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

Health Care Affordability Board
January 28, 2025
Public Comment

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

Date	Name	Written Comment
1/28/2025	Amber Ter-Vrugt, on behalf of Scripps Health	Thank you for the opportunity to provide comments today. I am Amber Ter-Vrugt, here representing Scripps Health. My comments today will exceed the time permitted, so I will provide the board with written copies. Scripps Health was founded more than 100 years ago. Today, Scripps treats more than 600,000 patients annually through the dedication of 3,000 affiliated physicians and more than 17,500 employees at our five acute-care hospital campuses, 32 outpatient centers and clinics, and hundreds of affiliated physician offices throughout the region, which are a critical part of San Diego's safety net. Scripps is a leader in disease and injury prevention, diagnosis, and treatment, and clinical research. And Scripps is the only health system in the region with two level 1 trauma centers. With highly respected graduate medical education programs, Scripps is a longstanding member of the Association of American Medical Colleges. Scripps has been ranked seven times as one of the nation's best health care systems by PINC AI, formerly known as Merative, IBM Watson Health, and Truven Health Analytics. And our hospitals are consistently ranked by U.S. News & World Report among the nation's best. Scripps is also recognized by the Advisory Board, Fortune, and Working Mother magazine as one of the best places in the nation to work. I recognize your meeting today is focused on sector targets, but we would like to step back and use the time this body has afforded us for public comment to open a window into the unintended impacts of earlier decisions set by the Office of Health Care Affordability (OHCA).

Date	Name	Written Comment
		We believe sector target decisions to be premature and lacking in needed analysis particularly because the impacts of earlier policies have not been evaluated. We do not dispute the collective goal and your charge to reduce health care costs without sacrificing quality of or access to health care. Unfortunately, the targets set by this body are not reducing the underlying costs. They are impeding our ability to return to financial stability, maintain access to care for our patients, and provide patient-centered care without needless bureaucratic barriers being imposed by health insurance companies. And that is because OHCA's policies are being used by the health insurance industry to impose conditions that are unattainable. Many insurance companies are erroneously claiming they can only increase compensation to providers by 3% based on OHCA requirements. As a result, insurance companies are demanding Scripps accept financial concessions that do not consider our increasing costs. With Medicare decreasing physician compensation by nearly 3%, and implementing a hospital increase that is locked in at rates below 3%, in addition to the retroactive rate increase process employed by Medi-Cal which also is lower than the rate of rising costs - these practices will be catastrophic for health care providers in our state. But there are winners - the insurance companies. Since 2023, rates charged by insurers for Covered CA plans, subsidized by the State, have increased by an average of 17.9% for their members in San Diego County, with Silver plans - the most popular tier - increasing an average of 21.95%, or $82 per month. And Platinum plans have seen an average increase of $94 per month. While the premiums increase to the patient, and the insurance company restricts the reimbursement to the healthcare provider below inflation area rates, the profits for the same organizations continue, sometimes more than $1 billion on a quarterly basis. Make no mistake, this is about insurance company profits and not decreasing costs for patients. Further, Curtailing commercial reimbursement far beyond what hospitals need to sustain their services is not an approach that fulfills OHCA’s multiple objectives. Not only does it not consider that Medicare and Medi-Cal don't contribute compensation increases commensurate with inflation or OHCA’s targets -- it also doesn't take into consideration costs that are not controlled by

Date	Name	Written Comment
		OHCA. Nothing in the OHCA policies address the costs that fall to the health care providers -- who are delivering the care to people with health care needs be they preventative, chronic, or urgent in nature. These costs are outside the control of providers. For example, Reducing payments to us does not make cutting edge cancer therapies less expensive, it doesn't increase access to patients in the community, and it will not support clinical quality initiatives. Inflationary pressures, including pharmaceuticals, have increased by 12%, In other examples, this year alone, Energy costs for our system increased by 9%. We cannot negotiate for discounts on our energy bills because OHCA creates a cost target. Labor costs have gone up another 5% this year following last year's increases due in part to the California health care worker Minimum Wage increase. This wage increase will increase our labor costs by $20 Million in the first 12 months. These costs are unfunded. Supply costs have increased on average 5% and are due in large part to state mandates following the COVID crisis. Insurance related costs have also increased. Medical malpractice insurance has gone up by 39%. And the list goes on. And these are just our costs of delivering care on a daily basis. In addition to the operating costs I just referenced that are outside our control, There is also the cost to Scripps of complying with the State seismic mandate. We have already committed, and nearly completed, almost $2B of work to comply with these mandates, And have additional future cost estimates that exceed $1.5B. And we're not even talking about the investment required to keep up with innovations in the delivery of health care or expansion efforts in the community for services that are desperately needed. For the sake of our patients and community, we must have the flexibility to invest in programs that promote an equitable future, one that invests in partnerships and innovations that will reduce health care costs in the long run and ensure we can provide state-of-the-art care to our community for the next hundred years. We understand that our ability to provide state-of-the-art care is not at the forefront of this board's policy-making charge, but it is the **first thing** people think about when they or a loved one need medical care. So, while health insurance companies continue to institute barriers to care through their bureaucratic policies and raise insurance premiums for our

Date	Name	Written Comment
		patients, costs continue to increase for providers like us, and the only thing being reduced are payments for care being provided by those in the community who deliver the care. Again, insurance companies are beholden to their shareholders, not their insureds. This toxic combination will put health care providers across the State of California in negative positions. More than 50% of hospitals are already operating at a loss. And in the end, our communities are the ones who get harmed. Scripps is in support of the office's mission to curb health care cost growth. But we cannot sacrifice access to, or the quality of, health care. It is in that spirit that we want you to know how the well-intended policies of this board are being misused, taken too far, and are impacting the delivery of quality healthcare in our community. Each day at Scripps, we put the vision of our founders into action, dedicating ourselves to quality, safe, cost-efficient, socially responsible health care for everyone we serve. We are grateful for the opportunity to share our perspective with this board. Thank you for your time.
2/19/2025	Montage Health	See Attachment #1.
2/20/2025	Natividad	See Attachment #2.
2/20/2025	Health Access California	See Attachment #3.
2/20/2025	California Association of Public Hospitals and Health Systems	See Attachment #4.
2/21/2025	California Hospital Association	See Attachment #5.
2/21/2025	Salinas Valley Health	See Attachment #6.

Attachment #1

MONTAGE Health

January 18, 2025

Kim Johnson
Chair, Office of Health Care Affordability
2020 W El Camoni Ave
Sacramento, CA 95833

Subject: Montage Health response to actions of the Office of Health Care Affordability
Submitted via email to ocha@hcai.ca.gov

Dear Chair Johnson,

Montage Health is deeply concerned by the actions taken under the aegis of the Office of Health Care Affordability (OCHA). Since its inception, this Board has allowed a small, yet vocal, group of organized labor representatives to seize control of the agenda, pushing a specific, false, and harmful rhetoric.

OCHA's analysis fails to clearly, consistently, or impartially identity "high-cost hospitals."

Initial data published by HCAI staff and shared at the December OHCA meeting highlighted just how problematic the study and analysis of hospital pricing is. Both HCAI staff and OHCA board members noted the lack of clear and consistent patterns. Notably, Community Hospital was absent from three of the four cost metrics presented without exclusions, which likely raised doubts among board members given the rhetoric from special interest groups about Community Hospital over the past year.

As a result, staff was directed to conduct a *new* analysis to identify "disproportionally high-cost hospitals." What resulted was a study in the power of creative statistics. Once again, Kaiser Permanente and several other acute care hospitals were excluded, and additional exclusions, like the arbitrary exclusion of hospitals that fall anywhere below the state's average number of admissions, were also excluded such that the new list of hospitals represents less than half the original size. The confounding new analysis arbitrarily examined three of the last five years rather than averaging all five years and focused on the commercial-to-Medicare ratio instead of a broader net patient revenue per case mix adjusted discharge ratio previously utilized. We can't help but wonder if this was all done for the express purpose of producing a curated list targeting the *three* hospitals that have been maligned by local special interest groups since this group's inception. OCHA's attempt to more consistently identify high-cost hospitals using these measures involves arbitrary and unjustified exclusions, raising serious questions around whether other considerations may be driving these decisions.

The focus on hospital margins rather than system margins continues to be concerning.

This approach ignores both the need for hospitals to generate sustainable margins to support their communities, and the economic realities of an integrated healthcare system. In 2024, Montage Health's system-wide net margin was 1.1%.

The use of a Commercial-to–Medicare Net Patient Ratio is problematic with regard to both the numerator and the denominator.

Utilizing Commercial NPR rather than average, all-payer, NPR fails to recognize wide variation in payer mix across different markets. An inferior payer-mix requires health systems to capture higher revenue from commercial payers (on a unit basis) or risk insolvency. This has been demonstrated multiple times in California through the distress and failures of hospitals across the state. Incorporating Medicare reimbursement as the denominator in a ratio only further distorts the data. Medicare reimbursement varies widely across the state by provider type and structure and does not uniformly reflect the cost of providing care to Medicare patients. By way of example, academic medical centers in Northern California receive Medicare reimbursement that is 60 percent higher than what Community Hospital of the Monterey Peninsula receives while their commercial reimbursement is 20 percent higher than Community Hospital. Yet, despite higher reimbursement in both the numerator and denominator, their Commercial-to-Medicare ratio is calculated to be 24% lower!

OCHA's definition of a hospital sector is wholly premature, coming years before statutory deadlines and is absent of basic due diligence.

We continue to urge the Board to consider the broader context. It is critical to recognize that Community Hospital of the Monterey Peninsula is not an isolated entity, but rather the core of an integrated delivery system that supports healthcare services across our region. We hope that OCHA will work collaboratively with organizations like ours to develop practical and sustainable solutions to these issues rather than focusing on a singular narrative in addressing a multifaceted problem.

