's incentives to move its commercial patient volume away from SMMC. In the absence of discount and profit-sharing Kaiser would be more inclined to save by reducing the proportion of their commercial patients at SMMC. If both discount and profit-sharing condition were removed, Kaiser costs per adjusted commercial patient-day at SMMC would be higher by about \$1,500, which would in turn increase annual cost per commercial enrollee between \$230-\$280 (depending on utilization and Kaiser expansion scenario). To the extent Kaiser passes these costs to the consumers that would increase premiums and slow down Kaiser enrollment growth.

In addition, Kaiser power to fully optimize the distribution of its patients across SMMC and Kaiser facilities is limited by the fact that most patients enter the hospital through emergency room or are maternity patients. Therefore, while Kaiser can respond to price increases with volume reduction it is unrealistic to get proportion of Kaiser's patients going to SMMC lower than 40%-45% without initiating transfer program, once the New Hospital is an in-network and Kaiser doctors are on staff.

Similarly, other payers can come up with steering provisions in their plans which create incentives for the patients to use other less expensive hospitals in order to compete with Kaiser

on price. To the extent they can do so, that would reduce SMMC's ability to increase price without losing patient volume. This could be addressed in the CiC conditions of approval.

### ***10.5.2 There are Factors that Could Limit SMMC's Incentives to Raise Prices***

SMMC-Providence does not necessarily derive financial benefit from Kaiser's expansion in the market, as long as Kaiser rates are discounted. Given Kaiser's discount of █%, Kaiser's increase in volume barely compensates for the decline in non-Kaiser commercial patient volume at SMMC – bringing in only around \$2 million when Kaiser's membership reaches its highest levels. However, in the absence of a discount SMMC could derive financial gains from foreclosure on Kaiser commercial rivals, as that will increase Kaiser admissions in the area, the majority of which would go to SMMC.

Strategically, however, increasing Kaiser dominance is a disadvantage for Providence system, as a majority owner of SMMC since there will be fewer commercial and Medicare patients left to be treated by Providence physician groups and, if, in the future, Kaiser decides to exit this CiC, SMMC-Providence will be losing majority of their commercial patients. In addition, SMMC might prefer to have more competing plans in the market because having fewer remaining insurance plans to contract with SMMC increases negotiating leverage of the remaining plans, limiting SMMC market power to raise price. As the recent research has shown, more competition in the insurance market is beneficial for providers.<sup>302</sup>

## **10.6 Proposed Conditions of Approval to Mitigate Anticompetitive Effects**

If the OCAG approves the proposed joint-venture, we recommend the conditions of approval below be considered by the OCAG in order to minimize the risks of potential anticompetitive effects.

### ***10.6.1 Potential Conditions of Approval Related to Information Sharing***

While the parties' agreements and SMMC's Anti-Trust Compliance Plan mostly cover the major areas of information-sharing concern, these documents are vague as to the specifics of how exchanges of this information will be limited. Moreover, even if its prohibitions were sufficiently explicit, the Anti-Trust Compliance Plan does not mandate any monitoring procedures, or create any new staff roles, such that its terms could be enforced.

Moreover, while the various agreements may prohibit sharing confidential information created following the closing date, there is no provision that limits the parties' sharing of information created prior to the transaction. For example, it appears that SMMC would be free to share third party payor-related information received prior to closing.

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<sup>302</sup> <https://www.nber.org/digest/jul20/concentration-and-pricing-power-hospitals-versus-insurers>

With these concerns in mind, we recommend that if the OCAG approves the CiC they consider the conditions below. We recommend the OCAG consider applying conditions for a period of at least ten years or until the New Hospital is operational and admitting patients. Further, once the New Hospital is operational and admitting patients these conditions would apply to the New Hospital for ten years or more. These conditions include:

- Prior to the Closing Date, the parties must appoint an Antitrust Compliance Officer charged with implementing and enforcing a Conflict Avoidance Policy (CAP) which would include the following elements:<sup>303</sup>
  - Policies and procedures governing the sharing of any information between Kaiser and SMMC personnel in all contexts (e.g., Board meetings, e-mails, in-person conversations, other staff meetings).
  - Firewalls:
    - Technological safeguards designed to prevent the sharing of confidential information by, e.g., password-protecting access to such information, firewall setup, and data encryption.
    - Physical security measures designed to keep confidential information in hard-copy form in areas not accessible to Kaiser personnel.
  - Employee training programs that outline the types of confidential information that may not be shared between Kaiser and SMMC.
  - The appointment of a third-party monitor, tasked with overseeing the exchange of any non-public financial, patient-related or otherwise confidential information between the parties (i.e., where such exchanges are for legitimate business purposes or patient care)
- The CAP shall be subject to the approval of OCAG.
- Notwithstanding the operation of the parties' CAP, discussions between the parties related to the New Hospital's future strategic plans (e.g., including planned expansions or contractions of services, or projections of future revenues or costs) or upcoming negotiations or contracts with other payers or counterparties must be monitored by the New Hospital's third-party monitor and may not include any proposed payer rates or line-item expenses.
- 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.

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<sup>303</sup> See DHCS "MAGELLAN MEDICAID ADMINISTRATION MEDI-CAL Rx PROGRAM CONFLICT AVOIDANCE REPORT AND PLAN" (<https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/MMA-DHCS-CAP-3.pdf>)

Notwithstanding this condition, the parties' may share patient data with one another to the extent necessary for the treatment or care of patients.

### **10.6.2 Potential Conditions of Approval Related to Competitive Effects**

To reduce the risk of anticompetitive effects, the terms of this CiC need to be modified to reduce the risk that Kaiser does not get an unfair price advantages relative to its competitors, and that Kaiser will be exposed to price increases as much as others if SMMC decides to raise prices.

The key CiC provision that aligns Kaiser and SMMC incentives and ability to increase rival costs is Kaiser's sharing of profits earned on the patients insured by its competitors at SMMC.

Eliminating profit-sharing would: 1) Expose Kaiser to price increases at SMMC, so Kaiser would be more likely to respond to price increase with volume reduction; 2) Reduce the effective discount that Kaiser gets for treating its commercial patients at SMMC;<sup>304</sup> 3) Decrease SMMC's need and incentives to raise prices in order to compensate for the loss of profits resulting from sharing █% of total profits with Kaiser.

Therefore, elimination of profit-sharing would considerably relieve anti-competitive effects of this CiC. However, careful consideration of the terms of CiC is necessary to disentangle Kaiser capital commitment from Kaiser profit-sharing in this enterprise.

An opportunity to have █% discount off average commercial rates would save Kaiser \$15 million annually just on its members that used SMMC as an emergency out-of-network provider in 2019<sup>305</sup>. As Kaiser enrollment grows, the costs of using SMMC as an out-of-network provider in the absence of CiC would grow proportionately, which means that potential annual savings for Kaiser from the affiliation with SMMC are even higher than estimated from 2019 Kaiser utilization.

In the absence of profit sharing, █% commercial rate discount might be justified with a combination of high Kaiser volume at the hospital and its capital commitment. In addition, a significant discount for Kaiser also ensures that SMMC has incentives to keep its contracts with Kaiser's rivals, since each additional non-Kaiser patient would be more profitable than a Kaiser patient. Thus, keeping a discount as a part of this deal reduces SMMC's willingness to foreclose on Kaiser rivals.

At the same time, if profit-sharing remains part of this CiC, then we recommend reducing the discount to █% as a second-best option designed to reduce Kaiser cost advantage versus its competitors, and to increase Kaiser's exposure to potential price-increases at SMMC.

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<sup>304</sup> As discussed in section 10.2.4,3 profit sharing is estimated to increase effective discount on Kaiser commercial patients by another █% (from █%).

<sup>305</sup> See appendix on competitive effects.

In addition to removal of profit-sharing, the conditions we suggest below would mitigate the risks of the competitive effects of the transaction. We recommend the OACG consider applying conditions for a period of at least ten years or until the New Hospital is operational and admitting patients. Further, once the New Hospital is operational and admitting patients these conditions would apply to the New Hospital for ten years or more. These conditions include:

- Remove caps on commercial Kaiser rates that under current CiC terms protect Kaiser from proportionate increases in commercial rates, or by requiring that the same caps on price increases apply to negotiated prices with other commercial payers.
- Impose caps on out-of-network rates charged for emergency utilization such that insurers can drop SMMC without paying exorbitant emergency rates. Given that most of the area's admissions come through the ED this would be critical to facilitating a competitive environment.
- Make the size of a discount independent of profit level at SMMC (i.e., do not allow increase in commercial discount if profits increase).
- Do not allow discount on the self-insured commercial plans where Kaiser performs administrative services only (ERISA plans).
- Develop conditions that prohibit anti-tiering, anti-steering and exclusivity clauses in SMMC contracts with other payers, which would allow payers to shift volume to less expensive hospitals in the event of price increase. This condition would make it more feasible to compete with Kaiser on costs and facilitate competition in the hospital market.
- Develop conditions that limit SMMC's ability to increase prices for Kaiser's rivals, including price caps on Medi-Cal and Medi-Care managed care rates, and caps on price increase for commercial payers.
- Develop conditions that strike out Kaiser power to veto a new payer contract (unless it clearly gives their rivals an unfair competitive advantage, such as designated capacity).

