Office of Health Care Affordability
Department of Health Care Access and Information

Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Hospital Sector Target Values

The Office of Health Care Affordability's Mission and Purpose

In 2022, the California Health Care Quality and Affordability Act (SB 184, Chapter 47, Statutes of 2022) established the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI). Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, OHCA's enabling statute emphasizes that it is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal.

Health care spending in California reached $10,299 per capita and $405 billion overall in 2020, up 30% from 2015.[1] Californians with job-based coverage are facing higher out-of-pocket costs, with the share of workers with a large deductible ($1,000 or more) increasing from 6% in 2006 to 42% in 2022.[2] For the fourth consecutive year, the 2024 California Health Care Foundation California Health Policy Survey reports that more than half of Californians (53%) – and nearly three-fourths (74%) of those with lower incomes (under 200% of the federal poverty level) – reported skipping or delaying at least one kind of health care due to cost in the past 12 months.[4] Among those who reported skipping or delaying care due to cost, about half reported their conditions worsened as a result. Further, high costs for health care disproportionately affect Black (40%) and Latino/x (36%) Californians who report they had problems paying or could not pay medical bills compared to White Californians at (25%).[3]

OHCA has three primary responsibilities to achieve its mission of improved consumer affordability: 1) slow health care spending growth through collection and reporting on total health care expenditure data and enforcing spending targets set by the Board; 2) promote high-value health system performance; and 3) assess market consolidation.

[1] State Health Expenditure Accounts by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trendsand-reports/national-health-expenditure-data/state-residence.
[2] Whitmore, H., & Satorius, J. (2021, August). California Health Care Almanac, California Employer Health Benefits: Are Workers Covered? California Health Care Foundation. https://www.chcf.org/wpcontent/uploads/2021/08/CAEmployerHealthBenefitsAlmanac2021.pdf.
[3] Bailey, L. R., Catterson, R., Alvarez, E., & Noble, S. (2023, February 16). The 2023 CHCF California Health Policy Survey. California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2023/02/2023CHCFCAHealthPolicySurvey.pdf.

Background

The statutory requirements for the timing and process of setting sector targets are described in the OHCA enabling statute and listed here.[4]

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.

The dates above for defining health care sectors and establishing sector specific targets do not preclude the Board from acting sooner. Throughout 2024, the Board considered sector definition and sector target setting options including geographic regions, provider category, payer and/or provider by market category, and individual health care entities. Fully integrated delivery systems (FIDS) are already defined in the statute and the Board may establish a FIDS target.

[4] These statutory requirements are from Article 3. Health Care Cost Targets [Health and Safety Code §127502].

The Board chose to focus on hospitals because they are a significant source of health care spending. CMS data shows that nearly 40% of health care spending in California occurs in hospitals, making this a potentially high-impact area to improve efficiency and affordability for consumers.[5] Additionally, hospital prices vary widely across the state, with over five times price variation that is not attributed to higher quality care or better clinical outcomes but is instead correlated with market concentration.[6] The high cost of hospital care is a reality corroborated by the extensive and regular testimony of public commenters at monthly public meetings of the Board. Finally, historical spending data is available through HCAI's Hospital Annual Disclosure Reports, such that trends and anomalies could be more comprehensively examined for hospitals, whereas the office has collected only two years of total medical expense data for other potential sectors.

In January 2025, the Board voted unanimously (6-0 with one member absent) in favor of defining a health care sector consisting of all hospitals as defined in the Health and Safety Code section 1250 et seq. OHCA will promulgate regulations to codify the definition of this initial sector. All facilities in this sector are subject to the statewide spending target unless and until the Board adjusts the target value for all or a portion of the health care entities in the sector.

In January 2025, the Board discussed adjusting the hospital sector spending target value specifically for select hospitals with disproportionately high costs. OHCA recommends the following methodology to (1) identify high-cost hospitals and (2) set target values for those facilities.

