OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

April 22, 2025

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Welcome, Call to Order, and Roll Call

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Agenda

Item #1 **Welcome, Call to Order, and Roll Call**
Secretary Kim Johnson, Chair

Item #2 **Executive Updates**
Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

Item #3 **Action Consent Item**
Vishaal Pegany

a) Vote to Approve March 25, 2025 Meeting Minutes

Item #4 **Action Item**

a) Vote to Establish Hospital Sector Target Methodology and Values – On or before June 1, the Board may establish a target value(s)
Vishaal Pegany

Item #5 **Informational Items**

a) Update on Measuring Hospital Outpatient Spending
Vishaal Pegany; CJ Howard, Assistant Deputy Director; Andrew Feher, Research and Analysis Group Manager; Mary Jo Condon, Freedman HealthCare

b) Follow up on Hospital Sector Target Methodology and Values including Summary of Public Comment
Vishaal Pegany; CJ Howard

c) Update on Cost and Market Impact Review Program
Sheila Tatayon, Assistant Deputy Director

d) Update on Quality and Equity Performance Measurement, including Public Comment and Advisory Committee Feedback
Margareta Brandt, Assistant Deputy Director; Janna King, Health Equity and Quality Performance Group Manager

e) Update on Behavioral Health Definition and Investment Benchmark, including Advisory Committee Feedback
Margareta Brandt; Debbie Lindes, Health Care Delivery System Group Manager

Item #6 **General Public Comment**

Item #7 **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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OHCA April 2025 Publications

- Earlier this month, OHCA posted on its website documentation on how to use the publicly available HCAI data to calculate Commercial Inpatient Net Patient Revenue per Case Mix Adjusted Discharge and Commercial to Medicare Payment to Cost Ratio.
- In addition, OHCA posted a dataset with unit and relative price measures for comparable hospitals from 2018 to 2022.

Proposed Hospital Sector Spending Target Values

In January 2025, the Health Care Affordability Board voted to establish a hospital health care sector to include hospitals defined in Health and Safety Code section 1250 et seq. All hospitals are subject to the statewide target unless and until the Board adjusts the target for all or a specified subset of hospitals within the sector.

At the February 2025 Health Care Affordability Board meeting, OHCA presented recommendations on a methodology to identify high-cost hospitals and adjust target values for those hospitals.

- The Board will have until June 1st to set sector targets for 2026 and can set targets for beyond 2026 at this time.
- A 45-day public comment window commenced on February 25th and will end on April 11, 2025.

OHCA has developed documentation to calculate Commercial Inpatient Net Patient Revenue per Case Mix Adjusted Discharge and Commercial to Medicare Payment to Cost Ratio along with other metrics to identify high-cost hospitals. In addition, OHCA shared data for all comparable hospitals from 2018 to 2022.

Facts about the Spending Target

WHAT THE SPENDING TARGET IS	WHAT THE SPENDING TARGET IS NOT
A **target** to track and evaluate the growth of health care spending.	A **price cap** or price reduction. A spending target looks forward, toward managing growth. It cannot roll back or cut prices.
A **measure of per capita growth in total medical expenses or total health care expenditures** (TME/THCE). When reported statewide, THCE is the annual sum of all health care expenditures on behalf of residents for health care services covered by public and private insurance.	A measure of **internal costs or operating expenses** of health care entities.
A **long-term framework** for industry action. Health care entities have the flexibility to manage growth in prices, volume, or both; meaning they are challenged to engage in efforts to improve affordability of health care.	A **single solution** to addressing health care affordability challenges within California. The spending target provides critical information and data to inform other OHCA policy or state initiatives to improve affordability and access.

Total medical expenses (TME) measures all payments from payers to providers for reimbursement of the cost of health care, including medical claims, pharmacy claims, and non-claims payments. Total health care expenditures (THCE) includes total medical expense plus administrative costs and profits of health insurers and health plans.

Quarterly Work Plan*

		Total Health Care Expenditures & Spending Targets	Cost and Market Impact Review (CMIR)	Promoting High Value
APRIL	Board	• Update on Measuring Hospital Outpatient Spending • Follow up on Hospital Sector Target Methodology and Values, including Summary of Public Comment • Vote to Establish Hospital Sector Target Methodology and Values (on or before June 1)	• CMIR Update	• Update on Quality and Equity Performance Measurement, including Public Comment and Advisory Committee Feedback • Update on Behavioral Health Definition and Investment Benchmark, including Advisory Committee Feedback
	AC	**No Meeting**		
		Office Plan: Submit Hospital Sector Definition Regulations to OAL		
MAY	Board	• Vote to Establish Hospital Sector Target Methodology and Values (on or before June 1) • Pharmaceutical Policy and Programs Branch Update • Baseline Report Update		• Update on Behavioral Health Definition and Investment Benchmark
	AC	**No Meeting**		
JUNE	Board	TBD	TBD	TBD
	AC	• Baseline Report Update		• Update on Behavioral Health Definition and Investment Benchmark

* Work plan is subject to change.

Future Topics Beyond June 2025

THCE & Spending Target

- Enforcement of the spending target - overview and begin discussion on reasonable factors for exceeding the target

Promoting High Value

- Approve Behavioral Health Benchmark
- Introduce Equity Adjustment and Quality Adjustment

Assessing Market Consolidation

- Update on Material Change Notices Received, Transactions Receiving Waiver or Warranting a CMIR, and Timing of Reviews for Notices and CMIRs

Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Public Comment

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Action Consent Item: Vote to Approve March 25, 2025 Meeting Minutes

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Informational Items

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Update on Measuring Hospital Outpatient Spending

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director
Mary Jo Condon, Freedman HealthCare

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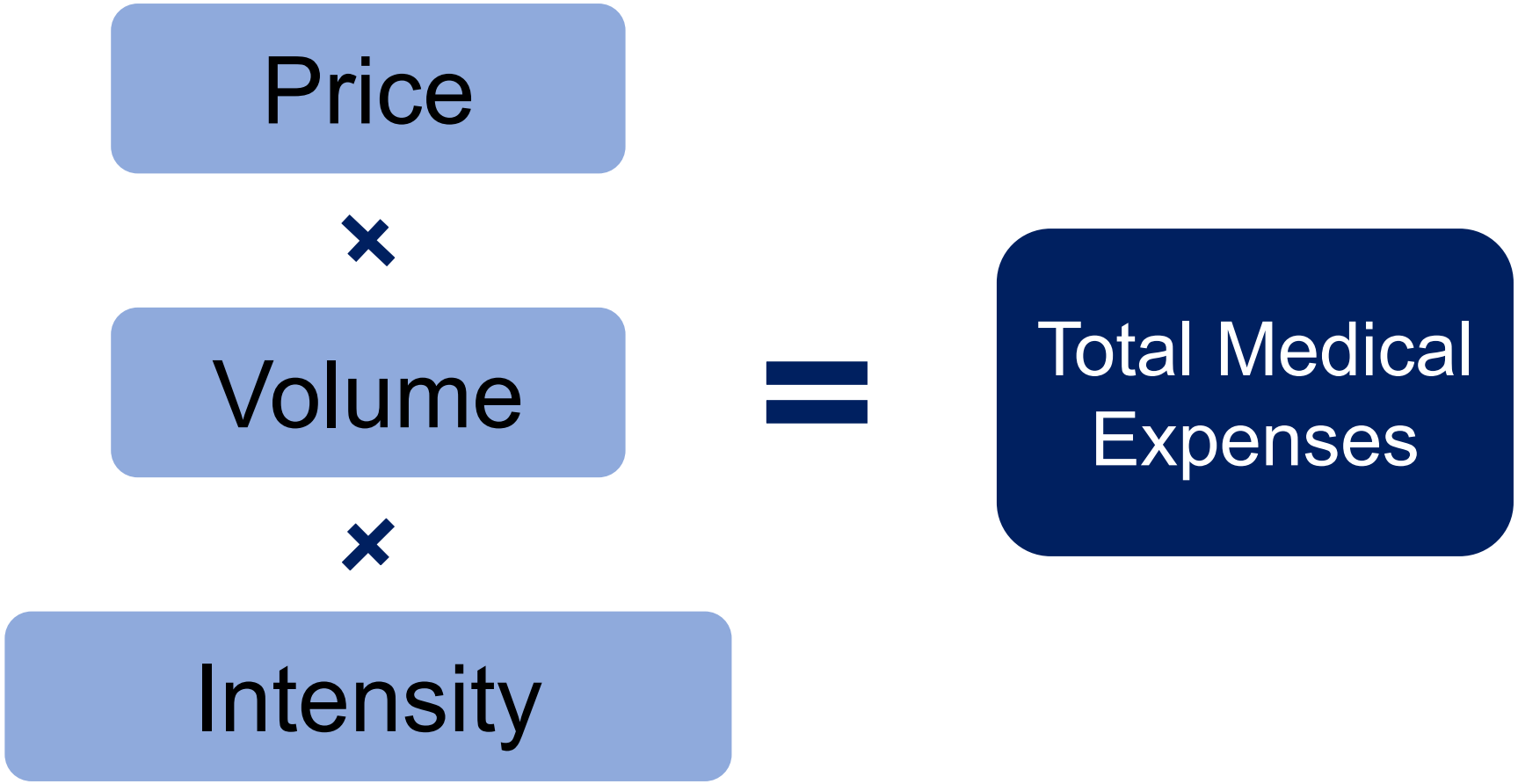
Goals for Today

1. Review OHCA's provisional approach to measuring inpatient hospital spending and how it will account for changes in **inpatient service intensity**.
2. Review OHCA's provisional approach to measuring outpatient hospital spending. Discuss options for accounting for **outpatient service intensity** including weighting methodologies and data sources.
3. Share information about what's included in the Healthcare Payments Database (HPD) to begin validating its use for this purpose.

Measuring Hospital Spending Using Hospital Revenue



Terminology: Inpatient and Outpatient Intensity

This slide defines key terminology related to measuring healthcare service complexity in inpatient and outpatient settings. Both the Case Mix Index and Outpatient Intensity Adjustment serve as indicators of the relative complexity and resource demands of the services provided.

Case Mix Index (CMI)	Measures the average severity, complexity, and resource needs of **inpatient hospital services**. Collected from the Patient Discharge Dataset.
Outpatient Intensity Adjustment (OIA)	Refers to the relative complexity and resource utilization across different types of **outpatient services**.

1. OHCA's Provisional Approach to Measuring Inpatient Hospital Spending

Applying CMI to Inpatient Discharges

Step 1

Multiply

Total inpatient discharges

x

Case Mix Index (CMI)

=

Case Mix Adjusted Discharge (CMAD)

then

Step 2

Divide

Inpatient Net Patient Revenue (NPR)

÷

Case Mix Adjusted Discharge (CMAD)

=

Inpatient NPR per CMAD

Example: Inpatient Provisional Approach

$$CMAD = Total\ inpatient\ (IP)\ discharges\ * CMI$$

*Example: 1,400 inpatient discharges * 1.25 CMI = 1,750 Case Mix Adjusted Discharges*

$$IP\ NPR\ per\ CMAD\ = \frac{IP\ NPR}{CMAD}$$

Example: $35 million Inpatient NPR÷ 1,750 CMADs
= $20,000 Inpatient NPR per CMAD

2. OHCA's Provisional Approach to Measuring Outpatient Hospital Spending

Terminology: Inpatient and Outpatient Intensity

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Today's Focus of Discussion

Provisional Measurement Approach for Outpatient Services

Based on feedback from Board meetings, OHCA has explored the Health Care Payments Database (HPD) to develop a measure for outpatient services.

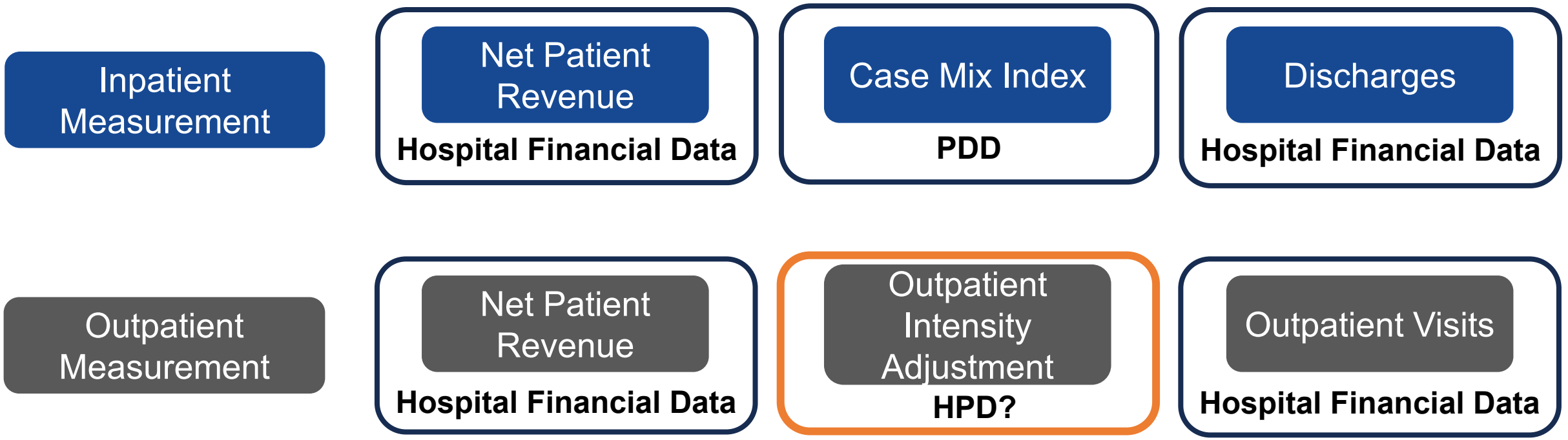
To develop an outpatient measure, claim-level information is required, collected and reported by health plans or the hospital.

A provisional hospital measurement was developed based on publicly available data. The Hospital Annual Financial Disclosure Report **(Hospital Financial Data)** and the Patient Discharge Data **(PDD)** captures the necessary information to develop an inpatient measure; however, it does not capture all the information needed to develop an outpatient measure.

The following slides outline an approach to fill that gap.

Provisional Measurement Data Sources

The HPD can be leveraged in conjunction with the Hospital Financial Data to develop a provisional outpatient measure.



Example: Outpatient Provisional Approach

$$Adjusted\ Outpatient\ Visits = Total\ outpatient\ (OP)\ visits\ * OIA$$

*Example: 10,000 outpatient visits * 1.3 OIA = 13,000 Adjusted Outpatient Visits*

$$OP\ Net\ Patient\ Revenue\ (NPR)\ per Adjusted\ Outpatient\ Visits = \frac{OP\ NPR}{Adjusted\ Outpatient\ Visits}$$

Example: $6.5 million Outpatient NPR÷ 13,000 Adjusted Outpatient Visits
= $500 OP NPR per Adjusted Outpatient Visit

Outpatient Intensity Adjustment Weighting Methodology Options

Both approaches below would use established methodologies for calculating Outpatient Intensity Adjustment and use data in the Healthcare Payments Database (HPD).

OPTION 1

Ambulatory Payment Classification (APC) Weights

- Calculates the relative resource needs for hospital outpatient services under the Outpatient Prospective Payment System (OPPS)

OPTION 2

3M™ Enhanced Ambulatory Patient Grouping (EAPGs)

- EAPGs offer more granularity in measurement of intensity
- Available by payer type and referenced to a full patient population (i.e., not only Medicare)

Considerations of Methodology Options

OPTION 1

Ambulatory Payment Classification (APC) Weights

- Most efficient option for applying Medicare's APC Relative Weights
- Publicly available and maintained by Medicare
- Since the methodology is maintained by Medicare, it may not best reflect all patients/services e.g., maternity, children's hospitals
- Weights would be applied to claims in the HPD

OPTION 2

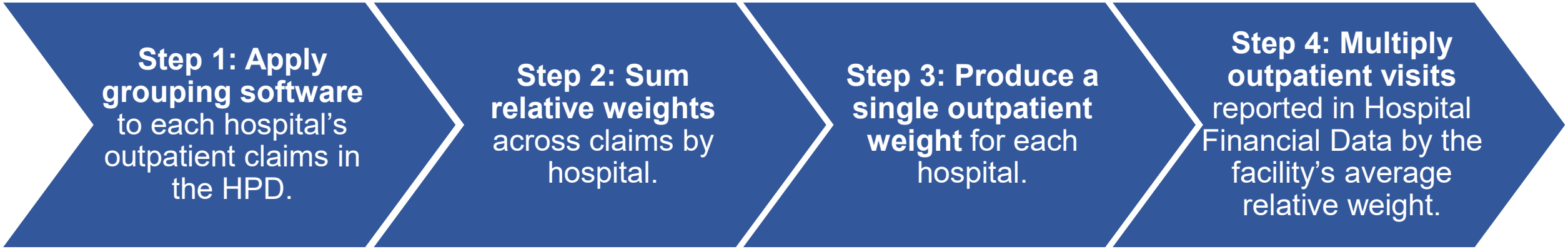
3M™ Enhanced Ambulatory Patient Grouping (EAPGs)

- Used for Medi-Cal reimbursement
- Most robust option to account for resource intensity for all patients
- Emulates payer-specific grouping, pricing and payment policy; more accurately reflects commercial plans and services
- Proprietary; less transparency than Medicare groupers
- Weights would be applied to claims in the HPD

Applying the Weighting Methodology to the Provisional Measure

Both options would use the HPD to generate an assessment of relative intensity of hospital outpatient care.

Process steps:



Applying OIA to Outpatient Services

Step 1

Multiply

Total outpatient services

x

Outpatient Intensity Adjustment (APC or EAPG weights)

=

Adjusted Outpatient Visits

then

Step 2

Divide

Outpatient NPR

÷

Adjusted Outpatient Visits

=

Outpatient NPR per Adjusted Outpatient Visit

3. Initial HPD Validation

HPD Validation Process Steps

In using the HPD we must ensure it is representative of hospital utilization. Given that we have hospital financials and inpatient case mix index (CMI) across multiple data sources, we can use these data to help validate the HPD.

Step 1: Compare Financials

- Compare overall as well as facility spending in the HPD with the HAFDR; perform correlation analysis.

Step 2: Calculate CMI in HPD

- Calculate CMIs in the HPD for Commercial, Medi-Cal and Medicare.

Step 3: Calculate CMI in PDD

- Calculate CMIs from the PDD for Commercial, Medi-Cal and Medicare.

Step 4: HPD/PDD Comparison

- Compare HPD and PDD CMIs (overall, facility-wide and by payer); perform correlation analysis.

The HPD is a Representative Sample of Hospital Utilization

- The HPD represents approximately 80% of California's healthcare experience. Specifically, the HPD includes approximately:
  - Member information for 82% of California's total population and 89% of California's insured population.
  - 90% of statewide emergency department visits.
  - 85% of inpatient admissions.
  - 76-89% of office visits.

- ***Why not 100%?*** Not all patient populations or payments are included in the HPD (e.g., self-pay, the uninsured, most of the self-insured, and smaller commercial health plans with <40k covered lives).

- Looking across four years, it also appears the data available has the same aggregate revenue and utilization trends as reported in the HCAI financials.

- ***Why does this matter?*** It helps demonstrate the HPD data is sufficiently representative of the hospital data at the aggregate level in the HCAI financials to support the use case.

Additional Analytical HPD Validation Steps

Below are additional steps that are being pursued to validate the HPD for hospital measurement purposes, e.g., that it is representative in developing an intensity adjustment.

Validation Option	Overview	Considerations
Assess the distribution of patients by sex and age group	Comparison of the completeness and representativeness of the population in the HPD	Helps identify missing populations or underrepresented groups in HPD
Assess per unit charges	Assess the consistency and reasonableness of charge data across different services, providers, and payers in the HPD	Helps assess whether HPD adequately captures variation in healthcare costs across setting

Challenges Faced by All Payer Claims Databases (APCDs)

Potential Limitations	Ways to Address
Nationally and in California, APCDs generally lack: • Care delivered to non-state residents • Care paid for by most self-funded plans • Payments outside insurance (e.g., self-pay, uninsured) • Some non-claims payments (e.g., supplemental payments, cost settlements from Medicare, and potentially capitated payments) • Payments through workers compensation, auto insurance, and other third-party liability insurance	***These limitations can be overcome with additional data sources or methodological approaches. For example:*** • Using pooled information for facilities with less data available in APCDs • Weight information to account for systematic gaps

Potential Timing of Development and Application of Outpatient Weights

April – June 2025

Apply weighting methods:

- *APC Relative Weights – April*
- *APR-DRGs & EAPGs – May to June*
- *Perform correlation and validation analyses*

March 2025

Applied CMI payer weights and performed initial HPD validation. Additional validation is in process.

