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Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Advisory Committee Meeting

January 21, 2025

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Welcome, Call to Order, and Roll Call

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Agenda

1. **Welcome, Call to Order, and Roll Call**
   Elizabeth Landsberg, Director
2. **Executive Updates**
   Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director
3. **Update on the THCE Data Submission Guide & Regulations**
   Margareta Brandt, Assistant Deputy Director; Andrew Feher, Research and Analysis Group Manager
4. **Introduce Sector Target Definition and Discussion**
   Vishaal Pegany; Andrew Feher
5. **Cost-Reducing Strategies – AltaMed**
   Efrain Talamantes, MD, MBA, MSc, SVP & COO, Health Services, AltaMed
6. **Update on Cost and Market Impact Review Program**
   Heather Hoganson, Health Systems Compliance Assistant Chief Counsel
7. **Update on Quality and Equity Performance Measurement**
   Margareta Brandt; Janna King, Health Equity and Quality Performance Group Manager
8. **Update on Behavioral Health Benchmark**
   Margareta Brandt, Debbie Lindes, Health Care Delivery System Group Manager
9. **General Public Comment**
10. **Adjournment**

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Executive Updates

Elizabeth Landsberg, Director

Vishaal Pegany, Deputy Director

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Quarterly Work Plan*

2025		Total Health Care Expenditures & Spending Targets	Cost and Market Impact Review (CMIR)	Promoting High Value
JANUARY	Board	• Board Vote to Define Hospital Sector(s) • Hospital Sector Data Analysis • Hospital Sector Target Setting Methodology • THCE Regulations and Data Submission Guide Updates	• CMIR Update	
	Board	Board Vote to Establish a Subcommittee for the Selection New Advisory Committee (AC) Members		
	AC	• THCE Regulations and Data Submission Guide Updates • Sector Target Definition and Methodology	• CMIR Update	• Update on Quality and Equity Performance Measurement • Update on Behavioral Health Benchmark (TBD)
FEBRUARY	Board	• Present Sector Definition Regulations • OHCA Recommends Sector Target Values Feb 21 (45-day comment period) • Baseline Report Outline/ Preview		• Update and Finalize Quality and Equity Performance Measurement • Update on Behavioral Health Benchmark (TBD)
	AC	**No Meeting**		
MARCH	Board	• Massachusetts Program Update • Oregon Program Update • Healthcare Payments Data Program Update • Sector Target Review/Discussion Cont.		• Update on Data Submission Guide • Update on Behavioral Health Benchmark (TBD)
		Office Plan: **Submit THCE Data Collection Regulations/Data Submission Guide Updates to OAL** **Submit Sector Target Definition Regulations to OAL**		
	AC	• Sector Target Definition Regulations • Sector Target Values		• Update and Finalize Quality and Equity Performance Measurement • Update on Behavioral Health Benchmark (TBD)

* Work plan is subject to change.

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Future Topics Beyond March 2025

THCE & Spending Target

- Board Reviews Public Comment Regarding Recommended Sector Target Values
- Adopt Sector Target Definition Regulations
- Establish Final Sector Target Value(s)

Promoting High Value

- Approve Behavioral Health Benchmark
- Adopt Quality and Equity Performance Measure Set (TBD)
- Introduce Equity Adjustment and Quality Adjustment

Assessing Market Consolidation

- Update on Material Change Notices Received, Transactions Receiving Waiver or Warranting a CMIR, and Timing of Reviews for Notices and CMIRs

Current Advisory Committee Members

Payers

Aliza Arjoyan
Senior Vice President of Provider Partnership and Network Management, Blue Shield of California

Yolanda Richardson
Chief Executive Officer, San Francisco Health Plan

Andrew See
Senior Vice President, Chief Actuary, Kaiser Foundation Health Plan

Hospitals

Barry Arbuckle
President & Chief Executive Officer, MemorialCare Health System

Tam Ma
Associate Vice President, Health Policy and Regulatory Affairs, University of California Health

Travis Lakey
Chief Financial Officer, Mayers Memorial Hospital District

Medical Groups

Hector Flores
Medical Director, Family Care Specialists Medical Group

Stacey Hrountas
Chief Executive Officer, Sharp Rees-Stealy Medical Centers

David S. Joyner
Chief Executive Officer, Hill Physicians Medical Group

Physicians

Adam Dougherty
Emergency Physician, Vituity

Parker Duncan Diaz
Clinician Lead, Santa Rosa Community Health

Sumana Reddy
President, Acacia Family Medical Group

Purchasers

Ken Stuart
Chairman, California Health Care Coalition

Suzanne Usaj
Senior Director, Total Rewards, The Wonderful Company LLC

Abbie Yant
Executive Director, San Francisco Health Service System

Health Care Workers

Stephanie Cline
Respiratory Therapist, Kaiser

Sarah Soroken
Mental Health Clinician, Solano County Mental Health

Cristina Rodriguez
Physician Assistant, Altura Centers for Health

Consumer Representatives & Advocates

Carolyn J Nava
Senior Systems Change, Disability Action Center

Mike Odeh
Senior Director of Health, Children Now

Kiran Savage-Sangwan
Executive Director, California Pan-Ethnic Health Network (CPEHN)

Rene Williams
Vice President of Operations, United American Indian Involvement

Marielle A. Reataza
Executive Director, National Asian Pacific American Families Against Substance Abuse (NAPAFASA)

Organized Labor

Joan Allen
Government Relations Advocate, SEIU United Healthcare Workers West

Carmen Comsti
Lead Regulatory Policy Specialist, California Nurses Association/National Nurses United

Janice O'Malley
Legislative Advocate, American Federation of State, County and Municipal Employees

Kati Bassler
President, California Federation of Teachers, Salinas Valley

Academics/ Researchers

Stephen Shortell
Professor, UC Berkeley School of Public Health

Highlighted= member term ends June 30, 2025

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AC Member Selection Timeline

January 2025 Board Meeting

Discuss 2025 AC selection

February–April 2025

Solicitation

April-May 2025

Selection

June 2025 Board Meeting

Appointments/ reappointments

September 2025 AC Meeting

First meeting for new members

National Health Expenditures (NHE) 2023 Growth Rates

- Health care spending reached $4.9 trillion in 2023, averaging $14,570 per person. This represents a per capita growth rate of 7.0%, significantly faster than 4.2% growth in 2022 and 4.0% in 2021.
- Growth was primarily driven by a 9.7% increase in spending on private health insurance (PHI), reaching $7,065 per person. A significant increase compared to 5.1% growth in 2022 and 6.8% in 2021.
  - Net cost of PHI (10.3% of PHI spending) - *represents the portion for administrative costs, taxes, fees* grew at 12.5% contributing to the rapid growth.
- Medicare also grew at a faster rate of 5.9% or $15,808 per person compared to growth of 4.4% in 2022 and 5.5% in 2021.
- Medicaid grew 7.1% or $9,502 per person from 2.1% in 2022 and -1.5% in 2021.

Source: Source: Martin, A. B., Hartman, M., Washington, B., & Catlin, A. (2024). *National health expenditures in 2023: Faster growth as insurance coverage and utilization increased*. *Health Affairs*. Advance online publication. https://doi.org/10.1377/hlthaff.2024.01375

National Health Expenditures (NHE) 2023 Growth Drivers

- Federal policies, such as the American Rescue Plan Act, drove the insured population to 92.5% in 2023, marking the highest coverage rate achieved in U.S history.
- The accelerated growth in spending is largely attributed to an increase in utilization and intensity of services provided.
- Health care prices increased by 3.0% in 2023, consistent with 3.1% in 2022, but above the average annual growth rate of 2.0% observed from 2016 to 2022.
- Three Largest Spending Categories:
  - Hospital care (31% of total spending) is up 10.4% from 3.2% in 2022 and 5.2% in 2021 – the fastest growth seen since 1990 at 10.8%
  - Physician and Clinical Services (20% of total spending) is up 7.4%, faster than 2022 at 4.6% and 6.9% in 2021.
  - Prescription Drugs (9% of total spending) is up 11.4%, faster than 2022 at 7.8% and 6.7% in 2021

Source: Martin, A. B., Hartman, M., Washington, B., & Catlin, A. (2024). *National health expenditures in 2023: Faster growth as insurance coverage and utilization increased*. *Health Affairs*. Advance online publication. https://doi.org/10.1377/hlthaff.2024.01375

Slide Formatting

Indicates items that the Advisory Committee provides input or recommendations on based on statute and other areas as requested by the Board or OHCA.

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Public Comment

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Update on the THCE Data Submission Guide & Regulations

Margareta Brandt, Assistant Deputy Director

Andrew Feher, Research and Analysis Group Manager

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Recap: Summary of APM Data Collection Approach

- APMs that count towards adoption goals are defined by HCP-LAN Category 3 and 4 and spending data is collected via Expanded Framework
  - Data collected for payment arrangements linked to quality and those not linked to quality separately at the market category and product type level
  - Payments must be linked to quality to count towards the adoption goals
- APM membership data collected by market category and product type at payer level to meet APM adoption goal requirement
- APM spending data as per member, per month and as a percent of total medical expense is collected at Expanded Framework subcategory level
  - Total medical expense and member months for members to be reported in the payment subcategory furthest along the continuum of provider clinical and financial risk

Recap: Summary of Primary Care Data Collection Approach

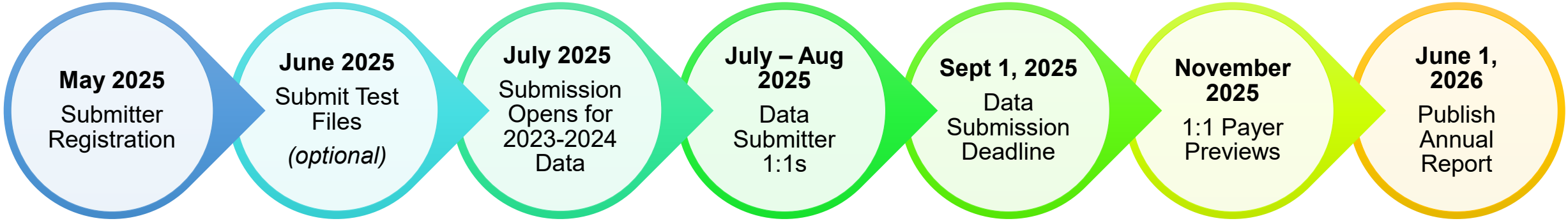
- Claims and non-claims primary care spending collected by market category and product type at payer level to track progress towards the annual improvement benchmark and 2034 primary care investment benchmark
- Claims and non-claims primary care spending collected based on methodology developed by OHCA with input from the Investment and Payment Workgroup
  - For claims, the primary care code set defines the provider taxonomies, the places of service, and the services that must be present on a claim for inclusion in primary care spending
  - For non-claims, submitters must follow the methodology for allocating a portion of non-claims payments to primary care for each Expanded Framework subcategory
- Behavioral health in primary care collected as part of primary care spending

2025 Data Collection Timeline

- Draft updates to regulations and DSG 2.0 released for public comment on January 8
- Comments due to OHCA@HCAI.ca.gov by **January 31, 2025**
- Anticipated submission to Office of Administrative Law in April 2025.

