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

Health Care Affordability Board
February 25, 2025
Public Comment

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

Date Received	Name	Written Comment
2/24/2025	Silicon Valley Leadership Group	See Attachment #1.
2/26/2025	Priya DeGani	Please, please do all that you can to lower the outrageous health care charges at Montage Chomp Health Care. (I am unfamiliar with SVH.) After a local newspaper ran an article last year on the burdensome, high cost of health care at Montage Chomp and SVH and Natividad, the very next week Montage Chomp—in pushing back, self-defense, it seems-- ran a full page ad in the paper proclaiming, boasting something to the effect of "We recently gave $19 million to . . . " some local philanthropic organization. As if that makes it OK to bankrupt and ruin patients' lives with their astronomical charges. It is a selfish, bizarre reasoning that Montage Chomp seems to hold, that having a hospital that looks like a beautiful spa/art gallery, and that makes grand public gestures of their exorbitant donations-- and at the same time-- that that somehow legitimizes their usurious charges-- and collections-- to poor and average patients, often bankrupting and ruining their lives. Montage also gives themselves very generous salaries. Residents in Monterey County cannot do this without your intervention and help. Please help bring equity, fairness and social justice to this crisis in healthcare.
2/28/2025	Lisa Mazelli	I just finished watching KSBW regarding the Monterey Bay area. I was a 38-year veteran with Kaiser Permanente. I started working in the Sand

Date Received	Name	Written Comment
		City 4 years ago. For the last 3 years I've gone to montage medical, chomp, Salinas valley medical and doctors on duty. I have never paid so much for health insurance, office visits or procedures. One example. I had a simple blood test done at montage medical (the marina ca location) the cost was $1,030. The same blood test would have been$10 at Kaiser Permanente. I fell and hit my head. I called montage medical for advice. I received little to know information or guidance (other than go to the emergency room or call 911) from the woman that answered the phone. She said she could send a message to my doctor. She explained he would get back to me within 48 hours. My general practitioner called me 7 to 9 days later. I do not believe the above hospitals located in Salinas and Monterey are concerned about their patients. I believe they are concerned more about the money then my well-being. I am ecstatic that Kaiser Permanente is now in Salinas and Monterey. They are a company filled with highly qualified doctors and nurses and specialists. Kaiser is concerned about their patients well-being. Montage, chomp, Salinas valley and doctors on duty could learn a lot. Honestly I think it's a matter of time before Kaiser Permanente has a large hospital in Salinas and Monterey. I appreciate you taking the time to read this email.
3/10/2025	Salinas Valley Health	See Attachment #2.
3/10/2025	Monterey Bay Teacher's Association	See Attachment #3.
3/17/2025	Marshall Medical	See Attachment #4.
3/17/2025	Bay Area Council	See Attachment #5.
3/17/2025	Montage Health	See Attachment #6.
3/20/2025	Valley Children's HealthCare	See Attachment #7.
3/20/2025	Health Access of California	See Attachment #8.
3/20/205	Dignity Health	See Attachment #9.

Date Received	Name	Written Comment
3/20/2025	Barton Health	See Attachment #10.
3/20/2025	California Hospital Association	See Attachment #11.
3/21/2025	Washington Health	See Attachment #12.

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SILICON VALLEY LEADERSHIP GROUP

"The leading business association of the innovation economy and its ecosystem."

OFFICE OF THE CEO

February 21, 2025

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

Subject: Recontextualizing High-Cost Hospitals in the Bay Area — And Reconsidering 1.7% Cost Growth Targets

Dear Chair Johnson,

The Silicon Valley Leadership Group (SVLG) and its members strongly support efforts to improve the affordability of health care while ensuring continued access to high-quality care. SVLG represents hundreds of Silicon Valley's largest employers, spanning diverse industries that power the innovation economy. While the majority of our members are technology companies—ranging from software and consumer devices to nanotechnology, semiconductors, and cleantech—our membership also includes businesses in financial and professional services, healthcare, higher education, nonprofits, and more. Our members include companies of all sizes, from high-growth startups to some of the world's most recognized brands. Given this broad representation, SVLG has a deep understanding of the economic and operational challenges that impact employers, employees, and healthcare providers alike and is committed to collaborating with OHCA to advance the goal of healthcare affordability without compromising quality or access.

We are deeply concerned that the Office of Health Care Affordability's (OHCA) proposed cost growth target of 1.7% presents challenges in accounting for the market conditions of providing health care in California—particularly in the Bay Area, where labor costs and other structural expenses tend to be higher than in other regions. SVLG encourages the OHCA Board to take a data-driven, sustainable approach that reflects these regional cost differences while supporting the long-term stability of the healthcare system. As currently outlined, aspects of OHCA's approach—including its designations of *high-cost hospitals* and differentiated cost growth targets—could have unintended consequences that impact access to care. Our membership has raised the following key concerns:

Reconsidering OHCA's Approach to Identifying *High-Cost Hospitals*

SVLG recognizes OHCA's commitment to improving healthcare affordability but believes the current methodology for identifying *high-cost hospitals* could benefit from further refinement. At the December 18th OHCA board meeting, staff and board members acknowledged inconsistencies in the data, underscoring the need for a more transparent and regionally responsive approach. Key metrics used to determine designations—such as inpatient revenue per discharge, operating margins, and third-party-to-Medicare cost ratios—often yield conflicting results, inadvertently categorizing hospitals in high-cost regions as inefficient. However, these designations do not fully account for structural economic factors like higher wages, real estate costs, and compliance with state-mandated regulations that drive expenses. With a slight modification in methodology, OHCA can better account for the regional challenges hospitals face and avoid imposing undue financial strain on institutions already under significant pressure.

Aligning Cost Growth Targets with Regional Economic Factors

While SVLG supports efforts to make healthcare more affordable, accessible, and equitable for patients, the proposed 1.7% cost growth target presents significant challenges, particularly for hospitals in the Bay Area, where economic pressures are among the highest in the nation. The recently published *high-cost hospital* list disproportionately affects Bay Area institutions—not due to inefficiencies, but because of unavoidable regional economic factors listed above and a rising demand for specialized care. Recent research from PwC indicates commercial healthcare spending nationwide is growing by over 7% year-over-year, making a 1.7% cap challenging to achieve without unintended consequences, which will inevitably be felt by patients and providers alike.

For SVLG's healthcare members, meeting the proposed 1.7% target could mean:

- **Reevaluating planned service expansions and community health investments** due to the high costs of necessary technology and real estate both essential for delivering quality healthcare.
- **Disruptions or reductions in service lines,** including those already facing financial challenges, such as behavioral health, geriatrics, and certain community health programs.
- **Challenges in meeting California's 2030 hospital seismic retrofitting requirements** due to financial constraints.

Representing hundreds of companies in the broader Silicon Valley region, SVLG opposes cost-growth targets that will disproportionately impact hospitals, healthcare providers, and, ultimately, patients. We urge OHCA to take a localized, flexible approach that considers regional economic factors. We propose that OHCA:

- **Reevaluate the methodology for identifying *high-cost hospitals*** by incorporating a broader set of financial and operational metrics that capture the economic landscape of different regions more accurately.

- **Pause implementation of cost-growth targets**, especially those under *high-cost* designations, until the development of a comprehensive methodology that recontextualizes operating in high-cost regions.
- **Engage with industry experts and legislators** to better understand the long-term impacts of cost-growth targets and their potential impact.

Beyond the immediate impact on hospitals, imposing rigid cost-growth targets sets a precedent for other commercial sectors that may bring unintended consequences. While healthcare may be the first to face these restrictions, other industries—such as pharmaceuticals, information technology, manufacturing, and professional services—could soon be subjected to constraints that impede California's economic competitiveness and consumer choice. A more flexible, data-driven approach is needed to support both the healthcare industry's long-term health and our communities' well-being, ensuring that affordability measures do not compromise quality or access to care.

SVLG remains dedicated to working with OHCA to achieve these goals and develop solutions that balance economic realities with the need for high-quality, accessible healthcare.

Sincerely,

Ahmad Thomas
CEO, Silicon Valley Leadership Group

Salinas Valley HEALTH

February 21, 2025

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

Subject: Appreciation for Discussion and Further Concerns on Hospital Sector and Targets

Dear OHCA Board Members,

We want to express our appreciation for the recent opportunity to engage in a discussion with OHCA leadership and Secretary Johnson.

During our meeting, we presented clear and transparent information to support the following key points:

- **Salinas Valley Health is a healthcare system, not just a hospital.** A system-level approach to evaluating our audited financial data is essential to accurately understand our operational dynamics and the value we provide to the community.
- **We should not be considered an "outlier."** As demonstrated, Salinas Valley Health delivers exceptional, high-quality care to all, with reasonable consolidated system margins that enable us to sustain our community-based health mission.
- **Imminent federal policy changes could have a severe impact on already uncertain and underfunded state and federal reimbursement models.** We strongly urge OHCA to assess the implications of these shifts before imposing additional spending targets on specific hospitals, particularly those with high Medi-Cal payer mixes.

Salinas Valley Health has provided OHCA with strong evidence of our current position and our ongoing, measurable efforts to improve healthcare affordability. The stakes are high—for our organization and, most importantly, for the community we serve. Acting hastily with an imperfect process could have devastating consequences, affecting our workforce, the government-insured patient population, and the scope of quality services we provide.

We urge OHCA to prioritize accuracy over expediency and to carefully consider the short- and long-term consequences of any actions taken. We remain committed to collaborating on solutions that reflect the realities of healthcare delivery.

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, PhD
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom

OHCA Board,

324 people have signed a petition on Action Network telling you to Letter to the Board of OHCA.

Here is the petition they signed:

> Dear Dr. David M. Carlisle, Dr. Sandra Hernandez, Kim Johnson, Dr. Richard Kronick, Ian Lewis, Elizabeth Mitchell, Dr. Donald B. Moulds, and Dr. Richard Pan,
>
> We the educators of the Monterey Bay Teachers Association wish to thank you for the time and dedication you have given to addressing the exorbitant Healthcare costs in California and especially in Monterey. We are growing accustomed to hearing shameful stories of our local system - stories of members in medical emergencies, arguing with their spouse about whether they can afford to seek help, stories of our friends unable to follow their physician's recommendations because, even for veteran educators in our system, affordable healthcare remains out of reach. In response to these unconscionable costs, our local hospital seems to have spent significant money on hiring a PR firm as we have seen numerous ads selling us the story that they are "here for our community," but actions speak louder than words.
>
> As you know, MCSIG (our local JPA) has recently gone into debt because of our local hospitals' exorbitant prices and as a result, they sent invoices to our local school districts. Monterey Peninsula alone is forced to pay them $800,000. This was on top of a 12% benefits increase from MCSIG this year. For reference, a 1% raise for educators in our district costs about $600,000. While our local hospital is continuing to build additional structures in the area, they are taking money directly from our pockets in more ways than one. This year we are making less than we were last year, and we lay much of the blame for that at the feet of our local hospitals.
>
> Your work has brought us hope, but these prices have been impossibly high for far too long and as they continue to rise we fear for the future for our colleagues, our students and our community. The work you are doing is far from easy and your goal to respond thoroughly means a great deal to us. However, we also urge you to act as expediently as possible to stem the rising tide of healthcare costs that threaten our community's wellbeing.
>
> Thank you again. We are cheering you on from the Monterey Peninsula.

You can view each petition signer and the comments they left you below.