## 11 Offsetting Efficiencies and Benefits

Economists have long recognized that mergers and other transactions may lead to efficiency gains, which may negate or mitigate any anticompetitive effects to which the mergers might otherwise give rise.<sup>306</sup> Our goal is to preserve competition and promote consumer welfare and efficiency gains from the transaction can not only enhance a consolidated firm's ability to compete effectively, but also, to the extent that they are passed on, benefit consumers in the

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<sup>306</sup> The 2010 Merger Guidelines acknowledge the role that efficiencies play in the analysis of competitive effects and describe the evidentiary standards that merging parties must satisfy for the agencies to credit their claimed efficiencies.<sup>2</sup>

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form of lower prices or improved quality. The standard approach is to begin with an evaluation of the transaction's competitive effects and following a finding of concerns of anticompetitive effects we consider whether efficiencies may reduce that prospect.<sup>307</sup>

In this section we:

- Discuss what "counts" as an efficiency,
- Review a case where efficiencies were a focus of a health care consolidations, and
- Examine efficiencies related to this CiC.

For efficiencies to be credited against anticompetitive effects they must be *cognizable*, meaning they must be merger-specific, verifiable, and not arise from anticompetitive reductions in output or service. To be merger specific the efficiencies cannot be reasonably achieved through some less restrictive, alternative arrangements that do not create the competitive concerns arising from transaction. Additionally, they should not be "vague" or "speculative," but rather, verifiable by some reasonable means.<sup>308</sup> Efficiencies meeting these criteria are weighed against the potential anticompetitive effects of the merger, and "[t]he greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies, and the more they must be passed through to customers."<sup>309</sup>

The Guidelines explain that "efficiencies are most likely to make a difference in merger analysis when the likely adverse competitive effects, absent the efficiencies, are not great. However, there is no "bright-line" test for "not great" and efficiencies almost never justify a merger to monopoly or near-monopoly."<sup>310</sup> In cases involving situations where the agencies have concluded that there is strong evidence of actual or likely anticompetitive effects from a transaction, the efficiencies must be "extraordinary" to overcome a presumption of anticompetitive effects.<sup>311</sup>

A case the focused heavily on the role of efficiencies counterbalancing anticompetitive effects involved a challenge by the FTC and Idaho Attorney General (along with St. Alphonsus, a competing hospital) to St. Luke's acquisition of Saltzer Medical Group (SMG) in Nampa, Idaho,

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<sup>307</sup> U.S. Dept. of Justice & Fed. Trade Comm'n Horizontal Merger Guidelines (2010) [hereinafter Guidelines], (<https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf> Accessed 10/12/2021)

<sup>308</sup> U.S. Dept. of Justice & Fed. Trade Comm'n Horizontal Merger Guidelines (2010) [hereinafter Guidelines], (<https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf> Accessed 10/12/2021)

<sup>309</sup> U.S. Dept. of Justice & Fed. Trade Comm'n Horizontal Merger Guidelines (2010) [hereinafter Guidelines], (<https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf> Accessed 10/12/2021)

<sup>310</sup> U.S. Dept. of Justice & Fed. Trade Comm'n Horizontal Merger Guidelines (2010) [hereinafter Guidelines], <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf> Accessed 10/12/2021)

<sup>311</sup> St. Alphonsus Med. Ctr. v. St. Luke's Health Sys., 778 F.3d 775, 790 (9th Cir. 2015) ([P]roof of 'extraordinary efficiencies' is required to offset the anticompetitive concerns in highly concentrated markets.)

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in 2013.<sup>312</sup> The merging parties argued that the acquisition was essential for St. Luke's and SMG to transition from a fee-for-service model of care to a more integrated, value-based health care delivery. The FTC claimed that the transaction would likely result in eased prices for primary care physician services sold to health plans. St. Luke's countered with an efficiency defense, arguing that the merger would create efficiencies far outweighing any anticompetitive effects." They argued that with a larger number of PCPs and a larger underlying patient population, they would be able to engage in more risk-based contracting; that patients would benefit from the more integrated health care delivery system, enabled in part by bringing the Saltzer physicians onto St. Luke's EMR system; patients would have greater access to primary care doctors; and SMG would have greater access to integrated IT systems.

The district court rejected St. Luke's claimed efficiencies on the basis that they were not merger-specific, and it concluded that St. Luke's efficiency defense could not overcome the fact that the acquisition was anticompetitive. The Ninth Circuit upheld the district court's ruling. According to the appeals court opinion, "It is not enough to show that the merger would allow St. Luke's to better serve patients."<sup>313</sup>

In this CiC it is clear that there are a number of benefits that would allow SMMC to better serve patients and the community at large, but there is little, if any, evidence that there are cognizable efficiencies that clearly offset competitive harm. First we discuss the benefits of the transaction and then we examine whether there are cognizable procompetitive efficiencies.

Some of the benefits include:

- A new state of the art facility, the New Hospital that is seismically-compliant whereas the current SMMC facility is not compliant.
- Expanded bed capacity for a hospital that is currently operating at a high occupancy level in an area with a growing population.
- The opportunity for improved quality by working with Kaiser to implement the Kaiser model of quality.
- The opportunity to improve physician recruitment in an area that has low physician to population ratios. (However, we also note that this could have an anticompetitive effect if Kaiser recruits physicians leaving too few non-Kaiser physicians in the area for competing insurers and hospitals to offer competitive alternative products).

All these are positive factors that, should they come to fruition, are very likely to improve patient care and would benefit the community. However, it is not clear from the documents provided by the parties to date that they are merger specific and verifiable.

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<sup>312</sup> FTC v. St. Luke's Health Sys., Ltd., No. 1:13-CV-00116-BKW, pp. 28-33 (D. Idaho Jan. 24, 2014) (hereafter St. Luke's-Saltzer).

<sup>313</sup> Saint Alphonsus Med. Ctr. v. St. Luke's Health Sys., Ltd., No. 14-35173 (9th Cir. Feb. 10, 2015).



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It is not clear that construction of the New Hospital can only be achieved through this CiC between SMMC and Kaiser. Providence provided documents to the California Attorney General that explore several options for retrofitting or other partnerships and does not demonstrate how the Kaiser CiC, specifically, is uniquely procompetitive in achieving the facility with expanded bed capacity.

It is also not clear that the CiC is necessary to improve SMMC's patient quality. As discussed earlier in this report, Kaiser is well respected for its quality of patient care and stated they will work with SMMC to improve care: "KP shall assist in SMMC's evaluation and improvement of its Quality Program to benefit all patients of the Facilities, which shall include a focus on patient safety initiatives and improving the facilities' CMS star ratings."<sup>314</sup> [REDACTED]

[REDACTED]. For example, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Summary Star Rating that combines all information about specific aspects of patient experience of care fell from 3 stars in 2017 to 1 star.<sup>315,316</sup> Their FY 2021 scorecard based on 2019 data showed small improvement but was well below the achievement threshold.<sup>317</sup> While arguably there are other opportunities to improve patient care without a CiC with Kaiser, e.g. engaging a consultants to develop a model of improved patient care, it is likely that Kaiser's infrastructure for care coordination and improvement would benefit SMMC. That said with no quantification or verification of how the relationship with Kaiser will uniquely improve care the parties do not provide support for this being a cognizable efficiency.

Regarding physician recruitment, Kaiser's access to SMMC could potentially lead to a recruitment growth for badly needed primary care physicians in the community, a result which could also benefit the specialist physicians who would see growth in their primary care referral base. Given that Kaiser offers physicians a good work-life balance and good retirement benefits it is often an appealing option to physicians and with access to SMMC, new physicians may be willing to serve the area. However, this is currently speculative and non-verifiable based on the data acquired to date.

One of the primary reasons Kaiser and Providence are engaging in this CiC is to limit risk associated with capital expenditures. The avoidance of capital expenditures may represent a

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<sup>314</sup> Notice of Affiliate Transaction – SMMC, at p. 207 (April 7, 2021) (on file with OCAG). (Also: "SMMC shall participate and cooperate with the KP utilization and case management programs for Members with respect to services provided at the New Hospital, and KP shall operate these programs in accordance with the HCSA and the Medical Management Terms set forth therein." At p 203).

