HCAi Department of Health Care Access and Information
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Health Care Affordability Board
December 16, 2024
Public Comments Received After Submission Deadline

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

Date	Name	Written Comment
1/24/2025	Valley Children's Healthcare	See Attachment #1.
1/24/2025	California Hospital Association	See Attachment #2.
1/24/2025	Dignity Health	See Attachment #3.
1/24/2024	UC Health	See Attachment #4.
1/24/2024	California Association of Public Hospitals	See Attachment #5
1/26/2024	Carli Barnett	I want to extend my sincere gratitude for the Office of Health Care Affordability Board's recent visit to Monterey County, but I must also emphasize the urgent need to address the affordability crisis afflicting our community. I respectfully urge the Board to impose a 0.1% sector target for the three hospitals—Community Hospital of the Monterey Peninsula (CHOMP), Salinas Valley Health, and Natividad—without delay. The affordability crisis in Monterey County is reaching alarming levels. While I appreciate the Board's efforts to convene in our region, it is crucial to recognize that the exorbitant hospital prices here are not merely a byproduct of labor costs or payer mix, as the hospitals have suggested, but rather a direct result of severe market concentration. The presentations at the August meeting, coupled with our own claims experience, make it clear that immediate action is needed.

Date	Name	Written Comment
		I am encouraged by the Board's willingness to engage with local testimonies, reflecting the real struggles faced by residents burdened by high medical costs. However, the time for discussion is running out; we need decisive action. I strongly believe that the three Monterey County hospitals warrant a 0.1% sector target starting in 2026. I hope the additional data analysis mentioned during the meeting can be expedited to avoid further delays in addressing this pressing issue. The hospitals are clearly aware of the OHCA Board's proceedings, as evidenced by their press releases following the August hearing. While I acknowledge CHOMP's commitment to reducing costs, it is simply not enough to alleviate the financial strain on our community. We need sustained, substantive change. Shining a light on the critical need for reform in Monterey County will not only encourage the hospitals to take meaningful steps but will also provide much-needed relief to our residents who are grappling with unprecedented healthcare costs. I deeply appreciate the dedication of the OHCA Board and its staff in championing this cause. The time for action is now- let us work together to make healthcare in Monterey County affordable for all.
1/27/2025	Providence Health	See Attachment #6.
1/27/2025	El Camino Health	See Attachment #7.

Valley Children's HEALTHCARE

January 24, 2025

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

Subject: **OHCA Board Must Delay Creation of a Hospital Sector**
(Submitted via email to Megan Brubaker)

Dear Chair Johnson,

Valley Children's Healthcare is deeply concerned by the speed with which the Office of Health Care Affordability is considering defining hospital-specific sector(s) and establishing one or more sector-specific targets. Patients' access to care is at stake — it is crucial that the office's actions be based on thorough analysis of the health care spending landscape, and that hospitals clearly understand how to comply with sector-specific targets.

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

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 difficult to understand how this proposal would meet OHCA's statutory requirement to "minimize fragmentation and potential cost shifting and encourage cooperation in meeting statewide and geographic region targets."

Further, OHCA has not yet finalized its method for measuring hospital spending. OHCA has a legal prerogative to inform the creation of sector targets with historical cost data. However, the lack of a finalized methodology means the relevant historical cost data has not been reviewed and leaves hospitals in the dark as to how to comply with the target. **Establishing hospital-specific sector(s) and corresponding targets is wholly premature.**

Valley Children's is already striving to meet the existing 3.5% spending target for 2025 through a number of different measures including the following.

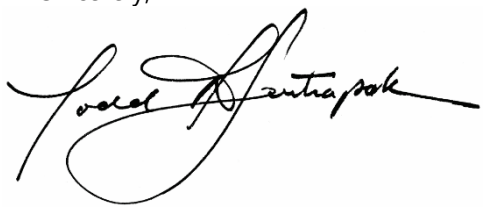
- Optimizing our staffing models and reducing turnover and vacancies to limit registry expenses and to ensure appropriate staffing for our patient volumes.
- Investing time and resources in developing tools to measure and manage productivity to meet our ever-evolving patient care needs based on fluctuations in volume and acuity.
- Participating in a Children's Hospital Association led data project through which we use peer comparative data to benchmark ourselves from a productivity standpoint.

All of these efforts are in addition to ongoing efficiency and productivity initiatives that include fully leveraging our group purchasing arrangements to manage our medication and supply inventories, regularly evaluating what services and functions we insource versus those we outsource and making the highest and best use of technology to improve efficiency for our patients, families and staff.

Lowering the spending target even further, without a clear understanding of how spending will be measured, means re-evaluating the services we provide and looking at ways to reduce current staff or hire fewer staff in the future. With much of the region that we serve categorized as Health Professional Shortage Areas by the federal government, staffing reductions necessitated by a further reduced target would only exacerbate already existing health care access challenges for children and their families.

On behalf of the children and families that we serve, Valley Children's urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets. We remain 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,



Todd A. Suntrapak,
President & Chief Executive Officer

cc: Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
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Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom

California Hospital Association

January 24, 2025

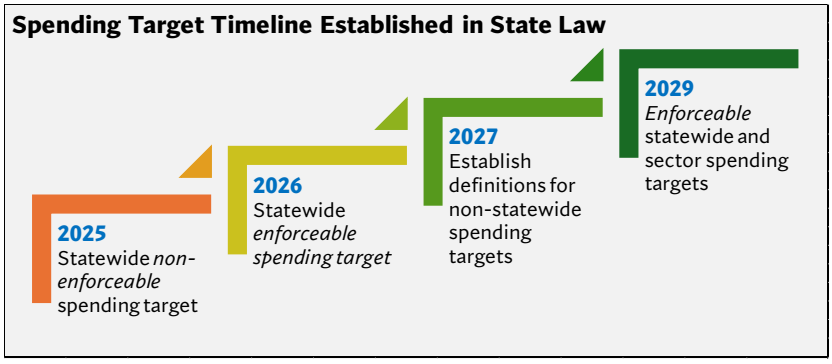
Kim Johnson
Chair, Health Care Affordability Board
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments for the January 2025 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

Hospitals Oppose OHCA's Rash Approach to Establishing a Hospital Sector Three Years Ahead of Schedule

At its January board meeting, OHCA appears poised to take the first official step toward the adoption of one or more hospital sector targets. Coming several years before the timeline laid out in law, this accelerated push toward implementation of sector targets contravenes clear statutory intent that OHCA and its regulated health care entities work collaboratively and learn together. As laid out in state law, focus should first be on striving to meet the state's ambitious statewide spending target, and only subsequently should OHCA move onto sectors. Equally problematic, OHCA's rush to develop sector-specific targets is occurring without the due diligence necessary to enact a sector target in a fair and data-informed manner. Accordingly, the California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, opposes the adoption of a hospital sector at this time.

State Law Intentionally Laid Out a Roadmap for Sector Target Implementation. The figure at left displays OHCA's key deadlines for implementing its spending targets under state law. While state law does provide some flexibility, the intent is clear: OHCA and its regulated entities should gain experience first under an unenforceable spending target in 2025, move to an enforceable target in 2026, take time to carefully define sector targets in 2027, and only then — with significant cushion for further thoughtful analysis — set sector targets in 2029. The current push toward sector targets is occurring not only three years ahead of schedule, but also over a period condensed from years into mere months.