Thank you,

Monterey Bay Teachers Association

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1. NICOLA LONG (*ZIP code: 93933)*

2. MICHELLE FAATUAI (*ZIP code: 93955-5521)*

3. Phil Santora (*ZIP code: 93940)*

4. AMANDA MUNOZ (*ZIP code: 93933)*

5. DANIELLE CROUCH (*ZIP code: 93906)*

6. JOEL MUNOZ SALINAS (*ZIP code: 93907)*

7. CYNTHIA APUADA (*ZIP code: 93906-4906)*

8. CHRISTOPHER APUADA (*ZIP code: 93906)*

9. ALBERT PLATT (*ZIP code: 95350-5049)*

10. QUINN HOUCHIN FIFE (*ZIP code: 93901)*

11. MARIANNE HARTFELT (*ZIP code: 93940-4321)*

12. VANESA CANO (*ZIP code: 93907)*

13. MA SALVACION TACORDA (*ZIP code: 93933)*

14. NICOLE SPILLET (*ZIP code: 93953-2842)*

15. ANGELICA ESPINOLA ROMERO (*ZIP code: 93940)*
Angelica Espinola

16. DAVID COLLYER (*ZIP code: 93950)*

17. TAYLOR HIYAMA (*ZIP code: 93940-3726)*

18. SUSAN CASTELLO (*ZIP code: 93955)*

19. CHARLES SCORPINITI (*ZIP code: 93950)*

20. Rosalyn Book (*ZIP code: 93955)*

21. AYKUI DAMARYAN-NORDLOFF (*ZIP code: 93923)*

22. CARLY SCHAEFFER (*ZIP code: 93950)*

23. MIRANDA FINELL (*ZIP code: 93933)*

24. HEATHER JOHNSON (*ZIP code: 93955)*

25. MARIA DE LEON (*ZIP code: 93933-2902)*

26. KATHLEEN WELLER (*ZIP code: 93940)*

27. JENNA GONZALEZ (*ZIP code: 93926)*

28. EUGENIE ADAMS (*ZIP code: 93933-2733)*

29. MICHELLE SORENSEN (*ZIP code: 93933)*

30. MANUEL AGUILERA VICENCIO (*ZIP code: 93940-3635)*
Manuel Aguilera Vicencio

31. DEANNA BASSO (*ZIP code: 93955-6907)*

32. LAUREN GRANT (*ZIP code: 95003-3201)*

33. Jason Ahmadi (*ZIP code: 93955)*

34. DAVID CHANDLER (*ZIP code: 93924)*

35. MALISSA BURNS (*ZIP code: 95076-8714)*

36. BROOKS FRYBARGER (*ZIP code: 93907)*

37. CAITLIN ALERU (*ZIP code: 93933)*

38. KRISTINA NOLAN (*ZIP code: 93933)*

39. SAMANTHA SCHUPP (*ZIP code: 93940-1584)*

40. STEPHANIE BEMBOOM (*ZIP code: 95076-9303)*

41. ELIZABETH RAGO (*ZIP code: 93940-2165)*

42. CLAIRE GODWIN (*ZIP code: 93933)*

43. NOLAN MUNGER (*ZIP code: 93908)*

44. MARIA CARNEY (*ZIP code: 93905-2265)*

45. TINA NGUYEN (*ZIP code: 93933)*

46. Torrey Barlow (*ZIP code: 93950)*

47. ADAM HIGGINS (*ZIP code: 93933)*

48. JESSICA HERNANDEZ (*ZIP code: 93940)*

49. LAURENCE STONE (*ZIP code: 93950)*

50. AISLINN MCELDERRY (*ZIP code: 93950)*

51. CHRISTOPHER BUSCH (*ZIP code: 95348)*

52. NICOLE SMITH (*ZIP code: 93940-6114)*

53. CHRISTINE MELLO (*ZIP code: 93933)*

54. OLIVIA CAIN (*ZIP code: 93950)*

55. GRETA HUANG (*ZIP code: 93933)*

56. MATTHEW HOLMES (*ZIP code: 93933-5116)*

57. MARTHA HENRY (*ZIP code: 93955-4510)*

58. JOHN JENKINS (*ZIP code: 93950-3209)*

59. RYAN OLSON (*ZIP code: 93901)*

60. JORDAN UNFRIED (*ZIP code: 93933-5003)*
I do not even take the insurance in my district, because my spouse has much better insurance, but I'm tired of friends moving away and not continuing to work in our area because they can't afford basic insurance for their family. This is incredibly insulting and has to be changed.

61. LARISSA SISON (*ZIP code: 93955-3304)*

62. RUCHELLE ALEJO (*ZIP code: 93933)*

63. ALEJANDRINA POOLE (*ZIP code: 93940-3344)*

64. JESSICA RAMIREZ-ESPINOLA (*ZIP code: 93940)*

65. VICTORIA CHIN (*ZIP code: 93955)*

66. LYNDSAY PINA (*ZIP code: 93933)*

67. OLIVIA CASTRO (*ZIP code: 93950-5371)*

68. ASTRID RODRIGUEZ (*ZIP code: 93933)*

69. AMANDA SHARPSHAIR (*ZIP code: 93933-4968)*

70. LISA CAHN (*ZIP code: 95003-2902)*

71. DEBBIE SANDWEISS (*ZIP code: 93940-4224)*

72. HILLARY FAWCETT (*ZIP code: 93955)*

73. ANDREA BALESTRIERI (*ZIP code: 93933)*
Andrea Balestrieri

74. REBECCA HUBICK (*ZIP code: 93940-1563)*

75. ALYSSA BENEDETTI (*ZIP code: 93933-5010)*

76. HOLLY MCKRILL (*ZIP code: 93907-1038)*

77. SELENE OGDEN (*ZIP code: 93924)*

78. SABRINA ALIOTTI (*ZIP code: 93955-5906)*

79. CHASE SCHILLING (*ZIP code: 93955)*

80. CHRISTIAN SOUSA (*ZIP code: 93940)*

81. ELIZABETH CAMBRA (*ZIP code: 93940-4323)*
Liz Cambra

82. TINA RENZULLO (*ZIP code: 93907)*

83. ANGELICA DIAZ-ROMAN (*ZIP code: 93933-2510)*

84. JULIE HAWS (*ZIP code: 93933-5033)*
Julie Hawz

85. LAUREL CRAFTON (*ZIP code: 93940)*

86. DARCY CHOWN (*ZIP code: 93933)*

87. MICHELLE PIERCE (*ZIP code: 93923-8383)*

88. DANIELLE BOUCHER (*ZIP code: 93933)*

89. JENIFER ALEXANDER (*ZIP code: 93940-2376)*

90. ADRIANA VARGAS SANDOVAL (*ZIP code: 93955-5516)*

91. JACQUELINE LAUTZENHISER (*ZIP code: 93924)*

92. Kimberlt Jimenez (*ZIP code: 93940)*

93. Christina McGovern (*ZIP code: 93940)*

94. SHERRY DE LEUW (*ZIP code: 93940-2540)*

95. ALLISON PREECE (*ZIP code: 93908-1584)*

96. SEAN PONSI (*ZIP code: 93901)*

97. JULIUS SONGCUAN (*ZIP code: 93933)*

98. KIMBERLEY PEAKE (*ZIP code: 93940)*

99. AARON BEECHER (*ZIP code: 93955-4112)*

100. GARY CANNON (*ZIP code: 93955)*

101. ALYSSA BURKE (*ZIP code: 93926)*

102. CHEYENNE MELVILLE (*ZIP code: 93950)*

103. DEBRA VIVOLO (*ZIP code: 93923-8838)*

104. MARY KLOTZ (*ZIP code: 93955-5374)*

105. JASON NICHOLSON (*ZIP code: 95004-9509)*

106. PHILIP SANTORA (*ZIP code: 93940)*

107. JOSEPH FINNEGAN (*ZIP code: 93955)*

108. MIA ESPARZA (*ZIP code: 93940)*

109. ANDREA MALDONADO (*ZIP code: 93933-3064)*

110. BRETT HOWARD (*ZIP code: 93940)*

111. WHITNEY THOMPSON-TOZIER (*ZIP code: 93955)*
Whitney Thompson

112. JENNIFER SHAYANI (*ZIP code: 93933)*

113. ARDEN CECILIA IBALLAR (*ZIP code: 93933)*

114. Desiree Albert (*ZIP code: 93940)*

115. SHEILA FIERRO (*ZIP code: 93933)*

116. ASHLEY SIEMENSMA (*ZIP code: 93955)*

117. TIMOTHY DUNN (*ZIP code: 93955)*

118. ERIN COSTELLO (*ZIP code: 93906)*

119. MARISA BENHAM (*ZIP code: 93955)*

120. VERONICA STILLINGER (*ZIP code: 93950-5411)*

121. UZIEL DIAZ (*ZIP code: 93955-3947)*

122. Mary Riedl (*ZIP code: 93940)*

123. KRISTINA CHAMP (*ZIP code: 93955)*

124. SHARLENE LINNEVERS (*ZIP code: 93923-8201)*

125. MICHELE FRIEDMAN (*ZIP code: 93940)*

126. EMILY ANDERSON (*ZIP code: 95039)*

127. JOYCE MATHERS (*ZIP code: 93933-3616)*

128. ARELA JANE TUMULAK (*ZIP code: 93955)*

129. ELEANOR MITCHELL (*ZIP code: 93940)*

130. DANIEL CUTLER (*ZIP code: 93940-5411)*

131. Shaina Volante (*ZIP code: 93933)*

132. KEIRA HORD (*ZIP code: 93933)*

133. BENJAMIN LAZARE (*ZIP code: 93950)*

134. Wendy McDonald (*ZIP code: 93933)*

135. GLENN DAVIS (*ZIP code: 95010)*

136. CHRIS FOWLER (*ZIP code: 93955)*

137. CHRISTOPHER CHOPYK (*ZIP code: 93940-3609)*

138. JENNIFER STRIEGEL (*ZIP code: 93940-4707)*

139. MOLLY MCNAMARA LEIN (*ZIP code: 93923)*

140. CYNTHIA HICKEY (*ZIP code: 93940-5601)*

141. SHALIMAR ENAJE (*ZIP code: 93933)*

142. MICHELLE HATCH (*ZIP code: 14150)*

143. ALICIA WELCH (*ZIP code: 93955-5242)*

144. TNAYA SCOTT (*ZIP code: 93955)*

145. Marissa Weseloh (*ZIP code: 95038)*

146. LEISA HIDAS (*ZIP code: 93940)*

147. Sandra Kohn (*ZIP code: 93940)*

148. Umeeta Dosange (*ZIP code: 93933)*

149. Emily Blythe (*ZIP code: 93955)*

150. Erik Ruggiero (*ZIP code: 93955)*

151. Emmich Flores (*ZIP code: 93933)*

152. KATHERINE BOERGER (*ZIP code: 93940)*

153. Catherine Rose (*ZIP code: 93933)*

154. Jordan Ataide (*ZIP code: 93908)*

155. Marybell Farber (*ZIP code: 93933)*

156. NICHOLAUS BOURGEOIS (*ZIP code: 93940-3353)*

157. KELLY CASE (*ZIP code: 93950-2765)*

158. Sydney Wallo (*ZIP code: 93933)*

159. Jaimie Adamson (*ZIP code: 93940)*

160. JACQUELINE SPEIDEL (*ZIP code: 95120)*

161. ERIN TAYLOR (*ZIP code: 93933)*

162. JAMEE LYNCH-MOORE (*ZIP code: 93933)*

163. RIKEE ROSS (*ZIP code: 93955)*

164. Angeline Epia (*ZIP code: 93933)*

165. Sean McCray (*ZIP code: 93950)*

166. Kelsey Nelson (*ZIP code: 93933)*

167. Aylin Lopez (*ZIP code: 93955)*

168. Geri Wood (*ZIP code: 93955)*

169. Kelly Yarborough (*ZIP code: 93907)*

170. HIROKO ZELLER (*ZIP code: 93955-4432)*

171. Sara Prather (*ZIP code: 93940)*

172. Marissa Cortez (*ZIP code: 93933)*

173. NATHAN SANTANA (*ZIP code: 93933)*

174. Makenna Johnson (*ZIP code: 93950)*

175. Crystal Nimmons (*ZIP code: 93955)*

176. Amanda Fay Sarmiento (*ZIP code: 93901)*

177. Hugo Cortez (*ZIP code: 93933)*

178. MARY CLEVELAND (*ZIP code: 93933)*

179. Becky Tarantino (*ZIP code: 93933)*

180. juan cisneros (*ZIP code: 93940)*

181. Wendi Everett (*ZIP code: 93940)*

182. Madelaine McSorley (*ZIP code: 93933)*
My family has had to seek medical treatment in Santa Cruz because it is more cost effective than our local hospital system in Monterey

