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

Health Care Affordability Board
December 16, 2024
Public Comment

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

Date	Name	Written Comment
12/16/2024	Salinas Valley Health System	See Attachment #1.
12/17/2024	Stephen Shortell	These comments are relevant to the December 16, 2024 meeting of the Board. 1) In regard to setting hospital sector targets, it will be helpful to examine the various hospital spending measures being considered by ownership (For Profit vs Not-for-Profit) and whether or not the hospital is a member of a system. I believe Rick Kronick, and Elizabeth Mitchell (perhaps others?) noted the same regarding the latter. 2) It will also be important when looking at the 19 Covered California regions or by county clusters to look at the degree of hospital concentration and insurer concentration using the widely accepted Herfindahl index measure. To examine how the degree of competition (or lack thereof) may be influencing spending. 3) In regard to the challenge of setting regional targets, a first step would be to simply aggregate current hospital spending data by hospital geographic location. Does not account for outpatient or other spending categories, of course, but given the high cost of inpatient care, it will capture a lot of the spending and give a first approximation. Happy to discuss any of these further. Steve Shortell - Advisory committee member.
01/16/2025	Analis Downer	I want to extend my sincere gratitude for the Office of Health Care Affordability Board's recent visit to

Date	Name	Written Comment
		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. 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.
01/17/2025	Northern Inyo Healthcare District	See Attachment #2.
01/17/2025	Ridgecrest Regional Hospital	See Attachment #3.

Date	Name	Written Comment
01/17/2025	NorthBay Health	See Attachment #4.
01/18/2025	Jody Roberts	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. 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.

Date	Name	Written Comment
01/18/2025	California Children's Hospital Association	See Attachment #5.
01/20/2025	Torrance Memorial Medical Center	See Attachment #6.
01/20/2025	Marshall Medical	See Attachment #7.
01/20/2025	United Hospital Association	See Attachment #8.
01/20/2025	Kern Medical	See Attachment #9.
01/22/2025	Stanford Medicine Children's Health	See Attachment #10.
01/22/2025	Michele Osorio	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. 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

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01/22/2025	Sandra Mettler	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. 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

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01/22/2025	Andrea Constant	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. 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.

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01/23/2025	Salinas Valley Health System	See Attachment #11.
01/23/2025	Barton Health	See Attachment #12.
01/23/2025	Huntington Health	See Attachment #13.
01/24/2025	Stanford Health Care	See Attachment #14.
01/24/2025	Stanford Health Care Tri-Valley	See Attachment #15.
01/24/2025	Health Access California	See Attachment #16.
01/24/2025	San Diego Chamber of Commerce	See Attachment #17.

December 16, 2024

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

Subject: Salinas Valley Health Response to Concerns Raised By The Office of Healthcare Affordability

Dear OHCA Board Members:

Since 1953, Salinas Valley Health (SVH), has operated as a public health care district led by an elected Board of Directors. Our mission is to provide outstanding, high quality, affordable healthcare to everyone in our community regardless of insurance or ability to pay.

During the August 2024 OHCA Board Meeting, there were repeated references to hospitals in Monterey County having "outlier" operating margins and high commercial insurance prices. SVH believes that the data presented is incomplete and misleading, and that proposed OHCA Board actions will likely result in a substantial reduction in community healthcare services, closure of programs, and adverse patient outcomes.

To address the access and affordability challenges in our community, SVH has successfully developed an integrated healthcare system comprised of the following:

1. **An acute care hospital with associated hospital-based outpatient departments (SVH Medical Center).**
   - Notably, the outpatient data referenced in the OHCA cost analysis only includes outpatient services under the hospital license (e.g., emergency department) and excludes the majority of our outpatient services which operate independently of the hospital license.
2. **The SVH Clinic System.**
   - SVH Clinics includes outpatient primary care and specialty clinics, a large population health division (dedicated to keeping patients well and out of the hospital), and outpatient imaging services.
   - These services do not come under the hospital license and are provided at considerable expense to the system while delivering significant financial benefit to our community.
3. **Low-cost, non-hospital-based healthcare alternatives.**
   - SVH has invested in an ambulatory surgery center, an outpatient endoscopy program, an outpatient radiation oncology program, and an outpatient urgent care center. These are cost-effective alternatives for services that would otherwise be performed at a hospital facility.

(Please see Attachment #1)

While all these entities report to our elected District Board, they have distinct contracting processes, revenue streams, and expense structures.

The analysis presented at the OHCA Board Meeting appears to rely exclusively on data from our Medicare Cost Report and HCAI filings. These reports only consider the acute care SVH Medical Center finances and ignore the other components of our healthcare system. We strongly believe this does not

accurately reflect SVH's economic realities as an integrated healthcare system, which was intentionally designed to enhance access, affordability, and quality. We believe that our costs and financial performance should be evaluated on a consolidated basis which more accurately reflects the true cost of providing healthcare services to the communities SVH serves.

(Please see Attachment #2 – which is the SVH Board-approved FY 2025 budget, showing the components and consolidated system revenue and losses.)

We believe that, as a consolidated healthcare system, our prices are at or below the Bay Area average and our operating margin is much lower than reported in the OCHA analysis.

Furthermore, despite operating in a community with a traditionally unfavorable payer mix (evident in OHCA data comparing our percentage of MediCal patients to the state average – Attachment #3), SVH has achieved:

- A **5-Star CMS Rating** (not reflected in the August OHCA data), and
- Our 11th consecutive **Leapfrog "A" Rating**.

Ongoing SVH Initiatives to Address Affordability and Access
SVH remains committed to addressing the challenge of providing affordable healthcare in our community through the following initiatives:

a. Supporting and developing lower-cost sites of care, such as our clinic system, ambulatory surgery center, outpatient radiation oncology center, and outpatient endoscopy center;

b. Expanding a robust outpatient population health division focused on preventive care to reduce high-cost illnesses;

c. Continuing to increase our focus on risk-based contracting with financial incentives tied to positive outcomes rather than costly utilization;

d. Investing in outpatient and inpatient quality measures, as evidenced by our national recognitions, which highlight improved outcomes and cost savings for patients and payers; and

e. Providing significant community investments in well-being initiatives, including a no-cost mobile health clinic (with over 17,000 patient encounters in underserved areas) and leadership in developing a county-wide Blue Zones Project.

Conclusion

Despite significant financial challenges, SVH remains dedicated to delivering inclusive, high-quality healthcare services to our community. Characterizing our system solely through the lens of our acute care hospital, rather than the broader context of our consolidated system, is inaccurate, demoralizing, and detrimental to community health and safety. We strongly urge OHCA to evaluate SVH as a consolidated healthcare system rather than focusing exclusively on economic data from our acute care hospital.

