



Health Care Affordability Board Meeting

December 16, 2024





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

Welcome, Call to Order, and Roll Call



Agenda

Item #1 Welcome, Call to Order, and Roll Call

Secretary Kim Johnson, Chair

Item #2 Executive Updates

Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

Item #3 Action Consent Item

Vishaal Pegany

a) Vote to Approve November 20, 2024 Meeting Minutes

Item #4 Informational Items

Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager; Vishaal Pegany; CJ Howard, Assistant Deputy Director

a) Introduce Behavioral Health Definition and Investment Benchmark, Including Advisory Committee Feedback

b) Sector Targets, Continued from November Board Meeting

Item #5 Public Comment

Item #6 Adjournment



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

Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director



Slide Formatting



Indicates informational items for the Board and decision items for OHCA



Indicates current or future action items for the Board

The logo for the Office of Health Care Affordability (OHCA) features the letters 'OHCA' in a bold, white, sans-serif font. A red curved line is positioned over the 'H', starting under the 'O' and ending under the 'A'.

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

Public Comment

The logo for the Department of Health Care Access and Information (HCAi) features the letters 'HCAi' in a bold, white, sans-serif font. A red curved line is positioned over the 'H'. Above the 'i' are several red dots of varying sizes, arranged in a slight arc.

Department of Health Care
Access and Information



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

Action Consent Item: Vote to Approve November 20, 2024 Meeting Minutes



Department of Health Care
Access and Information



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

Informational Items





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

Introduce Behavioral Health Definition and Investment Benchmark, Including Advisory Committee Feedback

Margareta Brandt, Assistant Deputy Director
Debbie Lindes, Health Care Delivery System Group Manager



Focus Areas for Promoting High Value

APM Adoption

- Define, measure, and report on alternative payment model adoption
- Set standards for APMs to be used during contracting
- Establish a benchmark for APM adoption

Primary Care Investment

- Define, measure, and report on primary care spending
- Establish a benchmark for primary care spending

Behavioral Health Investment

- Define, measure, and report on behavioral health spending
- Establish a benchmark for behavioral health spending

Quality and Equity Measurement

- Develop, adopt, and report performance on a single set of quality and health equity measures

Workforce Stability

- Develop and adopt standards to advance the stability of the health care workforce
- Monitor and report on workforce stability measures



Primary Care & Behavioral Health Investments

Statutory Requirements

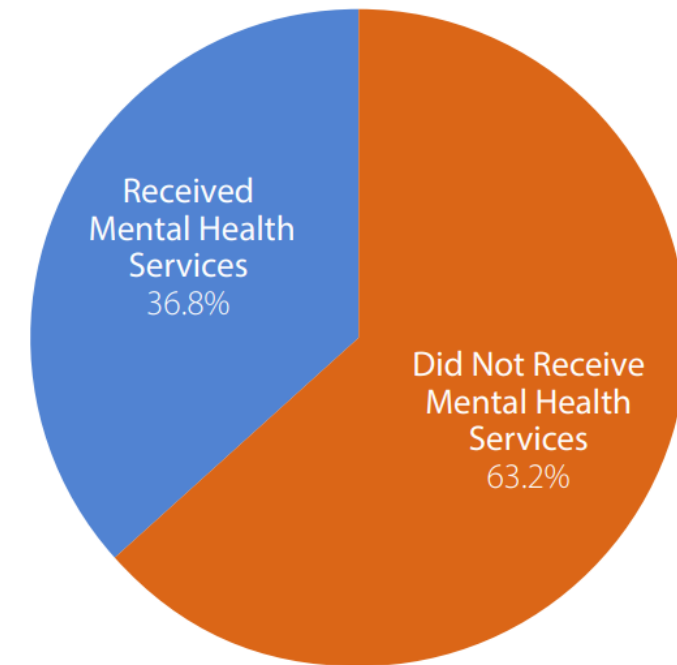
- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- **Measure the percentage of total health care expenditures allocated to primary care and behavioral health** and set spending benchmarks that consider current and historic underfunding of primary care services.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

Why Behavioral Health?

- In California, nearly 32% of adults report symptoms of anxiety and/or depression. Further, almost two-thirds of California adults with mental illness reported not receiving treatment.
- Evidence indicates that effective treatment for behavioral health conditions, especially in integrated care settings, contributes to better behavioral and overall health outcomes and correlates to reduced health care costs.

Mental Health Service Use Adults with AMI, California, 2017 to 2019

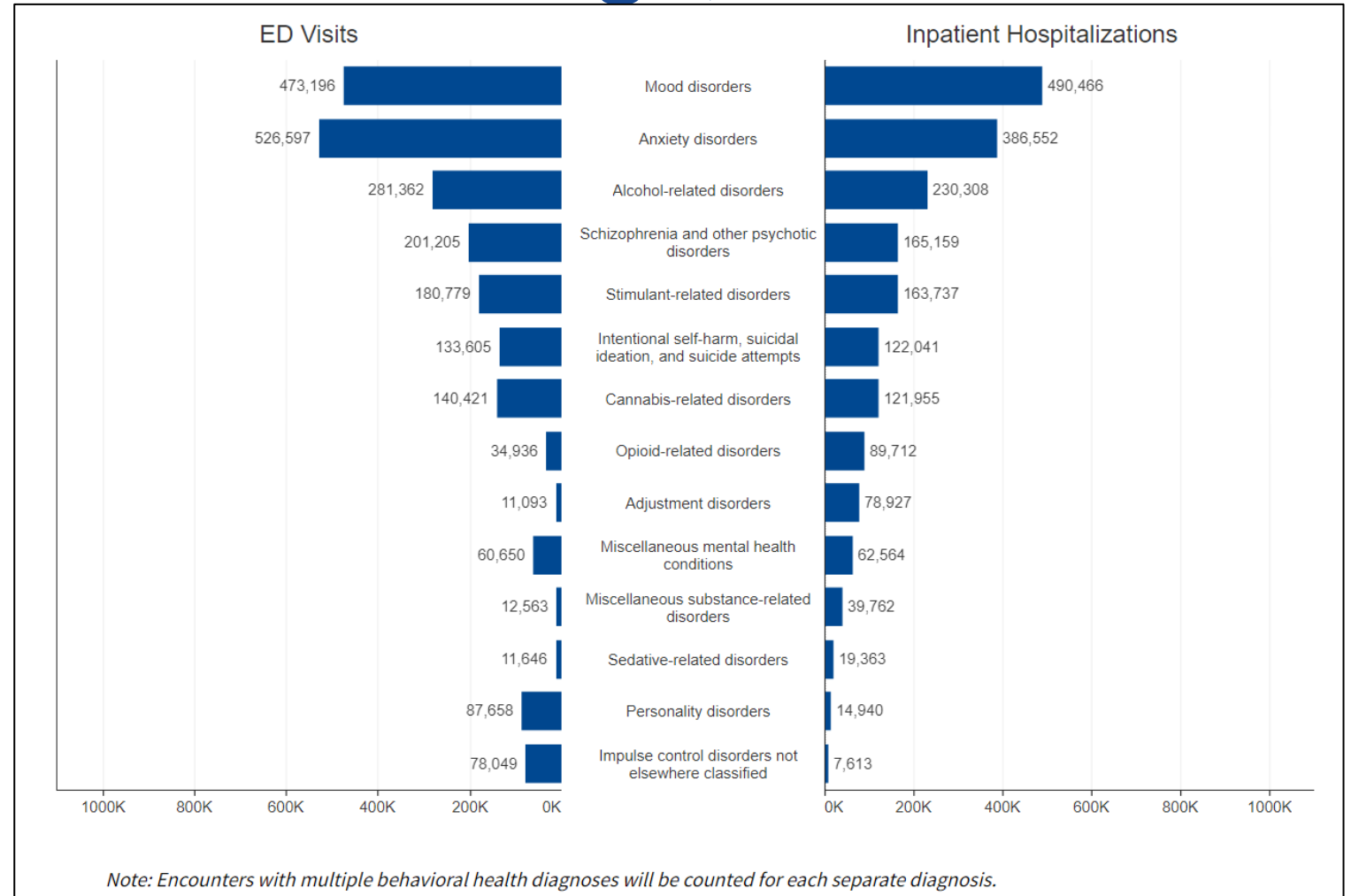
PERCENTAGE WHO ...



Notes: Estimates are annual averages based on combined 2017 to 2019 National Survey on Drug Use and Health data. *Mental health service use* is defined as receiving treatment or counseling for any problem with emotions, nerves, or mental health in the 12 months before the interview in any inpatient or outpatient setting, or the use of prescription medication for treatment of any mental or emotional condition that was not caused by the use of alcohol or drugs. Respondents with unknown service use were excluded. Estimates of any mental illness were based on self-report of symptoms indicative of any mental illness. *Any mental illness (AMI)* is a categorization for adults age 18 and older. See page 3 for full definitions.

Patient Discharge Data: Behavioral Health Diagnoses in Acute Care Settings, 2021

- Encounters for nearly 1 million emergency department visits and over 877,000 hospitalizations in California in 2021 included a mood or anxiety disorder diagnosis.
- Substance use disorders were the primary or secondary diagnosis for over 1.3 million hospitalizations and emergency department visits.



