OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Health Care Affordability Board Meeting

January 28, 2025

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Welcome, Call to Order, and Roll Call

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Agenda

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

Secretary Kim Johnson, Chair

Item #2 **Executive Updates**

Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director

Item #3 **Action Consent Item**

Vishaal Pegany

a) Vote to Approve December 16, 2024 Meeting Minutes

Item #4 **Action Item**

Vishaal Pegany; Megan Brubaker, Engagement and Governance Manager

a) Vote to Establish a Subcommittee for the Selection of Advisory Committee Members

b) Vote to Establish Hospital Sector(s)

Item #5 **Informational Items**

Vishaal Pegany; *CJ Howard, Assistant Deputy Director; Andrew Feher, Research and Analysis Group Manager; Margareta Brandt, Assistant Deputy Director; Sheila Tatayon, Assistant Deputy Director; Heather Hoganson, Assistant Chief Counsel*

a) Hospital Sector Data Analysis, Including Advisory Committee Feedback
b) Sector Target Setting Methodology
c) THCE Regulations and Data Submission Guide Updates, Including Advisory Committee Feedback
d) Update on Cost and Market Impact Review Program

Item #6 **Public Comment**

Item #7 **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 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.

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

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 informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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Action Consent Item: Vote to Approve December 16, 2024 Meeting Minutes

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Action Item: Vote to Establish Subcommittee for Selection of Advisory Committee Members

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Advisory Committee – Solicitation of Members

- 28 current members
- 12 members whose terms end on June 30, 2025
- Solicitation February – April 2025
- Option to reappoint current members

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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Advisory Committee Appointments: Statute

Representative Groups:

When appointing members to the advisory committee, the board shall aim for broad representation, including, at a minimum:

- representatives of consumer and patient groups
- payers
- fully integrated delivery systems
- hospitals
- organized labor
- health care workers
- medical groups
- physicians
- purchasers

Source: Health and Safety Code § 127501.12

Advisory Committee Appointments: Statute

Demonstrated and acknowledged expertise in at least one of the following areas:

- health care economics
- health care delivery
- health care management or health care finance and administration, including payment methodologies
- health plan administration and finance
- health care technology
- research and treatment innovations
- competition in health care markets
- primary care
- behavioral health, including mental health and substance use disorder services
- purchasing or self-funding group health care coverage for employees
- enhancing value and affordability of health care coverage, or
- organized labor that represents health care workers.

Source: Health and Safety Code § 127501.12

Advisory Committee Appointments: Statute

Group Composition

Shall consider the expertise of the other members and attempt to make appointments so that the composition of members reflects a diversity of expertise on health care entities, purchasers, and consumer advocacy groups.

Reflect State Diversity

In making appointments, shall take into consideration the state's diversity in culture, race, ethnicity, sexual orientation, gender identity, and geography so that composition reflects the communities of California. Appointing authorities shall consider the experience the member has as a patient or caregiver of a patient with a chronic condition requiring ongoing health care, which may include behavioral health care or a disability.

Source: Health and Safety Code § 127501.10

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

Board and Public Comment Requests From Last Cycle

- Retiree perspective
- Small business
- Current or past involvement with the Board or AC
- Updating optional demographic information (race, ethnicity, gender identity, sexual orientation, cultural perspective)

Does the Board have additions or modifications to this list for the subcommittee to consider?

Motion – AC Selection Subcommittee

Motion to appoint two Board members to a subcommittee that will work with staff to provide recommendations on Advisory Committee selection.

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Action Item: Vote to Establish Hospital Sector(s)

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Recap: Hospital Sector(s) Options

At the December Board meeting OHCA presented the following options to enable the Board to establish sector targets to address high-cost hospitals.

These options focus on how to define sectors. Subsequent discussions will address establishing sector target value(s).

1. Wait to define 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. Define a sector based on facility attributes and financial measures.
4. Define all hospitals as a sector and adjust the sector target for select facilities.

OHCA's Recommendation: Define all Hospitals as a Sector

If the Board intends to proceed with sector targets effective for calendar year 2026, OHCA recommends the Board define all hospitals as a sector.

If defined as a sector, hospitals would be subject to the statewide target unless and until the Board adjusts the target for all or a specified subset of hospitals within the sector.

This option enables the Board to respond timely to facilities with spending trends that do not advance consumer affordability.

OHCA's Recommendation: Define all Hospitals as a 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.
- HSC § 127502 (*l*)(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. (B) Not later than June 1, 2028, the board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate, in accordance with this chapter. (C) The development of sector targets shall be done in a manner that minimizes fragmentation and potential cost shifting and that encourages cooperation in meeting statewide and geographic region targets. (D) Sector targets adopted under this subdivision shall specify which single sector target is applicable if a health care entity falls within two or more sectors.

OHCA's Recommendation: Define all Hospitals as a Sector

Considerations:

- Based on 2020 CMS data, nearly 40% of health care spending in California occurs in hospitals.
- The approach for measuring hospital spending will be different from health plans and other provider types that rely upon attributed TME growth; establishing hospitals as their own sector aligns with measuring them differently.
- The Board can define all hospitals as a sector while in tandem OHCA can continue to refine its hospital measurement approach.
  - For inpatient spending, OHCA will use HCAI Hospital Annual Financial Data submitted by hospitals to measure Inpatient Net Patient Revenue per Case Mix Adjusted Discharge.
  - For outpatient spending, OHCA is evaluating a measurement approach that would consider the varying levels of resources associated with different outpatient encounters (e.g., ED visit vs. outpatient surgery).