OHCA Proposed Target Setting Methodology

Identification of High-Cost Hospitals

OHCA recommends selecting disproportionately high-cost hospitals that merit a lower target value by identifying hospitals that are repeat outliers on both unit and relative price measures, and applying a payer mix threshold. Before performing this analysis, OHCA removes hospitals whose financial data is not available or comparable to most California hospitals including Long Term Care Emphasis Hospitals, Psychiatric Health Facilities, Shriner's Hospitals, State Hospitals, and Kaiser Hospitals (as they are included in the definition of FIDS).

- **Unit Price Repeat Outlier**: OHCA recommends measuring unit price based on the measure, Commercial Inpatient Net Patient Revenue (NPR) per Case Mix Adjusted Discharge (CMAD). This is the amount of money a hospital generates

[5] 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.

[6] These findings were presented by Christopher Whaley at the August 2024 board meeting and is based on analysis of data from the following study: Whaley, C. M., Kerber, R., Wang, D., Kofner, A., & Briscombe, B. (2024). Prices paid to hospitals by private health plans: findings from round 5.1 of an employer-led transparency initiative.

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.[7] OHCA recommends considering a hospital a repeat outlier when its Commercial Inpatient NPR per CMAD is above the 85th percentile in 3 out of 5 years (2018-2022).

- **Relative Price Repeat Outlier**: OHCA recommends measuring relative price based on the measure, Commercial to Medicare Payment to Cost Ratio (PTCR), which is 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 payer pays relative to Medicare's standard rate for that service. OHCA recommends considering a hospital a repeat outlier when its Commercial to Medicare Payment to Cost Ratio is above the 85th percentile in 3 out of 5 years (2018-2022).

- **Payer Mix Threshold**: For the Commercial to Medicare Payment to Cost Ratio metric to be credible, a hospital's share of revenue needs to come from a broad payer mix. For this reason, OHCA recommends excluding hospitals that have less than 5% gross patient revenue from Medicare or Commercial payers.[8]

As listed in Table 2 (Proposed Sector Target Values for High-Cost Hospitals) below, the analysis results in 11 high-cost hospitals that are repeat outliers on the unit and relative price measures and meet the 5% payer mix threshold described above. Tables 3 and 4 in the appendix show the hospitals' values on the unit and relative price metric for each year form 2018-2022.

The recommended approach identifies hospitals that consistently have higher baseline costs than other hospitals in the sector. The most recent 5-year period for which data are available reflect the current trajectory of hospital spending. Including hospitals that are repeat outliers in 3 or more years acknowledges that this period includes the COVID-19 pandemic. OHCA notes however that the impacts of the global pandemic were experienced by all hospitals and many of the hospitals identified as high-cost hospitals were repeat outliers for all 5 years on both unit and relative price measures.

Target Setting Methodology and Target Value for High-Cost Hospitals

OHCA recommends setting the hospital sector target equal to the statewide target. Setting the hospital sector target equal to the statewide target clarifies that hospitals in

[7] Data for patients with commercial insurance as well as other government programs are reported in the Other Third-Party category for HCAI Hospital Annual Disclosure Reporting.
[8] Kronick, R., & Hoda Neyaz, S. (n.d.). *Private Insurance Payments to California Hospitals Average More Than Double Medicare Payments*. Retrieved June 3, 2025, from https://westhealth.org/wp-content/uploads/2023/11/West-Health-Policy-Center-Hospital-Pricing-Analysis-May-2019.pdf

this sector are subject to the statewide target unless and until the board modifies the spending target for the entire hospital sector or specific hospitals within the sector.