Investment and Payment Workgroup Members

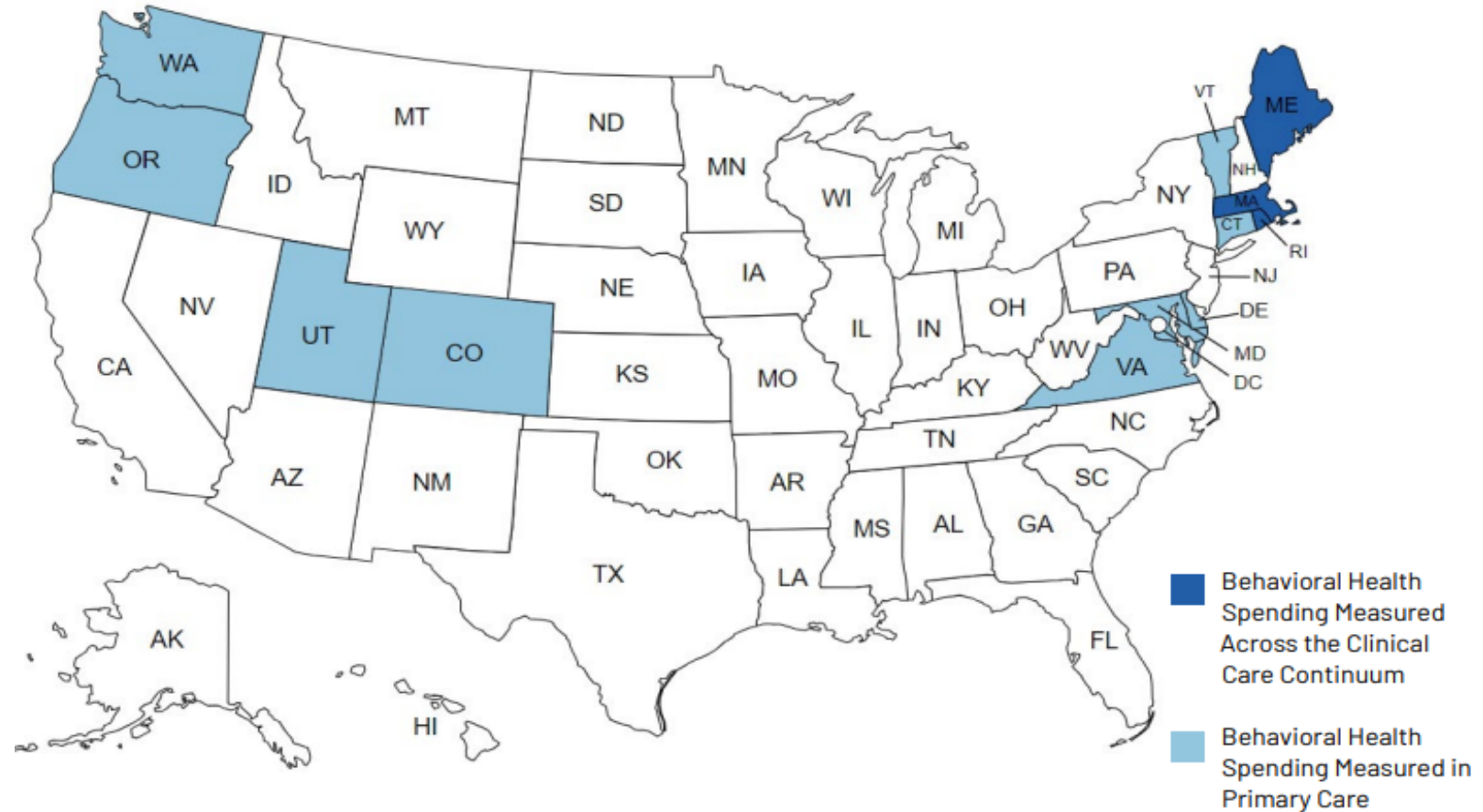
Providers & Provider Organizations 	Health Plans 	Academics & SMEs 
<p>Bill Barcellona, Esq., MHA Executive Vice President of Government Affairs, America's Physician Groups</p>	<p>Stephanie Berry, MA Government Relations Director, Elevance Health (Anthem)</p>	<p>Sarah Arnquist, MPH Principal Consultant, SJA Health Solutions</p>
<p>Lisa Folberg, MPP Chief Executive Officer, California Academy of Family Physicians (CAFP)</p>	<p>Rhonda Chabran, LCSW Vice President, Behavioral Health & Wellness, Kaiser Foundation Health Plan, Southern CA & HI</p>	<p>Crystal Eubanks, MS-MHSc Vice President Care Transformation, California Quality Collaborative (CQC)</p>
<p>Paula Jamison, MAA Senior Vice President for Population Health, AltaMed</p>	<p>Keenan Freeman, MBA Chief Financial Officer, Inland Empire Health Plan (IEHP)</p>	<p>Kevin Grumbach, MD Professor of Family and Community Medicine, UC San Francisco</p>
<p>Amy Nguyen Howell MD, MBA, FAAFP Chief of the Office for Provider Advancement (OPA), Optum</p>	<p>Nicole Stelter, PhD, LMFT Director of Behavioral Health, Commercial Lines of Business, Blue Shield of California</p>	<p>Reshma Gupta, MD, MSHPM Chief of Population Health and Accountable Care, UC Davis</p>
<p>Parnika Prashasti Saxena, MD Chair, Government Affairs Committee, California State Association of Psychiatrists</p>	<p>Yagnesh Vadgama, BCBA Vice President of Clinical Care Services, Autism, Magellan</p>	<p>Vicky Mays, PhD Professor, UCLA, Dept. of Psychology and Center for Health Policy Research</p>
<p>Catrina Reyes, Esq. Deputy General Counsel, California Primary Care Association (CPCA)</p>	<p>Consumer Reps & Advocates </p>	<p>Catherine Teare, MPP Associate Director, Advancing People-Centered Care, California Health Care Foundation (CHCF)</p>
<p>Janice Rocco Chief of Staff, California Medical Association</p>	<p>Beth Capell, PhD Contract Lobbyist, Health Access California</p>	<p>State & Private Purchasers </p>
Hospitals & Health Systems 	<p>Jessica Cruz, MPA Executive Director, National Alliance on Mental Illness (NAMI) CA</p>	<p>Lisa Albers, MD Assistant Chief, Clinical Policy & Programs Division, CalPERS</p>
<p>Ash Amarnath, MD, MS-SHCD Chief Health Officer, California Health Care Safety Net Institute</p>	<p>Nina Graham Transplant Recipient and Cancer Survivor, Patients for Primary Care</p>	<p>Teresa Castillo Chief, Program Policy Section, Medical Behavioral Health Division, Department of Health Care Services</p>
<p>Kirsten Barlow, MSW Vice President Policy, California Hospital Association (CHA)</p>	<p>Héctor Hernández-Delgado, Esq. Senior Attorney, National Health Law Program</p>	<p>Jeffrey Norris, MD Value-Based Care Payment Branch Chief, California Department of Health Care Services (DHCS)</p>
<p>Jodi Nerell, LCSW Director of Local Mental Health Engagement, Sutter Health</p>	<p>Cary Sanders, MPP Senior Policy Director, California Pan-Ethnic Health Network (CPEHN)</p>	<p>Monica Soni, MD Chief Medical Officer, Covered California</p>
		<p>Dan Southard Chief Deputy Director, Department of Managed Health Care</p>

Behavioral Health Spending Measurement Framework

States Measuring Behavioral Health Clinical Spending

Nine states measure behavioral health spending as part of their efforts to measure primary care spending.

Three states measure behavioral health spending across the full care continuum (Maine, Massachusetts, and Rhode Island). This is California's mandate as well.

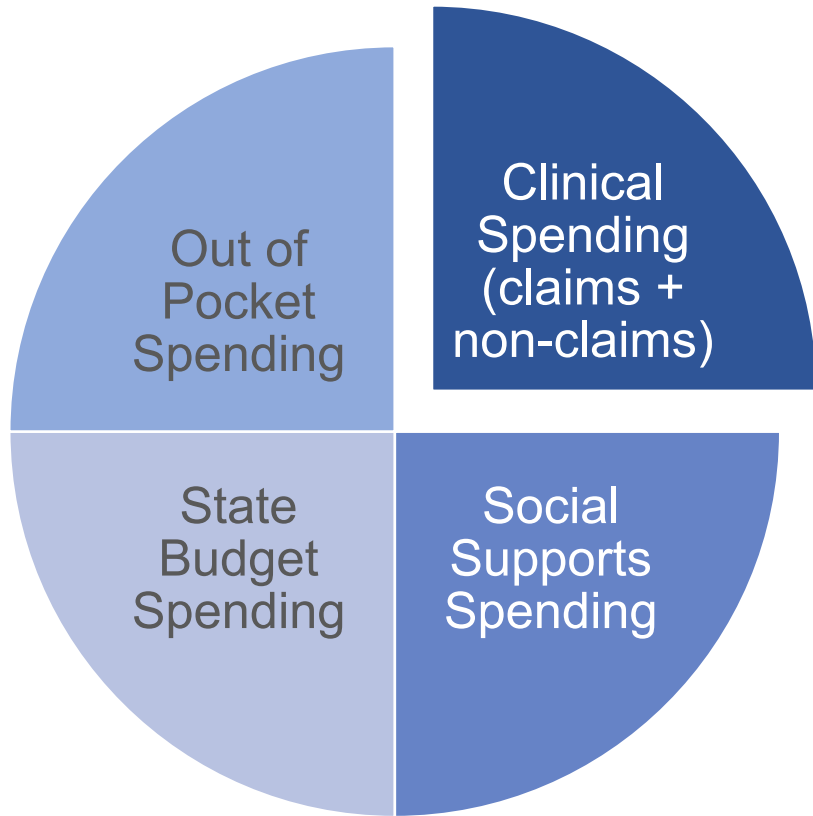


Potential Use Cases for OHCA's Behavioral Health Measurement

- Measure behavioral health spending as a percentage of Total Health Care Expenditures (THCE).
- Understand spending on mental health care and substance use disorder services.
- Understand spending on behavioral health services in primary care settings.
- Understand the distribution of behavioral health spending across different types of services and care settings.
- Establish a focused benchmark for behavioral health spending that supports statewide goals and priorities.

Data Collection and Measurement Scope

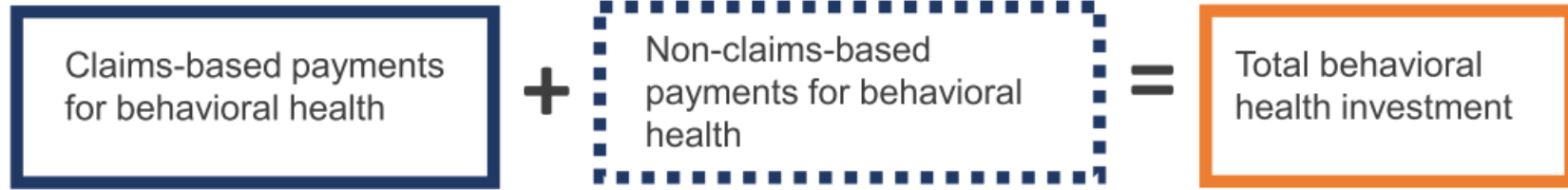
Clinical services are services provided by medical and allied health professionals to prevent, treat, and manage illness, and to preserve mental well-being across the clinical care continuum, paid via claims and non-claims payments (e.g., outpatient therapy visit, day treatment programs).



