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

Health Care Affordability Board
April 22, 2025
Public Comment

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

Date Received	Name	Written Comment
4/18/2025	Mitch Mashburn	Please explain how the “high cost” measures account for key external factors affecting hospitals and data accuracy, as the County is concerned about enacting policies with sweeping consequences for local patients and healthcare worker. Thank you for your consideration,
4/18/2025	PIH Health	See Attachment #1.
4/18/2025	Stanford Health Care Tri-Valley	See Attachment #2.
4/18/2025	California Hospital Association	See Attachment #3.
Received via post 5/05/2025	UNITE HERE Local 19	See Attachment #4.
Received via post 5/05/2025	SEIU Local 521	See Attachment #5.
Received via post 5/05/2025	Antelope Valley Medical Center	See Attachment #6.
5/14/2025	Sydney Pitcher	Californians like myself face high costs of living and cannot afford the ever-escalating price of health care.

Date Received	Name	Written Comment
		High health care expenses, specifically high hospital bills and monthly insurance premiums, have caused too many people to delay or ration care and make difficult decisions about what to prioritize financially. accessible and affordable. Healthcare is essential and must be viewed as a right for everyone instead of a privilege. I dare that we choose to crack down on greedy people who are making the healthcare crisis worse by charging outrageous healthcare and prescription drug prices, lowering the quality of care, creating healthcare staff shortages and longer wait times. I support the Office of Health Care Affordability's recommendation to set a specific, lower, spending target value for disproportionally high-cost hospitals without any further delays. Californians like myself need OHCA to make health care more affordable, especially now when people are struggling to afford food and rent.
6/04/2025	Washington Health	See Attachment #7.
6/04/2025	Health Access of California	See Attachment #8.
6/04/2025	California Hospital Association	See Attachment #9.

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April 17, 2025

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

Subject: **OHCA's Arbitrary, Unrealistic Spending Growth Targets Impede Patient Care** *(Submitted via email to Megan Brubaker)*

Dear Chair Johnson,

PIH Health, which operates hospitals in Downey, Downtown Los Angeles, and Whittier; 31 medical office buildings; and a multi-specialty medical group, is deeply concerned by not only the Office of Health Care Affordability's (OHCA's) imposition of a statewide target of 3.5% (moving down to 3% by 2027), but also its consideration of an **even lower** target for arbitrarily defined "high-cost" hospitals. These targets do not even cover inflationary increases for critical supplies and pharmaceuticals — and our ability to continue our mission of providing high-quality patient care is in jeopardy.

Before defining one or more hospital sectors, all stakeholders would benefit from a comprehensive analysis of spending across various segments of the health care industry, identification of areas in which spending growth is high, and a meaningful assessment of spending drivers to determine whether differences in spending are appropriate. Absent that analysis, it is impossible to understand how this proposal would meet OHCA's statutory requirement to maintain access to high-quality care and minimize fragmentation and potential cost shifting and encourage cooperation in meeting statewide and geographic region targets.

PIH Health is already striving to meet the existing 3.5% spending target for 2025 by:

- Implementing new strategic supply chain initiatives including standardizing products across our enterprise and entering into longer term agreements securing lower cost increases.
- Improvement in quality of care through length of stay reduction by clinical standardization and efficiency, operating of long-term care units, and providing lower-level care in our transitional care units.
- Increased access to home health services and urgent care clinics to reduce the number of costly inpatient admissions.
- All health systems have experienced a substantial increase in costs associated with seeking reimbursement from insurance companies for services provided to their members. PIH Health is working with insurance companies to reduce the administrative burden placed on healthcare organizations to obtain reimbursement for patient care.

Lowering the target even further, without a clear understanding of how spending will be measured, means that we would be forced to further reduce the care we provide. This could impact:

- Expansion of and/or continued access to our home health services and urgent care clinics.
- Implementation of new technologies that increase quality of care and improved outcomes to our patients thus potentially increasing the length of stay for patients.

Making healthcare more affordable — a priority for California hospitals — is a shared responsibility. To make a difference in the cost of care, the entire healthcare system — insurance companies, drug manufacturers, medical device suppliers, labor unions, governmental agencies, and others — must work together. **Fragmenting the healthcare field so early in the process undermines the collaboration that is key to our shared success.**

On behalf of the more than three million residents of our services areas, PIH Health urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets. PIH Health remains deeply committed to achieving our shared goals of affordable, high-quality care — and we ask that the office proceed with a keen eye toward ensuring care is not diminished in the pursuit of lower costs.

Sincerely,

James R. West
President and Chief Executive Officer
PIH Health

cc: Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom
Senator Bob Archuleta
Senator Maria Elena Durazo
Assemblymember Lisa Calderon
Assemblymember Mark Gonzalez
Assemblymember Blanca Pacheco

Stanford MEDICINE | Health Care Tri-Valley

April 18, 2025

Megan Brubaker
Office of Health Care Affordability
2020 W El Camino Ave., Suite 1200
Sacramento, CA 95833

Subject: **Stanford Health Care Tri-Valley Opposes Proposed Hospital Sector Spending Target Recommendations**
(Submitted via email to OHCA@HCAI.ca.gov)

Dear Ms. Brubaker,

At Stanford Health Care Tri-Valley (SHC TV), we combine the expertise of local physicians with the innovative power of Stanford Medicine. As part of Stanford Medicine's ecosystem, we are deeply committed to providing leading-edge treatments, technology, and care in our East Bay community and beyond. We value the opportunity to provide feedback on the Office of Health Care Affordability's proposed hospital-sector spending target recommendations.

We are concerned that adherence to OHCA's 3.5% spending growth target will adversely impact the patients we serve. SHC TV is a regional referral center, and serves both as a primary support for emergency and delivery services in our service area and a transfer center for certain specialty services with 2 transfers per day coming from San Joaquin and Santa Clara counties. Specialties we offer include advanced endoscopy, vascular and cardiac surgery.

SHC-TV employs 1,721 employees and 980 medical staff, operating 242 licensed beds, including 22 licensed ICU beds and 13 operating rooms. In the latest fiscal year, we serviced 313,884 outpatient visits, 42,592 emergency room visits, and 1,307 births.[1] **With nearly half of our operating costs tied to labor, the mandated 3.5% spending growth rate annually would also mean forcing us to choose between cutting our lifesaving patient care and providing security and stability for our workforce and their families.**

Additionally, uncertainties concerning widely anticipated federal cuts to Medicaid and Medicare pose threats to health care in California. Additionally, the foreseen reductions in federal biomedical research funding would significantly hinder our mission to train and partner with physician researchers. **Our focus to innovate clinical medical research that is translated into bedside care for complex cases is at the heart of our mission, and the proposed sector and sector rates will simply stifle future medical breakthroughs.**

Our largest payor is Medicare, followed by commercial insurers, then Medi-Cal, and then other (i.e., self-pay, workers' compensation, etc.) As you are familiar, Medicare and Medicaid are not fully reimbursed by the dollar. In 2022, Medicare paid just 82 cents for every dollar spent by hospitals caring for Medicare patients.[2] With Medicare constituting nearly half of our payor mix, we experience a substantial shortfall from

[1] Stanford Health Care Tri-Valley: About Us.pdf

[2] Infographic: Medicare Significantly Underpays Hospitals for Cost of Patient Care

government payors that critically impact our overall operations. Moreover, Californians face the imminent reality of Medicaid cuts at the federal level which will continue to create increased financial instability statewide.

Commercial payments play a vital role in our financial sustainability. For example, they enable us the capacity to attract and retain a highly qualified workforce, sustaining services that may otherwise operate at a loss, and supporting clinical infrastructure within our community. Another factor OHCA lacks in consideration are the increased state mandates on hospitals such as seismic compliance. As a result, California hospital construction costs continue to be the highest in the country by a significant margin. The costs that unavoidably result from the many levels of hospital regulation in California, both labor and non-labor related, must be considered.

In conclusion, we respectfully request a delay in implementing the proposed hospital sector and high-cost targets until a comprehensive impact analysis on patient care can be conducted. The proposed spending growth rate caps jeopardize our ability to sustain essential specialized services for our complex patients. This will force us to choose between workforce stability, patient care, and community investments which will undermine the health of our communities. Finally, OHCA's proposed methodology must account for the unique challenges posed by the high cost of living and employment in the San Francisco Bay Area, our partnerships in research and physician training, and the limitations imposed by federal reimbursement rates, which all contribute to our operational realities.

We appreciate the opportunity to share these critical insights and advocate for a more balanced approach that considers the nuances of delivering complex, high-quality health care in our community.

Respectfully,

Denise Bouillerce, Sr. Director Government & Community Relations
Stanford Health Care Tri-Valley

cc: Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan
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Darci Delgado, Assistant Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom
Senator Josh Becker
Senator Jerry McNerney
Assemblymember Rebecca Bauer-Kahan

California Hospital Association

April 18, 2025

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

Subject: **Hospitals Ask the Board to Reject OHCA's Proposed Hospital Sector Target Recommendations**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

California's hospitals share the goals of the Office of Health Care Affordability (OHCA) to create a more affordable, accessible, equitable, and high-quality health care system. Unfortunately, recent OHCA proposals threaten this shared and multifaceted vision for California's health care system. In February 2025, OHCA released its proposal to impose reduced spending targets on 11 hospitals determined to be "high cost." The proposal is deeply flawed, unfairly targets an arbitrary set of hospitals within single class of providers, comes before OHCA has done the necessary groundwork, relies on unsound methodologies and anomalous data, is inconsistent with key aspects of state law, and would endanger access to health care in communities across California. **That's why the California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, asks the board to reject the proposed recommendations and defer any additional action on sector targets until comprehensive consideration of sector targets — and their impacts on patients, workers, and communities — can be completed.** CHA's detailed comments on the proposal, submitted to OHCA on April 11, are attached to this letter.

At the board's March meeting, leaders from Massachusetts' and Oregon's spending target programs provided an update on their programs' progress to date. Most notably, Massachusetts' executive director discussed the only enforcement action taken against a regulated health care entity by any state spending target program to date: a performance improvement plan imposed on Mass General Brigham, a leading health system in Massachusetts. In December 2024, Mass General Brigham successfully completed its performance improvement plan, lowering its revenues by $197 million through a combination of reimbursement rate reductions, utilization reductions, and shifts in the sites of care, such as through Home Hospital care. However, just two short months later, Mass General Brigham announced the largest number of layoffs in its history, intended to address a $250 million budget shortfall. Thousands of people lost their jobs; these decisions are never easy for hospitals to make, but are often the result of having no

good options to ensure sustainability. Such unintended consequences must be carefully considered as California moves to adopt and enforce spending targets.

California's hospitals appreciate the opportunity to comment and look forward to continued engagement toward our shared goals of promoting affordability, access, quality, and equity in California's health care system.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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

Attachment: CHA comment letter to OHCA regarding proposed hospital sector targets

April 11, 2025

Megan Brubaker
Office of Health Care Affordability
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Requests Withdrawal of Proposed Hospital Sector Spending Target Recommendations to the Board**
(Submitted via Email to Megan Brubaker)

Dear Ms. Brubaker:

California's hospitals are committed to improving affordability, access, quality, and equity in California's health care system. However, they represent just one slice of the health care industry. Statewide, $2 out of every $3 of health care spending goes to providers and payers other than hospitals. Moreover, National Health Expenditure data show a significant gap between hospitals' efficiency and that of the health care field at large. Despite the state's high cost of living, per capita spending for all health care services ranks in the middle of the pack, at 29th lowest nationally. However, when narrowed to only per capita **hospital** spending, California's rank improves 11 places — landing at 18th lowest nationally. Accounting for California's nation-leading cost of living shows that hospitals are even more efficient, outpacing most of the nation in delivering cost-effective care to patients.

Unfortunately, the Office of Health Care Affordability (OHCA) continues to ignore these and other key facts. Its February 2025 proposal to establish reduced spending targets for hospitals determined to be "high cost" is deeply flawed. It unfairly targets a single class of providers, comes before OHCA has done the necessary groundwork, relies on unsound methodologies and anomalous data, is inconsistent with key aspects of state law, and would endanger access to health care in communities across California. **For these reasons, the California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, asks OHCA to withdraw its proposal until the office has addressed these issues and conducted a far more balanced consideration of sector targets under all relevant statutory factors.**

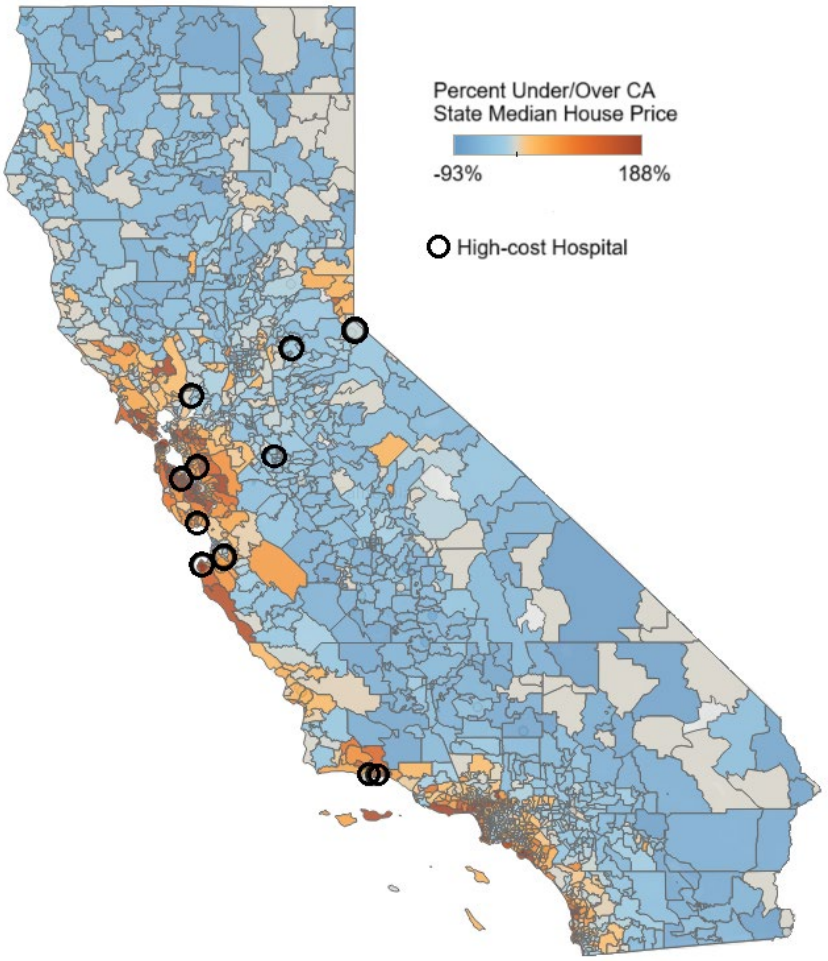
Flawed Approach for Identifying High-Cost Hospitals Leads to Illogical Results

OHCA proposes to designate hospitals as high cost if, for three out of five years between 2018 and 2022, they fell in the top 15% on two financial measures. The first measure reflects commercial inpatient reimbursement per case mix-adjusted discharge, while the second measure compares the relative cost coverage between hospitals' commercial and Medicare payers. Neither measure accounts for factors beyond hospitals' control that significantly influence their measured scores, and together generate an arbitrary list of hospitals that bear little relation to one another — other than the fact that they just happen to be high on two narrow measures that do not fully reflect the myriad factors influencing

hospital costs. Even at this late stage of the process, the office has yet to address questions about the underlying data's quality and appropriateness. Ultimately, these shortcomings are a result of OHCA moving too fast and neglecting legislatively mandated due diligence. That critical work must be completed prior to adopting policies that will profoundly impact millions of patients and workers who rely on hospitals. More detailed comments on the proposed methodologies are provided below.