Source: Wilson, K. (2023, March 14). "*2023 Edition – California Health Care Spending*." California Health Care Foundation. https://www.chcf.org/publication/2023-edition-california-health-care-spending/#related-links-and-downloads ; 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

Advisory Committee Feedback

- Many Advisory Committee members supported Option 4 and the flexibility it provides the Board in establishing sector targets for high-cost hospitals and the ability to address consumer affordability.
  - Some members noted that Option 4 allows the Board to accomplish the intent of Options 2 and 3 and provides flexibility in a dynamic environment that includes rising involvement of private equity and potential deregulation at the federal level.
  - Some members suggested that Monterey hospitals might be a good “test case” and that the onus should reside on the facility to tell OHCA and the Board if they need a different target or should be excluded.
- Some members suggested revisiting whatever targets are set and adjusting them over time.
- One member suggested setting sector targets by hospital categories rather than by individual entities. For example, all psychiatric health facilities or all academic medical centers. Another member noted it may be problematic to subject all hospitals within a hospital category to the same target and preferred Option 4 because it lets you address outlier hospitals.
- One member suggested the same target value for everyone in the sector and if the target is missed, OHCA can look at the entity’s performance retrospectively for justification.
- Some members expressed concern over the pace of setting sector targets when hospital spending measurement isn’t fully developed and the need for more developments around enforcement.

Draft Motion to Establish a Hospital Sector(s)

Define a health care sector consisting of all hospitals as defined in Health and Safety Code section 1250 et seq.

Hospital Sector Rulemaking Timeline for OHCA's Recommendation

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Informational Items

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Hospital Sector Data Analysis, Including Advisory Committee Feedback

Vishaal Pegany, Deputy Director

CJ Howard, Assistant Deputy Director

Andrew Feher, Research and Analysis Manager

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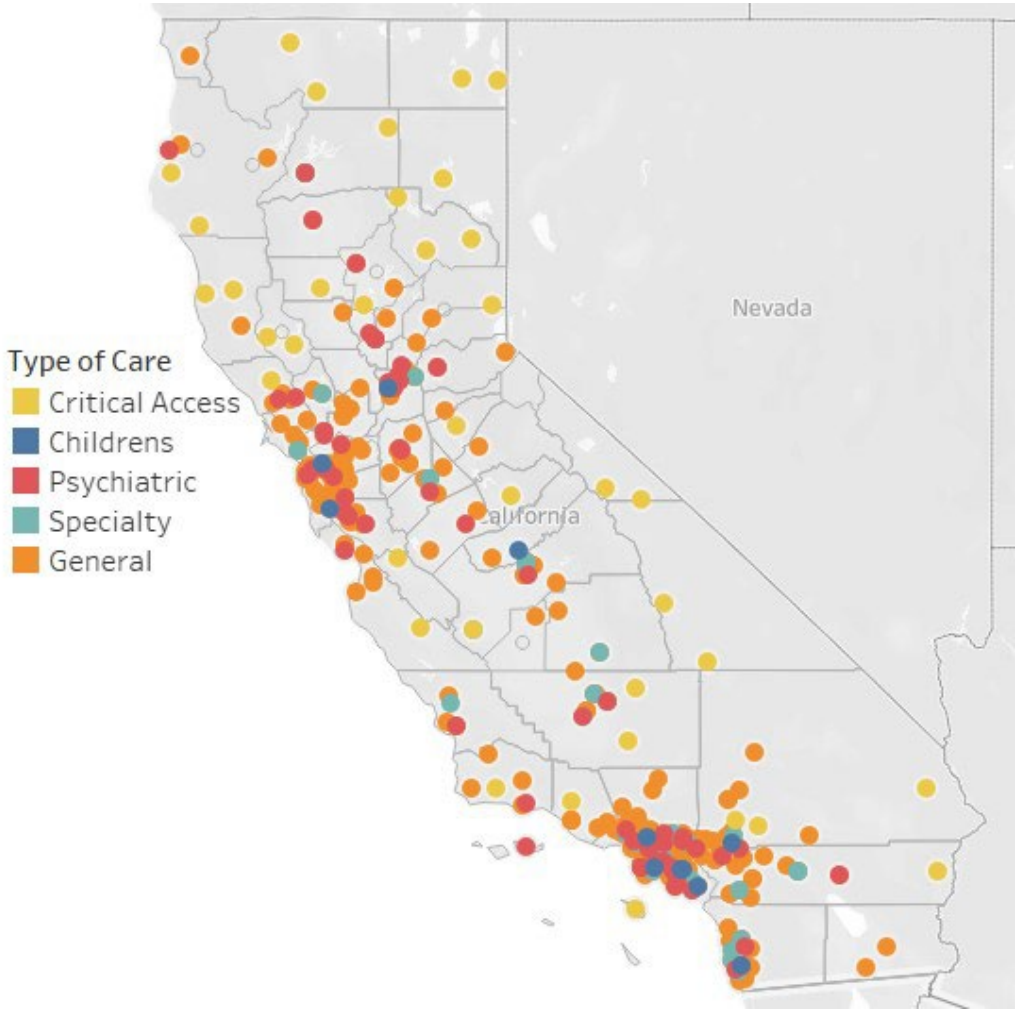
Hospital Sector Data Review

Board Follow-ups: Geographic Considerations

1. One Board Member asked that OHCA examine **county-level variation** in cost metrics.

2. One Board Member asked that OHCA stratify metrics by **urban vs. rural counties.**

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.

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.

HCAI Hospital Reporting Requirements

HCAI identifies hospitals that are not required to submit all Hospital Annual Report data as non-comparable. All remaining hospitals are considered comparable because they submit all data without any reporting modifications.