- Drafts available for review on HCAI website: https://hcai.ca.gov/about/laws-regulations/

2025 Data Collection Timeline



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Introduce Sector Target Definition and Discussion

Vishaal Pegany, Deputy Director

Andrew Feher, Research and Analysis Group Manager

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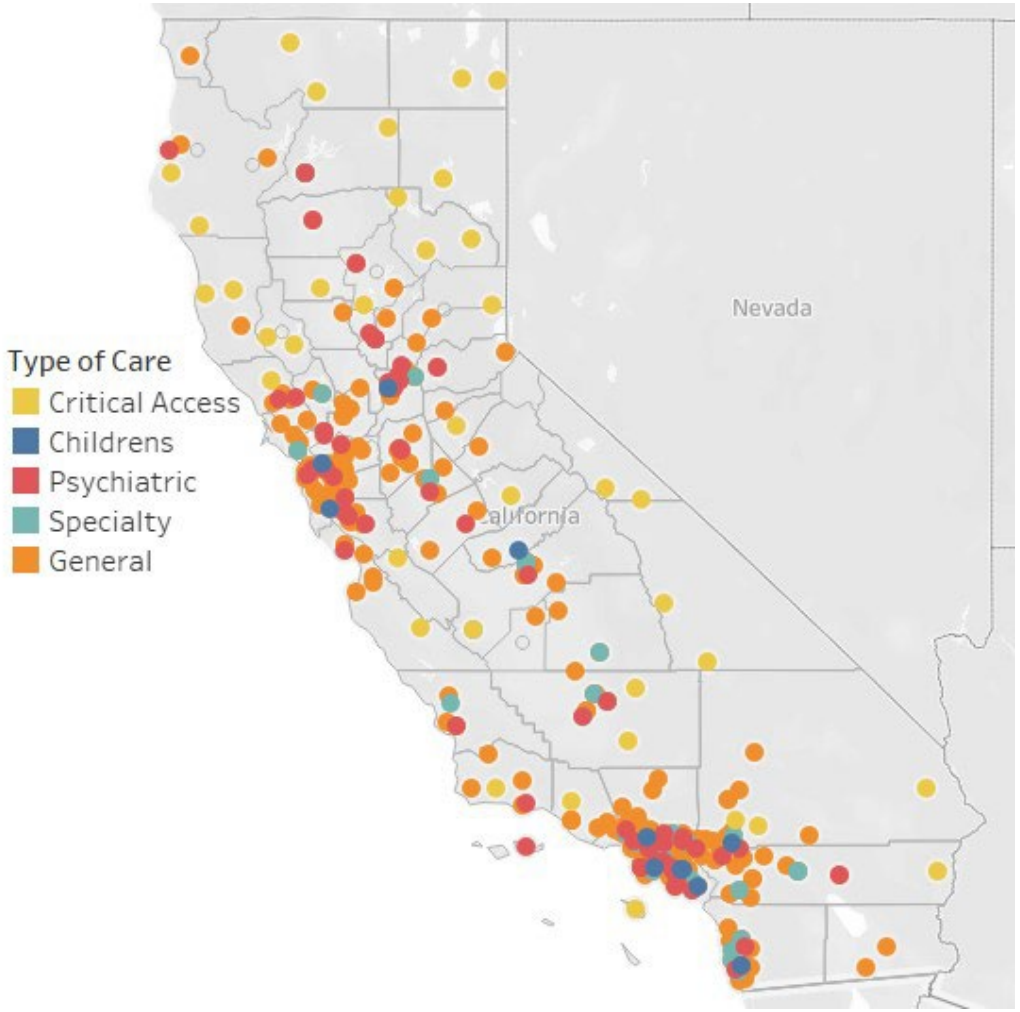
Landscape of California Hospitals

Hospitals in California



- California has 439* hospitals, ranging from large academic medical centers to community-based hospitals.
- Hospitals are distributed across urban and rural areas, with the highest concentration in major metropolitan areas like Los Angeles, San Francisco, and San Diego.
- California hospitals include general, children's, psychiatric, academic medical centers/teaching hospitals, county hospitals, small and rural hospitals, critical access hospitals and specialty care facilities providing specialized services (e.g., rehabilitation, cancer treatment, heart surgery, addiction recovery, respiratory care, neurological services, long-term care, orthopedic surgery, and mental health care).

* This number represents a distinct count of health care facilities subject to filing HCAI Hospital Annual Disclosure Reports. Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

Recap of November's Board Discussion

November Board Discussion

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

The attributes included:

1. Critical Access Hospitals
2. Small Hospitals
3. Psychiatric Hospitals
4. Children's Hospitals
5. Teaching Hospitals/Academic Medical Centers
6. Specialty Hospitals
7. State Hospitals
8. County Hospitals
9. Hospitals with long average lengths of stays

Definitions of Facility Attributes

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

Centers for Medicare & Medicaid. Critical Access Hospitals. Retrieved December 10, 2024, from https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals; Health and Safety Code § 1250.2 (a)(1); HCAI Hospital Annual Financial Data, Selected Data File Documentation For Report Periods Ended on or After June 30, 2004; California Health Facilities Commission, Hospital peer grouping for efficiency comparison (1982).

Definitions of Facility Attributes

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

* WIC § 14184.10 authorized a Medi-Cal demonstration project and defines facilities as designated public hospitals.
Sources: HCAI Hospital Annual Financial Data, Selected Data File Documentation For Report Periods Ended on or After June 30, 2004; WIC § 4100; California Health Facilities Commission, Hospital peer grouping for efficiency comparison (1982); Health and Safety Code § 127500.2 (h).

Hospital Attributes

Does the Advisory Committee have input on whether any of these attributes would merit special consideration or exemption from a high-cost sector definition, or high-cost sector target?

1. Critical Access Hospitals
2. Small Hospitals
3. Psychiatric Hospitals
4. Children's Hospitals
5. Teaching Hospitals/Academic Medical Centers
6. Specialty Hospitals
7. State Hospitals
8. County Hospitals
9. Hospitals with long average lengths of stays

Sector Target Implementation

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

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

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

In December, the Board focused its discussion on step one. The following slides recap the data that was shown to the Board in December and the potential options for defining a Hospital sector.

Data Review of California Hospitals

HCAI Hospital Reporting Requirements

- On an annual basis, individual hospitals and hospital systems report detailed facility-level data on services capacity, inpatient/outpatient utilization, patients, revenues and expenses by type and payer, balance sheet and income statement.
- Some hospitals are not required to submit all Hospital Annual Disclosure Report data either by statute or because a reporting modification has been granted.* This includes the following types of hospitals:

1. **Kaiser Hospitals:** By law, Kaiser is allowed to submit consolidated financial statements for its Northern and Southern Regions and limited financial and utilization data for its individual hospitals.
2. **LTC Emphasis Hospitals:** There are four large hospitals that primarily provide long-term care. Although each hospital submits a full disclosure report, HCAI advises against their inclusion because their data may distort certain aggregations.
3. **Psychiatric Health Facilities (County-Operated):** County-operated Psychiatric Health Facilities are permitted to submit limited data because of their small size, unique patient-mix, and type of care.
4. **Shriner's Hospitals:** Shriner's hospitals are permitted to submit limited data because of their charitable mission and because patients are not billed for services.
5. **State Hospitals:** State-operated hospitals are permitted to submit limited data because of their unique patient-mix and type of care.

*Reporting modifications are primarily granted when the data to be reported are not comparable to data filed by other hospitals.

Hospitals in California

Based on discussions with the Board, the following data in this section shows the Top 30 hospitals for five financial metrics from 2018-2022. These are a select and illustrative set of metrics for the Board's review and analysis. They are not meant to convey a methodology or recommendation on how to define a hospital sector or establish sector targets. These pooled metrics (i.e., including patients with Commercial, Medi-Cal, Medicare and other payer types) were:

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

The first section shows the Top 30 hospitals for each metric without any exclusions from the list below. Due to the differential reporting requirements noted on the prior slide, however, not all hospitals provide the requisite information to enable reporting across all financial metrics.

The second section shows the Top 30 hospitals for each financial metric, removing hospital with the following attributes:

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

Definitions of Metrics

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

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

Review of Hospital Data Metrics

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

Financial Metric (2018-2022)	Top 30 Range (High to Low)	Statewide Median (Without Exclusions)
Average Inpatient NPR Per CMAD	$402K to $28K	$13K
Average Commercial Inpatient NPR Per CMAD	$107K to $36K	$18K
Average Annual Growth in Inpatient NPR Per CMAD	79% to 15%	2%
Average Operating Margin	41% to 15%	3%
Average Commercial to Medicare Payment to Cost Ratio	857% to 300%	204%

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data. Statewide median descriptive statistics are weighted by the number of inpatient discharges. Data for commercial enrollees as well as other government programs are reported in the Other Third Party category for HCAI Hospital Annual Disclosure Reporting.

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

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

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

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

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

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

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

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Commercial Inpatient NPR per CMAD
1	Children's Healthcare Organization of Northern Ca - Pediatric Hospital	Santa Clara	N	Y	N	N	N	N	N	N	Y	$107,388
2	Laguna Honda Hospital and Rehabilitation Center	San Francisco	N	N	N	N	N	N	N	N	Y	$79,970
3	West Covina Medical Center	Los Angeles	N	Y	N	N	N	N	N	N	N	$72,876
4	Lucile Salter Packard Children's Hospital at Stanford	Santa Clara	N	N	Y	Y	N	N	N	N	N	$71,889
5	Catalina Island Medical Center	Los Angeles	Y	Y	N	N	N	N	N	N	Y	$69,274
6	Star View Adolescent - PHF	Los Angeles	N	Y	N	N	N	Y	N	N	Y	$67,188
7	La Casa PHF	Los Angeles	N	Y	N	N	N	Y	N	N	Y	$57,625
8	California Rehabilitation Institute	Los Angeles	N	N	N	N	Y	N	N	N	N	$57,519
9	Kindred Hospital - Los Angeles	Los Angeles	N	Y	N	N	N	N	N	N	Y	$55,665
10	Stanford Health Care	Santa Clara	N	N	N	Y	N	N	N	N	N	$51,282
11	Kindred Hospital - South Bay	Los Angeles	N	Y	N	N	N	N	N	N	Y	$48,088
12	UCSF Medical Center	San Francisco	N	N	N	Y	N	N	N	Y	N	$47,569
13	Salinas Valley Memorial Hospital	Monterey	N	N	N	N	N	N	N	N	N	$46,786
14	Kindred Hospital - Ontario	San Bernardino	N	Y	N	N	N	N	N	N	Y	$46,237
15	Totally Kids Rehabilitation Hospital	San Bernardino	N	Y	Y	N	Y	N	N	N	Y	$45,035