OHCA Plans to Adopt Sector Targets Before Achieving Basic Milestones and Prerequisites. The potential adoption of a hospital sector definition comes just weeks into implementation of the first statewide non-enforceable spending target — and before key milestones have been met:

- **OHCA has yet to analyze or report a single year of total health care expenditure data.** OHCA's first report on statewide health care spending is due June 1, 2025, the same deadline to adopt changes to the statewide target for 2026 (this would include sector-specific targets for 2026 should OHCA choose to adopt them ahead of its statutory deadline). However, the process for adopting a sector target requires antecedent steps that would take the entirety of the next four months to complete. As such, should OHCA adopt a sector target for 2026 at any meeting prior to June, it would have to forego grounding its decisions in the comprehensive spending data the agency is tasked with collecting, analyzing, and reporting on.
- **OHCA has yet to compare segments of the health care industry on standard financial measures.** A sound process for establishing data-driven sectors and corresponding targets would include collecting and comparing comparable data across different segments of the health care industry, then making data-informed decisions. OHCA is doing the opposite. Without having looked at such data, OHCA appears poised to make initial decisions on sectors based on which segment of the health care industry happens to have historical data available. As a result, OHCA is disregarding the fact that health plans earned 40% more total net income than hospitals in 2023; that (large group) premiums for two of the largest plans (Blue Shield of California and Anthem Blue Cross) went up by 8% and 15%, respectively this year; and that branded drug prices are projected to increase by 7% in 2025. Instead, OHCA is targeting a field facing stagnant revenues, explosive cost growth, and unsustainable recent financial performance that already is resulting in pullbacks of investment, service line reductions, and full closures.
- **OHCA has yet to fairly and comprehensively evaluate the drivers of health care spending.** A prudent approach to slowing the growth of health care spending — mindful of the serious potential for unintended and tragic consequences, including patients' inability to access lifesaving care — would first carefully study the drivers of health care spending, judiciously aim to distinguish between good spending and bad, and move to address high-cost, low-value care with reasonable precision. OHCA has barely begun this task and risks pursuing cuts in spending that are incompatible with providing the level and quality of care that Californians deserve.
- **OHCA has yet to determine how hospital spending will be measured.** OHCA has yet to make final decisions on how hospital spending will be measured. In fact, its intent is to adopt a temporary methodology for one or more years, then significantly change its approach as new data become available. Accordingly, it does not have an established methodology for measuring historical spending trends, identifying higher-cost hospitals, or informing regulated entities on how their spending will prospectively be measured against their spending target. This work should be completed before adopting a sector definition or target, so that the adopted sector target is credible, and hospitals are able to properly plan for compliance.
- **OHCA has yet to assess performance against, and the reasonableness of, the statewide spending target.** The timeline on Page 1 clearly demonstrates the intent in state law to gain experience under a statewide target before moving onto sector targets. By disregarding the statutory timeline, OHCA is foregoing the opportunity to assess whether the statewide spending target is working, whether it is reasonable and unattainable, if it is driving improvements in affordability without sacrificing quality and equity, and how different segments of the health care industry are performing relative to the target.

OHCA's Approach to Sector Definitions Ignores State Law. Existing law requires that sectors be developed *"in a manner that minimizes fragmentation and potential cost shifting and that encourages*

cooperation in meeting statewide and geographic region targets." No work has been done to ensure that OHCA's potential approach fulfills this requirement of state law. For example, the planned approach is likely to simply shift costs from hospitals to other providers and payers, creating earnings windfalls for health insurance companies and others even while Californians continue to struggle to pay their premiums and other costs of care.

Premature Adoption of Sector Targets Strains OHCA's Credibility and Impartiality. Adopting a hospital sector now would prejudicially target a set of providers for which data happens to be available. Not only is such an approach arbitrary, it also further debilitates a class of providers that is struggling to financially recover from the aftereffects of the worst pandemic in a century, that faces tens of billions in new costs annually from unfunded state mandates, and that is working to keep pace with increasing patient needs. In the face of every challenge, hospitals make sure their doors are open 24/7 to care for California's sickest and most vulnerable patients, including those without the ability to pay. In sum, imposing sector targets prematurely threatens successful implementation of OHCA's core functions and undermines both trust in the process and collaboration toward a shared vision of improved health care affordability for all Californians.

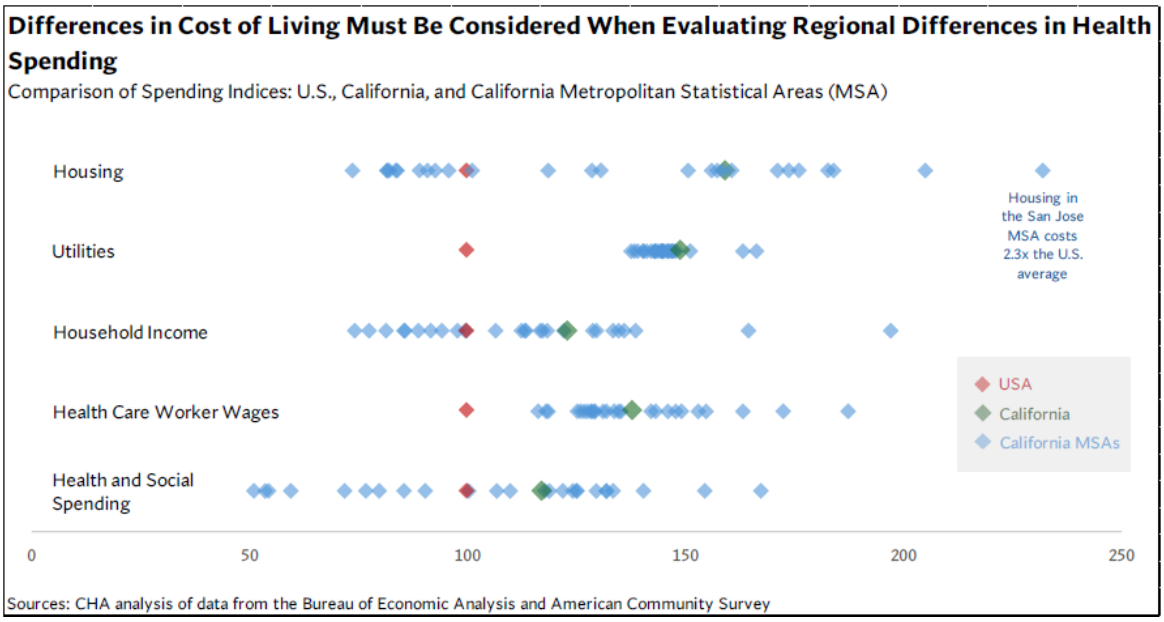
OHCA's Effort to Identify "High-Cost" Hospitals Shows How Much More Work Is Needed

At the Dec. 18 OHCA board meeting, OHCA staff presented a data analysis intended to identify high-cost hospitals throughout the state, with the purpose of potentially differentiating the spending target that applies to these high-cost hospitals. At the end of the review, both OHCA staff and board members remarked on the lack of clear and consistent patterns in the data. As the following analysis shows, we agree with that assessment. It shows just how much more work is needed to develop a defensible and rational methodology for identifying high-cost hospitals. Otherwise, OHCA risks setting different sector spending targets for different health care entities arbitrarily, creating unacceptable results that treat similarly situated hospitals differently and differently situated hospitals similarly.

Each Measure for Identifying High-Cost Hospitals Has Strengths — and Serious Weaknesses. Hospital finance is complex. As a result, no single financial measure cleanly separates high-cost hospitals from others without the need for significant contextualization. OHCA staff recognized this, putting forward multiple measures of hospital performance for consideration as options for identifying high-cost hospitals. Below are important tradeoffs to consider for each of these measures:

- **(Net patient) inpatient revenue per case mix-adjusted discharge.** This measure identifies which hospitals earn the most revenue per discharged patient, adjusted for the expected resource-intensity of their stay. A key advantage is that it considers all the major sources of direct patient revenue, regardless of whether it comes from a commercial insurer or public payer. Therefore, it accounts for the ubiquitous cross subsidization that results from some payers paying more than cost, and others paying far less. Unfortunately, it fails to control for differences in underlying operational costs between different hospitals, such as for those located in areas with higher costs of living, like the Bay Area. (The figure on the next page shows the extraordinary differences in cost of living between different regions of California.) Ultimately, using this measure to identify high-cost hospitals would punish hospitals for factors beyond their control and render them incapable of sustaining services in high-cost regions. Additionally, hospital decisions around contracting with on-call physicians — in large part driven by varying restrictions in state law — bias this measure (and others) against certain hospitals. Hospitals that employ physicians report not only facility fees in their revenues, but professional fees as well; hospitals that do not employ physicians do not report professional fee revenues. This makes the former appear higher cost

than the latter solely due to their physician employment decisions afforded by different treatment in state law.