<sup>315</sup> The Centers for Medicare & Medicaid Services (CMS), along with the Agency for Healthcare Research and Quality (AHRQ), developed the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as Hospital CAHPS®, to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care.

<sup>316</sup> [Part 3] Project Blossom - Response to AG's Request for Information Dated 9-21-21 [10-5-2021]

<sup>317</sup> [Part 3] Project Blossom - Response to AG's Request for Information Dated 9-21-21 [10-5-2021]

compelling rationale for a transaction and be a significant efficiency.<sup>318</sup> In this case Providence and Kaiser are reducing and thereby avoiding capital expenditures by partnering, assuming the alternative would be to retrofit or build a new facility without a partner for one or both of them. However, capital avoidance does not necessarily result in a consumer benefit unless the merging firms will pass these savings on to consumers.

Our findings suggest that there is certainly a risk of anticompetitive effects as a result of this transaction and we do not have any evidence of merger specific and verifiable procompetitive effects to balance the transaction's adverse competitive effects.

## **12 Summary of All Conditions for Consideration for Transaction Approval by the OCAG**

This section summarizes the conditions we believe should be considered by the OCAG to ensure access and availability to needed community services and to reduce the risk of competitive effects should they decide to approve this transaction. (Some, but not all, of the conditions include additional notes on the importance or relevance of the condition.) Many of these conditions will need additional detail before adoption, mechanisms for monitoring and enforcement, and possibly a process for reevaluation after a given period of time has passed. The duration, detail of terms, and enforcement of these conditions would be critical to mitigating the risk of anticompetitive effects in this transaction. We recommend that the OCAG consider applying all conditions to the current SMMC facility for a period of at least ten years or until the New Hospital is operational and admitting patients. Further, we propose that these conditions also apply to the New Hospital for ten years or more once it is operational and admitting patients.

### **12.1 Ensuring Availability and Accessibility to Basic Medical Services**

Access to medical care is a challenge across the Inland Empire, and particularly so in the High Desert, where the ratio of both primary care and specialty physicians to residents is among the lowest in the state. SMMC is currently the largest hospital in the area, offering the greatest breadth of services and specialties. The parties' petition provides the OCAG the opportunity to ensure that these service levels are maintained for High Desert residents into the future.

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<sup>318</sup> FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996) (finding that the merger of two hospitals would allow them to avoid otherwise planned capital expenditures related to a new inpatient bed tower).

Similarly, SMMC’s charitable activities in the region provide an important source of health care for low-income communities, and SMMC’s capital contributions to the construction of the new facility could impede on its charitable activities.

We propose the following conditions related to the availability and accessibility of health care services be considered by the California Attorney General (CA AG) for this Providence Kaiser CiC.

	<b>Condition</b>	<b>Additional Notes on Relevance</b>
A1	For at least ten years or until the New Hospital is operational and admitting patients, the current SMMC facility shall continue to operate as a general acute care (GAC) hospital. At the time the New Hospital opens, it shall continue to operate as a general acute care (GAC) hospital for a period of ten years or more.	There is little likelihood that Kaiser Providence will not continue to operate SMMC as a GAC. However, to ensure GAC hospital access, we propose the CA AG consider this condition, which is standard in non-profit GAC hospital mergers.
A2	For at least ten years or until the New Hospital is operational and admitting patients, the current SMMC facility shall maintain 24-hour emergency services at no less than current licensure and designation with the same types and/or levels of services, including a minimum of 44 emergency treatment stations. At the time the New Hospital opens, it shall continue to provide these emergency services for a period of ten years or more.	According to SMMC, its current ED (Emergency Department) capacity is already stretched thin. However, according to SMMC’s own estimates, 20% of ED use is misutilization, which can be addressed by other health care resources (e.g., urgent care centers). We propose that they maintain at least the current number of treatment stations.
A3	Within at least one year of Closing, SMMC shall present options for a SMMC trauma center and a plan for opening the trauma center or a compelling analysis as to why a trauma center is either not feasible or not an asset to the community. Additionally, the OCAG should have the option to require other conditions based on their review of the findings in the analysis.	None of the hospitals in the High Desert currently offer a trauma center; the nearest is at Loma Linda, located in the county's urban core.
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	According to Project Blossom Part 1, the New Hospital does not plan on keeping their six pediatric beds.

	<p>licensure, types, and/or levels of services for the following services:</p> <ul style="list-style-type: none"> <li>• Pediatric services, including a minimum of six licensed pediatric beds;</li> <li>• Cardiology services, including a minimum of two cardiac catheterization labs and the designation as a STEMI Receiving Center;</li> <li>• Critical care services, including a minimum of 20 intensive care beds;</li> <li>• Obstetrics services, including a minimum of 16 obstetrics beds; and</li> <li>• Neonatal intensive care services, including a minimum of eight neonatal intensive care beds and designation as a Level II Neonatal Intensive Care Unit.</li> </ul> <p>At the time the New Hospital opens, it shall continue to provide these services for a period of ten years or more.</p>	<p>They indicate they have an average daily census of one patient. However, HCAI 2019 Utilization data report eight beds and an average daily census closer to two. Pediatric inpatient unit capacity is decreasing in the US. A higher percentage of inpatient stays covered by Medicaid rather than private insurance often makes them less profitable and subject to cuts. Maintenance of a small number of pediatric beds would serve the community given that there is no nearby children’s hospital. The parties do not indicate any of the other service lines will be reduced, but this condition ensures that these needed services will be retained for the community.</p>
<p>A5</p>	<p>For at least ten years or until the New Hospital is operational and admitting patients, the current SMMC facility shall maintain the following services as committed to in Exhibit 8.13 of the Health System Combination Agreement:</p> <ul style="list-style-type: none"> <li>• Diabetes care services;</li> <li>• Imaging/radiology services;</li> <li>• Laboratory services;</li> <li>• Rehabilitation services;</li> <li>• Surgical services;</li> <li>• Women’s services; and</li> <li>• Wound care services.</li> </ul> <p>At the time the New Hospital opens, it shall continue to provide these services for a period of ten years or more.</p>	<p>The parties do not indicate any of these existing service lines will be reduced, but this condition ensures that these needed services will be retained for the community.</p>

<p>A6</p>	<p>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:</p> <ul style="list-style-type: none"> <li>• SMMC Medical Center Community Health Center, located at 18077 Outer Highway 18, Suite 100 in Apple Valley;</li> <li>• SMMC Community Health Center Hesperia Clinic, located at 17071 Main Street in Hesperia; and</li> <li>• SMMC Medical Center Healthy Beginnings Adelanto Clinic, located at 11424 Chamberlain Way, #9 in Adelanto.</li> </ul>	<p>Low-income populations are increasingly dependent on health clinics for primary care. They play an important role in keeping patients with non-emergency health needs out of the ED.</p>
<p>A7</p>	<p>For at least ten years or until the New Hospital is operational and admitting patients, the current SMMC facility shall maintain its California Children’s Services (CCS) certification, currently 7.13.102, to allow the facility to keep CCS-eligible NICU babies at the hospital, thereby allowing these babies (and families) to stay in the area to receive their care rather than being transferred out of the service area to other hospitals (e.g., Loma Linda, Children’s Hospital of Orange).</p> <p>At the time the New Hospital opens, it shall continue to maintain this certification for a period of ten years or more.</p>	<p>CCS is a California state-funded program for children with certain diseases or health problems. These represent vulnerable populations who tend not to generate high profits but need care.</p>
<p>A8</p>	<p>Within one year of Closing, the parties shall develop a plan, to be made available to the public, to explore the feasibility of the option of obtaining a special permit to establish a freestanding ED in Apple Valley at the existing SMMC site. (The Paradise, California</p>	<p>ED utilization is very high in the SMMC market area. Apple Valley residents are excited about the prospect of a larger hospital but are concerned that they will lose access to proximal ED services. A</p>

	<p>permit for a freestanding ED may be a guide for the parties.<sup>319)</sup></p> <p>Additionally, the OACG should have the option to require other conditions based on their review of the findings from the investigation of this option.</p>	<p>freestanding ED would address this concern.</p>
<p>A9</p>	<p>Prior to the Closing Date, the parties will enter into Trademark License Agreements that will permit the New Hospital LLC to incorporate the name and trademarks of SMMC, KFH and their respective affiliates into the future branding and marketing of the New Hospital.</p> <p>To ensure that non-Kaiser’s patients understand that they will enjoy access to the ED at the New Hospital (notwithstanding any Kaiser branding), we propose the OAG consider requiring the facility to post the California Patient Rights on their website and in their emergency room.<sup>320</sup></p>	<p>Given the high volume of emergency care, in the area it is important that residents understand their right to emergency care.</p>

