California Hospital Association

February 21, 2025

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

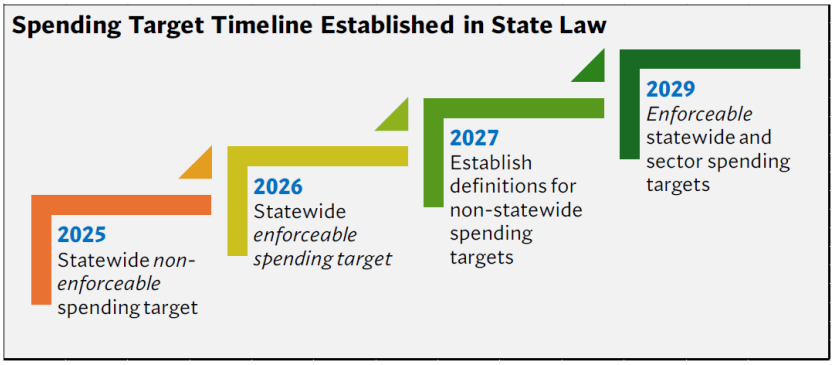
Subject: **Hospitals Oppose Flawed, Rushed Creation of Sector Targets**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson,

At its January 2025 meeting, the Office of Health Care Affordability (OHCA) board established a hospital sector and set its eye on creating a unique, lower target for purportedly "high-cost" hospitals. Not only is this conversation wholly premature, coming **three full years** before OHCA is statutorily required to develop such a target, it is also deeply flawed, ignoring critical factors relevant to understanding California's hospitals. The California Hospital Association, on behalf of more than 400 hospitals and health systems, urges the board to reconsider its approach — before patient care is irreparably damaged.

California's Hospitals Oppose the Rushed Creation of Hospital Sector Targets

OHCA's authorizing statute establishes the timeline for moving from a single statewide spending target to sector-specific targets. The statutory intent is clear: **first** make progress implementing core functions of the office, collectively learn and pursue innovative solutions, and encourage cross-sector collaboration on behalf of common goals; **then** carefully subdivide health care into sectors and explore differentiated targets. Instead, OHCA is poised to take these steps backwards by **first** targeting a single segment of the health care industry with strict spending targets, **then** looking at the data to evaluate effectiveness and



stepping back to encourage cooperation on shared objectives. This is the opposite of a sound process and ultimately will undermine OHCA's ability to fulfill its noble mission.

Sector Target Approach Is Premature. OHCA's hospital sector target proposal comes before OHCA has achieved basic prerequisites or milestones, calling into serious question whether office decisions affecting the lives and livelihoods of millions of Californians are being made with proper thoughtfulness.

- **OHCA Has Yet to Analyze or Report a Single Year of Comprehensive Spending Data.** OHCA is relying on new reporting from payers on total health care expenditures to comprehensively measure trends in health care spending. While the first two years' data have been collected, they have not been publicly analyzed or reported. As a result, OHCA currently only has preexisting datasets (designed for alternative purposes) available to inform its decisions. Unlike many other segments of the health care industry, hospitals have reported financial information to the state for decades. Now, OHCA is taking advantage of the fact that hospital financial data happens to be available to set special targets on hospitals, disregarding the opportunity to base its initial sector decisions on even a single reporting period's total health care expenditure data.
- **OHCA Has Yet to Evaluate Available Data for Any Other Potential Sector.** Making matters worse, other regulated health care entities report similar information to the state. For example, health plans — a nearly $300 billion industry in California — have publicly reported financial information for years, including on their earnings, assets, and premium growth. Long-term care facilities and clinics also report their financials to the state. OHCA could have evaluated at least other health care entities' financial information prior to proposing and making initial decisions on sector targets. It could have evaluated the 10% to 15% recent annual growth in health plan premiums, as just one example. And yet, OHCA has disregarded this information — on top of that from its forthcoming total health care expenditure data — as irrelevant to its decision making, betraying a worrying partiality and indifference to making data-informed and deliberate decisions.
- **OHCA Has Yet to Determine How Hospital Spending Will Be Measured.** OHCA has considered, but not finalized, a methodology for measuring hospital spending. Most notably, there is currently no clarity around how OHCA will measure hospital outpatient spending — one of just two major categories of hospital spending that reflects 40% of statewide hospital revenues. As such, OHCA is proposing a hospital sector target without having an established methodology for measuring historical spending trends, identifying higher-cost hospitals, estimating what a reasonable sector target would be, or informing hospitals on the types of spending they will need to limit to comply with their spending targets. This strains the credibility of both the process and any resultant rules.
- **OHCA Has Yet to Assess the Reasonableness of the Statewide Spending Target.** The timeline on Page 1 reveals the intent of state law — to learn from implementation of the statewide target before moving onto sector targets. By disregarding the statutory timeline, OHCA is ignoring any opportunity to assess whether the statewide spending target is reasonable and attainable, if it is driving improvements in affordability without sacrificing quality and equity, and how different segments of the health care industry are performing and therefore deserving of closer attention.