Commercial Reimbursement Measure Penalizes Hospitals for Operating in High-Cost Areas and Paying Their Workers Accordingly. California is home to four of the 10 highest cost-of-living metropolitan areas in the entire country. The Bay Area and Central Coast are extraordinarily expensive places to live, even by California standards. Predictably, OHCA's commercial reimbursement measure disproportionately identifies hospitals operating in high-cost areas, with eight of the 11 listed hospitals located in just these two regions of the state. The figure to the right shows just how expensive the cost of living is in the areas containing hospitals designated as high cost. To offer competitive wages in their communities, the 11 high-cost hospitals paid nonsupervisory workers an average salary of $111,350 in 2022 — 21% higher than the $91,883 average salary paid to comparable workers at other hospitals. Adequate compensation is critical to ensuring a strong, stable workforce. To avoid penalizing hospitals simply for negotiating commercial rates that allow them to pay their workers fairly, OHCA must evaluate and incorporate adjustments that account for differences in hospitals' operating costs due to cost-of-living factors beyond their control.

OHCA's High-Cost Hospitals Are Overwhelmingly Located in Regions with the Highest Cost of Living

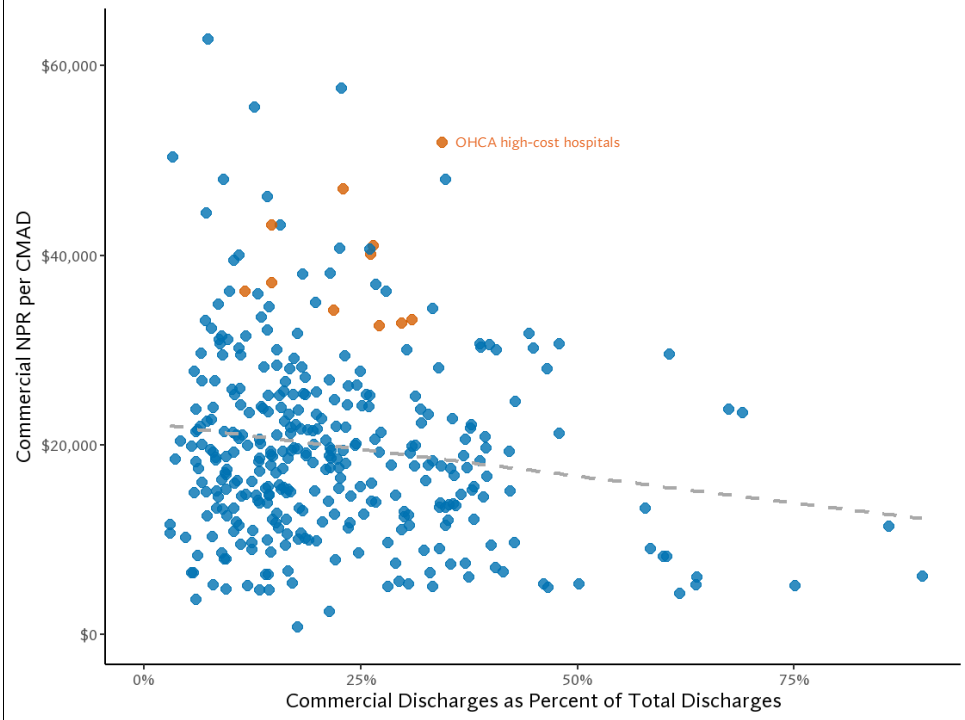


Source: American Community Survey 5-year average ending in 2023

Commercial Reimbursement Measure Myopically Focuses on a Small Subset of Patients and Services. Shortfalls in reimbursement from government payers — Medicare and Medi-Cal — force hospitals to rely on commercial payers to cover their costs. By looking only at hospitals' commercial reimbursement, the measure fails to control for the fact that some hospitals have more financially favorable payer mixes than others; hospitals without this distinct financial advantage need more revenue

per commercial patient to cover their costs. As the figure below shows, hospitals with higher commercial inpatient revenue per case mix-adjusted discharge have disproportionately small commercial payer mixes. By using this measure without any control for differences among hospitals in their payer mixes, OHCA risks penalizing hospitals for treating disproportionate shares of low-income Medi-Cal patients and elderly Medicare patients and making up their payment shortfalls the only way they can — through higher commercial payments. If hospitals were not able to recoup shortfalls in this way, the number operating at a loss (currently more than half of hospitals in California) would undoubtedly skyrocket, further eroding patients' access to care.

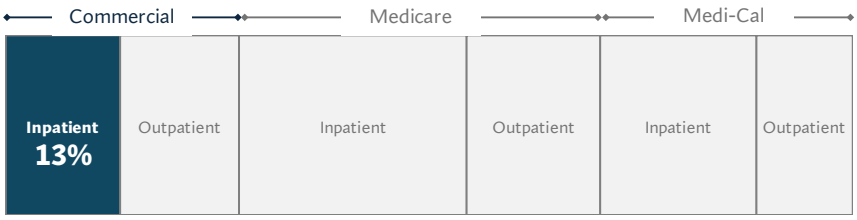
Hospitals with Higher Commercial Reimbursement Have Lower Commercial Patient Volumes



Note: Data reflect averages from the years 2018-2022 and include all hospitals not excluded from OHCA's analysis for its February 2025 high-cost hospital sector target proposal. NPR per CMAD means net patient revenue per case mix-adjusted discharge.

On top of overlooking reimbursement for 75% of the patients a typical hospital sees, OHCA's commercial reimbursement measure disregards 40% of the care hospitals provide: outpatient services. These services include emergency care, outpatient surgeries, specialty drug infusions, and other hospital services that do not require an admission. As the figure below shows, by ignoring government payers and outpatient services under this measure, OHCA is poised to determine hospitals' financial futures based on payments received for just 13% of the services provided. What's more, these payment data don't even reflect actual reported revenues, but rather an estimate (by OHCA's parent department, the Department of Health Care Access and Information) of the breakdown between hospitals' commercial revenues on the inpatient versus outpatient sides.

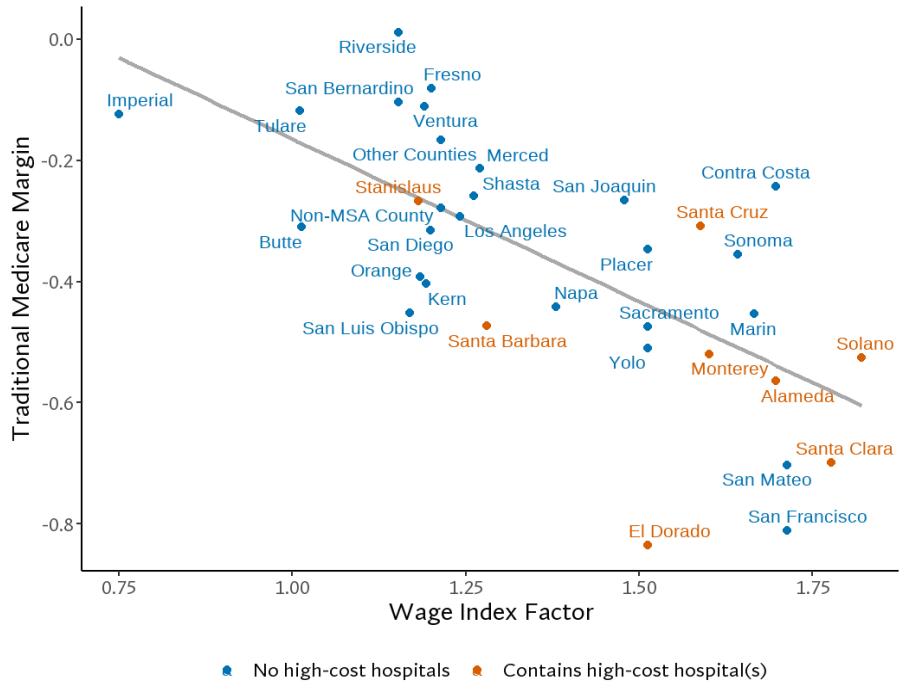
OHCA's Commercial Inpatient Revenue Measure Overlooks Reimbursement for All But 13% of the Services Hospitals Provide



Note: Reflects proportional breakdown of 2023 statewide gross patient revenue by payer and service type.

Medicare Payments Are an Inappropriate Benchmark for OHCA Target Setting. OHCA's second measure for identifying high-cost hospitals singles out those whose commercial payments cover their costs better than Medicare does. The foundational assumption is that Medicare hospital payment policies are sound and equitable — but that is not the case. Distortions and idiosyncrasies in Medicare payment policies significantly and variably

Medicare Payments Disproportionately Fail to Cover Costs in Higher-Cost Areas, as Indicated by the Area Wage Index



Note: Wage Index Factor reflects the area wage index averaged by county, weighted by traditional Medicare gross patient revenue. The margins are from pooled net patient revenues and expenses from the years 2018-2022. The methodology is based on that used in Gaudette É, Bhattacharya J. California Hospitals' Rapidly Declining Traditional Medicare Operating Margins. Forum Health Econ Policy. 2023 Mar 7;26(1):1-12. doi: 10.1515/fhep-2022-0038. PMID: 36880485.

reduce hospitals' Medicare reimbursement, often as a result of budget neutrality requirements in federal law that have the effect of redistributing funding from some hospitals to others. The figure to the left illustrates how far Medicare payments have diverged from what it costs to operate hospitals in different parts of the state. It shows the degree to which 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 the operating costs. Were the area wage index working properly, hospital margins on the traditional Medicare book of business would not have a consistent trend with the area wage index, since the area wage index-related payment adjustments would offset differences in regional costs. But there is a starkly negative trend, clearly indicating that the area wage index fails to fully compensate for the higher costs at hospitals located in more expensive areas. Differences in average salaries for nonsupervisory workers between OHCA's high-cost and other hospitals bear this out. While high-cost hospitals pay their nonsupervisory workers 21% more, their area wage index scores are just 8% higher, revealing wholly inadequate and inequitable cost coverage from Medicare payments.

A Handful of Payment Policies Cause a Significant Portion of the Medicare Funding Losses Incurred by Hospitals. A small set of distortions reduces Medicare payments to California hospitals by more than $1.3 billion annually, including:

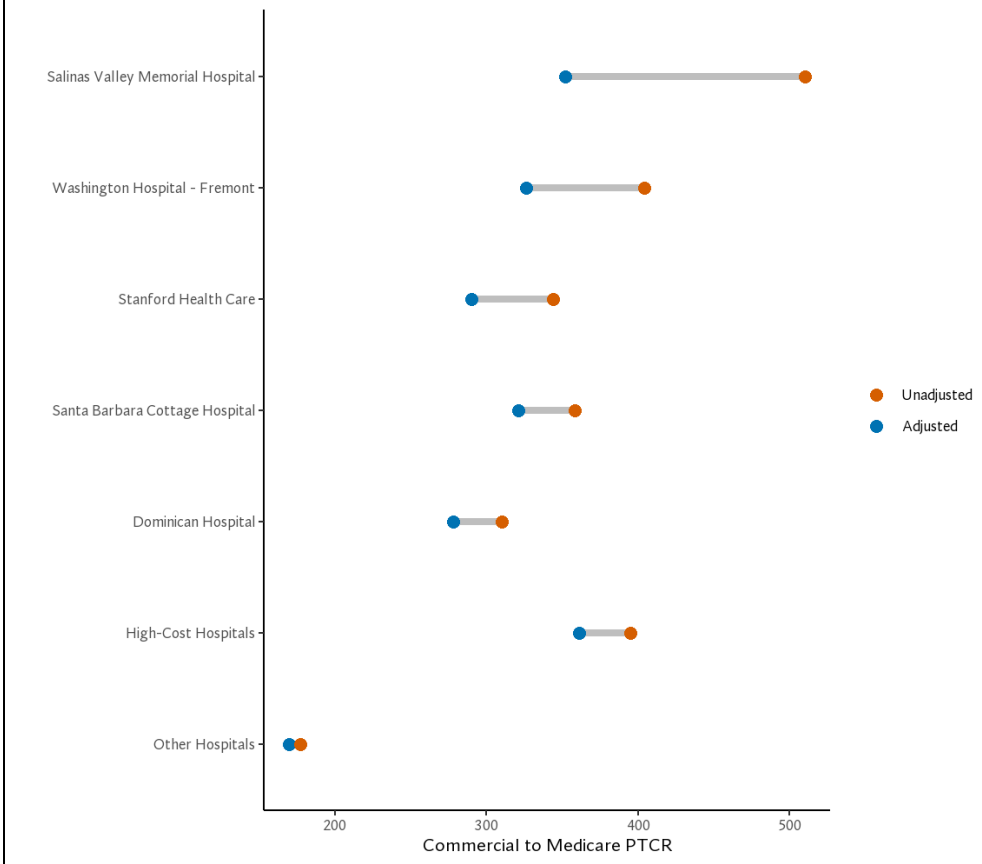
- **Occupational Mix Adjustment.** Due to nurse-staffing ratios, California hospitals employ a higher number of nurses relative to other professionals than hospitals nationally. However, for the purpose of estimating hospitals' area wage index scores, the federal government reverts the occupational mix of California's hospitals to the national average. This reduces California hospitals' Medicare payments by $435 million, with OHCA's high-cost hospitals bearing two to three times the losses of other hospitals, again distorting how hospitals score on OHCA's commercial-to-Medicare payment-to-cost ratio measure.
- **Graduate Medical Education Caps.** Medicare pays hospitals for providing graduate medical education, but the funding is generally capped at 1996 levels. As a result, California hospitals train more than 3,000 residents annually without any financial support from Medicare. One California

hospital on OHCA's high-cost list bears more than 25% of the $430 million in losses in Medicare funding due to the cap artificially boosting its commercial-to-Medicare payment-to-cost ratio score.