## 12.2 Ensuring Availability and Access to Reproductive Health Services & LGBTQ Care

SMMC’s Ethical and Religious Directives (ERDs) prohibit the hospital from providing certain reproductive health services to High Desert residents, and there is some precedent for the concern that these directives could also effectively constrain Kaiser physicians, depending on SMMC’s approach to operating the New Hospital. While the parties indicate that Providence, SMMC and Newco do not expect any impact on Kaiser or Permanente physicians from the applicability of the ERDs, Statement of Common Values, or any other restrictions to Kaiser or Permanente, conditions would allow the CA AG to ensure this protection.<sup>321</sup>

<sup>319</sup> A Feasibility Study: The Next Step in Developing a Freestanding Emergency Room in Paradise Adventist Health Feather River, Mar 26, 2020 (<https://www.adventisthealth.org/blog/2020/march/a-feasibility-study-the-next-step-in-developing-/> )

<sup>320</sup> The California Patient’s Guide, Chapter IV, Your Right to Emergency Care ( <http://calpatientguide.org/iv.html> )

<sup>321</sup> Project Blossom Part 1, Response to AG’s Request for Supplemental information 9-21-21

	Condition	Additional Notes on Relevance
B1	<p>Consistent with the 2019 Dignity Health merger with Catholic Health Initiatives to form Common Spirit, where the OCAG approved the merger under the condition that existing reproductive health services at the group of historically non-Catholic Dignity system hospitals be maintained for ten years (or more), Kaiser physicians would be allowed to continue to provide reproductive health services at SMMC for a designated period, e.g., 10 years (or more) or throughout the period of the CiC.</p>	<p>This would ensure the parties' intent: that Kaiser maintain existing reproductive health services post-CiC. Kaiser states that "Kaiser Permanente 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. This will not change as a result of this transaction."<sup>322</sup> However, documenting the terms for providing these services in a binding legal agreement will help ensure their availability.</p> <p>A process for monitoring their compliance on a regularly basis, whether quarterly or annually, could also be implemented and enforced.</p>
B2	<p>From the point of closing, the existing SMMC facility and the New Hospital will adopt policies that prohibit discrimination based on gender identity and gender expression and that are consistent with the policies outlined in the Transgender Affirming Hospital Policies Document.<sup>323</sup></p>	<p>It is important to make clear to patients that the hospital is firmly committed to the rights, and to freedom from harassment and discrimination, of all individuals.</p>

<sup>322</sup> KP AG Question #29 (October 26 2021)

<sup>323</sup> CREATING EQUAL ACCESS TO QUALITY HEALTH CARE FOR TRANSGENDER PATIENTS, May 26, 2016, Published by Lambda Legal, New York City Bar, Hogan Lovells, and Human Rights Campaign Foundation. [https://www.lambdalegal.org/sites/default/files/publications/downloads/hospital-policies-2016\\_5-26-16.pdf](https://www.lambdalegal.org/sites/default/files/publications/downloads/hospital-policies-2016_5-26-16.pdf) (<https://www.thehrcfoundation.org/professional-resources/transgender-affirming-hospital-policies>)

<p>B3</p>	<p>From the point of closing, the existing SMMC facility and the New Hospital shall prohibit discrimination based on any protected personal characteristic identified in state and federal civil rights laws, including section 51 of the California Civil Code and title 42, section 18116 of the United States Code. Categories of protected personal characteristics include:</p> <ul style="list-style-type: none"> <li>• Gender, including sex, gender, gender identity, and gender expression;</li> <li>• Intimate relationships, including sexual orientation and marital status;</li> <li>• Ethnicity, including race, color, ancestry, national origin, citizenship, primary language, and immigration status;</li> <li>• Religion;</li> <li>• Age; and</li> <li>• Disability, including disability, protected medical condition, and protected genetic information.</li> </ul> <p>Language like that used by the University of California San Francisco Hospital may be appropriate.<sup>324</sup></p>	<p>The New Hospital must be firmly committed to preventing discrimination based on any protected personal characteristics.</p>
<p>B4</p>	<p>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</p>	<p>According to interview notes dated 11/1/2021, Providence has a review process for emergency procedures with ERD implications. However, with the CiC “Providence has total ultimate control and authority of things that impact the ERDS”.<sup>325</sup></p>

<sup>324</sup> UCSF Health: Hospital Policies, <https://www.ucsfhealth.org/your-hospital-stay/hospital-policies>. (“It is our policy not to engage in discrimination against or harassment of any person employed or seeking employment or patient care with SMMC on the basis of race, color, national origin, religion, sex, gender identity, gender expression, pregnancy, physical, mental or other disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship or status as a covered veteran (special disabled veteran, Vietnam-era veteran or any other veteran who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized). Non-discrimination information is available in an alternate form of communication to meet the needs of people with sensory impairments.”)

<sup>325</sup> Confidential Notes - Kaiser 11-1-21



	<p>procedure at the New Hospital. Kaiser would in no way be limited in its existing provision of gender affirming procedures at Kaiser facilities.)</p> <p>(Note: This would not be necessary if Kaiser staff are allowed to perform procedures they decide are clinically necessary at SMMC and would otherwise perform at Kaiser facilities.).</p>	<p>Therefore, to ensure a common understanding early on, as a condition of approval, both parties would develop a legally binding document that ensures that the patient will receive appropriate care at SMMC where that care could be denied based on ERD implications.</p>
B5	<p>Prior to the Closing Date, the parties must ensure that Kaiser personnel have a point of contact at Kaiser for reporting any incidents of current SMMC facility or New Hospital management impeding Kaiser personnel’s ability to provide care in a manner consistent with personnel’s professional judgment.</p>	<p>A clear point of contact for Kaiser staff will reduce the likelihood that incidents impeding appropriate medical care go unaddressed.</p>

### 12.3 Ensuring Availability and Access for Vulnerable Populations

In the High Desert, Medi-Cal enrollees, those covered by other city or county health plans, and those with behavioral health care needs frequently suffer from a lack of access to health care professionals. While the facility may have sufficient capacity to serve Kaiser enrollees in addition to SMMC’s pre-existing patient population, the parties’ agreements do not provide explicit protections for Medi-Cal or county indigent enrollee access to care at the New Hospital.

Access to care is not as critical a challenge for Medicare enrollees, but given SMMC’s importance to this community, it is similarly necessary to preserve Medicare access.

	Condition	Relevance
C1	<p>For at least ten years or until the New Hospital is operational and admitting patients, the current SMMC facility shall continue to provide the same types and/or levels of emergency and non-emergency services to Medi-Cal Managed Care and traditional Medi-Cal beneficiaries, on the same terms and conditions as other similarly situated hospitals offering substantially the same</p>	

	<p>services, without any loss, interruption of service, or decrease of quality, or gap in contracted hospital coverage, including continuation of the contracts with IEHP, Molina and other existing contracts covering the Medi-Cal population.</p> <p>At the time the New Hospital opens, it shall continue to maintain these levels of care for a period of ten years or more.</p>	
C2	<p>For at least ten years or until the New Hospital is operational and admitting patients, the current SMMC facility shall continue to maintain its current city/county contracts for the programs listed below subject to the request and agreement of the appropriate city/county.</p> <p>At the time the New Hospital opens, it shall continue to maintain these contracts for a period of ten years or more.</p>	<p>Those covered by city/county contracts constitute a vulnerable population. Requiring SMMC to continue to serve these patients will help preserve their access to care.</p>
C3	<p>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.</p> <p>Services may include physical examinations, cancer screenings, immunizations, TB screening, and diabetes screening, among others.</p>	<p>Access to care is a challenge in the High Desert. The OAG has required the continuance of the mobile van program. We propose setting measurable objectives for the program and requiring that the parties report on progress towards those objectives.</p>
C4	<p>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.</p>	<p>Mental and behavioral health challenges in the community have been documented in community benefits reports and public surveys.</p>
C5	<p>Within one year of the Closing Date, the New Hospital will evaluate the use of the Apple Valley site for non-acute mental health services and any</p>	<p>SMMC has previously considered downsizing the Apple Valley campus and</p>

	<p>other behavioral health services that are lacking in the community and present their findings to the OCAG. The OCAG should have the option to require other conditions based on their review of the evaluation.</p>	<p>backfilling with mental health and non-acute services.<sup>326</sup></p>
<p>C6</p>	<p>For at least ten years or until the New Hospital is operational and admitting patients, the current SMMC facility shall continue to maintain a charity care policy that is no less favorable than SMMC’s current charity care policy and in compliance with California and Federal law. SMMC shall provide an annual amount of charity care equal to or greater than the amount consistent with the historic level of charity care provided by SMMC as calculated based on the average hospital charity care expenditure during the most recent three (3) years prior to the Closing Date for which data are available and determined in accordance with HCAI standards. This should be no less than \$4.7M, the average reported for “charity-other” based on data reported to HCAI (OSHPD) in the Hospital Financial Annual Disclosure reports 2017-2019 but should be updated after closing using the most current HCAI data. The definition and methodology for calculating “charity care” and the methodology for calculating “cost” based on the charges reported shall be the same as that used by HCAI for annual hospital reporting purposes. The Charity Care required annually will be increased on an annual basis by the rate of inflation as measured by the Consumer Price Index for Riverside-San Bernardino-Ontario, California or another appropriate index as determined by the OCAG.</p>	<p>Requiring SMMC to maintain current levels of charitable funding should protect this source of health care and community benefits for the region's low-income population.</p>

<sup>326</sup> SMMC has considered redeployment of the current site in connection with a community visioning process. Kindred Healthcare has expressed interest in providing long-term acute care, inpatient psychiatric care and inpatient rehabilitation, none of which are currently available in the High Desert.