July – October 2025

Hospital Payment Measurement Workgroup engagement and continued measure refinement.

Estimates assume weighting algorithms are applied to the HPD by April and reports are generated in the enclave.

Other Potential Data Sources

Outpatient Intensity Adjustment Data Source Options

Data Sources	Advantages	Drawbacks
Option A: Use existing data in the HPD	• Resource intensity calculated in a consistent manner • Leverages existing resources and requires less additional administrative burden from regulated entities	• Does not include all patients (about 80% included) • Data cannot be re-submitted or revised for past years; data is “as is” • Matching claims to individual facilities is difficult and may produce non-random discrepancies between facilities or across years
Option B: Collect new data from the commercial plans	• More likely to have grouping software and expertise than hospitals • Potential to fold into THCE and/or HPD reporting	• Will not include all patients • OHCA staff would be required to collect, validate, and compile the data for all commercial health plans (approximately 10 organizations reporting at the hospital level) • Introduces significant additional burden to submitters • Not all payers may have the ability to report desired details • Validation challenges
Option C: Collect new data from hospitals	• Offers opportunity to include all patients and would be most aligned with the financial data source • Potential to fold into hospital financial data reporting, which includes attestation to data’s accuracy	• Less likely to have grouping software and expertise • OHCA staff would be required to collect, validate, and compile the data for all hospitals (approximately 443 organizations) • Introduces significant additional burden to submitters • Not all hospital organizations may have the ability to report desired details • Validation challenges

Process Steps for New Data Collection

Below are the basic process steps that would be required for either of the new data collections discussed in Options 2 or 3. Timelines would vary based on the desired data collection method.

Step 1

Define data elements and format for collection

- Determine data submitters and identify the methods for data collection
- Develop data collection guidance to ensure consistency in reporting
- Promulgate regulations for implementation

Step 2

Implement and collect data

- Release updates and collect data from payers and/or hospitals
- Consolidate and integrate collected data into standardized formats

Step 3

Validate data and update measurement

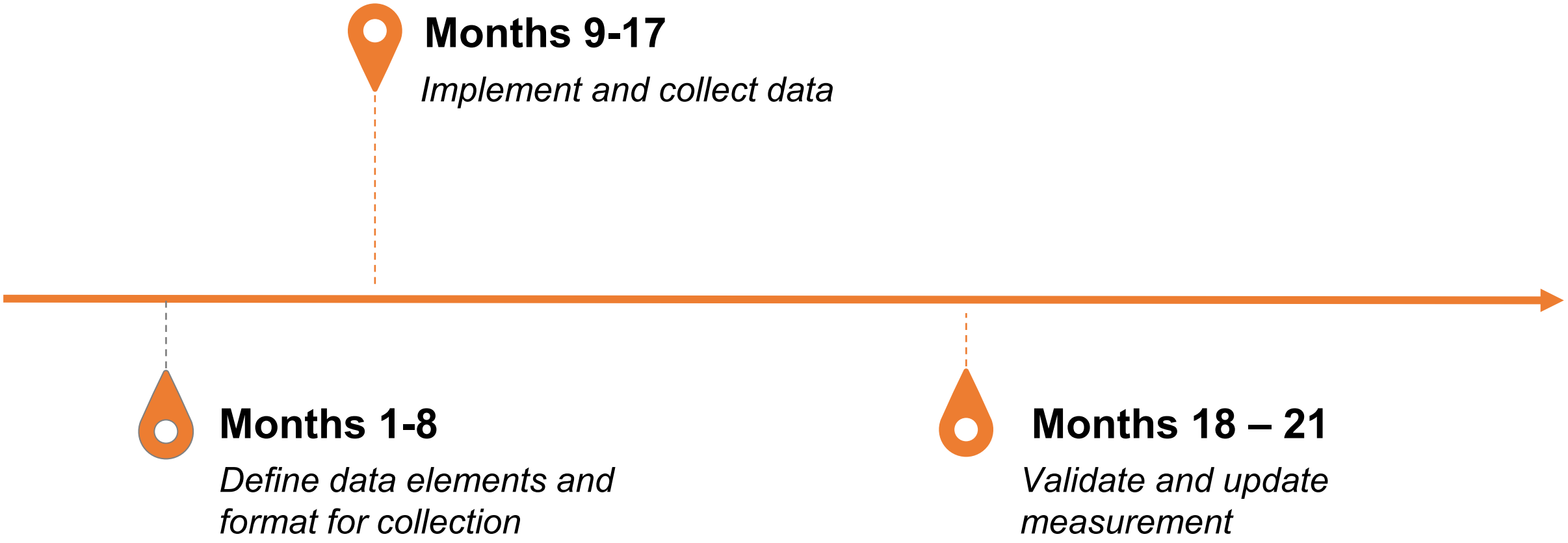
- Validate collected data with existing data, e.g. HPD or other data, to accuracy
- Use validated data to update outpatient hospital measurement

+

Ongoing infrastructure and management:

- Data collection oversight, including data aggregation, standardization and coordination with submitters
- Data validation and measurement updates
- Updates and management of the data collection process

Potential Timing of New Data Collection



Estimates assumes weighting algorithms are applied to the HPD by April 2025 and reports are generated in the enclave.

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Follow up on Hospital Sector Target Methodology and Values, including Summary of Public Comment

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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Summary of Hospital Engagement Feedback

Hospital Feedback

OHCA met with one additional hospital in April, which provided the following feedback:

- High quality surgeons and nurses command top of market wages.
- Support for case mix/acuity adjustment but note that it does not account for all elements of patient care, cost, or complexity.
- OHCA should consider a community complexity adjustment:
  - Shortages in other service areas or care settings (e.g., Skilled Nursing Facilities and Long-Term Acute Care facilities) may impact hospital costs.
  - OHCA should consider other investments that a hospital may make in expanding community care and access. (e.g., investments in home health agencies, skilled nursing, outpatient settings, physician organizations, etc.)
  - Not all entities in a region or community make commensurate investments in the regional health care infrastructure.
- OHCA should consider where an entity invests its resources, (i.e., does an entity re-invest in the local community or are revenues funneled out of state).
- OHCA should evaluate more than cost and assess the value a hospitals adds or provides to the community or region.

Summary of Public Comment

Public Comment

- OHCA received 328 public comments related to its sector target recommendation, including 247 letters from members of the public and 81 letters from organizations, groups, or health care entities.
- Comment letters came from individuals, unions, consumer advocacy groups, purchaser organizations, individual hospitals, and health plan, specialty care and hospital associations, among others.
- The summary slides that follow group the comments into these categories:
  - Timing of sector targets
  - Methodology for identifying high-cost hospitals
  - Sector target methodology and values
  - Unintended impacts to access, quality, and workforce stability
  - Costs out of hospitals' control
  - Other comments
  - Consumer impact

Note: This summary is not inclusive of all comments received. Please refer to the full set of public comment letters here: https://hcai.ca.gov/document/proposed-hospital-sector-target-values-public-comments/.

Timing of Sector Targets

CONCERNS

- Statutory deadline is not until 2027 to define initial sectors and 2028 to set sector targets. The statute allows for more time to develop sector target methodology and target.
- OHCA has yet to finalize a methodology for measuring hospital spending.
- There is a lack of historical data review with respect to the hospital measurement approach and other sectors of health care in California.
- Before defining hospital sectors, all stakeholders would benefit from a comprehensive analysis of spending across various segments of the health care industry, identification of high spending growth areas, and a meaningful assessment of spending drivers.
- OHCA needs time to study the high cost of trauma centers and the impact of operating trauma centers on hospitals' finances.
- OHCA needs time to perform analysis or review of the potential consequences of its hospital sector proposal on access, quality, equity, or workforce stability.
- OHCA should delay finalizing the hospital sector-specific targets until after both the adoption of the federal budget (for Fiscal Year 2026) and OHCA has completed an analysis of federal budget impacts on California's health care providers.
- Potential for as much as $880 billion in cuts to Medicaid that could reduce federal Medicaid eligibility or financing. OHCA should delay until the impact of federal Medicaid changes are known.

Timing of Sector Targets

SUPPORT

- Many or most of the hospitals on this list have been known as high-cost hospitals for decades. Those who counsel delay are those who profit from the existing system, not the consumers who suffer as a result of high health care costs. Consumers want change.
- Consumers are in a dire situation that demands immediate attention.
- Support using statutory flexibility for moving forward now to set lower cost growth targets for high-cost hospitals.
- OHCA's recommended pace is cautious, given the 20-year timeline for outliers' costs to align with others.
- OHCA is proposing an iterative process that can be refined over time.
- The sector target is an important first step.
- Time is of the essence to address the impact of high health care costs.
- We urge OHCA to take immediate action.
- Every day without action deepens the harm to working families, disproportionately impacting communities of color, low-income residents, and the uninsured. OHCA's mandate requires urgency.

Methodology for Identifying High-Cost Hospitals

CONCERNS

Unit Price Measure (Inpatient NPR Per CMAD)

- The Unit Price Repeat Outlier identification method can be modified to incorporate labor costs by applying the Medicare Wage Index to the calculation of Unit Price, ex:

$$\text{Unit Price} = \frac{\text{Commercial Inpatient Net Patient Revenue} * \text{Case Mix Adjusted Discharge}}{\text{Medicare Wage Index}}$$

Relative Price Measure (Commercial to Medicare Payment to Cost Ratio (PCTR))

- Medicare's area wage index, used to adjust hospital payments based on regional differences in hospitals' labor costs, fails to appropriately adjust payments based on underlying regional differences in operating costs.
- Formula to calculate Commercial to Medicare PTCR does not appropriately reflect the Medicare payment received by a hospital for a medical service in many cases. For example, structural differences between Medicare Fee for-Service (FFS) and Medicare Advantage Capitation.
- OHCA should modify the Commercial to Medicare PTCR formula to use only Medicare FFS in the denominator, rather than grouping all Medicare types together, to establish relative price. This would normalize the differences between Medicare FFS and Medicare Advantage capitation. Separating Medicare Advantage Capitation from Medicare FFS would also serve to recognize that capitated reimbursement structures lead to improved patient outcomes and reduced utilization.
- OHCA's measure for identifying high-cost hospitals singles out hospitals whose commercial payments cover their costs better than Medicare.

Methodology for Identifying High-Cost Hospitals

CONCERNS

3 out of 5 years and 2018-2022 Time Frame

- The years of 2018-2022 considered within the recommended methodology contain at least three years of financial impact from a global pandemic. The OHCA Board would be well-served by deferring their methodology adoption for a few months until the 2023 data can be included.

Discharge Threshold

- Lower discharges mean less revenue to cover the fixed costs required even for a small hospital.
- The board should consider volume data such as average daily census or discharges to evaluate a hospital's inclusion on the List.

Other

- 9 of the 11 hospitals were below the top 20% in all-payer reimbursement per case mix-adjusted discharge in 2022.
- Exempt safety net hospitals by increasing the commercial-payor-mix threshold to 20% or greater for hospitals to be included in the evaluation.
- Public health care systems report financials differently than private hospitals, e.g. coding practices. Public health systems also provide more complex care.
- Measuring health system revenues at individual hospital levels does not work with system financing.
- The existing list of top hospital outliers is heavily focused on Northern California facilities and it may exclude high-cost outliers in other parts of the state which should be included.

Methodology for Identifying High-Cost Hospitals

SUPPORT

- All of the data proposed to be used by OHCA for measuring very high-cost hospitals come from the financial data filed by hospitals with HCAI. Each hospital submits this data: we operate on the assumption that each hospital stands by the data they submitted.
- Beginning with high-cost outlier hospitals is aligned with affordability focus.
- High-cost hospitals are a major contributing factor to increasing health care costs in CA.
- OHCA's recommended methodology ensures hospitals on list are truly "high-cost"/outliers.
- The 11 highest cost hospitals are paid twice as much as the average CA hospital.
- None of the 11 high-cost hospitals were among the financially distressed hospitals receiving loans from HCAI.
- Employers and individual consumers pay these hospitals 4 to 8 times as much as what Medicare pays as a proportion of costs.
- We dispute the hospitals' contention that commercial payers "must" be charged more to make up for alleged shortfalls in payments from Medicare and Medi-Cal as well as to help underwrite deficits in other parts of their systems. These hospitals should find ways to decrease inefficiencies and reduce waste if they're looking for additional funds.
- These hospitals are twice as expensive as the average California hospital. It makes policy sense that the cost growth target for these hospitals would be half as high as the statewide target, which applies to all hospitals as well as all health plans, insurers and physician organizations.

Methodology for Identifying High-Cost Hospitals

SUPPORT

- Employer coverage and individual consumers pay these hospitals 4-5 times—or even 7-8 times—as much as what Medicare pays as a proportion of costs.
- When excessive amounts are paid for care at these hospitals, not only do members face staggering out-of-pocket bills but they also forgo money in wages increases.
- Monterey County, where the methodology identified two high-cost hospitals, has a rate of medical debt (6%) that is twice as high as California as a whole (3%).
- Support 0.1% or even lower for high-cost outlier hospitals.
- OHCA should use its authority to mandate detailed public reporting from these hospitals to justify cost, and impose non-compliance penalties.
- Methodology identifies the highest cost hospitals that lie at the heart of our current cost crisis.
- High-cost hospitals are being paid by employer coverage and individual consumers many times what Medicare pays.
- Focusing on high-cost hospitals is logical and impactful due to their severe impact on premiums, out-of-pocket costs, and debt.

Sector Target Methodology and Values

CONCERNS

- Target should consider/reflect inflation, demographic factors, trends in labor and tech costs, costs of new pharmaceuticals, policy changes, and upfront investments.
- The methodology does not consider payer mix.
- OHCA's commercial reimbursement measure disregards outpatient care - 40% of care hospitals provide.
- High acuity specialty hospitals have longer stays, intensive monitoring, multidisciplinary teams that cause higher per-patient costs.
- Financial estimates used in methodology do not always match actuals, skewing performance data.
- Methodology doesn't account for unique challenges that rural hospitals face.
- Specialty care hospitals should not be treated same in methodology.

Sector Target Methodology and Values

SUPPORT
• Support the proposed values and would prefer them to be lower. • Support the general direction of OHCA's approach, but emphasize the importance of a thoughtful, iterative process that can be refined over time. • OHCA's recommended methodology is transparent and relies on publicly available data reported by hospitals themselves. • Slowing hospital cost growth will also slow health plan cost growth since plans and insurers are paid administrative costs and profits as a percentage of claims paid to hospitals. • It makes sense to focus on hospital costs and to make hospitals a sector when so much of commercial coverage (40%) is spent on hospital care.

Unintended Impacts to Access, Quality, and Workforce Stability

CONCERNS

Teaching Hospitals and Physician Training

- Methodology does not address workforce training or graduate medical education and, in fact, will reduce funding for these essential programs.
- Targets would result in cuts to investments in physician training programs that have already proven to be successful.
- Teaching hospitals have higher operating costs and could shrink teaching programs to meet targets, negatively impacting workforce development.
- Hospitals will have a harder time recruiting/sustaining adequate workforce.

Cutbacks on Services

- Hospitals will have to cut back on specialty services currently offered and cut service lines that will become cost prohibitive.
- Capped growth threatens lines of business that are not financially viable such as Labor and Delivery.
- OHCA's spending target frameworks will force premature operational, financial and investment decisions impacting underserved communities.

Other

- Cost-cutting measures would happen at the patients' expense.
- Despite the clear requirements in state law that various goals for California's health care system be protected and meaningfully considered in the setting of spending targets, OHCA has performed no analysis or review of the potential consequences of its hospital sector proposal on access, quality, equity, or workforce stability.

Unintended Impacts to Access, Quality, and Workforce Stability

SUPPORT
• Consumers lack access today. • Members should not be afraid to go to the hospital out of fear they won't be able to pay the bill. • Hospital care makes up the largest portion of premiums. • Out-of-pocket costs are high for privately insured Californians with a hospital admission. • Hospital costs are the single largest reason for medical debt. • Half of California consumers report delaying/skipping care due to costs. • Costs are so great that care becomes inaccessible, and we must simply suffer through illness and injury while trying to do our already difficult jobs.

Costs Out of Hospital's Control

CONCERNS

Payer Mix and Reimbursement

- Commercial reimbursement is necessary for hospitals to be able to subsidize low Medi-Cal reimbursement.
- OHCA risks penalizing hospitals for treating disproportionate shares of low-income Medi-Cal patients and elderly Medicare patients; some hospitals have a more favorable payer mix.
- Safety net hospitals, physicians, clinics and other providers caring for Medi-Cal enrollees absorb the ongoing burden as the program continues to fall far short of reimbursing the cost of care.
- OHCA is not accounting for:
    - Each hospital's entire payer mix to ensure all hospitals are equitably profiled.
    - State/federal supplemental program payments to hospitals.

Geography

- Higher physician costs in some geographic areas compared to others.
- Commercial reimbursement measure penalizes hospitals for operating in high-cost areas and paying workers accordingly.

Costs Out of Hospital's Control

CONCERNS

Inflation and Tariffs

- Tariffs may increase cost of equipment, drugs, construction materials, electronics, etc.
- Targets are 35% below inflation, without considering potential tariffs.
- According to Kaufman Hall, western states' hospital costs are currently growing at 6% for labor, 8% for supplies like personal protective equipment, and 10% for drugs.
- Targets do not cover inflationary increases for critical supplies, pharmaceuticals, seismic compliance and state mandated wage increases.
- Spending target is well below rate of medical inflation and doesn't consider rising costs in staffing, medicine, and supplies.

Other

- Nothing seen in OHCA's methodology accounts for the COVID-19 pandemic in the analysis.
- Methodology fails to consider uncontrollable cost factors, such as 2030 seismic retrofitting, new minimum wage, as well as underfunding from Medicare/Medi-Cal.

Other Comments

CONCERNS

- The potential end result of the sector target: nearly $5 billion diverted from patient care by 2029, more than 10,000 lost jobs, and 83% of California's hospitals operating in the red.
- Basing the sector target solely on historical growth in household income is overly narrow and fails to account for multiple factors that impact health care spending.
- This spending target will significantly impact planned investment projects.
- Uncertainty at the federal level could result in cuts to eligibility and funding for Medicare and Medicaid.

Other Comments

SUPPORT

- Many hospitals have already provided examples of projects they plan to begin to meet OHCA's goals.
- Hospitals should find ways to decrease inefficiencies and reduce waste if they're looking for additional funds to cover shortfalls.

Consumer Impact

CONCERNS
• OHCA's attempt to cut health care costs will cause a loss of health care access. • Consider patients' perspective and not implement the cap as proposed without further and more thorough investigation. • OHCA's actions could peel away resources and force changes that could lessen the quality of care, especially when research and healthcare seem to be under attack.

Consumer Impact

SUPPORT

- Comment about the emotional and financial injustice of a $5,000 bill after two hours at the emergency room for shingles and the need for a fair price for health care access.
- Comment that so many people live with health issues rather than seeking treatment. Health care should not be something to be afraid of, and it should not be something only for the privileged and wealthy.
- Comment that the local but rural hospital generally charges double for the same services as the next community 45 minutes away and that many residents do not have sick leave or reliable transportation and must bear outrageous costs.
- Comment about a 123% health plan increase, resulting in canceling the plan and changing longstanding family doctors.
- Comment about Veterans benefits being gutted, the individual's elderly father being left without care for Parkinson's and not having the financial resources to make up the difference.
- Comment that going to recommended annual doctor appointments result in an overwhelming cost of bills for doing the bare minimum. They question the ability to be an educator in this area and the impact on teacher turnover and students' quality of education.
- Comment that every visit to the hospital results in a minimum payment of $100. Sometimes money is not available to pay bills and buy food. Last Christmas, there was no money to buy any presents and United Way helped pay the rent since we had to keep paying for treatments.