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

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

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Commercial Inpatient NPR per CMAD
16	Kindred Hospital - Paramount	Los Angeles	N	N	N	N	N	N	N	N	Y	$44,448
17	Kindred Hospital - Westminster	Orange	N	N	N	N	N	N	N	N	Y	$43,251
18	Northbay Medical Center	Solano	N	N	N	N	N	N	N	N	N	$43,072
19	Vibra Hospital of Sacramento	Sacramento	N	Y	N	N	Y	N	N	N	Y	$40,764
20	Santa Clara Valley Medical Center	Santa Clara	N	N	N	Y	N	N	N	Y	N	$40,121
21	Community Hospital of The Monterey Peninsula	Monterey	N	N	N	N	N	N	N	N	N	$39,887
22	Zuckerberg San Francisco General Hospital & Trauma Center	San Francisco	N	N	N	Y	N	N	N	Y	N	$38,954
23	University of California Davis Medical Center	Sacramento	N	N	N	Y	N	N	N	Y	N	$38,192
24	Kindred Hospital - Brea	Orange	N	Y	N	N	N	N	N	N	Y	$38,177
25	Kindred Hospital - San Francisco Bay Area	Alameda	N	Y	N	N	N	N	N	N	Y	$38,118
26	Barton Memorial Hospital	El Dorado	N	N	N	N	N	N	N	N	N	$37,954
27	Kentfield Hospital	Marin	N	N	N	N	Y	N	N	N	Y	$36,237
28	Kindred Hospital - La Mirada	Los Angeles	N	N	N	N	N	N	N	N	Y	$36,225
29	Monrovia Memorial Hospital	Los Angeles	N	Y	N	N	N	N	N	N	Y	$36,220
30	Doctors Medical Center - Modesto	Stanislaus	N	N	N	N	N	N	N	N	N	$36,132

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Review of Hospital Metrics Removing Specified Facilities

Hospital Analysis with Specified Exclusions

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

Key takeaways include:

Financial Metric (2018-2022)	Top 30 Range (High to Low)	Statewide Median (With Exclusions)
Average Inpatient NPR Per CMAD	$54K to $18K	$13K
Average Commercial Inpatient NPR Per CMAD	$57K to $28K	$18K
Average Annual Growth in Inpatient NPR Per CMAD	66% to 7%	2%
Average Operating Margin	39% to 12%	3%
Average Commercial to Medicare Payment to Cost Ratio	857% to 276%	208%

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data. Statewide median descriptive statistics are weighted by the number of inpatient discharges. Data for commercial enrollees as well as other government programs are reported in the Other Third Party category for HCAI Hospital Annual Disclosure Reporting

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

Key: Rank top 15 Rank 16-30

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

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

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

Key: Rank top 15 Rank 16-30

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

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

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

Key: Rank top 15 ■ Rank 16-30 ■

	Hospital	County	Teach	Spec	Psych	Public	Average Commercial Inpatient NPR per CMAD	Average Inpatient NPR per CMAD	Average Annual Growth per Inpatient NPR per CMAD	Average Operating Margin	Average Commercial to Medicare Payment to Cost Ratio
1	California Rehabilitation Institute	Los Angeles	N	Y	N	N	$57,519	$31,950	0%	16%	197%
2	Stanford Health Care	Santa Clara	Y	N	N	N	$51,282	$28,288	4%	9%	339%
3	UCSF Medical Center	San Francisco	Y	N	N	Y	$47,569	$28,658	3%	0%	238%
4	Salinas Valley Memorial Hospital	Monterey	N	N	N	N	$46,786	$17,886	0%	18%	476%
5	Northbay Medical Center	Solano	N	N	N	N	$43,072	$23,497	0%	1%	271%
6	Santa Clara Valley Medical Center	Santa Clara	Y	N	N	Y	$40,121	$25,319	3%	-10%	146%
7	Community Hospital of The Monterey Peninsula	Monterey	N	N	N	N	$39,887	$19,104	2%	12%	352%
8	Zuckerberg San Francisco General Hospital & Trauma Center	San Francisco	Y	N	N	Y	$38,954	$21,267	4%	-30%	218%
9	University of California Davis Medical Center	Sacramento	Y	N	N	Y	$38,192	$25,870	3%	6%	237%
10	Barton Memorial Hospital	El Dorado	N	N	N	N	$37,954	$18,094	-2%	6%	799%
11	Doctors Medical Center - Modesto	Stanislaus	N	N	N	N	$36,132	$13,456	1%	11%	347%
12	St. Francis Memorial Hospital	San Francisco	N	N	N	N	$35,395	$16,196	4%	-13%	236%
13	Marshall Medical Center	El Dorado	N	N	N	N	$35,193	$17,024	8%	2%	288%
14	Dominican Hospital	Santa Cruz	N	N	N	N	$34,474	$17,652	2%	9%	330%
15	St. Rose Hospital	Alameda	N	N	N	N	$33,414	$14,279	2%	-4%	180%

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

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

Key: Rank top 15 Rank 16-30

	Hospital	County	Teach	Spec	Psych	Public	Average Commercial Inpatient NPR per CMAD	Average Inpatient NPR per CMAD	Average Annual Growth per Inpatient NPR per CMAD	Average Operating Margin	Average Commercial to Medicare Payment to Cost Ratio
16	Regional Medical Center of San Jose	Santa Clara	N	N	N	N	$33,072	$15,466	3%	-7%	250%
17	Washington Hospital - Fremont	Alameda	N	N	N	N	$33,009	$19,448	2%	0%	358%
18	Santa Barbara Cottage Hospital	Santa Barbara	Y	N	N	N	$32,872	$18,420	2%	3%	305%
19	Alta Bates Summit Medical Center - Alta Bates Campus	Alameda	N	N	N	N	$32,058	$20,920	3%	-3%	256%
20	City of Hope Helford Clinical Research Hospital	Los Angeles	N	Y	N	N	$32,050	$25,584	0%	-3%	174%
21	Highland Hospital	Alameda	N	N	N	Y	$31,408	$23,901	23%	-16%	191%
22	Community Regional Medical Center - Fresno	Fresno	Y	N	N	N	$30,640	$15,065	3%	3%	136%
23	California Pacific Medical Center - Van Ness Campus	San Francisco	N	N	N	N	$30,446	$21,759	5%	-4%	253%
24	Ronald Reagan UCLA Medical Center	Los Angeles	Y	N	N	Y	$30,386	$25,395	2%	6%	142%
25	Cedars-Sinai Medical Center	Los Angeles	Y	N	N	N	$29,958	$21,663	3%	9%	278%
26	Monterey Park Hospital	Los Angeles	N	N	N	N	$29,734	$12,223	-1%	12%	857%
27	Alta Bates Summit Medical Center - Summit Hawthorne	Alameda	N	N	N	N	$29,610	$14,451	5%	-4%	294%
28	Providence Santa Rosa Memorial Hospital	Sonoma	N	N	N	N	$29,196	$15,313	3%	4%	279%
29	Adventist Health and Rideout	Yuba	N	N	N	N	$28,711	$16,141	6%	-7%	191%
30	Orange County Global Medical Center	Orange	N	N	N	N	$28,411	$10,076	-2%	-4%	404%

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

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

Key: Rank top 15 Rank 16-30

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

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

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

Key: Rank top 15 Rank 16-30

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

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

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

Key: Rank top 15 Rank 16-30

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

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

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

Key: Rank top 15 Rank 16-30

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

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

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

Key: Rank top 15 Rank 16-30

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

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

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

Key: Rank top 15 Rank 16-30

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

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

Hospital Data Review

Does the Advisory Committee have input on the data and metrics provided?

Sector Definition and Target Setting Options

Hospital Sector Options

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

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

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

Hospital Sector Options

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

Approach Summary:

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

Statute:

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

Hospital Sector Options

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

Considerations:

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

Implementation:

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

Hospital Sector Options

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

Approach Summary:

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

Statute:

- HSC § 127502 (b)(1): The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.
- HSC § 127502 (b)(2): The board may adjust cost targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, when warranted to account for the baseline costs in comparison to other health care entities in the health care sector and geographic region.

Hospital Sector Options

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

Considerations:

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

Implementation:

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

Hospital Sector Options

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

Approach Summary:

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

Statute:

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

Hospital Sector Options

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

Considerations:

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

Implementation:

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

Hospital Sector Options

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

Approach Summary

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

Statute

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

Hospital Sector Options

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

Considerations:

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

Hospital Sector Options

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

Implementation:

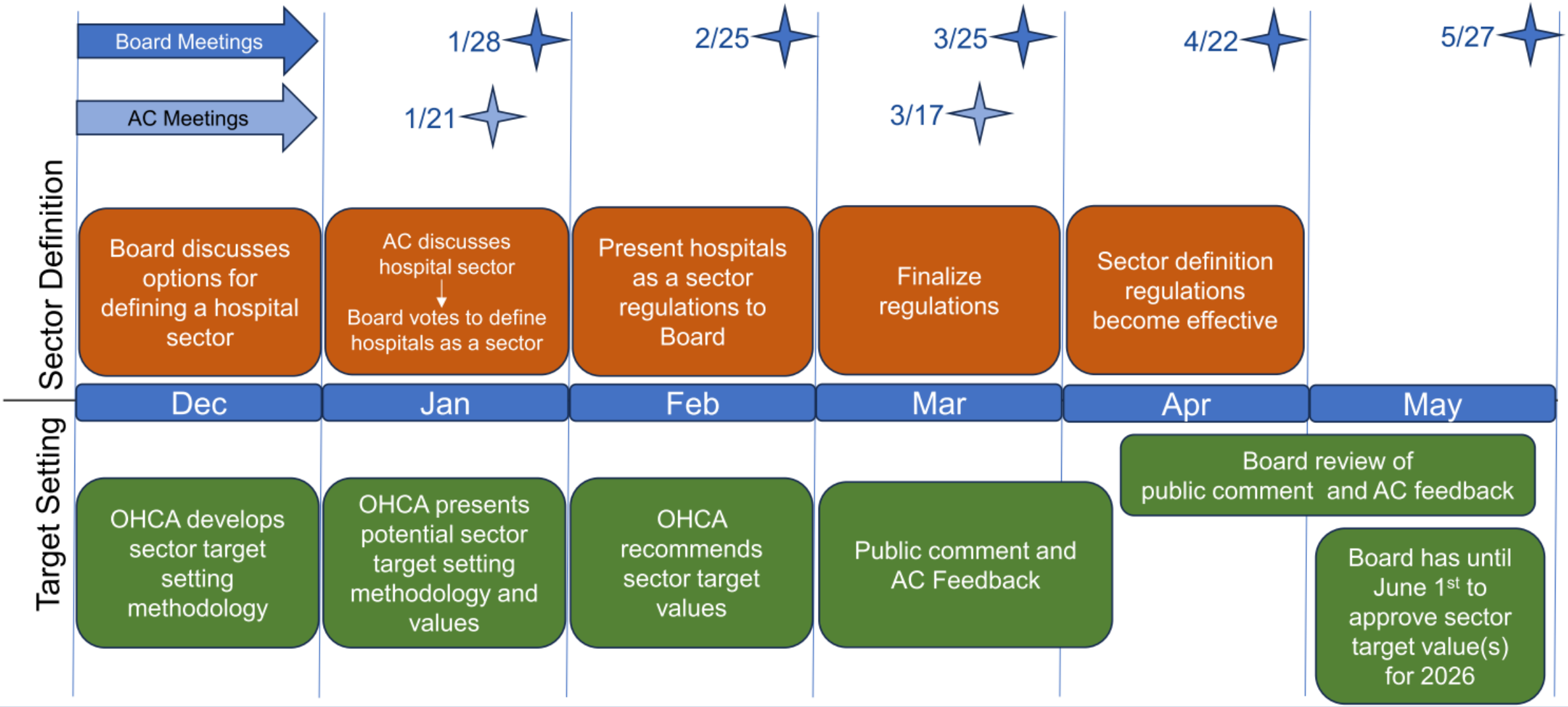
- **January 2025:**
  - The Office would present sector definition options to the Advisory Committee for their feedback.
  - The Board would vote to define hospitals as a sector.

- **February 2025:**
  - The Office would draft regulations with the approved sector definition, present to Board, and then seek OAL approval.
  - The Office would make recommendation for a sector target value(s) and present to Board.