We look forward to collaborating with the Office of Health Care Affordability and other stakeholders to address these challenges and ensure a sustainable healthcare system for the future. As appropriate, SVH would welcome discussion with individual OHCA board members or executives.
Respectfully submitted,

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

Attachment #1

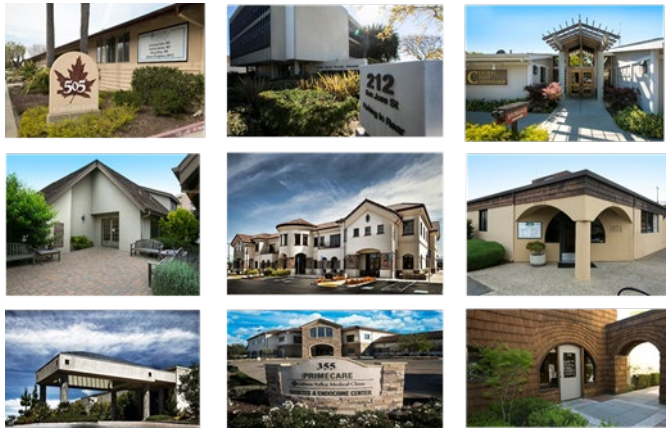
Salinas Valley HEALTH

A Public Healthcare District

Salinas Valley Health Medical Center

Hospital Based Outpatient Departments (HBOPs)

Accounted for by OHCA



<u>Salinas Valley Health Clinics</u>:
Primary Care and Specialty Clinics (~200 providers)

Population Health Division

SVH Clinics Outpatient Imaging

<u>Not</u> Accounted for by OHCA

<u>Community Partnerships</u>:
Monterey Peninsula Surgery Center
Doctors on Duty Urgent Care
Salinas Radiation Oncology
Monterey Bay Endoscopy Center

<u>Not</u> Accounted for by OHCA

Attachment #2

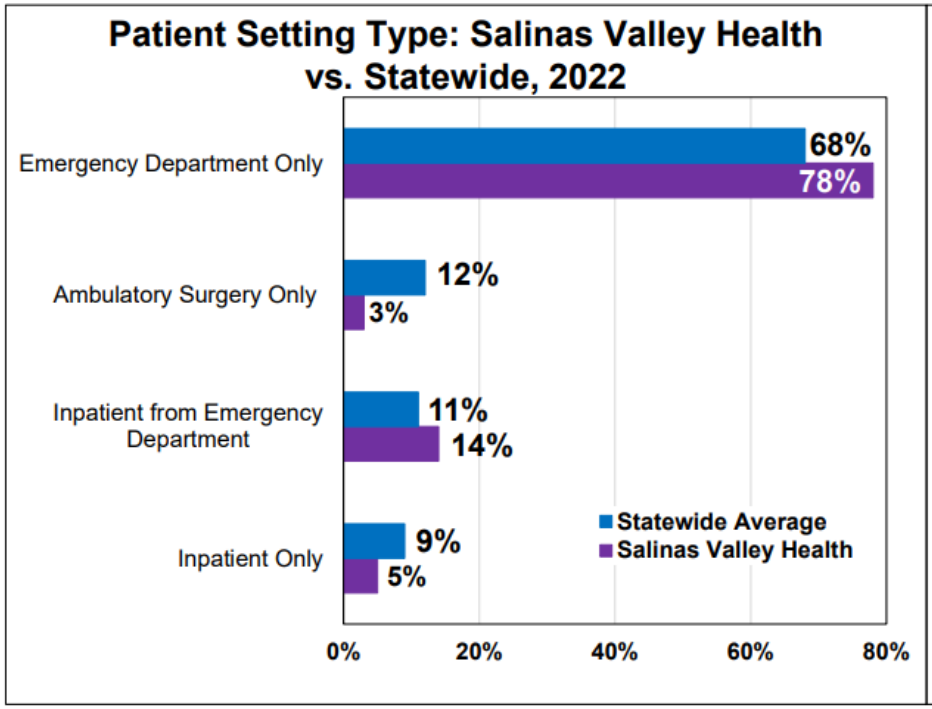
Budget FY 2025 - Consolidated

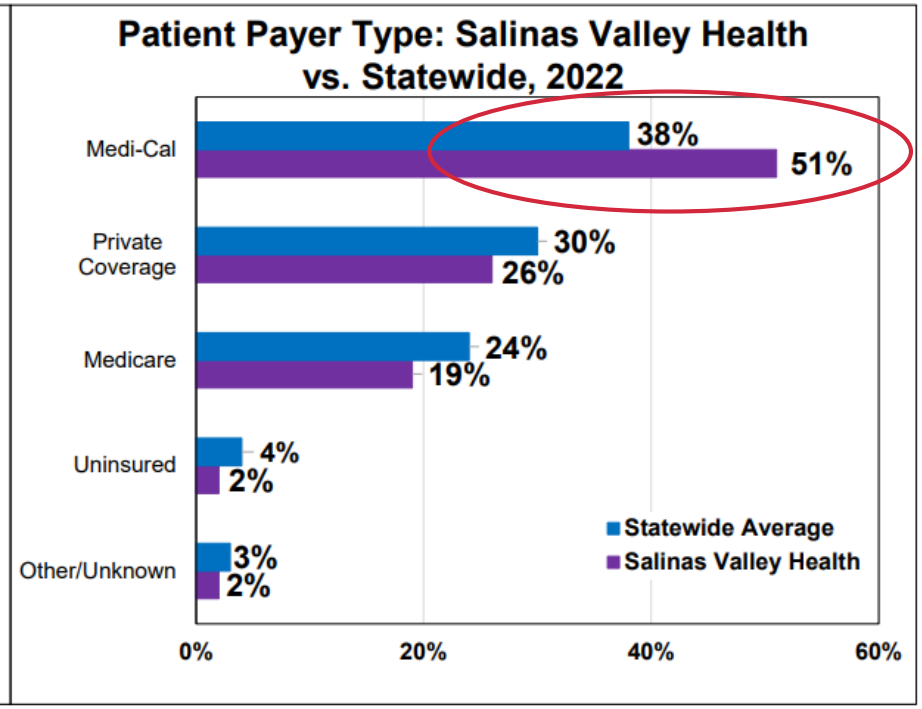
Hospital and HBOP departments | **SVH Clinics** | **Urgent care** | **Consolidated System**