- **Rural Floor Adjustment.** Medicare imposes a floor on urban hospitals' wage index scores equal to the statewide rural area wage index score. In California, this policy redistributes more than $100 million in Medicare payments away from hospitals in the Bay Area, Central Coast, and greater Sacramento region to other hospitals throughout the state. Predictably, hospitals in these three regions dominate OHCA's high-cost hospital list, in part due to this redistributive component of Medicare hospital financing.

Commercial-to-Medicare Payment-to-Cost Ratio Penalizes Hospitals with Worse Medicare Reimbursement. The $1.3 billion in Medicare funding losses are not borne equitably by all California hospitals. The 11 hospitals identified by OHCA as high cost represent a mere 3% of all hospitals in the state, but collectively bear nearly $300 million (21%) of the statewide losses from these distortions in Medicare payment policies. This artificially reduces their Medicare payment-to-cost ratio (the denominator in OHCA's measure), biasing their overall score on OHCA's commercial-to-Medicare payment-to-cost ratio upward. The figure to the right shows the effects these adjustments have on several high-cost hospitals' 2022 commercial-to-Medicare payment-to-cost ratios, while also showing the disproportionate effect on OHCA's high-cost hospitals. OHCA's spending targets must account for these inequities, not compound them by imposing harsher spending targets on hospitals with the greatest reductions in Medicare payments.

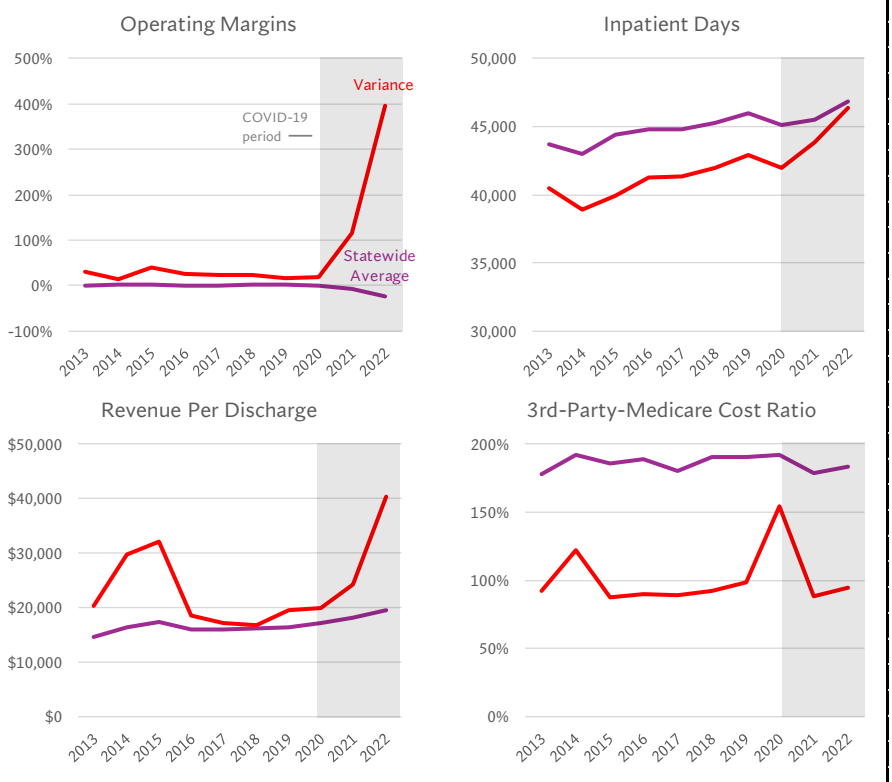
Correcting for Major Distortions in Medicare Payment Policies Substantially Reduces OHCA's High-Cost Hospitals' Scores on the Commercial-to-Medicare Payment-to-Cost Ratio (PTCR)



Note: Five Medicare payment policies artificially reduce hospitals' Medicare payments, depressing their Medicare payment-to-cost ratios, and inflating their scores on OHCA's relative cost measure. These reductions are not born equitably among hospitals. Instead, OHCA's high-cost hospitals bear a disproportionate burden. The five Medicare payment policies are: (1) the rural floor on the area wage index, (2) an adjustment to the area wage index to revert California's occupational mix to the national average, (3) caps on graduate medical education funding, (4) Medicare disproportionate share hospital funding reductions, and (5) limits on payments for bad debt.

Identifying Hospitals as High Cost Based on Financial Performance During the Pandemic Runs Counter to State Law. OHCA has proposed using data from 2018 through 2022 to determine which hospitals are high cost, completely disregarding the fact that the worst pandemic in a century hit in March 2020. In addition to upending people's lives and livelihoods, COVID-19 severely tested health care providers' finances and operations. Routine services were canceled, patients came to hospitals with greater health needs, costs exploded, and health care workers experienced unprecedented levels of burnout. As the figure to the left shows, these anomalies show up in the financial data OHCA is using to determine which hospitals are high cost.

Hospital Finances and Patient Volumes Were Highly Volatile During the COVID-19 Period



Financial metrics are calculated using same data and methodologies used by OHCA. Accordingly, "Revenue Per Discharge" is shorthand for inpatient net patient revenue per case-mix adjusted discharge. Variance is measured using standard deviation, making it directly comparable to the statewide average.

Recognizing the abnormalities in COVID-19 years and their potential to distort historical trends, state lawmakers required that OHCA's spending target methodology *"shall provide differential treatment of the 2020 and 2021 calendar years due to the impacts of COVID-19 on health care spending and health care entities"* (Health and Safety Code Section (HSC §) 127502(d)(3)).

Identifying "high cost" hospitals by measuring hospital performance **without differentiating for those years** ignores an important and express legal requirement to appropriately account for the impacts of COVID-19 on hospital and other health care providers' financing and operations. This disregard for the statutory requirement has a material effect — four hospitals on OHCA's high-cost list only meet the qualifying criteria based on their performance in 2020 and 2021, the two years lawmakers required to receive differential treatment.

Data Anomalies Show Analysis and Adjustments Are Needed. The data OHCA is using to determine which hospitals are high cost were neither designed nor have been used for OHCA's intended administrative purpose. Unsurprisingly, even a high-level review of the data has revealed anomalies and inconsistencies both over time and across hospitals. For example:

- **Abrupt Shifts in Commercial Reimbursement.** Two hospitals' commercial inpatient reimbursement per case mix-adjusted discharge measures fell precipitously during the period

under review, reflecting commercial reimbursement rate cuts of roughly 25% and 50% or, alternatively, the correction of previously faulty data.

- **Sudden Change in Medicare Cost Coverage.** One hospital saw its commercial-to-Medicare payment-to-cost ratio more than double in a one-year period due to its Medicare payment-to-cost ratio suddenly falling in a single year from roughly 0.6 (in line with the average for the other designated high-cost hospitals) to around 0.2 (64% lower than the average for those hospitals).
- **Differences in Reported Revenues Across Hospitals.** One hospital has a unique reporting structure that requires it to combine its professional and facility revenues in reporting its patient revenue; other hospitals only report their facility revenues. This difference in reporting increases the hospital's reported revenues by an estimated 10%, biasing its scores on OHCA's measures upwards.
- **Payments from Other Payers Are Wrongly Designated as Hospital Commercial Revenues.** Hospitals' financial reports did not separate out the payments they received from commercial payers during the five-year period used by OHCA to designate high-cost hospitals. Rather, these payments are lumped together with others, including those for government programs overseen by the Department of Health Care Services (DHCS) like California Children's Services, the Child Health Disability Prevention program, the Genetically Handicapped Persons Program, and the Short-Doyle program. Including funding from these programs distorts hospitals' measured performance on at least one of OHCA's measures.

OHCA must conduct further analysis and make appropriate changes to its proposal to ensure it is based on the best possible data before taking actions that endanger the financial and operational futures of the affected hospitals. For example, OHCA must provide hospitals with the opportunity to submit updated filings to correct clear errors, as is common with other state agencies that oversee hospital finances and reporting, like the DHCS. It also must properly separate out hospitals' commercial revenue from other sources given its intent to determine which hospitals are high cost based on their commercial reimbursement levels.

OHCA's Approach Yields an Incoherent Set of Hospitals. OHCA has set out to identify the highest cost hospitals in the state that substantially contribute to high health care costs broadly. The list generated, however, obviously does not match. It includes:

- Two Medicaid disproportionate share hospitals, which serve large numbers of Medi-Cal patients — California's most vulnerable seniors, children, and low-income individuals
- Six independent hospitals, which have little to no influence on the broader health care marketplace
- Two rural hospitals, which serve crucial roles in providing care to patients who have fewer options than those in urban areas
- Three small hospitals that discharge fewer than three commercial patients per day
- Four hospitals that lost money on their operations in 2022 and three that lost money in 2023 (with 6 of the 11 hospitals having unsustainable operating margins of less than 3%)

What's more, looking beyond commercial payers to Medi-Cal, Medicare, and other payers, 9 of the 11 hospitals were below the top 20% in all-payer reimbursement per case mix-adjusted discharge in 2022. In fact, one hospital's all-payer reimbursement was in the bottom 40% of all comparable hospitals and another's was in the bottom 60%, in both cases due to their low commercial volumes and poor reimbursement from government payers. What these hospitals do have in common is a tireless

dedication to serving their communities and providing accessible, high-quality, and affordable care, including for Californians who can least afford it.

Proposed Targets for High-Cost Hospitals Are Inconsistent with State Law and Would Jeopardize Access to Quality Care and Workforce Stability

OHCA Lacks Authority to Adjust Sector Targets as Proposed. State law establishes several authorities under which OHCA may impose spending targets on one or more health care entities. These include:

- **The statewide target**, applicable to all regulated health care entities (HSC § 127502(a))
- **Sector targets**, specific targets by health care sector, which may include fully integrated delivery systems, geographic regions, and individual health care entities (HSC § 127502(b)(1))
- **Targets adjusted by sector** (HSC § 127502(b)(2))
- **Adjusted targets for high- and low-quality providers**, targets adjusted downward "for health care entities that deliver high-cost care that is not commensurate with improvements in care," and vice versa (HSC § 127502(d)(6)(A))
- **Labor cost-adjusted targets**, accounting for actual or projected nonsupervisory employee organized labor costs (HSC § 127502(d)(7))
- **Individual entity sector targets**, based on an entity's status as a high-cost outlier (HSC § 127502(e)(1)).

In January 2025, OHCA's board assented to staff's recommendation to (1) define all hospitals as a single sector and (2) adjust the target for all or a specified subset of hospitals within the hospital sector. OHCA cited HSC § 127502(b)(2) as its legal authority to proceed as recommended. This provision states:

> *"The board may adjust cost targets **by** health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, when warranted to account for the baseline costs in comparison to other health care entities in the health care sector and geographic region." **(emphasis added)***

While OHCA's cited legal authority allows it to adjust targets **by** sector, it has proposed to adjust targets and apply differential standards **within** a single prospective sector. Related provisions in the enabling statute all conform with the above language, only allowing OHCA to establish or adjust targets **by** sector. While there are arguably exceptions under specified conditions where OHCA has authority to impose different targets within the same sector (see, HSC § 127502[d][6][A],allowing adjustment of targets upward or downward based on the level of quality improvement, and HSC § 127502[d][7], requiring target adjustments to account for nonsupervisory employee organized labor costs), neither of those scenarios are applicable to the immediate high-cost hospital proposal.

Instead, when setting a target for a high-cost entity that is different from the statewide or sector target that would otherwise apply, HSC § 127502(e) contemplates accomplishing that only through adoption of a sector definition comprised of that individual health care entity, to which uniquely established or adjusted targets could be applied based on the entity's status as a high-cost outlier or to encourage the entity to serve populations with greater health risks. The requisite use of one target per defined sector, outside the potential exceptions noted above, is further supported by HSC § 127502(*l*)(2)(D), which requires OHCA to "specify which single sector target is applicable if a health care entity falls within two or more sectors." **As a result of exceeding its statutory authority, OHCA must withdraw its hospital sector target proposal and return with an alternative consistent with its enabling statute.**

OHCA's Proposed Sector Target Value for 2026 Doesn't Align with Methodology, Potentially Due to Premature Rounding. OHCA's method for determining high-cost hospitals' sector target values is to derive a relativity score based on how much more costly this set of hospitals is on OHCA's two measures, compared to other hospitals. Then, OHCA divides the statewide spending target by this relativity score. This approach lacks a sound foundation by misapplying a within-year measure of hospital costliness to an across-year measure of hospitals' cost growth over time. In addition, as described later, it fails to consider whether the resulting target values are attainable, sustainable, and protective of access to care. On top of all these shortcomings, the starting value of the sector target is a full decimal point lower than expected according to the data and methodology presented at the February 2025 board meeting. Rather than resulting in a 1.8% value, CHA's replication of OHCA's presented methodology returns a 1.9% value — a seemingly small difference, but with major financial implications. OHCA's lower-than-expected value is likely due to premature rounding of the relativity scores, rather than waiting until the final calculation to round to the desired, single decimal point.