183. Nora Zimmerman (*ZIP code: 93940)*

184. CLARISSA MILLER (*ZIP code: 93940)*

185. Anthony Klevan (*ZIP code: 93950)*

186. Brooke Wilson (*ZIP code: 93940)*

187. ANN-MARGARET MANYAK (*ZIP code: 93933)*

188. Julia Crocker (*ZIP code: 93933)*

189. Annie Sours (*ZIP code: 93950)*

190. Megan Coleman (*ZIP code: 93940)*

191. BRENDA VALLE (*ZIP code: 93933)*

192. Elizabeth Heff (*ZIP code: 93950)*

193. THERESA NICKELLS (*ZIP code: 93921)*

194. ANDREA GONZALES (*ZIP code: 95023-5861)*

195. TAMMY MOULTON (*ZIP code: 93955-2161)*

196. CLAIRE FUERST (*ZIP code: 93940)*

197. ANDREA YOUNG (*ZIP code: 93955)*

198. KRISTINE NIEBRES (*ZIP code: 93955)*

199. SYLVIA VASQUEZ (*ZIP code: 93906)*

200. SHARDONNAY MACIAS (*ZIP code: 93955)*

201. ALEXANDRA DUNN (*ZIP code: 93950-3444)*

202. TANYA BAESA-SEVILLANO (*ZIP code: 93933)*

203. KALYN LEE (*ZIP code: 95355-7856)*

204. MARTHA DIAZ (*ZIP code: 93955)*

205. SARAH LESTER GUZMAN (*ZIP code: 93933-2416)*

206. JENNIFER ORTIZ (*ZIP code: 93933-2141)*

207. Clarissa Murillo (*ZIP code: 93933)*

208. TRICIA RAYE PAGOD (*ZIP code: 93955-4106)*

209. VALERIE RIVERA (*ZIP code: 93942)*

210. Tracy Gordo (*ZIP code: 93940)*

211. ALYSSA HERNANDEZ (*ZIP code: 93906)*

212. Keri Cooper (*ZIP code: 93933)*

213. Roel Dayaganon (*ZIP code: 93933)*

214. Charles Fleming (*ZIP code: 95076)*

215. JASMIN HERNANDEZ (*ZIP code: 93906)*

216. AMANDA KENNEDY (*ZIP code: 93905-2284)*
Amanda Kennedy

217. Thalia Fernandez Herrera (*ZIP code: 93940)*

218. ELIZABETH DESIMONE (*ZIP code: 93940-5411)*

219. SARAH POSS (*ZIP code: 93933)*

220. Ryan Harber (*ZIP code: 93955)*

221. JASON NEVES (*ZIP code: 93940-6302)*
Jason Neves

222. Phaedra Lujano (*ZIP code: 93940)*

223. ADAM FRIEDMAN (*ZIP code: 93940-5620)*

224. SOLANGE NASCIMENTO (*ZIP code: 93955)*

225. DOUGLAS GOLDMAN (*ZIP code: 93955)*

226. CHRISTINA COCKERHAM (*ZIP code: 93933)*

227. JOSHUA CARR (*ZIP code: 93933-4986)*

228. Martha Garcia (*ZIP code: 93955)*

229. Brooke Di Paolo (*ZIP code: 93940)*

230. jasmine merritt (*ZIP code: 95003)*

231. Malia Rivard (*ZIP code: 93940)*

232. Amanda Nizza (*ZIP code: 93955)*

233. Sarah Poss (*ZIP code: 93933)*

234. NANCY ISHAK (*ZIP code: 93933)*

235. Jennifer Nix (*ZIP code: 93950)*

236. Diana Morales (*ZIP code: 93950)*

237. Kisha Ferguson (*ZIP code: 93933)*

238. Susan Morgan (*ZIP code: 93940-1606)*

239. Stacy Gnibus (*ZIP code: 93940)*

240. Maria Mateo (*ZIP code: 93905)*

241. Elizabeth Heff (*ZIP code: 93950)*

242. Theresa Flanders (*ZIP code: 93955)*
It is a tragedy when we lose talented educators to other geographic regions with a lower cost of living, especially lower medical costs. Thank you for continuing to advocate for fairness and affordability.

243. Natalie Constable (*ZIP code: 93955)*

244. chloe cloutier (*ZIP code: 93933)*

245. Heather Sims (*ZIP code: 93940-2319)*

246. Kayla Piorkowski (*ZIP code: 93940)*

247. Kylie Dunn (*ZIP code: 93940)*

248. Maria Troncoso (*ZIP code: 93933)*

249. Joanna Guzman (*ZIP code: 93924)*

250. Jazmin Moore (*ZIP code: 93933)*

251. KRISTINE TAYLOR (*ZIP code: 93953)*

252. April Nellist (*ZIP code: 93933)*

253. Meggan Irish (*ZIP code: 95065)*

254. Alyssa Abigail Dy (*ZIP code: 93933)*

255. Linda Torre (*ZIP code: 93940)*

256. Lyca Napilitan (*ZIP code: 93933)*

257. jocelyne hernandez (*ZIP code: 95076)*

258. Donna Silvestre (*ZIP code: 93906)*

259. Victoria Odige (*ZIP code: 93933)*

260. Kim Stone (*ZIP code: 93950)*

261. Anne Madden (*ZIP code: 93940)*

262. Melo Amador (*ZIP code: 93907)*

263. Marla Locklear (*ZIP code: 93953)*

264. Allie Morgan (*ZIP code: 93955)*

265. Abigail Lopez (*ZIP code: 93933)*

266. Emily Donelan (*ZIP code: 93923)*

267. Eva Butler (*ZIP code: 93906)*

268. Nicole Esteybar (*ZIP code: 93933)*

269. Carol Macias (*ZIP code: 93955)*

270. Laura Worsfold (*ZIP code: 93955)*

271. JEREMY HAYNES (*ZIP code: 93940)*

272. Ben Martinez (*ZIP code: 93907)*

273. REYNALD QUERIMIT (*ZIP code: 93906)*

274. MICHAEL ROYSTER (*ZIP code: 93955-6000)*

275. Brent Kranig (*ZIP code: 93950)*

276. Diana Almaraz (*ZIP code: 93940-3840)*

277. Juan Garcia (*ZIP code: 93906)*

278. ARACELI CANCHOLA (*ZIP code: 93908-1537)*

279. Ron Woods (*ZIP code: 93940)*

280. ELIZABETH MCLEOD (*ZIP code: 93950-2901)*

281. Thomas Gregory (*ZIP code: 93950)*

282. Caitlyn Cowardin (*ZIP code: 93950)*

283. Jessica Jones (*ZIP code: 93955)*

284. Romnick Caldosa (*ZIP code: 93933)*

285. WENDY HENDRICKS (*ZIP code: 93940)*

286. KOHLTON CASTRO (*ZIP code: 93940)*

287. Dru Milligan (*ZIP code: 93940)*

288. Diana Price (*ZIP code: 93955)*

289. BARBARA ARNOLD (*ZIP code: 93922-0372)*

290. christina donlon (*ZIP code: 93955)*

291. Kristin Laub (*ZIP code: 93924)*

292. ALEXIS ISAEFF (*ZIP code: 93933)*

293. Alexandra McGann (*ZIP code: 93940)*

294. Marilyn Burgess (*ZIP code: 95076-0200)*

295. Francisco Morazan Jimenez (*ZIP code: 93955)*

296. Alondra Puga (*ZIP code: 93905)*

297. Jillian Chopyk (*ZIP code: 93940)*

298. Brianna Garcia (*ZIP code: 93906)*

299. Mary Dailey (*ZIP code: 93940-4923)*

300. Mia Esparza (*ZIP code: 93960)*

301. Nicole Aboujaoude (*ZIP code: 93955)*

302. Jaime Quiros (*ZIP code: 93901)*

303. Mariana Valenzuela Lara (*ZIP code: 93901)*

304. KRISTEN SLAVICK (*ZIP code: 93940)*

MARSHALL

March 19, 2025

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

Subject: **Low Spending Growth Targets Undermine Patient Care**
(Submitted via email to Megan Brubaker)

Dear Chair Johnson,

Marshall is deeply concerned by the speed with which the Office of Health Care Affordability (OHCA) is considering hospital sector-specific spending growth targets. Without clarity around how OHCA's targets would be measured or enforced, we believe the proposed action is premature. Moreover, OHCA has not considered the impacts these targets could have on patient care, making unintended detrimental effects more likely.

We remain concerned that the current methodology is flawed and will create financial havoc for smaller hospitals with lower discharges. 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 requirements to "maintain quality and equitable care" and "minimize fragmentation and potential cost shifting and encourage cooperation in meeting statewide and geographic region targets."

We also urge you to reinstate the exclusion for low-discharge facilities in your methodology. We believe that including low-discharge hospitals on the list of high-cost facilities fails to recognize the obvious fact that fewer patients mean distributing all costs across a smaller denominator. Perhaps equally as important, smaller facilities like ours lack the negotiating power of the large systems – large hospital networks and systems can negotiate higher commercial reimbursement and reduced supply expenses while enjoying economies of scale that smaller facilities cannot achieve. It's difficult to imagine how a community hospital like Marshall, with only 0.18% of the total discharges in the state, could measurably impact healthcare costs statewide. For these reasons, we urge you to reinstate the low-discharge exclusion.

On behalf of the 150,000 residents of our community, Marshall urges you to take the additional time that your regulations allow 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 thoughtfully with a keen eye toward ensuring care is not diminished in the pursuit of lower costs.

Sincerely,

Siri Nelson (Mar 17, 2025 09:29 PDT)

Siri Nelson, CEO and President

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

Assemblyman Joe Patterson
Senator Marie Alvarado-Gil

Monday, March 17th, 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 Bay Area Council 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 long-standing priority of the Council — 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 shared success.

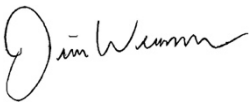
Before defining one or more hospital sectors, all stakeholders would benefit from a comprehensive analysis of spending across various segments of the health care industry, identification of areas in which spending growth is high, and a meaningful assessment of spending drivers to determine whether differences 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.

Lowering the target even further, without a clear understanding of how spending will be measured, means that our members would be forced to further reduce the care they provide. The Bay Area's unique and diverse set of hospitals provide everything from world-renowned specialty care to essential community services. The proposed target would prove unattainable, unsustainable, and unsupportive of efforts to improve the value of health care, not just lower its costs.