- **Growth in inpatient Revenue per case mix-adjusted discharge.** This measure identifies which hospitals had the highest growth in their revenue over a five-year period. A key advantage is that this measure most closely corresponds to OHCA's spending target(s), which apply to entities' spending growth rather than spending levels. However, whether high growth is potentially problematic is highly dependent on its starting point. A hospital charging disproportionately low rates and experiencing a negative operating margin may need to increase its revenues faster than other hospitals simply to survive. Targeting such a hospital with an inequitably lower spending target could leave it incapable of negotiating sustainable rates with payers and only increase its chances of closing or reducing services.
- **Operating margins.** This measure shows the extent to which a hospital's underlying operational revenues are keeping up with its expenses, rendering it a sustainable organization. High margins could reveal an opportunity for lower future revenue growth without as much risk of reductions in access or quality. However, using this measure to set stricter spending targets could simply penalize more efficient hospitals. Additionally, the measure is biased against hospitals that disproportionately cross-subsidize non-hospital services with expenditures that fall outside of the requirements of hospitals' financial reports, such as those that financially support their affiliated medical groups. Finally, the accounting practices of hospital systems make this a suboptimal measure for all but independent hospitals. For example, within systems, operating expenses (part of the calculation to determine operating margins) can vary depending on how a system apportions shared expenses to individual hospitals under its umbrella.
- **3rd party-to-Medicare cost ratio.** This measure aims to compare cost coverage between hospitals' commercial and Medicare payers. A higher ratio means commercial payers cover hospital's costs to a greater degree. There are distinct advantages of this approach, namely that it accounts for some of the differences in operational costs between hospitals, such as those located in high-cost regions and those that provide medical education. Nevertheless, it has major shortcomings, most notably by assuming the reasonableness of Medicare payment policies. Recent research casts doubt on the validity of this assumption, revealing that underpayment in

Medicare fee for service (FFS) is much greater for California hospitals located in high-cost regions.[1] According to the referenced 2023 study, a California hospital with a Medicare area wage index of 1.2 can expect to lose 25 cents on every dollar of care it provides to a Medicare FFS patient. However, a hospital with an area wage index of 1.8 can expect to lose around 60 cents for each dollar of care. (Medicare measures regional differences in hospital costs using the area wage index.) As the figure above demonstrates, this deficiency in Medicare payment policy inevitably makes a hospital that is disproportionately undercompensated by Medicare appear significantly higher cost under the 3rd party-to-Medicare cost ratio measure than another hospital, even if the two have equal operating margins. Accordingly, using this ratio to identify high-cost hospitals for spending target purposes would punish hospitals simply for having poor Medicare reimbursement and additional factors beyond their control. Ultimately, it would make operating in California's high cost-of-living regions only more challenging.

3rd Party-to-Medicare Cost Ratio Punishes Hospitals Whose Medicare Reimbursement Is Relatively Poor

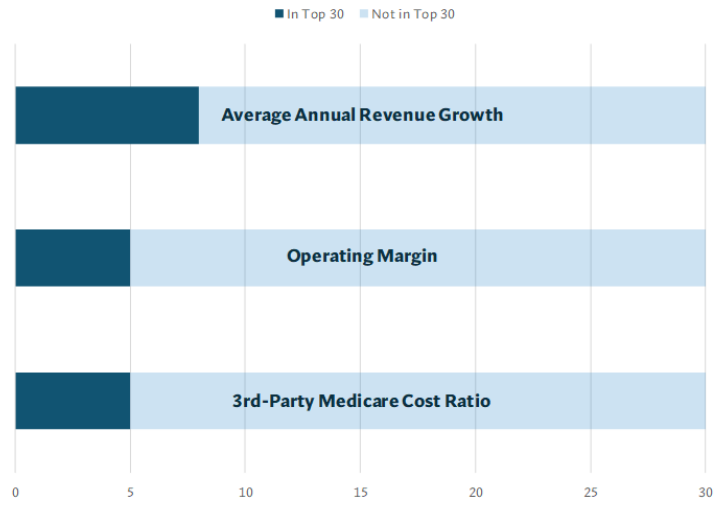
	Hospital in Low-Cost Region			Hospital in High-Cost Region		
	Revenue	Cost	Profit/Loss	Revenue	Cost	Profit/Loss
Medi-Cal	$5,000	$6,000	-$1,000	$5,000	$6,000	-$1,000
Medicare	$5,000	$6,667	-$1,667	$5,000	$12,500	-$7,500
3rd Party	$10,000	$5,000	$5,000	$25,244	$12,622	$12,622
Totals	*$20,000*	*$17,667*	*$2,333*	*$35,244*	*$31,122*	*$4,122*
Operating Margin		**12%**			**12%**	
3rd-Party-to-Medicare Cost Ratio		**267%**			**500%**	

Note: Examples reflect hypothetical hospitals with equal operating margins and equal reimbursement-to cost ratios for 3rd-party and Medi-Cal payers. The only material difference is the shortfall in Medicare reimbursement relative to cost, with the hospital in a low-cost region facing a 25% Medicare shortfall and the hospital in the high-cost region facing 60% Medicare shortfall (consistent with the estimates in the referenced research).

Measures Do Not Agree on Which Hospitals Are High Cost. In addition to each measure having idiosyncratic shortcomings, OHCA's attempt to identify high-cost hospitals using four distinct measures yielded wildly inconsistent results, failing to provide a data-informed answer on which hospitals to potentially target with a lower spending target. The following figure summarizes this striking lack of agreement between the measures, revealing that a hospital in the top 30 in terms of revenue per discharge (including OHCA's suggested exclusions) is highly unlikely to fall in the top 30 on any of the other measure. In fact, the inconsistency in hospitals' performance on these measures is so great that among the hospitals in the top 30 of revenue per discharge, roughly half experienced negative average operating margins during the full five-year period analyzed by OHCA. Thus, using this or a similar measure to identify which hospitals to apply a lower sector spending target to risks seriously undermining these hospitals' financial viability. The figure on the next

Measures for Identifying High-Cost Hospitals Disagree Far More Often Than Not

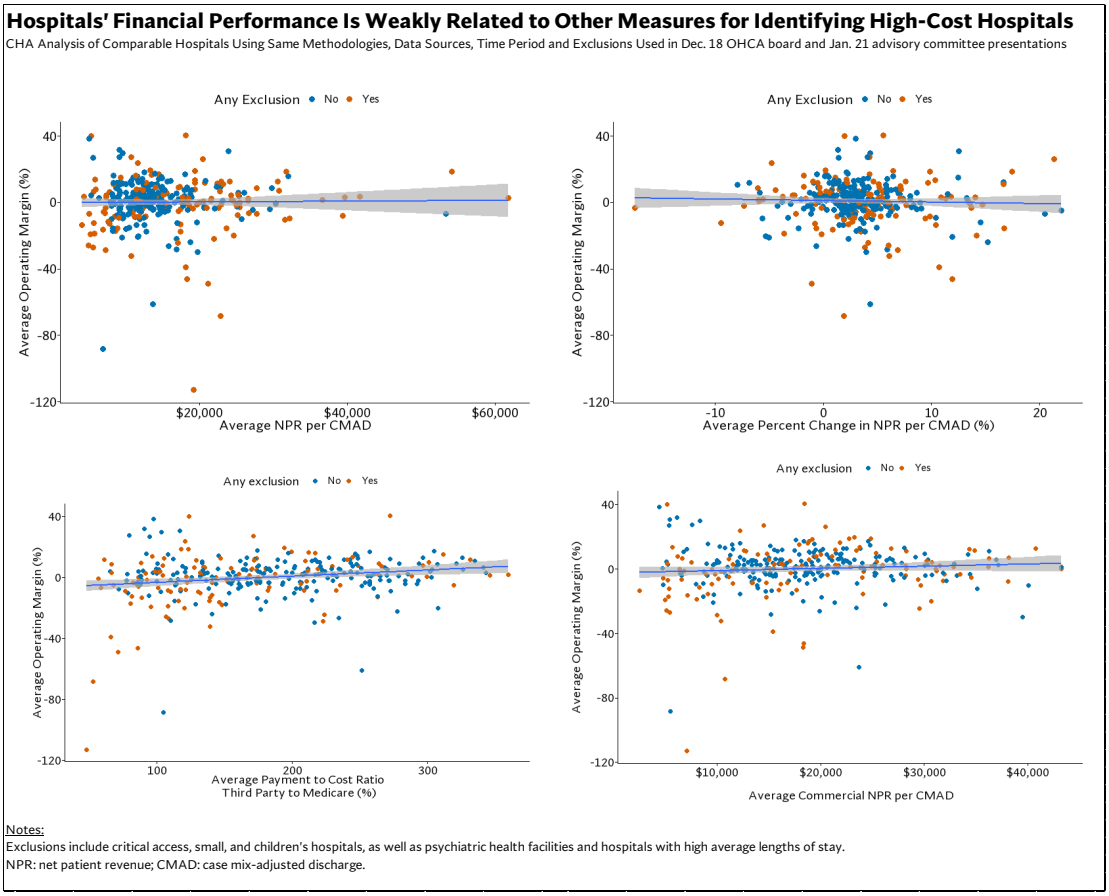
Count of Hospitals That Appear in Top 30 by Measure by Comparison to Hospitals in Top 30 in Inpatient Revenue Per Case-Mix-Adjusted Discharge