Type of Hospital	Number of Hospitals in 2023
Comparable	**367**
Non-Comparable	**72**
Kaiser	*31*
Long Term Care Emphasis (LTC)	*4*
Psychiatric Health Facilities (PHF)	*30*
Shriner's Hospitals	*1*
State Hospitals	*6*
Total	**439**

*Non-Comparable reporting modifications include: (1)Kaiser currently reports a subset of financial statement data at system level and not at the facility level, making hospital data not directly comparable to other hospitals. They began reporting additional individual hospital data (most notably revenue detail) in 2021. (2) Inclusion of LTC data may distort certain aggregations so it is not considered comparable; (3) PHFs submit a subset of report pages due to small size, patient mix and type of care; (4) Shriner's submits a subset of report pages that includes consolidated data for both facilities; (5) State hospitals submit a subset of report pages due to patient mix and type of care.

1. Board Follow-ups: County-level Analysis

Question: How do hospital cost metrics vary across counties?

Approach: Examine county-level variation in the following metrics weighted by inpatient discharges:

- Inpatient NPR per CMAD
- Commercial Inpatient NPR per CMAD
- Commercial to Medicare Payment to Cost Ratio

For this analysis, we focus on Comparable hospitals, excluding Kaiser hospitals, LTC Emphasis hospitals, Psychiatric Health Facilities, Shriner's Hospitals, and State hospitals.

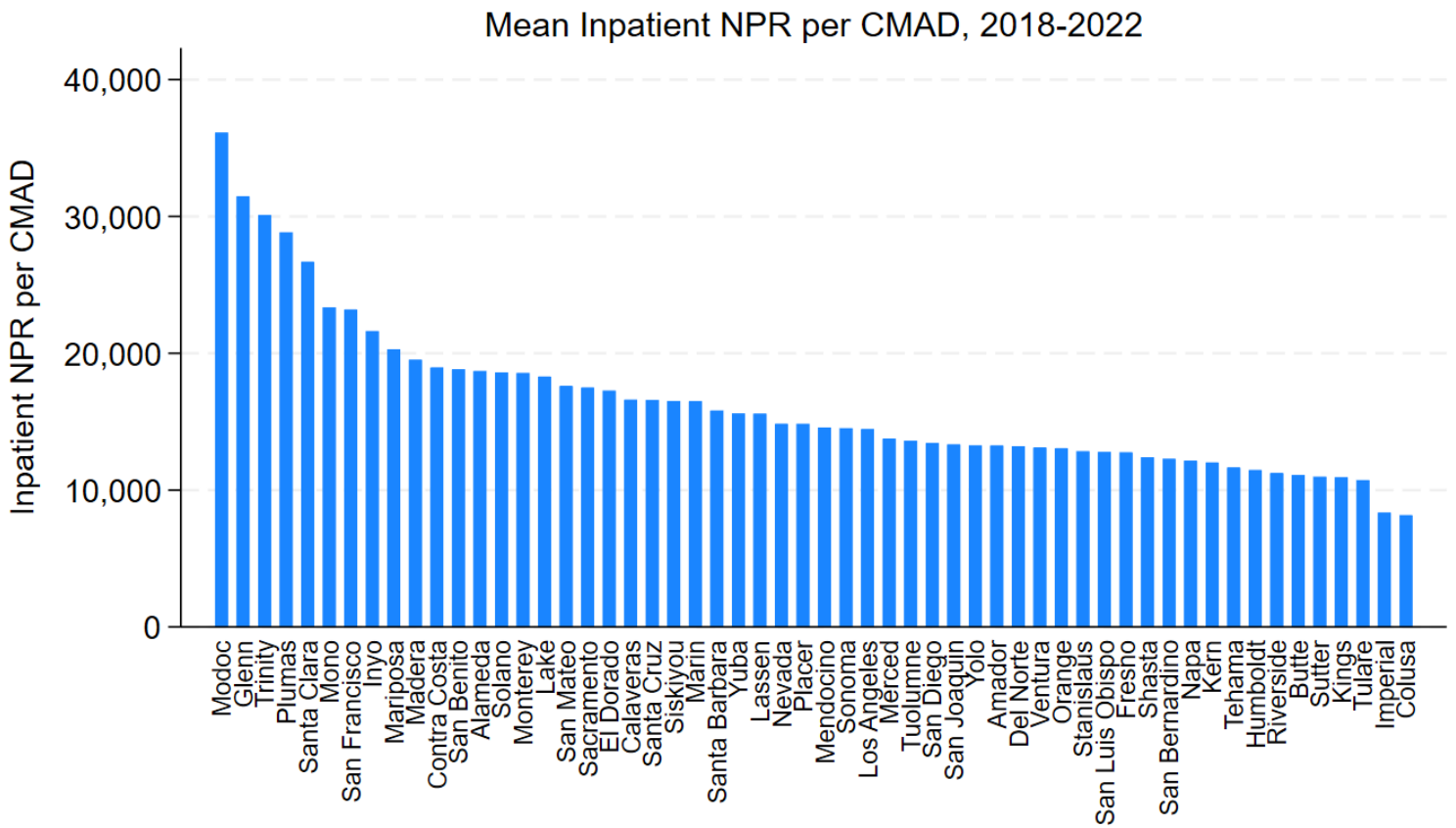
Definitions of Metrics

- **Inpatient Net Patient Revenue* (IP 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 all payers.**
- **Commercial Inpatient Net Patient Revenue (IP 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.
- **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.

*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. ** Includes Medicare, Medi-Cal, County and Other Indigent Programs, Other Third Parties, and Other Payers (uninsured and self pay patients). ***Data for commercial patients as well as other government programs are reported in the Other Third Parties category for HCAI Hospital Annual Disclosure Reporting.

Inpatient Net Patient Revenue Per CMAD

Statewide average Inpatient NPR per CMAD was $14.9K with a low of $8.2K in Colusa and a high of $36.1K in Modoc.