On behalf of our provider members and the patients they serve, the Bay Area Council 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,



Jim Wunderman
President & CEO
Bay Area Council

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 #6

MONTAGE Health

March 18, 2025

Kim Johnson
Chair, Office of Health Care Affordability
2020 W El Camoni Ave
Sacramento, CA 95833

Subject: Montage Health response to actions of the Office of Health Care Affordability
Submitted via email to ohca@hcai.ca.gov

Dear Secretary Johnson,

Montage Health continues to be deeply concerned about the speed with which the Office of Health Care Affordability (OHCA) is considering hospital sector-specific spending growth targets and the complete lack of clarity around how those targets would be measured or enforced. Moreover, OHCA has not considered the impacts these targets could have on patient care, likely decimating hospitals' ability to sustain vital patient services.

OHCA's approach to sector targets is both wildly premature and woefully inadequate, setting a dangerous precedent for future work.

Promoting health care affordability — 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. Similarly, any pricing controls need to be applied concurrently to prevent other industry stakeholders from profiting for isolated, premature price caps. Fragmenting the health care field so early in the process undermines 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 requirements to "maintain quality and equitable care" and "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 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.

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. A more oppressive and punitive cost cap applied to a select subset of so called "high-cost outlier hospitals" will impact several population health programs in Monterey County. We've analyzed the long-term impact of these draconian limits, and the impact to Community Hospital of the Monterey Peninsula (CHOMP) in 2029 will be greater than $80 million dollars. This will necessitate immediate, and continued reductions to programs and access to care. Should the OHCA board proceed with premature, arbitrary, and capricious cost caps, immediately impacted services will include several award-winning programs addressing obesity, diabetes, food insecurity, mental health, and the opioid epidemic. In addition, Montage Medical Group will hold off on hiring two new physicians in medical dermatology and primary care. Approximately 5,000 potential patient visits in critical disciplines will go unprovided due to these actions. Further, OHCA's rush to impose price caps will also result in a reduction of access to certain core services for our Medi-Cal patients. The damage to patient care resulting from these spending growth targets will only be further exacerbated by potential cuts to Medicaid and Medicare at the federal level, turning an extremely challenging situation into an impossible one.

OHCA's "engagement" with individual hospital leaders was an exercise in political theatre; our input and suggestions were ignored. When the leadership from HCAI and OHCA invited us to meet on February 18, 2025, to provide feedback on your proposed methodology, we advised you that the continued focus on hospital margins rather than systems margins is myopic and deeply problematic. This approach ignores both the need for hospitals to generate sustainable margins to support their communities, and the economic realities of an integrated healthcare system. We were told that it is "there is not existing database to measure" non-hospital, system-wide charges, charge ratios, or operating margins and that the only available data to HCAI is hospital cost reports. In other words, it is "too hard" for regulators to figure out how to incorporate system-level expenses and operating margins, so their impact on hospital charges will simply be ignored. When we discussed the shift of hospital generated revenue to fund critical clinical services operating outside of HCAI's archaic hospital cost reporting structure --- services like our 1204(a) community clinic --- it was suggested we "chose" to place our clinic services outside the hospital license. Nothing could be further from the truth. As a reminder, California statute has a bar on the corporate practice of medicine that prevents community hospitals from directly employing physicians. We would suggest that, just because something is "hard to do," doesn't mean it should not be pursued. Instead, OHCA appears to be sacrificing objectivity and rigorous analysis on the altar of political expedience and convenience. To make a point, Montage Health's 2024 system-wide net margin was 1.1 percent *after* utilizing $40 million in donated funds to subsidize our operations. Without the use of philanthropy, Montage Health finished with a negative operating margin in 2024; does that suggest a system in need of a more punitive cost cap?

Your leadership team solicited our input on the use of Commercial-to-Medicare Cost ratios and our input was completely ignored. We noted significant methodologic flaws with the use of commercial cost as a numerator and Medicare cost as a denominator. Our recommendation was a return to OHCA's original analysis utilizing Average Net Revenue per CMA analysis. This approach normalizes for materially significant regional variations in commercial payer mix. We noted that the use of Medicare payments as a benchmark is flawed. Using this a denominator fails to consider the wide variability in Medicare

payments among providers. Specifically, many hospitals, particularly AMCs, receive much higher Medicare reimbursement, thus lowering their Commercial-to-Medicare ratio.

During our meeting with OHCA, we asked whether there were any resources or energies focused on the State's largest commercial integrated delivery system. This system, of course, controls charges and revenues that dwarf, by an order of magnitude, the combined commercial charges of the 11 hospitals that OHCA have targeted. Unsurprisingly, we did not receive any response to that inquiry. Arbitrarily and capriciously selecting 11 is symbolic and will not bend the cost curve.

Lowering hospital charges does not guarantee that consumer/patients will realize any reduction in their premiums or out-of-pocket expenses. OHCA has not developed safeguards to ensure that savings generated would be passed on to consumers in the form of lower premiums and cost sharing, rather than retained by payers as higher profits. While growth in hospitals' patient care resources would be capped at around 1.7 percent growth, health insurance company premiums will be allowed to grow at twice that rate, further boosting insurers' profits.

OHCA's definition of a hospital sector is wholly premature, coming years before statutory deadlines and is absent of basic due diligence. On behalf of the patients we serve, Montage Health continues to urge you to consider the broader context and take additional time for analysis and discussion before finalizing sectors or corresponding targets.

Sincerely,

Steven Packer MD

Steven Packer, MD
President & CEO, Montage Health

cc: Members of the Health Care Affordability Board:
David Carlisle, MD, PhD
Sandra Hernandez, MD
Richard Kronick, PhD
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Richard Pan, MD, MPH
Elizabeth Landsberg, Director of Department of Healthcare 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

Valley Children's HEALTHCARE

March 20, 2025

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

Subject: Low Spending Growth Targets Undermine Patient Care

Dear Chair Johnson,

Valley Children's Healthcare is deeply concerned by the speed with which the Office of Health Care Affordability (OHCA) is considering hospital sector-specific spending growth targets. With an existing statewide target of 3.5% (dropping down to 3% by 2029), and complete lack of clarity around how that target would be measured or enforced, the proposed action is premature. Moreover, OHCA has not considered the impacts these targets could have on patient care, making detrimental effects all the more likely.

Promoting health care affordability — 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 undermines 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 requirements to "maintain quality and equitable care" and "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.

Office of the President
Valley Children's | HOSPITAL | MEDICAL GROUP | HOME CARE | FOUNDATION
9300 Valley Children's Place, Madera, CA 93636 • (559) 353-3000 • valleychildrens.org

Valley Children's continues to work hard to reduce hospital costs in anticipation of the inevitable reimbursement pressures caused by the 3.5% spending target for 2025 through a number of different measures including the following.

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

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

Patient care needs, economic trends, and the investments needed to comply with state mandates and move care from institutional settings and into the community increasingly reveal how difficult, if not impossible, meeting the statewide target will be.

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

With our current operating margin at breakeven, general inflation on the rise, and the uncertainties around future federal Medicaid funding, Valley Children's urges you to take additional time for analysis and discussion before finalizing sectors or corresponding targets. We remain deeply committed to achieving our shared goals of affordable, high-quality care — and we ask that the Office proceed with a keen eye toward ensuring care is not diminished in the pursuit of lower costs.

Sincerely,

Todd A. Suntrapak,
President & Chief Executive Officer

cc: Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
Dr. Sandra Hernández

Dr. Richard Kronick
Ian Lewis
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
State Senator Marie Alvarado-Gil
State Senator Anna Caballero
State Senator Shannon Grove
State Senator Melissa Hurtado
Assembly Member Juan Alanis
Assembly Member Joaquin Arambula
Assembly Member Jasmeet Bains
Assembly Member Stan Ellis
Assembly Member Heath Flora
Assembly Member Esmeralda Soria
Assembly Member David Tangipa

March 20, 2025

Kim Johnson, Chair
Health Care Affordability Board
Secretary of Health and Human Services

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability
Department of Health Care Access and Information
2020 W. El Camino
Sacramento, CA 95833

Re: Health Care Affordability Board meeting: March 25, 2025

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

Health Access California, the statewide health care consumer advocacy coalition committed to quality, equitable, affordable health care for all Californians offers comments prior to the Health Care Affordability Board meeting on March 25, 2025.

Health Access supports the lower cost growth targets for the eleven very high-cost hospitals, measured using the hospitals' own reporting of data for commercial coverage purchased by individual consumers and employers for workers and their dependents.

Consumer Perspective: Lack of Affordability=Lack of Access to Care Today

The current health care landscape in California, is one if which consumers lack access because of high health care costs, including very high hospital costs. Half of California consumers report skipping or delaying care—and half of them got worse as a result. At the August 2024 Health Care Affordability Board meeting, the Board heard dozens of consumers testify to the negative impacts of very high hospital costs in Monterey. Hospital care is the single most

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

common source of medical debt, despite the best efforts of Health Access and other consumer advocacy organizations in California and nationally to address medical debt.

Every dollar in the health care system comes out of the consumer's pocket:

- We pay for health care with lower wages and higher premiums, copays, deductibles and coinsurance as workers, dependents, and individual consumers.
- We pay for public programs like Medicare and Medi-Cal as taxpayers.
- Every dollar, every dime in health care starts with the consumer.

Saying that a consumer will meet their deductible during a hospital stay ignores the impact of hospital costs on premiums, including the share of premium paid by working families for coverage. California now ranks among the highest cost states in terms of share of premium and cost sharing for family coverage provided through employment[1].

It is our money, and we can't afford to go to the doctor, pick up the prescription, get the lab test we know we need or even when we need to, go to the emergency room because of nonavoidable care, care that can only be appropriately provided in an emergency room. The proposal before the Commission takes seriously these issues of consumer affordability and access and takes meaningful steps to rein in high costs.

Why Hospitals? It's Where the Money Is.

Four out of ten dollars spent on commercial coverage is spent on hospital care. It is the single biggest cost covered by premiums and cost sharing. No other category of spending comes close: not physician services, not prescription drugs, not health plan profits and overhead. Health plans and insurers are paid administrative costs and profits as a percentage of the claims paid to hospitals, physician services, prescription drugs, labs and imaging. If the Board can lower hospital cost growth, then it will slow health plan cost growth as well as making progress toward slowing the growth of consumer costs for premiums and cost sharing.

All Hospitals as a Sector

[1] https://www.commonwealthfund.org/blog/2025/how-affordable-job-based-health-coverage-workers

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Health Access supported the proposed emergency regulation to define all hospitals as a sector. Such a definition makes policy sense and is well within the statutory discretion awarded to the Office and the Board under the existing law.

Very High-Cost Hospitals

Health Access supports lower cost growth targets for the eleven very high-cost hospitals, a small fraction of the 439 California hospitals. Setting a statewide cost growth target for all health plans, all physician organizations, and all hospitals was an important step forward in the overall effort to control the growth in health care costs. This proposal is an important step forward in reducing health care costs that are excessively high compared to the average of similar entities. We support this proposal as we look forward to future work to further reduce health care costs.

What is a very high-cost hospital? It is a hospital that:

- Gets paid twice as much per risk-adjusted discharge as the average California hospital by commercial insurance[2].
- Gets paid a much higher proportion of costs for both inpatient and outpatient care by commercial insurance sold to individual consumers and employers for workers and their dependents when compared to Medicare[3].
- Meets both of these very high-cost criteria three years out of the last five years[4].