FY 2025 Budget

PL SUMMARY	SVHMC	SVHC	DOD	Foundation	CONSOLIDATED TOTAL
GROSS PATIENT REVENUE	3,082,128,594	181,705,003	35,244,846	0	3,299,078,443
NET PATIENT REVENUE	612,944,127	84,175,369	24,226,045		721,345,541
Yield	19.9%	46.3%	68.7%	0.0%	21.9%
OTHER REVENUE	17,432,028	9,551,011	778,531		27,761,570
TOTAL REVENUE	630,376,155	93,726,380	25,004,576	0	749,107,111
TOTAL OPERATING EXPENSES	574,968,314	157,618,459	24,709,863	4,604,507	761,901,143
OPERATING MARGIN	55,407,841	(63,892,079)	294,713	(4,604,507)	(12,794,032)
OPERATING MARGIN %	8.8%	-68.2%	1.2%	0.0%	-1.7%
EBITDA	84,897,179	(59,419,094)	1,016,748	(4,604,507)	21,890,326
EBITDA %	13.5%	-63.4%	4.1%	0.0%	2.9%
OTHER NON OPERATING INCOME	30,577,558	-	(44,207)	5,594,134	36,127,485
TOTAL MARGIN	85,985,399	(63,892,079)	250,506	989,627	23,333,453
TOTAL MARGIN %	13.6%	-68.2%	1.0%	0.0%	3.1%

Salinas Valley Health vs. Statewide Average: Patient Setting Type and Payer Mix





Source: HCAI Healthcare Utilization - Patient Level Administrative Data.

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HCAI Department of Health Care Access and Information

OHCA Board Meeting 8-28-2024; p. 93

Attachment #2

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

January 17, 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,

Northern Inyo Healthcare District (NIHD) 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.**

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

- Reduced labor costs by approximately 15% per adjusted bed day
- Reduced expenses 1% while growing revenue 14%

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:

- OB/Gyn
- Pediatrics
- Urology

On behalf of the approximately 13,000 patients we serve, NIHD urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets. NIHD 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,

Stephen DelRossi, MSA

Stephen DelRossi, MSA
Chief Executive Officer
Northern Inyo Healthcare District

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

Attachment #3

Ridgecrest
REGIONAL HOSPITAL

January 17, 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,

Ridgecrest Regional Hospital 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."

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Ridgecrest Regional Hospital is already striving to meet the existing 3.5% spending target for 2025 by:
- Suspending Specialty Services

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:
- **Labor & Delivery**
- **Specialty Services**
- **Community Outreach**

On behalf of the thousands of patients we serve, Ridgecrest Regional Hospital urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets.

Ridgecrest Regional Hospital remains deeply committed to achieving our shared goals of affordable, high-quality care — and we ask that the office proceed with a keen eye toward ensuring care is not diminished in the pursuit of lower costs.

Sincerely,

James Suver, CEO/President
Ridgecrest Regional Hospital

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

Attachment #4

NorthBay Health Administration Office
4500 Business Center Drive
Fairfield, Ca 94534

January 17, 2025

Kim Johnsona
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,

NorthBay Health 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."

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

Sincerely,

Mark Behl, MHA, MBA
President & CEO
NorthBay Health
P (707) 646-3100 | **E** Mark.Behl@NorthBay.org

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

Attachment #5

CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION

1215 K STREET, SUITE 1930
SACRAMENTO, CA 95814
916.552.7111
www.ccha.org

January 18, 2025

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

Submitted via email to Megan Brubaker at ohca@hcai.ca.gov

Subject: OHCA Board Must Delay Creation of a Hospital Sector

Dear Chair Johnson:

The California Children's Hospital Association 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.

Children's hospitals take their responsibility to meet the recently established statewide spending target very seriously and fully understand that the issue of health care affordability is a crucial and urgent one. That said, the process of dividing the health care system into sectors and establishing more niche targets must be undertaken cautiously, and with consideration of how the statewide target is impacting providers, insurance companies, drug manufacturers, medical device suppliers, labor unions, governmental agencies, and others. Rushing that process poses significant risks to the stability of the system, as well as to access for children and families.

Additionally, 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."

In 2023, we all learned just how fragile the state's current healthcare system is when Madera Community Hospital closed its doors. Two years later, state and local leaders are still working to reopen that facility and restore access to vital services for the community. Every year, new community hospitals announce the closure of pediatric and labor and delivery units. With warning signs like these, it is imperative that the Office of Healthcare Affordability work cautiously to balance the critical need for affordability with the equality important need for system sustainability.

For these reasons, CCHA urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets.

Sincerely,

Mira Morton
Vice President of Government Affairs
California Children's Hospital Association

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

TORRANCE MEMORIAL | An Affiliate of Cedars Sinai

Attachment #6

January 20, 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,

Torrance Memorial Medical Center 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.**

Torrance Memorial Medical Center is already striving to meet the existing 3.5% spending target for 2025 by:

- Optimize staffing levels using predictive analytics to align with patient volume and acuity.
- Reduce the length of hospital stays by improving care coordination.
- Minimize hospital readmissions by improving discharge planning and follow-up care.
- Use telehealth services to reduce in-person visit costs for routine consultations.
- Cross-train staff to increase flexibility and reduce reliance on temporary workers.
- Foster a culture of employee engagement to reduce turnover and recruitment costs.
- Enhance patient education to encourage adherence to treatment plans and reduce complications.
- Focus on infection control to avoid costly hospital-acquired infections.
- Partner with community organizations to address social determinants of health.
- Develop care management programs for high-cost, high-need patients.
- Promote wellness initiatives to reduce long-term healthcare costs.

On behalf of over a million patients we serve in our primary and secondary services areas, Torrance Memorial Medical Center urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets. Torrance Memorial Medical Center 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,

Keith Hobbs
President/CEO
Torrance Memorial Medical Center

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

MARSHALL

January 20, 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,

Marshall 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.

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."

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.**

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.**

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. Marshall is operating at a sub-zero operating margin now. While we have instituted many cost-savings measures, and continually focus on the efficient delivery of high-quality care, it is difficult to imagine how the many hospitals who share our financial challenges can reduce costs even further.

MARSHALL

On behalf of the 180,000 community members we serve, Marshall urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets. Marshall 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,

Siri Nelson, Chief Executive Officer

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

Attachment #8

United Hospital Association

January 17, 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,

The United Hospital Association (UHA) 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.

OHCA has yet to comprehensively compare spending across various segments of the industry, identify where spending growth is high, or meaningfully assess drivers to determine whether differences in spending growth are appropriate. Without first completing this analysis, it is difficult to understand how this proposal could meet OHCA's statutory requirement to "minimize fragmentation and potential cost shifting and encourage cooperation in meeting statewide and geographic region targets." 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.**

Further, OHCA has not yet finalized its method for measuring hospital spending. The relevant historical cost data has not been reviewed which disadvantages hospitals as they seek effective strategies for compliance. This proposal seems to violate OHCA's legal prerogative to inform the creation of sector targets with historical cost data and also leave hospitals with no guidance for complying with sector targets. **Establishing hospital-specific sector(s) and corresponding targets is premature.**

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

Please contact me at janelle@blancohopkins.com or UHA's legislative advocate, Meghan Loper, at mloper@lobbycal.com if you have any questions.