- **February to April 2025**
  - The Board would discuss appropriate hospitals to adjust the sector target for and the sector target value.
  - The Office would present proposed target value(s) to the Advisory Committee for their feedback.

- **April 2025 to May 2025:**
  - The Board would be able to vote on sector target value and any adjustments for selected hospitals 45 days after the Office's proposed targets are discussed at the February board meeting.

Sector Target Implementation Milestones



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Advisory Committee Feedback

Does the Advisory Committee have feedback on the following recommendation presented to the board:

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

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

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Update on Cost and Market Impact Review Program

Heather Cline Hoganson, Assistant Chief Counsel

OHCA Health Systems Compliance

HCAI

Department of Health Care Access and Information

OHCA's Determination To Conduct (or Waive) CMIR - Factors

The Office shall base its decision to conduct a CMIR on any of the following factors:

(A) The transaction may result in a negative impact on the availability or accessibility of health care services, including the health care entity's ability to offer culturally competent care.

(B) The transaction may result in a negative impact on costs for payers, purchasers, or consumers, including the ability to meet any health care cost targets established by the Health Care Affordability Board.

(C) The transaction may lessen competition or create a monopoly in any geographic service areas impacted by the transaction.

(D) The transaction may lessen competition for health care entities to hire workers or may negatively impact the labor market by, for instance, lowering wages or slowing wage growth, worsening benefits or working conditions, or resulting in other degradations of workplace quality.

(E) The transaction negatively impacts a general acute care or specialty hospital by, for instance, restricting or reducing the health care services offered.

(F) The transaction may negatively impact the quality of health care services available to patients from the parties to the transaction.

(G) The transaction is part of a series of similar transactions by the health care entity or entities that furthers a trend toward consolidation.

(H) The transaction may entrench or extend a dominant market position of any health care entity in the transaction, including extending market power into related markets through vertical or cross-market mergers.

(I) The transaction between a health care entity located in this state and an out-of-state entity may negatively impact affordability, quality, or limit access to health care services in California, or undermine the financial stability or competitive effectiveness of a health care entity located in this state.

Source: Cal. Code Regs., tit. 22, § 97441(a)(1)

CMIR Program Update: *Material Change Notices (MCNs) Received Since September 2024*

MCN Submitters	Transaction Summary	Submission Complete	Status
Alta Care Center LLC dba Alta Gardens Care Center	The membership interest in Alta Care Center LLC dba Alta Gardens Care Center is being sold from Summit Care LLC to Bold Quail 3 Operations Holdings LLC. The facility's real estate will be sold from Palmcrest Associates LTD L.P. to 13075 Blackbird Street Propco LLC.	January 2, 2025	In Review
Korean-American Medical Group, Inc and Swan Practice Holdings, P.C.	Korean-American Medical Group, Inc (KAMG), a physician-owned independent practice association, will become a subsidiary of Swan Practice Holdings, P.C. and become subject to an administrative services agreement with SMG Operating Company. KAMG's physician shareholders will also receive an indirect minority ownership interest in SMG Aggregator, LLC.	December 23, 2024	In Review

CMIR Program Update: *Material Change Notices (MCNs) Received Since September 2024*

MCN Submitters	Transaction Summary	Submission Complete	Status
CSI Medical Group, P.C.	Eric Schweiger, M.D. will acquire all of the equity interests of CSI Medical Group from Greg Morganroth, M.D.; the transaction will concurrently close with the sale of California Skin Institute Intermediate Holdings, LLC.	December 24, 2024	In Review
Ambry Genetics Corporation and Tempus AI, Inc.	Tempus AI, Inc. will acquire Ambry Genetics Corporation. Both parties previously partnered to distribute germline sequencing for inherited cancer risk and this acquisition intends to further expand inherited risk screening for cancer patients.	December 20, 2024	In Review

CMIR Program Update: *Material Change Notices (MCNs) Received Since September 2024*

MCN Submitters	Transaction Summary	Submission Completed	Status
KTLA Properties Limited Partnership	KTLA Properties Limited Partnership will sell substantially all of the assets of Alamitos West Health & Rehabilitation and Katella Senior Living Community to 3952 Katella Avenue, LLC, and 3902 Katella Avenue, LLC. The transaction will also transfer the operations of the Alamitos West Health & Rehabilitation and Katella Senior Living Community to Malcolm Healthcare, Inc. and Rigby Creek Senior Living, Inc.	November 5, 2024	CMIR Waived

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Update on Quality and Equity Performance Measurement

Margareta Brandt, Assistant Deputy Director

Janna King, Health Equity and Quality Performance Group Manager

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Department of Health Care Access and Information

OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Adopt and track performance on a single set of standard measures for assessing health care quality and equity across payers, fully integrated delivery systems, hospitals, and physician organizations.**
- **Use recognized clinical quality, patient experience, patient safety, and utilization measures**.
- Consider available means for **reliable measurement of disparities in health care**, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.
- **Reduce administrative burden** by selecting quality and equity measures that simplify reporting and align performance measurement with other payers, programs, and state agencies, including leveraging existing voluntary and required reporting to the greatest extent possible.
- **Coordinate with DMHC, DHCS, Covered California, and CalPERS**, and consult with external quality improvement organizations and forums, payers, physicians, other providers, and consumer advocates or stakeholders.

These criteria are summarized from Article 2. Office of Health Care Affordability, Health and Safety Code § 127501-127501.12 and Article 4. Quality and Equity Performance, Health and Safety Code § 127503.

OHCA's Quality and Equity Measure Set

Statutory Requirements

- **Promote the goal of improved affordability** for consumers and purchasers of health care, **while maintaining quality and equitable care**.
- OHCA may require a health care entity to implement a performance improvement plan that identifies the causes for spending growth and shall include specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. **The Director shall not approve a performance improvement plan that proposes to meet cost targets in ways that are likely to erode access, quality, equity, or workforce stability.**

These criteria are summarized from Article 3. Office of Health Care Affordability, Health and Safety Code § § 127502(c)(5) and 127502.5.

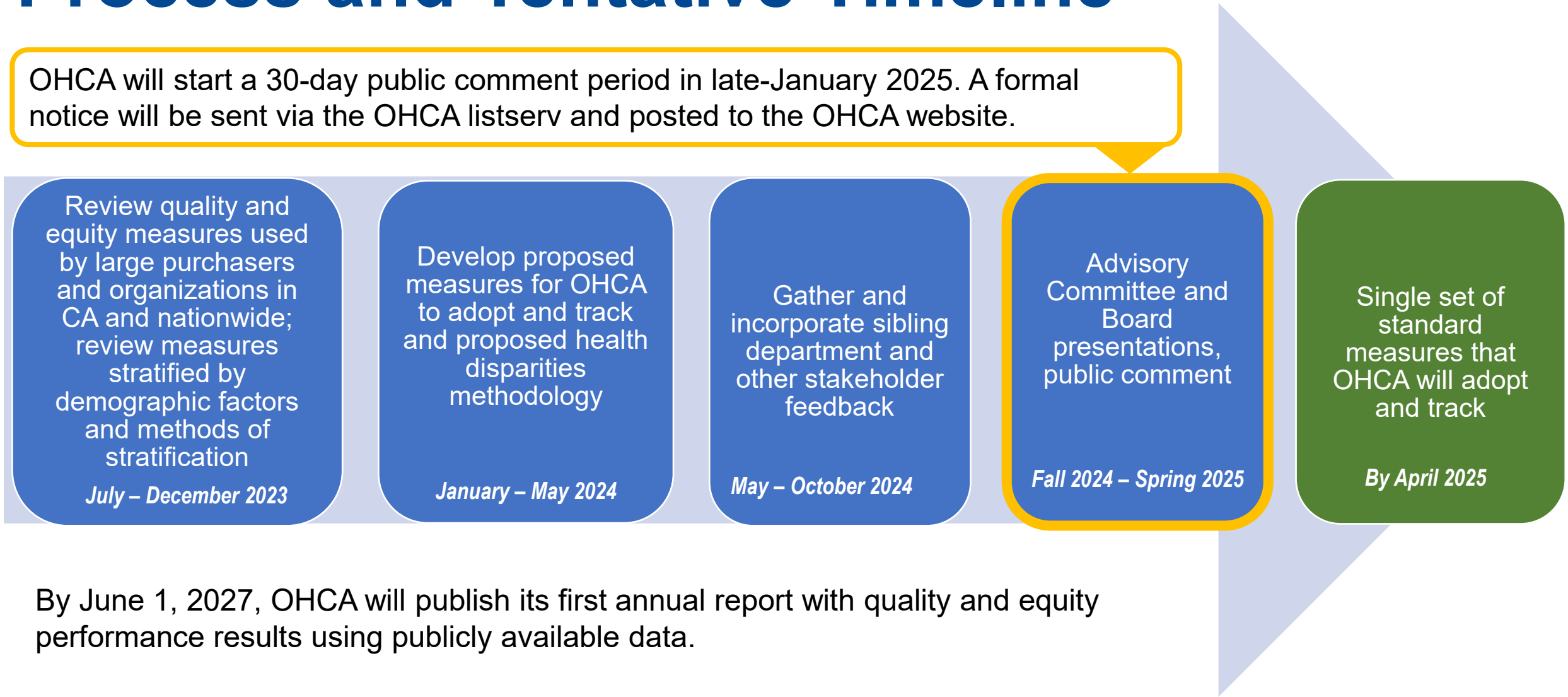
OHCA's Quality and Equity Measure Set

Purpose

- Promote high quality and more equitable health care for all Californians.
- Monitor changes in quality and equity as health care entities work to meet the spending growth target.
- Track progress towards OHCA's goals to improve access, affordability, and equity of health care for all Californians.

Process and Tentative Timeline

OHCA will start a 30-day public comment period in late-January 2025. A formal notice will be sent via the OHCA listserv and posted to the OHCA website.



By June 1, 2027, OHCA will publish its first annual report with quality and equity performance results using publicly available data.

Proposed Quality and Equity Measure Set

- OHCA is proposing to adopt all or a subset of three publicly available measure sets and their respective stratification requirements to measure quality and equity across health care entities.

Payers	Physician Organizations	Hospitals
Fully Integrated Delivery Systems[1]		
Adopt the full DMHC Health Equity and Quality Measure Set and stratification requirements	Adopt a subset of the OPA Health Care Quality Report Card measures[2]	Adopt the full HCAI Hospital Equity Measures Reporting Program measure set and stratification requirements

[1] For fully integrated delivery systems, which include a payer, physician organization, and hospital component, OHCA will measure performance of each of these component entities.
[2] OPA does not report measures stratified by demographic characteristics.

Board and Advisory Committee Feedback on Adding Measures

- The Board and Advisory Committee encouraged OHCA to add measures if possible, including:
  - More specialty care outcome and patient-reported outcome measures.
  - Actionable patient experience information.
  - More access measures, including timeliness of getting needed care.
  - More behavioral health measures, especially behavioral health outcome measures.
  - Cultural and linguistic appropriateness of care measures.
  - Structural measures, including social drivers of health (SDOH) screening, for payers and physician organizations.
  - Hospital safety measures.
- The Board and Advisory Committee remarked that current measures do not adequately measure population health and health care quality.