These thresholds apply to hospitals that have both at least 5% commercial revenue and 5% Medicare revenue. Applying this screen assures that both of the measures relying on commercial payments and Medicare are statistically credible. This screen removes 33 hospitals, fewer than 10% of the 439 California hospitals. We look forward to the inclusion of Kaiser hospitals in future analysis in a few years when there is five years of data on individual Kaiser hospitals.

[2] https://hcai.ca.gov/wp-content/uploads/2025/02/OHCA-Recommendations-to-Board-Proposed-Hospital-Sector-and-Target-2.pdf
[3] https://hcai.ca.gov/wp-content/uploads/2025/02/OHCA-Recommendations-to-Board-Proposed-Hospital-Sector-and-Target-2.pdf
[4] https://hcai.ca.gov/wp-content/uploads/2025/02/OHCA-Recommendations-to-Board-Proposed-Hospital-Sector-and-Target-2.pdf

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

Hospital Financial Data and Measures Developed for Cost Containment Purposes: It's the Data Each Hospital Submits.

All of the data proposed to be used by OHCA for measuring very high-cost hospitals come from the financial data filed by hospitals with HCAI. Each hospital submits this data: we operate on the assumption that each hospital stands by the data they submitted. Using this hospital-reported data to analyze hospital costs and inform sector-based targets is consistent with the aim of OHCA and HCAI more broadly.

The reason this data began to be collected fifty (50) years ago by the Department of Health Care Access and Information and its predecessor, the Office of Statewide Health Planning and Development, was precisely to control health care costs. The original purpose of OSHPD was to do health planning as part of a major reform effort in California and nationally to control health care costs. This reform effort led to the creation of the California Medical Assistance Commission which regulated hospital costs here as other agencies did in other states across the country.

Don't Delay. Californians Need Help Now.

Many or most of the hospitals on this list have been known as high-cost hospitals for decades. Health Access urges the Board to adopt lower cost growth targets for this small handful of very high-cost hospitals both to address these high-cost outliers and to send a message to all hospitals that the Board takes seriously its role of addressing health care affordability. Those who counsel delay are those who profit from the existing system, not those consumers who suffer as a result of high health care costs. Consumers want change.

Conclusion

Health Access looks forward to the Board using the statutory flexibility granted to it by the Legislature and the Governor to move forward to set lower cost growth targets for that subset of health care entities which are the very high-cost hospitals.

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

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Interim Executive Director

CC: Members of the Health Care Affordability Board
Richard Figueroa, Deputy Cabinet Secretary, Office of the Governor
Robert Rivas, Speaker, California Assembly, Attn.: Rosielyn Pulmano
Mike McGuire, President Pro Tempore, California State Senate, Attn.: Marjorie Swartz
Assemblymember Mia Bonta, Chair, Assembly Health Committee, Attn.: Lisa Murawski
Senator Caroline Menjivar, Chair, Senate Health Committee, Attn.: Teri Boughton
Paula Villescaz
Darci
Kim Chen

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

March 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,

On behalf of Dignity Health and the 29 hospitals we operate across California, we appreciate the opportunity to provide comments regarding OHCA's consideration of sector-specific spending targets and the methodology for determining a high-cost hospital list. We are deeply concerned about the speed of this process and urge the Office to take additional time for analysis and discussion before finalizing sectors or corresponding targets.

Patients' access to care is at stake across California. Dignity Health remains committed to achieving our shared goals of affordable, high-quality care, and we ask that OHCA proceed with a keen eye toward ensuring that care is not diminished in a hasty pursuit. Establishing a hospital sector-specific spending target first and identifying high-cost hospitals without a comprehensive analysis, including ignoring uncontrollable cost factors, risks destabilizing hospitals and reducing access to essential services.

Key Concerns and Considerations

1. Government Reimbursement and the Financial Realities of Hospital Operations

Dignity Health is the largest Medi-Cal provider in California, with approximately 75% of our patients relying on Medi-Cal or Medicare for coverage. Yet government reimbursement rates under these programs fall far short of covering actual costs, resulting in a financial loss of over $245 million for Dignity Health in the last fiscal year alone.

By focusing primarily on commercial payer revenue caps, OHCA is missing the bigger picture. Commercial rates have necessarily increased to offset government underpayment, a reality that must be acknowledged in any fair and effective cost containment strategy. Additionally:

- Medicare and Medi-Cal payments do not reflect rising operational costs: The pandemic, healthcare staffing shortages, and supply chain disruptions have driven costs significantly higher, particularly for salaries, wages, and benefits – and far above the overall target of 3.5% let alone the High Cost Hospital target of 1.8%.
- Hospital cost structures extend beyond direct patient care: Many hospitals, including Dignity Health, support services outside of their direct financial submissions, such as physician support and Integrated Delivery Networks, which help ensure patients receive coordinated care. These

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unbillable services not reflected in the charges submitted in the annual data. OHCA must revie

methodology, the data sources, and the underlying assumptions before finalizing spending targ

Sincerely,

Kelly Ash

cc: Members of the Health Care Affordability Board:

financial losses and impact commercial contract rates.

access to care.

careful management of discretionary spending, payer and supplier contracts, and service delivery. However, lowering the target further for certain hospitals—without a clear understanding of how spending will be measured—would force us to reduce the care we provide. While it is difficult to predict exactly which services would be impacted, it is clear that further constraints would negatively affect our ability to maintain or expand services for California's most vulnerable populations.

other stakeholders to achieve sustainable cost containment strategies. However, imposing spending targets without addressing the real cost drivers will only undermine hospitals' ability to provide high-quality care. We urge OHCA to take additional time for analysis and stakeholder engagement before finalizing any sector-specific targets or high-cost hospital determinations.

Vishaal Pegany, Deputy Director, Office of Health Care Affordability

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

March 19, 2025

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

Subject: **Barton Health Response to OHCA's Low Spending Targets**
(Submitted via email to Megan Brubaker)

Dear Chair Johnson,

Barton was made aware of our inclusion on the high-cost hospital list days before the February OHCA board meeting. We attended this meeting to learn more and to express our concerns about moving forward with OHCA's recommendations for spending growth limits. We appreciated the opportunity to meet with OHCA staff a couple of weeks ago to further discuss our concerns and will continue these discussions.

We are writing this letter today as the Executive Team of Barton Health, also known as Barton Memorial Hospital (Barton), to provide further information and reasons why acting on these spending growth limits will be harmful to Barton and to rural and small hospitals.

Barton is unique

OHCA has recommended excluding certain non-comparable hospitals from the high-cost hospital analysis. The exclusions included Kaiser and other hospital types. Like the other excluded hospitals, Barton is also unique and does not fit within a comparable group.

Our hospital is highly seasonal and depends on tourism. For example, during 2018 through 2022, 44% of our hospital revenue was derived from patients that live outside of our California primary service area. Due to variables such as snow, wildfires and the economy, the service demand of our hospital can be unpredictable so we must manage our revenue to cover our fixed costs. Dry winters attract less visitors whereas extra heavy winters (such as 2023) close the ski resorts and access to our community which results in losses. Having to account for these uncertain and unpredictable variables makes Barton unique when compared to other hospitals on the high-cost hospital analysis.

It is also important to note that Barton's primary service area located on the south shore of Lake Tahoe includes Nevada. In addition, Barton owns 50% of a critical access hospital located in Gardnerville, Nevada. This is another feature that makes Barton unique.

Additionally, Barton operates an attached 48-bed DP-SNF facility. Our main acute care hospital provides essential support services to the SNF facility. Both facilities are connected and utilize shared departments. Our SNF facility operates at capacity and exceeds our acute-care hospital census every day.

Although Barton is licensed as a 63-bed hospital, our census is more similar to a critical access hospital. During 2018-2022, our annual average daily census was less than 18. We explored converting to a critical access hospital last year, but due to our unpredictable and sometimes high seasonal demand, our census can exceed the 25-bed cap. If we had converted to a critical access hospital, our Medicare reimbursement would substantially increase and subsequently decrease the Commercial to Medicare Payment to Cost Ratio (PTCR) metric and remove us from the high-cost list. We chose not to convert as this would limit services that are community needs.

Exclude Rural and Small Sole-Community Hospitals

The original exclusions included hospitals with discharges below the state average of 7,500. Barton's discharges in 2018 were 2,380 and declined to 1,621 by 2022, a drop of 29%. Each year, more and more patient care is provided outside of the hospital's walls in ambulatory clinics. Lower discharges mean less revenue to cover the fixed costs required even for a small hospital.

Reconsider the Methodology Behind the High-Cost Metrics

Barton shares the concerns of other hospitals and the California Hospital Association in that carving out only hospital services does not give a complete picture of operations. Instead, a look at an entire organization's business provides a more accurate picture of the cost of care. Barton runs a low-volume hospital with a robust ambulatory footprint operated under our medical foundation. Barton has invested in a medical foundation in order to recruit and retain primary and specialty

care physicians to provide care close to home for our community. The medical foundation structure does add significant expense to our bottom line. Ambulatory clinics run losses as the reimbursement is based on the Medicare Fee Schedule which does not keep up with the increasing cost of care.

It is a foundational principle of our organization to provide the highest level of access to primary and specialty care to the members of our community. In alignment with this initiative, we have added over 50 providers to our medical staff since 2018. In addition to providing high levels of access in care we also aim to recruit the highest caliber of providers to ensure that we are delivering the highest quality of care as well. In order to accomplish this, we must remain competitive from a salary and compensation package

perspective in comparison to larger metropolitan areas. This can be incredibly challenging for a rural institution as though we recognize that many of these medical practitioners and the services they provide are needed within a community, they come with a substantial cost to our organization. This cost embodies not only the cost of recruitment but also maintaining a competitive salary to retain physicians in a rural area with a high cost of living.

We believe preventative healthcare is the right thing to do and results in healthier patients with reduced hospital utilization. However, reduced hospital utilization means that there is less revenue to cover the expensive fixed costs of hospital infrastructure.

The calculations for the high-cost hospital list also do not consider capital reinvestment in facilities and equipment. During 2018 through 2022, Barton invested over $80 million into our capital assets. This does not include upcoming seismic facility replacement.

Covering the Cost of Care

Another issue is that the calculations do not consider the entire payor mix of a hospital. For Barton, approximately 70% of our payors do not cover the cost of care.

Limiting net revenue growth will not cover the annual growth of costs. During 2018 through 2022, our overall operating costs increased by an average of 8%.

Currently, labor represents nearly 60% of our operating costs and the related costs increase by approximately 5% per year. Barton Health is located in a rural community with a year-round population of about 40,000. There are not enough licensed clinical employees located in our area, so we must recruit in urban areas such as Sacramento. Housing affordability and lack of workforce housing in South Lake Tahoe has a significant impact on our ability to recruit workers to support hospital operations. The cost of living in South Lake Tahoe is 15.9% higher than Sacramento and 24% higher than the national average. To retain our non-licensed employees, such as receptionists, patient service representatives, environmental services technicians, food service workers, and others, we need to be competitive our wages to retain employees who pay more for housing than their urban counterparts.

To maintain competitive salary scales, we perform an annual compensation analysis to determine the salary scales in our region. As a result, and further reliance on contract labor, our annual labor costs increase by approximately 5%.

Limiting our spending target to 1.8% in 2026 and to 1.6% in future years will not cover the salary increases and incentive programs needed to retain our staff. For Barton Health to render consistently exceptional patient care, a stable workforce is vital. Restricting our

spending growth target this year to 1.8% will precipitate the layoffs of employees and closure of business units to meet those targets.