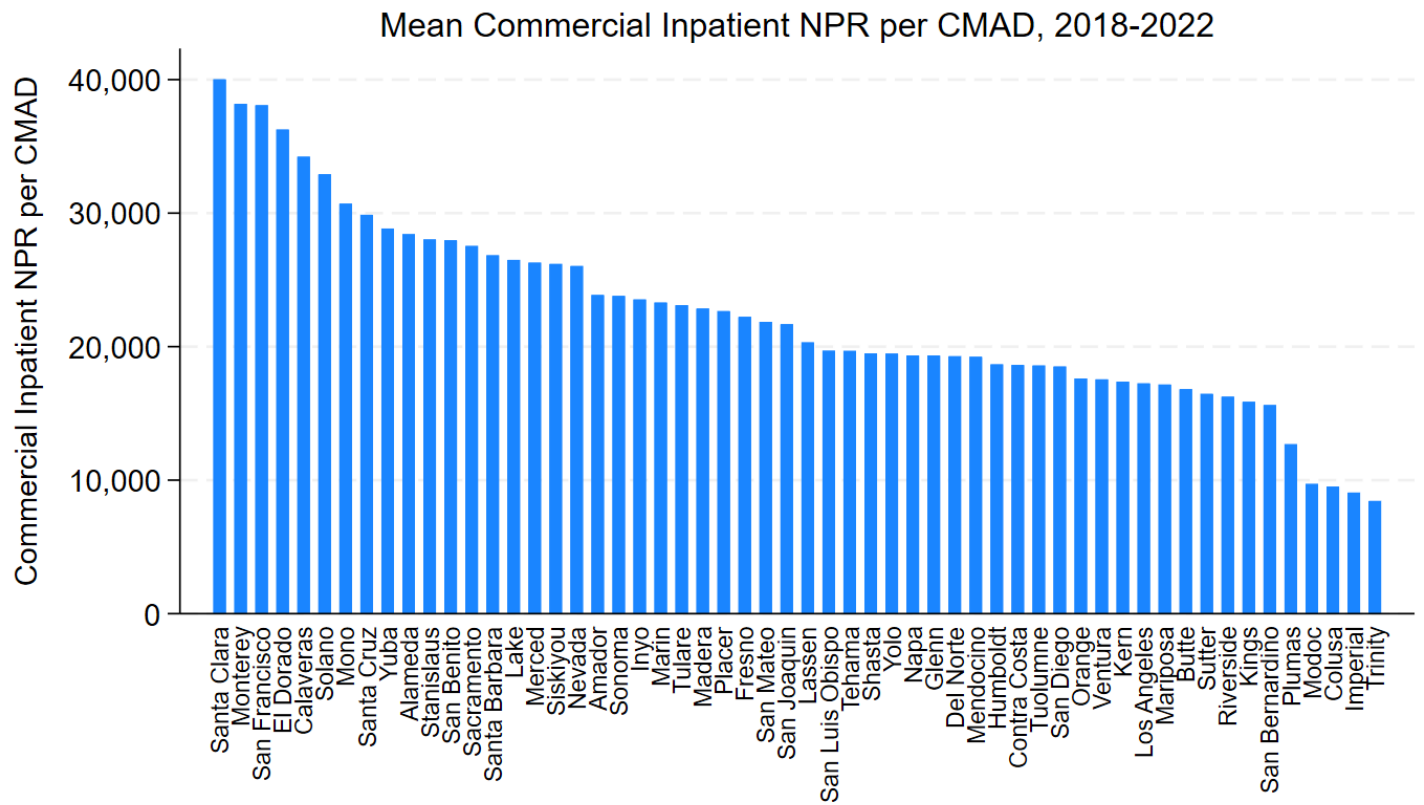


Top 10 counties:

- Modoc
- Glenn
- Trinity
- Plumas
- Santa Clara
- Mono
- San Francisco
- Inyo
- Mariposa
- Madera

Commercial Inpatient NPR Per CMAD

Statewide average Commercial Inpatient NPR per CMAD was $21.1K with a low of $8.4K in Trinity and a high of $40.0K in Santa Clara.