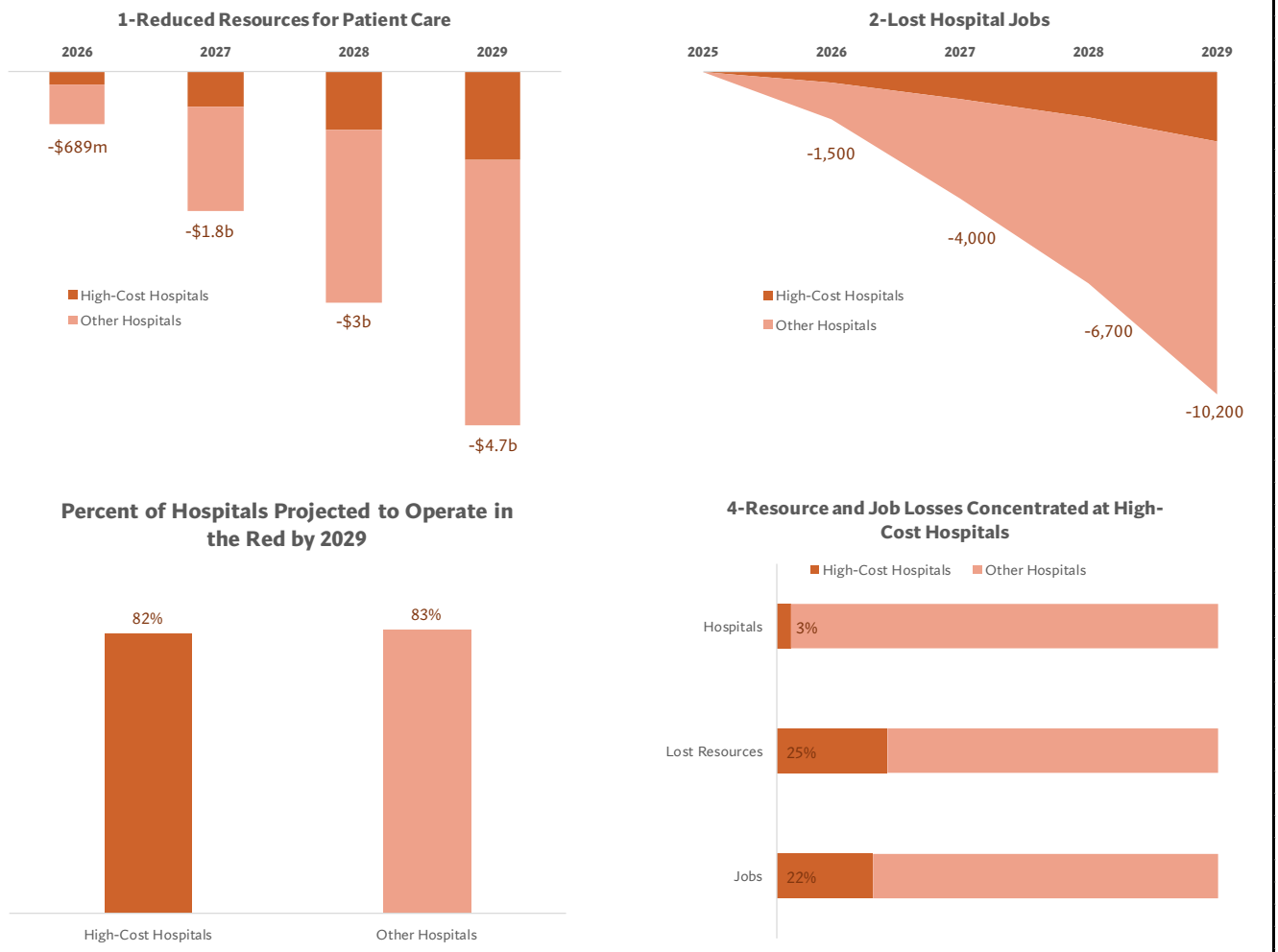
On Their Own, Proposed Sector Target Values Would Decimate Access to High-Quality, Equitable Care and Workforce Stability. OHCA has proposed sector targets of between 1.6% and 1.8% annually on hospitals designated as high cost. Such targets are 35% below projected inflation for all goods and services — even before factoring in the impact new tariffs will have on pricing for medical devices, pharmaceuticals, and other supplies hospitals need. This means real, inflation-adjusted cuts in hospital resources are coming, with real consequences for patients and health care workers.

What's worse, this understates the true magnitude of the proposed cuts given the current extraordinary cost growth pressure hospitals are facing. 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. The proposed high-cost hospital sector targets are 70% to 80% lower than the recent cost growth for these essential inputs. Such targets could only be met with draconian cuts to the affected hospitals' workforces and service lines, as well as the abandonment of investments to expand access to high-quality care.

The figure on the next page drives home the catastrophic effects of OHCA's proposed high-cost hospital sector target, in combination with the statewide target, on hospital care in the current inflationary environment. The figure compares projected revenue under the spending targets (starting at 1.8% for hospitals designated as high cost and 3.5% for other hospitals) and what is expected given recent trends. **The end result: 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.** These consequences would overwhelmingly fall on the high-cost hospitals; despite the proposed 11 hospitals representing just 3% of statewide hospitals, they would bear 25% of the losses in resources and 22% of the resulting job eliminations. Hospitals would be forced to take drastic actions to reduce services and workforce, or risk closing entirely. This would devastate the health and well-being of local communities.

Hospital Sector Targets Would Endanger Hospital Care in California, Especially in Areas with Hospitals Designated as High Cost

Projected Impact of the Statewide and Proposed Sector Targets on Hospital Resources, Jobs, Financial Sustainability



Notes:

Panel 1: Hospital resources are defined as net patient revenue. Lost resources reflect the difference between recent historical growth in net patient revenue and growth allowed under the spending targets.

Panel 2: Job losses are projected based on the expectation that hospitals scale down their workforces proportionate to their lost revenues.

Panel 3: Hospital operating margins are projected as the difference between allowable revenue growth under the spending targets and projected expense growth using recent historical trends.

Panel 4: Uses the definitions and terms defined above to show that despite making up a small portion (3%) of all hospitals in the state, OHCA's high-cost hospitals would bear enormously disproportionate negative consequences due to their reduced targets.

Negative Impacts of Proposed Targets Would Not Be Nullified by Selective Enforcement on the Back End. OHCA staff have promised to practice discretion and not aggressively enforce the sector targets in circumstances where excess growth is beyond the hospital's control. Unfortunately, the mere possibility of being forgiven at a later date for excess spending growth does not offer the security needed to avoid the devastating consequences of the sector targets under discussion. First, the designated hospitals would face major reputational consequences, causing patients — including those on Medicare and Medi-Cal — to seek care elsewhere. Second, health insurance companies would immediately pressure hospitals to accept rate increases at the insufficient sector target level. Hospitals would be left with no good options: those that accept the insufficient rate increases would inevitably be forced to make real cuts in patient care, while those that cannot accept the offered rates would undoubtedly face contract

terminations (this recently played out in San Diego, where thousands of patients lost their usual source of care because of an insurer's efforts to push inadequate rates on a local hospital). Third, the targets would stifle investment aimed at improving access to high-quality care, as affected hospitals will have no assurance that the increased revenues funding these investments will not be taken away on the back end due to violation of the aggressive targets.

Combining Proposed Sector Targets and Looming Federal and State Funding Cuts Would Unnecessarily Imperil Care. Federal policymakers are currently considering proposals to drastically cut funding for vital health care programs, potentially by tens of billions of dollars annually. Meanwhile, the state's already precarious budget situation on its own could necessitate significant cuts to health care programs and unquestionably forestalls the state's ability to backfill lost federal funding. Medi-Cal and Covered California are uniquely at risk. Millions of Californians could lose coverage, causing newly uninsured Californians to seek care in hospital emergency departments in droves; benefits and provider rates are similarly exposed to potential cuts. This would turn an already challenging financial environment, wherein more than half of California's hospitals operate in the red, into a full-blown crisis. Compounding federal funding threats and potential state budget solutions with unconscionably low sector targets would all but guarantee the dire consequences the Legislature sought to avoid when it initially created OHCA: cuts in hospital services, if not outright closures; chilling effect on investments; jobs lost; and reduced access to care for millions of Californians. Highly consequential decisions on sector spending targets must consider these potentially catastrophic policy changes for government health care programs. Finalizing a proposal before state and federal decisions are made would demonstrate a troubling disregard for OHCA's statutory mission to sustain and promote access to high-quality, equitable care. OHCA must take stock of the looming cuts to federal and state health care program funding before imposing even more aggressive targets than the statewide target currently in place.

OHCA Has Provided No Assurance That Patients Would Benefit from Sector Targets. OHCA has yet to propose a plan to ensure that the reduced spending targets imposed on hospitals would be passed to consumers in the form of lower premiums and cost sharing, rather than simply being retained by payers as higher profits. While payers contracting with the high-cost hospitals would benefit from limiting the growth of payments in 2026 to 1.8%, these payers' targets would remain at the statewide level, generating a margin for payers to use as they see fit, including for administration and profits. A comprehensive approach to sector targets could take this into account and ensure that commensurate adjustments are applied to payer targets to ensure that Californians actually benefit from differentiated provider targets OHCA is imposing.

Sector Target Proposal Is Inconsistent with the Letter and Spirit of State Law in Failing to Consider All Relevant Statutory Factors. In creating OHCA, state lawmakers clearly sought to prevent pure cost cutting at the expense of other goals for the state's health care system. Instead, they mandated OHCA proceed in a balanced fashion to

> *"improve the affordability, quality, equity, efficiency, access, and value of health care service delivery"* (HSC § 127500(c)).

Aside from the legislative intent, the spending target provisions in statute provide the same direction, requiring that all spending targets

> *"promote the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness"* (HSC § 127502(c)(5)).

This requirement to balance affordability with other equally important factors is specifically imported to the adoption of sector targets, stating they

> *"shall be informed by… consideration of access, quality, equity, and health care workforce stability and quality jobs"* (HSC § 127502(b)(3)).

Further, the enabling statute requires consideration of other factors in addition to or supplementing these overarching goals, including:

- HSC § 127502(c)(5): Targets must promote the stability of the health care workforce, both present and in the future
- HSC § 127502(d)(3): Target methodology must provide differential treatment of COVID years
- HSC § 127502(d)(4): Target methodology must allow for consideration of a host of factors impacting costs including but not limited to health care employment cost index, provider payer mix, state or local mandates, and federal/state policy changes
- HSC § 127502(d)(5): Target methodology must consider the level of hospital self-financing associated with Medi-Cal payments
- HSC § 127502(e): Target methodology for an individual health care entity sector must allow for treatment as a high-cost outlier while encouraging the entity to service populations with greater health risks taking into account patient mix and geographic costs
- HSC § 127502(*l*)(2)(C): Sector targets must be developed in a manner that minimizes fragmentation and potential cost shifting, and that encourages cooperation in meeting targets

Despite the clear requirements in state law that these 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. Similarly, OHCA has ignored or given merely cursory attention to these other legislatively mandated considerations in rushing to finalize its flawed proposal. Thus, OHCA has fallen short in its duty to adequately consider all the relevant statutory factors and demonstrate a rational connection between those and the targets embodied in its proposal. Most alarmingly, OHCA has provided no assurance that the exact consequences the Legislature sought to avoid would not inevitably follow the strict cost-cutting nature of the proposed sector targets. In light of recent hospital expense growth, alongside further imminent cost increases due to tariffs, other economic challenges, and looming federal/state budget actions, it is essential for OHCA to perform its due diligence to ensure that access to high-quality, equitable care is protected under its spending targets.

California's Hospitals Ask OHCA to Withdraw Its Proposal and Maintain the Statewide Spending Target for All Regulated Entities

OHCA's proposed hospital sector targets are three years ahead of the statutory timeline, are inconsistent with various requirements in state law, are based on data and methodologies with known shortcomings, and would jeopardize access to hospital care in communities across the state. The proposal has come before OHCA has given consideration to any other sector, evaluated the sustainability of the statewide spending target, or done the necessary groundwork to assure California's patients that its sector targets will maintain access to care, quality, and workforce stability. For these reasons, California's hospitals respectfully ask OHCA to withdraw its proposal and defer action until the above antecedent steps can be completed.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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

UNITE HERE! LOCAL 19

Enrique L. Fernandez - **Business Manager** • Debra Rockwood - **Financial Secretary - Treasurer**
Raquel Alvarez - **President** • Rose Rodriguez - **Vice President** • Sarah Julian - **Recording Secretary**
Trustees: Majid Barghi, James Kerkstra, Dolores Dominguez • **Executive Board:** Arturo Garcia, Scott Loberg, Alma Navarro, Jose Barba, Samuel Rasheed, Carlos Cortes

Wednesday, April 3, 2025

Secretary Kim Johnson
Chair, Office of Health Care Affordability
c/o Megan Brubaker (Megan.Brubaker@hcai.ca.gov)
2020 West El Camino Avenue, Suite 1200
Sacramento CA 95834

Dear Secretary Johnson and OHCA Board Members:

UNITE HERE Local 19 represents a diverse group of over 7,000 hardworking members who are integral to the hospitality and service industries in the Silicon Valley, Central Valley, Yosemite, and Monterey areas. These workers, who include hotel staff, food service employees, and other essential service workers, are known for their dedication and tireless efforts in delivering high-quality services to locals and tourists alike. Their commitment to their work often involves long hours with a good portion of our members working two or three jobs with demanding physical labor all while still managing to provide exceptional customer service. As a result of these hardworking efforts, Local 19 members have seen significant improvements in their lives through union representation, particularly in securing vital health care benefits.