Labor is a main component of our operating costs, but other necessary costs such as medical and pharmaceutical supplies are increasing by 5% and higher with the recent tariffs.

Data is Not Accurate

The data on the HCAI Annual Financial Disclosure Report (AFDR) does not accurately represent our actual data by financial class when compared to our EMR. The AFDR is using data from our financial statements that is highly reliant on estimates such as what we *expect* we will collect in net revenue. Beginning in 2019, a change in allocation was made in our financial statements to comply with the new *FASB ASU 2014-09 Revenue from Contracts with Customers (Topic 606)* in regard to the Implicit Price Concession. This adjustment was not allocated properly to financial classes resulting in a substantial understatement of Medicare net revenue with a significant overstatement of the PTCR metric used to determine if we are a high-cost hospital. Further analysis also found that the Commercial Inpatient Net Patient Revenue for CMAD was not based on accurate data for discharges by financial class. This metric was recalculated, and it was found that we were over the 85th percentile for only two of the five-year periods. This would disqualify us from the high-cost hospital list. This data will be shared with OHCA prior to the board meeting scheduled for March 25, 2025.

Devasting Impacts

During 2018 through 2022, Barton had operating losses for three of those years. We were forced to initiate painful financial improvement initiatives during 2023 as we were losing more than $1M per month. These changes put us on a stronger financial footing for 2024 and 2025 and allowed us to reduce our net revenue growth independently while maintaining access to care.

Imposing these net revenue growth restrictions will result in irreparable damage to our hospital and our community. Analysis projections provided that beginning in 2026 with a 1.8% net revenue cap, we would experience over $16M in annual operating losses. By 2029, our losses would explode to over $50M which is a cost equivalent to a third of our workforce. Barton would not be able to absorb even one year of these losses while maintaining the same service offerings and workforce.

Barton's operations at risk of closure include a top-rated Labor and Delivery (L&D) department, inpatient pediatrics, a Level III Trauma Center, and an Intensivist program that provides essential services to our community. While these services are costly, we believe

they are incredibly valuable to those we serve. The potential closures would require residents of the South Lake Tahoe region to travel 30-50 miles off the mountain to access care at other facilities. Over the years, we've worked hard to build a reputation for delivering high-quality care, and removing these services would be a significant step backward.

Negative impacts if OHCA moves forward with these net revenue growth limitations to Barton include: harm to our reputation that cannot be resolved under an appeal, reduced care available in our community, reduction to our workforce with detrimental effects to our community as one of the largest employers, increased leverage to commercial payors to demand further discounts, and a reduced ability to obtain financing.

Shared Goals

Barton shares the same goals as OHCA to reduce the cost of healthcare. Drastic net revenue growth caps will not accomplish this goal but will result in less access to care and sicker patients. Furthermore, including small hospitals to these limits will not move the needle in the state's overall goal to limit cost.

In conclusion, we are respectfully requesting that the OHCA board strongly reconsider moving forward with the recommendations to limit spending growth as presented.
Sincerely,

Clint Purvance, MD, CEO
Barton Health

Kelly Neiger, CFO
Barton Health

Elizabeth Stork, CAO
Barton Health

Carla Adams, CNO
Barton Health

David Young, MD
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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Darci Delgado, Assistant Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom
Mark Ghaly, California Secretary of Health and Human Services Agency
Rob Bonta, California Attorney General
Dr. Tomas Aragon, Director, California Department of Public Health
Alex Padilla, California US Senator
Adam Schiff, California US Senator
Kevin Kiley, California State Congressman
Marie Alvardo-Gil, California State Senator

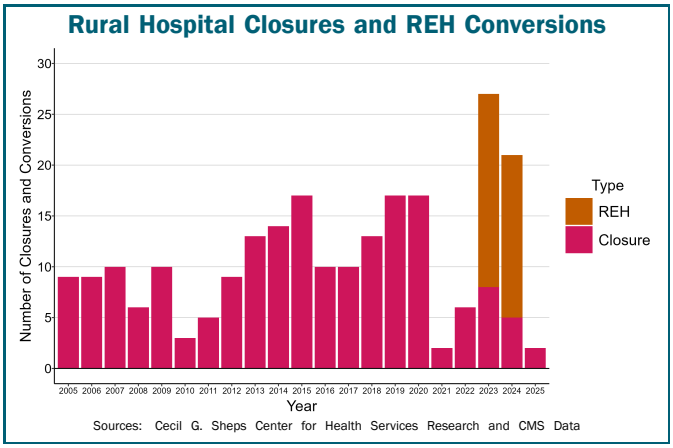
CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

RURAL HOSPITALS AT RISK OF CLOSING

Millions of Americans No Longer Have Hospital Care in Their Community

Over the past two decades, nearly 200 rural hospitals have closed. As a result, the millions of Americans who live in those communities no longer have access to an emergency room, inpatient care, and many other hospital services that citizens in most of the rest of the country take for granted.

In addition, 35 hospitals have eliminated inpatient services since the beginning of 2023 in order to qualify for federal grants that are only available for Rural Emergency Hospitals (REHs). Every year, more than 7,000 rural residents had received inpatient care in those hospitals, but now seriously ill individuals in their communities will have to be transferred to a hospital far from home in order to receive the services they need.

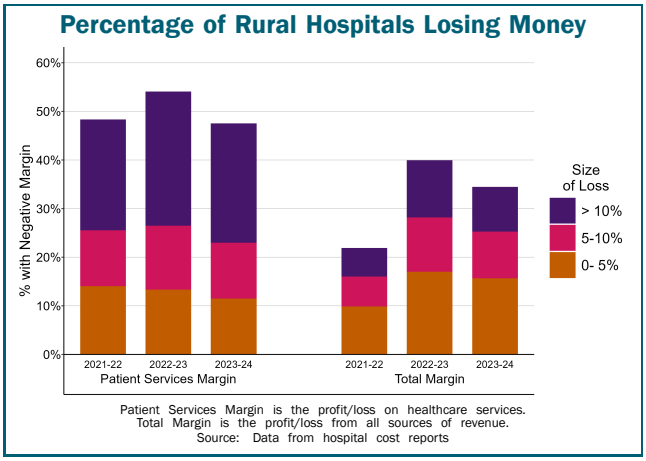


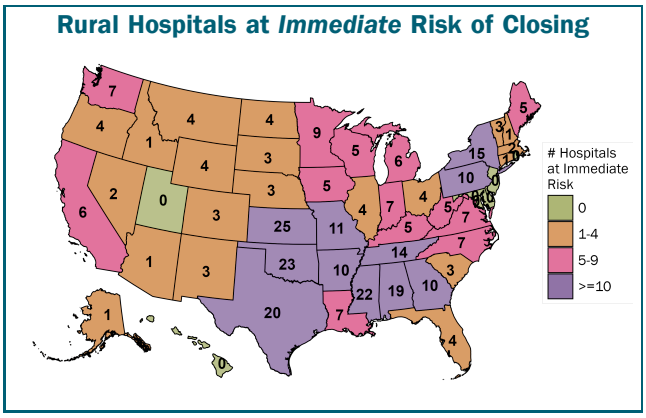
Hundreds More Rural Hospitals Could Close in the Near Future

More than 700 rural hospitals – one-third of all rural hospitals in the country – are at risk of closing because of the serious financial problems they are experiencing. Over 300 of these rural hospitals are at *immediate* risk of closing because of the severity of their financial problems. (See RuralHospitals.org for the methodology used to estimate risk of closing.)

- **Losses on Patient Services:** Almost half of the rural hospitals in the country lose money delivering patient services. It costs more to deliver health care in small rural communities than in urban areas, and many health insurance plans do not pay enough to cover these costs.
- **Insufficient Revenues From Other Sources to Offset Losses:** Many hospitals have managed to remain open despite losses on patient services because they receive local tax revenues or government grants. However, there is no guarantee that these funds will continue to be available in the future or that they will be sufficient to cover higher costs. The special federal assistance many hospitals received during the pandemic has now ended. As a result, more than one-third of rural hospitals lost money overall in 2023-24.
- **Low Financial Reserves:** The hospitals at greatest risk of closing have more debts than assets, or they do not have adequate net assets (i.e., assets other than buildings & equipment, minus debt) to offset their losses on patient services for more than a few years.

Rural hospitals are at risk of closing in almost every state. In the majority of states, over 25% of rural hospitals are at risk of closing, and in 11 states, over 50% are at risk.





Rural Hospital Closures Harm Patients and the Nation's Economy

Most at-risk hospitals are in isolated rural communities, where closure of the hospital would force residents of the community to travel a long distance for emergency or inpatient care. Moreover, in many cases, the hospital is the only place where residents can get laboratory tests or imaging studies, and it may be the principal source of primary care in the community. As a result, closure of the hospital would cause a loss of access to many essential healthcare services. In addition, rural hospital closures threaten the nation's food supply and energy production, because farms, ranches, mines, drilling sites, wind farms, and solar energy facilities are located primarily in rural areas, and they will not be able to attract and retain workers if health care isn't available in the community.

RURAL HOSPITALS AT RISK OF CLOSING

State	Hospital Closures Since 2005	Inpatient Service Closures (REH)[2]	Open Rural Inpatient Hospitals	Hospitals With Losses on Services[1]		Hospitals at Risk of Closing		Hospitals at Immediate Risk	
				Number	Percent	Number	Percent	Number	Percent
Kansas	10	3	97	83	86%	62	64%	25	26%
Oklahoma	9	4	77	51	66%	46	60%	23	30%
Mississippi	6	6	67	43	64%	38	57%	22	33%
Texas	25	4	159	106	67%	80	50%	20	13%
Alabama	8	1	50	31	62%	27	54%	19	38%
New York	6	1	51	33	65%	27	53%	15	29%
Tennessee	15	2	52	24	46%	18	35%	14	27%
Missouri	10	1	58	28	48%	27	47%	11	19%
Arkansas	2	4	46	35	76%	30	65%	10	22%
Georgia	9	3	69	28	41%	20	29%	10	14%
Pennsylvania	7	0	43	18	42%	18	42%	10	23%
Minnesota	6	1	97	35	36%	19	20%	9	9%
Louisiana	2	1	55	36	65%	22	40%	7	13%
Washington	1	0	45	30	67%	19	42%	7	16%
North Carolina	12	0	56	14	25%	10	18%	7	12%
Indiana	4	0	54	15	28%	9	17%	7	13%
Virginia	2	0	30	9	30%	9	30%	7	23%
California	8	0	58	25	43%	23	40%	6	10%
Michigan	4	1	64	20	31%	14	22%	6	9%
Iowa	2	0	93	31	33%	20	22%	5	5%
Kentucky	4	1	71	20	28%	17	24%	5	7%
Wisconsin	1	0	79	23	29%	12	15%	5	6%
West Virginia	4	0	33	14	42%	12	36%	5	15%
Maine	3	0	25	15	60%	11	44%	5	20%
North Dakota	1	0	39	22	56%	11	28%	4	10%
Illinois	4	0	75	20	27%	11	15%	4	5%
Montana	0	0	55	29	53%	10	18%	4	7%
Ohio	3	0	71	12	17%	8	11%	4	6%
Florida	8	0	22	12	55%	8	36%	4	18%
Wyoming	0	0	26	9	35%	8	31%	4	15%
Oregon	0	0	33	11	33%	7	21%	4	12%
Nebraska	2	1	71	37	52%	12	17%	3	4%
Colorado	0	0	43	18	42%	10	23%	3	7%
South Dakota	3	0	49	12	24%	10	20%	3	6%
Vermont	0	0	13	10	77%	9	69%	3	23%
South Carolina	4	0	24	11	46%	8	33%	3	12%
New Mexico	1	1	27	14	52%	7	26%	3	11%
Nevada	2	0	14	9	64%	6	43%	2	14%
Massachusetts	0	0	6	3	50%	3	50%	2	33%
Idaho	0	0	29	14	48%	9	31%	1	3%
Alaska	1	0	17	4	24%	5	29%	1	6%
Arizona	4	0	28	7	25%	3	11%	1	4%
New Hampshire	0	0	17	6	35%	2	12%	1	6%
Connecticut	0	0	3	3	100%	2	67%	1	33%
Hawaii	0	0	13	9	69%	8	62%	0	0%
Utah	0	0	21	7	33%	1	5%	0	0%
Maryland	1	0	5	0	0%	0	0%	0	0%
Delaware	0	0	2	0	0%	0	0%	0	0%
New Jersey	1	0	0	0	0%	0	0%	0	0%
Rhode Island	0	0	0	0	0%	0	0%	0	0%
U.S. Total	195	35	2,232	1,046	47%	748	34%	315	14%