Sincerely,

Steven Packer, MD
President & CEO, Montage Health

cc: Members of the Health Care Affordability Board:
- David Carlisle, MD, PhD
- Dr. Sandra Hernandez
- Dr. Richard Kronick
- Ian Lewis
- Elizabeth Mitchell
- Donald B. Moulds, PhD
- Dr. Richard Pan
- Elizabeth Landsberg, Director of Department of Healthcare Access and Information

Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom

February 20, 2025

Secretary Kim Johnson
Chair, Health Care Affordability Board
2020 West El Camino Avenue
Sacramento, CA 95833

Submitted electronically via Email to OHCA@hcai.ca.gov

Subject: Natividad Medical Center

Dear Chair Johnson,

Since 1886, Natividad Medical Center has been providing care to people in Monterey County. As the first public hospital in the state, owned and operated by the County of Monterey, our mission is "to continually monitor and improve the health of the people, including the vulnerable, in Monterey County through coordinated, affordable, high-quality health care. "

Natividad appreciates the importance and urgency of the work of the Office of Health Care Affordability (OHCA) and its Board, and it is important for the Board to understand our role as a safety net system.

Natividad is part of California's 17 designated public health care systems (PHS), which are the core of the state's health care safety net. As public systems, PHS also contribute roughly $4 billion annually to the Medi-Cal program, in place of the state's share. The services that Natividad and the other 16 PHS provide to communities are crucial to maintaining people's health throughout California.

Natividad's Role in Providing Critical Services to the Community

As the area's only Level II Trauma Center, Natividad provides a vital local community public service that treats the most severe and critical injuries — saving lives and allowing patients to receive specialized care closer to home. Our 24/7 trauma teams include trauma surgeons, neurosurgeons, orthopedic surgeons, interventional radiologists and nurse practitioners.

As Monterey County's only teaching hospital, our UCSF affiliated Family Medicine Residency program trains 30 doctors every year and most are bilingual.

Our extensive education programs train health professionals and students across a variety of disciplines every year, ensuring that we have torchbearers of California's public health system and future work force. Natividad has over 100 students at any given time and has education agreements with 32 colleges and universities. Natividad is the only hospital in Monterey County to train nursing students from both Monterey Peninsula College and Hartnell College. Our state-of-the-art simulation center trained 1,600 learners in FY 2024.

Natividad provides 24-hour acute inpatient mental health care for those most in need in a safe and structured environment.

Monterey County has one of the largest indigenous communities from Oaxaca in the U.S. and our award-winning indigenous language interpreters help patients, and their families communicate in Mixteco Guerrero, Mixteco San Martin Peras, Triqui Copala, Chatino, and Zapoteco.

Every year, about 2,400 babies take their first breath at Natividad, while our advanced Level III NICU care is available to babies born both at Natividad and at other hospitals.

Natividad's Sam Karas Acute Rehabilitation Center helps patients, including the most vulnerable, recovering from illness or injury reach their goals and have the skills they need to get home and get back to living life to its fullest. We've received the "Top Performer Award" for Centers for Medicare & Medicaid (CMS) quality metrics scoring in the top 10% for six consecutive years, while Lifepoint routinely ranks Natividad in the top 10% of its over 100 U.S. Acute Rehab Centers and Inpatient Rehabilitation Facilities.

Natividad expanded specialty services available and increased appointments available to address needs in the community, while expanding access to primary care at all Natividad Medical Group sites in Prunedale, East Salinas and the hospital.

Natividad is focused on remaining sustainable and continuing to support our mission during a time when over half of the hospitals are operating at a deficit. Maintaining a stable footing allows us to preserve access to care, and remain a major employer in the community, with a workforce of nearly 2,000.

Financing Challenges as a Safety Net System

Natividad has funded programs, including a specialized program that provided primary/specialty care/diagnostic services and prescription medications, for the uninsured. In addition, Natividad plays a large role in financing the care we provide to the

Medi-Cal and uninsured patients that we serve. We must rely on revenues from patient care to care for the low-income populations we serve and to maintain all our operations.

Most of Natividad's patients are covered by Medi-Cal and Medicare, specifically 80% versus the state average of 62%. This, coupled with uninsured patients, means that Natividad is reimbursed at government rates below our costs. As such, many of our health care services are provided for Monterey County at a significant overall financial loss.

In an effort to improve affordability, Natividad's charges have not increased since 2020. Natividad is always striving to be more efficient and sustainable.

We request Board consideration and exemption of Natividad as a PHS from the high-cost hospital-specific sector targets to ensure there are no adverse impacts, and to minimize impacts to access, quality, and equity for our communities' most vulnerable. We welcome the opportunity to discuss considerations for our system's financing and challenges as a safety net system with you further if it would be helpful. Thank you for your consideration.

Sincerely,

Charles Harris MD
Chief Executive Officer

Cc: Members of the Health Care Affordability Board:
Dr. David M. Carlisle
Dr. Sandra Hernandez
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Dr. Donald B. Moulds
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistance Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin

HEALTH ACCESS CALIFORNIA

February 20, 2025

Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

Re: December 2024 and January 2025 Health Care Affordability Board meetings

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

Health Access California, the statewide consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments and recommendations on the topics discussed at the January 2025 Health Care Affordability Board meeting and anticipated for the February 2025 Board meeting.

From the first meeting of the Board, the Board has focused on consumer affordability as the primary goal of the Office of Health Care Affordability and the cost growth targets. The overall cost growth target is based on the growth in median family income as a measure of the ability of consumers and other purchasers to afford health insurance for Californians. This cost growth target is intended to slow the growth of health care costs over time so that the health care industry, both providers and payers, have time to lower costs while improving quality and equity. Lowering costs will improve access in California, a state where half of consumers skip or delay care.

Health Access commends the Board for acting to move forward with regulations to define all hospitals as a sector. In this letter, we offer comments on:

- The need to act now on high-cost hospitals without delay

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- The importance of hospital costs in the midst of an epidemic of lack of affordability: deductibles, coinsurance, premium and share of premium
- Lower targets for high-cost hospitals in the context of the existing statewide cost target both slow overall growth in health care costs and reduce the highest cost outliers, for the Californians who get health insurance through a job and who pay an ever-increasing share of income for health care.
- The need for all hospitals, including Kaiser hospitals and others, to be included as part of the hospital sector for purposes of regulation and data, even as targets are set consistent with the statute.
- Additional comments on equity and quality measures as well as using the behavioral health benchmark to encourage prevention and better management of behavioral health conditions, in place of relying on jails and emergency rooms for care.

Don't Delay: Consumers Need Action Now as the Law Allows

Consumers are facing an affordability crisis today. The Health Care Affordability Board, and the Office, were created, as an alternative approach to rate regulation, to achieve greater consumer affordability. Californians today face an affordability crisis and high hospital costs contribute to that affordability crisis. That is why we ask the Board to press forward on lower cost growth targets for high-cost hospitals.

The law is clear: the Office and the Board may take action on the definition of sectors and lower cost growth targets sooner than the statutory deadlines. It is within both the letter and the intent of the law to move sooner than the deadlines imposed by law. What is hasty and ill-considered is the failure of too many hospitals and others to recognize the damage being done to Californians by the lack of affordability today.

<u>Section One: Consumer Affordability and Hospital Costs: High Cost Hospitals</u>

Consumer Affordability: Hospital Costs

Hospital Costs Are the Largest Single Share of Commercial Insurance Costs

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Hospital costs amount to about 40% of commercial insurance rates[1]. Hospital costs are:

- As large a share of health insurance premiums as physician services and prescription drug costs combined.
- Hospital costs, both inpatient and outpatient, are the largest single share of the premium dollar.
- As documented by the Congressional Budget Office, nationally, hospital costs paid by commercial payers average about 200% of Medicare while physician costs paid by commercial payers are closer to 125% of Medicare[2].
- To paraphrase Willie Sutton, hospitals are where lots of the money is.

Hospital costs translate directly into consumer lack of affordability for the large share of consumers with coinsurance. Hospital costs are the most common cause of medical debt. Hospital costs are the largest share of commercial insurance costs. These reasons alone justify a focus on hospital costs and the decision to treat all hospitals as a sector.

Hospital costs are not affordable for consumers. Hospital costs alone are a major reason why consumers need health insurance for themselves and their families. Even a high-income consumer might have difficulty affording a hospital stay of tens of thousands or hundreds of thousands of dollars without insurance coverage. Most Californians, 80%, live on less than $150,000 a year. For these Californians, even with health insurance, hospitals costs paid through coinsurance or the maximum out of pocket limit are unaffordable.

Coinsurance: Coinsurance is a percentage of the cost of care, often 10% or 20% or even 30% of the cost of care.

- About 70% of Californians with health coverage from private employers confront coinsurance for hospital costs[3].
- Higher cost hospitals mean higher coinsurance up to the maximum out of pocket limit in state and federal law, now almost $10,000[4], an enormous sum

[1] We cite health insurance premiums sold to employers and individuals, not National Health Expenditures, in part because NHE includes costs not included in THCE for those with commercial coverage, such as long term care which is both less needed for those under age 65 and less extensively covered by commercial insurance than Medicare or Medi-Cal.

[2] https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf

[3] https://laborcenter.berkeley.edu/wp-content/uploads/2024/02/Measuring-Consumer-Affordability_revisedFeb82024.pdf

[4] https://board.coveredca.com/meetings/2025/February%2020,%202025/2026_Benefit_Plan_Designs_.pdf

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for a California family living on a median income of about $85,000 and a financial challenge for those families in the $90,000- $150,000 a year range. Even a family in the top 20% with an income over $150,000 might find a sudden $10,000 cost challenging.

- Most consumers in Covered California have bronze or silver coverage with actuarial values of 60% or 70% respectively, and deductibles as large as $7,800 for bronze and hospital coinsurance of 30% for silver[5].

Deductibles: For many consumers who are unfortunate enough to have an emergency room visit or hospital stay in a year, that big cost usually comes unexpectedly. Often these consumers have not yet met their deductible:

- 80% of California consumers with employer coverage, either from public or private employers, now have a deductible.
- And the average family deductible exceeds $4,000[6].
- Those who work for large employers nationally have similar experience of larger and more prevalent deductibles[7].

Medical Debt: Because an emergency room visit or hospital stay so often results in enormous costs to the consumer, it is no surprise that hospital costs are the single largest factor in medical debt[8]. Medical debt to hospitals is usually larger than medical debt to other providers: Those who had debt owed to a hospital were almost four times more likely to have debt of $5,000 or more (26.4 percent), compared to those with debt only from non-hospital providers (6.2 percent).

State after state and the prior federal administration have taken action on medical debt to hospitals precisely because of the devastating impact on consumers and the well-documented fact that medical debt is not predictive of consumer willingness to repay other debt, such as car loans or mortgages[9].