Proposed OHCA Measures for Payers and Physician Organizations

Measure Name *(*Measures for payers only)*	Measure Category
Childhood Immunization Status	Process
Colorectal Cancer Screening	Process
Controlling High Blood Pressure	Outcome
Glycemic Status Assessment for Patients With Diabetes (<8.0% and/or >9.0%)[3]	Outcome
All-Cause Readmissions	Outcome
Asthma Medication Ratio	Process
Breast Cancer Screening Rate	Process
Child and Adolescent Well-Care Visits	Process
Immunizations for Adolescents	Process
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)*	Behavioral health, Process
CAHPS Health Plan Survey: Getting Needed Care (Adult and Child survey) or QHP Enrollee Experience Survey*	Access, Patient reported outcome or patient experience
Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care)*	Process
Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)*	Process

Sources: DMHC Licensing eFiling. (2024, June 28). APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024). https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-013-HealthEquityandQualityProgramPoliciesandRequirements(6_28_2024).pdf?ver=9wJvJOJ61DNjXvVpRgHqeQ%3d%3d.; OPA. (2024). Health Care Quality Report Cards. https://www.iiii.ca.gov/consumer-reports/health-care-quality-report-cards/.; Measures that align across the DMHC, DHCS, OPA, Covered CA, and CalPERS for payers and physician organizations.; In the DMHC Health Equity and Quality Measure Set, CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

Proposed OHCA Measures for Hospitals

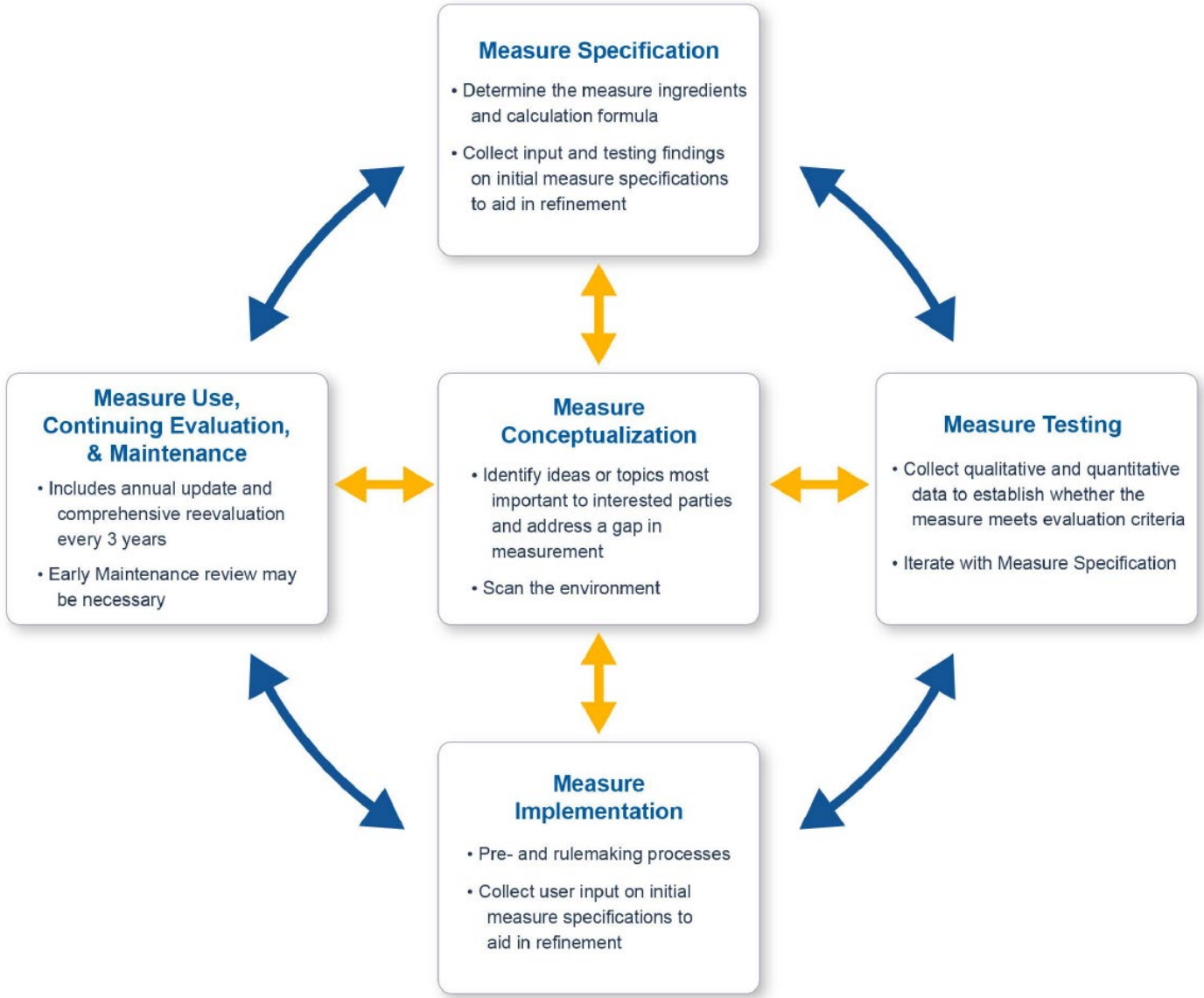
HCAI Hospital Equity Measures Reporting Program Measure Name	General Acute Hospital Measures	Acute Psychiatric Hospital Measures	Children's Hospital Measures	Measure Categories
Designate an individual to lead hospital health equity activities[1]	X	X	X	Structural
Hospital Commitment to Health Equity Structural Measure[1]	X	X	X	Structural
Provide documentation of policy prohibiting discrimination[1]	X	X	X	Structural
Report percentage of patients by preferred language spoken[1]	X	X	X	Structural
Screen Positive Rate for Social Drivers of Health[1]	X	X	X	Structural
Screening for Social Drivers of Health[1]	X	X	X	Structural
All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis	X	X		Safety, Outcome, Behavioral health
HCAHPS survey (Received information and education and would recommend hospital)	X	X		Patient reported outcome or patient experience
Pneumonia Mortality Rate	X	X		Safety, Outcome
All-Cause Unplanned 30-Day Hospital Readmission Rate	X		X	Safety, Outcome
Cesarean Birth Rate (NTSV)	X			Outcome
Death Rate among Surgical Inpatients with Serious Treatable Complications	X			Safety, Outcome
Exclusive Breast Milk Feeding	X			Process
Vaginal Birth After Cesarean Rate (VBAC)	X			Outcome
All-Cause Unplanned 30-Day Hospital Readmission Rate in an inpatient psychiatric facility		X		Safety, Outcome, Behavioral health
Screening for metabolic disorders		X		Process
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge		X		Behavioral health, Process
Pediatric experience survey with scores of willingness to recommend the hospital			X	Patient reported outcome or patient experience

Source: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/.

[1] Structural measures for all hospitals.

OHCA Will Monitor New Measures Under Development

- There are several stages of measure development and the timeline from conceptualization to implementation is resource-intensive and can take years.
- Partnership for Quality Measurement (PQM) circulates a Measures Under Consideration list, on a yearly basis, to gather feedback on measures CMS is considering adopting for use in quality reporting and value-based programs. PQM also convenes the Core Quality Measures Collaborative to create core sets in high-priority areas including behavioral health.

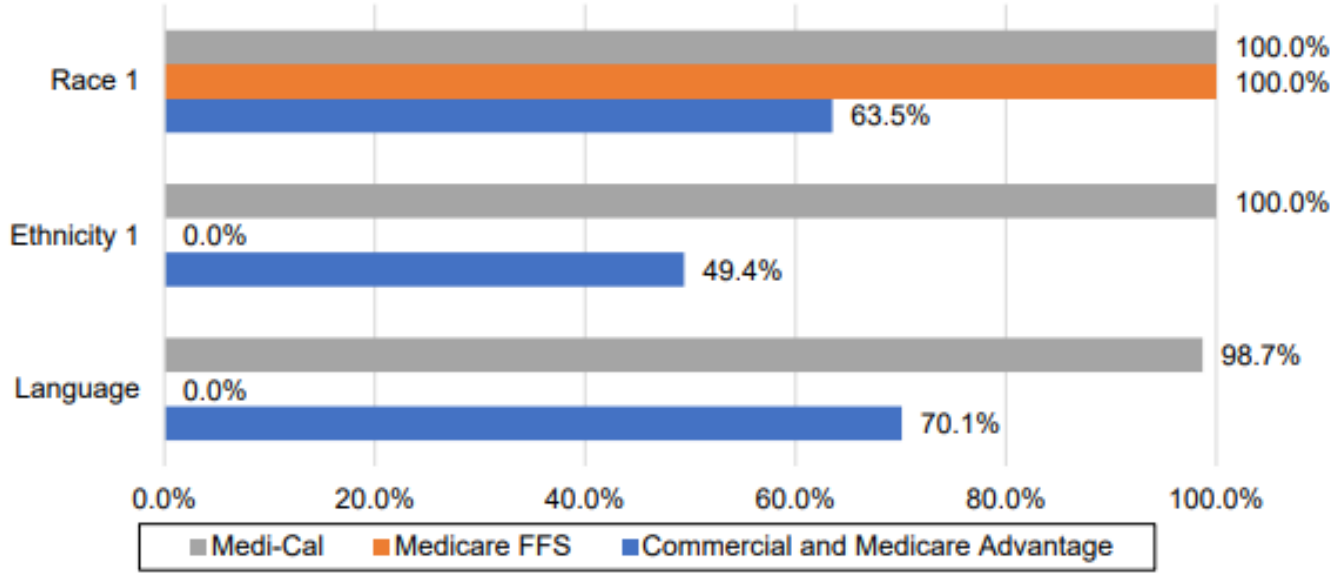


Sources: Centers for Medicare & Medicaid Services. (2024, December). *Blueprint Measure Lifecycle Overview | The Measures Management System*. https://mmshub.cms.gov/blueprint-measure-lifecycle-overview.; Partnership for Quality Measurement. (2024, November 25). *Now Open: 2024 Pre-Rulemaking Measure Review (PRMR) Measures Under Consideration (MUC) List for Public Comment*. https://p4qm.org/articles/now-open-2024-pre-rulemaking-measure-review-prmr-measures-under-consideration-muc-list.; Partnership for Quality Measurement. (n.d.). *Core Sets*. Retrieved December 11, 2024, from https://p4qm.org/CQMC/core-sets.

OHCA Will Monitor Efforts to Improve Stratification

- There are limitations and gaps in demographic data collection and reporting. A Health Care Payments Data (HPD) report shows incomplete data capture for race, ethnicity, and language.
- Key reasons why demographic data is not captured, incomplete, and/or challenging to compare across different data sources:
  - Demographic data is not collected
  - Non-standard data collection and reporting
  - Data quality cannot be confirmed
  - Privacy concerns
  - Cultural sensitivities
  - Many opt out of voluntary self-reported data

Completeness for Race, Ethnicity, and Language (2021)



- The Department of Managed Health Care (DMHC), DHCS, Covered California, and CalPERS are encouraging, requiring, and/or incentivizing health plans to have more complete demographic data for their members to improve health disparities analysis.

Sources: HCAI. (2024). *Program Report Health Care Payments Data Program*. https://hcai.ca.gov/wp-content/uploads/2024/02/HPD-Report-to-the-Legislature-March-2024-1.pdf.; CMS. (2022). *The Path Forward: Improving Data to Advance Health Equity Solutions*. https://www.cms.gov/files/document/path-forwardhe-data-paper.pdf.