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

Measuring Behavioral Health Investment

Numerator



X 100% =

Behavioral health investment as a % of total medical expense

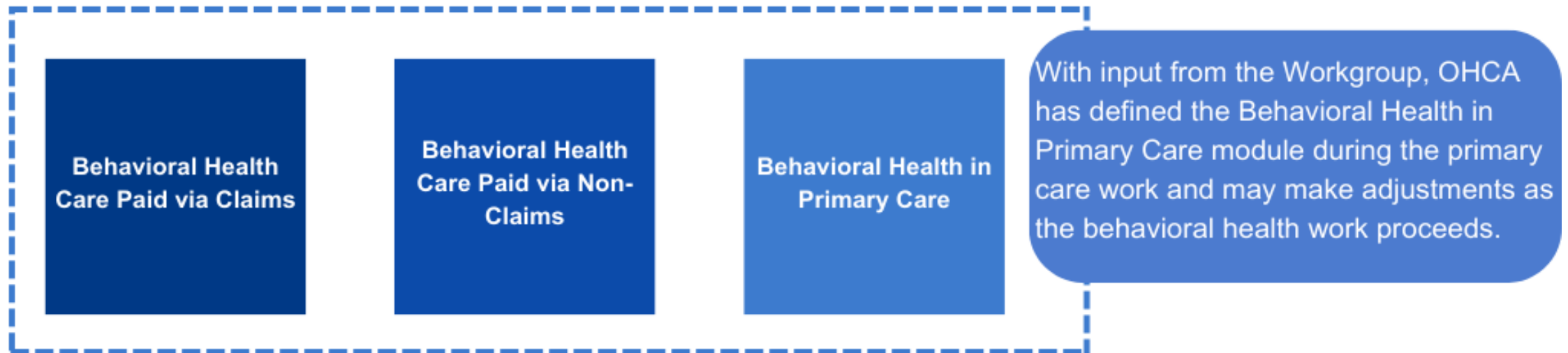


Denominator

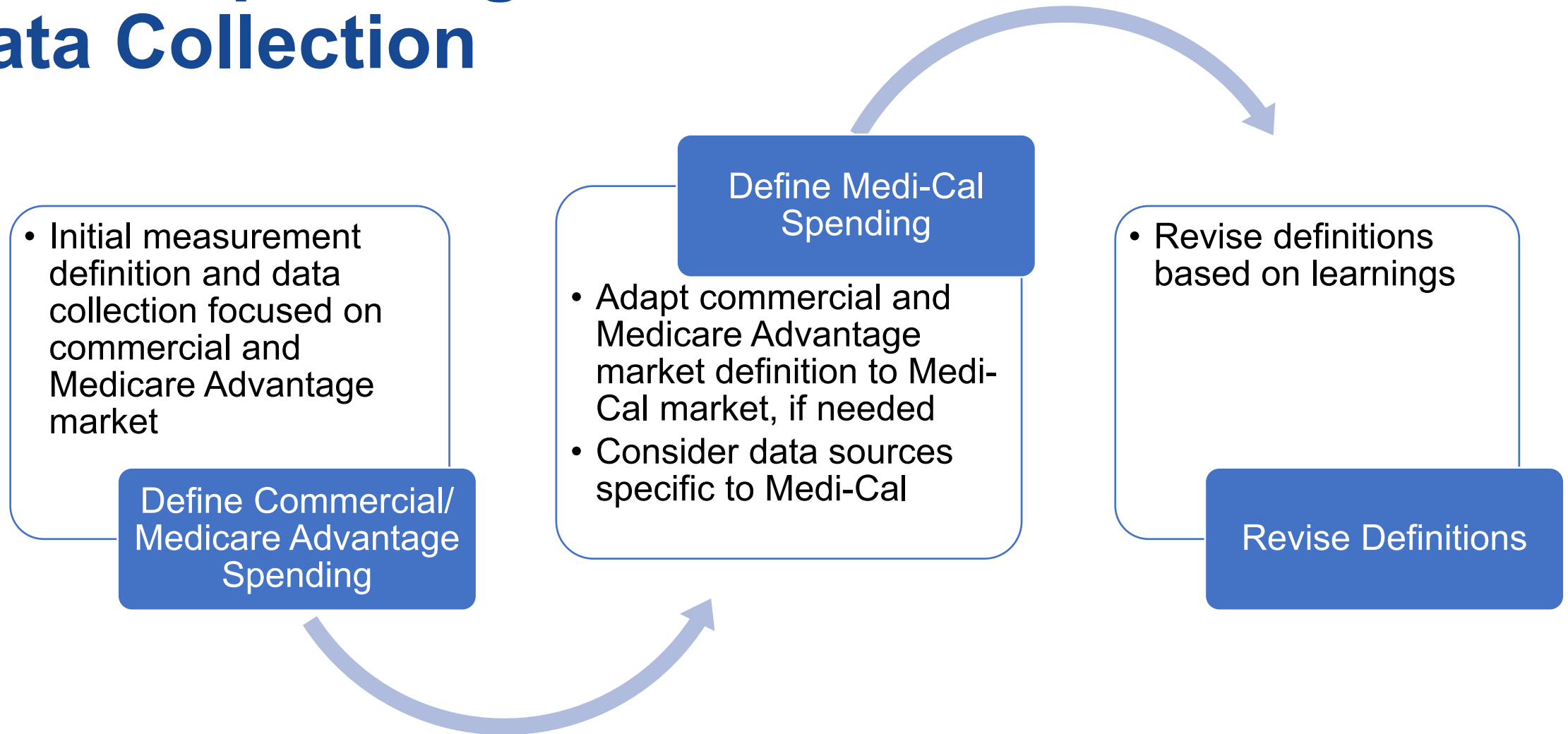
Note: The numerator will include patient out-of-pocket responsibility for behavioral health services obtained through the plan i.e., services for which a claim or encounter was generated. The denominator will include pharmacy spending and all patient out-of-pocket responsibility for services obtained through the plan.

Three Recommended Modules for Behavioral Health Spending Measurement

OHCA proposes to use three modules to measure behavioral health spending, following the approach for measuring primary care spending. Behavioral health in primary care will be measured separately so it can be included in analyses of behavioral health or primary care spending.



Proposed Phased Approach to Behavioral Health Spending Measurement Definition and Data Collection



Other State Approaches to Defining Behavioral Health

States develop behavioral health definitions to support data collection and measurement, reporting, all-payers claims databases analyses, and to inform state policy.

Behavioral Health Spend Definition	Restrict by Diagnosis	Categorize Services by Care Setting	Limit to Certain Provider Types
Milbank Memorial Fund	✓	✓	
Maine	✓		
Massachusetts	✓	✓	
Rhode Island	✓		

Milbank Memorial Fund (2024, April 10). *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending*. <https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/>

High-Level Considerations and Trade Offs






Key Decision	Considerations	Related Decisions
Restrict by Diagnosis	<p>Necessary to:</p> <ul style="list-style-type: none"> • Measure substance use disorder (SUD) and mental health (MH) separately • Capture spend by non-behavioral health clinicians (e.g., PCPs) and in non-behavioral health care settings (e.g., ED, acute care hospitals) due to broad service codes • Support a benchmark focused on specific diagnoses 	<ul style="list-style-type: none"> • Which diagnoses to include? • Include primary diagnosis or more? • Filter by diagnosis in the same way across all providers/facilities?
Categorize Services by Care Setting	<p>Necessary to:</p> <ul style="list-style-type: none"> • Understand spend by care setting (e.g., inpatient, outpatient) • Support a benchmark focused on certain care settings 	<ul style="list-style-type: none"> • Which care settings to include? • Which services to include? • How to treat behavioral health in primary care?
Limit to Certain Provider Types	<ul style="list-style-type: none"> • Excludes some behavioral health spend • With categorization, could support understanding spend by certain provider types • Necessary to support a benchmark focused on certain providers 	<ul style="list-style-type: none"> • Which types of providers to include? • Limit to certain providers for all care settings or only primary care?

OHCA Data Sources for Measuring Behavioral Health Investment

- OHCA will collect the data to measure behavioral health spending as part of its Total Health Care Expenditures (THCE) data collection efforts; THCE data submissions capture payments by payers and patients for covered behavioral health services.
- Behavioral health spending data will include claims and non-claims payments, which will be categorized using the Expanded Framework.
- OHCA will provide definitions, technical specifications, and technical assistance to support submitters accurately allocating payments to behavioral health, particularly for non-claims payment categories.
- OHCA is planning for initial behavioral health data collection and measurement efforts to focus on the commercial and Medicare Advantage populations.

Behavioral Health Investment Benchmark

Proposed Goals for Improved Behavioral Health Care

				
Accessible	Comprehensive	Coordinated	Equitable	High Quality
<ul style="list-style-type: none"> • Providers and services are available when and where needed • Culturally responsive and linguistically concordant • Affordable 	<ul style="list-style-type: none"> • Services across the continuum • More treatment in community and ambulatory settings, reduced need in emergency departments and correctional facilities 	<ul style="list-style-type: none"> • Services integrated across behavioral health settings and with primary care • Attentive and responsive to health-related social needs 	<ul style="list-style-type: none"> • Reduced disparities in utilization and outcomes • Reduced misinformation, stigma, and discrimination 	<ul style="list-style-type: none"> • Improved behavioral health and overall health outcomes • Low frustration, high satisfaction

OHCA's Role in Improving Behavioral Health Outcomes



Examples of How OHCA Can Support Better Behavioral Health Outcomes

Measure mental health spending and substance use disorder spending separately

Show how spending differs; compare to need as represented in prevalence data (from other sources)

Measure spending across service and treatment categories (e.g., primary care, outpatient, emergency/observation, inpatient)

Highlight goal to rebalance care toward prevention and outpatient care

Set spending benchmarks that focus on specific populations, services, or care settings

Motivate positive change towards meeting goals of an improved behavioral health system

Key Decisions for Measuring Behavioral Health Spending and Benchmark Setting

Determine priorities for measuring behavioral health spending

Consider need for a phased approach

Define approach to claims payments: diagnoses, services, care settings, providers

Define approach to non-claims payments

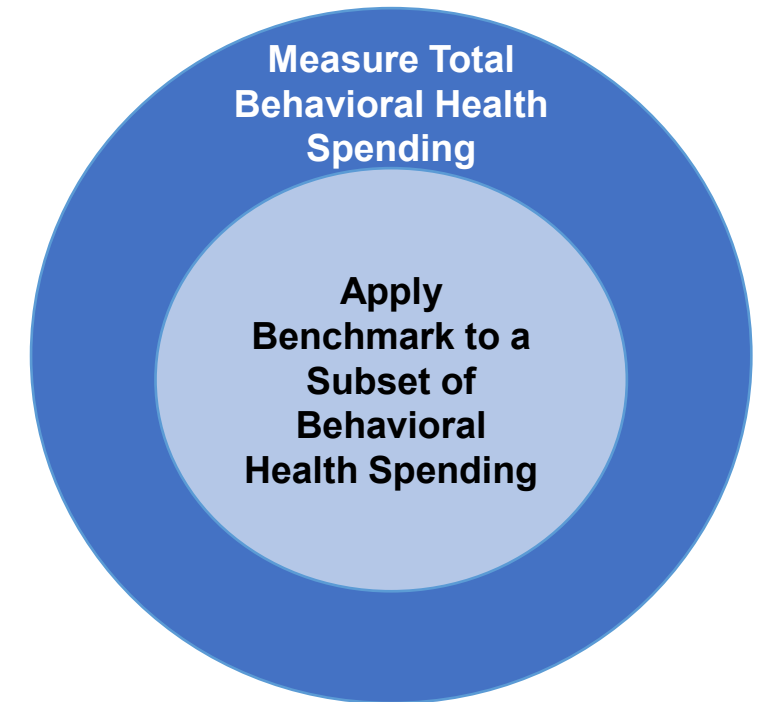
Define benchmark focus – conditions, care settings, population

Define benchmark structure and timing

Broad Measurement, Focused Benchmark

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

Spending Included



Example: Rhode Island Behavioral Health Investment Benchmark

The Rhode Island Office of the Health Insurance Commissioner (OHIC)'s **behavioral health spending obligation** focuses on community-based behavioral health care for commercial fully-insured children and adolescents, ages 0-18.