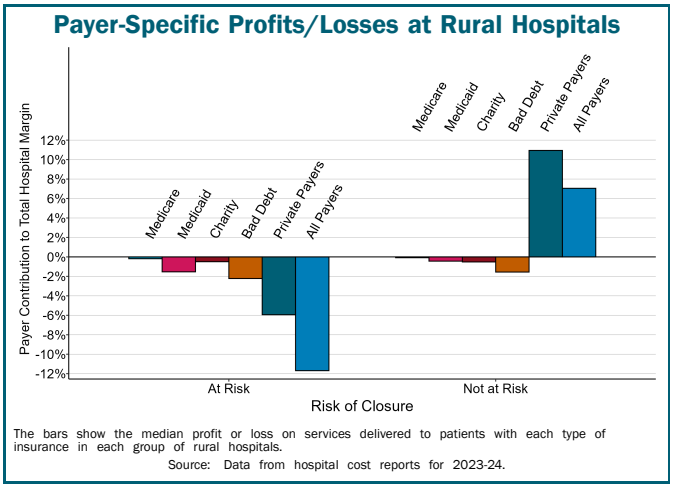
[1] Rural hospitals that had a negative margin (loss) on patient services in the most recent year available (2022-2024).
[2] Conversion to Rural Emergency Hospital (REH) which requires closure of inpatient services.

Data current as of February 2025

Closures Are Caused by Inadequate Payments from Private Health Plans

The primary reason hundreds of rural hospitals are at risk of closing is that private insurance plans are paying them less than what it costs to deliver services to patients. As shown below, although the at-risk hospitals are losing money on uninsured patients and Medicaid patients, **losses on private insurance patients are the biggest cause of overall losses**.

Conversely, many other rural hospitals are *not* at risk of closing because they make profits on patient services. They receive payments from private health plans that not only cover the costs of delivering services to the patients with private insurance, but those payments also offset the hospitals' losses on services delivered to uninsured and Medicaid patients.



Most "solutions" for rural hospitals have focused on increasing Medicare or Medicaid payments or expanding Medicaid eligibility due to a mistaken belief that most rural patients are insured by Medicare and Medicaid or are uninsured. In reality, about half of the services at the average rural hospital are delivered to patients with private insurance (both employer-sponsored insurance and Medicare Advantage plans). In most cases, the amounts these private plans pay, not Medicare or Medicaid payments, determine whether a rural hospital loses money.

How to Prevent Rural Hospital Closures

Private insurance companies and public insurance programs need to make significant changes in both the amounts and methods they use to pay for rural hospital services in order to prevent more rural hospitals from closing in the future.

Require That Health Insurance Payments Cover the Cost of Services in Rural Communities

Payments that are sufficient to cover the cost of services at large hospitals will not be adequate at small rural hospitals because it costs more to deliver healthcare services in rural communities. This is not because rural hospitals are inefficient, but because of the smaller number of patients served relative to the fixed costs of the services. For example, a small rural community will have fewer Emergency Department (ED) visits than a larger community simply because there are fewer residents, but the minimum cost of staffing the ED on a 24/7 basis will be the same, so the average cost per visit will be higher.

Congress should require that Medicare Advantage (MA) plans pay small rural hospitals adequately. MA plans should pay at least as much as Original Medicare pays for the same services, and plans should be required to pay claims in a timely fashion.

Employers and residents in rural communities should choose private insurance plans that pay their hospitals adequately. Most private insurance plans are unlikely to increase or change their payments unless businesses, local governments, and residents choose health plans based on whether they pay enough to sustain local healthcare services.

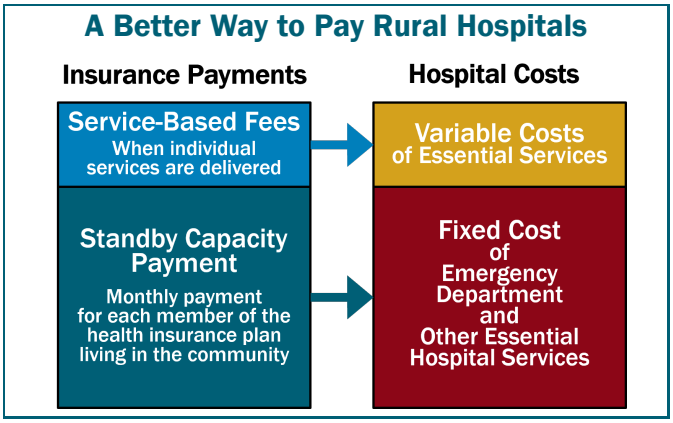
Rural hospitals should not be forced to eliminate inpatient care in order to receive higher payments for other services, as is required under the federal "Rural Emergency Hospital" program. Federal programs should preserve and expand rural healthcare services, not reduce them.

Increasing payments to levels sufficient to prevent closures of the at-risk hospitals would cost about $5 billion per year – 1/10 of 1% of total national healthcare spending. Most of the higher spending would support primary care and emergency care, since these are the biggest causes of losses at most small rural hospitals. Spending would likely increase as much or more if hospitals close, because reduced access to preventive care and failure to receive prompt treatment will cause rural residents to be sicker and need more services in the future.

Create Standby Capacity Payments to Support the Fixed Costs of Essential Rural Services

The financial problems at small rural hospitals are caused not only by the inadequate *amounts* paid by insurance plans, but by the problematic *method* all payers use to pay for services. The hospitals are paid nothing at all for one of the most important services for a rural community – having physicians and nurses standing by to treat an injury or serious health problem quickly. Having health insurance that pays fees when injuries or problems occur is of little value if there is no Emergency Department or inpatient care available for the resident to use.

In order to preserve and strengthen essential hospital services in rural communities, small rural hospitals need to receive *Standby Capacity Payments* from both private and public payers in addition to being paid Service-Based Fees when individual services are delivered. The Standby Capacity Payment would support the fixed costs of essential services at the hospital, and the Service-Based Fees would cover the variable costs of those services. More details on this approach are available in *A Better Way to Pay Rural Hospitals*.



California Hospital Association

March 20, 2025

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

Subject: **Hospitals Oppose Rash Sector Target Proposal**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

In February 2025, the Office of Health Care Affordability (OHCA) board reviewed the office's proposal to establish reduced spending targets on hospitals determined to be "high cost." As last month's conversation made clear, the proposal is rushed, based on questionable data and biased methodologies, and, if adopted, would recklessly endanger access to health care in communities across California. The California Hospital Association, on behalf of more than 400 hospitals and health systems, opposes the office's proposal and asks the board to defer any additional decisions on sector targets until myriad issues have been addressed and comprehensive consideration of sector targets is completed.

Hospital Sector Target Proposal Skips Essential Steps in the Policymaking Process

Patients Deserve a Comprehensive, Fully Considered Approach to Sector Targets. OHCA's enabling statute outlined a clear path of collaboration and learning under statewide spending growth targets, followed by careful and data-informed decisions on subdividing health care into sectors and exploring differentiated targets based on measured performance against the statewide target. With its proposal to establish unique hospital sector targets before many key steps have been completed, OHCA is choosing to diverge from the path articulated in state law. The result is a prejudicial targeting of a small set of hospitals with wholly unattainable limits on their revenue growth, without any consideration of the impacts these limits will have on these hospitals' patients and communities. Below are several of the steps OHCA is ignoring:

- **No Analysis of Comprehensive Health Care Spending Trends.** OHCA has collected, but not analyzed or reported, its comprehensive total health care expenditure (THCE) data — its principal data source on spending trends. A judicious approach would incorporate information on spending trends by service category from the THCE data into initial decisions on sectors.
- **No Consideration Given to Any Other Sector.** The lack of consideration given to the establishment of any other sector reveals a worrying partiality against the hospital field. At a minimum, OHCA could wait for the THCE data analysis to make more informed sector decisions. However, not having the THCE data is no defense, as other regulated health care entities have

reported financial data similar to hospitals' for many years — none of which has been even cursorily reviewed.

- **No Clarity on How Hospital Spending Growth Will Be Measured.** Because OHCA has not finalized a methodology for measuring hospital spending, neither hospitals nor the office itself know what the hospital sector targets mean for the affected organizations, workers, and patients.
- **No Assessment of the Reasonableness of the Statewide or Proposed Sector Targets.** Although state law affords OHCA time to assess performance against the statewide target before deciding on sector targets, OHCA's choice to move quickly disregards this key learning opportunity.

Singling Out Hospitals Strains OHCA's Impartiality and Credibility. Hospitals represent just one slice of the health care industry. Statewide, $2 out of every $3 dollars of health care spending goes to providers and payers other than hospitals. Moreover, half of California's hospitals are operating in the red and many more have margins lower than what is necessary to remain financially sustainable. And yet, OHCA is poised to adopt a hospital sector after giving no consideration to other potential sectors, prejudicially targeting a single set of providers for which data just happen to be available — despite the fact that similar data are available for other regulated entities. On top of destabilizing equitable access to high-quality hospital care, adoption of this proposal seriously challenges any appearance of impartiality on the office's part and ultimately undermines collaboration toward a shared vision of improved health care affordability.

Flawed Approach for Identifying High-Cost Hospitals Generates an Incoherent Set of Hospitals

OHCA proposes to designate hospitals as high cost if they fell in the top 15% on two financial measures for the majority of years between 2018 and 2022, following several important exclusions that together remove hospitals that accounted for nearly 20% of statewide discharges in 2022. The first measure reflects commercial inpatient reimbursement per case mix-adjusted discharge, while the second measure compares the degree to which a hospital's commercial payers reimburse its costs better than Medicare does. Both measures effectively punish hospitals for factors beyond their control, creating an arbitrary list of hospitals that happen to be high on just two of a variety of potential measures of hospitals' historical financial performance.

Commercial Reimbursement Measure Myopically Focuses on a Small Subset of Patients and Services and Ignores Geographic Differences. Shortfalls in reimbursement from government payers — Medicare and Medi-Cal — lead to hospitals' reliance on commercial payers to cover costs. By looking only at hospitals' commercial reimbursement, the measure fails to control for the fact that some hospitals have more financially favorable payer mixes than others, leading disadvantaged hospitals to needing more revenue per commercial patient to cover their costs. Unsurprisingly, hospitals at the top of this measure have disproportionately small commercial payer mixes.