Hospital Safety Measures Recommendation

- The HCAI Hospital Equity Measures Reporting Program measure set, which OHCA proposes to adopt, includes the best available outcome measures and patient reported outcome measures.
- For hospitals, these are key outcome measures and patient reported outcome measures for OHCA to track to promote high quality and more equitable care and to monitor changes in quality and equity as health care entities work to meet the spending growth target.
- At this time, OHCA recommends against adding hospital safety measures such as Healthcare Associated Infections and Adverse Events.

Healthcare Associated Infections

- OHCA will focus on the Hospital Equity Measures Reporting Program measure set initially and as HCAI expands data collection for hospitals, OHCA can reconsider adding Healthcare Associated Infection (HAI) measures.
- In the meantime, OHCA can reference the work of partner organizations tracking HAIs, including:
  - CMS's Hospital Inpatient Quality Reporting Program[1] and public reporting on CMS's Care Compare website;
  - The Center for Disease Control and Prevention's National Healthcare Safety Network;
  - The Department of Health Care Services' Quality Incentive Pool program; and
  - The California Department of Public Health's work to track and provide technical assistance to hospitals to reduce HAIs.

Sources: CMS. (2024). *Hospital Inpatient Quality Reporting Program.* https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/inpatient-reporting-program.; CMS.(2024). *Care Compare.* https://www.medicare.gov/carecompare/providerType=Hospital.; Center for Disease Control. (2024). *National Healthcare Safety Network.* https://www.cdc.gov/nhsn/index.html.; California Department of Health Care Services. (2023). *DHCS Quality Incentive Pool (QIP) Program PY 7 Measure Set.* https://www.dhcs.ca.gov/services/Documents/PY-7-Measure-Set.pdf.; California Department of Public Health Center for Health Care Quality. (2024).*Healthcare Associated Infections (HAIs) Program.* https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/HAIreport.aspx.

Adverse Events

- Since reports and investigations of adverse events, such as surgical error, are not standard measures of quality and equity, OHCA does not plan to add them to its measure set at this time.
- However, OHCA can reference the California Department of Public Health's tracking and investigations of adverse events pursuant to SB 1301 (Chapter 647, Statutes of 2006).

Sources: California Department of Public Health Center For Health Care Quality. (2024). *California Hospital Adverse Events Map.* https://cdphdata.maps.arcgis.com/apps/webappviewer/index.htmlid=ff84d556bfc44410ac478220b449d422.; California Department of Public Health Center For Health Care Quality (2024). *California Health Facilities: State Enforcement Actions.* https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/StateEnforcementActionsDashboard.aspx.

Summary of Board and Advisory Committee Feedback

Additional Measures	
Feedback Theme	**OHCA's Response**
The Board and Advisory Committee encouraged OHCA to add measures if possible, including: • More specialty care outcome and patient-reported outcome measures. • Actionable patient experience information. • More access measures, including timeliness of getting needed care. • More behavioral health measures, especially behavioral health outcome measures. • Cultural and linguistic appropriateness of care measures. • Structural measures, including SDOH screening, for payers and physician organizations. • Hospital safety measures.	• OHCA will monitor new measures under development. • There are nationwide limitations in measures available for programmatic use and the timeline of measure development from conceptualization to implementation is resource intensive and can take many years. • OHCA is required by statute to regularly review and update its measure set over time. The initial measure set is a starting point and can be updated over time. For example, including more measures as they become available for programmatic use. • OHCA recommends against adding additional hospital safety measures. The HCAI Hospital Equity Measures Reporting Program measure set includes the best available outcome measures and patient reported outcome measures and includes some safety measures.

Summary of Board and Advisory Committee Feedback

Limitations	
Feedback Theme	**OHCA's Response**
• Several AC members noted the need to continue working to remedy missing demographic data. • The AC and the Board had concerns that quality measures are limited in what quality of care and health outcomes they can capture. • An AC member noted that providers with more resources may be able to "game" quality measures. • An AC member noted concerns that some physician organizations are not included in the OPA Health Care Quality Report Cards.	• OHCA will support and monitor statewide efforts to collect more complete demographic data and outcome measure initiatives. • OHCA plans to look at the overlap of physician organizations reported through THCE and those in the OPA Health Care Quality Report Cards. Depending on the results of this analysis, OHCA will collaborate with OPA and IHA to explore how to better align physician organizations included in the THCE data and OPA Health Care Quality Report Cards. • One challenge is that there is currently no standard definition nor comprehensive list of physician organizations in California.

Summary of Board and Advisory Committee Feedback

Stratification	
Feedback Theme	**OHCA's Response**
• Several AC members had concerns with the limited health equity data for payers and physician organizations and noted problems with individual-level demographic data. AC members recommended stratifying more measures, including by race, ethnicity, age, disability status, and geographic region, especially for physician organizations. • A Board member questioned if the DMHC Demographic Data Metric includes age. • An AC member asked if OHCA can look at performance on Depression Screening and Follow-Up for Adolescents and Adults separately for adolescents and adults. • A Board member asked what OHCA's and HCAI's plans are regarding implementing the new race and ethnicity categories that OMB released earlier this year.	• OHCA will monitor efforts to improve demographic data and stratify more measures, especially for physician organizations. OHCA will collaborate with OPA and IHA to explore opportunities to publicly report stratified measures. • The DMHC Demographic Data Metric does not include age and DMHC will not be collecting the Depression Screening and Follow-Up for Adolescents and Adults measure broken down by age groups. • HCAI is working to adopt the changes to the race and ethnicity categories, including combining race and ethnicity and adding the new Middle Eastern or North African categorization, though it will take time. There will be a mapping process to map data based on the old race and ethnicity categories with the new categories.

Summary of Board and Advisory Committee Feedback

Reporting and Enforcement	
Feedback Theme	**OHCA's Response**
• Several AC members pushed to focus on OHCA's purpose and report information that is easily understandable, meaningful, and actionable, and suggested grouping measures (e.g., preventive care) and highlighting subgroups (e.g., older adults and people with disabilities). • AC members suggested reporting on the National Committee for Quality Assurance's (NCQA) Health Equity Accreditation. • The Board asked what OHCA can do if a health care entity meets the spending growth target but is performing poorly on quality and equity.	• OHCA welcomes specific recommendations of measures to monitor and is committed to public reporting that is clear, meaningful, and actionable. • OHCA will consider reporting which payers have achieved NCQA Health Equity Accreditation and NCQA Health Equity Plus Accreditation. • OHCA does not have enforcement authority for performance on the measure set but will publicly report performance on the measure set and flag decreases in quality and equity in its annual reports, including for those entities that meet the spending growth target. • In addition, statute allows OHCA to investigate where data indicates adverse impacts on cost, access, equity, or quality from consolidation or market power.

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Update on Behavioral Health Benchmark

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

HCAI

Department of Health Care Access and Information

Primary Care & Behavioral Health Investments

Statutory Requirements

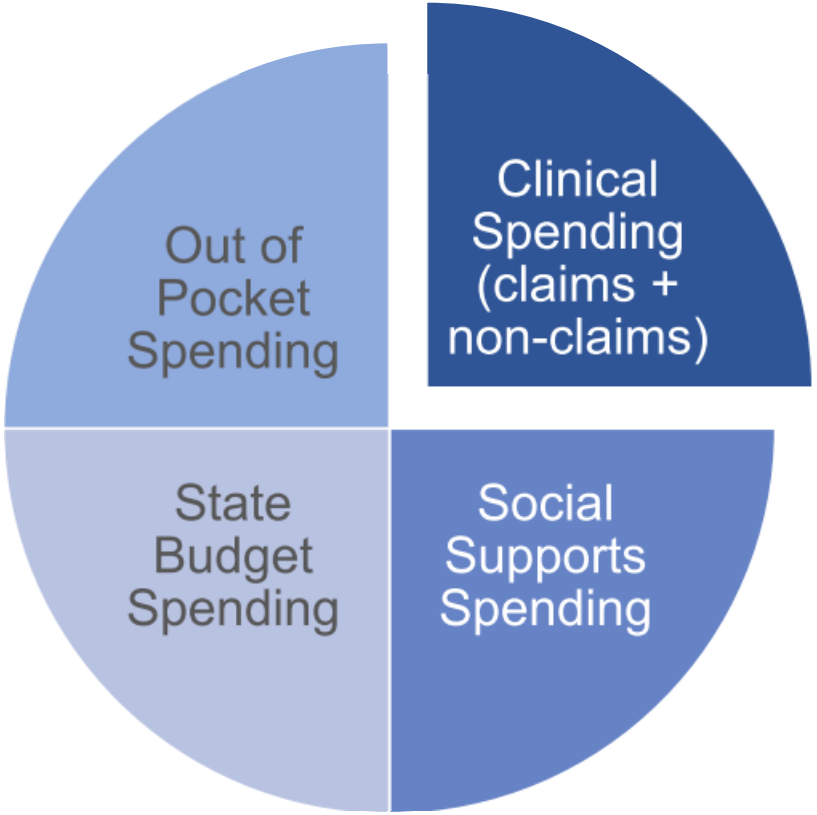
- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- **Measure the percentage of total health care expenditures allocated to PC and BH** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop benchmarks**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

Health and Safety Code § 127505

Behavioral Health Spending Measurement

Data Collection and Measurement Scope

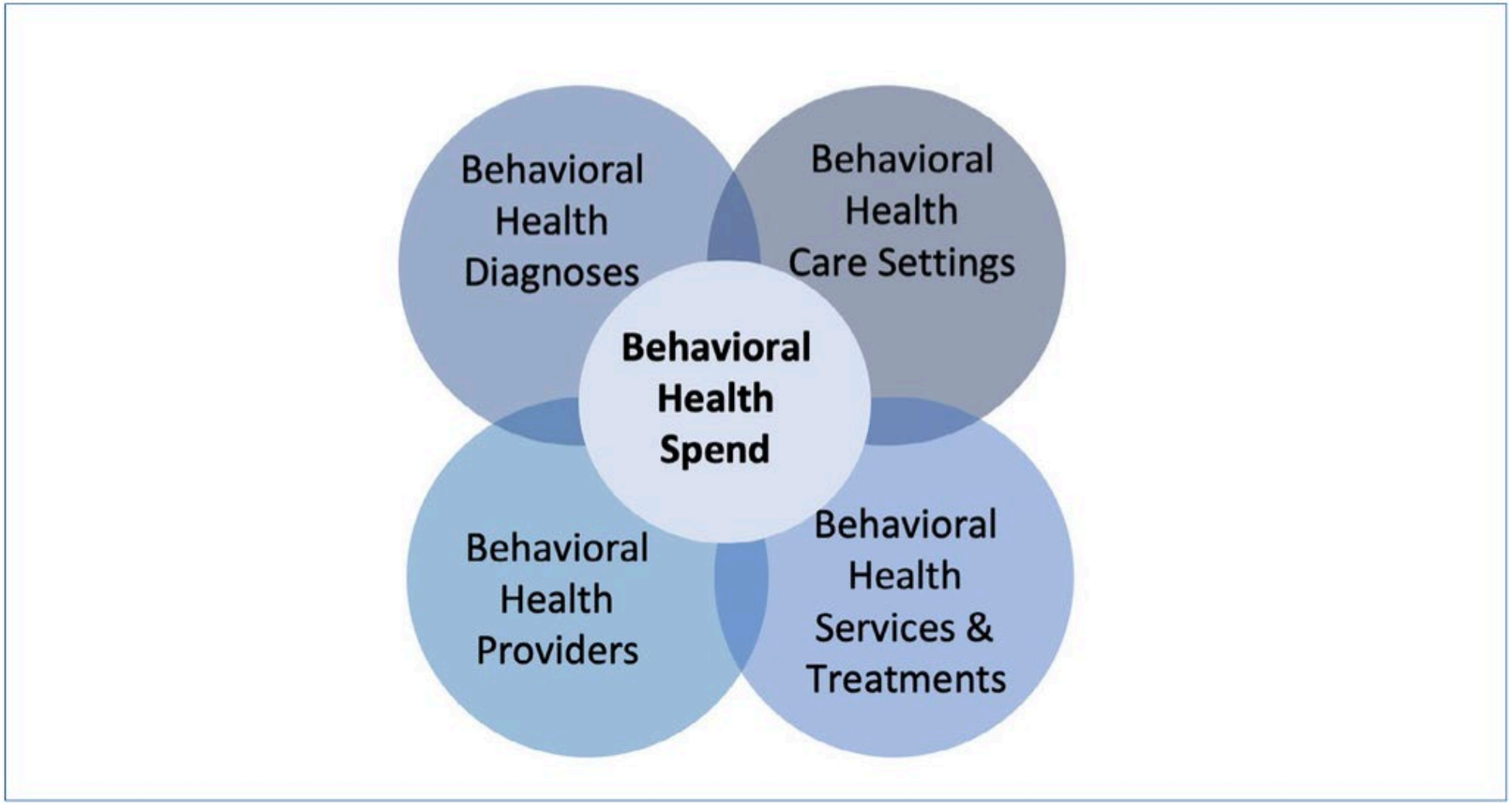
Clinical services are services provided by medical and allied health professionals to prevent, treat, and manage illness, and to preserve mental well-being across the clinical care continuum, paid via claims and non-claims payments (e.g., outpatient therapy visit, day treatment programs).