OHCA recommends the following steps for setting a target value for identified high-cost hospitals that compares them with other hospitals in the sector:

1. **Divide the identified high-cost hospitals' average Commercial Inpatient NPR per CMAD weighted by the number of inpatient discharges for the five-year period 2018-2022, by the outcome of all other comparable hospitals' average Commercial Inpatient NPR per CMAD weighted by the number of inpatient discharges for the five-year period.** [9]
   - The weighted average of the Commercial Inpatient NPR per CMAD for the identified high-cost hospitals is $40,200.[10]
   - The weighted average of the Commercial Inpatient NPR per CMAD for all other comparable hospitals is $20,200.
   - The result of dividing $40,200 by $20,200 is 2.0

2. **Divide the identified high-cost hospitals' average Commercial to Medicare Payment to Cost Ratio weighted by the number of inpatient discharges for the five-year period 2018-2022, by the outcome of all other comparable hospitals' average Commercial to Medicare Payment to Cost Ratio weighted by the number of inpatient discharges for the five-year period.**
   - The weighted average of the Commercial to Medicare Payment to Cost Ratio for the identified high-cost hospitals is 350%.[11]
   - The weighted average of the Commercial to Medicare Payment to Cost Ratio for all other comparable hospitals is 200%.
   - The result of dividing 350% by 200% is 1.8.

3. **Average the outcomes from the calculations in step 1 and step 2.**
   - The average of 2.0 and 1.8 is 1.9.

4. **Divide current statewide spending target by the average of the outcomes in step 3.**
   - The statewide spending target is 3.5% in 2026, 3.2% in 2027 and 2028, and 3.0% in 2029. The resulting recommended target values for the identified high-cost hospitals are 1.8% in 2026, 1.7% in 2027 and 2028, and 1.6% in 2029.

[9] 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. 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.
[10] Dollar amounts rounded to the nearest $100.
[11] Percent amounts rounded to the nearest tenth of a percent.

Table 1: Target Adjustment Calculations

Weighted Average Commercial Inpatient NPR per CMAD of High-Cost Hospitals (A)	Weighted Avg Commercial Inpatient NPR per CMAD All Hospitals (B)	Commercial Inpatient NPR Per CMAD Cost Relativity (C)=(A/B)	Combined Cost Relativity (G)=(C+F)/2	Statewide Spending Target for each performance year (H)		Recommended High-Cost Target Values by performance year (I)=(H/G)
$40,200	$20,200	2.0	1.9	2026	3.5%	1.8%
Weighted Average Commercial to Medicare PTCR of High-Cost Hospitals (D)	Weighted Average Commercial to Medicare PTCR all hospital (E)	PTCR Cost Relativity (F)=(D/E)		2027 & 2028	3.2%	1.7%
350%	200%	1.8		2029	3.0%	1.6%

Rooting the methodology in the statewide target underscores the principle of consumer affordability, as the statewide target is based on median household income growth, a key metric of consumer affordability. Under the status quo, the high-cost facilities would continue to grow no more than the statewide spending target but are doing so from a higher baseline level. Further limiting the rate of growth for these hospitals would bring the costs incurred by consumers for these hospitals more in line with the broader hospital sector, thereby reducing historical inequities between high-cost facilities and more efficient facilities. The impact of the slower rate of growth is that savings would lead to more equitable access to high-quality, affordable care for Californians.

The recommended target values for each year and facility are listed in Table 2. All other hospitals in the sector and health care entities are subject to the statewide spending target.

Multi-Year Target

OHCA recommends aligning the adjusted sector target values of these facilities with the current statewide spending target schedule, 2026-2029. A multi-year target provides hospitals long-term predictability. Knowing the target value in advance encourages cooperation within the health care industry to meet the targets and allows the targets to influence negotiations for contracting and inform strategic planning and operations.

Considerations for Revisiting the Target

In the event of extraordinary circumstances, including highly significant changes in the economy or the health care system, the Board may consider changes to the target. OHCA recommends that the Board meet annually to consider any needed updates to the target, including adjustments for unforeseen circumstances.