	<p>At the time the New Hospital opens, it shall continue to maintain the designated charity care levels for a period of ten years or more.</p>	
<p>C7</p>	<p>For at least ten years or until the New Hospital is operational and admitting patients, the current SMMC facility shall continue to expend an amount equal to or greater than the amount consistent with the historic level of community benefits provided by SMMC as calculated based on the average hospital community benefits expenditure during the most recent three (3) years prior to the Closing Date for which data are available and determined in accordance with HCAI standards. The community benefits required annually will be increased on an annual basis by the rate of inflation as measured by the Consumer Price Index for Riverside-San Bernardino-Ontario, California or another index as determined by the OCAG.</p> <p>Additionally, per the FY2019 community benefit report, the parties shall continue to allocate 10% of the New Hospital’s net income (net unrealized gains and losses) to the St. Joseph Health Community Partnership Fund to support low-income and underserved populations in the market area.</p> <p>At the time the New Hospital opens, it shall continue to maintain its community benefit levels per the agreed upon condition for a period of ten years or more.</p>	<p>Requiring SMMC to maintain current levels of charitable funding should protect this source of health care and community benefits for the region's low-income population.</p>
<p>C8</p>	<p>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.</p>	<p>Beds available on a first-come-first-serve basis will provide greater assurance that vulnerable populations with a lower hospital reimbursement rate will have access to SMMC when needed.</p>

## 12.4 Ensuring Competition

This section summarizes the conditions we believe should be considered by the OCAG to reduce the risk of competitive effects should they decide to approve this transaction. They are broad in nature and additional detail would be necessary for implementation including terms for monitoring compliance.

	Condition	Relevance
D1	<p>Prior to the Closing Date, the parties must appoint an Antitrust Compliance Officer charged with implementing and enforcing a Conflict Avoidance Policy (CAP) which would include the following elements:<sup>327</sup></p> <ul style="list-style-type: none"> <li>• Policies and procedures governing the sharing of any information between Kaiser and SMMC personnel in all contexts (e.g., Board meetings, e-mails, in-person conversations, other staff meetings).</li> <li>• Firewalls: <ul style="list-style-type: none"> <li>○ Technological safeguards designed to prevent the sharing of confidential information by, e.g., password-protecting access to such information, firewall setup, and data encryption.</li> <li>○ Physical security measures designed to keep confidential information in hard-copy form in areas not accessible to Kaiser personnel.</li> </ul> </li> <li>• Employee training programs that outline the types of confidential information that may not be shared between Kaiser and SMMC.</li> <li>• The appointment of a third-party monitor, tasked with overseeing the exchange of any non-public financial, patient-related or otherwise confidential information between the parties</li> </ul>	<p>A more detailed policy on information-sharing should help ensure that the parties are aware of which types of sharing may potentially run afoul of federal law.</p>

<sup>327</sup> See DHCS “MAGELLAN MEDICAID ADMINISTRATION MEDI-CAL Rx PROGRAM CONFLICT AVOIDANCE REPORT AND PLAN” (<https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/MMA-DHCS-CAP-3.pdf>)

	(i.e., where such exchanges are for legitimate business purposes or patient care)	
D2	Notwithstanding the operation of the parties' CAP, discussions between the parties related to the New Hospital's future strategic plans (e.g., including planned expansions or contractions of services, or projections of future revenues or costs) or upcoming negotiations or contracts with other payers or counterparties must be monitored by the New Hospital's third-party monitor and may not include any proposed payer rates or line-item expenses.	Sharing of information related to prices or expenses is especially likely to produce anticompetitive behavior.
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.	
D4	The parties shall strike Section 3.02(c)(ii)(A) and 3.02(c)(ii)(N) of their Operating Agreement, which require supermajority approval of the New Hospital's marketing and strategic plans.	To ensure the independence of SMMC and Kaiser, the terms of the CiC should not provide Kaiser unnecessary leverage over decisions that are unrelated to Kaiser's legitimate interests in preserving hospital capacity and service lines.
D5	Modify the CiC terms with respect to Kaiser's discount, profit-sharing and exclusive caps on Kaiser rate increases. In particular:	The terms of the agreement place Kaiser at a significant competitive advantage compared to rival insurers.

	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Make sure that Kaiser 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.</li> <li>• Remove the Kaiser discount for [REDACTED]</li> <li>• If Kaiser profit-sharing remains, reduce Kaiser discount off of commercial payer rates</li> </ul>	
D6	<p>Develop conditions that prohibit anti-tiering, anti-steering and exclusivity clauses in SMMC contracts with other payers will help payers to shift volume to less expensive hospitals in the event of price increase making it easier to compete with Kaiser on costs and facilitate competition in the hospital market</p>	<p>It is important that other insurers have the opportunity to create competitive alternative product offerings with other area hospitals.</p>
D7	<p>Develop conditions that limit SMMC’s ability to increase prices for Kaiser’s rivals, including price caps on Medi-Cal and Medi-Care managed care rates, and caps on price increase for commercial payers, as well as caps on out-of-network services (in case the Surprise Billing Act doesn’t work as intended).</p>	<p>SMMC could conceivably leverage its market power with large price increases.</p>
D8	<p>Develop conditions that strike out Kaiser power to veto a new payer contract (unless it clearly gives their rivals an unfair competitive advantage, such as designated capacity).</p> <p>Operationally, based on the current contract, it appears Kaiser can veto an exclusive contract binding the Company or any of the Company’s assets (i) with a health insurer, health plan or other third party payer for dedicated capacity or service ability at the New Hospital, or (ii) that is reasonably likely to lead to material reductions in capacity or access for Kaiser’s members at any hospital owned by the Company.</p>	<p>To promote competition in the insurance market Kaiser should not be able to veto contracts that SMMC would otherwise consider.</p>

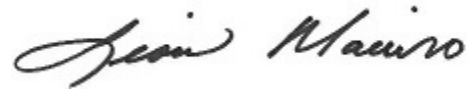
D9	<p>Keep the option to impose conditions at a later time related to mitigating the impact of physician consolidation. Time constraints and limited data available to us did not allow us to assess the risk of competitive effects for the physician market. Should the physician collaboration move beyond SMMC with the potential to have broader anticompetitive effects, e.g., if Kaiser and Providence start dividing up the market for specialty physicians services such that each would only provide certain services and they agreed not to compete, effectively engaging in market allocation, this would be worthy of a deeper investigation.</p>	<p>Preserving competition in the physician market is also important and relevant to the transaction.</p>



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## 13 Signature Page

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.

A handwritten signature in black ink that reads "Lisa Maiuro". The signature is written in a cursive style with a large initial "L" and "M".

Lisa Maiuro, MSPH, PhD

11/11/2021

## 14 Appendices

### 14.1 Appendix A: Key Terms of the Transaction

The proposed transaction includes the following key terms regarding the financing of the New Hospital's construction; each parties' rights to profits and shares of losses; payment rates for services that Kaiser contracts to SMMC physicians; and Kaiser's power to influence New Hospital business strategy and other decision-making as a minority stakeholder.

A summary of material terms of the CiC agreement are noted as follows:

- SMMC and Kaiser will enter into an agreement, characterized by the OCAG as a CiC, to build a replacement hospital.
- SMMC will contribute hospital assets and business (other than existing facility) land to build the new hospital and approximately \$600M cash in exchange for a majority control (70%).
- 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 CiC.
- Simultaneous with the LLC formation, SMMC and Kaiser will enter into a non-exclusive agreement for the provision of health care services at a discounted rate to Kaiser's members. The rates at SMMC for Kaiser's members are discounted off the commercial payer rates prior to the opening of the New Hospital and, in 2026 when the New Hospital is scheduled to open the discount is increased to ■%.
- Until the new hospital facility is operational, all results of operations will be solely for Providence St Joseph Health(PSJH). Kaiser's participation in upside/downside begins when the new hospital facility is operational, which is expected to be in 2026.
- The New Hospital will be Catholic-sponsored and operated in compliance with the ERDs.
- PSJH will occupy seven of ten board seats and all operations, staffing and leadership will be provided by PSJH.
- There will be a Quality Committee that will review and address issues related to quality of services provided at SMMC Hospital.
- SMMC will continue to utilize PSJH payer contracts.
- The CiC will agree to be bound by a Care Model Agreement to ensure the quality of care and continuity of care of Kaiser's members of the new hospital.