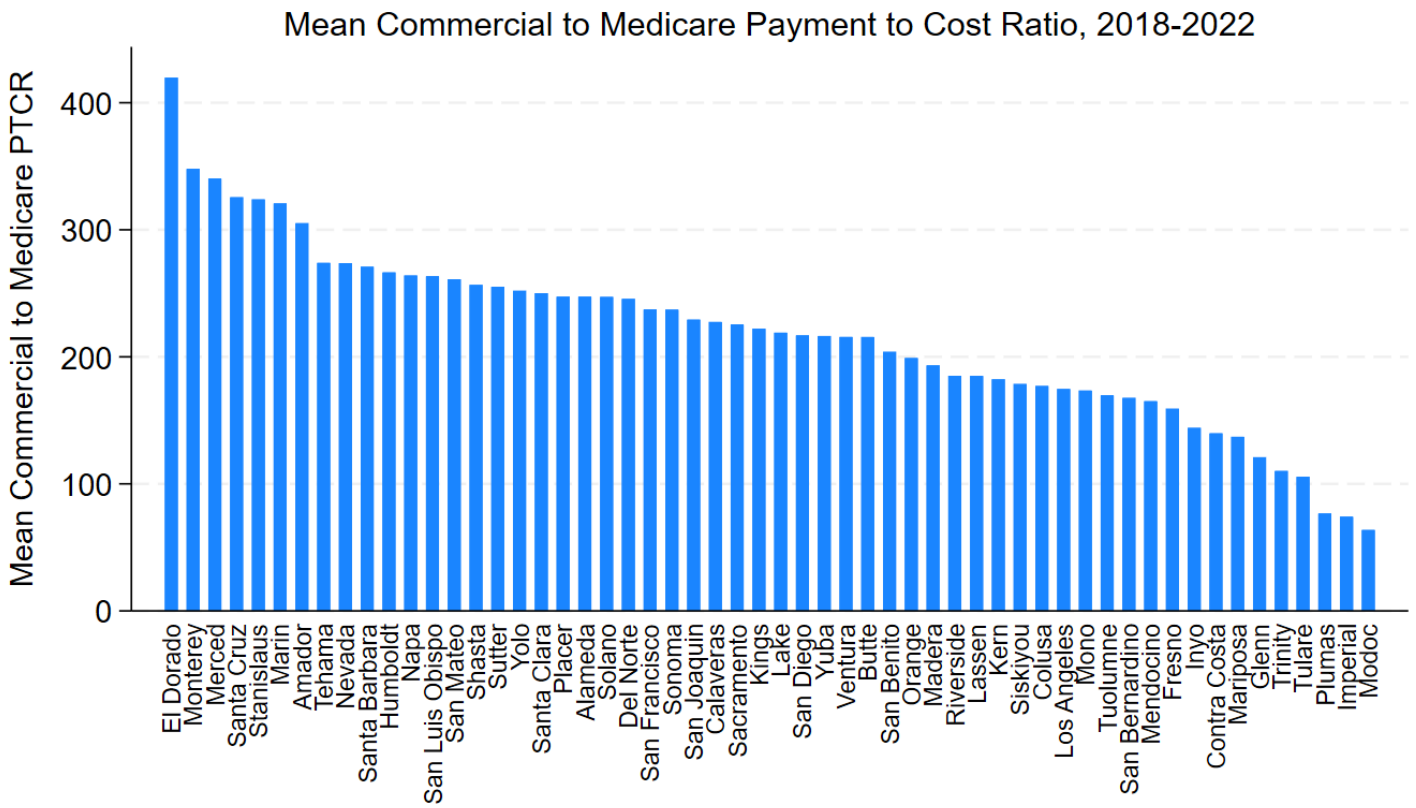


Top 10 counties:

- Santa Clara
- Monterey
- San Francisco
- El Dorado
- Calaveras
- Solano
- Mono
- Santa Cruz
- Yuba
- Alameda
- Stanislaus

Commercial to Medicare Payment to Cost Ratio (PTCR)

Statewide average Commercial to Medicare PTCR was 205% with a low of 63% in Modoc and a high of 420% in El Dorado.



Top 10 counties:

- El Dorado
- Monterey
- Merced
- Santa Cruz
- Stanislaus
- Marin
- Amador
- Tehama
- Nevada
- Santa Barbara

2. Board Follow-ups: Descriptive Statistics by Urban vs. Rural Counties, 2018-2022

- For this analysis, we focus on Comparable hospitals.
- Compared to hospitals in urban counties, hospitals in fully rural counties have higher average annual growth in Inpatient (IP) NPR Per CMAD, higher average Commercial to Medicare Payment to Cost Ratio (PTCR) and higher average operating margins

	Average IP NPR Per CMAD	Average Annual Growth in IP NPR Per CMAD	Average Commercial IP NPR Per CMAD	Average Commercial to Medicare PTCR	Average Operating Margin
Hospitals in Urban Counties	$14.9K	3.3%	$21.1K	204%	1.8%
Hospitals in Fully Rural Counties	$14.8K	4.2%	$21.5K	223%	2.7%

Definition of fully rural counties based on Federal Office of Rural Health Policy (FORHP): https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files. Descriptive statistics weighted by inpatient discharges.

Recap: Hospitals in California

For the December Board meeting, OHCA presented the Top 30 hospitals for each of four financial metrics from 2018-2022.* These were a select and illustrative set of metrics and 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)
- Growth: Average Annual Growth Per Inpatient NPR Per CMAD
- Profitability: Average Operating Margin
- Price: Average Commercial to Medicare Payment to Cost Ratio

This section shares one additional spending metric that primarily focuses on commercial patients:

- Spending: Average Commercial Inpatient NPR Per CMAD

The Top 30 hospitals are displayed <u>without</u> any potential exclusions and <u>with</u> the exclusions listed below:

- Critical Access Hospitals
- Psychiatric Health Facilities
- State Hospitals
- Long-Term Stay Hospitals (>20 days)
- Small Hospitals (<100 licensed beds)
- Children's Hospitals
- Kaiser Hospitals (FIDS)

* Financial metrics may not include all years.

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

Financial Metric (2018-2022)	Top 30 Range (High to Low)	Statewide Median (Without Exclusions)
Average Commercial Inpatient NPR Per CMAD	107K to 36K	$18K

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.

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

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Commercial IP 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 IP NPR Per CMAD Without Exclusions (2018-2022)

	Hospital	County	Critical Access	Small	Child	Teach	Spec	Psych	State	Public	Long Stay	Average Commercial IP 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.

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, Kaiser 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 Commercial Inpatient NPR Per CMAD	57K to 28K	18K

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.

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

Key: Rank top 15 Rank 16-30

	Hospital	County	Teach	Spec	Psych	Public	Average Commercial IP NPR Per CMAD	Average Inpatient NPR Per CMAD	Average Annual Growth per Inpatient NPR Per CMAD	Average Operating Margin	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 IP NPR Per CMAD With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

	Hospital	County	Teach	Spec	Psych	Public	Average Commercial IP NPR Per CMAD	Average Inpatient NPR Per CMAD	Average Annual Growth Per Inpatient NPR per CMAD	Average Operating Margin	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

Advisory Committee Feedback

- Some Advisory Committee Members suggested that some of the hospital data include more detail about:
  - Administrative expenses within Inpatient NPR.
  - Defining operating expenses within the Operating Margin metric.
  - The data elements used to compute Average Length of Stay.
- A few members expressed concern over the number of psychiatric hospitals falling within the data section review of metrics without specified exclusions.
  - Others flagged the high operating margins of several psychiatric hospitals.
- A few AC members expressed concern over using the Commercial to Medicare Payment to Cost Ratio as it pertains to comparability of patient services delivered under each payer, particularly maternity care. Another noted that the ratio assumes Medicare payments are equitable across hospitals and gave an example of two hospitals under the same system that vary in their base Medicare rates.
- One member noted that public hospitals engage in self-financing, and several UC hospitals have children's hospitals embedded within them, and thus warrant special consideration.
- Another member noted that small hospitals have volatility, and it may make more sense to focus on larger hospitals.