Sincerely,

Janelle Blanco

Janelle Blanco
Executive Director

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

KernMedical

January 21, 2025

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

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

Dear Chair Johnson,

The Kern County Hospital Authority, which owns and operates the Kern Medical hospital and clinics, 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.**

Kern Medical is already striving to meet the existing 3.5% spending target for 2025 through its:
- Robust productivity management system for staffing
- Sophisticated cost accounting system
- Hospital utilization functions focusing on appropriate use of resources
- Case management activities
- Patient referral system to appropriately facilitate patients between the hospital and clinics

Lowering the target even further, without a clear understanding of how spending will be measured, means our care will be impacted. It should be noted that half of the 910,000 people that live in Kern County are enrolled in Medi-Cal. Our organization is the designated public safety net hospital that underpins the delivery of healthcare in our community through its mission to care for the most vulnerable in this population as well as operates our county's teaching hospital that trained most of our county's physicians, and provides lifesaving specialty and trauma services not available elsewhere in our dramatically underserved area. Such specialty services include:

- The area's only trauma center within a radius of 75 miles, and one of the busiest in Southern California
- Acute behavioral inpatient services for patients with medical conditions
- Psychiatric crisis stabilization for the most at risk
- Sickle cell center
- Valley Fever Institute
- Gyn Oncology
- Urogynecology
- Hand surgery
- Oncology infusion services for Medi-Cal enrollees
- Neurosurgery for Medi-Cal enrollees
- Outpatient primary care and specialty clinics
- Addiction medicine clinics
- Outpatient clinics in homeless shelters and a 19-bed recuperative care center for homeless needing home health services post discharge from any area hospital
- A large Level 2 NICU caring for the area's most acute neonates
- Mobile clinics for outlying school districts serving vulnerable children and their families
- As a teaching hospital we invest a significant amount of our clinical margin supporting our relatively large physician graduate medical education residencies and fellowships because these programs' costs are not covered by available funding

Kern Medical continuously strives to enhance access to care, improve its quality, and operate in a cost effective and efficient manner in an immense geographically undeserved area.

On behalf of the more than 900,000 people we serve in our county, Kern Medical urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets. Kern Medical 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,

Scott Thygerson
Chief Executive Officer

cc: Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Dr. Sandra Hernandez
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.

OHCA Board Must Delay Creation of a Hospital Sector
January 21, 2025

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

Stanford MEDICINE
Children's Health

January 22, 2025

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

Subject: Defining Hospital-Specific Sectors and Spending Targets

Dear Chair Johnson:

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

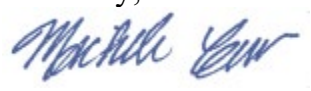
We agree that health care should be more affordable — it is a priority for California hospitals — and that it is a shared responsibility. To make a difference in the cost of care, the entire health care system — insurance companies, drug manufacturers, medical device suppliers, labor unions, governmental 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 spending targets is premature.**

We respectfully request that OCHA devote additional time for analysis and discussion before finalizing sectors or corresponding targets. We remain committed to achieving our shared goals of affordable, high-quality care, and we ask that you proceed with a keen eye toward ensuring care is not diminished in the pursuit of lower costs.

Sincerely,



Michele Lew
Senior Vice President & Chief Government Relations Officer

cc: Members of the Health Care Affordability Board:
David M. Carlisle, M.D., Ph.D.
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

Attachment #11

January 23, 2025

VIA U.S. MAIL & EMAIL

Members of the Health Care Affordability Board
2020 W. El Camino Avenue
Sacramento, CA 95833

Subject: Salinas Valley Health Input on Creation of a Hospital Sector

Dear OHCA Board Members:

In addition to the previous Salinas Valley Health letter submitted on December 16, 2024, explaining the complexity of the cost accounting for our healthcare system, we feel compelled to add public comment specifically related to the creation of a Hospital Sector.

While the Office of Health Care Affordability (OHCA) Board seeks to take timely action on the creation of a hospital sector, it is apparent from the OHCA Board's discussion on the topic in December that the attempt to define "hospital sector" is premature.

As Salinas Valley Health has clearly demonstrated in its prior correspondence with the OHCA Board, any cost analysis or sector definition needs to incorporate an evaluation of Salinas Valley Health as a healthcare system, inclusive of Salinas Valley Health clinic system which was designed specifically over the past decade to expand access to affordable care to everyone in the community and has demonstrated through financial data, the clinic system is financially subsidized by the Salinas Valley Health Medical Center.

1. **Making healthcare more affordable is a priority and must be evaluated at a system level.**

   - Notably, the outpatient data referenced in the OHCA cost analysis only includes "outpatient" services which are under the hospital license (e.g., emergency department) and excludes the majority of our clinic outpatient services which do not fall under the hospital license, but are District clinic operated pursuant to Section 1206(b) of the California Health and Safety Code.

2. **Affordability is a shared responsibility.**

   - The move to define a hospital sector (even if it analyzed on a healthcare system level) must include the associated costs of insurance companies, drug manufactures, medical device suppliers, labor unions, governmental agencies, and others involved in providing healthcare service.

   - Fragmenting the healthcare field so early in the process would undermine the collaboration and responsibility that is key to shared success.

3. **OHCA has not finalized its method for measuring hospital/healthcare system spending**

   - Lowering the target beyond the existing 3.5% spending target for 2025 without a clear understanding of historical cost data and an inclusive methodology creates confusion and ambiguity in an already complex analysis that has not been fully vetted.

Salinas Valley Health remains deeply committed to achieving shared goals of affordable, high quality care and urges OHCA to take the additional time needed for analysis and discussion before finalizing sectors or corresponding targets.

Respectfully submitted,

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

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

Attachment #12

Barton Health

2170 South Avenue
South Lake Tahoe
CA 96150

530.541.3420 TEL
bartonhealth.org

January 17, 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,

Barton Health 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.**

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

- Reorganized and eliminated some management positions
- Reorganized staff employee positions and eliminated some positions where appropriate
- Incorporating departmental productivity analysis

- Analyzed departments and service lines and eliminated where appropriate
-Monetized costly and underutilized property
- Reduced reliance on contract labor
- Renegotiating payor contracts

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:

- Our organization is geographically isolated in the Sierra Nevada mountains and the only hospital in our region that offers maternity and pediatric services. Additionally, approximately 50% of these patients have MediCal as a payor source. These are costly service lines where many small to medium hospitals have eliminated these services creating healthcare deserts for these services.
- Our payor mix is 60% government with increasing pressures on reimbursement.
- Our operating expenses are subject to approximately 5% annual inflation. In order to attract and retain trained staff, we must offer high wages and costly benefit plans.
- Our fixed costs such as insurance, utilities, technology have substantially increased over the last several years and expect these costs to continue to rise.