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[5] https://board.coveredca.com/meetings/2025/February%2020,%202025/2026_Benefit_Plan_Designs_.pdf

[6] https://laborcenter.berkeley.edu/wp-content/uploads/2024/02/Measuring-Consumer-Affordability_revisedFeb82024.pdf

[7] Claxton et al, May 2024, https://files.kff.org/attachment/health-policy-101-employer-sponsored-health-insurance.pdf

[8] https://www.urban.org/sites/default/files/2023-03/Most%20Adults%20with%20Past-Due%20Medical%20Debt%20Owe%20Money%20to%20Hospitals_0.pdf Across all income types, medical debt is more likely to have resulted from a hospital or both a hospital and doctor/dentist visit, in comparison to a doctor/dentist visit without a hospital, or other medical suppliers or providers.

[9] https://health-access.org/wp-content/uploads/2024/04/Medical-Debt-SB-1061-Fact-Sheet-9.4.24.pdf

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High-Cost Outlier Hospitals Should be the Focus

The law, in both its intent section and statutory provisions, anticipates that the Board and the Office will focus on high-cost outliers, including hospitals:

> *Intent:* (a) The Legislature finds and declares all of the following…
> (4) Escalating health care costs are being driven primarily by high prices and the underlying factors or market conditions that drive prices, particularly in geographic areas and sectors where there is a lack of competition due to consolidation, market power, venture capital activity, the role of profit margins, and other market failures. Consolidation through acquisitions, mergers, or corporate affiliations is pervasive across the industry and involves health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities. Further, market consolidation occurs in various forms, including horizontal, vertical, and cross industry mergers, transitions from nonprofit to for-profit status or vice versa, and any combination involving for-profit and nonprofit entities, such as a nonprofit entity merging with, acquiring, or entering into a corporate affiliation with a for-profit entity or vice versa.
> (l) It is the intent of the Legislature in enacting this chapter that the setting of health care cost targets distinguish between health care entities that deliver cost-efficient, high quality care and those that deliver high-cost care without commensurate improvements in overall quality[10].

The findings in the intent section are consistent with the Arnold & Whaley study that hospital mergers lead to increased hospital prices and spending which lead to lower wages for all workers with job-based coverage (not specific to health care workers).

> *Statutory provisions:* (e) The methodology for setting a sector target for an individual health care entity shall be developed taking into account the following:
> (1) Allow for the setting of cost targets based on the entity's status as a high-cost outlier[11].

The law reflects a considerable body of research about the impact of high-cost outliers on health care costs, much of this research focused on hospitals and California hospitals specifically. An overview of this many pieces of research can be

[10] Health and Safety Code 127500.5.
[11] Health and Safety Code 127502 (e) (1).

found in this study, The Sky's The Limit[12], and in the literature cited in the extensive litigation over the market behavior of the Sutter health system.

The analysis done by staff reveals that a relatively small number of hospitals, a dozen or so out of the 440 California hospitals, have very high commercial costs whether measured as a "commercial net patient revenue per cost mix adjust discharge" or by comparing commercial costs for the same care compared to what Medicare pays. This outcome came into sharper focus as staff focused on commercial payments. Notable findings from the staff analysis:

- The average commercial Inpatient Net Patient Revenue adjusted for case mix for the top 30 hospitals ranged from $107,000 to $36,000 while the statewide median is $18,000. In other words, hospitals in the top 30 high-cost hospitals are paid more than twice as much as the midpoint of payments by commercial payers for the same care and sometimes almost ten times as much.
- The comparison of commercial payments to Medicare payments for the *same services,* both inpatient and outpatient, is equally revealing:
    - The top 30 hospitals are paid from 857% of Medicare to 300% of Medicare while the statewide median is just over 200% of Medicare[13].
    - This means that the top hospital was paid almost NINE times as much by its commercial payers as Medicare paid for the same service while most California hospitals are paid about twice as much by commercial carriers as Medicare pays and the Medicare population is older, sicker and more complicated.
    - This finding is consistent with a Congressional Budget Office study[14] that looked at commercial prices for hospitals and physicians: "For hospitals' services as a whole, the prices paid by commercial insurers were more than double the prices paid by Medicare FFS, on average, in recent years." page 5.
    - It is also consistent with the presentation the Board heard in Monterey from Chris Whaley, a coauthor of the RAND hospital pricing study[15] which found variation in California hospital prices ranging up to five times as high as Medicare (slide 117) and the variation in commercial prices is not linked to quality (slide 125). The variation in costs is based

[12] https://www.chcf.org/publication/the-skys-the-limit/
[13] https://hcai.ca.gov/wp-content/uploads/2025/02/January-2025-OHCA-Board-Meeting-Presentation.pdf
[14] https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf
[15] Monterey slides, especially slide 117 and 125.

on commercial to Medicare ratios and seeks to account for patient mix, geographic wage differences, and other factors that might otherwise influence price variations.

The Board discussion during the January 2025 meeting touched on whether the goal of analyzing high-cost outliers is to reduce the dispersion around the mean or to lower the mean or median costs. Our answer is that we need to do both to control health care costs and that the Board has two approaches to cost growth targets to achieve this:

- First, by setting an overall state cost growth target that is based on median family income rather than prior health care cost growth, the Board has already taken action to move the cost growth trend downward over time.
- Second, by turning its focus on high-cost outliers, the Board has the opportunity to both lower the mean and reduce dispersion around the mean by enacting lower cost growth targets for the small segment of hospitals at the highest end of commercial costs.

Measures Focused on Commercial Spending on Hospital Care Generally Align

Health Access supports the use of commercial net inpatient revenue, adjusted for case mix, and the comparison on commercial revenue to Medicare for the same services. The use of measures that focus on payments by commercial insurance demonstrates that some hospitals are paid far in excess of 200% of Medicare for the same care paid for by Medicare. We support the use of both measures, and the approach of looking at whether a hospital exceeds very high thresholds in three of the last five years for the following reasons:

- First, these measures, commercial net inpatient revenue, adjusted for case mix, and the comparison of commercial spending to Medicare prices for the same services, capture the impact on commercial health insurance costs of high-cost outlier hospitals.
- Second, use of both measures is preferred because it captures outpatient spending as well as inpatient.
    - Hospital outpatient spending is about half of the spending by commercial insurers on hospital care. Excluding it entirely is inappropriate, but the existing HCAI data is limited in its usefulness for adjusting outpatient revenues by service intensity or case mix.

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    - We continue to have concerns about up-coding of case mix adjustment for inpatient care: using a second measure helps in part to address that concern.
- Third, looking at three years out of the prior five years addresses the tendency of the results to bounce around somewhat. It also has the benefit of treating the COVID year as the odd year it was.

Lower Cost Growth Targets for High-Cost Hospitals

Health Access supports lower cost growth targets for high-cost hospitals, defined in terms of commercial spending on hospital care.

- Moving to eliminating high-cost outliers on commercial costs by moving the highest-cost hospitals closer to either the mean or median both statewide and regionally.
- Sending market signals in more narrowly focused geographic areas, such as those where a small number of hospitals seem to move in alignment such as Monterey, or those where a hospital has a functional monopoly created either by abuse of consumer protections such as the time and distance standard or by geographic isolation from other hospitals.
- Sending market signals to so-called "must-have" hospitals for commercial networks that outlier high commercial costs will be addressed through state action by setting lower cost growth targets.

Target Value for High-Cost Hospitals

Many in the advocacy space would prefer that the law permitted targets to reduce current hospital spending, rather than simply constraining the rate of growth. Unfortunately, the law defines "cost growth targets" to require positive cost growth, even for those health entities that have abused their market power in the existing market dynamic.

Our goal in supporting lower cost growth targets for the high-cost outliers is both to move the highest-cost outliers more into alignment with other similar entities in the state and region but also to lower the mean or median spending on hospitals. The current median or midpoint for hospital spending by commercial payers is about 200% of Medicare, or twice as much, for the same service. As we have documented,

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the payments made by commercial payers to the 30 most expensive hospitals range from almost NINE times what Medicare would pay for the same service to three times as much. Lowering these hospital costs closer to the mean or median would benefit consumers by reducing costs.

Our goal is for these changes to occur in the reasonably foreseeable future of the next five to ten years. We emphasize again that for consumers who face an affordability crisis today, a decade is forever and the sooner the better. It is one thing to be on a path toward a better place. It is another to stall and delay and ignore the real damage caused today by lack of affordability. Because of our recognition that change takes time, Health Access supports multi-year targets similar to those for the statewide targets.

Exclusions: Good, Bad and Possibly Acceptable

Health Access supports the following exclusions, as appropriate given the nature of the hospitals involved:

- State hospitals
- Shriner's hospitals
- Critical access hospitals (as defined by federal rule)
- Distressed hospitals that have received loans under the HCAI program
- County psychiatric hospitals (four of them)

Health Access opposes the use of "comparable/noncomparable" hospitals as an archaic artefact of a data system created decades ago and not relevant to the current situation. The reliance on so-called "comparable" hospitals has contributed to confusion among stakeholders without a substantive policy justification. Specifically:

- Health Access opposes the exclusion of Kaiser hospitals from analysis as failing to recognize the change in law under SB 343 (Pan) of 2019 which required Kaiser to report at the hospital level for its individual hospitals.
- Health Access questions the exclusion of "psychiatric health facilities" (PHFs) for two reasons:
    - First, the very high profit margins for too many of these facilities exposed by the analysis of operating margins.

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- Second, the reality that the Newsom Administration has pushed hard to include behavioral health because it is as important as physical health. Excluding PHFs when this Administration, and OHCA, are focused on behavioral health seems contrary to the good work of this Administration.

Health Access very strongly opposes excluding the vast majority of hospitals. If we are going to look at high-cost outlier hospitals, the analysis cannot begin by excluding over 60% of all hospitals as was proposed in the January presentation by staff.

On one category of exclusions, we are tentatively willing to accept exclusion of those facilities that have less than 5% Medi-Cal revenue or 5% Medicare revenue or those that have less than 5% commercial revenue. Our hesitation reflects two things: First, the failure to provide a list of the facilities excluded under this rubric and second, the lack of clarity in the presentation about this definition. If our understanding of the definition and the list of affected hospitals is factually accurate, we would support this approach. If our understanding is wrong, we are not.