Spending obligation (benchmark):

- In 2025, carriers must increase per member, per month spending on community-based behavioral health care for target population to 200% of baseline (defined as calendar year 2022 spending).
- After 2025, carriers must have annual expenditures on community-based behavioral health care for the target population at the market average as determined by OHIC.
- Includes claims and non-claims spending for community-based behavioral health care.
- Applies to spending for residents of Rhode Island who receive care from providers located in Rhode Island.
- If carriers do not reach the benchmark, they will be subject to penalties determined by the Commissioner.

Tentative Timeline for Behavioral Health Work

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

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

X Provide Feedback

✓ Board Approval

October Advisory Committee Feedback

- Suggestion to engage additional stakeholders, such as: clinical professional organization representatives, behavioral health providers not in managerial roles, emergency medical services personnel, and people with lived experiences.
- Questions on how diagnosis codes will be used to measure behavioral health care.
- Discussion of Behavioral Health in Primary Care module:
 - Questions about how it will be defined.
 - Availability of primary care clinicians trained to provide behavioral health services is a concern.
 - Care management and care team infrastructure may not be adequate to support need.
- Prevention is important – not all is through the health care system.
- More behavioral health spend, such as through institutional care, does not necessarily mean better outcomes.
- Important to capture behavioral health spend via telehealth and spend under capitation.
- Access to care is critical with focus on therapy, peer support, wrap around services, etc.
- Affordability should be a goal for measuring and benchmarking, especially out-of-plan spending



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

Public Comment





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

Sector Targets

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director



Sector Target Implementation

The general process for establishing sector targets is a two-step process.

1. The Board **defines** sector(s)
 - a) The Board votes on sector(s) definition(s)
 - b) The Office promulgates regulations defining the sector(s)

2. The Board **establishes sector target(s) value(s)** annually
 - a) The Office recommends sector target(s) value(s) by March 1 in the year preceding the performance year (e.g., by March 1, 2025 for performance year 2026)
 - b) The Board approves sector target(s) value(s) by June 1 in the year preceding the performance year
 - c) The Board may approve multi-year sector targets

Today's discussion will focus primarily on step 1. The Office will return to the Board to address Step 2 as soon as January 2025.

Board Discussion Recap

Hospitals Sector Board Discussion Recap

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

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

Board members broadly suggested that many of these attributes may warrant distinct consideration, or even exclusion, when defining a hospital sector and establishing sector targets for hospitals.

Members suggested the following:

- Factoring in geography/rural areas to any hospital sector target.
- Since State and County Hospitals rely minimally on commercial payment, and in many cases are funded in whole or in part by state and local appropriations, they may not warrant a lower spending target value.
- Psychiatric Hospitals are funded differently by Medicare, so may warrant distinct treatment.
- Children's Hospitals receive very little Medicare funding, and some may have different billing practices.
- Long-Term Stay and Specialty Hospitals are likely a heterogeneous group, where some may warrant distinct treatment or consideration while others may not.
- Critical Access Hospitals and Small Hospitals, depending upon how they are defined, may not warrant lower targets.
- Most Teaching Hospitals and academic medical centers likely do not warrant distinct treatment.
- A review of hospital data by facility attributes and several financial metrics.

Data Review of California Hospitals

Hospitals in California

Based on discussions with the Board, the following data in this section shows the Top 30 hospitals for each of four financial metrics from 2018-2022.* These are a select and illustrative set of metrics for the Board's review and analysis. They are not meant to convey a methodology or recommendation on how to define a hospital sector or establish sector targets:

- Spending: Average Inpatient Net Patient Revenue (NPR) Per Case Mix Adjusted Discharge (CMAD)
- Growth: Average Annual Growth Per Inpatient NPR Per CMAD
- Profitability: Average Operating Margin
- Price: Average Payment to Cost Third Party to Medicare Ratio

The first section shows the Top 30 hospitals for each metric without any potential exclusions.

The second section shows the Top 30 hospitals for each financial metric with the following exclusions:

- Critical Access Hospitals
- Psychiatric Health Facilities
- State Hospitals
- Long-Term Stay Hospitals (more than 20 days)
- Small Hospitals (less than 100 licensed beds)
- Children's Hospitals
- Kaiser Hospitals (part of a FIDS)

* Data reported by hospitals for financial metrics may not include all years.

Definitions of Metrics

- **Inpatient Net Patient Revenue (NPR) Per Case Mix Adjusted Discharge (CMAD):** the amount of money a hospital generates for inpatient services, excluding charity care, bad debt, and contractual allowances adjusted by the number of hospitalizations to account for inpatient volume and inpatient intensity of services.
- **Annual Growth Per Inpatient NPR Per CMAD:** the year-over-year change in the amount of money a hospital generates per unit for inpatient services, excluding charity care, bad debt, and contractual allowances adjusted by the number of hospitalizations to account for inpatient volume and inpatient intensity of services.
- **Operating Margin:** the net income from operations divided by total operating revenue (net patient revenue plus other operating revenue). This ratio indicates the percentage of net patient revenue that remains as income after operating expenses have been deducted.
- **Payment to Cost Third Party to Medicare Ratio:** Medicare and Third-Party net patient revenue divided by Medicare and Third-party costs. This ratio compares the amount a third-party payer pays for a medical service compared to what Medicare would pay for the same service, showing how much more or less the third party pays relative to Medicare's standard rate for that service.

Note: Net Patient Revenue consists of the actual amount of revenue received from patients and third-party payers after subtracting the deductions from revenue from the sum of gross patient revenue and capitation premium revenue.

Definitions of Facility Attributes

- **Critical Access Hospital:** CAHs represent a separate provider type with their own Medicare Conditions of Participation (CoP) as well as a separate payment method. The CoPs for CAHs are listed in the “Code of Federal Regulations” at 42 CFR 485 subpart F.
- **Small Facility:** For this analysis, OHCA defines Small Facilities as those Hospitals with less than 100 licensed beds.
- **Psychiatric Hospital:** The designation of a psychiatric hospital is self-reported in the HCAI financial reporting. These hospitals provide a preponderance of psychiatric services.
- **Psychiatric Health Facility (PHF):** a health facility, licensed by the State Department of Health Care Services, that provides 24-hour inpatient care for people with mental health disorders or other persons described in the Welfare and Institutions Code.
- **Children’s Hospital:** The designation of a Children’s Hospital is self-reported in HCAI data. There are likely facilities that specialize in or focus on care for children that do not self-identify as a Children’s Hospital.
- **Teaching Hospital:** HCAI identifies teaching hospitals based primarily on the American Medical Association’s Graduate Medical Education (GME) Directory.

Definitions of Facility Attributes

- **Specialty Hospital:** There is not a statutory definition of what constitutes a specialty hospital. Examples of care provided by specialty hospitals may include rehabilitation, cancer treatment, heart surgery, addiction recovery, respiratory care, neurological services, long-term care, orthopedic surgery, and mental health care.
- **Designated Public Hospital (Public):** Facilities defined as “Designated Public Hospitals” per Welfare and Institutions Code (WIC) § 14181.10.* There may be other county or predominantly county run hospitals that are not included in this definition.
- **State Hospital:** Hospitals that provide mental and behavioral health services to patients referred by a county court, a prison, or a parole board as defined in WIC § 4100.
- **Long Stay Facility:** For this analysis, OHCA defines Long-Stay Facilities as those Hospitals with an average length of stay greater than 20 days.
- **Fully Integrated Delivery System Hospitals:** Hospitals that are part of a fully integrated delivery system as defined in Health and Safety Code § 127500.2 (h).

* WIC § 14184.10 authorized a Medi-Cal demonstration project and defines facilities as designated public hospitals.

Review of Hospital Data Metrics

Key Takeaways: Review of Metrics Without Specified Exclusions (2018-2022)

Financial Metric (2018-2022)	Top 30 Range (High to Low)	Statewide Median (Without Exclusions)
Average Inpatient NPR Per CMAD	\$402K to \$28K	\$12,791
Average Annual Growth in Inpatient NPR Per CMAD	79% to 15%	3%
Average Operating Margin	41% to 15%	1%
Average Payment to Cost Third Party to Medicare Ratio	857% to 300%	180%

Top 15 Average Inpatient NPR Per CMAD Without Specified Exclusions (2018-2022)

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Inpatient NPR per CMAD
1	Children's Healthcare Organization of Northern CA - Pediatric Hospital	Santa Clara	N	Y	N	N	N	N	N	N	Y	\$402,481
2	Laguna Honda Hospital and Rehabilitation Center	San Francisco	N	N	N	N	N	N	N	N	Y	\$136,200
3	Totally Kids Rehabilitation Hospital	San Bernardino	N	Y	Y	N	Y	N	N	N	Y	\$136,086
4	Joyce Eisenberg Keefer Medical Center	Los Angeles	N	N	N	N	N	Y	N	N	Y	\$134,932
5	Motion Picture and Television Hospital	Los Angeles	N	N	N	N	N	N	N	N	Y	\$99,305
6	Surprise Valley Community Hospital	Modoc	Y	Y	N	N	N	N	N	N	Y	\$89,990
7	Catalina Island Medical Center	Los Angeles	Y	Y	N	N	N	N	N	N	Y	\$83,903
8	Healthbridge Children's Hospital - Orange	Orange	N	Y	N	N	N	N	N	N	Y	\$81,517
9	Star View Adolescent (PHF)	Los Angeles	N	Y	N	N	N	Y	N	N	Y	\$67,188
10	Lucile Salter Packard Children's Hospital at Stanford	Santa Clara	N	N	Y	Y	N	N	N	N	N	\$60,867
11	La Casa Psychiatric Health Facility	Los Angeles	N	Y	N	N	N	Y	N	N	Y	\$59,470
12	Eastern Plumas Health Care	Plumas	Y	Y	N	N	N	N	N	N	Y	\$55,954
13	LAC/Rancho Los Amigos National Rehabilitation Center	Los Angeles	N	N	N	N	N	N	N	Y	N	\$54,042
14	Jewish Home	San Francisco	N	N	N	N	N	Y	N	N	Y	\$52,726
15	Mayers Memorial Hospital	Shasta	Y	N	N	N	N	N	N	N	Y	\$46,623