Below we review some of the terms of the agreement in more detail.

#### Contributions of Capital

Under the terms of the agreement, SMMC is to make the following contributions:

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- An initial capital contribution of \$42 million, and a total construction contribution, inclusive of the initial contribution, of up to \$609 million (i.e., 70% of the total capital contributed to Newco).<sup>328</sup>
- The real property upon which the New Hospital will be constructed.
- Existing Hospital's assets, including current SMMC contracts, equipment, inventories of supplies, "working capital" equal to 12% of the Existing Hospital's total net operating revenue in the most recent fiscal year, subject to certain exclusions. For example, SMMC will lease to Newco the real property where the Existing Hospital is located, though SMMC will retain ownership of this real property.<sup>329</sup>

Kaiser is to make the following contributions:

- An initial capital contribution of \$18 million, and a total construction contribution, inclusive of the initial contribution, of up to \$261 million (i.e., the remaining 30% of the total capital contributed to Newco).<sup>330</sup>

All future contributions of capital to the CiC will be in proportion to the parties' interests (i.e., 30% and 70% for Kaiser and SMMC, respectively).<sup>331</sup>

### **Distributions Following Closing Date**

Following the commencement of hospital operations, the parties are to be "allocated profits, surplus, losses and credits in proportion to their respective Percentage Interests."<sup>332</sup> Similarly, "earnings" and "distributions," including "excess cash distributions" (i.e., any funds left over after the New Hospital has paid its operating and interest expenses, set aside funds for tax withholding, and set aside sufficient reserve funds) are allocated based on the same percentages.

### **Kaiser's Contribution to Community Benefits**

To retain their tax-exempt status as non-profit hospitals, both Kaiser and SMMC must continue to provide charity care and community benefits, consistent with IRS regulations.<sup>333</sup>

### **Kaiser's Power on the Board of Managers**

The New Hospital's Board of Managers oversees the New Hospital's major strategic, operational, and financial decision-making. As the minority owner in the CiC, Kaiser is entitled to appoint three of the ten Managers serving on the Board. Effectively, this right provides Kaiser veto power over any decision that requires a supermajority of the Board to approve

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<sup>328</sup> Notice of Affiliate Transaction – SMMC, at pg. 77 (April 7, 2021) (on file with OCAG).

<sup>329</sup> Notice of Affiliate Transaction – SMMC, at pg. 17 – 23 (April 7, 2021) (on file with OCAG).

<sup>330</sup> Notice of Affiliate Transaction – SMMC, at pg. 77 (April 7, 2021) (on file with OCAG).

<sup>331</sup> Notice of Affiliate Transaction – SMMC, at pg. 80 (April 7, 2021) (on file with OCAG).

<sup>332</sup> Notice of Affiliate Transaction – SMMC, at pg. 85 (April 7, 2021) (on file with OCAG).

<sup>333</sup> Notice of Affiliate Transaction – SMMC, at pg. 59 (April 7, 2021) (on file with OCAG).

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(since, under the terms of the agreement, a supermajority must include at least one Manager appointed by Kaiser). Key decisions subject to the supermajority requirement include:<sup>334</sup>

- Any loans taken out by the CiC to finance new capital investments
- Changes to the schedule for issuing excess cash distributions
- The disposition of New Hospital assets, or the purchase or sale of real property
- Amendments to any of the agreements entered into between the parties
- Approval of the annual operating and capital budgets
- Appointment or removal of the New Hospital’s chief executive
- Closures of hospital departments or service lines, or reductions of more than 10% of overall bed capacity
- Approval of “exclusive contracts” that would provide another health plan “dedicated capacity or service ability at the New Hospital” or that is “reasonably likely to lead to material reductions in capacity or access for Kaiser’s members.”

Kaiser is prohibited, however, from participating in any negotiations between SMMC and other payers.<sup>335</sup>

### **Exclusivity Covenants**

For the period of the CiC and for one year following, Kaiser and SMMC have agreed not to participate in any other business that “owns or operates an acute care hospital within the Geographic Area,” though SMMC is permitted to continue operating the Existing Hospital at the current site.

### **Rules Regarding Kaiser Physicians’ Practices at the New Hospital**

While SMMC would operate and manage the New Hospital under the CiC, the parties acknowledge that SCPMG physicians will “be provided the necessary and appropriate access and privileges, including . . . sole admitting and discharge rights at the New Hospital, to have SCPMG physicians and allied health practitioners available to be the primary providers of the professional medical care to Members at the New Hospital.” SMMC also promises to coordinate utilization management, discharge planning, and information-sharing between SMMC and Kaiser physicians.<sup>336</sup>

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<sup>334</sup> Notice of Affiliate Transaction – SMMC, at pg. 64 (April 7, 2021) (on file with OCAG).

<sup>335</sup> Notice of Affiliate Transaction – SMMC, at pg. 245 (April 7, 2021) (on file with OCAG).

<sup>336</sup> Notice of Affiliate Transaction – SMMC, at pg. 201 – 203 (April 7, 2021) (on file with OCAG).

Notwithstanding the general requirement that Kaiser Physicians be afforded equal rights and privileges at the New Hospital, the New Hospital’s compliance with Providence’s Ethical and Religious Directives (“ERDs”) applies to all New Hospital services.<sup>337</sup>

### 14.2 Appendix B: State of California - Health Care Quality Report Card MA

















	Quality of Medical Care	Patients Rate Overall Experience	Total Cost of Care
Accountable Healthcare IPA (aka Accountable HealthPlan Medical)	Not willing to report	Not Rated	Not willing to report
Alliance Desert Physicians	 GOOD	 POOR	Not enough data to score reliably
Beaver Medical Group	 GOOD	 FAIR	 AVERAGE PAYMENT
Chaffey Medical Group	 FAIR	Not Rated	 AVERAGE PAYMENT
Choice Medical Group	 FAIR	 FAIR	 LOWER PAYMENT
Citrus Valley Physicians Group	 FAIR	Not Rated	 LOWER PAYMENT
Desert Oasis Healthcare	 GOOD	 GOOD	 HIGHER PAYMENT
Desert Valley Medical Group Inc.	 FAIR	Not Rated	 LOWER PAYMENT
Dignity Health Medical Group – Inland Empire	 FAIR	Not Rated	Not enough data to score reliably
Family Practice Medical Group of San Bernardino, Inc.	Not willing to report	Not Rated	Not enough data to score reliably
Heritage Victor Valley Medical Group	 FAIR	 FAIR	 AVERAGE PAYMENT
Hispanic Physicians IPA dba Medico Hispano IPA	 POOR	Not Rated	Not enough data to score reliably
Kaiser Permanente – Southern California Permanente Medical Group – San Bernardino County	 VERY GOOD	 VERY GOOD	 HIGHER PAYMENT

<sup>337</sup> Notice of Affiliate Transaction – SMMC, at pg. 58, 74 – 75 (April 7, 2021) (on file with OCAG).









La Salle Medical Associates, Inc.	 <b>FAIR</b>	<b>Not Rated</b>	Not enough data to score reliably
Lakeside Medical Organization	 <b>GOOD</b>	 <b>VERY GOOD</b>	 <b>HIGHER PAYMENT</b>
Loma Linda University Health Care	 <b>GOOD</b>	 <b>EXCELLENT</b>	Not enough data to score reliably
My Family Medical Group	 <b>GOOD</b>	<b>Not Rated</b>	 <b>LOWER PAYMENT</b>
Pinnacle Medical Group	 <b>GOOD</b>	 <b>FAIR</b>	 <b>AVERAGE PAYMENT</b>
Pomona Valley Medical Group, Inc.	 <b>GOOD</b>	 <b>FAIR</b>	 <b>LOWER PAYMENT</b>
Premier Healthcare	 <b>GOOD</b>	 <b>FAIR</b>	 <b>LOWEST PAYMENT</b>
PrimeCare	 <b>GOOD</b>	 <b>GOOD</b>	 <b>AVERAGE PAYMENT</b>
Redlands Yucaipa Medical Group	 <b>GOOD</b>	 <b>FAIR</b>	 <b>AVERAGE PAYMENT</b>
Regal Medical Group	 <b>FAIR</b>	 <b>FAIR</b>	 <b>HIGHER PAYMENT</b>
Riverside Physician Network	 <b>FAIR</b>	 <b>VERY GOOD</b>	 <b>AVERAGE PAYMENT</b>
San Bernardino Medical Group, Inc.	<b>Not willing to report</b>	<b>Not Rated</b>	Not enough data to score reliably
SMMC High Desert Medical Group	 <b>GOOD</b>	 <b>GOOD</b>	 <b>LOWER PAYMENT</b>
Upland Medical Group, Inc.	 <b>FAIR</b>	 <b>POOR</b>	 <b>AVERAGE PAYMENT</b>
Vantage Medical Group	 <b>FAIR</b>	<b>Not Rated</b>	Not enough data to score reliably