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

Sincerely,

Elizabeth Stork, CAO
Barton Health

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

Barton Health

2170 South Avenue
South Lake Tahoe
CA 96150

530.541.3420 TEL
bartonhealth.org

January 17, 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,

Barton Health 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."

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

- Reorganized and eliminated some management positions
- Reorganized staff employee positions and eliminated some positions where appropriate
- Incorporating departmental productivity analysis

- Analyzed departments and service lines and eliminated where appropriate
-Monetized costly and underutilized property
- Reduced reliance on contract labor
- Renegotiating payor contracts

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:

- Our organization is geographically isolated in the Sierra Nevada mountains and the only hospital in our region that offers maternity and pediatric services. Additionally, approximately 50% of these patients have MediCal as a payor source. These are costly service lines where many small to medium hospitals have eliminated these services creating healthcare deserts for these services.
- Our payor mix is 60% government with increasing pressures on reimbursement.
- Our operating expenses are subject to approximately 5% annual inflation. In order to attract and retain trained staff, we must offer high wages and costly benefit plans.
- Our fixed costs such as insurance, utilities, technology have substantially increased over the last several years and expect these costs to continue to rise.

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

Sincerely,

Carla Adams

Carla Adams, CNO
Barton Health

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

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January 17, 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,

Barton Health 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."

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

- Reorganized and eliminated some management positions
- Reorganized staff employee positions and eliminated some positions where appropriate
- Incorporating departmental productivity analysis

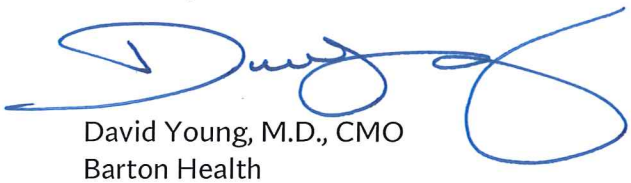
- Analyzed departments and service lines and eliminated where appropriate
-Monetized costly and underutilized property
- Reduced reliance on contract labor
- Renegotiating payor contracts

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:

- Our organization is geographically isolated in the Sierra Nevada mountains and the only hospital in our region that offers maternity and pediatric services. Additionally, approximately 50% of these patients have MediCal as a payor source. These are costly service lines where many small to medium hospitals have eliminated these services creating healthcare deserts for these services.
- Our payor mix is 60% government with increasing pressures on reimbursement.
- Our operating expenses are subject to approximately 5% annual inflation. In order to attract and retain trained staff, we must offer high wages and costly benefit plans.
- Our fixed costs such as insurance, utilities, technology have substantially increased over the last several years and expect these costs to continue to rise.

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

Sincerely,



David Young, M.D., CMO
Barton Health

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

Barton Health

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South Lake Tahoe
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January 17, 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,

Barton Health 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.**

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

- Reorganized and eliminated some management positions
- Reorganized staff employee positions and eliminated some positions where appropriate
- Incorporating departmental productivity analysis

- Analyzed departments and service lines and eliminated where appropriate
-Monetized costly and underutilized property
- Reduced reliance on contract labor
- Renegotiating payor contracts

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:

- Our organization is geographically isolated in the Sierra Nevada mountains and the only hospital in our region that offers maternity and pediatric services. Additionally, approximately 50% of these patients have MediCal as a payor source. These are costly service lines where many small to medium hospitals have eliminated these services creating healthcare deserts for these services.
- Our payor mix is 60% government with increasing pressures on reimbursement.
- Our operating expenses are subject to approximately 5% annual inflation. In order to attract and retain trained staff, we must offer high wages and costly benefit plans.
- Our fixed costs such as insurance, utilities, technology have substantially increased over the last several years and expect these costs to continue to rise.

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

Sincerely,

Clint Purvance, M.D.
President and CEO
Barton Health

cc: Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
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January 17, 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,

Barton Health 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.**

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

- Reorganized and eliminated some management positions
- Reorganized staff employee positions and eliminated some positions where appropriate
- Incorporating departmental productivity analysis

- Analyzed departments and service lines and eliminated where appropriate
- Monetized costly and underutilized property
- Reduced reliance on contract labor
- Renegotiating payor contracts

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. Current challenges that we face that would only be accelerated upon implementation of lower targets include:

- Our organization is geographically isolated in the Sierra Nevada mountains and the only hospital in our region that offers maternity and pediatric services. Additionally, approximately 50% of these patients have MediCal as a payor source. These are costly service lines where many small to medium hospitals have eliminated these services creating healthcare deserts for these services.
- Our payor mix is 60% government with increasing pressures on reimbursement
.- Our operating expenses are subject to approximately 5% annual inflation. In order to attract and retain trained staff, we must offer high wages and costly benefit plans.
- Our fixed costs such as insurance, utilities, technology have substantially increased over the last several years and expect these costs to continue to rise.

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

Sincerely,

Kelly Neiger, CFO
Barton Health

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

Huntington Health
An Affiliate of Cedars Sinai

Lori J. Morgan, MD, MBA
President and Chief Executive Officer

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P: (626) 397-5555 | www.huntingtonhealth.org

January 23, 2025

Honorable 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,

On behalf of my organization, Huntington Health, an affiliate of Cedars-Sinai and located in Pasadena, I am 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. Access to acute and emergency care for all Californians is at stake and therefore it is crucial that the Office's actions be based on a thorough analysis of the health care spending landscape, and that hospitals clearly understand how to comply with sector-specific targets.

Huntington Health operates a 544-bed acute care hospital and outpatient services at our Huntington Hospital campus and at locations throughout our community. Huntington is home to the largest emergency department and only level II trauma center in the San Gabriel Valley, providing access to lifesaving emergency and trauma care 24/7. Our Family Birth Center and level III neonatal intensive care unit (NICU) give babies the safest start to life. Leading cancer care, cardiology services, orthopedic care and advanced robotic surgery, and primary and specialty outpatient services, among many other health care services, are available to all who turn to us for care.

Making health care more affordable is a shared responsibility, and a high priority for California's hospitals. To be effective in reducing 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 responsibility and 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 utilize historical cost data in creating sector targets. However, the lack of a final 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** and comes at a time when greater than 50% of hospitals in California are suffering losses and continue to struggle from the structural changes to the industry caused by COVID. As a microcosm, Huntington Health has only posted 1 month of positive net operating income (from ongoing operations) since the initial COVID based closures to elective surgical cases in early 2020. These ongoing systemic challenges are made worse by low rate increases from governmental and non-governmental payers that do not keep up with unfunded mandates of minimum healthcare wage, staffing ratios, rest meal requirements that do not match workflow for a number of employees and other wage inflationary regulations.