Hospital Sector Regulations

Health Access supports defining all hospitals, including Kaiser hospitals as a sector. The law requires the following for a fully integrated delivery system[16]

> (i) (1) Until the board approves sector targets for fully integrated delivery systems, fully integrated delivery systems shall comply with the statewide cost target.
>
> (2) Targets set for fully integrated delivery systems shall include all health care services, costs, and lines of business managed by that system in each separately administered geographic service area of the state. The system shall provide sufficient data and information, comparable to other unintegrated payers and providers, including patient risk mix, *to the office to enable analysis and public reporting of performance, including by sector*, insurance market, line of business, and separately administered geographic service area. (emphasis added)

[16] Health and Safety Code Section 127502.

The law requires that Kaiser produces information sufficient to enable analysis and public reporting and comparable to other payers and providers. Failing to include Kaiser hospitals in the "hospital sector" definition for reporting purposes is thus contrary to the law. We acknowledge that the law repeatedly recognizes the role of the fully integrated delivery system, but the law also requires sufficient and comparable data.

It is correct that the legislation requiring Kaiser hospitals to report has only been in effect for a few years, the regulation defining all hospitals as a sector is likely to be in place for some years into the future. Failing to build in the change in reporting as a result of the change in the law would be a missed opportunity. Kaiser is an important part of the health care system in California: depending on how a health care market is defined, Kaiser is often a third or even half of the delivery system.

For these reasons, Health Access would oppose the exclusion of Kaiser from the definition of hospitals as a sector while acknowledging that the law requires targets for Kaiser to be handled separately.

Section Two: Equity/Quality Measures; Behavioral Health; Public Reporting

Equity and Quality Measures

Health Access will submit separate comments on the proposed equity and quality measures.

As we have in prior letters and comments, we note that the health acquired infection measures collected and enforced by the California Department of Public Health for almost twenty years have had the impact of actually improving quality by reducing patient harm. This is not a standard most quality measures have met in the last thirty years. These measures of HAIs also have important equity implications: CPEHN has sponsored legislation in this area which Health Access has supported.

Behavioral Health Measures and Benchmarks

Health Access joins many others in supporting the proposed Behavioral Health benchmark approach which is intended to move behavioral health from its current

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reality where consumers do not have timely access to necessary in-network care aimed at upstream prevention but instead too often rely on emergency rooms or worse yet, jails or the streets, to manage their behavioral health conditions.

Ideally, as with physical health, behavioral health conditions should be managed long before someone ends up in the emergency room. We will always need the availability of emergency room care when someone is destabilized or has significant physical health needs as well as behavioral health as well as hospital care and residential treatment for those for whom care cannot be managed in the outpatient setting. Because behavioral health has for so long been relegated to the periphery of health care, it is difficult to envision a day when many receive care at an earlier stage of the condition. But that should be the goal that underlies the benchmark.

This Administration has done more than any other Administration in the last forty years to work to improve care for behavioral health. This is one more piece of that effort.

Conclusion

Health Access urges the Health Care Affordability Board to act, and to act without delay, to build on the existing statewide cost growth target by setting lower cost growth targets for very high-cost hospitals. We support the use of measures that compare hospital costs paid for commercial coverage sold for employer coverage and individual coverage to the same services paid for by Medicare and work toward 200% of Medicare as an initial cost target. We regret that the law does not permit negative cost targets, but we urge the Board and staff to press forward to stop uncontrolled hospital costs for those of us with commercial coverage that is unaffordable for 80% of Californians.

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Interim Executive Director

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CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

February 20, 2025

Secretary Kim Johnson
Chair, Health Care Affordability Board
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: Request for Time-Limited Public Health Care System (PHS) Exclusion from High-Cost Hospital Sector Target(s)

Dear Chair Johnson,

On behalf of the members of the California Association of Public Hospitals and Health Systems, I am writing to express concerns with the current process being used to develop a high-cost hospital sector target(s) and to **urge that PHS be excluded from the high-cost hospital sector target(s) until concerns around the metrics and underlying data that disproportionately impact PHS are resolved.**

California's 17 public health care systems (PHS), which include county-operated and affiliated facilities and the five University of California health systems, are the core of the state's health care safety net. PHS have a mission and mandate to deliver high-quality care to all, regardless of ability to pay or insurance status, across a comprehensive range of services. Despite representing only 6% of all hospitals statewide, PHS provide 35% of all Medi-Cal and uninsured hospital care. They contribute over $4 billion annually to the Medi-Cal program, in place of the state's share, with many of their payments uniquely tied to quality and performance improvements. Additionally, these systems train a diverse and inclusive workforce, including nearly half of all new doctors in hospitals across the state.

We share the goals of the Office of Health Care Affordability (OHCA) and the Health Care Affordability Board to improve affordability for patients and slow the growth of health care spending. However, we have significant concerns with the rushed development of the high-cost hospital metrics and the underlying data being used to measure PHS' performance. We have conveyed a number of these concerns to OHCA and the Department of Health Care Access and Information (HCAI) leadership, and we appreciate their engagement with us.

While OHCA has acknowledged many of our concerns and is working to explore solutions for some or gain a deeper understanding of others, the issues remain unresolved, and we are concerned that they will not be incorporated in OHCA's proposed methodology for determining high-cost hospitals or resolved in time for the Board's adoption of the sub-sector target(s). Ensuring that accurate and appropriate data are used in calculating high-cost hospital targets is essential to generating meaningful findings. Without more time and careful consideration of these issues, there could be significant harm to the health care safety net.

We therefore urge the Board to avoid any adverse impacts to our systems by adopting a temporary exclusion for PHS from the high-cost hospital target(s). Going forward, we commit to continuing to work with OHCA and HCAI leadership to resolve these issues and

inform the development of a more meaningful methodology for determining high-cost hospitals in the state.

Our specific concerns are detailed below:

Concerns with High-Cost Hospital Metrics and PHS Considerations
In the December 2024 and January 2025 Health Care Affordability Board meetings, OHCA focused on potential ways to identify and measure "disproportionately high-cost hospitals." Several PHS appeared in OHCA's lists of high-cost hospitals in the state. We are concerned these metrics and underlying data do not account or adjust for several attributes that are unique to PHS' financing, including the following issues:

- PHS' Medi-Cal self-financed payments and HCAI hospital reporting: PHS play an enormous role in the Medi-Cal program. They do so not just as providers, but also as a source of financing, in which most of their Medi-Cal revenues are reimbursed through self-financed payments, meaning that PHS themselves – not the State – provide the non-federal share of the payment. For these Medi-Cal payments, PHS only receive as revenue the federally matched portion, or the net amount of the payment. It is only this portion that helps PHS cover the costs of the care. However, many PHS report the gross amount of the payment – both the non-federal share they provide and the federal match – in the Hospital Annual Financial Disclosure Reports (the data source being used to pull revenue information), which is different from how private hospitals report supplemental funding from the Hospital Quality Assurance Fee Program. Using this reported data drastically, and inaccurately, inflates PHS' revenues. For example, several PHS have a payer mix of more than 60% Medi-Cal, for which they are self-financing the majority of those payments. Using gross data for these payments significantly increases the inpatient NPR per CMAD results for these systems, leading to inaccurate outcomes in their performance on the metric.

  If Medi-Cal revenues are used in any way to determine which hospitals should be identified as high-cost, or in determining PHS' performance against spending targets (including the statewide target), this issue must be resolved for OHCA's analysis to be meaningful and valid.

  We appreciate recent conversations with OHCA to discuss this issue in more detail and look forward to partnering on a solution.

- Most county-affiliated PHS do not have commercial contracts: Most county-operated and/or -affiliated PHS primarily serve Medi-Cal and uninsured patients, and do not contract with plans to deliver services to a commercially insured patient population. However, PHS are major providers of intensive, high-cost services like trauma and burn care – services that are not provided by other hospitals in the community. Patients in need of this care (regardless of their type of coverage) are often served by one of our systems.

  Consequently, the revenue for the services provided by county-affiliated PHS in the commercial market (and captured in the metrics OHCA has proposed) is likely for very expensive and highly acute services with a relatively small patient population captured in the denominator (CMAD). This heavily skews PHS' performance on the metrics under consideration.

We look forward to having conversations with OHCA on this specific issue and how it can be resolved or accounted for in the high-cost hospital methodology.

- PHS facility attributes/services: PHS are integrated, systems of care. Several PHS that appeared in OHCA's high-cost hospitals' lists have other types of facilities, service lines, and/or facility attributes that impact their revenues and performance on the metrics when compared to standalone or community hospitals. For example:
    - One PHS included in one of the high-cost hospitals lists has three other hospitals on its license that are captured in the reporting and metric but that provide significantly different services, including psychiatric care, subacute care, and long-term care. These types of services and the associated data must be evaluated separately or reconciled in OHCA's analysis of high-cost hospitals to accurately make comparisons across hospitals for the metrics under consideration.
    - Nearly all PHS are major providers of very high intensity services. For example, eight of the 13 burn centers in California are operated by a PHS. All the University of California (UC) academic health centers operate a burn center and provide many other types of extremely high-cost quaternary and tertiary care, such as major organ transplants, and care for rare conditions like sickle cell disease and hemophilia. The CMI adjustment does not adequately account for the revenues needed to support these services and the variation in services across the hospital sector.

  In recent conversations, OHCA has acknowledged the need for continued engagement to inform how it will account for specific facility attributes and its measurement of health systems, and we look forward to partnering on solutions.

- Coding challenges, CMI adjustment issues, and need for outlier adjustments:
    - *Impacts due to limited coding abilities:* We appreciate OHCA's efforts to adjust for patient acuity in its analysis. However, the methodology OHCA is using benefits hospitals that have better coding abilities. PHS are not paid according to a diagnosis-related group (DRG) methodology for their Medi-Cal inpatient stays. Consequently, most county-affiliated PHS have more limited coding abilities and resources. County PHS have reported having a lower CMI compared to other similar hospitals, which resulted in questionable performance outcomes.

    - *Need for Outlier Adjustments:* PHS are serving some of the most high-risk and complex patients (e.g., burn, transplants, etc.) that are likely to have a longer length of stay than patients in other hospitals. The CMI adjustment being used to measure performance does not account for long lengths of stay nor adjusts for outlier stays. Further, many of our systems provide skilled nursing and sub-acute care, which is captured in the patient discharge data. It is unclear how the Medicare Severity-DRG (MS-DRG) adjusts for these stays, which could also significantly disadvantage PHS performance in OHCA's analysis.