One of the most important benefits Local 19 helps its members achieve is access to comprehensive health care coverage. This has been a crucial factor in improving the quality of life for many workers, especially in an industry where health benefits can often be limited or unavailable. With strong union representation, members gain access to medical, dental, and vision care, which not only helps them stay healthy but also provides peace of mind for their families. By securing these benefits, UNITE HERE Local 19 helps ensure that its members are supported both in their professional and personal lives, allowing them to focus on their work without the added stress of inadequate health care coverage. These benefits are a key part of the union's mission to ensure fair treatment and a better quality of life for all its members.

I write to urge you to adopt the proposed hospital sector definition and adjustment methodology for high-cost outliers. I also appeal to OHCA to take an aggressive approach to limiting health care cost growth, especially in the commercial market.

Our union has to bargain for the funds that pay for health benefits. That means every penny that goes to paying for rate increases is a penny that's not available for wage improvements, retirement security, or improved staffing levels. Over the last two decades, health care premiums have grown at more than twice the rate of inflation – even faster even than housing costs. With hospital-based costs accounting for around 40% of all health spending, reining in costs in that sector is critical.

The big majority of our members are excluded from Medi-Cal and from subsidized Covered California plans by virtue of their incomes, employment-based offers of coverage, or both. But that

does not mean it's easy for them to make ends meet in California today. The security that union-bargained health benefits provides them is absolutely indispensable to them and their families.

Hospital companies have recently started using the administration in Washington's attack on federal health funding as a rationale for raising prices even further. Whether they do so under the auspices of Congressional cuts, or any other excuse, the result will be the same: a further erosion of our members' security, and an even worse affordability crisis for working people in our state.

Please don't delay limiting the growth of health spending in the hospital sector, and take quick and effective action bend the cost curve in health care generally.

Yours truly,

Enrique L. Fernández
Business Manager of UNITE HERE Local 19

cc:
Members of the OHCA Board:
Dr. David Carlisle
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Dr. Donald Moulds
Dr. Richard Pan

Asm. Mia Bonta, Chair of the Assembly Health Committee, c/o Lisa Murowski (Lisa.Murawski@asm.ca.gov)
Sen. Caroline Menjivar, Chair of the Senate Health Committee, c/o Jen Flory (Jen.Flory@sen.ca.gov)
Richard Figueroa, Deputy Cabinet Secretary, Office of Gov. Gavin Newsom

LOCAL 521 SEIU Stronger Together

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REDWOOD CITY
This location has been closed. Please mail correspondence to our San Jose Headquarters

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www.seiu521.org

April 4, 2025

Sent via Electronic Mail: SACReceptionist@hcai.ca.gov

Office of Health Care Affordability
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833

Office of Health Care Affordability Board Members:

On behalf of the over 50,000 members represented by our Union, representing working families across the Monterey Bay region who are burdened by unaffordable healthcare, we urge the Office of Health Care Affordability (OHCA) to take immediate and targeted action to address excessive healthcare costs in our community.

While we commend OHCA's statewide annual cost growth target of 3%, this benchmark fails to address the acute crisis in Monterey County, where three of California's eleven most expensive hospitals operate: Community Hospital of the Monterey Peninsula, Salinas Valley Memorial Hospital, and Dominican Hospital. These institutions are consistently identified as high-cost outliers, with prices disconnected from quality or patient outcomes, placing an unsustainable strain on our members and the broader community.

Our Demands to OHCA:

1) Impose Lower Growth Targets for High-Cost Hospitals:
   a) The 3% statewide target is untenable for hospitals already charging exorbitant prices. We demand OHCA set a sector-specific growth limit of 0.1% or lower for these identified outliers without delay.

2) Enforce Transparency and Accountability:
   a) OHCA must use its authority to mandate detailed public reporting from these hospitals justifying their costs, with penalties for non-compliance.

3) Prioritize Monterey County for Intervention, Leverage OHCA's data analysis, enforcement, and regulatory tools to:
   a) Cap unjustified price increases.
   b) Investigate anticompetitive practices in our consolidated market.
   c) Collaborate with local stakeholders to implement corrective measures.

4) Reject Further Delays:
   a) 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.

Why This Matters:

- Over half of Californians skip or delay care due to costs—worsening health disparities.
- Monterey County's hospital prices are among the highest in the state, yet wages and access lag.
- OHCA has the statutory power and moral obligation to intervene.

We stand ready to mobilize our coalition to ensure OHCA fulfills its duty. The time for studies and incrementalism has passed. Monterey County needs enforceable cost controls now.

Sincerely,

Alicia Metters
Region II Vice President
Monterey, San Benito & Santa Cruz Counties

DN/sjw

cc: Riko Mendez, SEIU 521 Chief Elected Officer
Olivia Martinez, Region II Director
Monterey Bay Central Labor Council

Antelope Valley
Medical Center

April 3, 2025

Megan Brubaker
Office of Health Care Affordability
2020 W El Camino Ave., Suite 1200
Sacramento, CA 95833

Subject: **OHCA's Cost Cutting Measures Hurt Patients Like Me**
(Submitted via email to OHCA@HCAI.ca.gov)

Dear Ms. Brubaker:

Thank you for the opportunity to share my story. As a Californian who relies on care from Antelope Valley Medical Center, a facility of Antelope Valley Healthcare District; I'm greatly concerned that the Office of Health Care Affordability's attempts to cut health care costs will cause our patients and their families.

- **AVMC has a service area is 1,500 square miles that is located in the high desert of the northernmost part of Los Angeles County and east Kern County. As a level 2 Trauma Center, our medical center is vital for patient care. We serve well over 120,000 patients annually in our Emergency Room.**
- **We offer a wide array of services that include a pediatric unit, level IIIB NICU, EDAP, Behavioral Health Unit, Women's and Infants Pavillion including Labor & Delivery, Couplet Care, Perinatal Services, OB/Gyn Outpatient Services, Institute for Heart and Vascular Services, Accredited Chest Pain Center, Comprehensive Stroke Center, STEMI Receiving Center, National Comprehensive Community Cancer Center, and Home Health.**
- **This year we will open a Transplant Service Line and Pediatric Intensive Care Unit.**
- **In recent months we have also expanded outpatient services to better serve our community that include an Infusion Center, Laboratory Services, Rehabilitation, Expansion of our Emergency Department and Pharmacy Services.**

Please protect the lifesaving care for our patients and community.

Sincerely,

Edward Mirzabegian, MHA
Chief Executive Officer

Washington Health

June 4, 2025

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

Subject: **Office of Healthcare Affordability and Washington Health**
(Submitted via email to Megan Brubaker)

Dear Chair Johnson:

I write today to request that the Health Care Affordability Board remove Washington Health (WH) from the high-cost hospital list based on factors discussed below.

As a District hospital and a non-designated public hospital, Washington Health shares the goals of OHCA to improve the affordability of the health care system and maintain access to high quality health care. We do not believe that subjecting WH to the 1.8% growth target rate will achieve those goals, but instead will actually lead to higher health care costs as a result. In addition, WH is in the process of resubmitting data to HCAI to provide a more accurate representation of our financial situation, which we believe will result in WH no longer meeting the threshold for being a high-cost hospital.

On May 23, we met with OHCA staff to share information about how Washington Health's annual financial filings with HCAI have miscategorized certain health care data related to WH's self-insured status. This reporting error appears to have led the OHCA staff to overestimate WH's metrics, leading the health system to be included in the high-cost hospital category. Once WH has refiled its financial data with HCAI and the OHCA staff has been able to re-calculate the data, we request that the Health Care Advisory Board remove Washington Health from the high-cost hospital list.

Understanding that this may take some time, we also request that the Health Care Affordability Board make a public statement at the June Board meeting stating that OHCA staff is working with Washington Health to reconcile the reporting data.

We are gravely concerned that in order to meet this lower target rate, Washington Health will have no choice but to reduce or eliminate critical health services at a time when southern Alameda County residents are already facing serious health-care access challenges. We fear that the impact will be a reduction in timely access to non-emergent hospital services, forcing constituents to travel out of South County.

For decades, Washington Hospital has been a community champion in South County, providing high-quality health care to patients, regardless of their ability to pay. WH has also invested heavily in offering programs, classes, and services free of charge or at a

2000 Mowry Avenue
Fremont, CA 94538
510.797.1111

www.washingtonhealth.com

reduced cost. While we support the objectives and goals of OHCA to increase affordability and maintain access to the highest quality care for patients, the actions being pursued by the Health Care Affordability Board will only jeopardize our ability to continue this level of service to the community.

We appreciate your attention to this matter and look forward to your response.

Sincerely,

Kimberly Hartz
Chief Executive Officer
Washington Health

cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Senator Aisha Wahab
Assemblymember Alex Lee
Assemblymember Liz Ortega

HEALTH ACCESS CALIFORNIA

June 4, 2025

Kim Johnson, Chair,
Health Care Affordability Board

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

2020 W. El Camino, Ste. 800
Sacramento, CA 95833

Re: June 9, 2025 Health Care Affordability Board Meeting,

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

Health Access California, the statewide consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments on the target for very high-cost hospitals, benefits to consumers of cost growth targets, and measures of access, equity, quality and workforce stability, as well as principles and considerations for enforcement of the cost growth targets generally, and other matters.

We offer comments on the first-in-the nation adoption of lower cost growth targets for very, very high-cost hospitals. We also offer on how the OHCA targets that apply to health plans and insurers work together with medical loss ratio and rate review to benefit consumers. California law governing health plans and insurers also has numerous consumer protections assuring access to medically necessary care. State agencies, both regulators and contracting entities with managed care plans such as CalPERS and DHCS also have numerous measures of equity and quality. OHCA has added measures of workforce stability to track workforce impacts of cost growth targets. Finally, we turn to a beginning discussion of important elements of enforcement.

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

I. Very High-Cost Hospitals: Adoption of lower targets

A. Health Access Commends First-in-the-Nation Action to Set Lower Targets for Very, Very High-Cost Hospitals

Health Access commends the action of the Health Care Affordability Board to adopt lower cost growth targets for very, very high-cost hospitals. To us, it makes sense that hospitals with services that cost twice as much as those of the average hospital have a cost growth target half as high as the overall cost growth target that applies to all hospitals, insurers, health plans and large physician organizations.

In taking this action, California becomes the first state in the nation to set differential targets for very high-cost health care entities and to do so in a way that promotes convergence toward the mean, albeit over a long period. Addressing high-cost health care entities without commensurate improvement in quality is built into the governing law for the Office of Health Care Affordability. The Board action to adopt the lower cost growth targets for the very, very high-cost hospitals begins to make that a reality.

B. Annual Review of Very High-Cost Hospitals

Health Access supports annual review of very high-cost hospitals on a timeline consistent with the annual timeline for cost targets. This approach will reward those very high-cost hospitals who lower cost growth to grow closer to the mean by offering the potential to move to a higher cost growth target. As the Board discussed, annual review also includes the possibility that some hospitals will meet the thresholds as a very high-cost hospital and receive a lower target in future years. Hospitals with high costs that are only slightly below the thresholds set by the Board may go over those thresholds in the future.

Annual review of the very high-cost entities will allow evolution in measures, such as adding measures of the cost of outpatient care as the measure of intensity of outpatient services is developed. Other methodological improvements may include looking at confidence intervals for the thresholds for very high-cost entities. We also note that while this initial round focused on hospitals, other entities such as health plans and physician organizations merit future consideration.

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

C. Data Verification Steps

We were troubled by the statement by staff at the April Board meeting that any hospital wishes to correct its data that the hospital has previously submitted to HCAI and attested to its accuracy may do so. The opportunity for health care entities to revise the data retrospectively invites hospitals who don't like the results to cook the data after OHCA analyzes that data or to fail to take seriously the need for accurate reporting of data. Instead, hospitals should be encouraged to submit accurate data. The burden of reporting accurate information should rest with the data submitters. Enforcement of cost targets creates a considerable incentive to misreport or to revise data in order to escape enforcement. The current process of verification through desk audits for completeness may not suffice in this context.

A desk audit by HCAI of the data did not catch the substantial error in reporting that NorthBay persisted in for years by reporting Medicare Advantage revenue as commercial. This was both a large error and a consequential one. A simple cross check with another data source, perhaps even the HCAI hospital discharge data or the forthcoming HPD data, would have caught an error of that very considerable magnitude.

Health Access recommends that HCAI take steps to ensure that data is accurate as well as reported in a manner that superficially conforms to reporting requirements. Among the steps we suggest are:

1) Limit the period during which entities can revise data after submission to one year after data submission and require other errors to be corrected on a going-forward basis.
2) Report at each Health Care Affordability Board meeting on any hospital that revises its historical hospital financial data, the reason for the request, the likely impact of the changes, and the hospital attestation as to its efforts to minimize future errors. This will create a public record and allow monitoring: this step will be important as OHCA proceeds with enforcement.
3) Conducting a basic quality assurance process on data submissions to identify major errors in accuracy and reasonableness, in addition to the desk audit for completeness. We do not suggest that HCAI conduct labor-intensive full audits but rather a cross check against other data sources to catch major errors, such as reporting Medicare revenue as commercial. OHCA has

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considerable authority to obtain information from health care entities and should use it as needed to cross-check data submissions.

4) Offer public refresher courses on HCAI financial reporting, open to interested parties, including advocates and others as well as those doing the reporting. These courses should include the uses to which the data is being put.

There may be other steps to provide transparency and improve accuracy of data that are obvious to others. This effort need not be exhaustive, but hospitals and other entities should face some degree of accountability for self-reported data and not simply be excused from accountability under the targets by changing previously reported data without oversight or verification of the corrected data.