The acronym "PHF" stands for licensed Psychiatric Health Facility. The column label "Psych" means a hospital self-reports as a psychiatric hospital.
 Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

Top 16-30 Average Inpatient NPR Per CMAD Without Specified Exclusions (2018-2022)

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Inpatient NPR per CMAD
16	San Diego County Psychiatric Hospital	San Diego	N	N	N	N	N	Y	N	N	Y	\$40,659
17	Kindred Hospital - San Francisco Bay Area	Alameda	N	Y	N	N	N	N	N	N	Y	\$39,391
18	Southern Inyo Hospital	Inyo	Y	Y	N	N	N	N	N	N	Y	\$38,036
19	Kentfield Hospital	Marin	N	N	N	N	Y	N	N	N	Y	\$36,490
20	Seneca Healthcare District	Plumas	Y	Y	N	N	N	N	N	N	Y	\$35,601
21	San Mateo Medical Center	San Mateo	N	N	N	N	N	N	N	Y	Y	\$35,191
22	Glenn Medical Center	Glenn	Y	Y	N	N	N	N	N	N	Y	\$34,762
23	California Rehabilitation Institute	Los Angeles	N	N	N	N	Y	N	N	N	N	\$31,950
24	Resnick Neuropsychiatric Hospital at UCLA	Los Angeles	N	Y	N	N	N	Y	N	N	N	\$31,240
25	Kindred Hospital - Brea	Orange	N	Y	N	N	N	N	N	N	Y	\$30,750
26	Vibra Hospital of Sacramento	Sacramento	N	Y	N	N	Y	N	N	N	Y	\$30,616
27	Trinity Hospital	Trinity	Y	Y	N	N	N	N	N	N	Y	\$30,531
28	Kindred Hospital - Paramount	Los Angeles	N	N	N	N	N	N	N	N	Y	\$30,311
29	Contra Costa Regional Medical Center	Contra Costa	N	N	N	N	N	N	N	Y	N	\$29,654
30	UCSF Medical Center	San Francisco	N	N	N	Y	N	N	N	Y	N	\$28,658

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
 Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

Top 15 Average Annual Growth in Inpatient NPR Per CMAD Without Specified Exclusions (2018-2022)

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Annual Growth per Inpatient NPR per CMAD
1	Sonoma Specialty Hospital	Sonoma	N	Y	N	N	N	N	N	N	Y	79%
2	Providence St. Jude Medical Center	Orange	N	N	N	N	N	N	N	N	N	66%
3	Glenn Medical Center	Glenn	Y	Y	N	N	N	N	N	N	Y	61%
4	Alameda Hospital	Alameda	N	N	N	N	N	N	N	Y	Y	50%
5	Marie Green Psychiatric Center (PHF)	Merced	N	Y	N	N	N	Y	N	N	N	37%
6	Telecare Riverside County Psychiatric Health Facility (PHF)	Riverside	N	Y	N	N	N	Y	N	N	N	35%
7	Children's Healthcare Organization of Northern Ca - Pediatric Hospital	Santa Clara	N	Y	N	N	N	N	N	N	Y	34%
8	Southern Inyo Hospital	Inyo	Y	Y	N	N	N	N	N	N	Y	33%
9	Sutter Surgical Hospital - North Valley	Sutter	N	Y	N	N	N	N	N	N	N	24%
10	Healthbridge Children's Hospital - Orange	Orange	N	Y	N	N	N	N	N	N	Y	23%
11	Highland Hospital	Alameda	N	N	N	N	N	N	N	Y	N	23%
12	Joyce Eisenberg Keefer Medical Center	Los Angeles	N	N	N	N	N	Y	N	N	Y	22%
13	La Casa Psychiatric Health Facility (PHF)	Los Angeles	N	Y	N	N	N	Y	N	N	Y	22%
14	Ventura County Medical Center	Ventura	N	N	N	N	N	N	N	Y	N	22%
15	Casa Palmera Care Center, LLC	San Diego	N	Y	N	N	Y	N	N	N	Y	21%

The acronym "PHF" stands for licensed Psychiatric Health Facility. The column label "Psych" means a hospital self-reports as a psychiatric hospital.
 Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

Top 16-30 Average Annual Growth in Inpatient NPR Per CMAD Without Specified Exclusions (2018-2022)

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Annual Growth per Inpatient NPR per CMAD
16	LAC/Rancho Los Amigos National Rehabilitation Center	Los Angeles	N	N	N	N	N	N	N	Y	N	19%
17	Laguna Honda Hospital and Rehabilitation Center	San Francisco	N	N	N	N	N	N	N	N	Y	19%
18	Palomar Rehabilitation Institute	San Diego	N	Y	N	N	Y	N	N	N	N	17%
19	Jerold Phelps Community Hospital	Humboldt	Y	Y	N	N	N	N	N	N	Y	17%
20	Gateways Hospital and Mental Health Center	Los Angeles	N	Y	N	N	N	Y	N	N	Y	17%
21	Trinity Hospital	Trinity	Y	Y	N	N	N	N	N	N	Y	16%
22	Sempervirens (PHF)	Humboldt	N	Y	N	N	N	Y	N	N	N	16%
23	San Luis Obispo County (PHF)	San Luis Obispo	N	Y	N	N	N	Y	N	N	N	16%
24	Hi-desert Medical Center	San Bernardino	N	N	N	N	N	N	N	N	N	15%
25	Crestwood (PHF)- Bakersfield	Kern	N	Y	N	N	N	Y	N	N	N	15%
26	Ridgecrest Regional Hospital	Kern	Y	N	N	N	N	N	N	N	N	15%
27	College Medical Center	Los Angeles	N	N	N	N	N	N	N	N	N	15%
28	Crestwood (PHF) - San Jose	Santa Clara	N	Y	N	N	N	Y	N	N	Y	15%
29	George L. Mee Memorial Hospital	Monterey	Y	Y	N	N	N	N	N	N	Y	15%
30	Seneca Healthcare District	Plumas	Y	Y	N	N	N	N	N	N	Y	15%

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
 Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

Top 15 Average Operating Margin Without Specified Exclusions (2018-2022)

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Operating Margin
1	Merritt Peralta Institute Chemical Dependency Recovery Hospital	Alameda	N	Y	N	N	Y	N	N	N	N	41%
2	BHC Alhambra Hospital	Los Angeles	N	Y	N	N	N	Y	N	N	N	40%
3	Canyon Ridge Hospital	San Bernardino	N	N	N	N	N	Y	N	N	N	39%
4	Sierra Vista Hospital	Sacramento	N	N	N	N	N	Y	N	N	N	32%
5	College Hospital Costa Mesa	Orange	N	N	N	N	N	Y	N	N	N	31%
6	Fremont Hospital	Alameda	N	N	N	N	N	Y	N	N	N	30%
7	Heritage Oaks Hospital	Sacramento	N	N	N	N	N	Y	N	N	N	28%
8	Hoag Orthopedic Institute	Orange	N	Y	N	N	Y	N	N	N	N	27%
9	Del Amo Hospital	Los Angeles	N	N	N	N	N	Y	N	N	N	27%
10	Casa Palmera Care Center, LLC	San Diego	N	Y	N	N	Y	N	N	N	Y	26%
11	San Jose Behavioral Health	Santa Clara	N	Y	N	N	N	Y	N	N	N	24%
12	Crestwood (PHF) - San Jose	Santa Clara	N	Y	N	N	N	Y	N	N	Y	21%
13	USC Kenneth Norris Jr. Cancer Hospital	Los Angeles	N	Y	N	N	Y	N	N	N	N	20%
14	Memorial Hospital Los Banos	Merced	N	Y	N	N	N	N	N	N	N	19%
15	Children's Hospital at Mission	Orange	N	Y	Y	N	N	N	N	N	N	19%

The acronym "PHF" stands for licensed Psychiatric Health Facility. The column label "Psych" means a hospital self-reports as a psychiatric hospital.
 Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

Top 16-30 Average Operating Margin Without Specified Exclusions (2018-2022)

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Operating Margin
16	Eastern Plumas Health Care	Plumas	Y	Y	N	N	N	N	N	N	Y	19%
17	Trinity Hospital	Trinity	Y	Y	N	N	N	N	N	N	Y	19%
18	Goleta Valley Cottage Hospital	Santa Barbara	N	Y	N	N	N	N	N	N	N	18%
19	Mercy Hospital - Folsom	Sacramento	N	N	N	N	N	N	N	N	N	18%
20	Scripps Green Hospital	San Diego	N	N	N	N	Y	N	N	N	N	18%
21	Crestwood (PHF) – Carmichael	Sacramento	N	Y	N	N	N	Y	N	N	N	18%
22	Salinas Valley Memorial Hospital	Monterey	N	N	N	N	N	N	N	N	N	18%
23	Los Robles Hospital and Medical Center	Ventura	N	N	N	N	N	N	N	N	N	17%
24	Good Samaritan Hospital - San Jose	Santa Clara	N	N	N	N	N	N	N	N	N	17%
25	Desert Valley Hospital	San Bernardino	N	N	N	N	N	N	N	N	N	16%
26	Santa Ynez Valley Cottage Hospital	Santa Barbara	Y	Y	N	N	N	N	N	N	N	16%
27	California Rehabilitation Institute	Los Angeles	N	N	N	N	Y	N	N	N	N	16%
28	Los Angeles Community Hospital	Los Angeles	N	N	N	N	N	N	N	N	N	16%
29	Scripps Memorial Hospital - La Jolla	San Diego	N	N	N	N	N	N	N	N	N	16%
30	Aurora San Diego	San Diego	N	N	N	N	N	Y	N	N	N	15%

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
 Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

Top 15 Average Payment to Cost Third Party to Medicare Ratio Without Specified Exclusions (2018-2022)