Huntington Hospital has already worked to implement cost reduction measures to meet the existing 3.5% spending target for 2025, including:

- Maximizing recruitment of direct hire staff positions to minimize reliance on registry and traveler staff.
- Utilizing group purchasing opportunities to reduce costs for vendor services and supplies.
- Review and cancellation of all purchased service contracts and memberships that are not of absolute necessity and cannot be otherwise replicated internally or at lower cost.
- Collaborating with our medical staff to reduce medical device costs while maintaining quality of care.
- Collaborating with our community skilled nursing, long term care or other step-down facilities to ensure appropriate level of care is provided for patients.
- Ensuring staffing levels are commensurate with ratio requirements but efficiently staffing to volume for clinical and non-clinical areas.

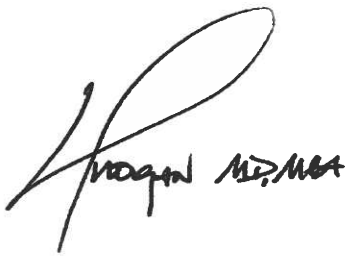
If the board takes action to lower the target even further, without providing a clear understanding of how the spending will be measured, Huntington Health, and other hospitals around the state, would be forced to reduce the care we provide. In our community, impacts could include:

- Huntington Health's ability to provide costly new and lifesaving technology that is of high value to the health of the San Gabriel Valley community.
- Replacement of aging and non-supported diagnostic radiology and other medical equipment that is key to diagnosing disease and safe care during hospitalization.
- As one of the few remaining hospital providers of Behavioral Care, Huntington Health would have to review its planned expansion of services and potentially plan closure of necessary but under-reimbursed and thus economically unsustainable services.
- Planned physician foundation expansions would need to be reassessed which would continue to leave gaps in primary care and specialty coverage for a number of specialties that are underrepresented in the San Gabriel Valley.

- The viability Huntington Health's long-standing Senior Care Network that focuses on helping seniors stay in their homes as they age and reduces costly hospital readmissions across a large swath of LA County would need to be reassessed as it is a community benefit that is not economically viable without cross subsidization.
- Programs such as Health Counseling, Community Flu Clinics, Fentanyl Education Program and Huntington Health's Diabetes Empowerment and Education Program as well as many others would be at risk.
- Huntington Health's long-standing medical education program which prepares many medical residents for providing care in our State and specifically the San Gabriel Valley community would be at risk of limitation or future closure.

On behalf of our community and its reliance on Huntington Health for 24,000 inpatient visits, 123,000 outpatient visits, and 77,000 emergency department visits each year, I urge you to take additional time for thoughtful analysis and discussion before finalizing sectors or corresponding targets. Huntington Health remains deeply committed to achieving our shared goals of affordable, high-quality care, and we ask that the Office ensure that as it proceeds with its charge, the health care available in our community and throughout California is not diminished in the pursuit of lower costs.

Sincerely,



Lori J. Morgan, MD, MBA
President and Chief Executive Officer

cc: Paul Johnson – Board Chair, Huntington Health
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

Stanford MEDICINE
Health Care

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,

Stanford Health Care 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."

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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. As predominantly tertiary and quaternary sites of care, Stanford Health Care has of the highest case mix indexes in the country because we specialize in caring for complex diseases and conditions. Adherence to an even lower spending target would effectively prevent us from providing the specialized lifesaving care our practitioners are trained to provide – including, but not limited to complex oncology cases, critical transplantation procedures, highly advanced cardiothoracic surgeries, level one trauma services, and mental health care.

On behalf of the patients we serve, Stanford Health Care 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,

Jason J Hill

Associate Vice President, Government Affairs
Stanford Health Care

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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Stanford MEDICINE | Health Care Tri-Valley

January 23, 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,

Stanford Health Care Tri-Valley 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.

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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. As a community hospital and affiliate of Stanford Health Care, Stanford Health Care Tri-Valley sees a variety of case mix indexes. The proposed target would prove unattainable, unsustainable, and unsupportive of our organizations efforts to improve the value of health care, not just lower its costs. Adherence to an even lower spending target would effectively prevent us from providing the necessary care our practitioners are trained to provide.

On behalf of the patients we serve, Stanford Health Care Tri-Valley 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,

Denise Bouillerce

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

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

HEALTH ACCESS CALIFORNIA

January 23, 2025

Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability
2020 W. El Camino
Sacramento, CA

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

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

Health Access California, the statewide consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments and recommendations on the topics discussed at the December 2024 Health Care Affordability Board meeting and anticipated for the January 2025 Board meeting.

The Health Care Affordability Board has already set enforceable statewide targets for health plans, hospitals, large physician organizations and other health care entities for the years 2025-2029. The Board has also heard important testimony about lack of affordability for most Californians, including research based on data and opinion surveys, as well as testimony from a variety of Californians, including those with multiple sclerosis (MS), small business owners, working families and more. The Board traveled to Monterey where it heard from the community about the damage caused by high hospital costs, high costs that are not explained by risk mix, quality, payer mix, the cost of living, health care worker wages, or any other obvious factor except the regional market.

In the context of this work by the Board and the Office on the lack of affordability of health care for consumers and other purchasers, Health Access offers the following recommendations and observations:

- Health Access supports defining “hospitals” as a sector and setting lower cost growth targets for individual hospital entities that are “high cost” outliers.
- Health Access seeks confirmation that all hospitals, and all hospital spending, remain subject to the statewide cost growth targets, beginning with the current statewide targets. Health Access recognizes that some

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hospitals may be excluded but we are extremely troubled by most possible exclusions.

- Health Access supports the use of multiple measures to define "high cost" outlier hospitals.
- Health Access offers comments and recommendations on measures of hospital spending, including updating current HCAI financial reporting without waiting for perfect data to set initial lower cost growth targets based on data available at the time.
- Health Access recommends consideration of health or hospital systems as well as individual facilities be further developed: virtually every dollar in a health system derives from a health care entity subject to the target.

Defining Hospitals as a Sector and Setting Lower Cost Growth Targets for High-Cost Outliers

At the December 2024 Board meeting, staff presented four options to define sectors for consideration by the Board. Health Access supports Option 4 that would define all hospitals as a sector and lower the cost growth target for high-cost facilities. This option is consistent with the enabling statute while allowing the Board and staff greater flexibility in defining high-cost outliers, as envisioned in the statute.