Source: Data are from OHCA's Data Review of California Hospitals from the Dec. 16, 2024 Health Care Affordability Board Meeting, specifically slides 56-57 that compare hospitals with OHCA's suggested exclusions.

[1] 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.

page shows the weak relationships between operating margin and the other financial measures reviewed by OHCA's board and advisory committee for all comparable hospitals (not simply the top 30 hospitals), while the appendix shows the remaining relationships among the measures for all comparable hospitals.



Exclusions Require a Sound Rationale. At the Dec. 18 board meeting, OHCA presented a number of hospital characteristics and suggested excluding hospitals with a subset of these characteristics from its list(s) of high-cost hospitals. The table on the next page compares the set of hospital characteristics reviewed by OHCA, those suggested to qualify hospitals for exclusion, and a wider set of additional relevant hospital characteristics that were not considered. While exclusions based on hospital characteristics may be warranted, OHCA has not provided a compelling rationale for why its chosen set of exclusions is reasonable and better than a wide variety of alternatives. Below are just several of the thorny issues that must be addressed prior to establishing a list of characteristics that exclude certain hospitals from negative adjustments to their spending targets.

Numeric Cutoffs Could Result in Similar Hospitals Facing Radically Differently Sector Targets. OHCA has suggested excluding small hospitals with fewer than 100 beds and hospitals with average lengths of stay longer than 20 days from its list of high-cost hospitals. Why these specific thresholds were chosen is unclear — and both could result in similarly situated hospitals above and below the thresholds receiving radically different sector targets. Take, for example, hospitals with average lengths of stay just above and below the 20-day threshold. The former, which would qualify for exclusion, had average operating margins of negative 2.2% between 2018 and 2022; nonqualifying hospitals had average operating margins of negative 2.4%.

Categorical Attributes Mask Underlying Variation in Service Delivery, Leading to Potentially Unjustified Differences in Treatment from OHCA. Patterns of hospital service delivery are incredibly diverse. Psychiatric hospitals do not exclusively provide psychiatric inpatient care. Children's hospitals are not the only ones to provide specialized children's services. Academic medical centers are a minority of teaching hospitals. Public hospitals are not the only disproportionate share Medi-Cal providers. Moreover, licensing decisions by hospitals complicate what attributes, revenues, and costs get applied to a single "hospital" or spread out among multiple hospitals in their financial filings. Nevertheless, the categories used by OHCA aim to strictly delimit hospitals across categorical distinctions that do not truly or fully exist, such as when distinguishing between psychiatric hospitals and general acute hospitals that provide significant psychiatric care. To this end, OHCA must take care not to adopt rules based on false distinctions that do not appropriately capture differences in care delivery.

Unclear How OHCA Chose Which Characteristics Qualify Hospitals for Exclusion from its List of High-Cost Hospitals

Hospital Types	Identified	Excluded
Cancer treatment centers		
Children's	Yes	Yes
Critical access	Yes	Yes
Designated public	Yes	
District and municipal		
Disproportionate share		
Free	Yes	Yes
Fully integrated delivery system	Yes	Yes
Independent		
Investor-owned		
Long-term stay facilities	Yes	Yes
Maternity care		
Not-for-profit		
Psychiatric health facilities	Yes	Yes
Psychiatric	Yes	
Quaternary care		
Rehabilitation		
Research		
Rural		
Small facilities	Yes	Yes
Specialty	Yes	
State	Yes	Yes
Teaching	Yes	
Trauma centers		

Comparison of various hospital characteristics, those identified by OHCA in its Dec. 18 board presentation, and those suggested to exclude hospitals from being a high-cost hospital

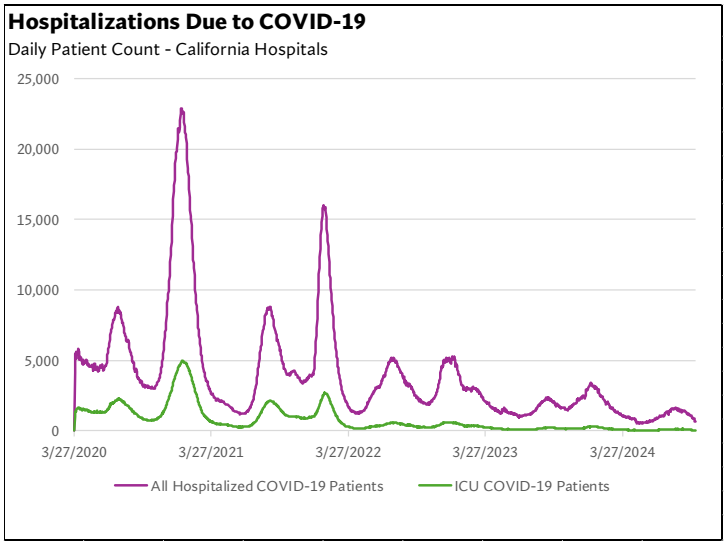
Rural Hospitals Should Be Considered for Exclusion, in Addition to Critical Access Hospitals. Critical access hospitals represent a subset of rural hospitals with a special designation and reimbursement methodology from Medicare. OHCA has recommended excluding critical access hospitals from its list of high-cost hospitals. While protecting the state's 38 critical access hospitals is absolutely essential, rural hospitals are generally highly vulnerable to closures and service line reductions. OHCA should provide a clear rationale for why the broader set of rural hospitals are not recommended for exclusion.

Isolating High-Cost Hospitals Exceeding an Arbitrary Cutoff Would Subject Similarly Performing Hospitals to Potentially Hugely Different Spending Targets. OHCA's Dec. 18 slides used top-30 cutoffs on four financial measures to isolate high-cost hospitals. This binary approach above and below the top 30 risks treating nearly identically situated hospitals differently. As the table below shows, this could result in a hospital with inpatient revenue per (case mix-adjusted)

Hospitals Right Above and Below An Arbitrary Top-30 Cutoff Could Be Treated Very Differently

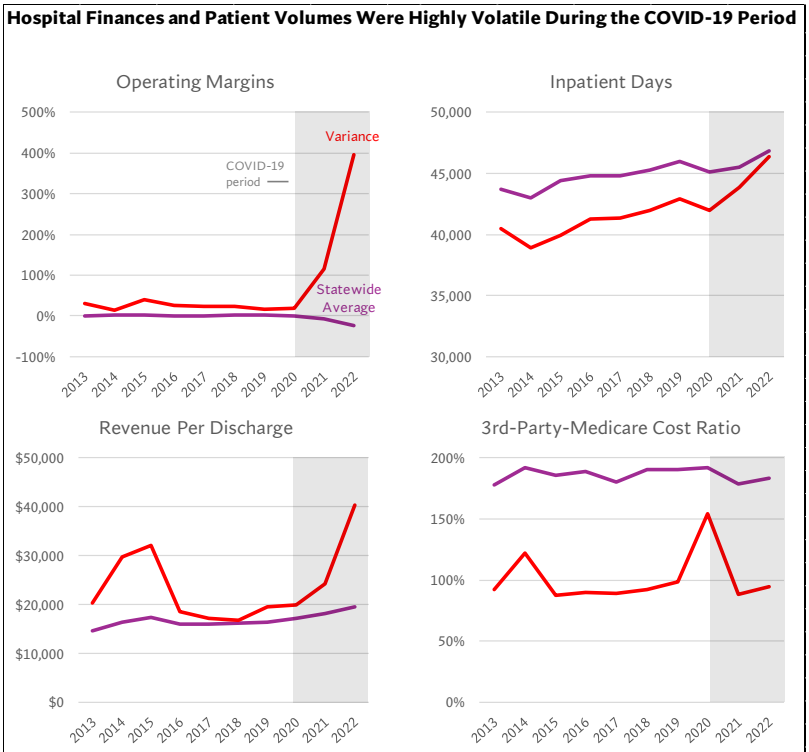
	30th-Ranked Hospital	31st-Ranked Hospital	Percent Difference
Net Patient Revenue Per Discharge	$26,580	$26,570	0.04%
Average Annual Growth	11.9%	11.8%	0.1%
Operating Margin	15.1%	15.0%	0.1%
3rd Party-to-Medicare Cost Ratio	299.5%	296.5%	3%