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Payment to Cost Third Party to Medicare Ratio
1	Monterey Park Hospital	Los Angeles	N	N	N	N	N	N	N	N	N	857%
2	Barton Memorial Hospital	El Dorado	N	N	N	N	N	N	N	N	N	799%
3	Southern Inyo Hospital	Inyo	Y	Y	N	N	N	N	N	N	Y	489%
4	Salinas Valley Memorial Hospital	Monterey	N	N	N	N	N	N	N	N	N	476%
5	Orange County Global Medical Center	Orange	N	N	N	N	N	N	N	N	N	404%
6	Goleta Valley Cottage Hospital	Santa Barbara	N	Y	N	N	N	N	N	N	N	382%
7	Mercy Hospital - Folsom	Sacramento	N	N	N	N	N	N	N	N	N	382%
8	Doctors Hospital of Manteca	San Joaquin	N	Y	N	N	N	N	N	N	N	381%
9	Children's Hospital Los Angeles	Los Angeles	N	N	Y	Y	N	N	N	N	N	376%
10	Barstow Community Hospital	San Bernardino	N	Y	N	N	N	N	N	N	N	370%
11	Mercy Medical Center - Merced	Merced	N	N	N	N	N	N	N	N	N	362%
12	Washington Hospital - Fremont	Alameda	N	N	N	N	N	N	N	N	N	358%
13	Novato Community Hospital	Marin	N	Y	N	N	N	N	N	N	N	356%
14	Community Hospital of The Monterey Peninsula	Monterey	N	N	N	N	N	N	N	N	N	352%
15	Emanuel Medical Center	Stanislaus	N	N	N	N	N	N	N	N	N	351%

The acronym "PHF" stands for licensed Psychiatric Health Facility. The column label "Psych" means a hospital self-reports as a psychiatric hospital.
 Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

Top 16-30 Average Payment to Cost Third Party to Medicare Ratio Without Specified Exclusions (2018-2022)

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Payment to Cost Third Party to Medicare Ratio
16	Watsonville Community Hospital	Santa Cruz	N	N	N	N	N	N	N	N	N	348%
17	L.A. Downtown Medical Center	Los Angeles	N	N	N	N	N	N	N	N	N	347%
18	Doctors Medical Center - Modesto	Stanislaus	N	N	N	N	N	N	N	N	N	347%
19	Stanford Health Care	Santa Clara	N	N	N	Y	N	N	N	N	N	339%
20	Sutter Tracy Community Hospital	San Joaquin	N	Y	N	N	N	N	N	N	N	338%
21	Dominican Hospital	Santa Cruz	N	N	N	N	N	N	N	N	N	330%
22	Marin General Hospital	Marin	N	N	N	N	N	N	N	N	N	329%
23	Petaluma Valley Hospital	Sonoma	N	Y	N	N	N	N	N	N	N	320%
24	Sharp McDonald Center	San Diego	N	Y	N	N	Y	N	N	N	N	309%
25	Memorial Hospital Modesto	Stanislaus	N	N	N	N	N	N	N	N	N	307%
26	Sutter Amador Hospital	Amador	N	Y	N	N	N	N	N	N	N	306%
27	Santa Barbara Cottage Hospital	Santa Barbara	N	N	N	Y	N	N	N	N	N	305%
28	Stanford Health Care Tri-Valley	Alameda	N	N	N	N	N	N	N	N	N	302%
29	Los Robles Hospital and Medical Center	Ventura	N	N	N	N	N	N	N	N	N	301%
30	Sierra Nevada Memorial Hospital	Nevada	N	N	N	N	N	N	N	N	N	300%

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
 Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

Review of Hospital Metrics Removing Specified Facilities

Hospital Analysis with Specified Exclusions

Based on feedback from the Board, OHCA presents the following Top 30 data excluding hospitals with the following attributes: Critical Access Hospitals, Children’s Hospitals, Psychiatric Health Facilities, Small Hospitals (<100 beds), and Long-Term Stay Hospitals (>20 days).

Key takeaways include:

Financial Metric (2018-2022)	Top 30 Range (High to Low)	Statewide Median (With Exclusions)
Average Inpatient NPR Per CMAD	\$54K to \$18K	\$12,647
Average Annual Growth in Inpatient NPR Per CMAD	66% to 8%	3%
Average Operating Margin	39% to 12%	2%
Average Payment to Cost Third Party to Medicare Ratio	857% to 276%	198%

Top 15 Average Inpatient NPR Per CMAD With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

	Hospital	County	Teaching/ AMC	Specialty	Psych	Public	Average Inpatient NPR per CMAD	Average Annual Growth per Inpatient NPR per CMAD	Average Operating Margin	Average Payment to Cost Third Party to Medicare Ratio
1	LAC/Rancho Los Amigos National Rehabilitation Center	Los Angeles	N	N	N	Y	\$54,042	19%	-7%	144%
2	California Rehabilitation Institute	Los Angeles	N	Y	N	N	\$31,950	0%	16%	197%
3	Contra Costa Regional Medical Center	Contra Costa	N	N	N	Y	\$29,654	2%	-4%	120%
4	UCSF Medical Center	San Francisco	Y	N	N	Y	\$28,658	3%	0%	238%
5	Stanford Health Care	Santa Clara	Y	N	N	N	\$28,288	4%	9%	339%
6	Foothill Regional Medical Center	Orange	N	N	N	N	\$26,170	3%	-5%	82%
7	Alhambra Hospital Medical Center	Los Angeles	N	N	N	N	\$26,031	8%	4%	109%
8	University of California Davis Medical Center	Sacramento	Y	N	N	Y	\$25,870	3%	6%	237%
9	City of Hope Helford Clinical Research Hospital	Los Angeles	N	Y	N	N	\$25,584	0%	-3%	174%
10	Ronald Reagan UCLA Medical Center	Los Angeles	Y	N	N	Y	\$25,395	2%	6%	142%
11	Santa Clara Valley Medical Center	Santa Clara	Y	N	N	Y	\$25,319	3%	-10%	146%
12	College Hospital Costa Mesa	Orange	N	N	Y	N	\$24,736	14%	31%	117%
13	Highland Hospital	Alameda	N	N	N	Y	\$23,901	23%	-16%	191%
14	Northbay Medical Center	Solano	N	N	N	N	\$23,497	0%	1%	271%
15	John Muir Medical Center - Walnut Creek	Contra Costa	N	N	N	N	\$21,904	4%	9%	102%

Top 16-30 Average Inpatient NPR Per CMAD With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

	Hospital	County	Teaching/ AMC	Specialty	Psych	Public	Average Inpatient NPR per CMAD	Average Annual Growth per Inpatient NPR per CMAD	Average Operating Margin	Average Payment to Cost Third Party to Medicare Ratio
16	California Pacific Medical Center - Van Ness Campus	San Francisco	N	N	N	N	\$21,759	5%	-4%	253%
17	El Camino Health	Santa Clara	N	N	N	N	\$21,693	3%	13%	283%
18	Cedars-Sinai Medical Center	Los Angeles	Y	N	N	N	\$21,663	3%	9%	278%
19	Zuckerberg San Francisco General Hospital & Trauma Center	San Francisco	Y	N	N	Y	\$21,267	4%	-30%	218%
20	Alta Bates Summit Medical Center - Alta Bates Campus	Alameda	N	N	N	N	\$20,920	3%	-3%	256%
21	Keck Hospital of USC	Los Angeles	Y	N	N	N	\$20,718	7%	-3%	180%
22	LAC/Harbor - UCLA Medical Center	Los Angeles	Y	N	N	Y	\$19,863	12%	-12%	94%
23	Adventist Health Delano	Kern	N	N	N	N	\$19,530	5%	-14%	125%
24	Washington Hospital - Fremont	Alameda	N	N	N	N	\$19,448	2%	0%	358%
25	East Los Angeles Doctor's Hospital	Los Angeles	N	N	N	N	\$19,406	4%	8%	114%
26	Sacramento Behavioral Healthcare Hospital, LLC	Sacramento	N	N	Y	N	\$19,118	N/A	-1771%	114%
27	Community Hospital of The Monterey Peninsula	Monterey	N	N	N	N	\$19,104	2%	12%	352%
28	LAC/Olive View - UCLA Medical Center	Los Angeles	Y	N	N	Y	\$18,948	12%	-24%	140%
29	Good Samaritan Hospital - San Jose	Santa Clara	N	N	N	N	\$18,699	0%	17%	232%
30	Valley Presbyterian Hospital	Los Angeles	N	N	N	N	\$18,663	7%	5%	108%

Top 15 Average Annual Growth in Inpatient NPR Per CMAD With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

	Hospital	County	Teaching/ AMC	Specialty	Psych	Public	Average Annual Growth per Inpatient NPR per CMAD	Average Inpatient NPR per CMAD	Average Operating Margin	Average Payment to Cost Third Party to Medicare Ratio
1	Providence St. Jude Medical Center	Orange	N	N	N	N	66%	\$9,327	4%	136%
2	Highland Hospital	Alameda	N	N	N	Y	23%	\$23,901	-16%	191%
3	Ventura County Medical Center	Ventura	N	N	N	Y	22%	\$15,894	-5%	101%
4	LAC/Rancho Los Amigos National Rehabilitation Center	Los Angeles	N	N	N	Y	19%	\$54,042	-7%	144%
5	Hi-Desert Medical Center	San Bernardino	N	N	N	N	15%	\$15,425	5%	118%
6	College Medical Center	Los Angeles	N	N	N	N	15%	\$12,499	13%	123%
7	College Hospital Costa Mesa	Orange	N	N	Y	N	14%	\$24,736	31%	117%
8	Aurora Las Encinas Hospital	Los Angeles	N	N	Y	N	13%	\$6,411	3%	92%
9	Loma Linda University Medical Center - Murrieta	Riverside	N	N	N	N	13%	\$10,047	-9%	116%
10	Arrowhead Regional Medical Center	San Bernardino	Y	N	N	Y	12%	\$12,384	-21%	199%
11	Aurora San Diego	San Diego	N	N	Y	N	12%	\$10,995	15%	102%
12	LAC/Harbor - UCLA Medical Center	Los Angeles	Y	N	N	Y	12%	\$19,863	-12%	94%
13	LAC/Olive View - UCLA Medical Center	Los Angeles	Y	N	N	Y	12%	\$18,948	-24%	140%
14	Hollywood Presbyterian Medical Center	Los Angeles	N	N	N	N	11%	\$14,763	6%	102%
15	Paradise Valley Hospital	San Diego	N	N	N	N	10%	\$10,766	4%	119%

Top 16-30 Average Annual Growth in Inpatient NPR Per CMAD With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