Health Access supports setting lower cost growth targets for high-cost outlier hospitals. As the work on Monterey demonstrates, and a large body of research on regional differences in hospital costs in California also demonstrates, there is considerable variation in hospital costs in California by both region and specific hospitals and health systems even controlling for patient acuity and complexity of care.

All Hospitals, and All Hospital Spending, Subject to the Statewide Target

All hospitals, and all hospital spending, are subject to the statewide cost growth targets adopted by the Board for the years 2025-2029. Health Access also seeks confirmation of the verbal statements of OHCA staff that any exclusion of hospitals in the December 2024 Board presentation was purely for purposes of presentation. Instead of clarifying the discussion, the use of exclusions complicated and confused the discussion. Again, we note that we recognize that some categories of hospitals, such as critical access hospitals, deserve different consideration. But almost all hospitals and hospital spending should be subject to scrutiny.

We are very troubled by the possibility that many hospitals would be excluded or otherwise exempted from scrutiny as "high cost" outliers. For example, defining "small" hospitals as hospitals with fewer than 100 beds excludes a disproportionate number of hospitals in the Los Angeles basin because of the rapid post-World War II development of Los Angeles. In another example, the Sutter system includes a number of hospitals with fewer than 100 beds and the Sutter system precipitated years of anti-trust litigation

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over the high costs of all the hospitals in that system. Failing to consider many or most of the 440 California hospitals as possible high-cost outliers would be contrary to the spirit of the OHCA law.

Health Access would not oppose excluding state hospitals or Shriner's hospitals from consideration. But the categories of exclusions presented at the last Board meeting were very broad and very troubling.

Measures to Define Hospitals Subject to Lower Cost Growth Target:

Health Access supports the use of measures to define "high cost" outlier hospitals including comparing commercial or private payments to Medicare as well as looking at risk-adjusted net patient revenue for commercial lines of business. OHCA has already made the decision to measure the targets separately for Medicare, Medi-Cal and commercial lines of business.

Health Access does not support the use of "operating margins" at the facility level because "operating margins" at the facility level ignores how health systems, or investors if investor-owned, are able to minimize apparent operating margins by upstreaming money to corporate entities or investors. Looking at systems and ownership type will be necessary in order to ensure that facilities are not evading the targets by moving money around.

Health Access recommends using the ratio of commercial payments to Medicare as a good starting point for evaluating hospitals as high-cost outliers. We have previously pointed to the RAND studies on hospital pricing and the work by Kronick et al comparing commercial payments to Medicare for the same care. This approach allows an apples-to-apples comparison, comparing what private insurance pays for the same care that Medicare pays for, whether it is a low-level emergency room visit, trauma care, a week in the ICU or heart surgery. The average hospital in California is paid twice as much by commercial insurance as Medicare pays for the same care but these high-cost hospitals are paid three or four times as much as Medicare pays or even more for the same care.

In reviewing last month's presentation, Health Access was concerned that net patient revenue for all lines of business obscured how much commercial payers, such as health plans, health insurers, and self-insured plans pay compared to Medicare and Medi-Cal. Separating out net patient revenue for commercial coverage resolves this concern. Health Access is interested in reviewing data on inpatient net revenue, risk-adjusted using standard measures such as case-mix adjusted discharges (CMAD), separated into market segments (commercial, Medicare, and Medi-Cal). Medi-Cal inpatient payments for hospitals should track Medicare payments if the QAF provider tax revenue is correctly accounted for. It is commercial payments that have skyrocketed, worsening affordability for consumers and other purchasers of commercial coverage.

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High-Cost Outliers: Top 10% or 20% of Hospitals

Too many hospitals in California are paid in excess of 200% of Medicare by commercial payers. Health Access again recommends that the top 10% or 20% of hospitals with high costs for commercial coverage compared to Medicare payments have lower cost growth targets than the existing statewide target that applies to all hospitals for 2025-2029.

Staff presented data on 30 hospitals, which is not even 10% of the 439 California hospitals. We ask that the Board be presented with data on the top 20% of hospitals using "third-party" payer data compared to Medicare as the measure. If staff would do this, it would allow the Board and stakeholders to get a better sense of the high-cost outlier hospitals.

Health Systems, Not Just Individual Facilities: A More Complete Picture

Obtaining a complete picture of the financial situation of an individual facility requires examining the finances of the health system of which it is a part. As demonstrated by the work on Monterey, even a stand-alone hospital can be part of a system as CHOMP is part of Montage health system.

Many individual facilities are part of large health systems, sometimes multi-state systems whether domiciled here in California or elsewhere. A robust literature indicates that consolidation of hospitals and health systems has increased costs without improving quality and sometime diminishing access. This has been true even in states like California where the Attorney General has some capacity to impose time-limited restrictions preventing diminished access on hospital transactions involving nonprofit entities.

To get a complete picture of both the financial capacity and the ability to manage care to lower costs while improving quality requires looking beyond the four walls of a single hospital to the larger hospital or health system. HCAI in other programs takes this view: for example, the distressed hospital loan program was only available to stand-alone hospitals, not to hospitals that are part of a larger system. It is essential that OHCA move toward looking at systems in order to effectively evaluate the ability of facilities to comply with targets and to minimize evasion of the cost growth targets by hiding money at the system level.

Health Access recommends looking at financial data as well as performance on equity, quality and access at the system level rather than the individual facility level.

Health System Finances Derive from Individual Facilities and Related Health Care Entities.

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Every dollar in a health system derives from care provided to patients by individual facilities and related health care entities, such as physician organizations, labs and imaging. Dollars such as the QAF and the MCO tax again derive from care provided to patients and paid by taxpayers because of the care given to patients. These dollars may be increased by investing reserves in various investments[1]. But the dollar that grows when invested originates from a dollar that came out of the pocket of a consumer in foregone wages for employer coverage, cost sharing for all sorts of commercial coverage, or public dollars that start in a taxpayer's pocket.

The underlying spirit behind the creation of the Office of Health Care Affordability requires a broad look at the health systems encompassing various health care entities, both in terms of the impact on payers and the ability of health systems to meet the triple aim of lower costs, better care and improved equity and to minimize the temptation to hide money, or lack of compliance, at the system level.

Current Data Availability and the Need to Update and Standardize Data Reporting

Health Access recognizes both that the law directs OHCA to use existing data sources as much as possible and that HCAI has some authority[2] to update and standardize data reporting that has not been used in recent decades for the purpose of controlling the rate of cost growth in health care. OHCA, and HCAI, have been mindful that the Health Payments Database is coming online during the target period of 2025-2029 and will provide important data once available. Health Access supports the use of available measures and appreciates that other data is becoming available in the next few years.