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

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

Defining Behavioral Health Spending



Measuring Behavioral Health Spending

Numerator

Claims-based payments for behavioral health + Non-claims-based payments for behavioral health = Total behavioral health investment

Denominator

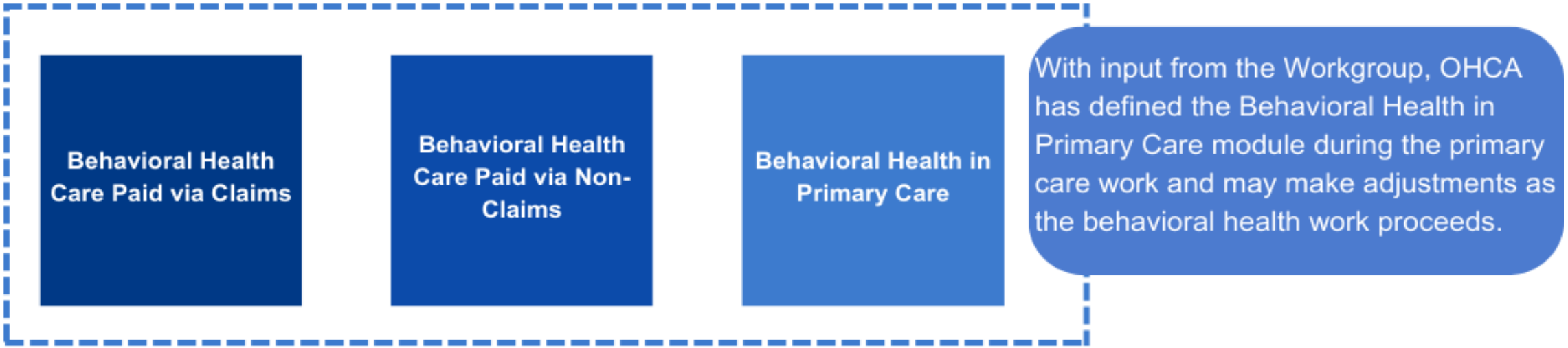
Total claims-based payments + Total non-claims-based payments = Total medical expense

X 100% = Behavioral health investment as a % of total medical expense

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

Three Recommended Modules for Behavioral Health Spending Measurement

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

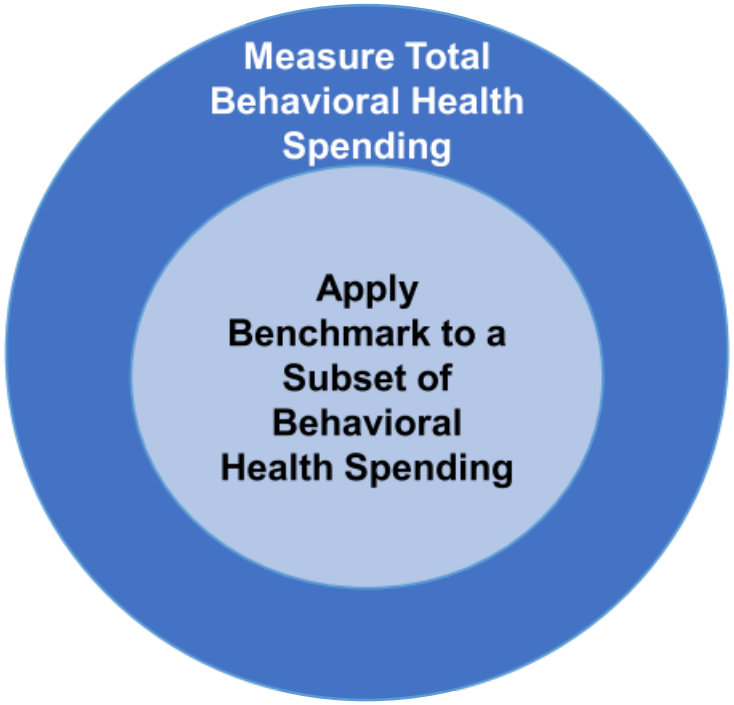


Behavioral Health Investment Benchmark

Broad Measurement, Focused Benchmark

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

Spending Included

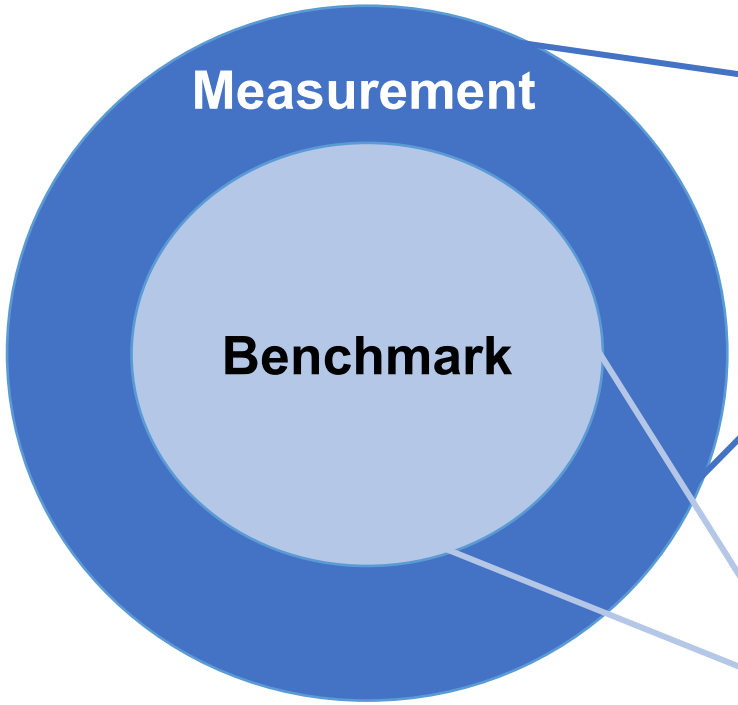


Benchmark Straw Model

Question	Working Straw Model
What should the increased behavioral health investment achieve?	Increased investment should help individuals in need of behavioral health care to receive more timely, high quality, and culturally-responsive care, in more appropriate settings, and with less out-of-pocket spending via improved access to outpatient and community-based services that are in-network.
How should OHCA structure the benchmark to achieve this aim?	Include in-network outpatient and community-based behavioral health services covered via commercial and Medicare Advantage* plans, excluding pharmaceutical spend.**

*OHCA would initially focus on commercial and Medicare Advantage and expand to Medi-Cal when data collection and methodology allow. **Still under consideration.

Example: Measurement vs. Benchmark



Potential Service Categories for Total Spend Measurement:

- Long-term Care
- Residential
- Inpatient (including partial hospitalization)
- Emergency Department/Observation
- Outpatient Facility and Professional, including
  - Primary Care
  - Telehealth
  - Community-based services
- Community-based Mobile Clinic Services

Potential Service Categories for Benchmark:

- Outpatient Facility and Professional (including Primary Care, Telehealth, Community-based Services)
- Community-based Mobile Clinic Services

Benchmark Straw Model Rationale

- **Focus on outpatient and community-based care**
  - Emphasizes prevention and population health
  - Acknowledges that increased investment in upstream care can reduce demand for more resource-intensive services
  - Aligns with and complements other state policies focused on access, parity, and investments in expansion of facility infrastructure
- **Access**
  - Nearly two thirds of adults with any mental illness did not receive mental health services;[1] California ranks 49th among states on this measure[2]
  - 63% of adolescents with symptoms of a major depressive episode did not receive treatment;[1] California ranks 46th among states on this measure[2]
  - Among Californians who tried to make a mental health appointment in 2023, more than half (55%) waited longer than they thought reasonable[3]

[1] California Health Care Foundation, Mental Health Care in California, July 2022.
[2] Commonwealth Fund, 2023 Scorecard on State Health System Performance
[3] California Health Care Foundation, The 2024 CHCF California Health Policy Survey, January 2024.

Benchmark Straw Model Rationale

- **Network**
  - Among Californians who tried to make a mental health appointment in 2023, more than half (52%) reported difficulty finding a provider that takes their insurance[1]
  - Californians used out-of-network psychiatrists and psychologists in 2021 more than 15 times as frequently as out-of-network medical/surgical specialist physicians, and any out-of-network BH clinician almost 6 times more frequently as medical/surgical physicians[2]
- **Cultural responsiveness**
  - Only about a third of Californians who are of Latino or Asian, Native Hawaiian or Pacific Island ethnicities agree that their local communities have mental health workers that have knowledge about their ethnic groups' needs[3]

[1] California Health Care Foundation, The 2024 CHCF California Health Policy Survey, January 2024.
[2] Mark and Parish, Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue. RTI International, April 2024.
[3] NORC, The 2020-2021 California Communities Mental Health Services Survey, Sept. 2021

Alignment Opportunities: Prop 1 (2023)

Legislation	Element	OHCA Alignment
Proposition 1	Behavioral Health Services Act focus on community-based care.	Focused benchmark incentivizes payers to increase investment in community-based services.
	Behavioral Health Infrastructure Bond Act authorizes $6.4 billion in bonds to finance behavioral health treatment beds, supportive housing, community sites, and funding for housing veterans with behavioral health needs.	Focused benchmark on community-based services would complement Proposition 1 investments and direct investment to additional areas of need.