	Hospital	County	Teaching/ AMC	Specialty	Psych	Public	Average Annual Growth per Inpatient NPR per CMAD	Average Inpatient NPR per CMAD	Average Operating Margin	Average Payment to Cost Third Party to Medicare Ratio
16	Adventist Health St. Helena	Napa	N	N	N	N	10%	\$11,958	-4%	198%
17	Lompoc Valley Medical Center	Santa Barbara	N	N	N	N	9%	\$14,554	-1%	97%
18	Methodist Hospital of Southern California	Los Angeles	N	N	N	N	8%	\$10,874	-1%	134%
19	Southern California Hospital at Hollywood	Los Angeles	N	N	N	N	8%	\$11,344	-2%	251%
20	Alhambra Hospital Medical Center	Los Angeles	N	N	N	N	8%	\$26,031	4%	109%
21	Marshall Medical Center	El Dorado	N	N	N	N	8%	\$17,024	2%	288%
22	Palomar Medical Center Poway	San Diego	N	N	N	N	8%	\$14,011	1%	174%
23	Providence Mission Hospital	Orange	N	N	N	N	8%	\$12,051	1%	196%
24	Providence St. Joseph Hospital	Orange	N	N	N	N	8%	\$13,511	-3%	94%
25	USC Verdugo Hills Hospital	Los Angeles	N	N	N	N	8%	\$9,433	-5%	88%
26	College Hospital	Los Angeles	N	N	Y	N	8%	\$12,422	2%	113%
27	Eden Medical Center	Alameda	N	N	N	N	8%	\$15,668	5%	293%
28	Providence St. Mary Medical Center	San Bernardino	N	N	N	N	8%	\$10,413	4%	253%
29	Valley Presbyterian Hospital	Los Angeles	N	N	N	N	7%	\$18,663	5%	108%
30	Keck Hospital of USC	Los Angeles	Y	N	N	N	7%	\$20,718	-3%	180%

Top 15 Average Operating Margin With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

	Hospital	County	Teaching/ AMC	Specialty	Psych	Public	Average Operating Margin	Average Inpatient NPR per CMAD	Average Annual Growth per Inpatient NPR per CMAD	Average Payment to Cost Third Party to Medicare Ratio
1	Canyon Ridge Hospital	San Bernardino	N	N	Y	N	39%	\$5,259	3%	99%
2	Sierra Vista Hospital	Sacramento	N	N	Y	N	32%	\$9,166	1%	94%
3	College Hospital Costa Mesa	Orange	N	N	Y	N	31%	\$24,736	14%	117%
4	Fremont Hospital	Alameda	N	N	Y	N	30%	\$9,624	4%	104%
5	Heritage Oaks Hospital	Sacramento	N	N	Y	N	28%	\$9,231	4%	77%
6	Del Amo Hospital	Los Angeles	N	N	Y	N	27%	\$5,598	1%	108%
7	Mercy Hospital - Folsom	Sacramento	N	N	N	N	18%	\$13,672	2%	382%
8	Scripps Green Hospital	San Diego	N	Y	N	N	18%	\$12,585	4%	146%
9	Salinas Valley Memorial Hospital	Monterey	N	N	N	N	18%	\$17,886	0%	476%
10	Los Robles Hospital and Medical Center	Ventura	N	N	N	N	17%	\$13,788	4%	301%
11	Good Samaritan Hospital - San Jose	Santa Clara	N	N	N	N	17%	\$18,699	0%	232%
12	Desert Valley Hospital	San Bernardino	N	N	N	N	16%	\$8,444	0%	206%
13	California Rehabilitation Institute	Los Angeles	N	Y	N	N	16%	\$31,950	0%	197%
14	Los Angeles Community Hospital	Los Angeles	N	N	N	N	16%	\$11,738	7%	103%
15	Scripps Memorial Hospital - La Jolla	San Diego	N	N	N	N	16%	\$14,263	1%	242%

Top 16-30 Average Operating Margin With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

	Hospital	County	Teaching/ AMC	Specialty	Psych	Public	Average Operating Margin	Average Inpatient NPR per CMAD	Average Annual Growth per Inpatient NPR per CMAD	Average Payment to Cost Third Party to Medicare Ratio
16	Aurora San Diego	San Diego	N	N	Y	N	15%	\$10,995	12%	102%
17	Desert Regional Medical Center	Riverside	N	N	N	N	15%	\$15,139	5%	249%
18	Memorial Hospital of Gardena	Los Angeles	N	N	N	N	14%	\$14,772	6%	150%
19	Sharp Memorial Hospital	San Diego	N	N	N	N	14%	\$12,062	4%	256%
20	Whittier Hospital Medical Center	Los Angeles	N	N	N	N	13%	\$10,765	4%	176%
21	Emanuel Medical Center	Stanislaus	N	N	N	N	13%	\$10,234	4%	351%
22	San Ramon Regional Medical Center	Contra Costa	N	N	N	N	13%	\$15,491	0%	213%
23	Sutter Roseville Medical Center	Placer	N	N	N	N	13%	\$15,538	1%	249%
24	El Camino Health	Santa Clara	N	N	N	N	13%	\$21,693	3%	283%
25	College Medical Center	Los Angeles	N	N	N	N	13%	\$12,499	15%	123%
26	Southwest Healthcare System - Murrieta	Riverside	N	N	N	N	12%	\$9,335	0%	191%
27	Adventist Health Hanford	Kings	N	N	N	N	12%	\$10,911	3%	223%
28	Monterey Park Hospital	Los Angeles	N	N	N	N	12%	\$12,223	-1%	857%
29	Placentia Linda Hospital	Orange	N	N	N	N	12%	\$8,420	-1%	266%
30	Community Hospital of The Monterey Peninsula	Monterey	N	N	N	N	12%	\$19,104	2%	352%

Top 15 Average Payment to Cost Third Party to Medicare Ratio With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

	Hospital	County	Teaching/ AMC	Specialty	Psych	Public	Average Payment to Cost Third Party to Medicare Ratio	Average Inpatient NPR per CMAD	Average Annual Growth per Inpatient NPR per CMAD	Average Operating Margin
1	Monterey Park Hospital	Los Angeles	N	N	N	N	857%	\$12,223	-1%	12%
2	Barton Memorial Hospital	El Dorado	N	N	N	N	799%	\$18,094	-2%	6%
3	Salinas Valley Memorial Hospital	Monterey	N	N	N	N	476%	\$17,886	0%	18%
4	Orange County Global Medical Center	Orange	N	N	N	N	404%	\$10,076	-2%	-4%
5	Mercy Hospital - Folsom	Sacramento	N	N	N	N	382%	\$13,672	2%	18%
6	Mercy Medical Center - Merced	Merced	N	N	N	N	362%	\$13,210	2%	7%
7	Washington Hospital - Fremont	Alameda	N	N	N	N	358%	\$19,448	2%	0%
8	Community Hospital of The Monterey Peninsula	Monterey	N	N	N	N	352%	\$19,104	2%	12%
9	Emanuel Medical Center	Stanislaus	N	N	N	N	351%	\$10,234	4%	13%
10	Watsonville Community Hospital	Santa Cruz	N	N	N	N	348%	\$12,119	-6%	-22%
11	L.A. Downtown Medical Center	Los Angeles	N	N	N	N	347%	\$9,211	-2%	-2%
12	Doctors Medical Center - Modesto	Stanislaus	N	N	N	N	347%	\$13,456	1%	11%
13	Stanford Health Care	Santa Clara	Y	N	N	N	339%	\$28,288	4%	9%
14	Dominican Hospital	Santa Cruz	N	N	N	N	330%	\$17,652	2%	9%
15	Marin General Hospital	Marin	N	N	N	N	329%	\$16,291	2%	6%

Top 16-30 Average Payment to Cost Third Party to Medicare Ratio With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

	Hospital	County	Teaching/ AMC	Specialty	Psych	Public	Average Payment to Cost Third Party to Medicare Ratio	Average Inpatient NPR per CMAD	Average Annual Growth per Inpatient NPR per CMAD	Average Operating Margin
16	Memorial Hospital Modesto	Stanislaus	N	N	N	N	307%	\$12,649	3%	9%
17	Santa Barbara Cottage Hospital	Santa Barbara	Y	N	N	N	305%	\$18,420	2%	3%
18	Stanford Health Care Tri-Valley	Alameda	N	N	N	N	302%	\$15,418	6%	3%
19	Los Robles Hospital and Medical Center	Ventura	N	N	N	N	301%	\$13,788	4%	17%
20	Sierra Nevada Memorial Hospital	Nevada	N	N	N	N	300%	\$13,286	2%	0%
21	Alta Bates Summit Medical Center - Summit Hawthorne	Alameda	N	N	N	N	294%	\$14,451	5%	-4%
22	Eden Medical Center	Alameda	N	N	N	N	293%	\$15,668	8%	5%
23	Marshall Medical Center	El Dorado	N	N	N	N	288%	\$17,024	8%	2%
24	Mills-peninsula Medical Center	San Mateo	N	N	N	N	284%	\$15,266	2%	4%
25	El Camino Health	Santa Clara	N	N	N	N	283%	\$21,693	3%	13%
26	Providence Santa Rosa Memorial Hospital	Sonoma	N	N	N	N	279%	\$15,313	3%	4%
27	Tenet Health Central Coast Twin Cities Community Hospital	San Luis Obispo	N	N	N	N	278%	\$12,576	4%	11%
28	Cedars-Sinai Medical Center	Los Angeles	Y	N	N	N	278%	\$21,663	3%	9%
29	Methodist Hospital - Sacramento	Sacramento	N	N	N	N	276%	\$14,939	2%	-4%
30	Sequoia Hospital	San Mateo	N	N	N	N	276%	\$17,072	2%	-2%

Sector Definition and Target Setting Options

Defining Other Sectors

In response to Board requests, the Office has identified options for the Board's consideration to address disproportionately high-cost hospitals. In November, the Board expressed interest in potentially defining other sectors based on geographic region, medical group/provider organizations, and market category. Based on timing and data availability, the Office has limited the scope of today's discussion to defining a potential hospital sector.

Statute requires the Board to define initial sectors on or before October 1, 2027, and that the setting of different targets by health care sector is informed by historical cost and other relevant supplemental data. To define a sector and establish targets for performance year 2026, the Board would need to establish sector definitions, and the Office would need to recommend target values on or before March 1, 2025.

The Office has limited data to inform the establishment of potential sectors beyond Hospitals.

- **Physician Organizations:** The Office has very limited data on Total Medical Expense growth attributed to physician organizations. The Office is developing strategies to improve physician organization reporting.
- **Geographic Regions:** The Office has limited data on regional Total Medical Expenditure growth to inform defining appropriate geographic regions. Additional annual data reporting and supplemental data sets will be informative to defining geographic sectors in future years.
- **Market Category Sectors:** Additional data reporting and analysis of California's cost growth trends may inform defining market category sectors and target values.

Defining an initial hospital sector will not preclude the board from adding or defining geographic, market category, physician organization, or other sectors in the future.

Hospital Sector Options

Based on discussions with the Board, the Office has developed options to enable the Board to establish sector targets to address high-cost hospitals.

These options focus on how to define and establish sectors; the Office can return in subsequent meetings with options on establishing the sector target value(s).