    - *Need for Adjustment for Children's Services:* Several PHS provide high-intensity services like trauma and neonatal intensive care to children. The UC academic health centers that appear on OHCA's high-cost hospitals lists have children's hospitals embedded within their systems and often receive referrals from other nearby children's hospitals. The MS-DRG does not adequately adjust for children's services, which is a reason being considered by OHCA and its Board

to exclude children's hospitals from the high-cost hospital sector target development. This is an issue that also impacts some PHS and results in skewed performance in OHCA's analysis.

We appreciate OHCA's attention to these issues and its openness to work towards resolving them. OHCA staff have expressed an interest in learning more about PHS' payment methodology and how this impacts coding abilities and performance outcomes, potential adjustments for outlier stays, and conveyed that it is looking at a tool to better adjust for children's services. CAPH remains committed to working with OHCA to resolve these concerns.

In addition to the concerns described above that are unique to PHS, we also encourage OHCA and the Board to consider a broader challenge with the measurement methodology:

- Discrepancies with OHCA's methodology to estimate inpatient vs. outpatient revenues and actual revenue split: For some payers, OHCA must estimate the allocation of inpatient NPR vs. outpatient NPR based on billed charges. Several PHS have found OHCA's estimates to be significantly different when compared to actual inpatient and outpatient NPR amounts. Further, some PHS have unique payment methods that could further skew performance. For example, one county-PHS is uniquely paid via an all-inclusive bundled charge methodology rather than through itemized billing. From their analysis, the split between inpatient and outpatient using gross charges (OHCA's approach) is skewed heavily to inpatient, inflating the proportion of NPR to inpatient. These nuances must be considered as OHCA works to identify which hospitals should be considered "high cost."

  We understand OHCA does not anticipate making any changes to its estimate of inpatient NPR. We remain concerned about this approach for the reasons described above and would encourage further consideration so that OHCA's analysis is valid and meaningful.

We Urge the Board to Adopt a Temporary Exclusion for PHS from the High-Cost Hospital Sector Targets

For all of the reasons described above and given OHCA and the Board's rapid timeline to adopt high-cost hospital sector target(s), we urge the board to temporarily exclude PHS. More time is needed to carefully consider and work through these concerns. We appreciate the dialogue and engagement with OHCA and HCAI staff and are hopeful we can find a resolution that will result in meaningful and accurate conclusions.

Thank you for your consideration and partnership to support California's health care safety net.

Sincerely,

Erica B. Murray
President and CEO

cc: Members of the Health Care Affordability Board:

Dr. David M. Carlisle
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Dr. Donald B. Moulds
Dr. Richard Pan

Elizabeth Landsberg, Director, HCAI
Vishaal Pegany, Deputy Director, OHCA
Darci Delgado, Assistant Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom
Michelle Baass, Director, Department of Health Care Services

California Hospital Association

February 21, 2025

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

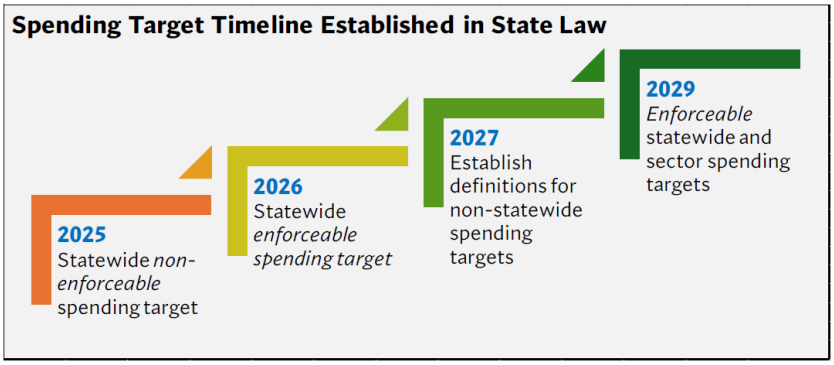
Subject: **Hospitals Oppose Flawed, Rushed Creation of Sector Targets**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson,

At its January 2025 meeting, the Office of Health Care Affordability (OHCA) board established a hospital sector and set its eye on creating a unique, lower target for purportedly "high-cost" hospitals. Not only is this conversation wholly premature, coming **three full years** before OHCA is statutorily required to develop such a target, it is also deeply flawed, ignoring critical factors relevant to understanding California's hospitals. The California Hospital Association, on behalf of more than 400 hospitals and health systems, urges the board to reconsider its approach — before patient care is irreparably damaged.

California's Hospitals Oppose the Rushed Creation of Hospital Sector Targets

OHCA's authorizing statute establishes the timeline for moving from a single statewide spending target to sector-specific targets. The statutory intent is clear: **first** make progress implementing core functions of the office, collectively learn and pursue innovative solutions, and encourage cross-sector collaboration on behalf of common goals; **then** carefully subdivide health care into sectors and explore differentiated targets. Instead, OHCA is poised to take these steps backwards by **first** targeting a single segment of the health care industry with strict spending targets, **then** looking at the data to evaluate effectiveness and



stepping back to encourage cooperation on shared objectives. This is the opposite of a sound process and ultimately will undermine OHCA's ability to fulfill its noble mission.

Sector Target Approach Is Premature. OHCA's hospital sector target proposal comes before OHCA has achieved basic prerequisites or milestones, calling into serious question whether office decisions affecting the lives and livelihoods of millions of Californians are being made with proper thoughtfulness.

- **OHCA Has Yet to Analyze or Report a Single Year of Comprehensive Spending Data.** OHCA is relying on new reporting from payers on total health care expenditures to comprehensively measure trends in health care spending. While the first two years' data have been collected, they have not been publicly analyzed or reported. As a result, OHCA currently only has preexisting datasets (designed for alternative purposes) available to inform its decisions. Unlike many other segments of the health care industry, hospitals have reported financial information to the state for decades. Now, OHCA is taking advantage of the fact that hospital financial data happens to be available to set special targets on hospitals, disregarding the opportunity to base its initial sector decisions on even a single reporting period's total health care expenditure data.
- **OHCA Has Yet to Evaluate Available Data for Any Other Potential Sector.** Making matters worse, other regulated health care entities report similar information to the state. For example, health plans — a nearly $300 billion industry in California — have publicly reported financial information for years, including on their earnings, assets, and premium growth. Long-term care facilities and clinics also report their financials to the state. OHCA could have evaluated at least other health care entities' financial information prior to proposing and making initial decisions on sector targets. It could have evaluated the 10% to 15% recent annual growth in health plan premiums, as just one example. And yet, OHCA has disregarded this information — on top of that from its forthcoming total health care expenditure data — as irrelevant to its decision making, betraying a worrying partiality and indifference to making data-informed and deliberate decisions.
- **OHCA Has Yet to Determine How Hospital Spending Will Be Measured.** OHCA has considered, but not finalized, a methodology for measuring hospital spending. Most notably, there is currently no clarity around how OHCA will measure hospital outpatient spending — one of just two major categories of hospital spending that reflects 40% of statewide hospital revenues. As such, OHCA is proposing a hospital sector target without having an established methodology for measuring historical spending trends, identifying higher-cost hospitals, estimating what a reasonable sector target would be, or informing hospitals on the types of spending they will need to limit to comply with their spending targets. This strains the credibility of both the process and any resultant rules.
- **OHCA Has Yet to Assess the Reasonableness of the Statewide Spending Target.** The timeline on Page 1 reveals the intent of state law — to learn from implementation of the statewide target before moving onto sector targets. By disregarding the statutory timeline, OHCA is ignoring any opportunity to assess whether the statewide spending target is reasonable and attainable, if it is driving improvements in affordability without sacrificing quality and equity, and how different segments of the health care industry are performing and therefore deserving of closer attention.

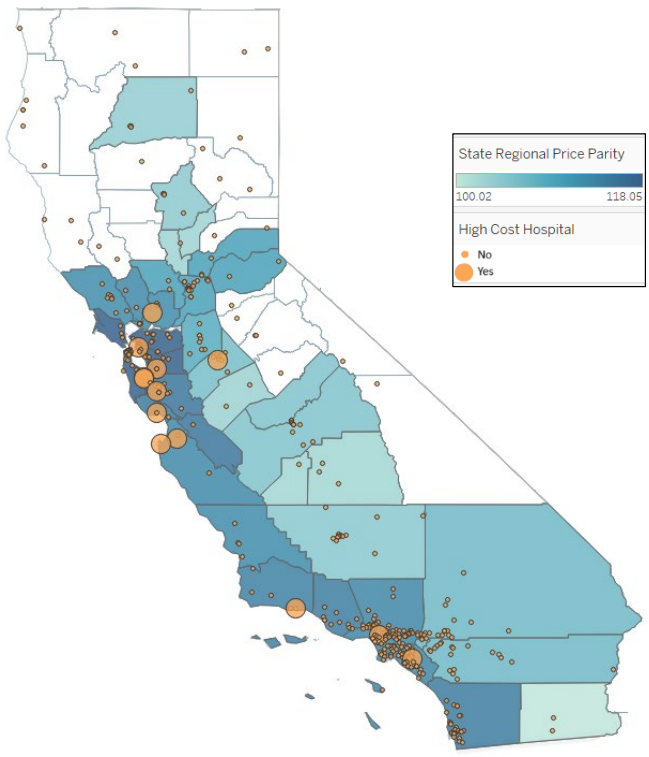
OHCA's Approach for Identifying "High-Cost" Hospitals Is Seriously Flawed

In January 2025, OHCA put forward two methods for identifying high-cost hospitals, with board members expressing interest in deeming hospitals identified by both methods as high cost and subject to lower sector targets. However, both methods — as well as the data underlying them — suffer from critical flaws that render them unsuitable for their intended purpose.

Commercial Reimbursement Measure Ignores Basic Health Care Facts Related to Hospital Finance. This measure attempts to identify which hospitals earn the most commercial revenue per discharged patient, adjusted for the expected resource-intensity of their stay — but has at least three major flaws.