Consumer Impact

SUPPORT

- Comment about the constant fear of losing limited financial resources due to the greed and neglect of the wealthy and powerful while foregoing dental care, treatment for osteoarthritis, and other potentially debilitating health conditions.
- Comment that hospitals should stay within the Medicare allowable amounts when billing patients instead of gouging the people who are paying out of pocket. Excessive out of pocket expenses often result in medical bankruptcy and even homelessness.
- Comment that OHCA must work for consumers, and has the power to slow health care spending, promote high value care for consumers, and help hold the health industry accountable. Do not let health care corporations water this power down.
- Support for the Board's proposal to further cap the price increases for local hospitals…out of pocket costs used to be $0 a month and they have increased to $1500 a month.

Board Discussion History

Hospital Sector Definition and Target Setting Discussion History

The following slides are a summary of sector target discussions held over the last eight months regarding the definition of a hospital sector, as well as the development of a methodology and target values for high-cost hospitals.

In August 2024, the Health Care Affordability Board meeting was held in Monterey and focused on the high price of care in the region.

- OHCA, Covered California, and researcher Christopher Whaley presented data highlighting health care costs in California and the Monterey region. The presentation included consideration of hospital price, quality, payer-mix and market concentration.
- The Board heard from almost 100 members of the public about their experiences affording health care in the region.
- OHCA and researcher Christopher Whaley presented the Board with actions California could take to address hospital affordability concerns, as well as the tools OHCA and the Board have to address affordability, specifically for hospitals.

Hospital Sector Definition and Target Setting Discussion History

In October 2024, the Board discussed the statutory options to potentially address the high cost of care in Monterey County that various stakeholders highlighted in the August meeting.

- The Board urged the Office to provide options to address to high-cost hospitals as quickly as possible through sector targets.
- The Board asked the Office to provide options that broadened the scope to include all hospitals in California, as well as options that narrowly focused on Monterey County.

Hospital Sector Definition and Target Setting Discussion History

In November 2024, the Board discussed potential attributes of facilities that may warrant special consideration when establishing a sector and sector target for disproportionately high-cost hospitals.

The attributes discussed included: Critical Access, Small, Psychiatric, Children's, Teaching/Academic Medical Center, Specialty, State, County, and Long-Term Stay.

Board members broadly suggested that few of these attributes may warrant distinct consideration, when defining a hospital sector and/or establishing sector targets for hospitals. The Board requested to review hospital data by facility attributes and several financial metrics to inform defining a hospital sector.

Hospital Sector Definition and Target Setting Discussion History

In December 2024, OHCA and the Board discussed hospital spending data, and reviewed data showing the top 30 hospitals on four measures stratified by various hospital types & characteristics.

The purpose of the discussion was to inform the Board's deliberations related to defining a hospital sector and determine if any hospital types should be excluded from a potential hospital sector definition.

Hospital Sector Definition and Target Setting Discussion History

- In December 2024, Board members suggested the following:
  - There was not a clear pattern in the data to merit: narrowly defining a subset of hospitals as a sector, creating multiple hospital sectors, nor preemptively excluding any hospital type from a hospital sector definition
  - The hospital landscape in California is complex; no one attribute, or combination of attributes would merit exclusion from establishing lower target values, and all hospitals need to be evaluated.
  - The nuances of hospitals should be considered when adjusting the target of a facility.
  - Certain metrics were more informative than others when identifying high-cost hospitals that merit a different target. Specifically, metrics that show how hospitals compare on commercial prices for services.
  - A review of hospital cost metrics by county.
- Additionally, OHCA and the Board discussed options the Board had for defining sectors and establishing targets for performance year 2026. Several Board members expressed support for defining all hospitals as a sector and adjusting the target for select high-cost hospitals.

Hospital Sector Definition and Target Setting Discussion History

In January 2025, the Board voted to define all hospitals as a sector. This enables the Board to adjust targets for facilities in the sector.

OHCA presented the Board with an initial methodology to identify high-cost hospitals that may merit lower target values. This methodology included a unit price and relative price measure. The methodology included a discharge threshold that would only qualify larger hospitals for a lower target value, precluding approximately 60% of hospitals from an adjusted target.

- Many Board members agreed that using multiple measures was an appropriate way to identify high-cost outliers that merit a lower target value.
- Members and stakeholders suggested the discharge threshold was too high and that the discharge threshold be lowered or removed to include more hospitals in this determination.

Hospital Sector Definition and Target Setting Discussion History

In February 2025, OHCA presented to the Board its recommended methodology for identifying high-cost hospitals and adjusting target values for those facilities.

The methodology recommends identifying high-cost hospitals as those that:

1. are above the 85th percentile, for three out of five years from 2018-2022, on two measures, Commercial Inpatient Net Patient Revenue (NPR) per Case Mix Adjusted Discharge (CMAD) and Commercial to Medicare Payment to Cost Ratio (PTCR)
2. have a payer-mix threshold of 5%, and
3. have comparable financial data in the HCAI Hospital Annual Disclosure Reports.

Hospital Sector Definition and Target Setting Discussion History

The methodology recommends adjusting target values for the facilities that meet the specified criteria, using the cost relativity approach of:

1. Dividing the identified high-cost hospitals' average Commercial Inpatient NPR per CMAD weighted by the number of inpatient discharges for the five-year period 2018-2022, by the outcome of all other comparable hospitals' average Commercial Inpatient NPR per CMAD weighted by the number of inpatient discharges for the five-year period.
2. Dividing the identified high-cost hospitals' average Commercial to Medicare PTCR weighted by the number of inpatient discharges for the five-year period 2018-2022, by the outcome of all other comparable hospitals' average Commercial to Medicare PTCR weighted by the number of inpatient discharges for the five-year period.
3. Averaging the outcomes from the calculations in step 1 and step 2
4. Dividing current statewide spending target by the outcome in step 3.

Proposed Hospital Sector Target Considerations

Adjust Targets for High-Cost Hospitals

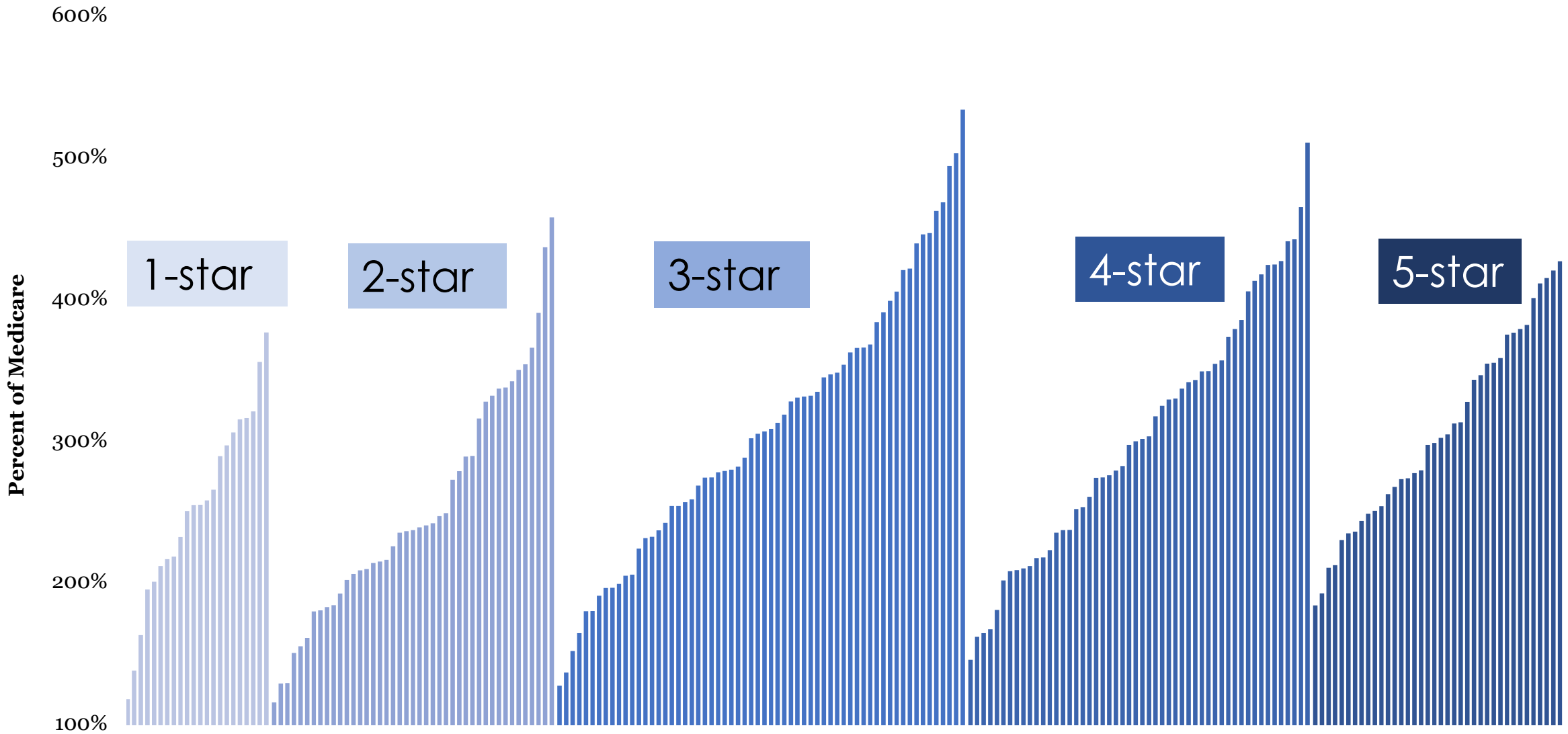
- Under the status quo, the high-cost facilities would continue to grow no more than the statewide spending target but are doing so from a higher baseline level. Further limiting the rate of growth for these hospitals would bring the costs incurred by their consumers more in line with the broader hospital sector, thereby reducing historical inequities between high-cost facilities and more cost-efficient facilities.
  - In a Board follow-up item from February 2025, OHCA presented data to show that it would take approximately 20 years for the average of the high-cost hospitals to come in line with hospitals at the 85th percentile of spending.
- A slower rate of spending growth promotes more equitable access to more affordable care for Californians.
- Rooting the adjustment methodology in the statewide target underscores the principle of consumer affordability, as the statewide target is based on median household income growth, a key metric of consumer affordability.

See appendix slides for Discussion History of the Statewide Spending Target.

Improving Affordability while Maintaining Quality of Care

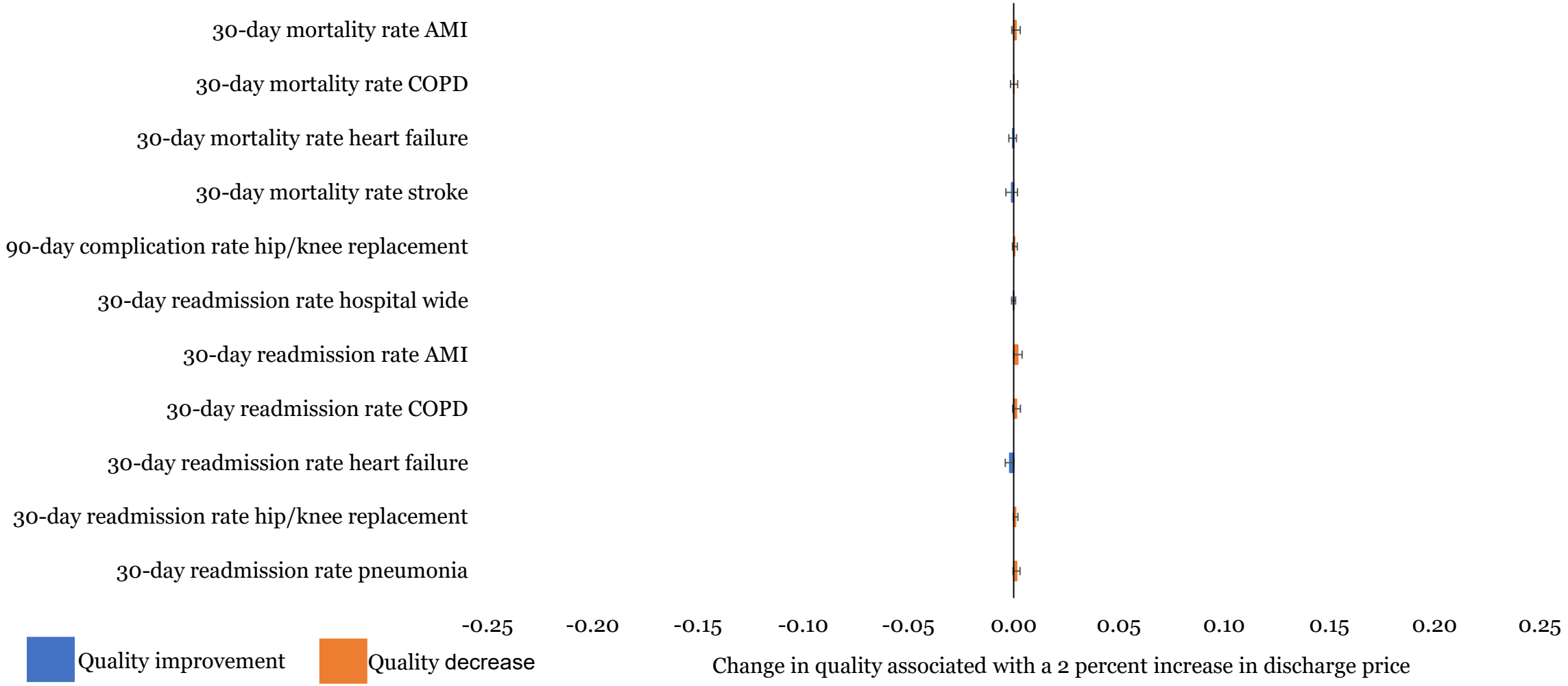
- In August 2024, Christopher Whaley presented research showing that quality is not linked to price.
- This data demonstrated that hospital prices vary widely across the state, with over five times price variation that is not attributed to higher quality care or better clinical outcomes.
- Even though some hospitals identified as high-cost in OHCA's proposal have high quality ratings, CMS star quality data suggest the same quality ratings can be achieved at a lower cost.

5x variation in California hospital prices is not linked to CMS quality stars



Source: Analysis of Prices Paid to Hospitals by Private Health Plans data. Whaley et al. 2024

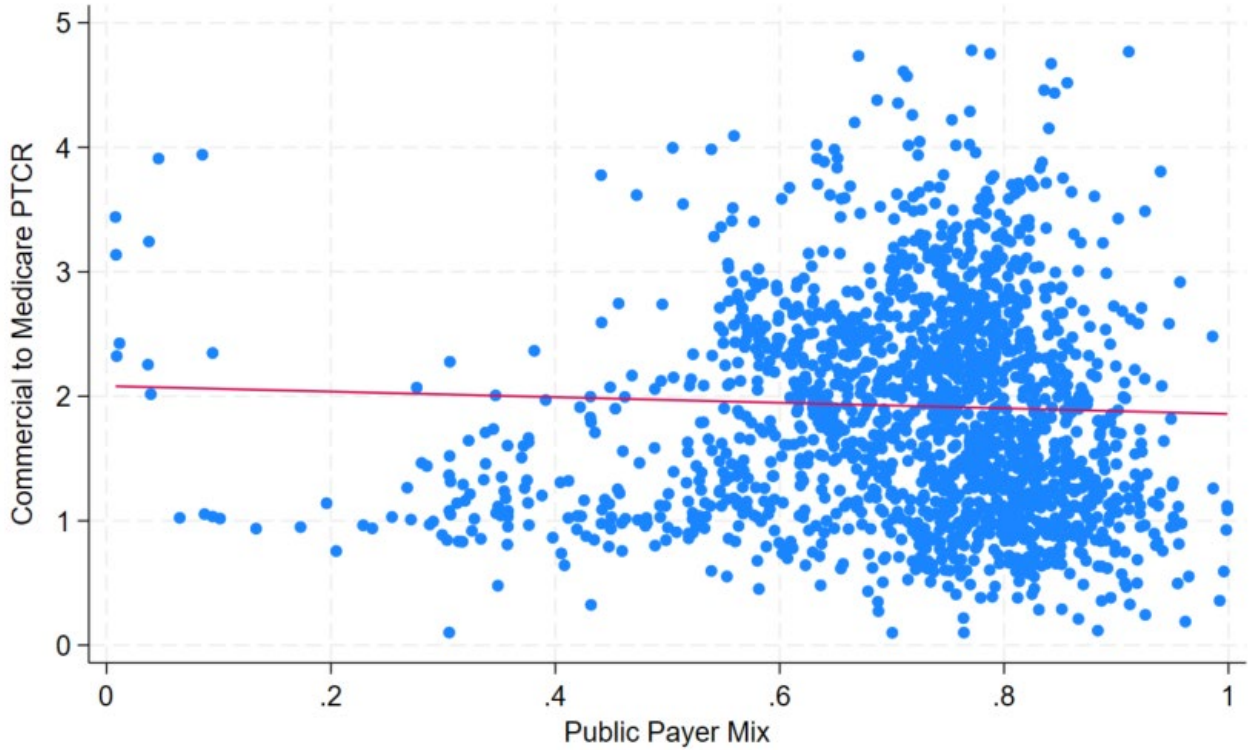
Hospital price increases don't lead to clinical quality improvements



Source: Crespin and Whaley. 2022. "The Effect of Hospital Discharge Price Increases on Publicly Reported Measures of Quality." *Health Services Research*.

Higher Public Payer Mix Does Not Explain High Relative Prices

The scatterplot shows that the share of revenue from public payers is not correlated with relative price.



Source: OHCA analysis of HCAI Annual Financial Disclosure Report data among Comparable hospitals, 2018-2022.

Workforce Stability

- The spending targets are intended to promote workforce stability by working in tandem with OHCA's workforce stability standards – a set of best practice standards for health care entities to implement. The purpose of the standards is to assist health care entities in implementing cost-reducing strategies that advance the stability of the health care workforce, and without exacerbating existing health care workforce shortages.
- Adjusting the hospital sector target promotes the use of more sustainable, cost-efficient employment, retention, and training practices in high-cost hospitals. For example, reducing costs associated with turnover and contract labor.

OHCA

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Public Comment

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Action Item: Vote to Establish Hospital Sector Target

Vishaal Pegany, Deputy Director

HCAI

Department of Health Care Access and Information

Descriptive Statistics for High-Cost Hospitals, 2018-2022

Hospital[c]	Average Licensed Beds	Average Staffed Beds	Average Inpatient Discharges	Average Discharge Percentile	Average Operating Margin[ab]	Average Commercial IP NPR per CMAD[b]	Average Commercial IP NPR per CMAD percentile[b]	Average Public Payer Mix[b]
Other Comparable Hospitals	**211**	**133**	**7,904**	**50%**	**3.69%**	**$20,191**	**48%**	**72%**
11 High-Cost Hospitals	**292**	**186**	**12,171**	**67%**	**9.60%**	**$40,247**	**92%**	**71%**
Barton Memorial Hospital	111	62	1,870	26%	7.47%	$37,954	92%	57%
Community Hospital of The Monterey Peninsula	286	203	13,674	79%	13.78%	$39,887	94%	71%
Doctors Medical Center – Modesto	461	360	24,390	95%	12.71%	$36,132	91%	82%
Dominican Hospital	222	152	10,025	68%	10.18%	$34,474	91%	75%
Goleta Valley Cottage Hospital	51	10	1,501	23%	23.11%	$32,418	88%	64%
Marshall Medical Center	117	62	4,999	50%	2.92%	$35,193	89%	79%
Northbay Medical Center	191	132	9,738	67%	1.40%	$43,072	85%	77%
Salinas Valley Memorial Hospital	263	131	10,876	70%	22.13%	$46,786	97%	72%
Santa Barbara Cottage Hospital	519	269	17,525	86%	3.62%	$32,872	89%	71%
Stanford Health Care	608	512	28,340	97%	10.30%	$51,282	98%	56%
Washington Hospital – Fremont	385	154	10,946	70%	-0.29%	$33,009	89%	72%

[a] Operating Margin is calculated as [(Total Operating Revenue – Other Operating Revenue) / (Total Operating Expenses– Other Operating Revenue) - 1].
[b] Group averages are weighted by inpatient discharges.
[c] Only comparable hospitals with at least 365 days in reporting period are included

Characteristics of High-Cost Hospitals, 2018-2022

Hospital	Critical Access*	Small**	Children's	Teaching***	Specialty	Psychiatric	State-owned	Public****	Long Stay*****
Barton Memorial Hospital	N	N	N	N	N	N	N	N	N
Community Hospital of The Monterey Peninsula	N	N	N	N	N	N	N	N	N
Doctors Medical Center – Modesto	N	N	N	N	N	N	N	N	N
Dominican Hospital	N	N	N	N	N	N	N	N	N
Goleta Valley Cottage Hospital	N	Y	N	N	N	N	N	N	N
Marshall Medical Center	N	N	N	N	N	N	N	N	N
Northbay Medical Center	N	N	N	N	N	N	N	N	N
Salinas Valley Memorial Hospital	N	N	N	N	N	N	N	N	N
Santa Barbara Cottage Hospital	N	N	N	Y	N	N	N	N	N
Stanford Health Care	N	N	N	Y	N	N	N	N	N
Washington Hospital – Fremont	N	N	N	N	N	N	N	N	N

*The critical access flag is sourced from the California Department of Public Health's list.
** The small flag is dependent on if a hospital averages less than a 100 licensed beds.
*** The teaching flag is sourced from the HADR data
**** The public flag is sourced from the California Association of Public Hospitals and Health Systems (CAPH's) member list.
***** The long stay flag is dependent upon if the average length of stay for a hospital is greater than 20 days.