Source: CHA's analysis of hospital financial data for the years 2018-2022. Percent differences for the latter three variables are shown as percentage point differences since they are comparing percent-based measures.



discharges that is 0.04% higher than their next closest peer being subject to a radically different spending target. Moreover, identifying that hospital as having 0.04% higher revenue per discharge would depend heavily on measurement decisions and realities, such as the most recent year in which data are available and how many years are aggregated together to smooth the variation, rather than fundamental differences between the hospitals above and below the cutoff.

Including the COVID-19 Pandemic Years in Data for Identifying High-Cost Hospitals Introduces Serious Distortions. Between 2020 and 2022, the world experienced the worst pandemic in a century. California's hospitals stepped up, weathered unprecedented patient volume and workforce stability and safety challenges, and ultimately saved thousands of lives. The figure above shows the data on COVID-19 hospitalizations. At its two highest daily peaks in 2021 and 2022, nearly 23,000 and over 16,000 COVID-19 patients, respectively, were being treated in California's hospitals, reflecting at its worst roughly 60% of the daily census for statewide general acute beds. While routine services were canceled, sicker patients needing longer stays and more complex care overwhelmed hospitals' already stretched workforces. Costs went up enormously, while reimbursements became increasingly volatile and stagnant. Ultimately, as the figure to the right shows, these were anything but typical years for hospital operations and their finances. And yet, OHCA is seeking to potentially make sector target decisions based on these three highly irregular COVID-19 years. This would ultimately bias their measures and punish hospitals for factors far beyond their control.



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.

Conclusion

Adopting one or more sector targets now, long before its statutory deadlines and before OHCA has performed its basic due diligence, would be wholly premature. It demonstrates partiality versus one segment of the health care field — the only segment OHCA has investigated in any depth. It comes at a time when Californians need more and better health care — investments in behavioral health, more access to primary care services, and a greater emphasis on equitable outcomes — and as hospitals

struggle just to stay afloat. Imminent federal attempts to defund California's already fragile health care delivery system could turn an already challenging situation into catastrophe for hospitals, their workers, and their patients. CHA opposes the creation of a hospital sector at this time.

Sincerely,

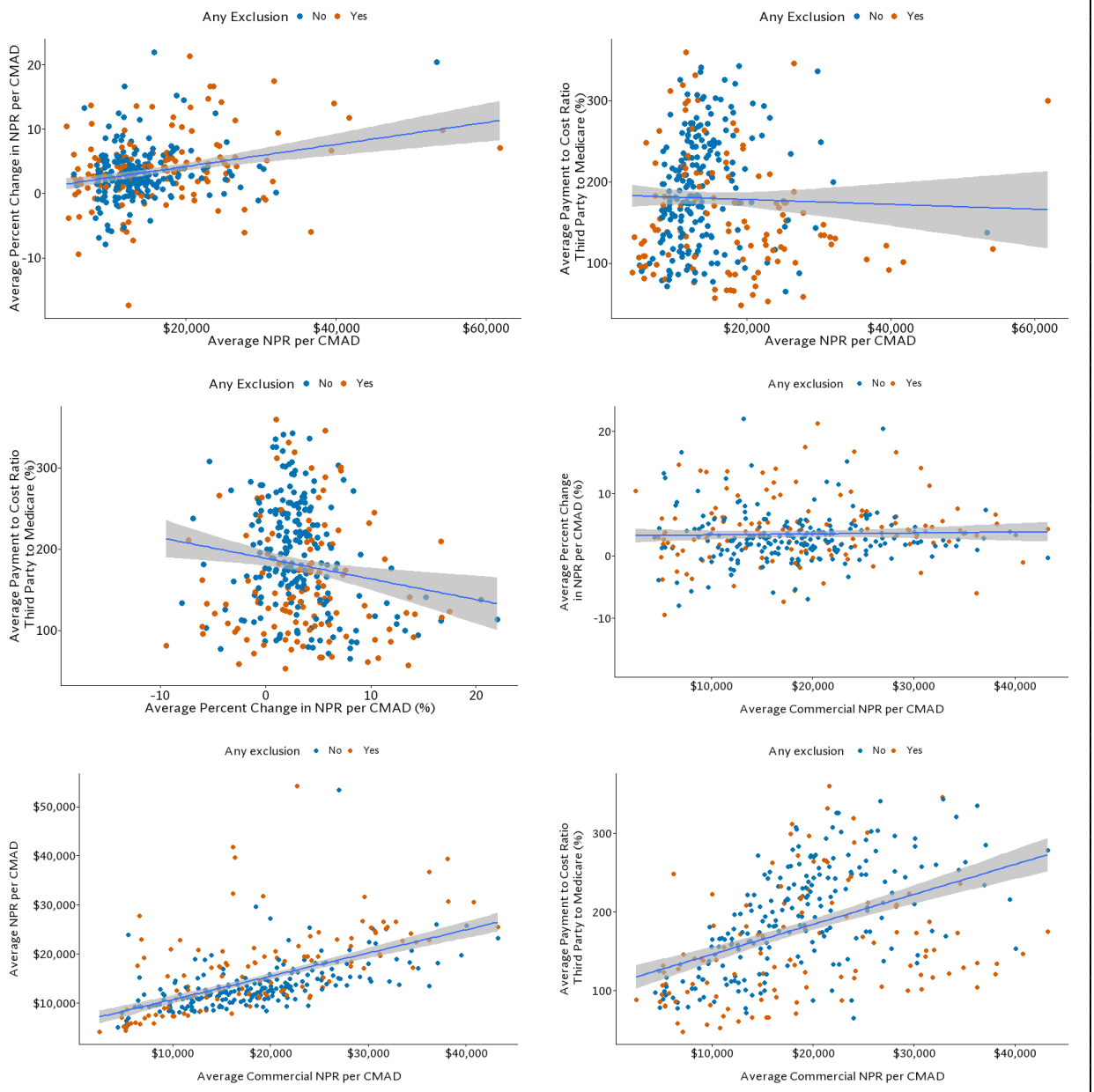
Ben Johnson
Group Vice President, Financial Policy

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

Appendix Figure

Data Analysis Reveals Weak, Inconsistent, and Counterintuitive Relationships Among Measures Used by OHCA to Identify High-Cost Hospitals

CHA Analysis of Comparable Hospitals Using Same Methodologies, Data Sources, Time Period and Exclusions Used in OHCA's Dec. 18 board and Jan. 21 advisory committee presentations



Notes:

Exclusions include critical access, small, and children's hospitals, as well as psychiatric health facilities and hospitals with high average lengths of stay.

NPR: net patient revenue; CMAD: case mix-adjusted discharge.

January 24, 2025

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

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(Submitted via email to Megan Brubaker)

Dear Chair Johnson,

Dignity Health, and our 29 hospitals statewide, are deeply concerned by the speed with which the Office of Health Care Affordability is considering defining hospital-specific sector(s) and establishing one or more sector-specific targets. Patients' access to care is at stake — it is crucial that the office's actions be based on thorough analysis of the health care spending landscape, and that hospitals clearly understand how to comply with sector-specific targets.