Advisory Committee Follow-ups: Kaiser Hospitals

The Advisory Committee asked why Kaiser hospitals are not included in the sector definition and the sector target data analysis.

- The statute expressly excludes fully integrated delivery systems (FIDS) from Board action to define them as a sector as FIDS are already defined in the statute.
  - HSC § 127502 (*l*)(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.
- The board may establish a fully integrated delivery system target:
  - 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.

Kaiser Hospitals Compared to Comparable Hospitals, 2021-2022

- Beginning in 2021, Kaiser began reporting additional individual hospital-level data, which enables comparisons of Kaiser hospitals to Comparable hospitals on a subset of cost metrics.
- Compared to Comparable hospitals, the 31 Kaiser hospitals had higher average Inpatient (IP) NPR per CMAD, lower growth in IP NPR per CMAD from 2021 to 2022 and lower average Commercial IP NPR per CMAD.

	Average IP NPR Per CMAD	Growth in IP NPR Per CMAD from 2021 to 2022	Average Commercial IP NPR Per CMAD	Average Commercial to Medicare PTCR
Kaiser Hospitals	$16.1K	-4.2%	$19.7	N/A*
Comparable Hospitals	$15.7K	4.5%	$21.6K	200%

Descriptive statistics weighted by inpatient discharges.
*Kaiser hospitals report income statements and balance sheets at the hospital level, but they do not report the cost and revenue detail, thus leaving us unable to calculate payment to cost ratios.

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Sector Target Setting Methodology

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Department of Health Care Access and Information

Options to Identify Disproportionately High-Cost Hospitals

To set target values, we must consider:

1. How to identify disproportionately high-cost hospitals that merit a lower target?

2. How to determine sector target values for high-cost hospitals.

Today, OHCA will present options for each of these and solicit Board input.

At the February Board meeting, OHCA will present recommended target values, and the Board will discuss OHCA's recommendation. A 45-day public comment window will begin on February 25th. The Board will have until June 1st to set targets for 2026 and can set targets for beyond 2026 at this time.

Identifying Disproportionately High-Cost Hospitals

Options to Identify Disproportionately High-Cost Hospitals

How to identify disproportionately high-cost hospitals that merit a lower target value?

Option 1: Repeat Outlier on Unit Price as Measured by Commercial Inpatient NPR per CMAD

- Unit Price represents dollar amounts. Accounts for the amount and intensity of care delivered, which better isolates the price per unit of inpatient service for Commercial payers.

Option 2: Repeat Outlier on Relative Price as Measured by Commercial to Medicare Payment to Cost Ratio (PTCR)

- Relative = Commercial payments relative to Medicare payments. Medicare is chosen as a benchmark due to its nationally consistent pricing algorithms, which includes cost-sensitive adjustments (e.g., wage index, teaching status).

Option 3: Repeat Outlier on Both Unit and Relative Price Measures

Measures: Advantages and Limitations

Measure	Description	Advantages	Limitations
Commercial Inpatient NPR per CMAD	Price per standard unit for Commercial inpatient care	• Consistent estimate of inpatient prices • May be calculated for almost all hospitals • More directly applicable to Commercial cost growth and targets	• Limited to inpatient revenue • More sensitive to coding intensity
Commercial to Medicare Payment to Cost Ratio	Relative price comparing cost coverage of Commercial to Medicare	• Contextualizes commercial payments based on standard, national benchmark • Includes inpatient and outpatient revenue	• Not an appropriate measure for hospitals with low Medicare or Commercial revenue • Medicare may pay some hospitals differently for the same service (e.g., Sole Community Hospitals, Medicare Dependent Hospitals)

Descriptive Statistics Among Comparable Hospitals, 2018-2022

Before showing the set of hospitals identified as high-cost outliers, we first present averages – both within-year and across the five-year time-series – to help illustrate how the outlier hospitals compare to the broader population of comparable hospitals.

Year	Average Commercial Inpatient NPR Per CMAD	Average Commercial to Medicare Payment to Cost Ratio
2018	$20.7K	207%
2019	$20.6K	207%
2020	$20.9K	207%
2021	$21.3K	197%
2022	$22.0K	204%
Pooled average	**$21.1K**	**205%**

Descriptive statistics weighted by the number of inpatient discharges.

Option 1: Repeat Outlier on Unit Price – Commercial Inpatient NPR Per CMAD

Approach

- OHCA removed hospitals for which comparable financial data is not available (i.e., Kaiser hospitals, LTC Emphasis hospitals, Psychiatric Health Facilities, Shriner's Hospitals, and State hospitals).
- OHCA identified 23 hospitals that met all the following criteria:
    1. Unit Price Repeat Outlier: Commercial Inpatient NPR Per CMAD is above the inpatient discharge-weighted 80th percentile in **3 out of the past 5 years from 2018-2022.**
    2. Payer Mix Threshold: At least 5% gross patient revenue for Medicare and Commercial.
    3. Inpatient Discharge Threshold: Above the average number of inpatient discharges.