Potential Adjustments to OHCA's Recommendation

Potential Options For Board Consideration

The Board has the decision-making authority to decide whether to apply lower targets and to determine the target adjustment methodology and target values.

Potential adjustments to OHCA's recommendation for **identifying high-cost hospitals**:

1. A discharge threshold that would remove smaller hospitals. In December 2024, the office presented an option to only include hospitals with above average discharges. OHCA's February 2025 recommendation removed a discharge threshold, though the Board could consider removing hospitals below a specified threshold value (e.g., 30th percentile).
2. Remove hospitals that demonstrate a decreasing trend in the unit and/or relative price metric.

Establishing a Discharge Threshold

History:

- In January 2025, OHCA presented a discharge threshold. The threshold was set to exclude hospitals that were below the statewide average number of discharges. This average is approximately equal to the 60th percentile.
- The average or 60th percentile would have removed Goleta, Barton and Marshall from the high-cost outlier list.
- The Board and advocates opposed removing 60% of the hospitals from being considered for a reduced target. A threshold was supported initially by input from the Advisory Committee to focus efforts on the larger hospitals that are bigger drivers of cost and market dynamics.

Feedback: Both the Advisory Committee as well as several hospitals suggested that hospital size should play a role in determining whether they should be subject to a reduced target.

Potential Option: The Board could impose a discharge threshold at the 30th percentile, which would remove Goleta and Barton from the high-cost outlier list.

Total Inpatient Discharge Percentiles and Hospital Size Metrics in 2022

The table below shows how different discharge thresholds correspond to different metrics of hospital size among the 366 Comparable hospitals in 2022.

	<= 10th Percentile of Discharges	< = 20th Percentile of Discharges	<= 30th Percentile of Discharges	<= 40th Percentile of Discharges	<= 50th Percentile of Discharges	> 50th Percentile of Discharges
Average # of inpatient discharges	232	455	786	1,224	1,711	13,650
Average # of licensed beds	49	58	64	78	89	333
Average # of staffed beds	32	37	39	46	51	221
Average daily census*	28	34	36	43	48	211

* Average daily census = Patient Days / Number of Days in Filing Period

Consider Recent Trend

History: A Board member asked what happens when we see an improving trend in more recent years.

Feedback: The Board could remove hospitals that demonstrate an improving trend in the more recent years from the high-cost hospitals.

Potential Option: The Board could exclude high-cost hospitals that have decreasing values for two consecutive years on the Commercial Inpatient NPR per CMAD and Commercial to Medicare PTCR measures, which results in the hospital falling below the 85th percentile in the most recent reporting year.

Commercial Inpatient NPR per CMAD for Repeat Outlier Hospitals, 2018-2022

Discharge Trend above 85%

Hospital	2018	2019	2020	2021	2022	Pooled Avg 2018-22
All Other Comparable Hospitals	**$19.9K**	**$19.6K**	**$20.0K**	**$20.3K**	**$21.0K**	**$20.2K**
11 High-Cost Hospitals	**$37.8K**	**$40.8K**	**$41.0K**	**$40.2K**	**$41.5K**	**$40.2K**
Barton Memorial Hospital	$44,175	$37,411	$39,998	$33,344	$34,843	$38.4K
Community Hospital of The Monterey Peninsula	$32,729	$41,866	$42,292	$43,655	$38,891	$39.9K
Doctors Medical Center – Modesto	$27,288	$40,915	$35,947	$36,831	$39,679	$36.0K
Dominican Hospital	$37,237	$33,720	$33,201	$34,923	$33,291	$34.5K
Goleta Valley Cottage Hospital	$29,669	$30,225	$31,738	$35,619	$34,842	$31.9K
Marshall Medical Center	$37,593	$37,125	$40,612	$31,305	$29,328	$35.5K
Northbay Medical Center	$56,414	$59,246	$53,057	$24,582	$22,062	$42.8K
Salinas Valley Memorial Hospital	$46,937	$43,061	$44,748	$50,400	$48,784	$46.7K
Santa Barbara Cottage Hospital	$31,185	$30,325	$36,617	$32,636	$33,596	$32.8K
Stanford Health Care	$47,705	$47,374	$49,091	$53,366	$58,873	$51.5K
Washington Hospital – Fremont	$32,200	$33,404	$30,929	$33,082	$35,432	$32.9K

Commercial to Medicare Payment to Cost Ratio for Repeat Outlier Hospitals, 2018-2022

Discharge
Trend
above 85%

Hospital	2018	2019	2020	2021	2022	Pooled Avg 2018-22
All Other Comparable Hospitals	**202%**	**199%**	**200%**	**190%**	**197%**	**200%**
11 High-Cost Hospitals	**328%**	**365%**	**356%**	**344%**	**352%**	**350%**
Barton Memorial Hospital	409%	888%	981%	776%	942%	773%
Community Hospital of The Monterey Peninsula	239%	436%	352%	362%	369%	353%
Doctors Medical Center - Modesto	325%	371%	341%	324%	371%	347%
Dominican Hospital	355%	313%	336%	315%	333%	331%
Goleta Valley Cottage Hospital	368%	391%	398%	370%	384%	383%
Marshall Medical Center	266%	302%	306%	297%	267%	288%
Northbay Medical Center	396%	290%	329%	174%	165%	269%
Salinas Valley Memorial Hospital	405%	457%	461%	556%	501%	475%
Santa Barbara Cottage Hospital	293%	300%	310%	310%	311%	305%
Stanford Health Care	328%	336%	341%	351%	340%	340%
Washington Hospital - Fremont	349%	394%	353%	329%	364%	359%

Draft Motions

Draft Motion 1 to Define High-Cost Hospitals and Adjust Target Values

1. Set the hospital sector spending target equal to the statewide spending target;
2. Identify Barton Memorial Hospital, Community Hospital of the Monterey Peninsula, Doctors Medical Center- Modesto, Dominican Hospital, Goleta Valley Cottage Hospital, Marshall Medical Center, Northbay Medical Center, Salinas Valley Memorial Hospital, Santa Barbara Cottage Hospital, Stanford Health Care and Washington Hospital-Fremont as high-cost hospitals as they are above the 85th percentile for three out of five years from 2018-2022 on Commercial Inpatient NPR per CMAD and Commercial to Medicare PTCR, that have a payer mix threshold of 5%, and defined as having comparable financial data in the HCAI Hospital Annual Disclosure Reports; and
3. Adjust the spending target value for high-cost hospitals by dividing the statewide spending target by the average of the high-cost facilities' cost relativity values on Inpatient NPR per CMAD and Commercial to Medicare PTCR which equates to 1.8% in 2026, 1.7% in 2027 and 2028, and 1.6% in 2029.

Draft Motion 1: Adjusting the Target Value for the 11 Identified High-Cost Hospitals

Weighted Average Commercial Inpatient NPR per CMAD of High-Cost Hospitals (A)	Weighted Avg Commercial Inpatient NPR per CMAD All Other Hospitals (B)	Commercial Inpatient NPR Per CMAD Cost Relativity (C)=(A/B)	Combined Cost Relativity (G)=(C+F)/2	Statewide Spending Target for each performance year (H)		Recommended High-Cost Target Values by performance year (I)=(H/G)
$40,200	$20,200	2.0	1.9	2026	3.5%	1.8%
Weighted Average Commercial to Medicare Payment to Cost Ratio(PCTR) of High-Cost Hospitals (D)	Weighted Average Commercial to Medicare PTCR All Other Hospitals (E)	PTCR Cost Relativity (F)=(D/E)		2027 & 2028	3.2%	1.7%
350%	200%	1.8		2029	3.0%	1.6%

Draft Motion 1: Target Values for High-Cost Hospitals

Hospital*	2026	2027	2028	2029
Barton Memorial Hospital	1.8%	1.7%	1.7%	1.6%
Community Hospital of The Monterey Peninsula	1.8%	1.7%	1.7%	1.6%
Doctors Medical Center – Modesto	1.8%	1.7%	1.7%	1.6%
Dominican Hospital	1.8%	1.7%	1.7%	1.6%
Goleta Valley Cottage Hospital	1.8%	1.7%	1.7%	1.6%
Marshall Medical Center	1.8%	1.7%	1.7%	1.6%
Northbay Medical Center	1.8%	1.7%	1.7%	1.6%
Salinas Valley Memorial Hospital	1.8%	1.7%	1.7%	1.6%
Santa Barbara Cottage Hospital	1.8%	1.7%	1.7%	1.6%
Stanford Health Care	1.8%	1.7%	1.7%	1.6%
Washington Hospital – Fremont	1.8%	1.7%	1.7%	1.6%

*All other hospitals in the sector and health care entities are subject to the statewide spending target.

Draft Motion 2 to Define High-Cost Hospitals and Adjust Target Values

1. Set the hospital sector spending target equal to the statewide spending target;
2. Identify Community Hospital of the Monterey Peninsula, Doctors Medical Center- Modesto, Dominican Hospital, Marshall Medical Center, Northbay Medical Center, Salinas Valley Memorial Hospital, Stanford Health Care, Santa Barbara Cottage Hospital, and Washington Hospital- Fremont as high-cost hospitals as they are above the 85th percentile for three out of five years from 2018-2022 on Commercial Inpatient NPR per CMAD and Commercial to Medicare PTCR, are above the 30th percentile in annual discharges, have a payer mix threshold of 5%, and have comparable financial data in the HCAI Hospital Annual Disclosure Reports;
3. Exclude high-cost hospitals that have decreasing values for two consecutive years on the Commercial Inpatient NPR per CMAD and Commercial to Medicare PTCR measures, which results in the hospital falling below the 85th percentile in 2022 (therefore, Marshall Medical Center and Northbay Medical Center are excluded); and
4. Adjust the spending target value for high-cost hospitals by dividing the statewide spending target by the average of the high-cost facilities' cost relativity values on Inpatient NPR per CMAD and Commercial to Medicare PTCR which equates to 1.8% in 2026, 1.7% in 2027 and 2028, and 1.6% in 2029.

Draft Motion 2: Adjusting the Target Values for the 7 Identified High-Cost Hospitals

Weighted Average Commercial Inpatient NPR per CMAD of High-Cost Hospitals (A)	Weighted Avg Commercial Inpatient NPR per CMAD All Other Hospitals (B)	Commercial Inpatient NPR Per CMAD Cost Relativity (C)=(A/B)	Combined Cost Relativity (G)=(C+F)/2	Statewide Spending Target for each performance year (H)		Recommended High-Cost Target Values by performance year (I)=(H/G)
$40,400	$20,300	2.0	1.9	2026	3.5%	1.8%
Weighted Average Commercial to Medicare Payment to Cost Ratio(PCTR) of High-Cost Hospitals (D)	Weighted Average Commercial to Medicare PTCR All Other Hospitals (E)	PTCR Cost Relativity (F)=(D/E)		2027 & 2028	3.2%	1.7%
351%	198%	1.8		2029	3.0%	1.6%

Draft Motion 2: Target Values for High-Cost Hospitals

Hospital*	2026	2027	2028	2029
Community Hospital of The Monterey Peninsula	1.8%	1.7%	1.7%	1.6%
Doctors Medical Center – Modesto	1.8%	1.7%	1.7%	1.6%
Dominican Hospital	1.8%	1.7%	1.7%	1.6%
Salinas Valley Memorial Hospital	1.8%	1.7%	1.7%	1.6%
Santa Barbara Cottage Hospital	1.8%	1.7%	1.7%	1.6%
Stanford Health Care	1.8%	1.7%	1.7%	1.6%
Washington Hospital – Fremont	1.8%	1.7%	1.7%	1.6%

*All other hospitals in the sector and health care entities are subject to the statewide spending target.

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Public Comment

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Update on Cost and Market Impact Review Program

Sheila Tatayon, Assistant Deputy Director
OHCA Health System Compliance

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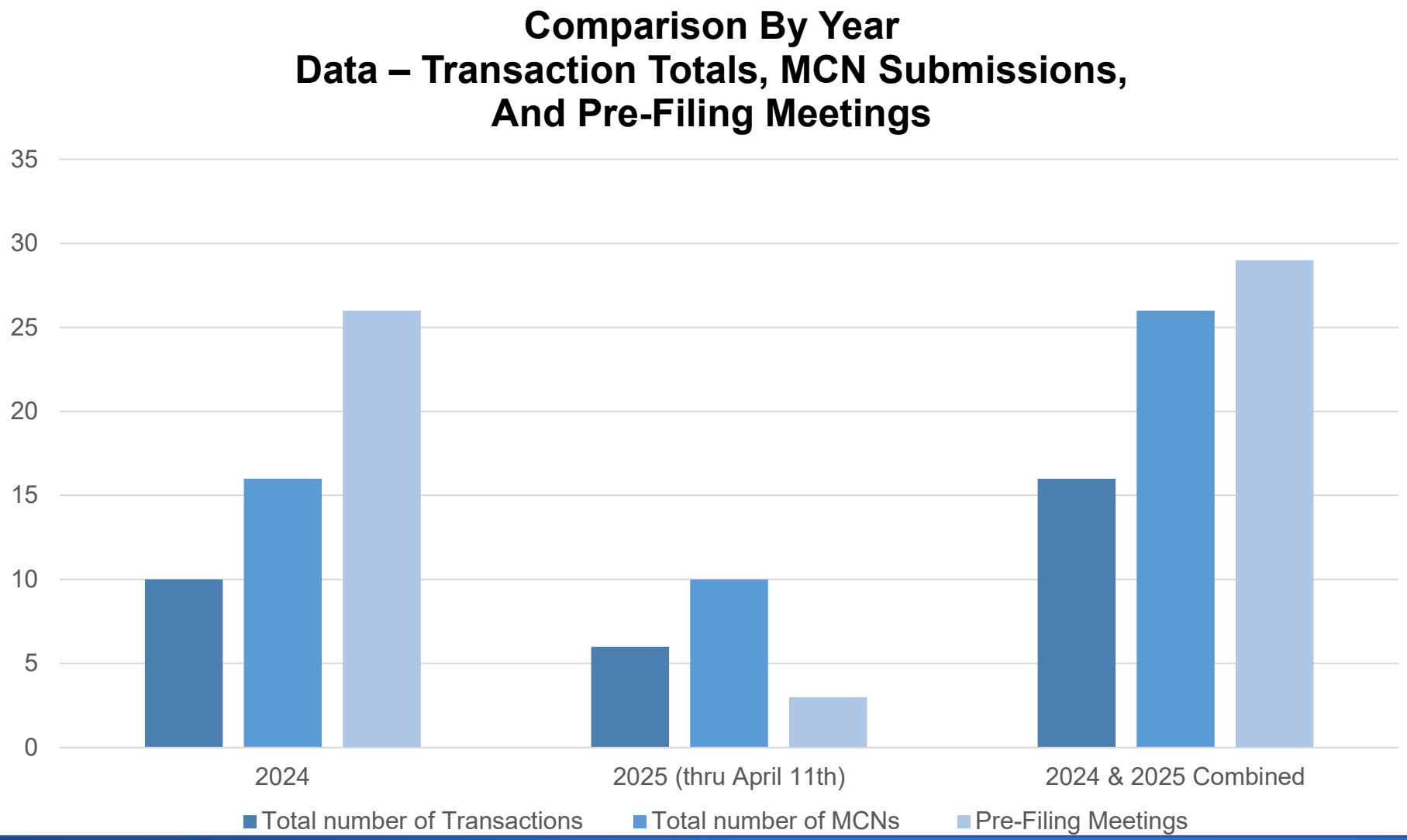
Department of Health Care Access and Information

CMIR Program April 2024 to April 2025



April 1- December 31, 2024

- 10 transactions
- 16 different MCN submissions (number of submitters per transaction varies)
- 26 Pre-Filing Meetings

January 1, 2025 - April 11, 2025

- 6 transactions
- 10 different MCN submissions
- 3 Pre-Filing Meetings

Total Transactions To Date

- 16 transactions

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CMIR Program – One Year Later, April 2024 to April 2025

Type of Transaction	Number	Percentage
Skilled Nursing Facilities (SNFs)	6	37%
Laboratories	3	19%
Physician Organizations	3	19%
Health Plans (HPs)/HPs plus Physician Organizations and/or Hospital	3	19%
Federally Qualified Health Centers (FQHCs)	1	6%
Total	**16**	**100%**

Evaluation of Transactions that May Be Subject to OHCA Review

OHCA learns of transactions that may be subject to review, but were not submitted to OHCA, through:

- Tracking of public information.
- Working with other state agencies.
- Messages from public commenters.

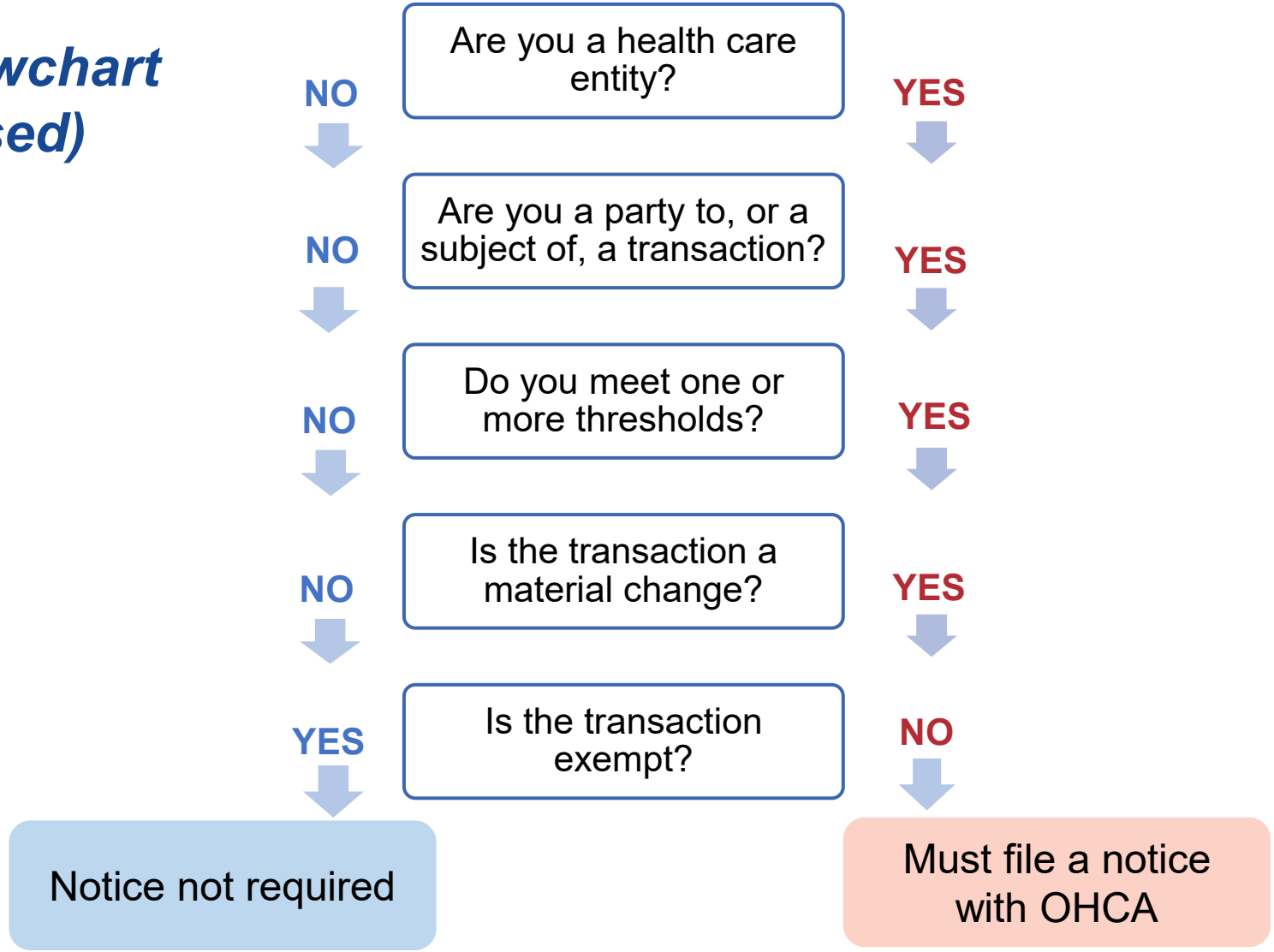
OHCA gathers information about these transactions and evaluates if they meet OHCA's reporting requirements.