Dignity Health is the largest provider of Medi-Cal services in California, making up a significant portion of the state's safety net. Three fourths of all patients that come to Dignity have either Medi-Cal or Medicare. Unfortunately, Government reimbursement has not not kept pace with the rising costs of labor, supplies and drugs, and general inflation leading to a loss of over $245 million last fiscal year for Dignity.

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

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 difficult to understand how this proposal would meet OHCA's statutory requirement to "minimize fragmentation and potential cost shifting and encourage cooperation in meeting statewide and geographic region targets."

Analysis of areas like high cost of pharmacy and drugs, keeping up with inflation, and government mandated spending at the state and federal level are needed to ensure realistic targets can be achieved within our sector. The lack of any consideration for the impact of high-cost drugs is a material oversight in the methodology, particularly as sectors like gene therapy continue to mature and produce ever increasingly expensive and costly drugs.

for the next six complete further seismic improvements to our buildings by 2030.

Attachment #4

UNIVERSITY OF CALIFORNIA HEALTH

University of California Health
1111 Franklin Street
Oakland, CA 94607

universityofcalifornia.health

ACADEMIC HEALTH CENTERS
UC Davis Health
UC Riverside Health
UC San Diego Health
UCI Health
UCLA Health
UCSF Health

HEALTH PROFESSIONAL SCHOOLS
Schools of Dentistry
Schools of Medicine
Schools of Nursing
School of Optometry
Schools of Pharmacy
Schools of Public Health
School of Veterinary Medicine

INSTITUTES
Global Health Institute

January 24, 2025

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

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

Subject: Concerns with Hospital Sector Target Development & Request to Delay the Creation of Hospital-Specific Sector Target(s)

Dear Secretary Johnson,

On behalf of University of California Health (UCH), I am writing to request the Health Care Affordability Board to delay adoption of hospital-specific sector target(s) to provide additional time for the Board, the Office of Health Care Affordability (OHCA), and stakeholders to consider the complexity of health care financing and historical cost data to inform the targets as well as minimize impact to access, quality, equity, and workforce stability.

University of California (UC) Health and its six academic health centers and 21 health professional schools are part of California's public health care system that form the core of the state's health care safety net. UC Health's mission is to improve the health and well-being of all people living in California now and in the future by educating and training the inclusive workforce of tomorrow; delivering exceptional and equitable care; and discovering life-changing treatments and cures.

UC's academic health centers are also "designated public hospitals" for purposes of the Medi-Cal program and support the state's investment in innovative Medi-Cal quality, payment and service delivery reforms by funding the non-federal share that is necessary to match federal financial participation to cover and pay for these programs.

Delay Adoption of Hospital Sector Target(s)

UC Health echoes the concerns raised by the California Association of Public Hospitals and Health Systems (CAPH) and the California Hospital Association (CHA). We urge the board to not establish a hospital-specific sector(s) and corresponding targets until the following issues are addressed:

- ***Evaluate performance against the 2025 statewide target first:*** All hospitals are subject to the statewide health care spending growth target adopted by the board less than a year ago in April 2024. The Board thoughtfully chose to phase-in the 3% growth target over a five-year period to provide OHCA and health care entities a glide path to meeting the statewide target. Furthermore, OHCA's governing statute, the California Health Care Quality and Affordability Act, outlines a framework that provides OHCA and health care entities with an opportunity to evaluate performance before making the target enforceable by making 2025 a measurement year and 2026 the first enforceable year. The Board should allow for time for evaluation of health care entities' performance against the target, the development of enforcement policies, and opportunities to work through data collection and reporting processes prior to defining health care sectors and setting sector-specific targets.

- ***Additional work needed on hospital spending measurement and enforcement:*** The methodology for hospital spending measurement and guidance on the enforcement of targets is still in development, leaving hospitals without critical information about how their spending will be measured and how targets will be enforced. Furthermore, the hospital spending measurement workgroup has uncovered many nuances with data sources and measurement approaches along with challenges with how public health care systems' data is reported and captured in the spending performance analysis. These issues have not yet been fully addressed and need additional thoughtful consideration before hospital spending target(s) are adopted.

For these reasons, UC Health urges the Board to not establish a hospital sector or set a hospital-specific target(s) at this time to provide time. The statute permits the Board to establish sector targets on or before October 2027, which allows time to evaluate performance against the 2025 statewide target and complete the necessary work to measure hospital spending and define enforcement criteria.

Concerns with High-Cost Hospital Metrics and Data

We have significant concerns with the metrics recently presented by OHCA staff to inform discussions on how to define a high-cost hospital. We request consideration of the following issues when crafting metrics or exclusions to identify high-cost hospitals:

- **Medi-Cal self-financed payments:** UC is the second largest provider of Medi-Cal inpatient services and as a public entity, most of UC's Medi-Cal revenues are reimbursed through self-financed payments. These complex financing mechanisms impact UC's reporting, performance, and revenues. Furthermore, there is considerable variance in the timing and reporting of Medi-Cal supplemental payments because of federal reporting requirements and when payments are paid and reflected in revenues. Any metric used to identify high-cost hospitals must account for this financing structure, which is unique to UC and other public health systems.
- **Adjustments for high-cost tertiary and quaternary care and innovative therapies:** UC academic health centers provide an outsized amount of high-cost tertiary and quaternary care services for the most complex and high-risk patients. This includes trauma and burn care, organ transplants, and care for conditions such as cancer, sickle cell disease, and hemophilia. UC patients have a longer length of stay than patients in community hospitals. Case-mix adjustments need to account for these high-cost services and longer lengths of stay and outlier stays.

Evaluation of hospital costs must be balanced with the costs associated with innovation and medical advancements that treat and cure disease. UC Health researchers are running more than 4,600 clinical trials investigating treatments for more than 2,400 conditions, elevating care for current and future patients. The availability of new, innovative therapies that save lives can be high-cost and are often only available at a selected number of hospitals in the state and nation. Examples of high-cost, lifesaving, and innovative therapies available at UC Health include CAR-T therapies for the treatment of blood cancers, Zolgensma for infants with spinal muscular atrophy, and Zynteglo for cure of sickle cell anemia. The availability of high-cost, innovative therapies must be accounted for in metrics for hospital costs.

- **Adjustments for children's services:** UC's academic health centers operate four children's hospitals that serve the most critically ill children, three of which are embedded in a hospital. OHCA staff has suggested that freestanding children's hospitals should be excluded from a high-cost hospital sector target because the MS-DRG does not accurately adjust for children's services. UC requests that similar consideration be provided to our hospitals that have children's hospitals embedded within a hospital.
- **Training California's health care workforce:** As California's public academic health system, UC Health plays a critical role in educating the state's future health care workforce and promoting OHCA's goal of maintaining workforce stability. We train many of the state's future doctors, nurses, and other health professionals across our 21 health professional schools, enrolling approximately 16,000 health sciences students, trainees, and residents. More than 70 percent of our students build their careers in California after graduating from our health professional schools. UC Health provides approximately $1 billion in direct annual support to the UC Schools of Medicine. This is an expense that most other health care providers do not incur but should be considered in evaluating provider costs and affordability.

- **Investments to expand capacity and meet California's health care needs:** UC Health continues to make tremendous investments to meet the state's health care needs. All of UC Health's hospitals are operating at or above their maximum capacity and we are unfortunately unable to accommodate thousands of transfer requests each year because of space and staffing limitations. Like many other hospitals, we continue to face challenges with discharging patients to post-acute care settings.

  UC Health is making significant investments to increase our capacity throughout the state by increasing the number of beds through construction and acquisition and partnering with other providers to make UC care available at community hospitals and clinics. Furthermore, UC Health is expanding capacity and services for vulnerable communities as many other hospitals and health systems cut critical services or exit the market. Our academic health centers have acquired hospitals from for-profit systems that have chosen to exit certain markets and from non-profit systems that are not able to sustain services. We are proud to keep these hospitals open, convert them to public ownership, save thousands of jobs, and preserve and expand access for communities that rely on these facilities. Enforcement of the statewide spending target, and any hospital sector-specific target must allow UC Health to cover construction costs and debt service associated with expanding its capacity.