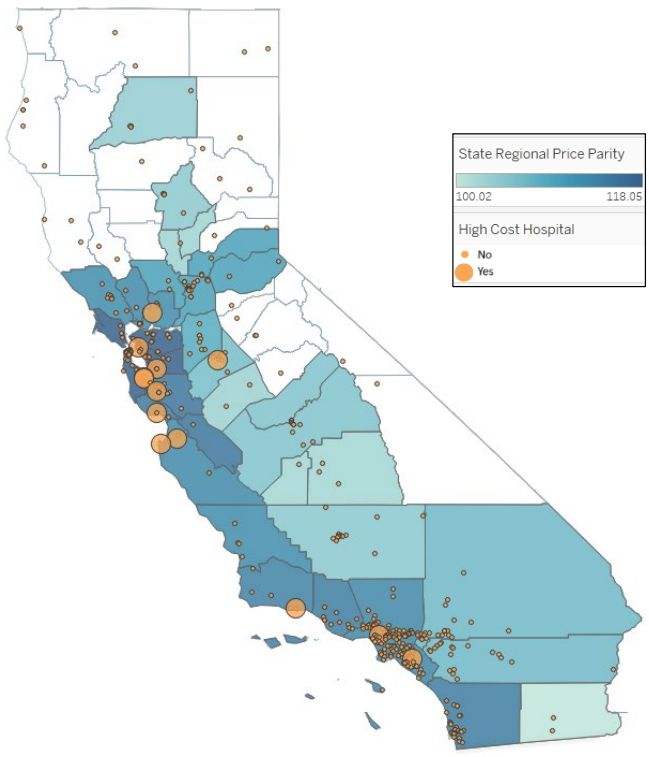
OHCA's Approach for Identifying "High-Cost" Hospitals Is Seriously Flawed

In January 2025, OHCA put forward two methods for identifying high-cost hospitals, with board members expressing interest in deeming hospitals identified by both methods as high cost and subject to lower sector targets. However, both methods — as well as the data underlying them — suffer from critical flaws that render them unsuitable for their intended purpose.

Commercial Reimbursement Measure Ignores Basic Health Care Facts Related to Hospital Finance. This measure attempts to identify which hospitals earn the most commercial revenue per discharged patient, adjusted for the expected resource-intensity of their stay — but has at least three major flaws.

Measure Fails to Account for Underlying Differences in the Cost of Providing Patient Care. The cost of living and of doing business varies enormously throughout California. Real estate costs in the San Jose region are more than 40% higher than California overall. Median household income in the San Francisco-Bay Area is 11% higher than in the Inland Empire. These underlying economic conditions heavily influence hospitals' costs — including through higher labor, facility, and purchased services costs — and, in turn, what hospitals must charge commercial payers to remain financially sound. Predictably, 19 of the 23 hospitals in the top 20% of hospitals in terms of commercial reimbursement are located in the seven highest-cost metropolitan service areas (MSAs) in California (there are 26 MSAs in total in California). Clearly, this measure singles out hospitals in high-cost regions, penalizing them for factors beyond their control.