- For transactions that may meet the requirements, OHCA sends letters to the parties informing them of requirements and requesting further explanation.
- OHCA has identified and evaluated 13 transactions.
- Inquiry letters for one of the identified transactions resulted in a material change notice submission, with other submissions pending.

*The public can notify OHCA of transactions via the email for OHCA's Compliance Branch: cmir@hcai.ca.gov

Do you need to file notice with OHCA?

MCN Flowchart (condensed)



See the HCAI website for FAQs.

https://hcai.ca.gov/affordability/ohca/assess-market-consolidation/mcn-cmir-faqs/

https://hcai.ca.gov/wp-content/uploads/2024/10/OHCA-MCN-Submission-Flow-Chart-2024.pdf

CMIR Program One Year Later: April 2024 to April 2025

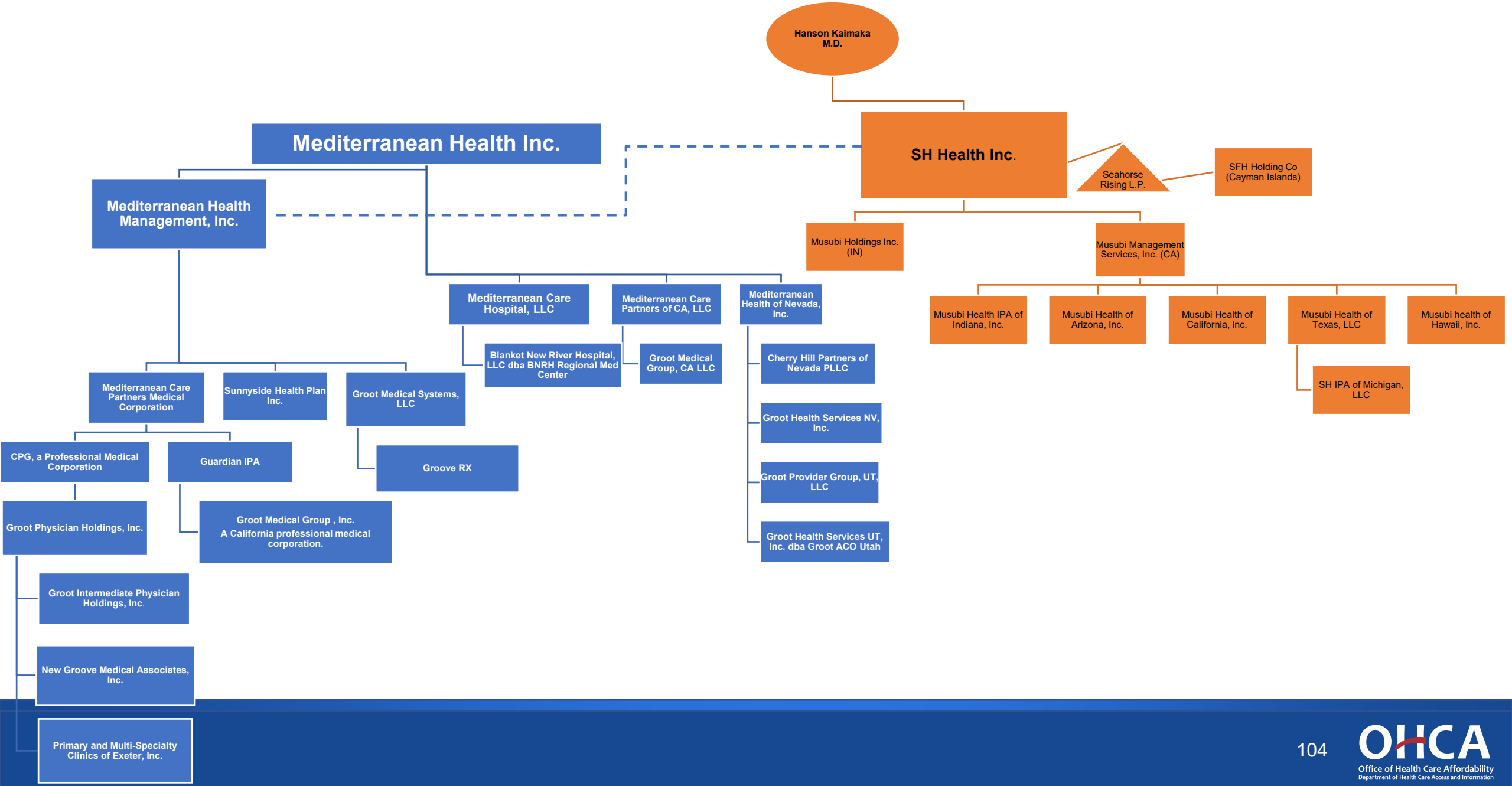
Transaction Notices are available at: https://hcai.ca.gov/affordability/ohca/assess-market-consolidation/material-change-transaction-notices-mcn-and-cost-and-market-impact-review-cmir/

OHCA issued waivers for all transactions reviewed to date.

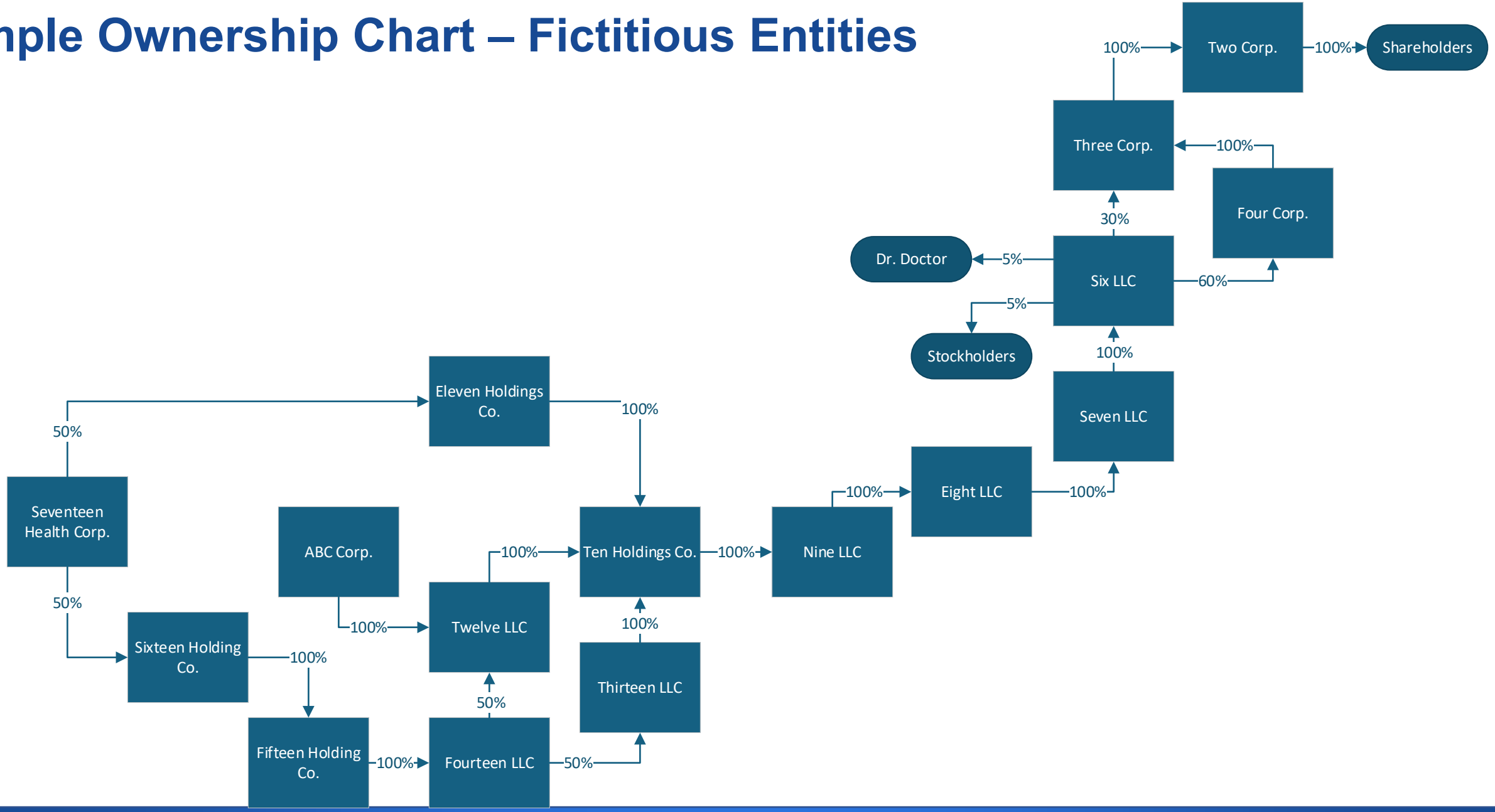
OHCA considers 9 factors in determining whether to issue a waiver or conduct a Cost and Market Impact Review for a transaction

Comparison – Massachusetts Health Policy Commission (since 2013) 180 transaction/6 Cost and Market Impact Reviews; Oregon Health Authority (March 2022) 51 transactions/5 Comprehensive Reviews

Sample Transaction Organization Chart – Fictitious Entities



Sample Ownership Chart – Fictitious Entities



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Material Change Notices Received Since January 2025

MCN Submitters	Transaction Summary	Submission Complete	Status
West Coast Hospitals, Inc.	Lazer Holdings LLC will acquire the operations of a skilled nursing facility in Santa Cruz County from West Coast Hospitals, Inc. The real estate will transfer from Coast Health Services, LLC to Freedom Propco LLC.	April 7, 2025	In Review

5 additional transactions are in review for completeness and will be posted to website once material change notices are deemed complete.

Transaction Reviews Completed Since January 2025 (Material Change Notices Submitted in December 2024)

MCN Submitters	Transaction Summary	Submission Complete	Status
CSI Medical Group, P.C.	Eric Schweiger, M.D. will acquire all of the equity interests of CSI Medical Group from Greg Morganroth, M.D.; the transaction will concurrently close with the sale of California Skin Institute Intermediate Holdings, LLC.	December 24, 2024	CMIR Waived *(February 5, 2025)*
Korean-American Medical Group, Inc and Swan Practice Holdings, P.C.	Korean-American Medical Group, Inc (KAMG), a physician-owned independent practice association, will become a subsidiary of Swan Practice Holdings, P.C. and become subject to an administrative services agreement with SMG Operating Company. KAMG's physician shareholders will also receive an indirect minority ownership interest in SMG Aggregator, LLC.	December 23, 2024	CMIR Waived *(January 23, 2025)*

Transaction Reviews Completed Since January 2025 (Material Change Notices Submitted in December 2024)

MCN Submitters	Transaction Summary	Submission Complete	Status
Ambry Genetics Corporation and Tempus AI, Inc.	Tempus AI, Inc. will acquire Ambry Genetics Corporation. Both parties previously partnered to distribute germline sequencing for inherited cancer risk and this acquisition intends to further expand inherited risk screening for cancer patients.	December 20, 2024	CMIR Waived *(January 30, 2025)*

Transaction Reviews Completed Since January 2025 (Material Change Notices Submitted in 2025)

MCN Submitters	Transaction Summary	Submission Complete	Status
Alexandria Care Center LLC	The membership interest in Alexandria Care Center LLC is being sold from Summit Care LLC to BQ Operations Holdings LLC. The leasehold interest in the facility is also being assigned to BQ Operations Holdings LLC by Summit Care LLC.	February 3, 2025	CMIR Waived *(March 14, 2025)*
Prospect Health Plan, Inc; Prospect Medical Group, Inc (on behalf of itself and its eight wholly-owned subsidiaries); Alta Newport Hospital, LLC (d/b/a Foothill Regional Medical Center; And Metropolitan IPA	Astrana Health, Inc will acquire certain assets of Prospect Health Systems including Prospect Medical Group, Inc and its eight subsidiaries, Prospect Health Plan, Inc, and Alta Newport Hospital, LLC (d/b/a Foothill Regional Medical Center).	January 28, 2025	CMIR Waived *(April 3, 2025)*

Transaction Reviews Completed Since January 2025 (Material Change Notices Submitted in 2025)

MCN Submitters	Transaction Summary	Submission Complete	Status
Agile Occupational Medicine, LLC and Kain Akeso Medical Holdings, LLC	Pursuant to a letter of intent between Agile and Kain Akeso Medical Holdings, LLC (the MSOs), the Agile business (conducted by Agile Occupational Medicine, LLC and its affiliates) intends to combine with the Akeso Occupational Health business (conducted by Kain Akeso Medical Holdings, LLC).	January 24, 2025	CMIR Waived *(March 5, 2025)*
Sharon Care Center LLC	The membership interest in Sharon Care Center LLC is being sold from Summit Care LLC to BQ Operations Holdings LLC. The leasehold interest in the facility is also being assigned to Sharon Care Center LLC by Leasehold Resource Group LLC.	January 15, 2025	CMIR Waived *(February 26, 2025)*

Transaction Reviews Completed Since January 2025 (Material Change Notices Submitted in 2025)

MCN Submitters	Transaction Summary	Submission Complete	Status
Alta Care Center LLC dba Alta Gardens Care Center	The membership interest in Alta Care Center LLC dba Alta Gardens Care Center is being sold from Summit Care LLC to Bold Quail 3 Operations Holdings LLC. The facility's real estate will be sold from Palmcrest Associates LTD L.P. to 13075 Blackbird Street Propco LLC.	January 2, 2025	CMIR Waived *(February 12, 2025)*

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Update on Quality and Equity Performance Measurement, including Public Comment and Advisory Committee Feedback

Margareta Brandt, Assistant Deputy Director

Janna King, Health Equity and Quality Performance Group Manager

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OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Adopt and track performance on a single set of standard measures for assessing health care quality and equity across payers, fully integrated delivery systems, hospitals, and physician organizations.**
- **Use recognized clinical quality, patient experience, patient safety, and utilization measures**.
- Consider available means for **reliable measurement of disparities in health care**, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.
- **Reduce administrative burden** by selecting quality and equity measures that simplify reporting and align performance measurement with other payers, programs, and state agencies, including leveraging existing voluntary and required reporting to the greatest extent possible.
- **Coordinate with the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Covered California, and CalPERS**, and consult with external quality improvement organizations and forums, payers, physicians, other providers, and consumer advocates or stakeholders.

These criteria are summarized from Article 2. Office of Health Care Affordability, Health and Safety Code § 127501-127501.12 and Article 4. Quality and Equity Performance, Health and Safety Code § 127503.

OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Promote the goal of improved affordability** for consumers and purchasers of health care, **while maintaining quality and equitable care**.
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. **The Director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.**

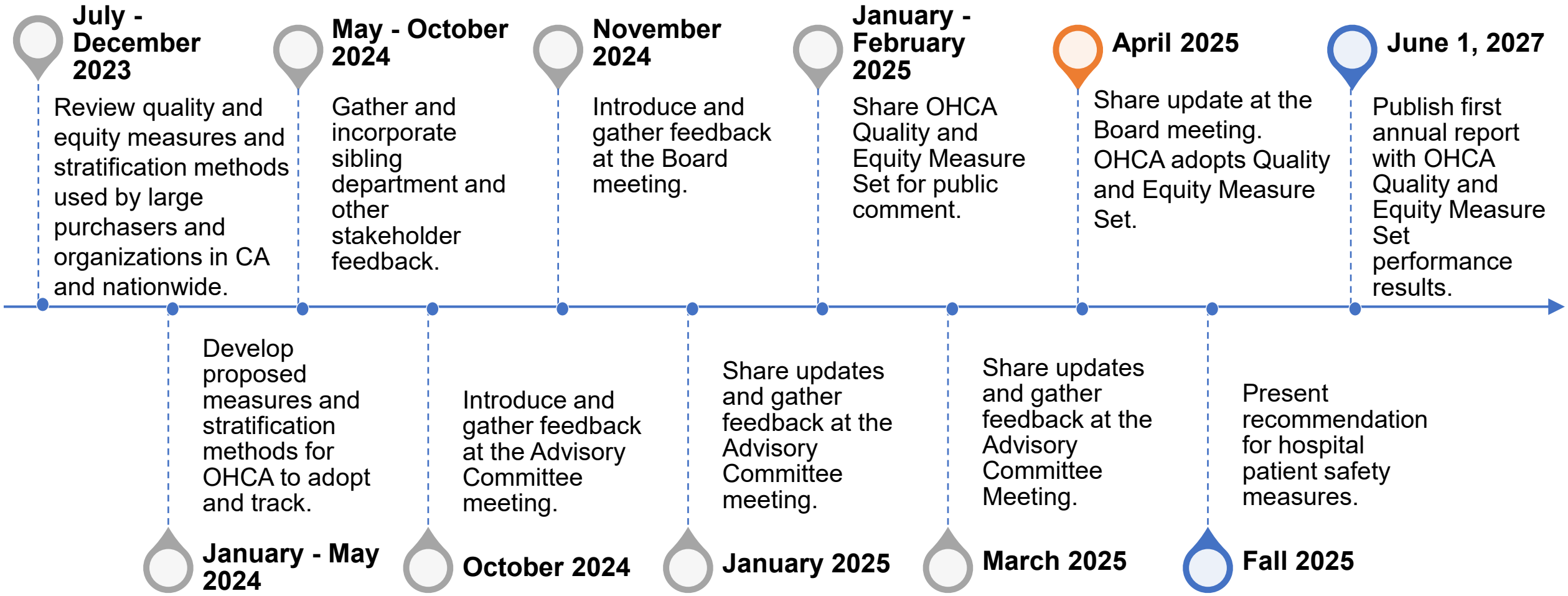
These criteria are summarized from Article 3. Office of Health Care Affordability, Health and Safety Code § § 127502(c)(5) and 127502.5.

OHCA's Quality and Equity Measure Set

Purpose

- Promote high quality and more equitable health care for all Californians.
- Monitor changes in quality and equity as health care entities work to meet spending targets.
- Track progress towards OHCA's goals to improve access, affordability, and equity of health care for all Californians.

Quality and Equity Measure Set Process and Progress



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Quality and Equity Measure Set

- In April 2025, OHCA is adopting all or a subset of three publicly available measure sets and their respective stratification requirements to measure quality and equity across health care entities.
- In Fall 2025, after collaborating with sibling state departments, OHCA will present a recommendation on hospital patient safety measures.
- OHCA will continue to explore including additional equity analyses beyond the stratification requirements by demographic characteristics used by the measure set owners.