1. Wait to establish sector targets for performance year 2027 or later.
2. Define the Community Hospital of the Monterey Peninsula (CHOMP), Salinas Valley Memorial Hospital, and Natividad Medical Center as a sector and establish target(s) for those facilities.
3. Establish a sector based on facility attributes and financial measures.
4. Define all hospitals as a sector and adjust the sector target for select facilities.

Hospital Sector Options

1. Wait to establish sector targets for performance year 2027 or later.

Approach Summary:

The Board could decide to wait to establish sector targets for performance year 2027 for high-cost hospitals, which means that OHCA would propose sector targets in winter/spring of the year preceding the applicable performance year.

Statute:

Health and Safety Code (HSC) § 127502 (I)(2)(A): On or before October 1, 2027, the board shall define initial health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems, considering factors such as delivery system characteristics. Sectors may be further defined over time.

Hospital Sector Options

1. Wait to establish sector targets for performance year 2027 or later.

Considerations:

- All facilities are subject to the statewide spending target.
- For many facilities, the statewide spending target will be a reduction in spending growth compared with historical trends.
- Waiting to develop a hospital sector target allows the Office to direct attention to other efforts, such as physician organization attribution and spending target enforcement.

Implementation:

The Office and Board will continue to analyze existing data and evaluate approaches to implementing sector targets, including high-cost hospitals.

Hospital Sector Options

2. Define CHOMP, Salinas Valley Memorial Hospital, and Natividad Medical Center as a sector and establish target(s) for those facilities.

Approach Summary:

The Board would define the three Monterey facilities as a sector and establish target(s) for them.

Statute:

- HSC § 127502 (b)(1): The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.
- HSC § 127502 (b)(2): 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.

Hospital Sector Options

2. Define CHOMP, Salinas Valley Memorial Hospital, and Natividad Medical Center as a sector and establish target(s) for those facilities.

Considerations:

- This approach is narrowly tailored to address the high-cost of three hospitals that have been brought to the Board's attention.
- Defining such a narrow sector would limit the Board's ability to later adjust the spending target to only these facilities because the statute only allows adjustments when warranted to account for the baseline costs in comparison to other health care entities in the health care sector and geographic region.
- The Board would still be able to adjust the target of each facility.
- Stakeholders might challenge why these three facilities are defined as a single sector, when data show that there are other high-cost hospitals.

Implementation:

- The Board would vote to define the three hospitals as a sector at a future board meeting.
- The Office would draft and seek to implement regulations defining the sector.
- The Office would return to the Board with options for establishing target value(s) for the sector.

Hospital Sector Options

3. Establish a sector based on facility attributes and financial measures.

Approach Summary:

The Board could define a high-cost hospital sector that includes a subset of hospitals based on facilities that are disproportionately high cost, define potential inclusion and/or exclusion criteria based on financial metrics and facility attributes, and establish target(s) for those facilities.

Statute:

- HSC § 127502 (b)(1): The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.
- HSC § 127502 (b)(2): 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.
- HSC § 127502 (b)(3): The setting of different targets by health care sector...shall be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs pursuant to § 127506.

Hospital Sector Options

3. Establish a sector based on facility attributes and financial measures.

Considerations:

- The Board would need to decide which metrics should be used to determine which facilities would be included or excluded in the sector.
- Not all attributes that may warrant inclusion or exclusion (e.g., Children's Hospitals, Public Hospitals) are readily identifiable or defined in statute or regulation, and many are self-reported.
- The Board may need to develop definitions for these facility attributes, and potentially how financial measures would be operationalized in the definition because the definitions would be in regulations.
- This approach may unintentionally include or exclude entities that may not warrant a target different from than the statewide target.
- This approach would require additional time to develop and implement and the Office would not be able to implement sector definition regulations and recommend target values for Performance Year 2026.

Implementation:

- The Office would continue to work with the Board on developing a process, based on financial measures and facility attributes, for defining hospitals that would be included in the sector definition.
- Once the process for defining included hospitals is agreed upon, the Office would seek to promulgate regulations and return to the Board with options for establishing target(s) for the sector.

Hospital Sector Options

4. Define all hospitals as a sector and adjust the sector target for select facilities.

Approach Summary

The Board could define all hospitals as a sector. If established as a sector, hospitals would be subject to the statewide target unless and until the Board adjusts the target for all or a specific subset of hospitals within the sector.

Statute

- HSC § 127502 (b)(1): The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.
- HSC § 127502 (b)(2): 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*.
- HSC § 127502 (b)(3): The setting of different targets by health care sector...shall be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs pursuant to § 127506.

Hospital Sector Options

4. Define all hospitals as a sector and adjust the sector target for select facilities.

Considerations:

- Allows the Board to consider the unique attributes of each facility and adjust cost targets of individual hospitals to account for baseline costs in comparison to other hospitals in the sector and geographic region.
- Enables the Board to strategically modify, tailor, and adapt its use of the sector target tool to promote consumer affordability.
- This approach would not limit the Board from adding additional sectors in the future (e.g., geographic).
- Enables the Board to adjust targets for all or a select portion of the hospitals in the sector annually.
- The approach for measuring and reporting hospital performance against the spending target will be different from health plans and other provider types that rely upon attributed TME growth; establishing hospitals as their own sector aligns with how they are measured differently.
- This option could be implemented to enable adjusting of sector targets as soon as performance year 2026.

Hospital Sector Options

4. Define all hospitals as a sector and adjust the sector target for select facilities.

Implementation:

- **January 2025:**

- The Office would present sector definition options to the Advisory Committee for their feedback.
- The Board would vote to define hospitals as a sector.

- **February 2025:**

- The Office would draft regulations with the approved sector definition, present to Board, and then seek OAL approval.
- The Office would make recommendation for a sector target value(s) and present to Board.

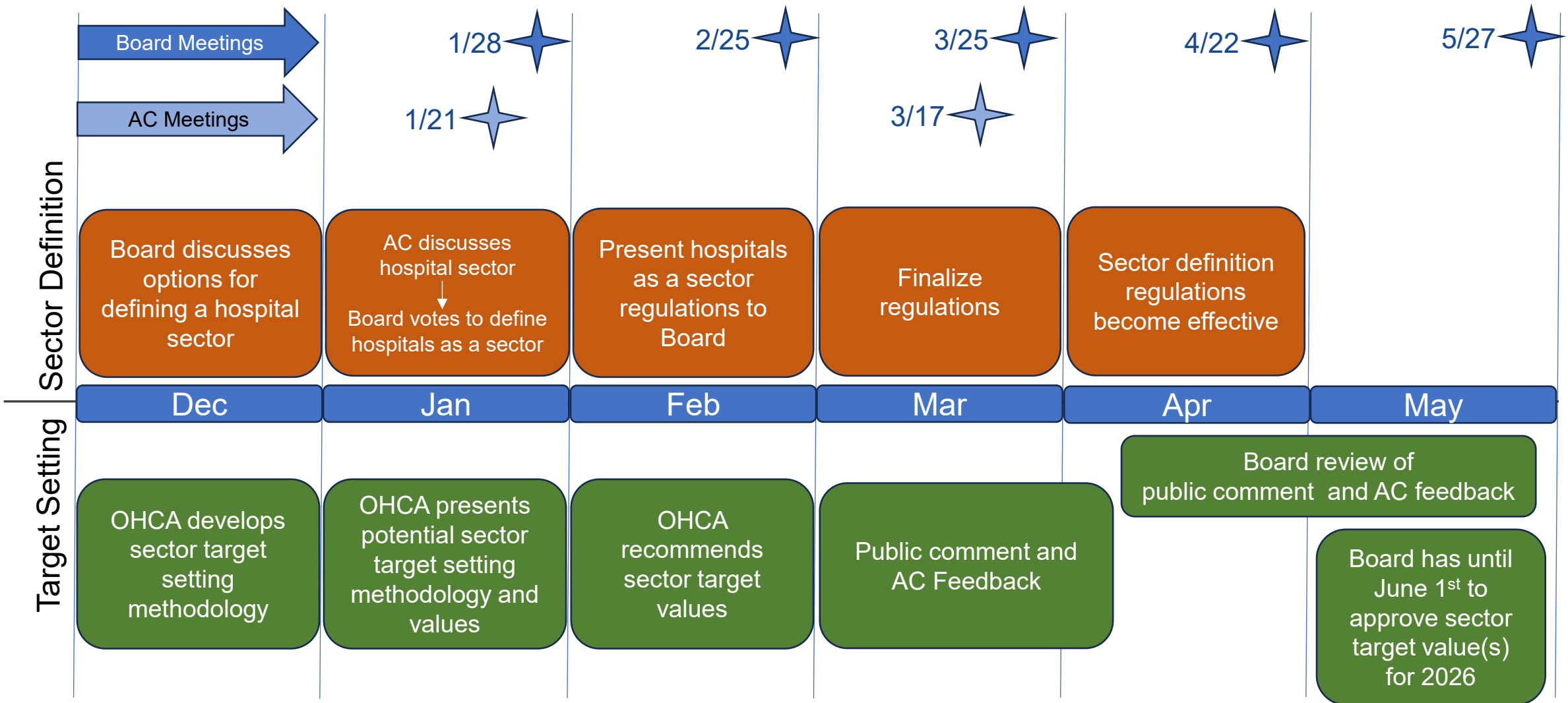
- **February to April 2025**

- The Board would discuss appropriate hospitals to adjust the sector target for and the sector target value.
- The Office would present proposed target value(s) to the Advisory Committee for their feedback.

- **April 2025 to May 2025:**

- The Board would be able to vote on sector target value and any adjustments for selected hospitals 45 days after the Office's proposed targets are discussed at the February board meeting.

Sector Target Implementation Milestones





Recommendation

If the Board intends to proceed with sector targets effective for calendar year 2026, OHCA recommends implementing Option 4.

Option 4 will provide the Board with the ability to consider the details and attributes of each hospital prior to implementing a target value that differs from the statewide spending target. This option enables the Board to respond timely to facilities with spending trends that do not advance consumer affordability.



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

Public Comment





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

General Public Comment

Written public comment can be emailed to:

ohca@hcai.ca.gov

To ensure that written public comment is included in the posted board materials, e-mail your comments at least 3 business days prior to the meeting.



**Next Board Meeting:
January 28, 2024
10:00 a.m.**

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

The logo for the Office of Health Care Affordability (OHCA) features the letters 'OHCA' in a bold, white, sans-serif font. A red curved line is positioned over the 'H', starting under the 'O' and ending under the 'A'.

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

Adjournment

The logo for the Department of Health Care Access and Information (HCAi) features the letters 'HCAi' in a bold, white, sans-serif font. A red curved line is positioned over the 'H'. Above the 'CAi' portion, there is a series of red dots of varying sizes that form an arc. Below the main text, the full name of the department is written in a smaller, white, sans-serif font.

Department of Health Care
Access and Information