Alignment Opportunities: SB 855 (2020)

Legislation	Element	OHCA Alignment
SB 855	Requires insurers cover “medically necessary treatment” for all mental health and substance use disorders.	Includes a broad set of services to treat mental health and substance use disorders.
	Mandates in-network coverage for out-of-network providers when access is not available within geographic and timely access standards.	Incentivizes payers to increase investment in-network BH coverage.
	Prohibits plans from denying medically necessary services on the basis they should be or could be covered by a public entitlement program.	Benchmark focus on in-network care.

Alignment Opportunities: SB 221 (2021)

Legislation	Element	OHCA Alignment
SB 221	Ensures that appointments with nonphysician mental health and substance use disorder providers are subject to the timely access requirements.	Focused benchmark on community-based services provided in-network seeks to increase access. Potential HPD Analyses that can leverage OHCA's behavioral health measurement definition: • Quality measures related to behavioral health care and follow-up • Number and distribution of providers and facilities billing for behavioral health services • Licensed providers in payer networks as a percentage of total licensed providers in California
	Ensures that an enrollee undergoing a course of treatment for an ongoing mental health or substance use disorder condition can get a follow-up appointment within 10 business days.	
	If a plan operates in an area with a shortage of providers and is not able to meet the geographic and timely access standards with an in-network provider, the bill requires the plan to arrange coverage outside its contracted network.	

Stakeholder Feedback

December Board Feedback

Feedback
• Support for a focused benchmark approach. • Interest in shaping the benchmark to support clearly-articulated statewide goals. • Highlighted importance of future incorporation of Medi-Cal. • Need for continued collaboration and information sharing with parallel efforts including those measuring out-of-plan spending. • Interest in alignment with other transformation efforts including legislation to strengthen behavioral health system and enhance access to school-based care.

Investment and Payment Workgroup Feedback

Feedback
• Overall strong Workgroup support for benchmark straw model though a few members have raised questions or expressed concern that the straw model excludes inpatient, long-term care, and residential settings. • Interest in aligning with Proposition 1, SB 855, and SB 221. • Strong Workgroup support for including autism and other developmental disorders in claims-based behavioral health measurement. • Mixed support for including the medical procedures related to dementia and adverse effects of self-harm, though stronger support for including the behavioral health treatments related to those diagnosis categories. • Workgroup members favor a broad definition of diagnoses and a wide, yet more focused, list of services for behavioral health treatments.

Tentative Timeline for Behavioral Health Work

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

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

X Provide Feedback ✓ Board Approval

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General Public Comment

Written public comment can be emailed to: ohca@hcai.ca.gov

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Next Advisory Committee Meeting:

March 17, 2025
9:00 a.m.

Location:
To Be Determined

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Adjournment

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Appendix

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Potential Hospital Categories to Consider

1. Critical Access Hospitals
2. Small Hospitals
3. Psychiatric Hospitals
4. Children's Hospitals
5. Teaching Hospitals/Academic Medical Centers
6. Specialty Hospitals
7. State Hospitals
8. County Hospitals
9. Hospitals with long average lengths of stays

1. Critical Access Hospitals

Context:

There are 38 Critical Access Hospitals in California. These hospitals are in rural parts of California and are the only sources of care available for residents in these areas.

Considerations:

- Rely predominantly on public payers (Medicare & Medicaid).
- Very small commercial coverage patient populations.
- Represent a small percentage of total hospital spending in the state.
- High operating costs to provide essential services in remote areas with small patient populations.
- Typically have small operating margins.

Note: Full definition of a Critical Access Hospital can be found in the appendix. Source: Health Resources and Services Administration Data Explorer, https://data.hrsa.gov/tools/data-explorer?paramServiceId=CMS&paramCMSSubCat=Critical%20Access%20Hospitals.

2. Small Hospitals

Context:

There are multiple ways to define small hospitals (e.g., licensed bed count, total discharges, total operating revenues, other).

Consideration:

- Tend to vary greatly year-to-year in spending, with small changes leading to significant fluctuations.
- Represent a small portion of overall statewide hospital spending, specifically 3% of the total Net Patient Revenue.

3. Psychiatric Hospitals

Context:
Based on HCAI data, there are 66 psychiatric hospitals in California. The designation of a psychiatric hospital is self-reported/identified. These hospitals provide a preponderance of psychiatric services.

Considerations:
- Only 1% of Net Patient Revenue and Total Operating Revenue across all hospitals.
- For psychiatric hospitals in California, the average length of stay is 12.4 days, while for general acute care hospitals it is 5.7 days.

Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

4. Children's Hospitals

Context:

Based on HCAI data, there are 10 children's hospitals in California. The designation of a Children's Hospital is self-identified in HCAI data. There are likely facilities that specialize in or focus on care for children that do not self-identify as a Children's Hospital.

Considerations:

- Children's Hospitals generally specialize in higher acuity care or specialized services.

Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

5. Teaching Hospitals

Context:

Based on HCAI data, there are 44 teaching hospitals* in California. HCAI identified teaching hospitals based primarily on the American Medical Association's Graduate Medical Education (GME**) Directory.

Considerations:

- Costs associated with GME and other resources may skew upward the average cost per discharge.
- Although there are only 44 Teaching hospitals, they make up 40% of total operating revenue for all hospitals.

*Includes Academic Medical Centers. **Graduate Medical Education is more commonly referred to as "residency" and "fellowship" training. The 3 to 9 years of training allows physicians to specialize and practice independently following medical school. Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

6. Specialty Hospitals

Context:

There is not a statutory definition of what constitutes a specialty hospital, however, based on HCAI data there are 38 self-reported specialty hospitals. Examples of care provided by specialty hospitals may include rehabilitation, cancer treatment, heart surgery, addiction recovery, respiratory care, neurological services, long-term care, orthopedic surgery, and mental health care.

Considerations:

These facilities may offer services that are not always widely available throughout California's hospital network and may have different cost structures or cost drivers leading to higher average costs and/or higher average growth rates.

Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

7. State Hospitals

Context:
Based on HCAI data, there are 6* state hospitals in California that provide mental and behavioral health services to patients referred by a county court, a prison, or a parole board. California's state hospitals are Atascadero, Coalinga, Metropolitan (in Los Angeles County), Napa, Patton, and Porterville. Funding for these hospitals is through the General Fund and reimbursements from counties.

Considerations:
- These state-run facilities support correctional health care services.
- Their funding comes through a state appropriation determined through the state budget process.
- They do not submit all financial exhibits to HCAI.

*The Department of State Hospitals operates Atascadero, Coalinga, Metropolitan, Napa and Patton. Porterville Developmental Center (https://hcai.ca.gov/facility/porterville-developmental-center/) is operated by the Department of Development Services and is licensed as a general acute hospital.
Source: 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx

8. County Hospitals

Context:

Counties are responsible for health care for low-income uninsured residents who have no other sources of care. There are 12 counties that run hospitals or health care systems. Some counties own and operate hospitals and clinics; some counties only operate clinics and contract with private or University of California hospitals for care.

Considerations:

- County hospitals are core providers to Medi-Cal and uninsured patients.
- There is significant variation among counties regarding program design, eligibility, administration and funding.

California Association of Public Hospitals & Health Systems, "Public Health Care System Financing 101 (December 2023), https://caph.org/wp-content/uploads/2023/12/Public-Hospital-Finance-2023-Annual-Conference.pdf; California State Association of Counties, "Overview of How California Counties Deliver Health Care Services," https://www.counties.org/sites/main/files/file-attachments/fact_sheet_county_health_care.pdf

9. Hospitals with long average lengths of stays

Context:

Some hospitals tend to have relatively longer lengths of stay. Based on HCAI data, in 2023 the median hospital has an average length of stay of 5.8 days and the average length of stay across all discharges statewide is 6.7 days. 66 hospitals have an average length of stay of 20 or more days.

Considerations:

These facilities often have high costs on a per discharge basis regardless of measurement approach.

Source: Internal Analysis of 2023 CY Hospital Annual Selected File (October 2024 Extract), https://data.chhs.ca.gov/dataset/ea0c8ca9-023e-46a3-b95b-b9d4ab8ec195/resource/244efb23-daf0-4137-9609-1bc25e4612b8/download/hadr-2023.xlsx.

Proposed Quality and Equity Performance Measures

Measures for Payers and Physician Organizations (Plus Measures for Hospitals)

Measures	OHCA	
Childhood Immunization Status[1]	Payers	Physician organizations
Colorectal Cancer Screening[1]		
Controlling High Blood Pressure[1]		
Glycemic Status Assessment for Patients With Diabetes (<8.0% and/or >9.0%)[1]		
All-Cause Readmissions		
Asthma Medication Ratio		
Breast Cancer Screening Rate		
Child and Adolescent Well-Care Visits		
Immunizations for Adolescents		
Depression Screening and Follow-Up for Adolescents and Adults (Depression Screening and Follow-Up on Positive Screen)		
CAHPS Health Plan Survey: Getting Needed Care (Adult and Child survey) or QHP Enrollee Experience Survey[2]		
Prenatal and Postpartum Care (Postpartum Care and Timeliness of Prenatal Care)		
Well-Child Visits in the First 30 Months of Life (0 to 15 Months and 15 to 30 Months)		
HCAI Hospital Equity Measures Reporting Program measure set (full)		☑

- OHCA proposes to adopt the full DMHC measure set for payers, the overlap of DMHC and OPA measure sets for physician organizations, and all HCAI Hospital Equity Measures Reporting Program measures.
- The payer and physician organization measure sets should become more aligned as measures are added to the OPA Health Care Quality Report Cards.

[1] Measures that align across all California State Departments for payers and physician organizations.
[2] In the DMHC Health Equity and Quality Measure Set, CAHPS Child Survey is only for applicable Medicaid plans. CAHPS health plan survey does not apply to Exchange plans. Exchange plans will report to the DMHC on the QHP Enrollee Experience Survey in measurement year 2024.

Measures for Hospitals (Plus Measures for Payers and Physician Organizations)

HCAI Hospital Equity Measures Reporting Program Measure Name	General Acute Hospital Measures	Acute Psychiatric Hospital Measures	Children's Hospital Measures	OHCA
Designate an individual to lead hospital health equity activities[1]	X	X	X	Hospitals
Hospital Commitment to Health Equity Structural Measure[1]	X	X	X	
Provide documentation of policy prohibiting discrimination[1]	X	X	X	
Report percentage of patients by preferred language spoken[1]	X	X	X	
Screen Positive Rate for Social Drivers of Health[1]	X	X	X	
Screening for Social Drivers of Health[1]	X	X	X	
All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis	X	X		
HCAHPS survey (Received information and education and would recommend hospital)	X	X		
Pneumonia Mortality Rate	X	X		
All-Cause Unplanned 30-Day Hospital Readmission Rate	X		X	
Cesarean Birth Rate (NTSV)	X			
Death Rate among Surgical Inpatients with Serious Treatable Complications	X			
Exclusive Breast Milk Feeding	X			
Vaginal Birth After Cesarean Rate (VBAC)	X			
All-Cause Unplanned 30-Day Hospital Readmission Rate in an inpatient psychiatric facility		X		
Screening for metabolic disorders		X		
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge		X		
Pediatric experience survey with scores of willingness to recommend the hospital			X	
DMHC Health Equity and Quality Measure Set (full) and OPA Health Care Quality Report Card Measures (subset)				☑

Source: HCAI. (n.d.). *Hospital Equity Measures Reporting Program*. https://hcai.ca.gov/data/healthcare-quality/hospital-equity-measures-reporting-program/.

[1] Structural measures for all hospitals. For more detail on these measures, see Appendix.