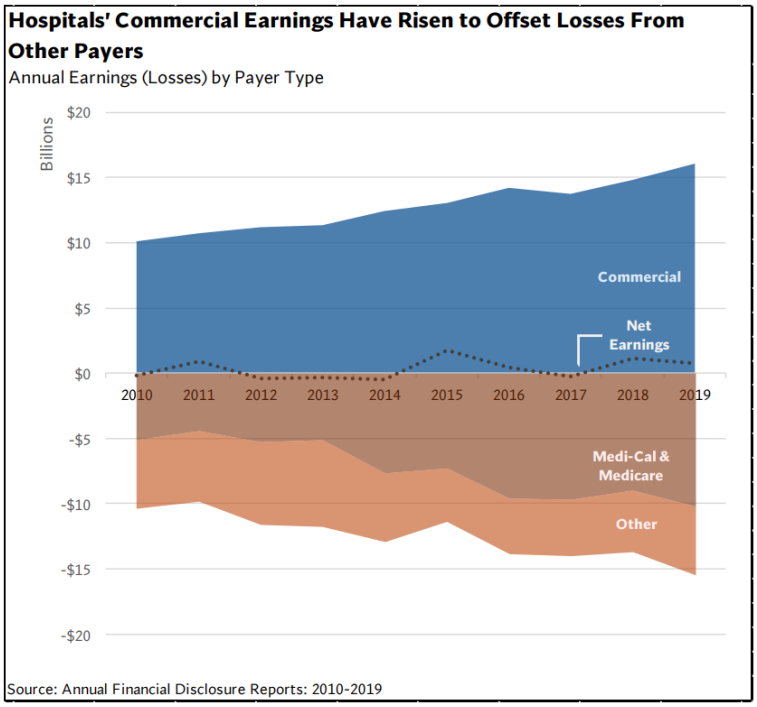
OHCA's High-Cost Hospitals Are Predominantly Located in Areas With High Costs of Living

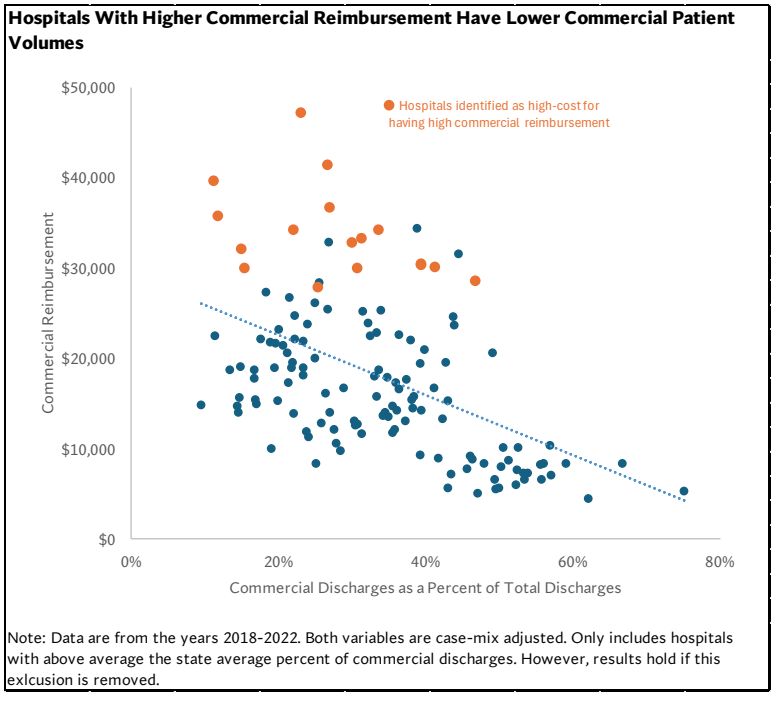


Regional price parity is a price index that compares price levels across different regions of the United States

Measure Does Not Control for Payer Mix. For most hospitals, commercial insurers are the only payers that pay above cost. As the figure on the top of the next page shows, statewide, hospitals lose enormous sums of money caring for Medicare and Medi-Cal patients. Commercial payers increasingly make up for this shortfall, and in the end hospitals just barely break even. However, this statewide data masks enormous variability among hospitals related to the degree to which commercial payers cross-subsidize losses from government payers. Consistent with the finding that losses from government payers are shifted to higher burdens on commercial payers, CHA's January letter showed that higher commercial reimbursement