In short, trust but verify.

II. Benefit to Consumers, Working Families and Other Purchasers: Insurers and Health Plans

Before the creation of OHCA, costs for hospitals, physicians, and pharmaceutical manufacturers escalated without limit, leaving consumers and other purchasers to pay higher and higher insurance premiums for coverage with more cost sharing while there was no public venue for complaint, aside from the legislative process. The Health Care Affordability Board now provides a public venue where consumers can speak out about the negative impacts of health care costs created by escalating claims costs for hospital care, professional services, prescription drug costs and more.

Small businesses can, and have, dropped coverage or failed to offer it because the cost of coverage keeps climbing. Larger employers are required to provide coverage to some workers but not all. In response to higher and higher health care costs, most larger employers have shifted more and more of the cost of care and coverage to workers and their dependents or even eliminated coverage for dependents. Most consumers and working families cannot even drop coverage because of the individual mandate. In most instances, we have no choice but to pay the price, whatever it is[1].

[1] The ACA and now California law does allow those consumers whose costs are very high to be excused from the individual mandate.

Some have asserted that somehow health plans and insurers have escaped scrutiny. In fact, the opposite is true. Insurers and health plans are subject to not only the OHCA cost growth targets but also a medical loss ratio and annual rate review, laws that are designed to benefit consumers and other purchasers. Instead, it is hospitals, health systems, physician organizations and pharmaceutical manufacturers that have raised prices and costs with impunity, able to ignore the impact on consumers and other purchasers of higher and higher health care costs, while escaping limits on profit and overhead and annual review of rates. The enabling statute for OHCA and companion provisions enacted in the same legislation regarding the Department of Managed Health Care and the California Department of Insurance are intended to create coordination and collaboration among these state agencies so that the OHCA cost growth targets work in tandem with the medical loss ratio and rate review laws.

A. Cost Growth Targets Apply to Insurers and Health Plans

First, insurers and health plans are subject to the same statewide cost-growth target as hospitals and large physician organizations.

The OHCA law adds an additional incentive for insurers and health plans to meet the target:

> (h) (1) Targets set for payers shall also include targets on administrative costs and profits to deter growth in administrative costs and profits.
> (2) The targets established for a payer's administrative costs and profits under this subdivision may be subject to annual adjustment, but shall not increase to the extent the costs for the medical care portion of the medical loss ratio exceed a target[2].

No similar provisions apply to providers, including hospitals, health systems, and large physician organizations in which their profits and administrative costs are reduced if those entities fail to meet the overall cost growth targets.

B. Medical Loss Ratio Limits Profits and Administrative Costs for Insurers and Health Plans, But Not Hospitals, Not Physician Organizations, Not Pharmaceutical Manufacturers

[2] Health and Safety Code 127502 (h) (1) and (2). Please note: (h) (3) requires OHCA to consult with DMHC and CDI to assure actuarial soundness and rate review.

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Second, unlike hospitals, health systems, and physician organizations or pharmaceutical manufacturers, as a result of the Affordable Care Act, insurers and health plans are subject to a medical loss ratio that limits profits and administrative costs to no more than 20% of the total rate for individual coverage and 15% of the rate for small employer coverage. Large employer coverage often has an even lower medical loss ratio, sometimes less than 10%. That means 80% or 90% of the rate is spent on claims costs from hospitals, health systems, physician organizations and prescription drugs, not insurer profits and overhead.

Before OHCA, when claims costs rose, insurers profited because their share of the premium dollar is a capped percentage of the rate if the cost of hospitals, physician services and prescription drugs increased. The arithmetic is simple:

- If the premium is $1,000 a month, then the insurer made $200 a month for profits and administrative costs.
- Today when the average annual premium for an individual often averages $2,000 a month, the insurer makes $400 a month.

The medical loss ratio limits the profits and overhead of insurers and health plans, but the ever-rising costs of claims for hospital care, professional services, lab, imaging and prescription drugs drives up rates.

No such provisions limiting profit and overhead apply to hospitals or health systems, no matter how large or how lucrative. Not Sutter, not Dignity, not UC, not Providence, not Stanford, not CHOMP, none of them. While administrative costs and revenues in excess of costs may be derived from the existing HCAI data reporting, no limits on administrative cost or profits apply to these entities.

The medical loss ratio requirements do not apply to physician organizations, no matter how large. In California, some physician organizations have literally thousands of physicians serving hundreds of thousands of consumers, but their profits and administrative costs are not publicly reported.

Pharmaceutical manufacturers do report their extensive profits to their shareholders and other investors. Drug companies report some data on drug costs to state government and pharmacy benefit managers would report more under pending legislation. But, again, profits and overhead are not limited.

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C. Annual Rate Review for Insurers and Health Plans, Not Hospitals, Not Physician Organizations, Not Pharmaceutical Manufacturers

Since the early implementation of the Affordable Care Act in California in 2010, health plans and insurers have been subject to annual rate review, saving California consumers from more than $300 million in unreasonable or unjustified rate increases[3]. Since 2016, insurers and health plans that charge rates found to be unreasonable or unjustified by either the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) must disclose to consumers and other purchasers that their rates have been determined unreasonable or unjustified—and give those purchasers an opportunity to shop for other coverage[4].

In contrast, hospitals, hospital systems, physician organizations and pharmaceutical manufacturers have no annual rate review and thus have raised prices and costs without hindrance, It is the consumer or the working family that pays higher health care costs, in the form of higher premiums or higher, more frequent cost sharing when hospitals, health systems, physician organizations and pharmaceutical manufacturers raise prices.

Insurers and health plans are subject to multiple laws intended to ensure that lower costs for hospitals, physician services, and pharmaceuticals benefit consumers and other purchasers. These include limiting the percent of the premium dollar that goes to overhead and profits as well as annual rate review and now, the OHCA cost growth targets. All of these consumer protections should work together to slow the growth of health care costs that come out of the pockets of consumers. But it starts with addressing the underlying causes of rising costs: for hospitals, health systems, physician services and prescription drugs.

III. Access, Quality, Equity, Consolidation, and Workforce Stability

Health Access strongly supports the triple aim of lower costs, improved outcomes and increased equity built on a foundation of laws requiring timely access to necessary care. California law has numerous provisions requiring measurement of access, quality and equity or workforce stability, many of which were sponsored or

[3] www.dmhc.ca.gov and the California Department of Insurance

[4] Since the enactment of this disclosure law, SB 908, 2016, no health plan or insurer has proceeded with an unreasonable rate—except for Kaiser with large group purchasers in recent years.

supported by Health Access and other advocates. We outline these provisions here because some have questioned whether OHCA should do more to measure impacts of cost targets: the OHCA law already requires OHCA to take these existing measures into account.

A. Access Measures:

Today the main barrier to timely access to care is the cost of care because of copays, coinsurance and deductibles that are unaffordable for the average California family.

California law includes numerous access measures enforced by the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI), as well as the Department of Health Care Services (DHCS) for Medi-Cal managed care. These access measures are more extensive than those required in most or sometimes any other state or by federal law. The OHCA law requires OHCA to work with its sister state agencies but does not require OHCA to set its own access standards. Those who question whether OHCA should look at access ignore this substantial body of state law.

Among the standards enforced by DMHC are:

- Time/distance standards for both hospitals and primary care: generally 15 miles or 30 minutes travel time.
- Network adequacy: Health plans are required to have an adequate network.
- Medically necessary care at in-network cost sharing: If a consumer needs highly specialized medical care that is not available in-network, the health plan is required to arrange for out of network care at in-network cost sharing. This applies even more strongly to behavioral health under Health and Safety Code 1347.72.
- Timely Access to Care: Consumers have a right to timely access to care, generally 10 days for a non-urgent primary care appointment and 15 days for a non-urgent specialist appointment or more quickly if clinically appropriate. Other requirements apply.
- Accurate provider directories with no ghost networks of providers that are not actually providing in-network care.

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DHCS enforces a variety of requirements for access and network adequacy for Medi-Cal managed care plans, including:

- Access requirements for physicians, hospitals, and more.
- Time and distance standards.

Health Access has fought for these requirements and continues to fight to enforce them effectively to assure meaningful access to care. We recognize that too many consumers still cannot get timely necessary care, especially both primary care and behavioral health. The responsibility for enforcing these requirements is that of DMHC, CDI, and DHCS, not OHCA or HCAI.

B. Equity and Quality Measures

Other state agencies collect numerous measures of equity and quality:

- Covered California collects over 50 measures of equity and quality.
- DMHC has focused on 13 key measures applicable to high prevalence conditions in a commercial population such as childhood immunizations, diabetes and high blood pressure.
- DHCS also collects dozens of measures
- The Office of Patient Advocate (OPA) has several dozen composite measures, each composed of multiple measures.
- CalPERS similarly collects numerous measures.
- CDPH collects measures related to patient safety in health facilities such as health acquired infections.

The OHCA law required OHCA to develop a measure set based on the measures collected by other state agencies and update it annually. Health Access submitted comments supporting and suggesting some future improvements to the initial measure set has been reviewed by the Board and adopted.

C. Workforce Stability

The OHCA law also requires OHCA to collect measures of workforce stability because a stable workforce is more cost effective and more likely to accomplish good health outcomes than a destabilized workforce with high turnover and

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excessive use of registry or other temporary personnel. OHCA has adopted a broad array of measures to monitor workforce stability in the coming years.

IV. Enforcement: Guidelines and Standards

Enforcement of the cost growth targets has been a focus of Health Access since the discussions preceding the enactment of the Office of Health Care Affordability. Each state has taken its own path in developing cost targets and the accompanying enforcement. Under the statute, enforcement is the responsibility of staff in consultation with the Board. OHCA has adopted cost targets based on consumer ability to afford care and coverage as well as targets aimed at reducing very high-cost entities. Effective enforcement is the next step in providing consumers meaningful change.

This is intended as a beginning discussion on enforcement. We focus in this letter on aspects of enforcement other than the ability to impose commensurate penalties because we expect other aspects of enforcement to be in more frequent application.

Health Access supports:

- Recognition of the specifics of California law, which is different than that in other states.
- Burden of proof on the entity to demonstrate reasons for failure to comply
- Consideration of the policy significance of the reasons for failure to comply, whether an entity is moving in the right direction in terms of policy change to limit cost growth, and distinguishing statistical noise or variability from real, meaningful change.
- Public process and limited confidentiality, consistent with the statute
- Consideration of whether waivers of enforcement are appropriate at all and if so, what "reasonable" factors are within the control of the entity partly or in whole
- Independent estimates of the cost of compliance with new state mandates and compliance with longstanding state mandates.
- Prescription and device costs at cost, not six or eight or eleven times costs—and consideration of whether lower costs were within the control of the

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health system or health plan and its contracting pharmacy benefit manager if any.
- Consideration of labor costs consistent with California law, which is different than other states.

We offer more discussion on each of these points.

A. California Law is Different than Other States

The Board has heard presentations from other states about how enforcement of the cost targets has proceeded in those states. Health Access recommends that any discussion of enforcement begin with a recognition that California law is different than that of other states and that careful consideration be given to whether the reasons an entity exceeds the target are within the control of the entity.

Each state has its own laws on what factors and processes must be considered in enforcement of the cost growth targets. For example, Oregon law codifies a set of reasonableness factors, that on their face appear to provide justifiable reasons for an entity to exceed the cost growth target but on closer scrutiny, these reasonableness factors or exceptions are subject to considerable abuse or misleading estimates of impact that overestimate the cost.

California law recognizes that an entity that exceeds a cost growth target may do so because of factors outside the control of the entity but also that factors may be wholly or partly within the control of the entity. Specifically, the law cites "the extent to which each entity has control over the applicable components of its cost target[5]." A useful example is prescription drug costs. Prescription drug costs are partly within the control of the entity; the acquisition cost of a drug or device should be negotiated either by the entity or a pharmacy benefit manager on its behalf and charges in excess of cost are within the control of the entity. Our view is that the amount billed to the payer should not exceed the acquisition cost except for a modest amount.

B. Burden of Proof on Entity Exceeding Target

The OHCA enabling statute puts the burden of proof on the entity that exceeds the target to demonstrate that it exceeded the target for reasons beyond the control of

[5] Health and Safety Code Section 127502.3 (a)

the entity in whole or in part. The law requires that before taking enforcement action, the office shall provide notice to the entity, giving the entity 45 days to respond, providing additional information, including information that may justify a waiver of the cost targets.

The law also states:

> (3) If the office determines that the additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate[6].

The burden to demonstrate compliance is on the entity, not the Office.

C. Changes with Policy Significance, Trends, and Statistical Noise versus Meaningful Change

Health Access recommends that the Office consider the policy significance of the reasons for failure to comply, whether an entity is moving in the right direction in terms of policy change to limit cost growth, and distinguishing statistical noise or variability from real, meaningful change. To use an example from a Board member, if a very high-cost hospital falls from the 86th percentile to the 84th percentile that is not a meaningful policy impact in terms of cost growth and should not result in a change in the applicable cost target. Trend also matters: is cost growth slowing or accelerating? Finally, the Office should consider whether a change reflects statistical noise or normal variability versus meaningful change. In some instance, it may take a few years to determine this while in others, it may be immediately obvious that the change in meaningful and the reasons for it. Other states have adopted various measures of statistical significance such as confidence intervals, but technical measures alone do not suffice.

D. Partial Impact

Health Access recommends that the Office consider the magnitude of factors affecting the ability of an entity to meet the cost target. Some factors affecting compliance with the cost growth targets, either the statewide target or the very high-cost target, affect only a fraction of the costs. For example, while the cost of GLP-1 drugs looms large at the moment, but those costs are a fraction of outpatient drug costs that amount to about 20% of the premium dollar while hospital costs are

[6] Health and Safety Coe 127502.5 (b) (3)

roughly 40% of the premium dollar. Thus, a hike in prescription drug costs for a subset of drugs, even a large one, affects only a fraction of the premium dollar. This fractional impact should be calculated to provide an accurate measure of the impact on the capacity of health plans and insurers to comply with the statewide cost growth target. Similarly, an increase in compensation in radiology techs is likely a modest fraction of hospital labor costs and thus an even more modest subset of direct patient care costs. Doing the arithmetic to compute the impact, and making that arithmetic public, will be important to enforcement going forward.