We appreciate the Board's consideration of UC Health's unique role as the state's public academic health system and our tripartite mission of teaching, research and public service to the people of California. UC Health respectfully requests the Board defer action on defining and setting a hospital sector target to provide more time to consider and resolve the myriad issues raised in this comment letter. We need clarity on these issues for both the statewide target as well as any hospital sector targets that may be created. We look forward to continuing our work together to address health care spending growth and our shared commitment to accessible, affordable, equitable, high-quality, and universal care for every California resident.

Sincerely,

Tam M. Ma
Associate Vice President
Health Policy and Regulatory Affairs

cc: Members of the Health Care Affordability Board:
Dr. David M. Carlisle
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Dr. Donald B. Moulds
Dr. Richard Pan
Elizabeth Landsberg, Director, 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

CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

January 24, 2025

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

Subject: Concerns with Hospital Sector Target Development & Request to Delay the Creation of Hospital-Specific Sector Target(s)

Dear Chair Johnson,

On behalf of the members of the California Association of Public Hospitals and Health Systems (CAPH) and the millions of patients they serve, **I am writing to express concerns on the pace of the development of the hospital-specific sector target(s) and to urge a delay of the adoption of these.**

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

As safety net providers, PHS appreciate that health care costs can be a major barrier for patients in accessing needed services and what the burden of medical financial hardship can mean for individuals and their families. These systems have played a longstanding role in serving our state's low-income and uninsured populations and have supported and helped to implement numerous statewide efforts to expand and strengthen coverage, especially in Medi-Cal, which does not impose costs on patients. For those who do face affordability challenges, PHS offer a number of financial support programs to offer services for free or at a reduced cost.

Adoption of Hospital Sector Target(s) Should Be Delayed

While we understand and share the goals that the Health Care Affordability Board and Office of Health Care Affordability (OHCA) are working to advance, we have significant concerns with the speed at which the hospital-specific sector target(s) are being developed. This expedited pace is resulting in the glossing over or even dismissal of critically important context as part of the discussion and the development and advancement of problematic and inaccurate data. We are deeply concerned that the ultimate consequence will be adverse impacts to safety net health care systems and our patients. For PHS specifically, the complexity of our financing and the need to utilize historical cost data to inform the development of spending targets necessitates this longer timeline, if we are to ensure the use of accurate and appropriate data.

Hospitals will already be subject to the statewide health care spending target, which was adopted by the Board less than a year ago. The Board thoughtfully chose to phase in the 3% growth target over a five-year period to provide OHCA and health care entities with a glide path to meeting the statewide target. Further, the statute outlines an opportunity to evaluate performance prior to requiring enforcement of the target, by making 2025 a measurement year and 2026 the first enforceable year. The Board should allow for time for evaluation of health care entities' performance against the target, the development of enforcement policies, and opportunities to work through data collection and reporting processes prior to defining health care sectors and setting sector-specific targets.

OHCA is also still in the process of developing a methodology for how hospitals' spending performance should be measured and in working with external stakeholders, has uncovered many nuances with the data sources and measurement approaches. These issues – including a number of challenges for how PHS' data is reported and captured in the spending performance analysis -- have not yet been addressed and require additional thoughtful consideration and resolution. Without such consideration, OHCA will likely propose spending targets that do not reflect the full picture of PHS' services, spending, and costs.

We urge a timeline that is more consistent with the statute, which permits the Board to wait to establish sector targets until on or before October of 2027. This delay is necessary due to the complexity of health care financing and need for historical cost data to inform the development of these, and the time that is needed to carefully consider how sector targets should be defined to minimize any adverse impacts.

PHS' Concerns with High-Cost Hospital Metrics and Data

To inform the discussion on how to define a high-cost hospital, OHCA has presented data to the Board and Advisory Committee on the top 30 worst-performing hospitals in California on five metrics. We have significant concerns with three of the metrics, which captured many public health care systems in the top 30 lists. These include the inpatient net patient revenue (NPR) per case mix adjusted discharge (CMAD) metric; average annual growth in inpatient NPR per CMAD metric; and the commercial NPR per CMAD metric.

These metrics and the underlying data fail to account for the unique role PHS play in providing the non-federal share for Medi-Cal services and the unique implications for this financing structure. Without acknowledging and/or adjusting the data for these financing structure, the lists OHCA is presenting are not an accurate representation of PHS financing or high-cost hospitals in California.

We outline our specific concerns with the metrics below:

Revenues and Payments in the Annual Financial Disclosure Reports (AFDR) and Impacts to Performance on the Metrics

- *Medi-Cal Self-Financed Payments:*
  As described, PHS play an enormous role in the Medi-Cal program. They do so not just as providers, but also as a source of financing, in which most of their Medi-Cal revenues are reimbursed through self-financed payments, meaning that PHS themselves – not the State – provide the non-federal share of the payment. For these Medi-Cal payments, PHS only receive as revenue the federally matched portion, or the net amount of the payment. It is only this portion that helps PHS cover the costs of the care. However, many PHS report the gross amount of the payment – both the non-federal share they provide and the federal match – in the AFDR (the data source being used to pull revenue

information). Using this reported data drastically, and inaccurately, inflates PHS' revenues. For example, several PHS (including systems that appeared in the top 30 lists) have a payer mix of more than 60% Medi-Cal, for which they are self-financing the majority of those payments. Using gross data for these payments significantly inflates the inpatient NPR per CMAD results for these systems, leading to inaccurate outcomes in their performance on the metric.

- *Significant Variance in the Timing and Reporting of Medi-Cal Supplemental Payments*
  There is significant variance in both the timing and reporting of Medi-Cal supplemental payments, which has an adverse impact for PHS performance on the average annual growth of inpatient NPR per CMAD. For example, due to a change in federal reporting requirements, PHS were required to change their reporting on one of their large value-based Medi-Cal supplemental payments from non-patient revenue to patient revenue during the timeframe of the analysis of high-cost hospitals that OHCA conducted. This caused a very large increase in PHS' reported net patient revenue and significantly impacted their performance on the average annual growth metric.

  Additionally, there can often be delays in the timing of supplemental payments, where payments scheduled to occur in the last quarter of the year spill over to the first quarter of the following year. These timing variances drive a significant level of discrepancies and instability in PHS revenues and performance on a growth rate metric and makes the year-over-year analyses appear lopsided.

  Finally, many PHS are <u>systems</u> of care and have multiple hospitals and outpatient facilities operating under one entity, as a system. Supplemental payments are often paid out at the system level, and there are challenges determining the funding allocations between hospitals. This type of revenue and delivery structure does not lend itself well to OHCA's analysis and creates challenges for PHS performance on the high-cost metrics.

- *Payments for Uninsured Care May Be Captured in the Analysis*
  County PHS also report revenues for care provided to uninsured patients. We are concerned that these revenues could be captured in OHCA's analyses, potentially impacting PHS performance outcomes. The inclusion of uninsured-related revenue does not align with the current methodology to measure total medical expenditures or prior intent expressed by OHCA and the Board. We therefore need more time to better understand the degree to which these data are being reported and included.

<u>Data Timeframe and Pandemic Impacts</u>
OHCA's analysis captured hospital's financial data from 2018-2022. It is unclear how temporary revenue sources related to the COVID-19 pandemic response might have impacted performance outcomes. PHS played an integral role during the pandemic, with many standing up testing and vaccine sites for county residents and providing care for patients hospitalized with COVID-19. These responsibilities and investments had significant financing impacts. For example, many received temporary funding to help offset costs (e.g., Provider Relief Funds, American Rescue Plan Act funds, COVID-19 Accelerated and Advanced Payments, etc.). The treatment of these funds should be further explored and adjusted for, if needed, in performance outcomes.

<u>Case Mix Adjustment Coding Challenges</u>
- *Impacts Due to Limited Coding Abilities*

We appreciate OHCA's efforts to adjust for patient acuity in its analysis. However, the methodology OHCA is using benefits hospitals that have better coding abilities. PHS are not paid according to a diagnosis-related group (DRG) methodology for their Medi-Cal inpatient stays. Consequently, most county PHS have more limited coding abilities and resources. County PHS have reported having a low case-mix index compared to other similar hospitals, which resulted in questionable performance outcomes.