Payers	Physician Organizations	Hospitals
Fully Integrated Delivery Systems[1]		
Adopt the full Department of Managed Health Care (DMHC) Health Equity and Quality Measure Set and stratification requirements	Adopt a subset of the Center for Data Insights and Innovation Office of the Patient Advocate (OPA) Health Care Quality Report Card measures[2]	Adopt the full HCAI Hospital Equity Measures Reporting Program measure set and stratification requirements

[1] For fully integrated delivery systems, which include a payer, physician organization, and hospital component, OHCA will measure performance of each of these component entities.
[2] OPA does not report measures stratified by demographic characteristics.

Measures for Payers and Physician Organizations

Measure Name *(*Measures for payers only)*	Measure Category
Childhood Immunization Status	Process
Colorectal Cancer Screening	Process
Controlling High Blood Pressure	Outcome
Glycemic Status Assessment for Patients With Diabetes (<8.0% and/or >9.0%)	Outcome
All-Cause Readmissions	Outcome
Asthma Medication Ratio	Process
Breast Cancer Screening Rate	Process
Child and Adolescent Well-Care Visits	Process
Immunizations for Adolescents	Process
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)*	Behavioral health, Process
CAHPS Health Plan Survey: Getting Needed Care (Adult and Child survey) or QHP Enrollee Experience Survey*	Access, Patient reported outcome or patient experience
Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care)*	Process
Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)*	Process

Sources: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d.; OPA. (2024). Health Care Quality Report Cards. https://www.iiii.ca.gov/consumer-reports/health-care-quality-report-cards/.; In the DMHC Health Equity and Quality Measure Set, CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

Measures for Hospitals

HCAI Hospital Equity Measures Reporting Program Measure Name	General Acute Hospital Measures	Acute Psychiatric Hospital Measures	Children's Hospital Measures	Measure Categories
Designate an individual to lead hospital health equity activities	X	X	X	Structural
Hospital Commitment to Health Equity Structural Measure	X	X	X	Structural
Provide documentation of policy prohibiting discrimination	X	X	X	Structural
Report percentage of patients by preferred language spoken	X	X	X	Structural
Screen Positive Rate for Social Drivers of Health	X	X	X	Structural
Screening for Social Drivers of Health	X	X	X	Structural
All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis*	X	X		Outcome, Behavioral health
HCAHPS survey (Received information and education and would recommend hospital)	X	X		Patient reported outcome or patient experience
Pneumonia Mortality Rate*	X	X		Outcome
All-Cause Unplanned 30-Day Hospital Readmission Rate*	X		X	Outcome
Cesarean Birth Rate (NTSV)	X			Outcome
Death Rate among Surgical Inpatients with Serious Treatable Complications	X			Safety, Outcome
Exclusive Breast Milk Feeding	X			Process
Vaginal Birth After Cesarean Rate (VBAC)	X			Outcome
All-Cause Unplanned 30-Day Hospital Readmission Rate in an inpatient psychiatric facility*		X		Outcome, Behavioral health
Screening for metabolic disorders		X		Process
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge		X		Behavioral health, Process
Pediatric experience survey with scores of willingness to recommend the hospital			X	Patient reported outcome or patient experience

*These measures promote overall patient safety but are not labeled as safety measures.

Source: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/.

Recap of Public Comment, Advisory Committee, and Board Feedback

- Public comment and AC members shared general support for alignment efforts.
- Public comment, AC, and Board members suggested adding Healthcare-Associated Infections measures and/or other hospital patient safety measures.
- Public comment, AC, and Board members recommended additions, modifications and/or removal of measures.
- Public comment, AC, and Board members encouraged more stratification requirements while noting challenges in collecting demographic data.
- Public comment recommended changes to the stratification requirements.
- Board members had a question about reporting and enforcement.
- Public comment requested that OHCA consider innovative ways to utilize data for reports and delay or change public reporting requirements for some measures.
- Public comment, AC, and Board members noted limitations of the OHCA Quality and Equity Measure Set.

Ongoing Work to Align Hospital Patient Safety Measures

- OHCA received feedback to consider adding Healthcare-Associated Infection (HAI) measures to the OHCA Quality and Equity Measure Set to improve its ability to monitor patient safety as hospitals work to meet spending targets.
- Sibling state departments, including CalPERS and Covered California, are currently working to develop a priority set of hospital patient safety measures, including consideration of HAI measures.
- OHCA will review this set of hospital patient safety measures and will reconsider adding HAIs and potentially other hospital patient safety measures to the OHCA Quality and Equity Measure Set, with input from the AC and Board in Fall 2025.

Background on Sibling Department Hospital Safety Measures

- Health and Safety Code 1288.55 and 1288.8 requires CDPH to oversee the prevention, surveillance, reporting, and response to Healthcare-Associated Infections (HAI) in California's hospitals and other healthcare facilities. CDPH HAI measures include:
  - Central line-associated bloodstream infections (CLABSI)
  - Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections (BSI)
  - Vancomycin-resistant Enterococci (VRE) bloodstream infections (BSI)
  - Clostridioides difficile infections (CDI)
  - Surgical site infections (SSI) – 28 operative procedures including colon surgery, c-section, hip and knee prosthesis, and transplants.
- CDPH does not stratify HAI measure performance by demographic characteristics.
- The Covered California 2023-25 contract requires health plans to work with hospitals to improve performance on the same 5 HAIs as CDPH (CLABSI, MRSA, CDI, SSI Colon Surgery, and VRE) though Covered California has removed a specific hospital measure list in the 2026-2028 contract.
- The current CalPERS contract emphasizes improvement on 6 HAIs, 4 of which are tracked by CDPH (CLABSI, MRSA, CDI, SSI Colon Surgery, Catheter-Associated Urinary Tract Infection [CAUTI], and Sepsis Management) though these specific measures may be removed in future contracts.

Sources: CDPH. (2024, April 29). *Healthcare-Associated Infections (HAI) Program*. Healthcare-Associated Infections (HAI) Program. https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/HAI_LiaisonIP.aspx. Covered California. (2022, August 1). *Attachment 1 To Covered California 2023-2025 Individual Market QHP Issuer Contract: Advancing Equity, Quality, And Value*. Covered California 2023-2025 Individual Market Attachment 1. https://hbex.coveredca.com/stakeholders/plan-management/library/2023-2025_QHP_IND_Attachment_1_1-24-22_Clean.pdf. SSI Colon Surgery is a subset of the SSIs that CDPH tracks.

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Update on Behavioral Health Definition and Investment Benchmark, including Advisory Committee Feedback

Margareta Brandt, Assistant Deputy Director

Debbie Lindes, Health Care Delivery System Group Manager

HCAI

Department of Health Care Access and Information

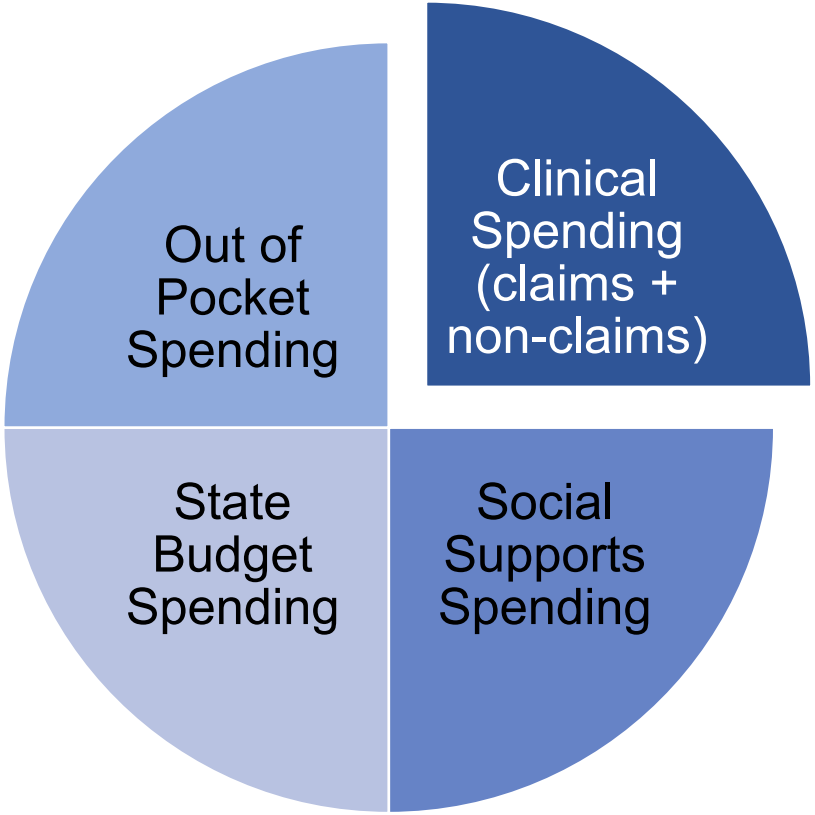
Primary Care & Behavioral Health Investments

Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- **Measure the percentage of total health care expenditures allocated to PC and BH** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health.
- Promote improved outcomes for primary care and behavioral health.

Data Collection and Measurement Scope

Clinical services are services provided by medical and allied health professionals to prevent, treat, and manage illness, and to preserve mental well-being across the clinical care continuum, paid via claims and non-claims payments (e.g., outpatient therapy visit, day treatment programs).



- Initial focus on clinical services and health care payers (e.g., commercial and Medicare Advantage).
- Possibility of using supplemental data sources to capture spending from other categories in the future.

Adapted from Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

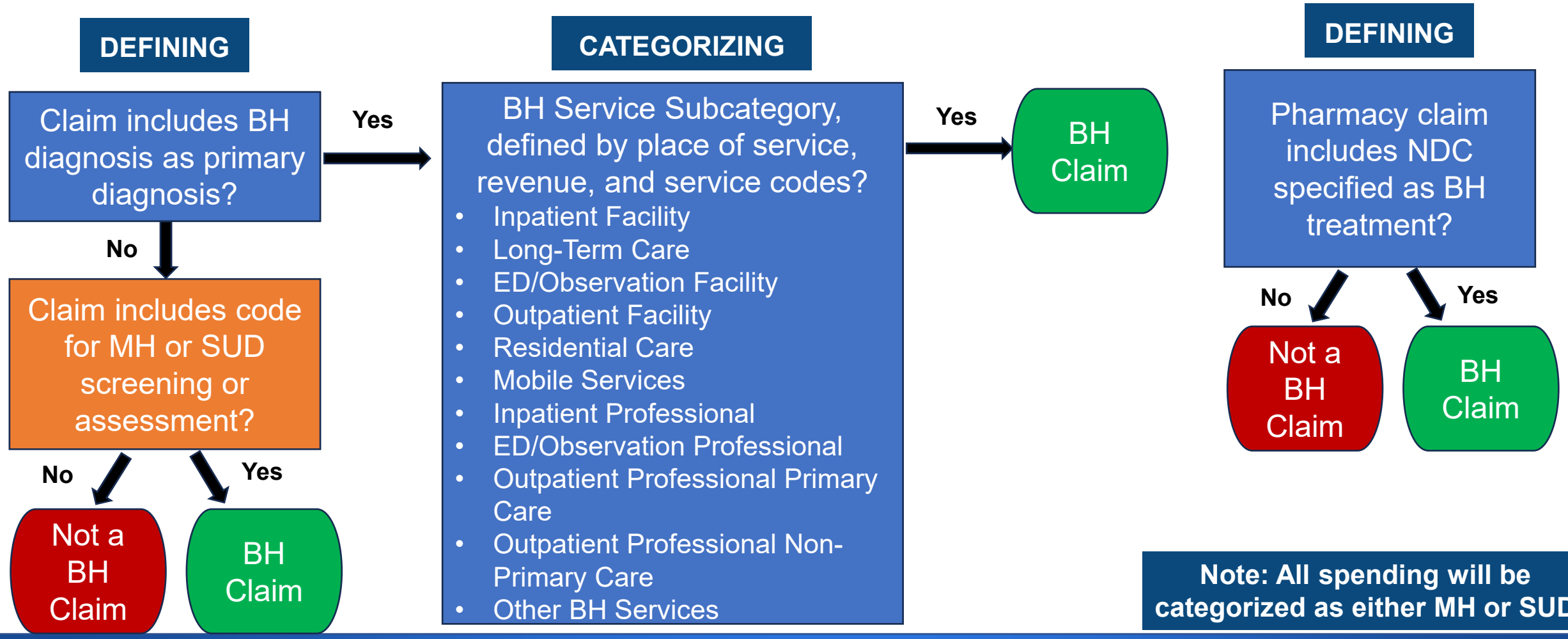
Behavioral Health Spending Measurement: Claims-Based Spending

Behavioral Health Claims-Based Measurement Definition Principles

1. **Include all claims* with a primary behavioral health diagnosis** in measurement
   - Claims with service codes for mental health or substance use disorder screening or assessment also included, regardless of primary diagnosis code
2. **Categorize claims** using place of service, revenue, and service codes
   - "Other Behavioral Health Services" category captures claims with a primary behavioral health diagnosis code that do not have a place of service, revenue, or service* code associated with another subcategory
3. **Include pharmacy claims** with a National Drug Code (NDC) specified by OHCA as a behavioral health treatment
   - Measured separately, so can be included or excluded for analysis
   - Categorized as mental health or substance use disorder claims
   - Behavioral health diagnosis not required

*OHCA is considering applying a service code filter to the "Other Behavioral Health Services" category.

Process Map for Identifying Behavioral Health (BH) Claims



Note: All spending will be categorized as either MH or SUD

Proposed Reporting Categories and Service Subcategories

Reporting Categories	Service Subcategories
Outpatient/Community Based*	Community Based Mobile Clinic Services
	Outpatient Professional Primary Care
	Outpatient Professional Non-Primary Care
	Outpatient Facility
Emergency Department	Emergency Department / Observation; Facility (no inpatient admission)
	Emergency Department / Observation; Professional (no inpatient admission)
Inpatient	Inpatient; Facility
	Inpatient; Professional
Long-Term Care and Residential	Long-term Care
	Residential Care
Other	Other Behavioral Health Services
Pharmacy	Mental Health (MH) Prescription Drug Treatments Substance Use Disorder (SUD) Prescription Drug Treatments

These categorizations may change as OHCA develops the final behavioral health investment benchmark and begins data collection.

*Proposed behavioral health investment benchmark includes spend in this category.

Behavioral Health Spending Measurement: Non-Claims Spending

Behavioral Health Non-Claims Measurement Definition Principles

- Data collection via Expanded Non-Claims Payments Framework.
- Include all behavioral health non-claims subcategories.
- Allocate payments to behavioral health by various methods:
  - **Population health, behavioral health integration, and care management payments** only when paid to behavioral health providers.
  - **Practice transformation, IT infrastructure, and other analytics payments** not to exceed a set upper limit.
  - **Behavioral health capitation payments** included in full
  - **Professional and global capitation payments** and **payments to integrated, comprehensive payment and delivery systems** allocated to behavioral health using a method similar to that for primary care.

Expanded Framework, Categories A-C

Green = Include all of payment (if for BH)
Orange = Include portion of payment
White = Excluded or not applicable

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Pay-for-reporting payment	2B
B2	Pay-for-performance payment	2C
C	**Shared Savings Payments and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A
C2	Procedure-related, episode-based payments with risk of recoupments	3B
C3	Condition-related, episode-based payments with shared savings	3A
C4	Condition-related, episode-based payments with risk of recoupments	3B
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B

Expanded Framework, Categories D-F

Green = Include all of payment (if for BH)
Orange = Include portion of payment
White = Excluded or not applicable

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category
D	**Capitation and Full Risk Payments**	
D1	Primary Care Capitation	4A
D2	Professional Capitation	4A
D3	Facility Capitation	4A
D4	Behavioral Health Capitation	4A
D5	Global Capitation	4B
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C
E	**Other Non-Claims Payments**	
F	**Pharmacy Rebates**	

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Spending
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	Include payments to behavioral health providers and provider organizations for care management/coordination and for integration with primary care or social care.
A2	Primary care and behavioral health integration*	
A3	Social care integration	
A4	Practice transformation payments	Limit the portion of practice transformation and IT infrastructure payments allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
A5	EHR/HIT infrastructure and other data analytics payments	
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	Include performance incentives in recognition of reporting, quality, and outcomes made to behavioral health providers.
B2	Retrospective/prospective incentive payments: pay-for-performance	

*May be paid to primary care or multi-specialty provider organizations for this purpose.

Overview of Recommended Non-claims Behavioral Health Care Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	Not Applicable
C2	Procedure-related, episode-based payments with risk of recoupments	
C3	Condition-related, episode-based payments with shared savings	Include spending for service bundles for a behavioral health-related episode of care.
C4	Condition-related, episode-based payments with risk of recoupments	
C5	Risk for total cost of care (e.g., ACO) with shared savings	Not Applicable
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	Not Applicable
D2	Professional capitation	Calculate a fee-for-service equivalent based on a fee schedule for primary care services multiplied by the number of encounters.
D3	Facility capitation	Not Applicable
D4	Behavioral Health capitation	Allocate full behavioral health care capitation amount to behavioral health care spending.
D5	Global capitation	Calculate a fee-for-service equivalent based on a fee schedule for primary care services multiplied by the number of encounters.
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	
E	Other Non-Claims Payments	Limit the portion of other non-claims payments* allocated to behavioral health spending the proportion of total claims and capitation payments going to behavioral health.
F	Pharmacy Rebates	Not applicable.

*May include retroactive denials, overpayments, payments made as the result of an audit, or other payments that cannot be categorized elsewhere.

Equation for Allocating Practice Transformation, EHR/HIT, and Other Non-Claims Payments to Behavioral Health

$$\text{Subcategory A4 Behavioral Health Spend*} = \Sigma \text{ Practice Transformation Payments} \times \frac{\text{Behavioral Health Claims + Behavioral Health Capitation}}{\text{Claims: Total Claims + Capitation and Full Risk Payments}}$$

*This equation would also be used to allocate Category A5 EHR/HIT Infrastructure and Data Analytics and Category E Other Non-Claims Payments to behavioral health.

Apportioning Professional and Global Capitation to Behavioral Health

Example for a Professional Capitation arrangement:

$$\frac{\Sigma\ (\#\ \text{of BH Encounters x FFS-equivalent Fee})_{segment}}{\Sigma\ (\#\ \text{of All Professional Encounters x FFS-equivalent Fee})_{segment}} = \text{Behavioral Health spend paid via professional capitation}$$

x Professional Capitation Payment

"Segment" means the combination of payer type (e.g., Medicaid, commercial), payer, year, and region or other geography as appropriate.

Note: Methodology aligns with OHCA primary care approach.

Example of Non-Claims Capitation Formula

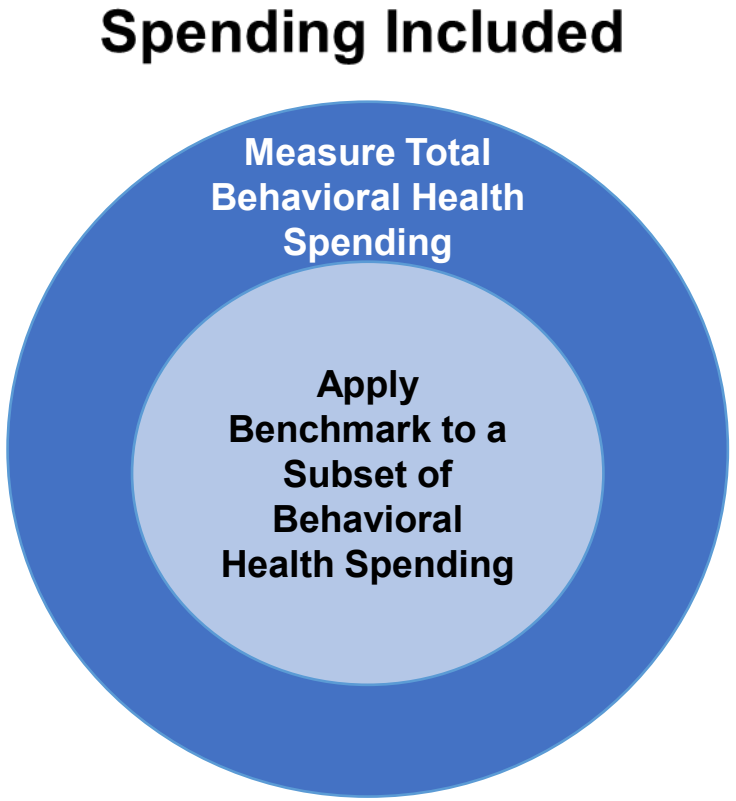
Payer A has four types of capitation arrangements with provider groups. Three of the arrangements cover some behavioral health services. The table below describes the portion of the payer's capitation payments that would be allocated to behavioral health.