Source: State of California - Health Care Quality Report Card (San Bernadino County), 2020-21 Edition  
[https://reportcard.opa.ca.gov/rc/medicalgroup-rating.aspx?county=SAN\\_BERNARDINO](https://reportcard.opa.ca.gov/rc/medicalgroup-rating.aspx?county=SAN_BERNARDINO)

### 14.3 Appendix C: State of California - Health Care Quality Report Card Commercial

	Quality of Medical Care
Alliance Desert Physicians	 <b>GOOD</b>
Beaver Medical Group	 <b>VERY GOOD</b>
Chaffey Medical Group	 <b>GOOD</b>
Choice Medical Group	 <b>GOOD</b>
Citrus Valley Physicians Group	Not enough data to score reliably
Desert Oasis Healthcare	 <b>VERY GOOD</b>
Desert Valley Medical Group Inc.	 <b>GOOD</b>
Dignity Health Medical Group – Inland Empire	 <b>GOOD</b>
Family Practice Medical Group of San Bernardino, Inc.	 <b>GOOD</b>
Heritage Victor Valley Medical Group	 <b>VERY GOOD</b>
Kaiser Permanente – Southern California Permanente Medical Group – San Bernardino County	 <b>VERY GOOD</b>
La Salle Medical Associates, Inc.	 <b>FAIR</b>
Lakeside Medical Organization	 <b>VERY GOOD</b>
Loma Linda University Health Care	 <b>VERY GOOD</b>
My Family Medical Group	 <b>VERY GOOD</b>
Pinnacle Medical Group	 <b>VERY GOOD</b>
Pomona Valley Medical Group, Inc.	 <b>GOOD</b>

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Premier Healthcare	 <b>VERY GOOD</b>
PrimeCare	 <b>GOOD</b>
Redlands Yucaipa Medical Group	 <b>GOOD</b>
Regal Medical Group	 <b>GOOD</b>
Riverside Physician Network	 <b>GOOD</b>
San Bernardino Medical Group, Inc.	Not willing to report
St. Mary High Desert Medical Group	 <b>VERY GOOD</b>
Upland Medical Group, Inc.	 <b>GOOD</b>
Vantage Medical Group	 <b>FAIR</b>



#### **14.4 Appendix D: Availability of Gender-Affirming Healthcare Services, 2019**

As part of our analysis related to access and availability of services for the SMMC market area residents, the OCAG asked us to look at whether area residents received gender-affirming healthcare services, and where they received those services. Below we describe our methodology and findings.

In summary, we find that based on 2019 data, residents in Riverside and San Bernardino Counties rely heavily on Kaiser facilities for gender-affirming healthcare services.

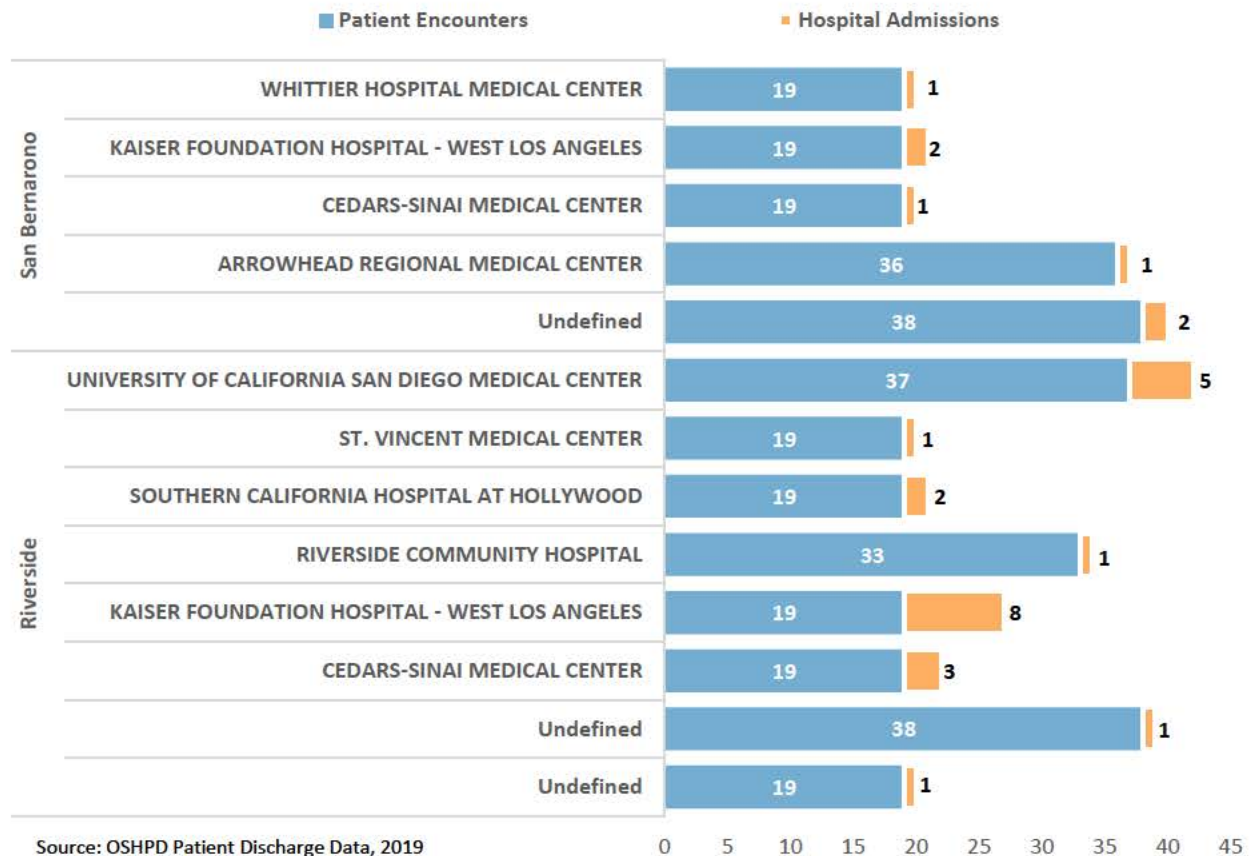
**Methods:** The California Attorney General provided five ICD-10 codes typically associated with gender-affirming healthcare:

- F64.0 Transsexualism
- F64.2 Gender identity disorder of childhood
- F64.8 Other gender identity disorders
- F64.9 Gender identity disorder, unspecified

These codes were not intended to be an exhaustive list to capture all gender-affirming healthcare, but rather as an indicator as to whether gender-affirming care is available in the region. We examined both inpatient hospital data using HCAI Patient Discharge Data (PDD) 2019, and ambulatory care data using HCAI Ambulatory Surgery Care (ASC) data, 2019, for residents in San Bernardino County, where SMMC is located, and Riverside County, south of San Bernardino. We identified the locations used by patients living in these two counties to receive care, regardless of whether it was in the patient's county or not.

**Findings:** There were few (29), inpatient admissions for this limited set of ICD-10 gender-affirming diagnosis codes as a primary diagnosis for residents in either San Bernardino or Riverside. Only seven patients in San Bernardino had one of the selected ICD-10 codes, and most of those (four), used facilities in Los Angeles (Exhibit 33 Gender-Affirming Patient Encounters by Location). Arrowhead Regional, a hospital in San Bernardino County, had one admission. For patients from Riverside, Kaiser West Los Angeles was the most frequently used hospital location.

Exhibit 27 Gender-Affirming Patient Encounters by Location, 2019



There were 128, ASC records for these select ICD-10 gender-affirming diagnosis codes for residents in either San Bernardino or Riverside Counties. There were 101 unique encounters, suggesting that there were 101 individual patients who had ASC encounters, some for multiple encounters. Kaiser Fontana was by far the most frequently used facility by patients in both San Bernardino and Riverside Counties, accounting for 96 of the 128 ambulatory surgery encounters.