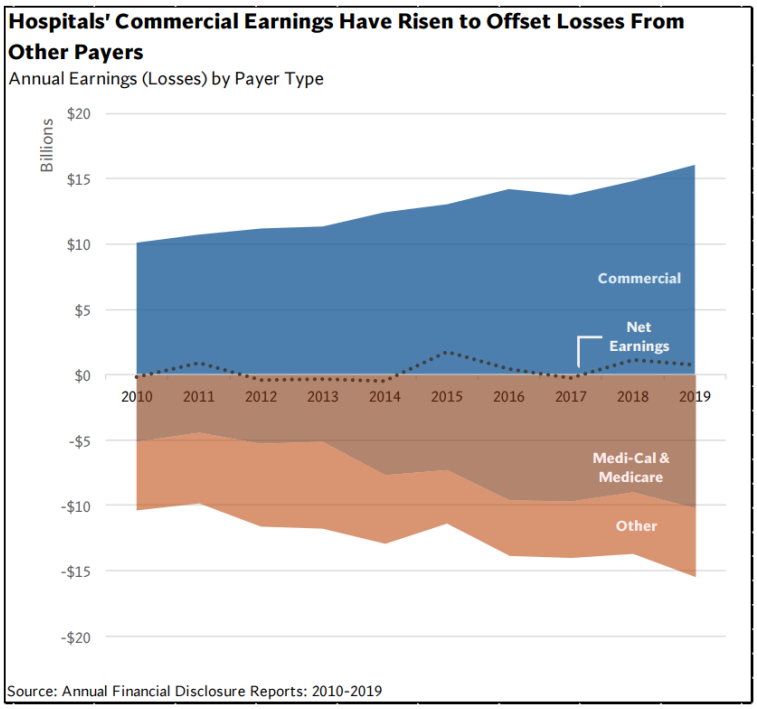
Measure Fails to Account for Underlying Differences in the Cost of Providing Patient Care. The cost of living and of doing business varies enormously throughout California. Real estate costs in the San Jose region are more than 40% higher than California overall. Median household income in the San Francisco-Bay Area is 11% higher than in the Inland Empire. These underlying economic conditions heavily influence hospitals' costs — including through higher labor, facility, and purchased services costs — and, in turn, what hospitals must charge commercial payers to remain financially sound. Predictably, 19 of the 23 hospitals in the top 20% of hospitals in terms of commercial reimbursement are located in the seven highest-cost metropolitan service areas (MSAs) in California (there are 26 MSAs in total in California). Clearly, this measure singles out hospitals in high-cost regions, penalizing them for factors beyond their control.

OHCA's High-Cost Hospitals Are Predominantly Located in Areas With High Costs of Living

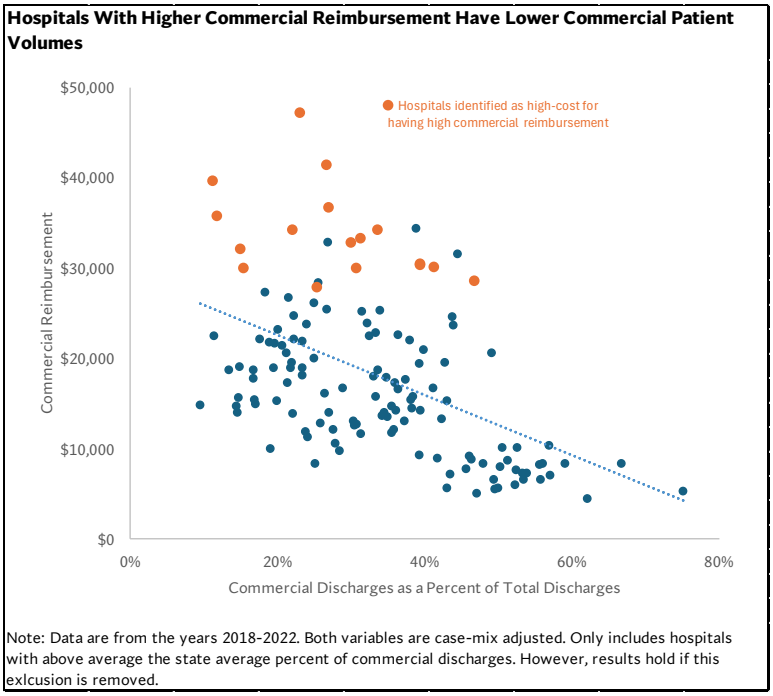


Regional price parity is a price index that compares price levels across different regions of the United States

Measure Does Not Control for Payer Mix. For most hospitals, commercial insurers are the only payers that pay above cost. As the figure on the top of the next page shows, statewide, hospitals lose enormous sums of money caring for Medicare and Medi-Cal patients. Commercial payers increasingly make up for this shortfall, and in the end hospitals just barely break even. However, this statewide data masks enormous variability among hospitals related to the degree to which commercial payers cross-subsidize losses from government payers. Consistent with the finding that losses from government payers are shifted to higher burdens on commercial payers, CHA's January letter showed that higher commercial reimbursement



does not lead to higher operating margins for individual hospitals. Rather, higher commercial reimbursement is often canceled out by greater shortfalls in government payer revenues. The graph below provides further evidence for the cost shift (contradicting information presented to OHCA at its August 2024 board meeting), showing that hospitals with higher commercial reimbursement tend to have lower commercial patient volumes (as a percentage of total patient volume). Together, these findings show that hospitals' higher commercial rates are compensating for relatively poor payer mixes and the related shortfalls in government payer reimbursement. This cost shift is arguably a frustrating aspect of the health care system, but it is the only way hospitals — 53% of which operate at a loss — are able to keep their doors open. To level the playing field in a way that doesn't undermine patient care, government payers must pay their fair share. By identifying hospitals as high cost using this measure, OHCA would effectively punish hospitals that disproportionately care for elderly patients on Medicare and low-income and disabled patients on Medi-Cal.



Measure Ignores 40% of the Services Hospitals Provide. Hospitals provide a mix of inpatient and outpatient services; the latter include emergency department visits and a wide variety of non-emergency hospital outpatient services. By ignoring outpatient services, this measure fails to incorporate any information on 40% of a typical hospital's service mix in determining whether it is high cost, and therefore risks targeting hospitals that cross-subsidize relatively unprofitable outpatient services with relatively profitable inpatient services.

As a result of these and other flaws, 10 out of the 23 hospitals identified by this measure as high cost had negative average operating margins over the same five-year period (2018-22)

that OHCA analyzed. Subjecting such hospitals to a reduced, high-cost hospital spending target would jeopardize this group's financial stability even more.

Relative Commercial-to-Medicare Payment-to-Cost Ratio Has Irredeemable Flaws. The second measure OHCA intends to use to identify high-cost hospitals compares the degree to which a hospital's commercial payments cover their costs better than its Medicare payments do. By incorporating cost into the equation, the measure ostensibly controls for the appropriate and unavoidable variation in hospitals' operating costs. However, its validity fully depends on the accuracy and appropriateness of Medicare payment policies — a wholly unfounded assumption. In fact, just a small number of distortions in Medicare payment policies significantly and variably reduce hospitals' Medicare reimbursement. These generally result from budget neutrality requirements that mean any boost in funding for certain hospitals is offset by cuts for other hospitals. They include:

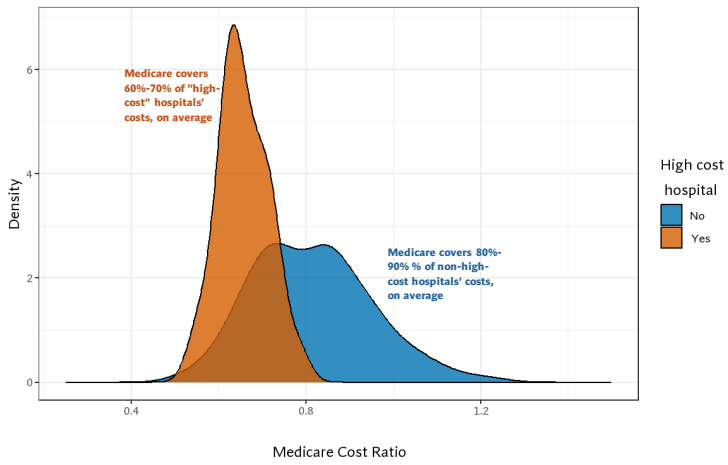
- Adjustments to the area wage index to impose a minimum score for rural hospitals and revert the occupational mix of California's hospitals to the national average
- Caps on funding for graduate medical education, disproportionate share hospital reductions, and limits on payments for bad debt

Collectively, these distortions reduce Medicare payments for California hospitals by well over $1 billion annually. However, the reductions are not borne comparably by all hospitals. Rather, hospitals identified as high cost based on their commercial-to-Medicare payment-to-cost ratios experience much higher reductions in their Medicare payments (nearly 11%) compared to other hospitals (less than 6%).

For example, Medicare graduate medical education payments are designed to cover the program's share of the cost of training new generations of health care providers. However, artificial caps put in place to restrain program spending have resulted in teaching hospitals receiving no increased funding for new physician residency positions added since 1996. This Medicare funding cap directly distorts the denominator of the commercial-to-Medicare cost ratio, since affected hospitals have a higher proportion of their Medicare expenses left unreimbursed by the Medicare program. For one hospital, this distortion is so large that it increases its commercial-to-Medicare cost ratio by an estimated 24 percentage points.