E. Enforcement: Public Process, Limited Confidentiality

One of the most important aspects of OHCA's work to date has been public transparency and public involvement. Health Access recommends that the Office use its authority under the law for public transparency in the enforcement process as well as the process for setting the cost growth targets and the benchmarks for other changes.

The OHCA enabling statute specifies the steps that must be made public in the enforcement process. Specifically, if an entity exceeds the target, the office must notify the entity and then "the office shall make public the extent to which the entity exceeded the target"[7]. In Massachusetts and Oregon, cost target reporting has included reporting performance of all entities by line of business (Medicare, Medicaid, commercial) and whether the entity exceeded the target. Health Access supports similar reporting in California as consistent with public transparency.

If an entity is subject to a performance improvement plan, the OHCA statute also provides that

> The office shall publicly post the identity of a health care entity implementing a performance improvement plan and, at a minimum, a detailed summary of the entity's compliance with the requirements of the performance improvement plan while the plan remains in effect and shall transmit an approved performance improvement plan to appropriate state regulators for the entity[8].

This provision makes clear that public transparency is an important component of the enforcement process.

[7] Health and Safety Code 127502.5 (c) (1)
[8] Health and Safety Code 127502.5 (c) (2)

The law further provides only narrow confidentiality of information submitted by an entity in the course of enforcement. The law states:

> Information that is otherwise publicly available, or that has not been confidentially maintained by the source, shall not be considered nonpublic information[9].

Examples of information that has not been confidentially maintained include information reported to other state or federal agencies and information reported to investor calls or bond rating agencies as well as information otherwise made public outside the organization. Information such as trade secrets may be withheld if it is in the public interest, not in the interest of the entity seeking to keep confidential the information.

F. Possible Waiver of Enforcement

The law provides for a waiver of enforcement in certain circumstances:

> (i) The office may establish requirements for health care entities to file for a waiver of enforcement actions due to reasonable factors outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives to minimize future costly care, such as increasing access to primary and preventive services, or under extraordinary circumstances, such as an act of God or catastrophic event. The entity shall submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. The office shall request further information, as needed, in order to approve or deny an application for a waiver[10].

The first point to note is that the Office is not required to establish a waiver of enforcement. The Office "may" establish a policy of waiver of enforcement. If the Office, in consultation with the Board, chooses to do so, then the implications and conditions of such waivers should be carefully and publicly considered. The Office may also choose not to waive enforcement.

The second point is that the list of "reasonable factors" is limited to those outside the entity's control. The question to ask is whether the factor that leads to exceeding the cost target is a "reasonable" factor "outside the entity's control". As we discuss further, many factors are partly or entirely within the control of the

[9] Health and Safety Code 127502.5 (c) (4)

[10] Health and Safety Code 127502.5 (i)

entity and thus should disqualify the entity from any waiver of enforcement. Definitions that are overly broad or applied broadly without considering the net effect on the ability to comply with the target have the potential to structurally weaken the cost growth target program, reducing the benefit to consumers. In other states, broad definitions of "reasonable factors" have had the effect of lessening the benefit to consumers.

G. Cost Factors: State Mandates, Mandated Benefits, Other Changes in Law

"State or local mandates[11]" are recognized in the California law as a factor that should be considered in developing the methodology and changes in state or federal law as possible reasons for a waiver of enforcement. Consideration of mandates applies with respect to enforcement, whether or not the staff chooses to implement waivers of enforcement.

While some mandates may increase costs for providers or payers, estimates by the affected entities often overestimate likely impacts or ignore the ability of entities to plan for and thus manage the cost implications. We also note that the law refers to changes in state or federal law, rather than pre-existing mandates where the cost is built into the base of spending.

Health Access urges that any consideration of cost impacts of mandates be based on estimates from impartial sources, rather than studies funded by the affected industry. Examples of independent analyses include:

- Actuarial analyses such as the study recently done for DMHC on the premium impacts of enhanced Essential Health Benefits (EHB).
- Analyses done by the California Health Benefits Review Program (CHBRP).

Other analyses such as those commissioned by the California Health Care Foundation or those from various University of California research units should be evaluated and subject to validation of methodology and sources of data.

Conversely, analyses paid for by the affected entity or industry are often subject to methodological or estimation errors. For example, estimates of costs of seismic compliance often overestimate but sometimes underestimate the cost of

[11] Health and Safety Code 127502 (d) (4)

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compliance or comingle other updating desires with the actual cost of compliance. Marble lobbies are not a state mandate.

Health Access opposes considering the costs of longstanding mandates such as hospital seismic retrofit or the nurse ratios. Seismic compliance involves assuring that a hospital can be operational after an earthquake rather than being evacuated after a catastrophic seismic event. These hospital seismic requirements date to 1994. Thirty years is sufficient time to plan for and manage major capital costs such as seismic compliance. The failure of a minority of California hospitals to plan to comply with existing law is not a "reasonable" factor "beyond the control of the entity"[12]. If the entity had planned and budgeted for compliance with the law, it could have paid off these costs over 30 years. Similarly, the nurse ratios have been state law for over 25 years and compliance with those requirements should be baked into the underlying costs.

The Governor and the Legislature recently acted to enhance the essential health benefits required for individual and small employer coverage under state law: this proposal is pending federal approval and further legislative action. Independent actuarial analyses estimated the cost impacts on premiums as well as population health impacts: such analyses can be used to determine a reasonable factor resulting from a state mandate beyond the control of health plans and insurers.

H. Cost Factors: Pharmaceutical and Device Costs

Prescription drug costs should only be a "reasonable" factor for exceeding the cost target if the hospital, large physician organization, or health plan (and its pharmacy benefit manager, if any) can demonstrate that charges for prescription drugs are not inflated and that the entity attempted to negotiate lower drug costs. This applies to both outpatient prescription drugs as part of the premium dollar and those drugs administered in health facilities and physician offices. The cost of drugs administered in health facilities and physician offices is counted in the cost of those entities as well as in the relevant benefit category for insurer rate review.

[12] Assembly Health analysis of SB 1432 Caballero, 2024, later vetoed, found that out of 3,340 hospital buildings in California subject to hospital seismic requirements, only 658 buildings, less than 20% of the total failed to comply with the structural building requirements while about 60% had not yet complied with the major nonstructural requirements. www.leginfo.legislature.ca.gov

Medicare limits physician offices to the actual cost of drugs plus 6% for an administration fee. In contrast, hospitals markup drug prices to be six or eight times or even 11 times[13] as much as the cost of the drug as demonstrated by this exhibit: https://hcai.ca.gov/wp-content/uploads/2025/04/April-2025-Exhibits-from-the-Board-Hearing.pdf. Other research indicates that pharmaceutical costs are factors within the control of the hospital, health system, or physician organization as well as the health plan or insurer and pharmacy benefit manager. One example of such research:

- Robinson et al found that "Hospitals can reduce what they pay to manufacturers for the drugs, especially if they are eligible for 340B discounts, and can increase what they are paid for the drugs by imposing markups on the reimbursement prices they charge to insurers.[14]"
- The same study found:
  After adjustment for differences across drugs, patient demographic characteristics, and geographic regions, we found that hospitals eligible for federal 340B discounts charged reimbursement prices to insurers that were 289% above those charged by physician practices, whereas hospitals not eligible for 340B discounts charged reimbursement prices 276% above those charged by physician practices. The markup of reimbursement prices charged to insurers over the acquisition prices paid to drug manufacturers highlights the importance of payer mix to hospitals and physician practices, given that Medicare pays a markup above the acquisition price of only 6%.

Absent proof that the cost of drugs or devices reflects actual costs plus a modest mark-up, prescription drug costs and device costs should not be considered a reasonable factor for exceeding the cost growth targets.

I. Cost Factors: Labor Costs

Health Access questions whether labor costs should be treated in the same manner as in other states since California law is different than the law in other states with respect to labor costs. For health care employers with collective bargaining agreements, which are legally binding contracts, increases in labor costs may be

[13] Doctors Modesto: NASHP: https://tool.nashp.org/

[14] https://www.nejm.org/doi/full/10.1056/NEJMsa2306609#:~:text=Hospitals%20can%20reduce%20what%20they,prices%20they%20charge%20to%20insurers.

considered prospectively. For other employers without collective bargaining agreements, labor costs are measured retrospectively. For all entities, we commend the approach taken in examining the hospitals in Monterey County in which the OHCA staff, using HCAI data, determined that wages for most hospital workers, aside from hospital administrators, were not higher than wages in the Bay Area. The August 2024 Board presentation also demonstrated that physician compensation was only slightly higher than the Medicare rates.

V. Conclusion

Health Access commends the action of the Board to set lower cost targets for very high-cost hospitals and the decision to review this list annually, in the hope that some hospitals will improve and get off the list. Conversely, we are troubled by the lack of data verification when hospitals or other entities seek to change their data post-hoc.

Health Access notes that health plans and insurers are subject not only to the OHCA cost targets but also to caps on profits and overhead as well as annual rate review. Providers such as hospitals, health systems, and large physician organizations are subject only to the OHCA cost targets, not to caps on profits and overhead and not to annual rate review, even though the cost of hospitals, physician services, and prescription drugs comprises 80% to 90% of the premium dollar.

Health Access points to the numerous provisions of existing California law requiring reporting on access as well as equity and quality measures and OHCA's monitoring of workforce stability.

Health Access supports an enforcement process, grounded in the California law, in which the burden of proof is on the entity that exceeds the cost growth target to demonstrate that any alleged reasons for exceeding the target are outside the control of the entity in whole or in part, and are sufficient to explain the failure to meet the target. Health Access supports public notice of enforcement and limited confidentiality of information provided in the context of enforcement, consistent with the law. Many factors asserted as reasons for cost growth exceeding the targets are within the control of the affected entity, from prescription drug costs to

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the cost of compliance with state mandates. We have a strong preference for independent estimates of the cost of compliance, or failing that, careful evaluation of studies. We note the California law on labor costs is different than that of other states. As the work on enforcement progresses, we will have other observations to offer.

Thank you for your consideration.

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Executive Director

CC: Members, Health Care Affordability Board
Richard Figueroa, Deputy Cabinet Secretary, Office of the Governor
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Robert Rivas, Speaker, California Assembly, Attn.: Rosielyn Pulmano
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Mary Watanabe, Director, Department of Managed Health Care
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Assemblymember Mia Bonta, Chair, Assembly Health Committee, Attn.: Lisa Murawski
Senator Caroline Menjivar, Chair, Senate Health Committee, Attn.: Teri Boughton
Brendan McCarthy, Deputy Secretary, California Health and Human Services Agency, Attn.: Darci Delgado
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Josephine Figuroa, Deputy Commissioner, California Department of Insurance

California Hospital Association

June 4, 2025

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

Subject: **Hospital Ask for Reconsideration and Reevaluation of Hospital Spending Targets and Spending Measurement**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

California's hospitals share the goals of the Office of Health Care Affordability (OHCA) to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of our more than 400 hospital members, the California Hospital Association (CHA) appreciates the opportunity to comment.

Spending Targets and Their Enforcement Must Be Revisited Now

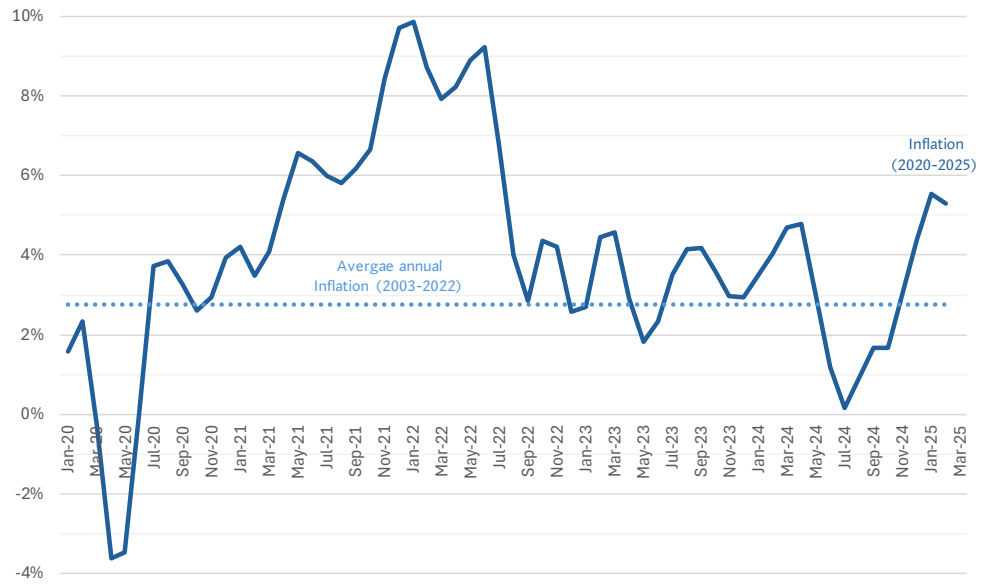
OHCA Must Reevaluate Targets in Light of Impending Federal and State Health Care Cuts. At its April 2025 meeting, the Office of Health Care Affordability (OHCA) board adopted hospital sector targets, finalizing this decision moments after hearing significant concerns about the proposal. This target was ultimately finalized three years ahead of statutory timelines, before OHCA established a methodology for measuring hospital spending, and before any meaningful analysis of the targets' impact on patient care has been conducted. Even more troublingly, it came just as devastating state and federal budget proposals are being considered. Without immediate reconsideration of both the current statewide target of 3.5% and the "high-cost" hospital target of 1.8%, hospitals across California will be forced to drastically reduce services provided, worker compensation, and staffing levels. **Hospitals urge the OHCA board to adjust these targets to account for the new challenges presented by the One Big Beautiful Bill Act and Governor Newsom's May budget revision, each of which would strip billions of dollars from California hospitals and the health care system at large.**

OHCA's enforceable spending targets will take effect just as hospitals are navigating draconian cuts to federal and state funding for California's health care delivery system. With inflation again above 5% in California, OHCA's targets are 30%-70% lower than current price level growth for all goods and services. Compounding these cuts is the federal government proposal that seeks $100 billion in cuts for Medi-Cal and Covered California over the next 10 years. The health care coverage losses alone are expected to increase uncompensated care costs for hospitals by 40%. At the same time, the governor has proposed billions more in cuts to Medi-Cal, impacting both eligibility and provider payments. **With more than 50%**

of hospitals already operating in the red, many will not survive these concurrent efforts to defund and destabilize the health care system. OHCA must ensure that its decisions do not exacerbate the disastrous effects of state and federal policies by revisiting the spending targets already established. In addition, OHCA must make clear that providers' efforts to secure adequate reimbursement in the face of unprecedented cuts in public programs are appropriate and justifiable reasons for exceeding the spending targets.