Option 1: Repeat Outlier on Unit Price – Commercial Inpatient NPR Per CMAD

	List of Hospitals
Above 90th percentile	Community Hospital of The Monterey Peninsula
	Doctors Medical Center – Modesto
	Dominican Hospital
	Northbay Medical Center
	Salinas Valley Memorial Hospital
	Santa Clara Valley Medical Center
	Stanford Health Care
	UCSF Medical Center
	University of California Davis Medical Center
	Zuckerberg San Francisco General Hospital & Trauma Center
Above 85th percentile	California Pacific Medical Center - Van Ness Campus
	Regional Medical Center of San Jose
	Ronald Reagan UCLA Medical Center
	Santa Barbara Cottage Hospital
	Washington Hospital – Fremont
Above 80th percentile	Alta Bates Summit Medical Center - Alta Bates Campus
	Alta Bates Summit Medical Center - Summit Hawthorne
	Cedars-Sinai Medical Center
	El Camino Health
	Highland Hospital
	Natividad Medical Center
	Orange County Global Medical Center
	Sutter Medical Center - Sacramento

Option 2: Repeat Outlier on Relative Price – Commercial to Medicare Payment to Cost Ratio

Approach

- OHCA removed hospitals for which comparable financial data is not available (i.e., Kaiser hospitals, LTC Emphasis hospitals, Psychiatric Health Facilities, Shriner's Hospitals, and State hospitals).
- OHCA identified 23 hospitals that met all the following criteria:
    1. Relative Price Repeat Outlier: Commercial to Medicare Payment to Cost Ratios above the inpatient discharge-weighted 80th percentile in **3 out of the past 5 years from 2018-2022.**
    2. Payer Mix Threshold: At least 5% gross patient revenue for Medicare and Commercial.
    3. Inpatient Discharge Threshold: Above the average number of inpatient discharges.

Option 2: Repeat Outlier on Relative Price – Commercial to Medicare Payment to Cost Ratio

	List of Hospitals
Above 90th percentile	Community Hospital of The Monterey Peninsula
	Doctors Medical Center – Modesto
	Dominican Hospital
	Emanuel Medical Center
	Marin General Hospital
	Memorial Hospital Modesto
	Mercy Medical Center – Merced
	Orange County Global Medical Center
	Salinas Valley Memorial Hospital
	Santa Barbara Cottage Hospital
	Stanford Health Care
	Washington Hospital – Fremont
Above 85th percentile	Eden Medical Center
	El Camino Health
	Mills-peninsula Medical Center
	Northbay Medical Center
Above 80th percentile	Alta Bates Summit Medical Center - Summit Hawthorne
	Cedars-Sinai Medical Center
	Community Hospital of San Bernardino
	Los Alamitos Medical Center
	Mercy Medical Center – Redding
	Methodist Hospital – Sacramento
	Sharp Chula Vista Medical Center

Option 3: Repeat Outlier on Both Unit and Relative Price Measures

Approach

- OHCA removed hospitals for which comparable financial data is not available (i.e., Kaiser hospitals, LTC Emphasis hospitals, Psychiatric Health Facilities, Shriner's Hospitals, and State hospitals).
- OHCA identified 12 hospitals that met all the following criteria:
    1. Unit Price Repeat Outlier: Commercial Inpatient NPR per CMAD is above the 80th percentile in **3 out of the past 5 years**
    2. Relative Price Repeat Outlier: Commercial to Medicare Payment to Cost Ratio is above the 80th percentile in **3 out of the past 5 years**
    3. Payer Mix Threshold: At least 5% gross patient revenue for Medicare and Commercial.
    4. Inpatient Discharge Threshold: Above the average number of inpatient discharges.

Option 3: Repeat Outlier on Both Unit and Relative Price Measures

	List of Hospitals	County	Pooled Average Commercial Inpatient NPR per CMAD, 2018-2022	Pooled Average Commercial to Medicare Payment to Cost Ratio, 2018-2022
Above 90th percentile	Community Hospital of The Monterey Peninsula	Monterey	$39.9K	353%
	Doctors Medical Center – Modesto	Stanislaus	$36.0K	347%
	Dominican Hospital	Santa Cruz	$34.5K	331%
	Salinas Valley Memorial Hospital	Monterey	$46.7K	475%
	Stanford Health Care	Santa Clara	$51.5K	340%
Above 85th percentile	Northbay Medical Center	Solano	$42.8K	269%
	Santa Barbara Cottage Hospital	Santa Barbara	$32.8K	305%
	Washington Hospital – Fremont	Alameda	$32.9K	359%
Above 80th percentile	Alta Bates Summit Medical Center – Summit Hawthorne	Alameda	$29.3K	297%
	Cedars-Sinai Medical Center	Los Angeles	$29.9K	278%
	El Camino Health	Santa Clara	$28.4K	282%
	Orange County Global Medical Center	Orange	$27.8K	406%

Descriptive statistics weighted by the number of inpatient discharges.

Board Input

Does the Board have feedback on the three options for identifying high-cost hospitals that merit a sector target lower than the statewide spending target?

Options for Setting Sector Target Value(s)

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.

Source: Health and Safety Code § 127502 (b)(1)(2)

Options

After a hospital sector is defined, the Board can set or adjust targets as follows:

1. Targets for individual hospital in the sector
2. Targets for a group of hospitals in the sector
3. One target for all hospitals in the sector

In the following slides, the Office presents a formula-based approach for adjusting the statewide spending target for a group of high-cost hospitals. This approach would be transparent and easily understandable for the public and regulated entities.