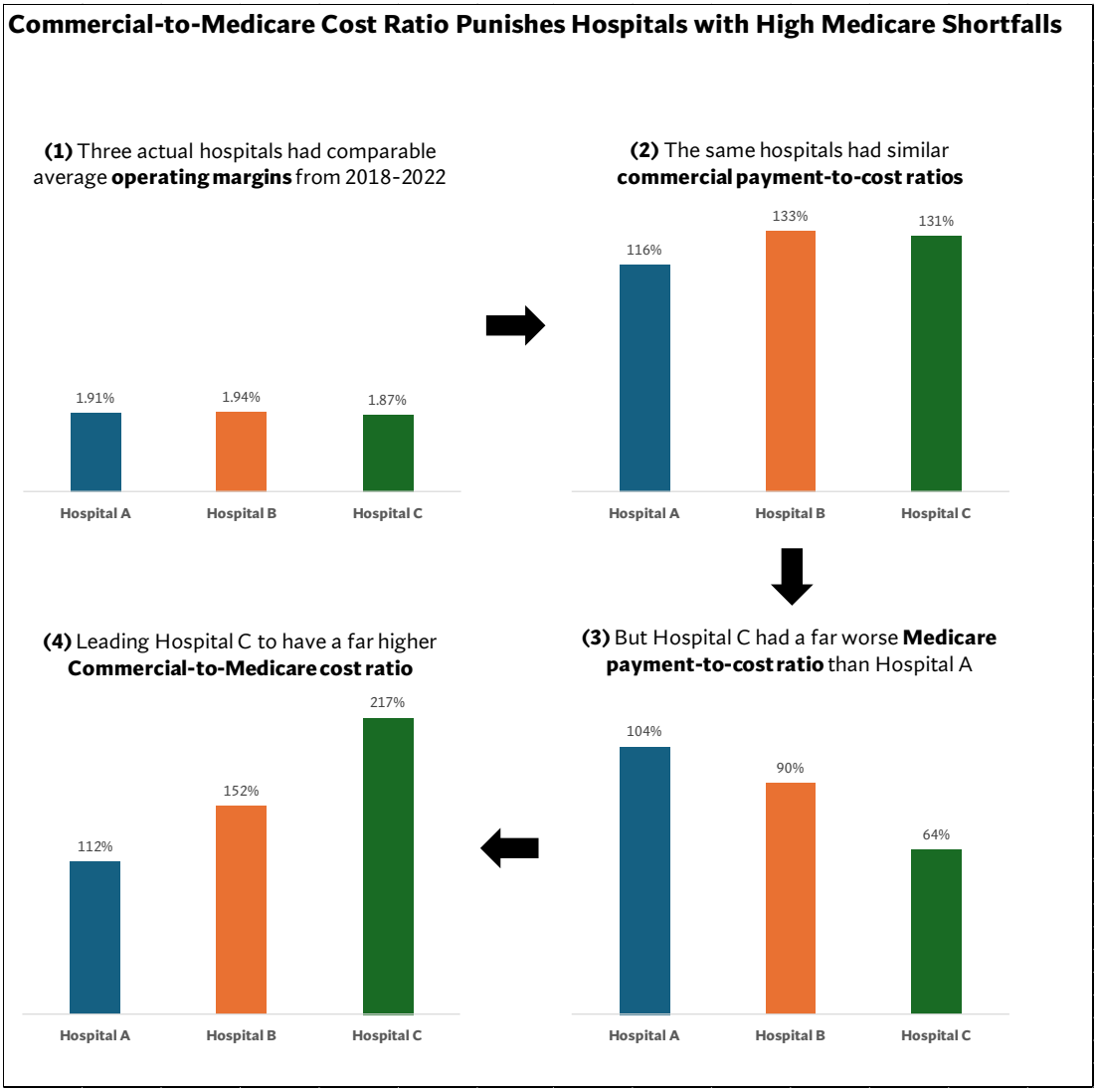
Commercial-to-Medicare Payment-to-Cost Ratio Measure Punishes Hospitals with Large Medicare Shortfalls. Using Medicare benchmarking to identify high-cost hospitals is inappropriate not only in concept but also in reality, creating concrete distortions in how hospitals are assessed under OHCA's methodologies. The figure to the right shows the key distortion for all hospitals that OHCA included in its analysis: the ratio systematically over-identifies hospitals

Commercial-to-Medicare Cost Ratio Identifies Hospitals That Have Poor Medicare Cost Coverage



Note: High-cost hospitals include the 23 identified by OHCA using the commercial-to-Medicare cost ratio. Data are from 2018-2022 with the same exlcusions used by OHCA.

whose Medicare payments fall short of their Medicare costs. High-cost hospitals on this measure are paid by Medicare at 60% to 70% of what it costs for them to care for their Medicare patients. Hospitals that are not high cost have Medicare shortfalls that are roughly half as large. The next figure further drives this home, looking at three **real** hospitals' financial metrics over the past five years. Each hospital had roughly equivalent operating margins and comparable commercial payment-to-cost ratios (the numerator in OHCA's measure). However, Hospital C had a far worse Medicare payment-to-cost ratio (the denominator in OHCA's measure), leading to a score on OHCA's commercial-to-Medicare payment-to-cost ratio of nearly double that of Hospital A and 40% **higher** than Hospital B's despite having **lower** operating margins and a **lower** commercial payment-to-cost ratio. Simply put, this OHCA measure punishes hospitals with the largest Medicare losses. Ultimately, Medicare's failure to accurately cover hospitals' variable patient care costs must not be compounded by serving as the basis for California's approach.



Combining Two Flawed Measures Does Not Address Their Underlying Issues. In January, OHCA board members expressed a preference for deeming hospitals as high cost if they are in the top 10% to 20% of all non-excluded hospitals on both of the measures previously described, commercial reimbursement and

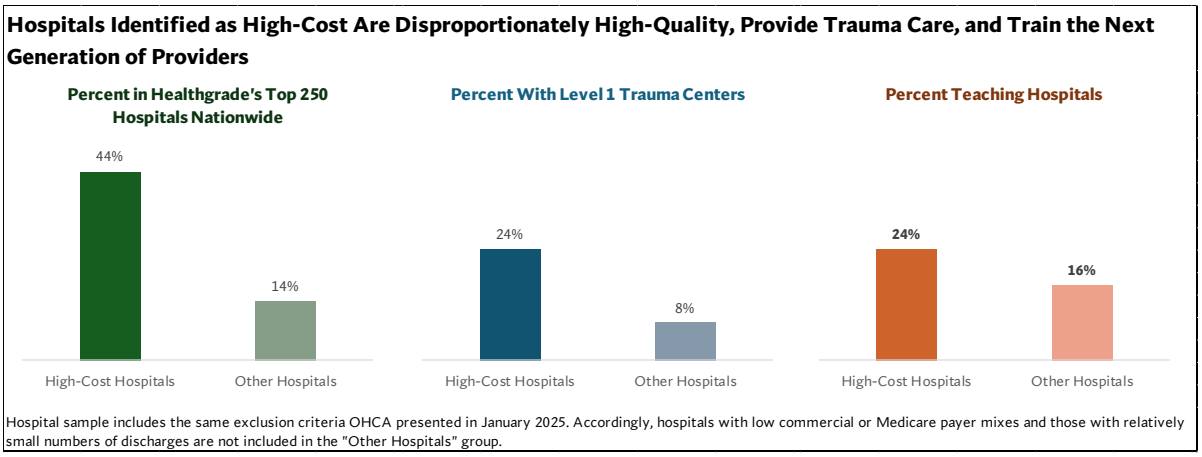
the commercial-to-Medicare payment-to-cost ratio. This approach is unsatisfactory, as the flaws in one measure do not adequately make up for those in the other. Fundamentally, the first measure fails to control for cost shifting, cross-subsidization across service lines, and differences in hospital costs. The second measure, meanwhile, largely penalizes hospitals that are forced to shift costs onto other payers due to their larger Medicare shortfalls, while failing because it benchmarks based on Medicare reimbursement policies that do not appropriately account for underlying differences in hospitals' cost of care. More work is clearly needed, not a rushed adoption of policies that will impact access to care for millions of Californians based on faulty methodologies.

Data OHCA Relies Upon for Identifying High-Cost Hospitals Paint a Limited, Inaccurate Picture. OHCA is assessing hospital financial reports from 2018-22 to determine which hospitals are high cost — but those data are extremely limited and unreliable.

- **Data Provide a Fractional View into Hospitals' and Health Systems' Overall Finances.** OHCA's methodology evaluates individual hospitals' financial data — ignoring that the majority of the state's hospitals are either part of multi-hospital systems, financially interdependent with affiliated medical groups, or both. By looking only at individual hospitals, OHCA has failed to account for the fact that, within such hospitals and health systems, a higher-earning hospital commonly cross-subsidizes unprofitable components of the system to ensure that vital patient services remain available, even if they are not financially viable. Multiple hospitals have demonstrated this essential interdependence within hospital finance in their communications to OHCA. Nevertheless, OHCA appears poised to proceed with a hospital sector target based on a partial view of hospital and health system finances. OHCA should not proceed with hospital sector targets until it properly evaluates the scope and impacts of cross-subsidization present within health systems.
- **COVID-19 Distorted Hospitals' Financials for 3 out of the 5 Years OHCA Relies Upon.** While evaluating multiple years is appropriate given shocking year-to-year volatility in these data, the period chosen raises questions because it includes the COVID-19 pandemic. The onset of the pandemic in the spring of 2020 brought with it a collapse in elective procedures and routine care, while the next two years brought waves of acutely ill patients, emergency department and inpatient overcrowding, discharge delays, and exploding costs that far outstripped any associated increases in revenues. Despite these shocks to hospital finances — clearly indicated in HCAI and other financial reporting — OHCA seeks to use data from the COVID-19 years to determine which hospitals to penalize with low sector targets.

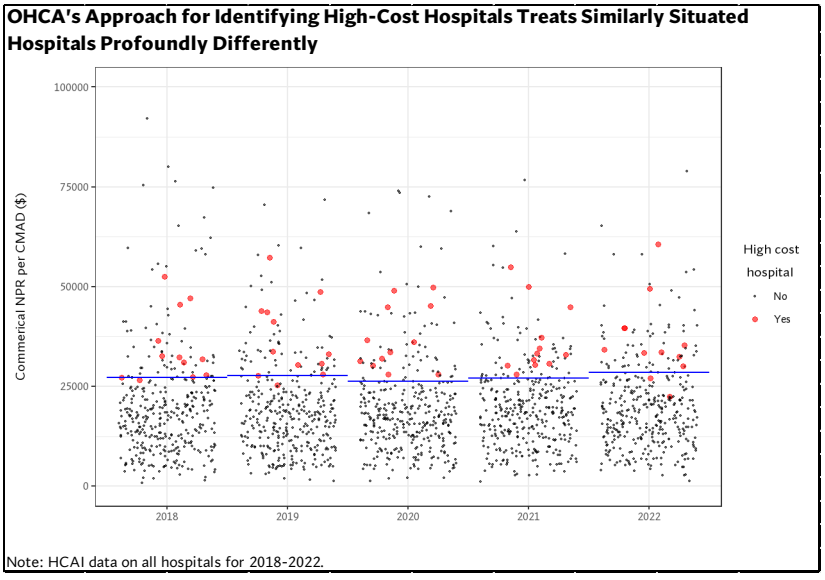
Approach Disproportionately Targets High-Quality Hospitals That Provide Complex Care and Train the Next Generation of Providers. OHCA is statutorily required to consider the quality of care a health care entity provides when considering sector targets. Yet, to date, OHCA has entirely avoided any serious analysis of hospital quality, instead simply assuming that there is no association between hospital cost and quality. However, the data simply do not bear this out. The figure below shows that 44% of the hospitals identified by OHCA as high cost are in Healthgrade's Top 250 highest quality hospitals, **nationally.** This percentage is 9 times higher than would be expected if there were no relationship

between cost and quality, as has been presented in testimony to OHCA's board. Absent a relationship, 5% of OHCA's high-cost hospitals would be predicted to fall in Healthgrade's Top 250 list. While it is clear that California's hospitals outperform other hospitals nationally in terms of being extremely high quality, the figure above also shows that OHCA's high-cost hospitals are disproportionately recognized within California for the quality of care they provide. There are other differences between OHCA's high-cost hospitals and others that also must be considered before proceeding to targets. As shown in the figure, OHCA's high-cost hospitals are 3 times as likely as other California hospitals to operate level 1 trauma centers, and disproportionately serve as major teaching centers for the next generation of providers. Ultimately, this clearly indicates that OHCA is not adequately controlling for salient differences among hospitals in its attempt to identify hospitals that are unjustifiably high cost.