### 14.5 Appendix E: Details on Medi-Cal Capacity Analysis

The increase in demand for inpatient services at the New Hospital is the result of three likely impacts of the CiC : 1) population growth, 2) expanded use of SMMC by existing Kaiser’s members and 3) expanded use of SMMC by new Kaiser’s members. This appendix addresses our estimates for expanded use of SMMC by existing and new Kaiser’s members. First, the availability of the New Hospital to SMMC market area residents is expected to increase Kaiser’s share of the commercial and Medicare Advantage markets in this area. Among these new Kaiser enrollees, many will be pre-existing users of SMMC’s inpatient services, but some currently use other hospitals in the area (e.g., Victor Valley Global Medical Center or Desert Valley Hospital). Second, any *current* Kaiser enrollee living in the SMMC market area will be

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more likely to use SMMC for inpatient services than under the status quo. In other words, the New Hospital will also divert inpatient admissions from Kaiser's other locations, specifically Kaiser Fontana / Ontario. While all patients in the SMMC market area live closer to the New Hospital than to Kaiser Fontana / Ontario or any other Kaiser facility, not all patients will switch; further details are provided below about assumptions regarding the proportion that will switch.

As to the issue of Kaiser's increasing market share, residents living within the market area and enrolled in commercial, Medicare Advantage, or Medi-Cal coverage accounted for 39,803 discharges in 2019.<sup>338</sup> Kaiser enrollees accounted for 4,765 (12%) of this total, with Kaiser accounting for 34% of total market area commercial enrollment, 27% of Medicare Advantage enrollment, and 3% of Medi-Cal enrollment.

Given that statewide, Kaiser accounts for roughly 50% of Medicare Advantage enrollment in markets in which it competes, we assume for purposes of this analysis that Kaiser's share of enrollment will increase to 35% of the Medicare Advantage market and 40% of the commercial market by 2026 (the first year post-Closing Date), and to 50% of both markets by 2035. Kaiser's share of total Medi-Cal enrollment increases only modestly, from 2.6% of the market to 4%.<sup>339</sup>

To estimate the net increase in patient days served at SMMC attributable to the CiC, we projected SMMC's share of ED, maternity care, and scheduled admissions of Kaiser enrollees, and then utilized existing Kaiser data on average lengths of stay, by payer type and service provided, to calculate the expected number of added patient days.<sup>340</sup>

In 2019, SMMC provided an estimated 300 discharges to Kaiser enrollees, accounting for roughly 10.3% of Kaiser enrollee ED admissions from the SMMC market area, 5.7% of maternity care admissions, and 0% of scheduled admissions.<sup>341</sup> As shown in Exhibit 34, Estimated Kaiser Admissions and Market Shares, under the CiC, we expect these shares will increase as follows:

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<sup>338</sup> HCAI Patient Discharge Data, 2019. Across all types of coverage, residents accounted for 41,555 discharges. For purposes of estimating the increase in demand due to Kaiser's members, we exclude the payer markets (e.g., county indigent coverage) in which Kaiser is not active.

<sup>339</sup> For purposes of simplicity, Kaiser is not expected to gain significant market share in Medi-Cal, given its requirement that individuals may only enroll in Medi-Cal through Kaiser if they have previous Kaiser's membership. See <https://thrive.kaiserpermanente.org/medicaid/medi-cal-california/why-kp>.

<sup>340</sup> A portion of these patient days would be served regardless of whether the CiC is approved. Because Kaiser is expected to capture additional market share because of the CiC, some of its future enrollees already use SMMC for inpatient services. The Access and Capacity Model accounts for this dynamic to avoid double-counting.

<sup>341</sup> HCAI Patient Discharge Data, 2019

Exhibit 28 Estimated Kaiser Admissions and Market Shares, 2019, 2026 & 2035

Percent of Kaiser Admissions at SMMC	2019 (Actual)	2026 (Estimated)	2035 (Estimated)
Emergency Department	10.3%	80%	80%
	5.7%	75%	75%
Scheduled Share	0.9%	30%	30%
Kaiser Market Share (SMMC Market Area)	Status Quo	2026 (Estimated)	2035 (Estimated)
Commercial	33.8%	40%	50%
Medicare	26.7%	35%	50%
Medi-Cal	2.6%	3.9%	3.9%

Source: OSHPD Patient Discharge Data, 2019

- Inpatient Admissions from the ED:* Even though only a small minority of ED visits result in hospital admissions, this is the most common method of admission (i.e., more so than scheduled admissions and maternity admissions). By definition, all Kaiser enrollees in the Market Area will live closer to the New Hospital than to Kaiser Fontana and are thus more likely to choose the New Hospital over Kaiser Fontana in the event of an emergency. In some cases, however, these residents will be traveling from a non-home address (such as their place of employment), in which case another hospital may be closer. Moreover, Kaiser Fontana’s high share of total status quo ED admissions (71% of the total attributable to Kaiser’s SMMC market area members) suggests that, even in the case of an emergency, enrollees are in many cases willing to travel farther for admission at a Kaiser facility even when non-Kaiser facilities offer shorter travel times. Our model assumes that Kaiser enrollees in the area access the New Hospital for 80% of ED admissions, up from a status quo percentage of 10.3%. While most of this increase represents reduced ED volume at Kaiser Fontana, it also accounts for reduced demand at Desert Valley Hospital, which we expect to lose admissions to SMMC given the close proximity of the New Hospital.
- Scheduled Inpatient Admissions:* Scheduled admissions comprise a relatively small portion of admissions. For two reasons, the New Hospital is not expected to capture the majority of Kaiser’s scheduled inpatient admissions. First, as there are more Kaiser’s patients in the Inland Empire’s urban core, Kaiser Fontana will likely remain the flagship Kaiser location in the broader region, with a greater number of Kaiser-affiliated specialists than at the New Hospital. Second, treatment of Kaiser’s patients at the New Hospital may frequently require Kaiser to pay SMMC, so Kaiser is financially incented to instead refer its patients to available physicians at its other locations. The Report Model assumes that the New Hospital will account for roughly 30% of scheduled admissions of SMMC market area Kaiser’s members, up from 0% under the status quo.

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- *Maternity Care Inpatient Admissions:* The New Hospital's share of maternity care admissions depends in part on Kaiser enrollee perceptions of the quality of the maternity care facilities at the New Hospital. We assume for purposes of this analysis that Kaiser will at least employ OBGYNs and provide inpatient maternity care at the New Hospital, and that the New Hospital accounts for 75% of maternity care admissions, up from 6% under the status quo.

As summarized in Exhibit 35, Sensitivity Analysis of New Hospital Capacity, Patient Days, the combined effect of (1) increases in Kaiser's market share; (2) the New Hospital's increased share of Kaiser member inpatient utilization; and (3) population growth, we project that by 2035, Kaiser will account for 6,031 discharges and 25,335 patient days at the New Hospital, or 29.1% of total discharges and 27.1% of total patient days (up from just 300 discharges and 1,008 patient days at SMMC in 2019).

[REDACTED]

[REDACTED].<sup>342</sup> As shown below, in Exhibit # 35 Sensitivity Analysis of the New Hospital Capacity, Patient Days a comparison of report model and [REDACTED] estimates of capacity for 2035, nearly the entire difference between the models owes to

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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<sup>342</sup> [Part 2] Project Blossom - Response to AG's Request for Information Dated 9-21-21 [10-5-2021]

Exhibit 29 Sensitivity Analysis of New Hospital Capacity, Patient Days

<b>Status Quo, 2019</b>						
	<b>Discharges</b>	<b>Patient Days</b>	<b>ALOS</b>			
<b>TOTAL</b>	<b>14,054</b>	<b>64,671</b>	<b>4.6</b>			
New Kaiser	-	-	-			
SMMC*	14,054	64,671	4.6			
<b>Projections Side By-Side</b>						
	<b>Kaiser Model, 2035</b>			<b>Report Model, 2035</b>		
	<b>Discharges</b>	<b>Patient Days</b>	<b>ALOS</b>	<b>Discharges</b>	<b>Patient Days</b>	<b>ALOS</b>
<b>TOTAL</b>	<b>19,925</b>	<b>76,364</b>	<b>3.83</b>	<b>20,741</b>	<b>93,404</b>	<b>4.5</b>
Kaiser	6,536	23,581	3.61	6,031	25,335	4.2
SMMC	13,389	52,783	3.94	14,710	68,069	4.63
<b>Projection Comparison (Kaiser Model vs. Report Model)</b>						
		<b>Discharges</b>	<b>Patient Days</b>	<b>ALOS</b>		
	<b>TOTAL</b>	<b>(816)</b>	<b>(17,040)</b>	<b>(0.67)</b>		
	Kaiser	505	(1,754)	(0.59)		
	SMMC	(1,321)	(15,286)	(0.69)		

Source: OSHPD Patient Discharge Data, 2019

\*Under the 2019 status quo, SMMC discharges include those of Kaiser patients. Because Kaiser transfers its members who are admitted to SMMC to Kaiser locations prior to discharge, thus artificially reducing its ALOS, we do not present Kaiser's ALOS at SMMC under the status quo. Kaiser's ALOS under the Report Model is based on OSHPD 2019 data.