Table 2: OHCA Recommended Target Values for High-Cost Hospitals

Hospital	2026	2027	2028	2029
Barton Memorial	1.8%	1.7%	1.7%	1.6%
Community Hospital of the Monterey Peninsula	1.8%	1.7%	1.7%	1.6%
Doctors Medical Center - Modesto	1.8%	1.7%	1.7%	1.6%
Dominican Hospital	1.8%	1.7%	1.7%	1.6%
Salinas Valley Memorial Hospital	1.8%	1.7%	1.7%	1.6%
Stanford Health Care	1.8%	1.7%	1.7%	1.6%
Goleta Valley Cottage Hospital	1.8%	1.7%	1.7%	1.6%
Marshall Medical Center	1.8%	1.7%	1.7%	1.6%
Northbay Medical Center	1.8%	1.7%	1.7%	1.6%
Santa Barbara Cottage Hospital	1.8%	1.7%	1.7%	1.6%
Washington Hospital - Fremont	1.8%	1.7%	1.7%	1.6%

All other hospitals in the sector and health care entities are subject to the statewide spending target.

Appendix

Table 3: Commercial Inpatient NPR per CMAD Repeat Outlier Hospitals 2018-2022
Shaded cells indicate values above the *85th percentile for the year.*

Hospital	2018	2019	2020	2021	2022	Pooled Average 2018-22
All Other Comparable Hospitals	$19.9K	$19.6K	$20.0K	$20.3K	$21.0K	$20.2K
11 High-Cost Hospitals	$37.8K	$40.8K	$41.0K	$40.2K	$41.5K	$40.2K
Barton Memorial Hospital	$44,175	$37,411	$39,998	$33,344	$34,843	$38.4K
Community Hospital of The Monterey Peninsula	$32,729	$41,866	$42,292	$43,655	$38,891	$39.9K
Doctors Medical Center - Modesto	$27,288	$40,915	$35,947	$36,831	$39,679	$36.0K
Dominican Hospital	$37,237	$33,720	$33,201	$34,923	$33,291	$34.5K
Salinas Valley Memorial Hospital	$46,937	$43,061	$44,748	$50,400	$48,784	$46.7K
Stanford Health Care	$47,705	$47,374	$49,091	$53,366	$58,873	$51.5K
Goleta Valley Cottage Hospital	$29,669	$30,225	$31,738	$35,619	$34,842	$31.9K
Marshall Medical Center	$37,593	$37,125	$40,612	$31,305	$29,328	$35.5K
Northbay Medical Center	$56,414	$59,246	$53,057	$24,582	$22,062	$42.8K
Santa Barbara Cottage Hospital	$31,185	$30,325	$36,617	$32,636	$33,596	$32.8K
Washington Hospital - Fremont	$32,200	$33,404	$30,929	$33,082	$35,432	$32.9K

Table 4: Commercial to Medicare Payment to Cost Ratio Repeat Outliers 2018-2022
Shaded cells indicate values above the 85th percentile or above for the year.

Hospital	2018	2019	2020	2021	2022	Pooled Average 2018-22
All Other Comparable Hospitals	202%	199%	200%	190%	197%	200%
11 High-Cost Hospitals	328%	365%	356%	344%	352%	350%
Barton Memorial Hospital	409%	888%	981%	776%	942%	773%
Community Hospital of The Monterey Peninsula	239%	436%	352%	362%	369%	353%
Doctors Medical Center - Modesto	325%	371%	341%	324%	371%	347%
Dominican Hospital	355%	313%	336%	315%	333%	331%
Salinas Valley Memorial Hospital	405%	457%	461%	556%	501%	475%
Stanford Health Care	328%	336%	341%	351%	340%	340%
Goleta Valley Cottage Hospital	368%	391%	398%	370%	384%	383%
Marshall Medical Center	266%	302%	306%	297%	267%	288%
Northbay Medical Center	396%	290%	329%	174%	165%	269%
Santa Barbara Cottage Hospital	293%	300%	310%	310%	311%	305%
Washington Hospital - Fremont	349%	394%	353%	329%	364%	359%