Method for Distinguishing High-Cost Hospitals Would Treat Similarly Situated Hospitals Profoundly Differently. OHCA is poised to subject hospitals with similar financial metrics to profoundly different spending targets, due to the inclusion of arbitrary exclusion factors and an arbitrary cutoff value. The exclusionary factors include:

- Ignoring hospitals for which comprehensive data is not yet available in lieu of waiting, in certain instances, for these data to become available
- Removing hospitals with low commercial and Medicare payer mixes
- Eliminating hospitals with discharge numbers below the statewide average

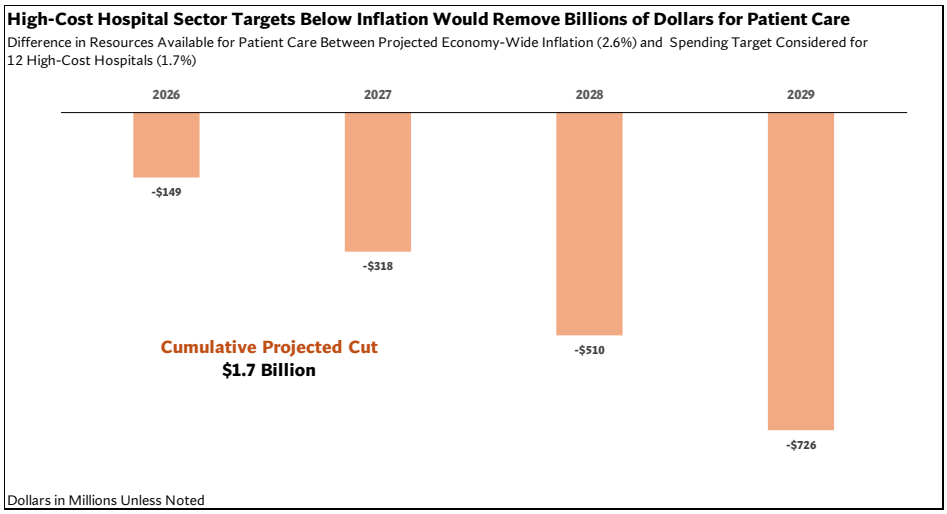


Then, OHCA deems hospitals as high cost if they are above the 80th percentile in at least 3 out of 5 years on one of two measures of costs. As the figure to the right shows, this

approach singles out a minority of hospitals above OHCA's arbitrary percentile cutoff. Moreover, using a percentile cutoff approach fails to distinguish between hospitals that are true outliers from those that merely happen to be at the top of the distribution. For methodological decisions as important as this, OHCA should show its background work, including sensitivity analyses detailing why the exact thresholds of 80% and 3 out of 5 are deemed appropriate.

Sector Target Values Under Consideration Would Threaten Hospitals' Capacity to Provide High-Quality Care

Sub-Inflationary Targets Would Decimate Hospitals' Ability to Sustain Services and Their Workforces. OHCA presented sector spending target options of between 1.7% and 1.9% for hospitals designated as high cost. Such low potential spending targets would predictably and unacceptably endanger patient care. They are as low as 35% below projected inflation for all goods and services, therefore reflecting a real cut in resources. Affected hospitals would not be able to sustain their workforces, afford drugs and supplies, maintain their facilities, or continue to financially support essential community services and quality improvement activities that lose money every day but are critical to supporting their communities' well-being. In fact, even the above inflationary comparison understates the draconian implications of the presented sector target values given recent growth in the costs of fundamental inputs into patient care. A recent analysis of financial data for hospitals in the western United States showed that costs are currently growing at 6% for labor, 8% for supplies like personal protective equipment, and 10% for drugs. A 1.7% target is 70% to 80% lower than the recent cost growth for these essential inputs — demonstrating a complete lack of sustainability in the high-cost sector targets OHCA is considering.



Sector Targets Would Further Destabilize Already Struggling Hospitals. Of the 34 hospitals identified as high cost by OHCA on either of its measures, 13 (almost 40%) lost money on their operations over the five-year period OHCA analyzed. Even when limited to the 12 hospitals identified by both measures as high cost, three (25%) lost money on their operations. Imposing a drastically deficient sector target on these struggling hospitals would endanger their ability to sustain their services, jeopardizing life-saving care for the patients that rely on them.

OHCA Risks Compounding the Harms of Federal Efforts to Defund California's Health Care System

Federal policymakers are currently considering proposals to drastically cut funding for vital health care programs. Particularly at risk is the Medicaid program and enhanced premium support for those with individual market coverage. California's health care programs are especially vulnerable. Medi-Cal covers nearly 15 million Californians (more than a third of the state's population) and is sustained by $118 billion in federal funding. The cuts currently under consideration could remove tens of billions of dollars in federal funding from California's health care system, which the state could not backfill with given its own precarious budget situation. This means cuts to coverage, benefits, and provider rates are on the horizon, with potential to turn a merely challenging financial environment wherein more than half of California's hospitals operate in the red into a full-blown crisis. Compounding federal funding threats with unconscionably low sector targets would make it certain that hospital services would be cut, workers would be laid off, and access to care would be curtailed for millions of Californians. Making highly consequential decisions on sector spending targets prior to these potentially catastrophic federal actions would demonstrate wanton disregard for OHCA's statutory mission to sustain and promote access to high-quality, equitable care.

Support Patients, Not Insurance Company Profits

While OHCA is singling out hospitals with unattainably low sector targets at far less than general inflation, health insurance companies are increasing consumer premiums by 10% or more annually. State agencies like the California Public Employees' Retirement System (CalPERS) recently offered one of the state's highest-cost health insurance companies a premium increase 40% higher than OHCA's statewide spending target, just as OHCA appears poised to impose spending targets on select hospitals that are roughly 50% lower than the statewide target. Furthermore, OHCA has provided no assurance that any lower spending targets imposed on hospitals would be passed to consumers in the form of lower premiums and cost sharing, rather than simply being retained by payers as higher profits. No commensurate adjustments to payers' targets are being considered, leaving it unclear who will benefit from OHCA's targeting of a small set of providers. Before proceeding, OHCA should clearly state why it is not striving to ensure any strict targets on providers translate into savings for the California residents who pay billions of dollars in premiums to health insurance companies every year.

Conclusion

Hospitals Recommend an Alternative Path for OHCA: A Sound Process to Ensure Buy-In and Avoid Catastrophic Consequences for Patients. California's hospitals are deeply concerned that OHCA's rush to adopt sector targets has failed to follow a sound process or allowed due consideration of relevant factors and stakeholder input. Ultimately, these failures undermine the office's credibility, making the achievement of OHCA's broadly shared goals only more challenging. California's hospitals recommend an alternative path:

- Review total health care expenditure data first so that the office's decisions are informed by comprehensive spending data itself

- Learn from early implementation and develop policies accordingly, rather than setting sector targets three years ahead of schedule
- Inform regulated entities of how to conform with state rules prior to setting stringent targets, so they may better comply with their unique sector targets
- Evaluate the potential unintended consequences of its policies before imposing them, so that patients are not hurt by the imposition of ill-conceived policies

Ultimately, hospitals ask for a sound process, deliberation that incorporates the voices of regulated entities, and judicious and well-considered decisions that demonstrate deep understanding of the health care system. The process for setting sector targets has not met these basic standards to date, but there still is time for OHCA to reverse course and improve the process through which it decides the fate of millions of Californians.

California's hospitals appreciate the opportunity to comment and look forward to continued engagement to improve OHCA's approach so that it best serves Californians.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency

February 21, 2025

VIA U.S. MAIL & EMAIL
Members of the Health Care Affordability Board
2020 West El Camino Avenue
Sacramento, CA 95833

Subject: Appreciation for Discussion and Further Concerns on Hospital Sector and Targets

Dear OHCA Board Members,

We want to express our appreciation for the recent opportunity to engage in a discussion with OHCA leadership and Secretary Johnson.

During our meeting, we presented clear and transparent information to support the following key points:

- **Salinas Valley Health is a healthcare system, not just a hospital.** A system-level approach to evaluating our audited financial data is essential to accurately understand our operational dynamics and the value we provide to the community.
- **We should not be considered an "outlier."** As demonstrated, Salinas Valley Health delivers exceptional, high-quality care to all, with reasonable consolidated system margins that enable us to sustain our community-based health mission.
- **Imminent federal policy changes could have a severe impact on already uncertain and underfunded state and federal reimbursement models.** We strongly urge OHCA to assess the implications of these shifts before imposing additional spending targets on specific hospitals, particularly those with high Medi-Cal payer mixes.

Salinas Valley Health has provided OHCA with strong evidence of our current position and our ongoing, measurable efforts to improve healthcare affordability. The stakes are high—for our organization and, most importantly, for the community we serve. Acting hastily with an imperfect process could have devastating consequences, affecting our workforce, the government-insured patient population, and the scope of quality services we provide.

We urge OHCA to prioritize accuracy over expediency and to carefully consider the short- and long-term consequences of any actions taken. We remain committed to collaborating on solutions that reflect the realities of healthcare delivery.

Respectfully submitted,

Allen Radner, MD
President/Chief Executive Officer
Salinas Valley Health

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David M. Carlisle, MD, PhD
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