	Total Dollars Paid Via Capitation Category	Dollars Attributed to Behavioral Health	Dollars Attributed to Behavioral Health Equal To
Behavioral Health Capitation	$100,000,000	$100,000,000	Total amount paid in behavioral health capitation
Professional Capitation	$250,000,000	$5,000,000	Use formula on the previous slide to calculate FFS equivalents for behavioral health services.
Global Capitation	$1,000,000,000	$10,000,000	Use formula on the previous slide to calculate FFS equivalents for behavioral health services.
Facility Capitation	$500,000,000	$0	N/A

Behavioral Health Investment Benchmark Development

Broad Measurement, Focused Benchmark

- **Measurement:** OHCA will be measuring **total** behavioral health spending as a percentage of total health care expenditures.
- **Benchmark:** OHCA proposes that the behavioral health investment benchmark applies to a **subset** of behavioral health care spend.



Challenges in Establishing a Behavioral Health Benchmark

While aligning the behavioral health and primary care investment benchmarks might be desirable, there are several challenges in establishing the behavioral health benchmark that were not present in setting the primary care benchmark:

- Complete, reliable data on behavioral health spending are lacking, particularly at the detailed subcategory level and for certain payer types.
- There is no track record of the structures, levels, or effectiveness of behavioral health investment benchmarks in other states.
- There is a lack of national and international evidence for what constitutes the "right" or "desired" level of behavioral health spending.

Key Decisions for Benchmark Setting

- Should the benchmark be a percentage of total medical expenses or a per member, per month amount?
- Should the benchmark focus on incremental or long-term improvement, or some combination?
- What should the timeline be for achieving the benchmark?

Set a benchmark based on the percent of total medical expense or a per member, per month amount?

Statute suggests a preference for using percent of total medical expense (TME) as a basis for benchmarking, which would be consistent with other approaches.

Reasons for Percent of TME

- Statute suggests preference for this approach.
- Communicates that increased spending on behavioral health care should reallocate rather than increase total spending.
- Consistent with the approach to the primary care investment benchmark.

Reasons for Per Member, Per Month (PMPM)

- Easier to reflect the cost of achieving behavioral health delivery goals.
- May guard against the benchmark becoming unnecessarily inflationary if total medical expense increases are higher than expected.
- More consistent with how payers typically measure health care costs.
- Consistent with the Rhode Island benchmark, the only other state behavioral health benchmark in the country.

Set an annual improvement or long-term investment benchmark? Or some combination?

An annual improvement benchmark meets each payer where they are today, and the long-term investment benchmark offers a vision for the future across all payers.

Reasons for Annual Improvement

- Consistent with statutory guidance to recognize differences across payers and patient populations.
- Acknowledges care delivery transformation takes time.
- Current and desired spending levels are unclear, so annual improvement gives more latitude.

Reasons for Long-Term Investment Goal

- Sets a vision for the future.
- Can reflect the potential budget needed to develop necessary behavioral health infrastructure.
- Can reflect current thinking on the “right” level of behavioral health care investment.

Reason for Combination

- Allows all to succeed at a reasonable pace.
- Aligns with the approach to the primary care investment benchmark.

How long should the time horizon be for the behavioral health investment benchmark?

Considerations

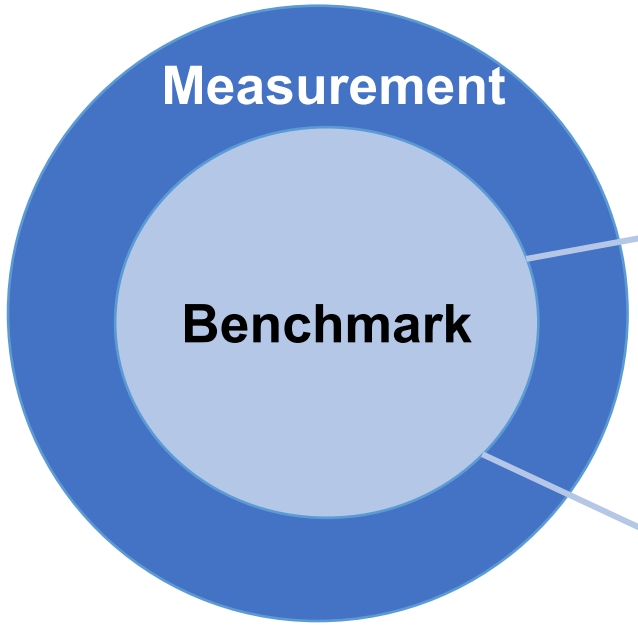
- Benchmark should be aggressive in pursuit of the policy goals underlying it.
- Benchmark should also reflect reasonable expectations of how long it will take to achieve.
- Align benchmark with other adopted OHCA benchmarks:
  - Spending target (2029)
  - Primary care investment and alternative payment model adoption (2034)

Other OHCA Benchmarks

Health Care Spending Target	• 3.5% in 2025 and 2026 • 3.2% in 2027 and 2028 • 3.0% in 2029 and beyond
APM Adoption	• Biannual improvement goals by payer type • By 2034: 95% for Commercial HMO and Medicare Advantage; 75% for Medi-Cal; 60% for Commercial PPO
Primary Care Investment	• For each payer, 0.5 to 1.0 percentage points per year as percent of TME • By 2034, 15% of TME for all payers

- Combine incremental and long-term goals.
- Acknowledge payers' different starting points and capacity for short-term improvement.
- Allow for adjustment as picture becomes clearer with more data
- Set a long-term vision aligned with state policy goals.

Recommendation: What is Included in the Benchmark



Outpatient/Community-Based Service Claims Subcategories:

- Community Based Mobile Clinic Services
- Outpatient Professional PC
- Outpatient Professional Non-PC
- Outpatient Facility

Non-claims payments in other Expanded Framework categories:

A: Population Health and Practice Infrastructure Payments
B: Performance Payments
D: Capitation Payments (outpatient/community-based service subcategories only)

Stakeholder Feedback

February Board Meeting

Feedback

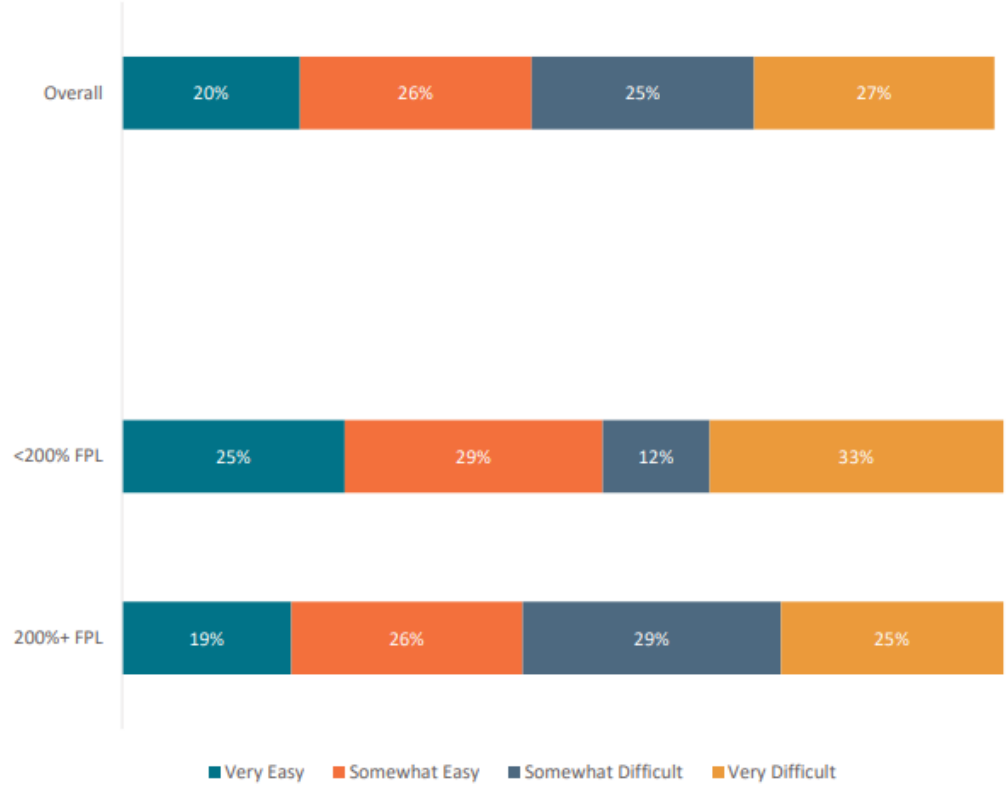
- Highlighted the importance incorporating Medi-Cal into the definition and spending data collection in the future, given OHCA's proposed phased approach to start with Commercial and Medicare Advantage.
- Interest in understanding the rationale behind excluding inpatient spend in the proposed behavioral health investment benchmark.
- Interest in tracking inpatient behavioral health spend, pharmacy costs, and payment rates for behavioral health services.
- Interest in capturing behavioral spend occurring in schools.
- Discussion of how to broadly track behavioral health transformation across the state.
- Interest in understanding the reasons for poor access and low network participation, from payer and provider perspectives.

Benchmark Proposal Rationale: Low In-Network Access

- Among Californians who tried to make a mental health appointment in 2023, more than half (52%) reported difficulty finding a provider that takes their insurance.
- California Department of Managed Health Care (DMHC) investigated 4 plans and enrollees in 3 of those 4 plans experienced difficulty obtaining behavioral health services.

Figure 43. More Than Half of Californians Who Tried to Make a Mental Health Appointment Report Having Difficulty Finding a Mental Health Care Provider Who Takes Their Insurance

Q: OVERALL, HOW EASY OR DIFFICULT IS IT FOR YOU TO FIND A MENTAL HEALTH PROVIDER WHO TOOK YOUR INSURANCE?



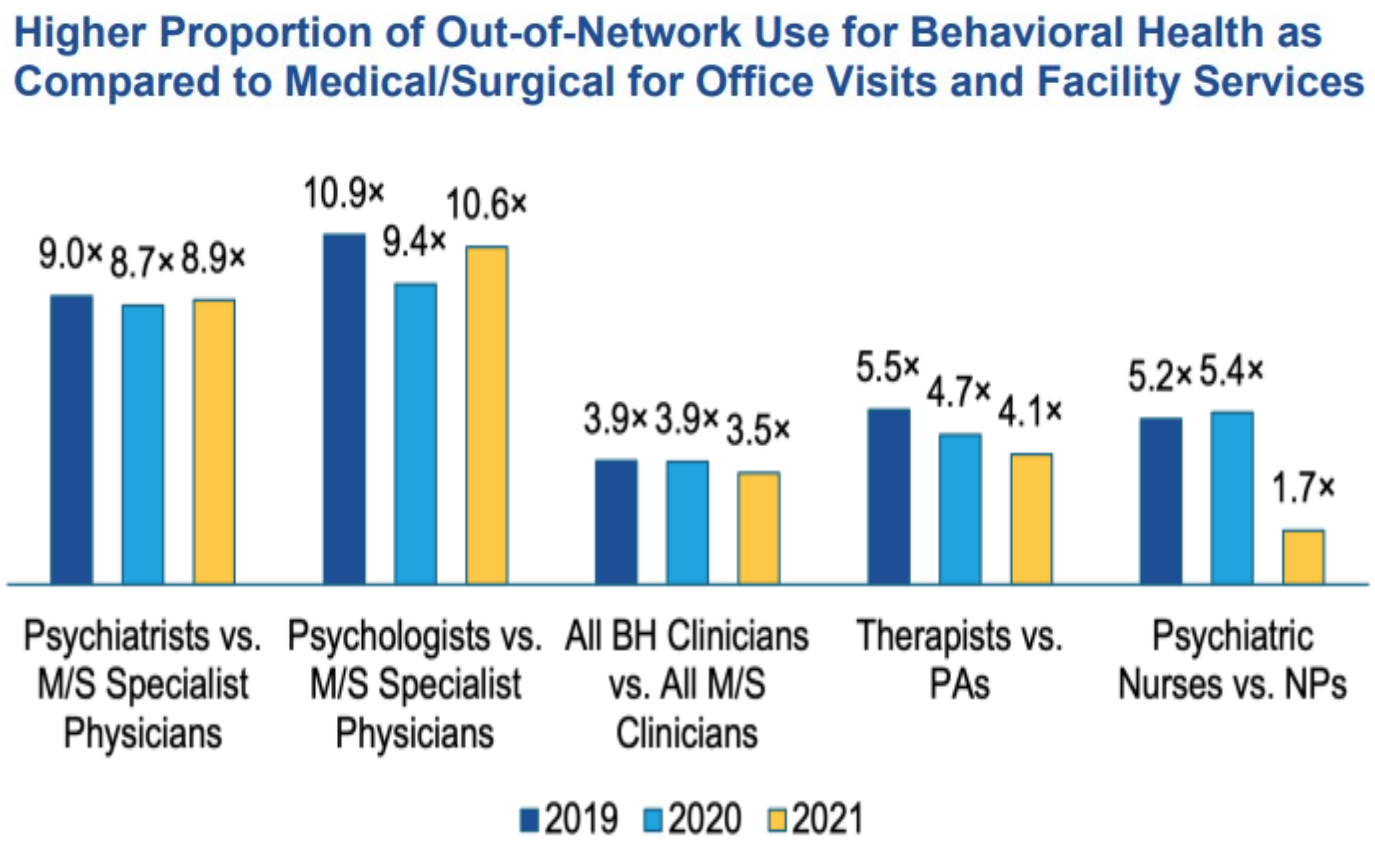
Notes: Sample includes 3,431 California residents age 18 and older. "I don't have insurance" or did not answer not shown. See topline for full question wording and response options. *FPL* is federal poverty level.

Source: CHCF/NORC California Health Policy Survey (September 18–October 25, 2023).

Sources: California Health Care Foundation, The 2024 CHCF California Health Policy Survey, January 2024. https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFCAHealthPolicySurvey.pdf
DMHC Behavioral Health Investigations: Phase Two Summary Report, June 2024. https://www.dmhc.ca.gov/Portals/0/Docs/DO/BHIPhase2SummaryReportFINAL.pdf

Benchmark Proposal Rationale: Low In-Network Access

- Californians used out-of-network psychiatrists and psychologists in 2021 more than 15 times as frequently as out-of-network medical/surgical specialist physicians, and any out-of-network BH clinician almost 6 times more frequently as medical/surgical physicians.
- California's disparities between out-of-network use of BH clinicians vs. medical/surgical clinicians are well above the nationwide average.



Source: Mark and Parish, Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue. RTI International, April 2024. https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf

Barriers to Behavioral Health Provider Participation in Health Plan Networks

- **Low Reimbursement Rates In-Network vs. Out-Of-Network**
  - Reimbursement rates are significantly lower in-network compared to earnings out-of-network.
  - The shortage of mental health providers relative to demand enables some providers to opt out of insurance and charge higher prices.

- **Solo Practices and Heavy Admin Burden**
  - Solo practices often do not have the infrastructure to manage the administrative tasks required to contract with insurance companies.

Sources: ProPublica, Why I Left the Network, August 2024. Mental Health Care in California, July 2022. https://projects.propublica.org/why-i-left-the-network/
JAMA Network, Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care. February 2014. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1785174
NAMI, Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity, November 2016. https://www.nami.org/wp-content/uploads/2023/08/Mental_Health_Parity2016.pdf
Psychology.org, Therapists Who Don't Accept Insurance, August 2024. https://www.psychology.org/resources/therapists-who-dont-accept-insurance/

Barriers to Behavioral Health Provider Participation in Health Plan Networks

- **Insurer Interference with Patient Care**
  - Providers report that insurers may limit or question necessity of care through benefit design, prior authorizations, or claims denial.
  - DMHC investigations found that several health plans conducted utilization management for behavioral health services not subject to prior authorization.

- **“Ghost” Networks**
  - Insurer provider directories are not always up-to-date or accurate, and listed providers may not be accepting new patients.
  - A Congressional “secret shopper” study found that 80% of mental health providers listed as in-network were “ghost” providers – unreachable, not accepting new patients, or out of network.

Sources: ProPublica, Why I Left the Network, August 2024. Mental Health Care in California, July 2022. https://projects.propublica.org/why-i-left-the-network/
DMHC Behavioral Health Investigations: Phase One Summary Report 2023. https://www.dmhc.ca.gov/Portals/0/Docs/DO/BHISummaryReport_FINAL.pdf
Health Affairs, Phantom Networks Prevent Children And Adolescents From Obtaining The Mental Health Care They Need. July 2022. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00588
Senate Committee on Finance, Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks. May 03, 2023.
https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf.

March Advisory Committee Meeting

Feedback

- Support for structuring the benchmark as a per member per month (PMPM) amount.
- Mixed support for the outpatient/community-based focus of the benchmark.
  - Desire to increase access to upstream care balanced by concerns that access challenges exist across the spectrum of care.
- Desire to ensure that behavioral health integration and whole person care is incentivized and measured.
  - Concern about missing care from PCPs if only primary diagnosis is considered.
  - Interest in understanding if encounter data diagnosis fields are well populated to identify behavioral health spend.
- Concern that measuring clinical spending paid by payers misses important parts of the behavioral health support system that occur outside health care settings.
- Concerns about the possibility of incentivizing use of untested approaches such as artificial intelligence through the investment benchmark.

Investment and Payment Workgroup Input on Key Decisions

1. Percentage of total medical expense or per member, per month (PMPM)?
   - Majority of workgroup members support a PMPM benchmark.
   - Strong workgroup interest in reporting on both percentage of total spending and PMPM.
2. Incremental or long-term improvement, or both?
   - Most workgroup members support a combined approach.
3. Timeline
   - Strong support for aligning with primary care and APM timeline (2034).
   - Members interested in revisiting the benchmark at shorter intervals to consider adjustments based on data.

Tentative Timeline for Behavioral Health Work

Between meetings, OHCA will revise draft behavioral health definitions and investment benchmarks based on feedback.

	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Workgroup	X	X	X	X	X	X	X	X	X
Advisory Committee		X		X			X		
Board	X		X		X	X		X	✓

X Provide Feedback ✓ Board Approval

Discussion

- Does the Board have feedback regarding the proposed reporting categories and subcategories for measuring behavioral health?
- Does the Board have feedback regarding the proposed methods for allocating non-claims payments to behavioral health measurement?

Discussion

- Does the Board have recommendations on the key decisions for setting a behavioral health investment benchmark?

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAi

Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

General Public Comment

Written public comment can be emailed to:
ohca@hcai.ca.gov
To ensure that written public comment is included in the posted Board materials, e-mail your comments at least 3 business days prior to the meeting.

HCAI
Department of Health Care Access and Information

Next Board Meeting:
May 27, 2025
9:00 a.m.

Location:
May Lee State Office Complex
651 Bannon St.
Auditorium, Room 300
Sacramento, CA 95811

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Adjournment

HCAI

Department of Health Care Access and Information

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Appendix

HCAI

Department of Health Care Access and Information

Summary of Hospital Engagement Feedback

Hospital Feedback

Question: Can OHCA meet with hospitals and collect feedback on the presented methodology for identifying high-cost hospitals?

Approach:

- As a reminder, OHCA met with 5 hospitals between the January 2025 Board meeting and the February 2025 Board meeting: Community Hospital of the Monterey Peninsula, Salinas Valley Health, Sharp HealthCare, Stanford Tri-Valley, and Stanford HealthCare.
- OHCA met with an additional 7 hospitals between the February 2025 Board meeting and the March 2025 Board meeting: Barton Memorial Hospital, Washington Health, Marshall Medical Center, Dominican Hospital, Doctors Medical Center-Modesto, Northbay Medical Center, and Cottage Health (Santa Barbara and Goleta Valley Cottage Hospitals) .