Additionally, outpatient services comprise 40% of the services hospitals provide. Nevertheless, OHCA's measure ignores this entire category of services — which include emergency care, outpatient surgeries, and specialty drug infusions, among other services — punishing hospitals whose inpatient care cross-subsidizes losses on the outpatient services they provide. **Ultimately, by disregarding the 40% of hospital services provided in outpatient care, and the roughly 75% of inpatient care paid for by government programs, OHCA has chosen to rely on a measure that ignores nearly 90% of the care hospitals provide.**

Finally, the measure fails to account for regional cost differences. In essence, OHCA assumes that a hospital in the Bay Area, one of the highest cost areas in the whole country, should be paid no more than a hospital in the Inland Empire, where the cost of living is considerably lower.

Commercial-to-Medicare Payment-to-Cost Ratio Penalizes Hospitals with Worse Medicare Reimbursement. OHCA's second measure for identifying high-cost hospitals singles out those whose commercial payments cover their costs better than Medicare does. The foundational assumption is that Medicare hospital payment policies are sound and equitable. Unfortunately, this is not the case. Distortions and idiosyncrasies in Medicare payment policies significantly and variably reduce hospitals' Medicare reimbursement, often as a result of budget neutrality requirements that redistribute funding from some hospitals to others. Examples include:

- A floor on the area wage index to boost payments for rural hospitals
- Adjustments to the area wage index to revert the occupational mix of California's hospitals to the national average
- Caps on funding for graduate medical education
- Medicare disproportionate share hospital funding reductions
- Limits on payments for bad debt

The above distortions reduce Medicare payments for California hospitals by over $1.3 billion annually, but are **not** borne equitably by all hospitals. Rather, the 11 hospitals (4% of all impacted hospitals) identified by OHCA as high cost collectively bear nearly $300 million (21%) of the statewide losses from these distortions in Medicare payment policies. The effect is to artificially reduce their Medicare payment-to-cost ratio (the denominator in OHCA's measure), biasing their score on OHCA's commercial-to-Medicare payment-to-cost ratio upward.

In addition to the above distortions, Medicare payment policies allow critical access hospitals (rural hospitals that meet certain conditions, like being located at a minimum distance from another hospital and having 25 beds or fewer) to receive cost-based reimbursement, theoretically ensuring their Medicare payment-to-cost ratio is close to 1. Rural hospitals that just miss the conditions for being designated as critical access hospitals, or that elect not to be based on the needs of their communities, do not have access to equally favorable Medicare reimbursement. As a result, they regularly experience major losses on their Medicare patients, biasing their score on OHCA's measure upward, and through no fault of their own, making them all the more likely to find themselves on OHCA's high-cost list.

Data Anomalies Show More Analysis Is Needed Prior to the Adoption of the Sector Targets. In February, OHCA reviewed high-cost hospitals' scores on OHCA's two measures over the five-year period under review. This uncovered several anomalies. First, two hospitals' commercial inpatient reimbursement per case mix-adjusted discharge measures fell precipitously during the period under review, potentially reflecting commercial reimbursement rate cuts of roughly 25% and 50% respectively or, alternatively, the correction of previously faulty data. Another hospital saw its commercial-to-Medicare payment-to-cost ratio more than double in a one-year period resulting from its Medicare payment-to-cost ratio suddenly falling in a single year from roughly 0.6 to around 0.2. **OHCA must conduct further analysis and make appropriate changes to its proposal before finalizing actions that endanger the financial and operational futures of the affected hospitals.**

OHCA's Approach Yields an Incoherent Set of Hospitals. OHCA's list of hospitals contains one academic medical center, two Medicaid disproportionate share hospitals, six independent hospitals, nine

Northern California hospitals, and two rural hospitals. Two hospitals had an average daily patient census smaller than 13 in 2022, with a third seeing just 43 patients in inpatient beds on any given day. Although, by OHCA's design, the 11 hospitals have high commercial reimbursement, their average all-payer inpatient reimbursement per case mix-adjusted discharge is just around the 75th percentile, 10 percentage points lower than OHCA's chosen threshold for designating a hospital as high cost on its measures. In fact, one hospital's all-payer reimbursement was in the bottom 40% of all comparable hospitals statewide in 2022. Four hospitals lost money on their operations in 2022, with one recently reporting it has barely more than 14 days cash on hand to support its operations. Several hospitals report using their hospital margins to sustain professional services in their communities, due to the latter being reimbursed at a loss. Ultimately, these surprising attributes show that OHCA has fallen short of identifying a set of hospitals with unjustifiably high costs, and that significantly more work is needed before moving forward.

Proposed Sector Targets Would Decimate Hospital Care, Without Any Commensurate Benefit to Patients

Adoption of Sub-Inflationary Targets Would Endanger Access to Care and Violate OHCA's Multipronged Mission. OHCA has proposed sector targets of between 1.6% and 1.8% annually on hospitals designated as high cost. Such targets are as low as 35% below projected inflation for all goods and services, burdening affected hospitals with the task of sustaining patient care in the face of real cuts to their allowable revenue growth. Making matters worse, hospital costs are not currently growing at economy-wide inflation. According to Kaufman Hall, western states' hospital costs are currently growing at 6% for labor, 8% for supplies like personal protective equipment, and 10% for drugs. The proposed high-cost hospital sector targets are 70% to 80% lower than the recent cost growth for these essential inputs. Such targets would have to be met with draconian cuts to the affected hospitals' workforces and service lines, as well as abandonment of investments to expand access to high-quality care — unavoidable actions all in conflict with OHCA's statutory mandate to promote affordability while maintaining access to quality care.

Negative Impacts of Proposed Targets Would Not Be Nullified by Selective Enforcement on the Back End. OHCA staff have promised to practice discretion and not aggressively enforce the sector targets in circumstances where excess growth is beyond the hospital's control. Unfortunately, the uncertain possibility of being forgiven at a later date for excess spending growth is not sufficient to avoid the devastating consequences of the sector targets under discussion. First, the designated hospitals would face major reputational consequences, causing patients, including those on Medicare and Medi-Cal, to seek care elsewhere. Second, health insurance companies would immediately pressure hospitals to accept rate increases at the insufficient sector target level. There would be no good option for hospitals: Those that accept the insufficient rate increases would inevitably be forced to make real cuts in patient care. Those that cannot accept the offered rates would undoubtedly face contract terminations — as recently experienced in San Diego, where thousands of patients lost their usual source of care. Third and finally, the targets will chill investment aimed at improving access to high-quality care, as hospitals will have no assurance that the increased revenues funding these investments will not be taken away on the back end due to violation of the aggressive targets.

The Rash Adoption of Draconian Hospital Sector Targets Would Compound the Harms of Pending Federal Funding Cuts. Federal policymakers are currently considering proposals to drastically cut funding for vital health care programs. Particularly at risk is the Medicaid program and enhanced premium support for those with individual market coverage. California's health care programs are

especially vulnerable. Medi-Cal covers nearly 15 million Californians (more than a third of the state's population) and is sustained by $118 billion in federal funding. The cuts currently under consideration could remove tens of billions of dollars in federal funding from California's health care system, which the state could not backfill given its own precarious budget situation. This means cuts to coverage, benefits, and provider rates are on the horizon, with potential to turn a merely challenging financial environment, wherein more than half of California's hospitals already operate in the red, into a full-blown crisis. Compounding federal funding threats with unconscionably low sector targets would make it certain that hospital services would be cut, workers laid off, and access to care curtailed for millions of Californians. Making highly consequential decisions on sector spending targets prior to these potentially catastrophic federal actions would demonstrate a profound disregard for OHCA's statutory mission to sustain and promote access to high-quality, equitable care.

Conclusion

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

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
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

Washington Health

March 19, 2025

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

Subject: **Low Spending Growth Targets Undermine Patient Care**
(Submitted via email to Megan Brubaker)

Dear Chair Johnson,

Washington Health is deeply concerned by the speed with which the Office of Health Care Affordability (OHCA) is considering adoption of hospital sector-specific spending growth targets. With a statewide target of 3.5% already in place and complete lack of clarity around how that target would be measured or enforced, the proposed action is premature.

In addition, we disagree with the OHCA staff's recommendation that Washington Health be subject to smaller growth targets as a "high-cost hospital." In our opinion, the "high-cost hospital" characterization is derived from bad (and outdated) data, opaque analysis, and a lack of understanding about hospitals finances. For these reasons, we request that Washington Hospital be removed from this high-cost list and that the Board delay a vote on adopting a hospital sector target until such time as the issues raised in this letter are addressed.

- Data: As this exercise is beginning to reveal, there is huge variability in how hospitals file their annual financial data reports with HCAI, which makes apples-to-apples comparisons impossible. Large health systems can allocate costs across hospitals, but for Washington Health, an independent non-designated public hospital, all our costs are included in the report. HCAI data was never intended to be used in this manner, which accounts for much of the weakness in OHCA's analysis.

- Analysis: We have been unable to replicate the OHCA analysis of our HCAI data to determine how we were included in the list of 11 high-cost hospitals, and we don't trust that the analysis accurately represents our financial situation. This is particularly true because Medicare reimbursement varies dramatically between hospitals and health systems. We believe that our Medicare cost recovery rate is dramatically skewing the picture being painted by OHCA. But we can't tell, because we don't know how they conducted their analysis.

- Lack of understanding about hospital financing: We are grateful that the OHCA leadership met with us to hear our concerns. The meeting gave us an opportunity to discuss the inflationary cost pressures we are subject to with labor, supplies, pharmaceuticals and technology. We were also able to explain that we have had negative margins for the past two years, so meeting these cost-growth targets will inevitably result in service reductions. Finally, we described our payor mix, which is

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77% governmental and all other with only 23% commercial. Fewer than 2,800 of our annual discharges are sponsored by commercial payors. Nothing in the OHCA definition of "high-cost hospitals" accounts for this broader picture, and the punitive reduced cost growth targets demonstrate a lack of comprehension about current financial and operating conditions for hospitals in the state.

Furthermore, we are dismayed about the reputational damage OHCA has done (and continues to do) to Washington Health by categorizing us a "High-Cost Hospital." No one has given a moment's thought to the detrimental consequences that this inaccurate and misleading label will have on our organization in the eyes of local residents who rely on us – as they have since 1958 – to provide health care to all, regardless of their ability to pay.

Patient care needs, economic trends, and the investments needed to comply with unfunded state mandates increasingly reveal how difficult, if not impossible, meeting the statewide target will be. Lowering the target even further means that we would be forced to further reduce the care we provide. This could impact our obstetrical service, trauma center, an urgent care center we had planned to open later this year, and an outpatient health center scheduled for 2027.

Promoting health care affordability — 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. Many of the 11 hospitals on the "high-cost hospital" list are small, independent hospitals, and the net effect on health care costs in the state by targeting this group for lowered growth targets will be de minimus.

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 requirements to "maintain quality and equitable care" and "minimize fragmentation and potential cost shifting, and encourage cooperation in meeting statewide and geographic region targets."

On behalf of the 10,459 patients admitted into our hospital last year, Washington Health urges you to remove us from this list given faulty data, opaque analysis, and a failure to account for our hospital financial realities. Failure to do so will ultimately harm patient care in our community where we are the choice for care for the uninsured and underinsured. We also feel additional time is needed for analysis and discussion before finalizing sectors or corresponding targets. Washington 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 quality of care and access to care are not diminished in the pursuit of lower costs.

Sincerely,

Kimberly Hartz
Chief Executive Officer

cc: Members of the Health Care Affordability Board:
David M. Carlisle, MD, PhD
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