Formula-Based Approach to Adjust Targets for High-Cost Hospitals

- The target value for high-cost hospitals could be based on the statewide spending target and adjusted according to the average cost relativity of the included hospitals.
- The hospitals could be assigned a cost relativity tied to the California statewide mean for Commercial Inpatient NPR Per CMAD (or other measure).
  - For example, the statewide spending target for 2025 is 3.5%, and if a hospital is on average twice the statewide mean on Commercial Inpatient NPR per CMAD, they could be assigned a cost relativity of 2.0, then the hospital's target would be adjusted as follows:

[Statewide target] / [Hospital cost relativity] = [Hospital target]
3.5% / 2.0 = 1.75%

Formula-Based Approach to Adjust Targets for High-Cost Hospitals

Considerations:

- Target values are directly related to hospitals' costs.
- Methodology for setting the high-cost hospital target is transparent.
- This method could be adjusted on a facility-by-facility basis.
  - Could create a different target value for each individual hospital, which increases administrative burden and complexity for industry to track and implement the specific target values.
  - Different values may result in challenges in communicating the policy to the public.

Example: High-Cost Hospitals Above the 90th Percentile on Unit and Relative Price

If the Board agreed that the 5 highest-cost hospitals (i.e., those above the 90th percentile on unit and relative price) merited a lower target value:

From 2018-2022, their average inpatient discharged-weighted Commercial Inpatient NPR Per CMAD was $42.8K compared to $20.4K for all other Comparable hospitals.

$$\$42.8K / \$20.4K = 2.10$$

$$3.5\% / 2.10 = 1.7\%$$

The spending target for these 5 hospitals would be 1.7%

Example: High-Cost Hospitals Above the 80th Percentile on Unit and Relative Price

If the Board agreed that the 12 high-cost hospitals (i.e., those above the 80th percentile on unit and relative price) merited a lower target value:

- From 2018-2022, their average inpatient discharged-weighted Commercial Inpatient NPR Per CMAD was $36.0K compared to $19.9K for all other Comparable hospitals.

$$\$36.0K / \$19.9K = 1.8$$

$$3.5\% / 1.8 = 1.9\%$$

The spending target for these 12 hospitals would be 1.9%

Board Input

Does the Board have input on how to set target values for disproportionately high-cost hospitals?

Does the Board have input on how many years this sector target should be set for?

- Targets can be revisited after they are set and be modified by the Board.

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THCE Regulations and Data Submission Guide Updates, Including Advisory Committee Feedback

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Department of Health Care Access and Information

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

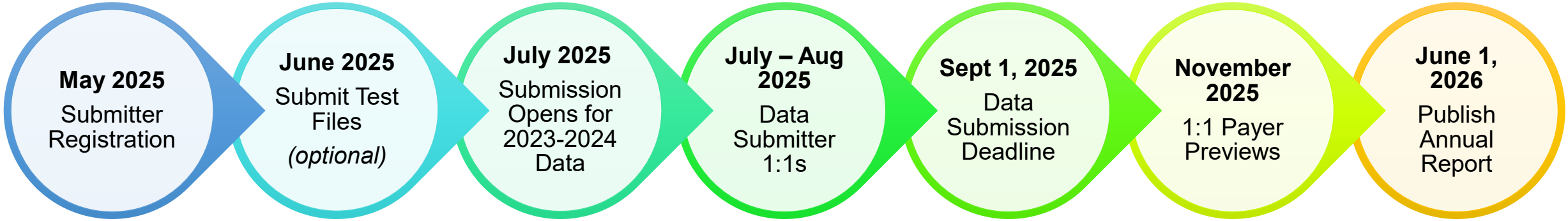
- Claims and non-claims primary care spending collected by market category and product type at payer level to track progress towards the annual improvement benchmark and 2034 primary care investment benchmark
- Claims and non-claims primary care spending collected based on methodology developed by OHCA 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



AC Feedback

None provided.

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Update on Cost and Market Impact Review Program

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OHCA's Determination To Conduct (or Waive) CMIR of a Material Change Transaction - 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 Transaction Reviews*

- 2024 (April 1st to December 31st) – **10 complete transactions for review**
  - 1 submitted and withdrawn after discussion with OHCA
  - 16 Separate Complete Submissions (Parties to or subjects of the transaction)
  - 8 CMIR Waivers issued by OHCA
    - Average time for review: 22 working days
  - 2 still in review (December submissions)

- 2025 – 3 complete transactions for review
- Since October's Board Update, 7 complete submissions
- All complete submissions are available at https://hcai.ca.gov/affordability/ohca/assess-market-consolidation/material-change-transaction-notices-mcn-and-cost-and-market-impact-review-cmir/

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

MCN Submitters	Transaction Summary	Submission Complete	Status
Agile Occupational Medicine, LLC and Kain Akeso Medical Holdings, LLC	Pursuant to a letter of intent between Agile and Kain Akeso Medical Holdings, LLC (the MSOs), the Agile business (conducted by Agile Occupational Medicine, LLC and its affiliates) intends to combine with the Akeso Occupational Health business (conducted by Kain Akeso Medical Holdings, LLC).	January 24, 2025	In Review
Sharon Care Center LLC	The membership interest in Sharon Care Center LLC is being sold from Summit Care LLC to BQ Operations Holdings LLC. The leasehold interest in the facility is also being assigned to Sharon Care Center LLC by Leasehold Resource Group LLC.	January 15, 2025	In Review

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	CMIR Waived

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 October 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

CMIR Program Update: *Inquiries Received*

CMIR Inbox CMIR@HCAI.ca.gov	Emails received and responded to (Generally within 2 business days)	Virtual Meetings due to Emails
Since October	39	10
2024 Totals	117	23

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Public Comment

HCAI

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Department of Health Care Access and Information

General Public Comment

Written public comment can be emailed to:

ohca@hcai.ca.gov

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

HCAi

Department of Health Care Access and Information

Next Board Meeting:

February 25, 2025
10:00 a.m.

Location:
To Be Determined

OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

Adjournment

HCAI

Department of Health Care Access and Information