Discussion included:

- Overview from the hospitals on their facilities and programs.
- Feedback on the proposed options for identifying disproportionately high-cost hospitals that may merit a lower spending target value.
- Suggestions for different measures OHCA could consider to identify disproportionately high-cost hospitals.

Hospital Feedback

Identification of High-Cost Hospitals:

- **Discharge Threshold:** Multiple hospitals asked why the discharge threshold presented in January was removed from the recommendation and expressed support for bringing back a discharge threshold. One hospital suggested we use the 25th or 50th percentile as it would account for hospitals that have low discharges, but do not have the ability to spread their fixed costs across a larger system.
- **Margins:** Incorporate operating margins into the identification of these hospitals. Use operating margins for health systems to identify outliers, not operating margins of individual facilities.
- Evaluate at a health system level rather than individual hospital; a hospital may have high margins, yet the hospital may incur costs outside of the hospital but within its system (e.g., clinics) that potentially have much lower margins.
- Incorporate rates of charity care into the analysis.

Hospital Feedback

- **Unit Price Measure:** Use average net patient revenue per case mix adjusted discharge (instead of using commercial-only) to account for the total cost of care.
- **Relative Price Measure:** This measure is not an appropriate point for comparison because of different circumstances of hospitals, such as those that have higher Medicare reimbursement rates or Graduate Medical Education payments. The ratio favors academic medical centers that get more reimbursement.
- **Repeat Outlier:** One hospital suggested looking at years that did not include the COVID years but acknowledged that only looking at pre-COVID years wouldn't capture accurately the situation today.
- **Payer Mix Threshold:** One hospital suggested exempting any hospital whose commercial payer mix is under 20%. This would eliminate many safety net hospitals from consideration.

Hospital Feedback

Other feedback and comments:

- Smaller Hospitals:
  - Volatility in inpatient discharges.
  - Inadequate commercial reimbursements for physician services delivered by medical foundations.
  - Fixed costs for smaller hospitals/systems can’t be spread out across multiple facilities as they are for larger systems.
  - Less negotiating leverage on high-cost drugs, medical device implants, etc. They use a group purchasing organization, but do not have as much negotiating leverage as large systems.
- District hospitals: Survive on their own operations and currently have a negative margin. Have had to engage in cost savings measures, such as closing service lines and early retirements.

Hospital Feedback

Other feedback and comments:
Consideration is needed for:

- Unintended consequences affecting access to care due to aggressive pricing caps
- Clinical innovation, investments, and expansion of services resulting in high up-front costs.
  - Investments made in lower cost outpatient settings so that members use our system later and ensuring hospitals have an incentive to make these investments.
- Workforce
  - High-cost living areas resulting in increased compensation and benefits for employees of facilities.
  - Health care workforce shortages and ability to attract and retain physicians to provide needed specialty care in geographically isolated areas.
  - Labor costs are driven by union contracts.
- Finances
  - Payer mix as this is biggest factor that increases the delta between government rates and commercial rates.
  - To break even, hospitals must cover costs from uninsured and charity care.
  - Medicare compensation: Geographic regions where Medicare compensation is lower than other parts of the state and declining. Medicare Advantage may have a higher base rate, but there is expense for appealing claim denials.
  - The impact of federal actions, such as increased tariffs, proposed cuts by Congress that may impact Medi-Cal/Medicare funding and ultimately payments to hospitals.

Hospital Feedback

Other feedback and comments:

Consideration is needed for:

- Commercial revenue and payment to cost ratio measures alone do not account for value. Propose that OHCA explain high-cost hospitals using the following seven criteria: 1) access; 2) payer mix; 3) graduate medical education, including slots not funded by CMS; 4) cost of living; 5) seismic status; 6) quality of care; and 7) scope of services delivered.
- Growing share of aging compared to younger population.
- Seismic standard requirements.
- Hospitals that are the safety net hospitals where there is not a county hospital.
- Damaging the reputation of the hospitals by placing them on a high-cost hospital list.
- Affordability efforts should be focused on greater price transparency.

Discussion History of the Statewide Spending Target

Note: These slides are from the April 2024 Health Care Affordability Board Meeting Presentation.

Spending Target Discussion History

The following slides are a summary of spending target discussions held regarding the target value over the last six months.

In September, OHCA and the Board:

- Reviewed spending target statutory requirements and considerations, including Board and Office responsibilities and the spending target timeline.
- Reviewed other states' target setting methodologies.
- Assessed economic indicators and population-based measures, including:
  - Gross State Product
  - Potential Gross State Product
  - Median Family Income
  - Average Wage
  - Inflation (measured by CPI-U)
  - Median Age
- Discussed use of historical and forecasted data.
- Reviewed spending target adjustment factors identified in statute.

Spending Target Discussion History

In October, OHCA and the Board:

- Reviewed statutory requirements for developing the statewide spending target methodology and the target percentage value.
- Discussed historical spending growth in California over varying time horizons.
- Continued discussions regarding economic indicators and the differences between actual historical data vs. forecasted data.
- Discussed OHCA's preliminary recommendation that the statewide spending target should:
  - Be a single economic indicator
  - Rely on median household income
  - Use historical data
- Discussed population-based research to inform the target value, including:
  - Age and sex
  - Chronic disease prevalence
  - Disability status
- Discussed the pros and cons of multi-year targets, including duration and a fixed vs. phased-in approach.
- Discussed OHCA's preliminary recommendation of a 5-year initial target for calendar years 2025 – 2029 with a phased-in target value over the first 2-5 years of the program, then remaining fixed.
- Discussed the impacts of revisiting the target mid-year or mid-cycle.

Spending Target Discussion History

In December, OHCA and the Board:

- Discussed potential adjustments related to trends in technology and the price of health care technologies but OHCA recommended no adjustment.
- Presented OHCA preliminary proposal: adoption of a 3% statewide per capita spending targets for 2025-2029 based on a weighted average of historical median household income change over the 20-year period from 2002-2021 with no phase-in.
- Presented background on median household income changes from 2002-2021.
- Discussed OHCA reasoning for not recommending population-based adjustments.
- Proposed that the Board commit to evaluating the target for potential adjustments on an annual basis.

Spending Target Discussion History

In January, OHCA and the Board:

- Recapped affordability challenges in California, including disproportionate impacts on communities of color.
- Discussed research on opportunities for savings that could slow spending growth.
- Discussed OHCA recommendation for the statewide spending target, including rationale for:
  - An economic indicator of historical median household income based on the average rate of change over the last 20 years (2002-2022).
  - Not applying population- or technology-based adjustments.
  - Meeting annually to consider whether there are needed updates to the target, including adjustments for unforeseen circumstances.

Spending Target Discussion History

In February, OHCA and the Board:

- Discussed Advisory Committee summary feedback on OHCA's recommendation
- Discussed factors for consideration that may contextualize spending growth when assessing against the target.

In March, OHCA and the Board:

- Discussed written public comment summary feedback on OHCA's recommendation, as well as Advisory Committee responses to public comments.

Population Aging

- The proportion of Californians 65 and older is projected to increase; the costs of this population are predominantly covered by Medicare.
- Initially, OHCA will report THCE adjusted for changes in the age and sex composition of an entity's population. These adjustments will account for year-over-year changes in an entity's population.
- OHCA is committed to continually evaluating the impact of aging on THCE. Based on baseline and other annually reported data, OHCA will assess whether adjustments to the approach or the target(s) are merited.
- An aging population will impact spending growth. Health care for seniors and end-of-life care present an important opportunity to improve care, enhance patient satisfaction, and improve consumer affordability.

Descriptive Statistics for High-Cost Hospitals, 2018-2022

Hospital[c]	Average Medi-Cal Payer Mix	Average Medicare Payer Mix	Average Public Payer Mix[b]
11 High-Cost Hospitals	**24%**	**47%**	**71%**
Barton Memorial Hospital	23%	34%	57%
Community Hospital of The Monterey Peninsula	15%	56%	71%
Doctors Medical Center – Modesto	42%	40%	82%
Dominican Hospital	23%	52%	75%
Goleta Valley Cottage Hospital	14%	50%	64%
Marshall Medical Center	20%	58%	79%
Northbay Medical Center	34%	43%	77%
Salinas Valley Memorial Hospital	28%	44%	72%
Santa Barbara Cottage Hospital	20%	51%	71%
Stanford Health Care	14%	42%	56%
Washington Hospital – Fremont	20%	52%	72%

[b] Group averages are weighted by inpatient discharges.
[c] Only comparable hospitals with at least 365 days in reporting period are included

Cost and Market Impact Reviews

OHCA's Determination To Conduct (or Waive) CMIR of a Material Change Transaction - Factors

The Office shall base its decision to conduct a CMIR on any of the following factors:

(A) The transaction may result in a negative impact on the availability or accessibility of health care services, including the health care entity's ability to offer culturally competent care.

(B) The transaction may result in a negative impact on costs for payers, purchasers, or consumers, including the ability to meet any health care cost targets established by the Health Care Affordability Board.

(C) The transaction may lessen competition or create a monopoly in any geographic service areas impacted by the transaction.

(D) The transaction may lessen competition for health care entities to hire workers or may negatively impact the labor market by, for instance, lowering wages or slowing wage growth, worsening benefits or working conditions, or resulting in other degradations of workplace quality.

(E) The transaction negatively impacts a general acute care or specialty hospital by, for instance, restricting or reducing the health care services offered.

(F) The transaction may negatively impact the quality of health care services available to patients from the parties to the transaction.

(G) The transaction is part of a series of similar transactions by the health care entity or entities that furthers a trend toward consolidation.

(H) The transaction may entrench or extend a dominant market position of any health care entity in the transaction, including extending market power into related markets through vertical or cross-market mergers.

(I) The transaction between a health care entity located in this state and an out-of-state entity may negatively impact affordability, quality, or limit access to health care services in California, or undermine the financial stability or competitive effectiveness of a health care entity located in this state.

Source: Cal. Code Regs., tit. 22, § 97441(a)(1)

CMIR Program Update: Inquiries Received

CMIR Inbox CMIR@HCAI.ca.gov	Emails received and responded to (Generally within 2 business days)	Virtual Meetings due to Emails
2024 Totals	134	26
2025 Totals	15	3

Public Comment, Advisory Committee, and Board Feedback on the Quality and Equity Measure Set

Summary of Public Comment

General Support	
Feedback Theme	**OHCA's Response**
• General support for alignment efforts and streamlining quality and equity performance measurement under a standard set. • Appreciation that OHCA included the Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care) measures in its proposal.	• OHCA appreciates this feedback.

Summary of Public Comment

Measure Set Recommendations	
Feedback Theme	**OHCA's Response**
Recommendation to add measures, including: • The California Department of Public Health's Healthcare-Associated Infections (HAI) Program measures. • A comprehensive plan for measuring access to care. • More outcome measures in the non-hospital measure sets. • Measures on post emergency department follow-up care for patients with substance use disorder. • More behavioral health measures.	• OHCA's statute requires that the OHCA Quality and Equity Measure Set use recognized measures and leverage existing voluntary and required reporting to the greatest extent possible. OHCA is uplifting measure sets developed through intensive multi-stakeholder processes and relying on existing measure sets with the aim to reduce administrative burden. • OHCA is required by statute to regularly review and update its measure set over time. The initial measure set is a starting point and can be updated over time.

Summary of Public Comment

Measure Set Recommendations	
Feedback Theme	**OHCA's Response**
Recommendation to remove/modify measures, including: • Consider reducing the payer measure set to 10-measures. • Remove the Immunizations for Adolescents measure to reduce unnecessary duplication with the Child and Adolescent Well-Care Visits measure. • Remove All-Cause Readmissions for payers. • Remove Screening and Positive Rate for Social Drivers of Health measures for hospitals. • Remove Death Rate Among Surgical Inpatients with Serious Treatable Complications measure for general acute care hospitals. • Remove Pneumonia Mortality Rate measure for acute psychiatric hospitals. • Remove the Glycemic Status Assessment for Patients with Diabetes < 8% measure and only keep the Glycemic Status Assessment for Patients with Diabetes > 9% measure. • Modify the Childhood Immunization Status Combo 10 measure to Combo 7.	• OHCA's statute requires that the OHCA Quality and Equity Measure Set use recognized measures and leverage existing voluntary and required reporting to the greatest extent possible. OHCA is uplifting measure sets developed through intensive multi-stakeholder processes and relying on existing measure sets with the aim to reduce administrative burden. • OHCA is required by statute to regularly review and update its measure set over time. The initial measure set is a starting point and can be updated.

Summary of Public Comment

Limitations	
Feedback Theme	**OHCA's Response**
• Request to comprehensively capture important trends in access, quality, and equity. • Concern that the CAHPS Health Plan Survey: Getting Needed Care does not accurately measure a member's ability to get needed care.	• Adopting the OHCA Quality and Equity Measure Set is a starting point. OHCA will continue to work with sibling state departments and other partners to evolve these measure sets and collaboratively address the limitations.

Summary of Public Comment

Stratification	
Feedback Theme	**OHCA's Response**
• Request to clarify sexual orientation and disability stratification categories and to reduce stratification requirements for hospital-level reports to ensure these significant efforts produce meaningful results. • Recommendation to stratify physician organization measures by sexual orientation, gender identity, race, and ethnicity when such data becomes available from other agencies or sources. • Recommendation for OHCA to go beyond stratifying by race, ethnicity, sexual orientation, and gender identity. • Recommendation for OHCA to partner with research institutions to further support data analysis, particularly for health equity analyses and identifying health disparities. • Recommendation to take a more thorough look every five to seven years as quality and equity measurement and measure sets evolve and the ability to stratify data improves.	• Many state departments are working to encourage, require, and/or incentivize hospitals to have more complete demographic data, and we hope this will help improve the data available for health equity analyses. OHCA will collaborate across HCAI and with sibling state departments to reinforce and support these efforts. • OHCA will monitor efforts to improve demographic data and stratify more measures for physician organizations. OHCA will collaborate with OPA and IHA to explore opportunities to publicly report stratified measures. • OHCA will support and monitor efforts to advance health equity and reduce health disparities. • OHCA is required by statute to regularly review and update its measure set over time.

Summary of Public Comment

Reporting and Enforcement	
Feedback Theme	**OHCA's Response**
• Data reporting for hospitals has more stringent stratification requirements compared to reporting for payers and physician organizations and OHCA should consider stratification as an area of flexibility in reporting until these can be aligned. • Concern that the data collection and analysis for hospitals will be challenging and require additional resources. • Recommendation to delay publicly reporting the Well-Child Visits in the first 30 Months of Life (0-15 months and 15-30 months) measure until the enhancements to DHCS newborn enrollment can be realized. • Recommendation to regionally group data or incorporate multi-year datasets to find innovative ways to utilize existing data, particularly when sample sizes are small. • De-emphasize 2024 HCAHPS results since the survey is changing in 2025, making 2024 benchmarks invalid. • Monitor the Depression Screening and Follow-Up measure and do not publicly report performance due to data reporting challenges.	• OHCA is uplifting measure sets developed through intensive multi-stakeholder processes and relying on existing measure sets with the aim to reduce administrative burden. • OHCA does not have standalone enforcement authority for performance on the measure set but will publicly report performance on the measure set and flag changes in quality and equity in its annual reports, including for those entities that meet the spending targets. • OHCA will begin reporting on quality and equity performance in the June 2027 annual report. OHCA will coordinate with measure set owners and health care entities on measure changes that impact reporting.

Summary of Advisory Committee and Board Feedback

General Support	
Feedback Theme	**OHCA's Response**
• Several Advisory Committee (AC) members shared general support for alignment efforts and streamlining quality and equity performance measurement and not creating new measures.	• OHCA appreciates this feedback.

Summary of Advisory Committee and Board Feedback

Measure Set Recommendations	
Feedback Theme	**OHCA's Response**
Board and AC members encouraged OHCA to add or modify measures if possible, including: • Adding Healthcare-Associated Infection (HAI) measures and other hospital patient safety measures. • Adding more patient-reported outcome measures. • Adding actionable patient experience measures. • Adding more behavioral health measures, especially behavioral health outcome measures. • Adding cultural and linguistic appropriateness of care measures. • Adding more safety and access measures, including timeliness of getting needed care. • Adding structural measures, including social drivers of health screening for payers and physician organizations. • Modifying measures involving childhood immunizations so health care entities are not penalized for increasing vaccine hesitancy. • Modifying measures involving the flu vaccine to account for the lack of availability of the flu vaccine between May and September.	• In Fall 2025, after collaborating with sibling state departments, OHCA will present a recommendation on hospital patient safety measures. • OHCA will regularly review and update its measure set over time as required by statute. • OHCA intends to monitor new measures under development and consider incorporating these measures into its measure set. • There are nationwide limitations in measures available for programmatic use and the timeline of measure development from conceptualization to implementation can take many years. • OHCA's statute requires that the OHCA Quality and Equity Measure Set use recognized measures and leverage existing voluntary and required reporting to the greatest extent possible. OHCA is uplifting measure sets developed through intensive multi-stakeholder processes and relying on existing measure sets with the aim to reduce administrative burden.

Summary of Advisory Committee and Board Feedback

Limitations	
Feedback Theme	**OHCA's Response**
• AC and Board members had concerns that quality measures are limited in what quality of care and health outcomes they can capture. • An AC member noted that providers with more resources may be able to "game" quality measures. • An AC member noted concerns that some physician organizations are not included in the OPA Health Care Quality Report Cards.	• OHCA plans to look at the overlap of physician organizations reported through THCE and those in the OPA Health Care Quality Report Cards. Depending on the results of this analysis, OHCA will collaborate with OPA and IHA to explore how to better align physician organizations included in the THCE data and OPA Health Care Quality Report Cards. • One challenge is that there is currently no standard definition nor comprehensive list of physician organizations in California.

Summary of Advisory Committee and Board Feedback

Stratification	
Feedback Theme	**OHCA's Response**
• Several AC members had concerns with the limited health equity data for payers and physician organizations and noted problems with individual-level demographic data, including missing data. • AC members recommended stratifying more measures, including by race, ethnicity, age, disability status, and geographic region, especially for physician organizations. • An AC member suggested OHCA require physician organizations to provide demographic data if they have it. • An AC member noted physician organizations have challenges collecting demographic data as many historically marginalized groups prefer not to share this information. • A Board member asked what OHCA's and HCAI's plans are regarding implementing the new race and ethnicity categories that OMB released in March 2024. • An AC member asked if OHCA can look at performance on Depression Screening and Follow-Up for Adolescents and Adults separately for adolescents and adults. • A Board member questioned if the DMHC Demographic Data Metric includes age.	• OHCA will support and monitor efforts to improve demographic data and stratify more measures, including by race, ethnicity, age, disability status, and geographic region. • For physician organizations, OHCA will collaborate with OPA and IHA to explore opportunities to publicly report stratified measures. • HCAI is working to adopt the changes to the race and ethnicity categories, including combining race and ethnicity and adding the new Middle Eastern or North African categorization, though it will take time. There will be a mapping process to map data based on the old race and ethnicity categories with the new categories. • The DMHC Demographic Data Metric does not include age and DMHC will not be collecting the Depression Screening and Follow-Up for Adolescents and Adults measure broken down by age groups.

Summary of Advisory Committee and Board Feedback

Reporting and Enforcement	
Feedback Theme	**OHCA's Response**
• The Board asked what OHCA can do if a health care entity meets the spending target but is performing poorly on quality and equity. • Several AC members pushed to focus on OHCA's purpose and report information that is easily understandable, meaningful, and actionable, and suggested grouping measures (e.g., preventive care) and highlighting subgroups (e.g., older adults and people with disabilities). • AC members suggested reporting on the National Committee for Quality Assurance's (NCQA) Health Equity Accreditation.	• OHCA does not have standalone enforcement authority for performance on the measure set but will publicly report performance on the measure set and flag changes in quality and equity in its annual reports, including for those entities that meet the spending growth target. • In addition, statute allows OHCA to investigate where data indicates adverse impacts on cost, access, equity, or quality from consolidation or market power. • OHCA welcomes specific recommendations of measures to monitor and is committed to public reporting that is clear, meaningful, and actionable. • OHCA will consider reporting which payers have achieved NCQA Health Equity Accreditation and NCQA Health Equity Plus Accreditation.