With respect to hospital financial and discharge data, Health Access continues to have several concerns:

- Inconsistent reporting of the hospital Quality Assurance Fee (QAF) is troubling because it is the QAF that provides the funding to raise Medi-Cal reimbursement to 100% or more of Medicare reimbursement. If Medicare is sufficient for an efficiently run hospital, then Medi-Cal payments slightly higher than 100% of Medicare payments are equally sufficient. Because of the vital importance of the QAF revenues in assuring adequate reimbursement of hospital care by Medi-Cal, it is important that the reporting on QAF revenues be mandatory and consistent. It is not clear that this is currently the case but that could be corrected.
- "Audited" hospital financial and discharge data:
    - It is factually accurate that HCAI conducts a desk audit for data completeness. However, to the best of our knowledge, HCAI does not audit the accuracy of the data provided by hospitals but instead relies on self-reported data.
    - As the data is used for OHCA purposes, errors and inconsistencies in reporting are bound to become evident.

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- Outpatient care financials: Hospitals appear to have the capacity to provide more detailed financial data on outpatient hospital care. The HCAI reporting which was initiated decades ago does not collect this information, but it could, and it should.
- Outpatient care service mix or case mix: The mix of services or care provided in the outpatient setting is very different than for inpatient care—and the mix of patients is similarly different, with a much broader range of acuity than those requiring inpatient care. Again, we point to Medicare as a possible source for service mix or case mix measures.
- Third party payer: According to the data manual and glossary, this category includes a variety of payers, including workers compensation, fixed indemnity, California Children Services, and other minor payers as well as commercial health insurance. It would be a useful improvement to update this data category to separate out commercial health insurance (paid by health care service plans, health insurers, and third-party administrators or administrative service organizations on behalf of self-insured health plans) from other types of third-party payers. We estimate that about 90% of all third-party discharges are commercial insurance: the remaining 10% is creating statistical noise and may disproportionately affect certain types of hospitals[3]. Doing that would eliminate some of the data noise in this category and more closely align with the OHCA mission.

There may be other data problems of which we are not aware at this point in the work.

As with other areas of OHCA work, we raise these concerns not to impede that work but to point to additional improvements that are needed as OHCA and HCAI move forward. Health Access supported cost growth targets and supports lower cost growth targets for "high cost" outliers based on currently available data while pushing for improving and updating data.

Summary:

- Health Access supports moving ahead to set lower cost growth targets for high-cost outlier hospitals by the deadline of June 1, 2025, for the 2026 target year.
- Health Access supports Option 4 to define all hospitals as a sector and then to determine lower cost growth targets for specific hospitals as consistent with both the letter and the intent of the law.
- Health Access opposes most exclusions or exemptions of hospitals for consideration as high-cost outliers with very limited exceptions.
- Health Access supports measures of high-cost outlier hospitals that separate commercial health insurance from Medicare and Medi-Cal, consistent with earlier decisions to review target performance for each major market segment as well as comparisons of the cost of services covered by commercial coverage to Medicare.

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- Health Access recommends consideration of the financial performance of health systems because of the risk of gaming target performance at the individual facility level.
- Health Access offers recommendations on improvements to current HCAI data reporting while urging action on high-cost outliers for the 2026 performance year.

We look forward to continued discussions with the Board and staff.

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Interim Executive Director

CC: Health Care Affordability Board
Corrin Buchanan, Acting Deputy Secretary, Program and Fiscal Affairs, California Health and Human Services Agency
Darci Delgado, PsyD, Assistant Secretary, California Health and Human Services Agency
Mary Watanabe, Director, Department of Managed Health Care
Josephine Figueroa, Deputy Commissioner, Department of Insurance
Richard Figueroa, Assistant Cabinet Secretary, Governor's Office
Assemblymember Robert Rivas, Speaker of the Assembly, Attn: Roz Pulmano
Senator Mike McGuire, President Pro Tempore, Attn: Margie Swartz
Scott Wiener, Chair, Senate Budget Committee, Attn: Scott Ogus
Jesse Gabriel, Chair, Assembly Budget Committee, Attn: Patrick Le
Caroline Menjivar, Chair, Senate Health Committee, Teri Boughton, Consultant
Mia Bonta, Chair, Assembly Health Committee, Riana King, Consultant

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Attachment #17

San Diego Regional Chamber

402 West Broadway, Suite 1000
San Diego, CA 92101-3585
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January 24, 2025

Kim Johnson
Chair, Health Care Affordability Board
Secretary, California Health and Human Services Agency
2020 W El Camino Avenue
Suite 1200
Sacramento, CA 95833

Subject: Concerns with Creation of Hospital Sector Spending Target

Dear Secretary Johnson,

On behalf of the San Diego Regional Chamber of Commerce (Chamber), I am writing to express our concerns with the Office of Health Care Affordability's (OHCA) proposed hospital-sector spending target. Improved healthcare affordability is a laudable goal that our members support, but unfortunately OHCA's consideration of this spending target is premature. Establishing a hospital-sector target at this time, without proper industrywide spending analysis and without a defined method for measuring hospital spending, may negatively impact access to care for residents and workers in the San Diego region and throughout California. We encourage the Health Care Affordability Board to delay consideration of this spending target until further research and analysis can be conducted.

OHCA should not move forward with a hospital-sector spending target without finalizing a concrete method for actually measuring hospital spending. OHCA is required under law to use historical cost data and establish a tailored methodology for calculating past spending and informing future spending targets. Without this method being established, hospitals will not know how to comply with any new spending target. Furthermore, OHCA and the Health Care Affordability Board must take into consideration the cost pressures that are unique to our state's hospital systems. Hospitals face a number of state requirements and mandates that are different from other sectors of the health care industry, and any method for calculating a spending target must take these cost pressures into consideration.

As the largest local Chamber on the west coast, we represent approximately 2,200 regional businesses and 300,000 employees. Our region's employees count on access to reliable care from hospital systems, both in the hospital and in outpatient settings. Establishment of a hospital-specific spending target may imperil health care access that is critical for San Diegans. An arbitrary target that does not consider the many costs involved in the provision of care may force our region's hospitals to curtail certain services. Additionally, we ask you to bear in mind that the vast majority of California's hospitals are non-profit entities simply trying to keep their doors open—a task that is becoming more difficult in California as we have witnessed the closures of several

hospitals in recent years, including Madera Community Hospital. Lowering health care spending cannot be achieved successfully by ignoring the complex economic realities faced by our region's hospitals.

We appreciate your understanding of our concerns and look forward to continuing dialogue and collaboration on improving healthcare affordability and access in our state. If you have any questions, please contact Evan Strawn, Policy Advisor (estrawn@sdchamber.org).

Sincerely,

Jessica Anderson
Interim President & CEO
San Diego Regional Chamber of Commerce