OHCA Must Incorporate Factors Critical to Maintaining Access and Quality into Spending Targets and Enforcement. Despite the first enforceable spending target going into effect next year, OHCA has not provided any guidance on how enforcement decisions will be made or carried out. Hospitals lack clarity on how they will be judged against the spending targets and what factors, if any, OHCA would deem as justifiable reasons for growing above the spending targets. To allow providers to plan, OHCA should establish these factors in advance, not after an enforcement period has ended. Adjustment should be directly incorporated into the spending targets for factors that can be estimated on a statewide basis. For example, in California, inflation averaged 2.8% between 2003-22, the period of median household income growth on which OHCA based the statewide spending target. Now, as Figure 1 shows, inflation is higher than 5%, nearly twice the historical level. In response, just last month, the California Department of Finance upgraded its expectations for inflation for 2025 through 2028, raising its projection by between 0.5% and 1.5% depending on the year. To account for these elevated inflation levels and ensure providers can sustain access to care and workforce stability, OHCA should adjust the spending target to account for elevated inflation expectations and other predictable macroeconomic factors affecting underlying costs in health care and beyond. The Rhode Island Health Care Cost Trends Steering Committee did just that for 2023 to 2025 to account for contemporary, atypical macroeconomic trends.

Figure 1: Inflation Is Back Above 5%, Far Higher Than Average Inflation for Historical Upon Which the Statewide Spending Target Was Based



Sources: Legislative Analyst's Office April 21, 2025 Inflation Tracker for 2020-2025 inflation and Department of Finance calendar year average inflation for 2003-2022.

To date, OHCA has introduced for consideration several factors that could justify exceeding the spending targets. These are listed in Figure 2 (on the next page), alongside additional factors that have not been considered to date. Hospitals ask that all of these factors be specifically enumerated in the regulations that further define the enforcement process, alongside a provision requiring other relevant factors not specifically enumerated be considered as appropriate.

OHCA Failed to Adequately Consider Quality, Access, and Workforce Stability When Setting Hospital Sector Targets

State law requires OHCA to incorporate various factors into its decisions on spending targets, including whether access would be sustained and quality jobs would be preserved (see provision (b)(3) of section 127502 of the Health and Safety code). In its decision on the hospital sector targets, OHCA gave cursory attention to the relationship between hospital reimbursement and quality, citing only the work of a single researcher with a single perspective. Worse, it entirely ignored the impacts of its targets on access to hospital care, health equity, or workforce stability and the availability of quality jobs.

Figure 2: Factors for Justifiable Growth Above the Spending Target

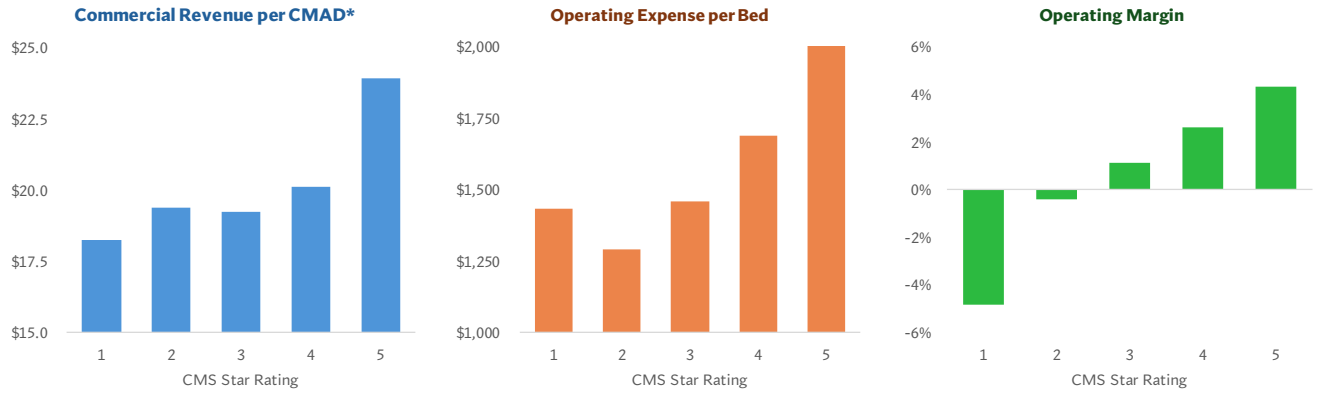
Factors OHCA Has Previously Considered
Acts of God or catastrophic events
Annual changes in age and sex of the entity's population
Changes in an entity's patient base / acuity
Changes in Medicare and Medi-Cal reimbursement
Costs associated with increased organized labor costs
Emerging and unforeseen advances in medical technology
Emerging high-cost / high-value pharmaceuticals
Investments to improve care and reduce future costs
Statutory changes impacting health care costs
Additional Factors
Changes in insurance coverage and uncompensated care
Changes in service offerings
Payment settlements and other factors that drive revenue volatility
Macroeconomic trends, including as applicable on a regional basis
Length of stay and hospital throughput
Outlier hospital stays
Overall labor cost growth
Payer mix
Regulatory changes affecting health care costs
Medical supplies and capital facility cost growth
Tariffs and other supply chain shocks

Research on the Relationship Between CMS Star Ratings and Prices, Cited at the April Board Meeting, Has Serious Weaknesses. The RAND report led by Dr. Christopher Whaley and cited by OHCA claims there is no meaningful relationship between hospital prices and quality, based on a simple comparison of average prices across Centers for Medicare & Medicaid Services (CMS) star ratings. This conclusion is methodologically weak as it omits any statistical testing and fails to control for critical structural factors like hospital size, payer mix, or geography. While Whaley finds that there is price variation within each star rating group, his analysis stops short of asking whether financial strength supports quality performance after accounting for relevant differences among hospitals.

To test whether a model that incorporates these differences would return the same results, CHA modeled the likelihood of a hospital receiving a 4- or 5-star CMS quality rating in 2022. CHA examined mean commercial net patient revenue per case mix-adjusted discharge, operating margin, and total operating expense per bed as predictors from the 2018-22 Annual Financial Disclosure Report data, while controlling for teaching status, critical access designation, and payer mix. As Figure 3 on the next page shows, hospitals with stronger financial performance were significantly more likely to achieve high star ratings, demonstrating that hospital financial resources play an essential role in supporting quality.

Figure 3: California Hospitals With Strong Financial Performance Have Higher Quality Scores

Dollars in Thousands



*Reflects net patient revenue per case mix-adjusted discharge.

Note: CMS Star Rating data are from 2022 and financial data are 2018-2022 pooled averages from hospitals' Annual Financial Disclosure Reports. Differences in financial performance are statistically significant at the $p < 0.05$ level when comparing hospitals with a 4- or 5-Star rating to those with ratings of 3 or lower.

OHCA Selectively Cited Certain Results from a Second Study on Quality. In a second study referenced by OHCA and published in *Health Services Research,* Whaley and colleagues examine whether year-over-year increases in commercial hospital prices are associated with changes in clinical quality. They find no statistically significant effects across selected outcome measures; OHCA points to this result to conclude that "hospital price increases do not lead to clinical quality improvements." However, OHCA's presentation not only overlooks major limitations in the study's scope and methodology, but also omitted relevant results from that paper that undermines this central takeaway.

In addition to clinical measures, the paper also evaluated patient experience, measured by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. The results showed what Whaley and coauthors described as "striking" statistically significant positive associations with price increases across 7 of 10 domains. However, OHCA staff did not present these findings, leaving the board with an incomplete view of this research. Patient experience is not an optional add-on; HCAHPS scores are a core CMS quality domain. Finally, this study only looks at price **changes** over time and does not investigate how hospitals' long-term financial position may contribute to quality.

Broader Academic Literature Reveals the Importance of Financial Performance for Quality Care. OHCA's exclusive reliance on two studies from a single researcher offers a narrow and incomplete view of the evidence. In fact, multiple studies have demonstrated that hospitals with stronger financial positions are more likely to deliver higher-quality care. A 2022 scoping review covering 69 studies found that nearly half reported a positive association between hospital financial performance and quality. No studies showed a clear negative relationship. Additionally, a 2022 working paper from the National Bureau of Economic Research found that patients admitted to higher-priced hospitals had lower mortality and better outcomes. Finally, a 2022 study in the journal, *PLOS ONE*, showed hospitals that delivered higher-quality care were also more likely to demonstrate better financial performance, supporting the idea that investment in quality — when hospitals are financially capable of doing so — yields real returns.

The Legislature Has Raised Concerns that Sector Targets Will Endanger Access to Quality Care, Workforce Stability, and Hospital Operations

OHCA's fast-paced adoption of the hospital sector spending target has led the Legislature to seek additional information and insight into its actions. Most recently on April 30, 2025, members from both houses of the Legislature sent a letter about the statewide and hospital sector spending targets to California Department of Health and Human Services Secretary and OHCA board chair Kim Johnson. The letter requested information on OHCA's analyses of the spending targets and their impacts on health care access, quality care, and workforce stability. It further asks how OHCA will ensure that hospitals are not driven to a financial crisis in adhering to the sub-inflationary spending target. These are critical questions that hospitals share and have raised with OHCA.

At the May Senate subcommittee budget hearing, legislators raised further questions after they were "concerned" to learn that the spending targets did not take into account cost drivers such as inflation and state mandates (e.g., seismic and the health care minimum wage) and that there is no clear way to determine whether the spending targets will result in lower health insurance premiums to consumers. Of note, legislators contend that OHCA's spending targets do not reflect the operational reality hospitals face in keeping up with rising costs and new state mandates, all while maintaining a workforce that meets the needs of providing high-quality care to all Californians.

The creation of OHCA was a joint effort between the Administration and the Legislature. OHCA has a responsibility to meaningfully address the concerns and questions raised by the Legislature. CHA urges OHCA to abide by statutory requirements and additional relevant considerations in its pursuit of improving affordability, a goal that hospitals share.

Provisional Approach for Measuring Hospital Spending Raises Important Questions

At the April 2025 board meeting, OHCA introduced a substantially revised approach to measuring hospital spending. While the approach for measuring inpatient spending was unchanged from when OHCA last convened its Hospital Spending and Measurement Workgroup or discussed the matter with the board, staff presented an entirely new approach for measuring outpatient spending. Rather than bootstrapping measured outpatient spending based on known measures of inpatient spending, OHCA's new approach would separately measure outpatient spending as outpatient revenue per intensity-adjusted visit. This measure would be created by marrying hospital reported financial and utilization data and a new and untested data source — the Healthcare Payments Database (HPD) — with which OHCA would estimate each hospital's outpatient intensity adjustment score. While the approach has conceptual appeal in that it accounts for service volumes and intensity, it also raises several fundamental concerns:

- **No Expert Feedback –** It appears OHCA has settled on a methodology without first consulting the workgroup OHCA created specifically for this purpose. As such, experts in hospital financing did not have any opportunity to review and provide feedback on the provisional methodology prior to even preliminary decisions being made.
- **An Untested Approach –** Calculating the outpatient intensity adjustment with the HPD relies on a new and emerging data source that has never been used for this purpose. While hospitals have some experience with the ambulatory payment classification system, CHA has yet to identify a hospital with experience using the enhanced ambulatory patient groups (EAPGs) methodology. As such, OHCA's preferred methodology for creating an outpatient intensity adjustment appears to be entirely unfamiliar and untested in California. While OHCA shared that Medi-Cal uses EAPGs, it is unknown when or where this is the case as the Department of Health Care Services,

Medi-Cal's administrator, uses a fee schedule to pay for outpatient services on a per-service/procedure basis, rather than using EAPGs.

- **Marrying Multiple Data Sources Introduces Complications –** Unlike the methodology for inpatient spending measurement, OHCA's outpatient methodology combines hospital- and payer-reported data. This introduces various challenges. For example, hospital-reported data include all hospital visits, whereas a substantial proportion of these visits will be missing from the HPD data due, in large part, to the fact that reporting for self-insured is voluntary. According to data from the California Health Care Foundation, the self-insured reflect 15%-20% of all insured Californians and 30% of the commercially insured (OHCA's primary population of interest). Such levels of incompleteness in the HPD raises questions about the reliability and accuracy of the outpatient intensity adjustments; these must be addressed prior to implementation.
- **No Assurance of Transparency –** OHCA's enabling legislation requires that any adopted risk adjustment methodologies be transparent to the public (see provision (f)(1) of Health and Safety Code Section 127502). However, claim-level HPD data are not generally available to the public except through specific requests and is subject to various conditions (such as are necessary to protect patient privacy). If OHCA is to use these data for the purpose of measuring hospital performance against the spending target, the office must find a way to ensure that the underlying data and methodology can be validated by regulated entities.

California's hospitals appreciate the opportunity to comment and look forward to continued engagement toward our shared goals of promoting affordability, access, quality, and equity in California's health care system.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
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