- *Need for Outlier Adjustments*
  Although coding resources may be more limited for certain PHS, we know they are serving some of the most high-risk and complex patients (e.g., burn, transplants, etc.) that are likely to have a longer length of stay than patients in other hospitals. The case-mix adjustment index being used as part of the current methodology to measure performance does not account for long lengths of stay nor adjusts for outlier stays. Further, many PHS provide skilled nursing and sub-acute care, which is captured in the patient discharge data. It is unclear how the Medicare Severity-DRG (MS-DRG) adjusts for these stays, which could also significantly disadvantage PHS performance in OHCA's analysis.

- *Need for Adjustment for Children's Services*
  Several PHS provide high-intensity services like trauma and neonatal intensive care to children. Three of the University of California medical centers have children's hospitals embedded within their systems and others often take patients from nearby children's hospitals. The MS-DRG does not adequately adjust for children's services, which is a reason being considered by OHCA and its Board to exclude children's hospitals from the high-cost hospital sector target development. This is an issue that also impacts some PHS and results in skewed performance in OHCA's analysis.

<u>Concerns Over the Methodology Determining Inpatient Vs. Outpatient Hospital NPR Allocations</u>
For some payers, OHCA must estimate the allocation of inpatient net patient revenue (NPR) vs. outpatient NPR based on billed charges. Several of our members found the results for their system based on OHCA's methodology to be significantly different when compared to their actual inpatient and outpatient NPR amounts. Further, some PHS have unique payment methods that could further skew performance. For example, one county PHS is uniquely paid via an all-inclusive bundled charge methodology rather than through itemized billing. From their analysis, the split between inpatient and outpatient using gross charges (OHCA's approach) is skewed heavily to inpatient, inflating the proportion of NPR to inpatient. These nuances must be considered as OHCA works to identify which hospitals should be considered "high cost."

<u>Facility Attributes and Services Lines</u>
Several PHS that appeared in OHCA's top 30 lists have other types of facilities, service lines, and/or facility attributes that impact their revenues and performance on the metrics when compared to standalone or community hospitals. For example:

- One PHS captured in the top 30 hospitals with the highest inpatient NPR per CMAD is licensed as both an acute care hospital and a rehabilitation hospital, but it primarily provides rehabilitation services. Rehabilitation hospitals provide significantly different services, have different lengths of stays, and treat a much different patient population than general acute care hospitals. They should not be included in this analysis.
- Another PHS included in the top 30 lists has three other hospitals on its license that are captured in the reporting and metric but that provide significantly different services, including psychiatric care, subacute care, and long-term care.

- As a final example, and as described above, all three UC medical centers captured on the top 30 lists have children's hospitals embedded within their medical centers, which impacts their performance.

This type of context is critically important for understanding the spending performance data and must be considered in any determinations of hospital sector targets.

Considerations for Commercial Revenues

Finally, as OHCA presents data on a new metric to the Board on average commercial inpatient NPR per CMAD, which it shared at the January 21st Advisory Committee meeting, we caution against narrowly viewing this data and performance outcomes. Most county PHS primarily serve Medi-Cal patients and do not have contracts with commercial plans. The patients with commercial coverage that they do serve tend to be for extremely intensive and high-cost services that other hospitals in the community do not provide, such as trauma and burn care. Therefore, the revenues captured for commercially insured patients appear to be significantly higher for PHS relative to other hospitals and the number of discharges is much smaller. This significantly skews their performance on such a metric.

It must also be acknowledged that the UC medical centers' service mix and intensity, and the level of extremely high-cost tertiary and quaternary care being provided (e.g., transplant services, treatment for rare diseases like hemophilia and bone marrow care) is vastly different compared to other hospitals, also skewing their performance on such a metric.

OHCA and the Board must account for issues like the ones outlined above to prevent any harm to safety-net systems in the identification of high-cost hospitals and development of sector target(s). We urge the Board to delay the creation of hospital-specific sector targets to give OHCA adequate time to work through these data challenges and ensure no adverse impacts to safety-net systems through the creation of these targets.

Thank you for the opportunity to provide comments and for your consideration. We would be pleased to discuss these recommendations with you further or answer any questions you may have. Please contact Haleigh Mager-Mardeusz, Associate Director of Policy, if you would like to follow up.

Sincerely,

Erica B. Murray
President and CEO

cc: Members of the Health Care Affordability Board:
Dr. David M. Carlisle
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Dr. Donald B. Moulds
Dr. Richard Pan

Elizabeth Landsberg, Director, 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
Michelle Baass, Director, Department of Health Care Services

Providence

3345 Michelson Drive
Suite 100
Irvine, CA 92612

January 25, 2025

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

Re: Proposed Delay for Office of Health Care Affordability's Establishment of Hospital-Specific Spending Targets

Dear Chair Johnson,

On behalf of Providence, we appreciate the opportunity to comment on the proposed regulations for the California Health Care Affordability Board's establishment of hospital-specific spending targets. Providence is deeply concerned about maintaining our patients' access to care - especially the significant Medi-Cal population we serve, which is put in jeopardy by the speed with which the Office of Health Care Affordability (OHCA) is considering defining hospital-specific sector(s) and establishing one or more sector-specific targets.

Patients' access to care is at stake. It is crucial that the Office's actions be based on a thorough analysis of the healthcare spending landscape and that hospitals clearly understand how to comply with sector-specific targets.

Making health care more affordable — a priority for Providence — is a shared responsibility. To make a difference in the cost of care, the entire health care system — insurance companies, drug manufacturers, medical device suppliers, labor unions, governmental agencies, and others — must work together. Fragmenting the health care field so early in the process would undermine the collaboration that is key to our shared success and necessary to maintain patient access.

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 such analysis, it is difficult to understand how this proposal would meet OHCA's statutory requirement to "minimize fragmentation and potential cost shifting and encourage cooperation in meeting statewide and geographic region targets."

Further, OHCA has not yet finalized its method for measuring hospital spending. OHCA has a legal prerogative to inform the creation of sector targets with historical cost data. However, the lack of a finalized methodology means the relevant historical cost data has not been reviewed, leaving hospitals in the dark as to how to comply with the target. Establishing hospital-specific sector(s) and corresponding targets is wholly premature.

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

- Consolidating administrative functions
- Streamlining billing and payment operations
- Prioritizing regional care models with multiple centers of excellence
- Leveraging technology to streamline administrative tasks
- Reevaluating capital projects outside of those focusing on caregiver and patient safety
- Converting facilities to more cost-effective renewable energy

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:

- Hospital service lines, especially in rural areas and underserved areas
- Longer patient wait times for important tests or procedures
- Investments in surgical or diagnostic equipment
- Investments in caregiver development and retention

On behalf of the 1.5 million California patients we serve, Providence urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets. Providence 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,

Laureen Driscoll
South Division Chief Executive
Providence

Cc: Members of the Health Care Affordability Board
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

El Camino Health

Hospital Campuses

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Los Gatos, CA 95032
408-378-6131

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January 27, 2025

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

SUBJECT: Definition of Hospital-Specific Sector(s) and Spending Targets

Dear Chair Johnson:

El Camino Health is deeply concerned by the speed with which the Office of Health Care Affordability (OHCA) is considering defining hospital-specific sector(s) and establishing one or more sector-specific targets. Because patients' access to care is at stake, it is crucial that the office's actions be based on thorough analysis of the health care spending landscape, and that hospitals clearly understand how to comply with sector-specific targets.

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

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 difficult to understand how OHCA can meet its statutory requirement to "minimize fragmentation and potential cost shifting and encourage cooperation in meeting statewide and geographic region targets."

Further, OHCA has not yet finalized its method for measuring hospital spending. OHCA has a legal prerogative to inform the creation of sector targets with historical cost data. However, the lack of a finalized methodology means the relevant historical cost data has not been reviewed and leaves hospitals in the dark as to how to comply with the target. Establishing hospital-specific sector(s) and corresponding targets is premature.

El Camino Health urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets. Our organization remains deeply committed to achieving our shared goals of affordable, high-quality care – and we ask that the Office of Health Care Affordability ensure that access to care is not diminished in the pursuit of lower costs.

Sincerely,

Jon Cowan
Executive Director, Government Relations & Community Partnerships

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