does not lead to higher operating margins for individual hospitals. Rather, higher commercial reimbursement is often canceled out by greater shortfalls in government payer revenues. The graph below provides further evidence for the cost shift (contradicting information presented to OHCA at its August 2024 board meeting), showing that hospitals with higher commercial reimbursement tend to have lower commercial patient volumes (as a percentage of total patient volume). Together, these findings show that hospitals' higher commercial rates are compensating for relatively poor payer mixes and the related shortfalls in government payer reimbursement. This cost shift is arguably a frustrating aspect of the health care system, but it is the only way hospitals — 53% of which operate at a loss — are able to keep their doors open. To level the playing field in a way that doesn't undermine patient care, government payers must pay their fair share. By identifying hospitals as high cost using this measure, OHCA would effectively punish hospitals that disproportionately care for elderly patients on Medicare and low-income and disabled patients on Medi-Cal.





Measure Ignores 40% of the Services Hospitals Provide. Hospitals provide a mix of inpatient and outpatient services; the latter include emergency department visits and a wide variety of non-emergency hospital outpatient services. By ignoring outpatient services, this measure fails to incorporate any information on 40% of a typical hospital's service mix in determining whether it is high cost, and therefore risks targeting hospitals that cross-subsidize relatively unprofitable outpatient services with relatively profitable inpatient services.

As a result of these and other flaws, 10 out of the 23 hospitals identified by this measure as high cost had negative average operating margins over the same five-year period (2018-22)

that OHCA analyzed. Subjecting such hospitals to a reduced, high-cost hospital spending target would jeopardize this group's financial stability even more.

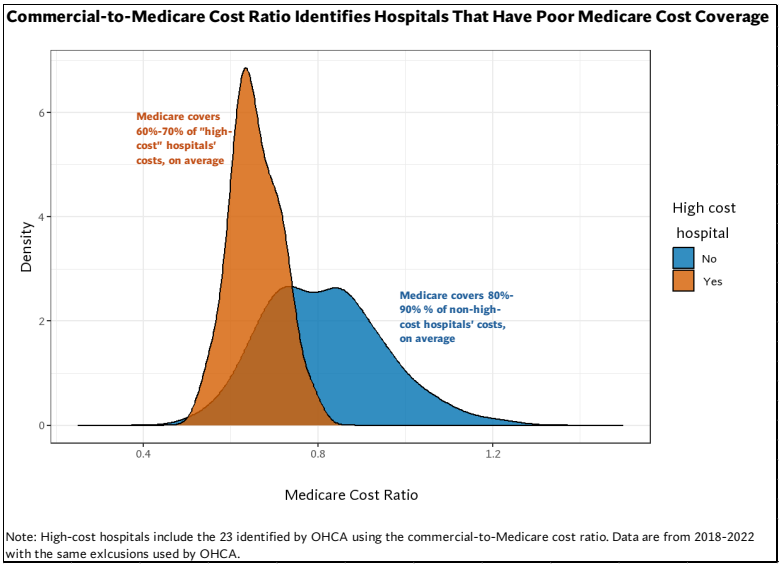
Relative Commercial-to-Medicare Payment-to-Cost Ratio Has Irredeemable Flaws. The second measure OHCA intends to use to identify high-cost hospitals compares the degree to which a hospital's commercial payments cover their costs better than its Medicare payments do. By incorporating cost into the equation, the measure ostensibly controls for the appropriate and unavoidable variation in hospitals' operating costs. However, its validity fully depends on the accuracy and appropriateness of Medicare payment policies — a wholly unfounded assumption. In fact, just a small number of distortions in Medicare payment policies significantly and variably reduce hospitals' Medicare reimbursement. These generally result from budget neutrality requirements that mean any boost in funding for certain hospitals is offset by cuts for other hospitals. They include:

- Adjustments to the area wage index to impose a minimum score for rural hospitals and revert the occupational mix of California's hospitals to the national average
- Caps on funding for graduate medical education, disproportionate share hospital reductions, and limits on payments for bad debt

Collectively, these distortions reduce Medicare payments for California hospitals by well over $1 billion annually. However, the reductions are not borne comparably by all hospitals. Rather, hospitals identified as high cost based on their commercial-to-Medicare payment-to-cost ratios experience much higher reductions in their Medicare payments (nearly 11%) compared to other hospitals (less than 6%).

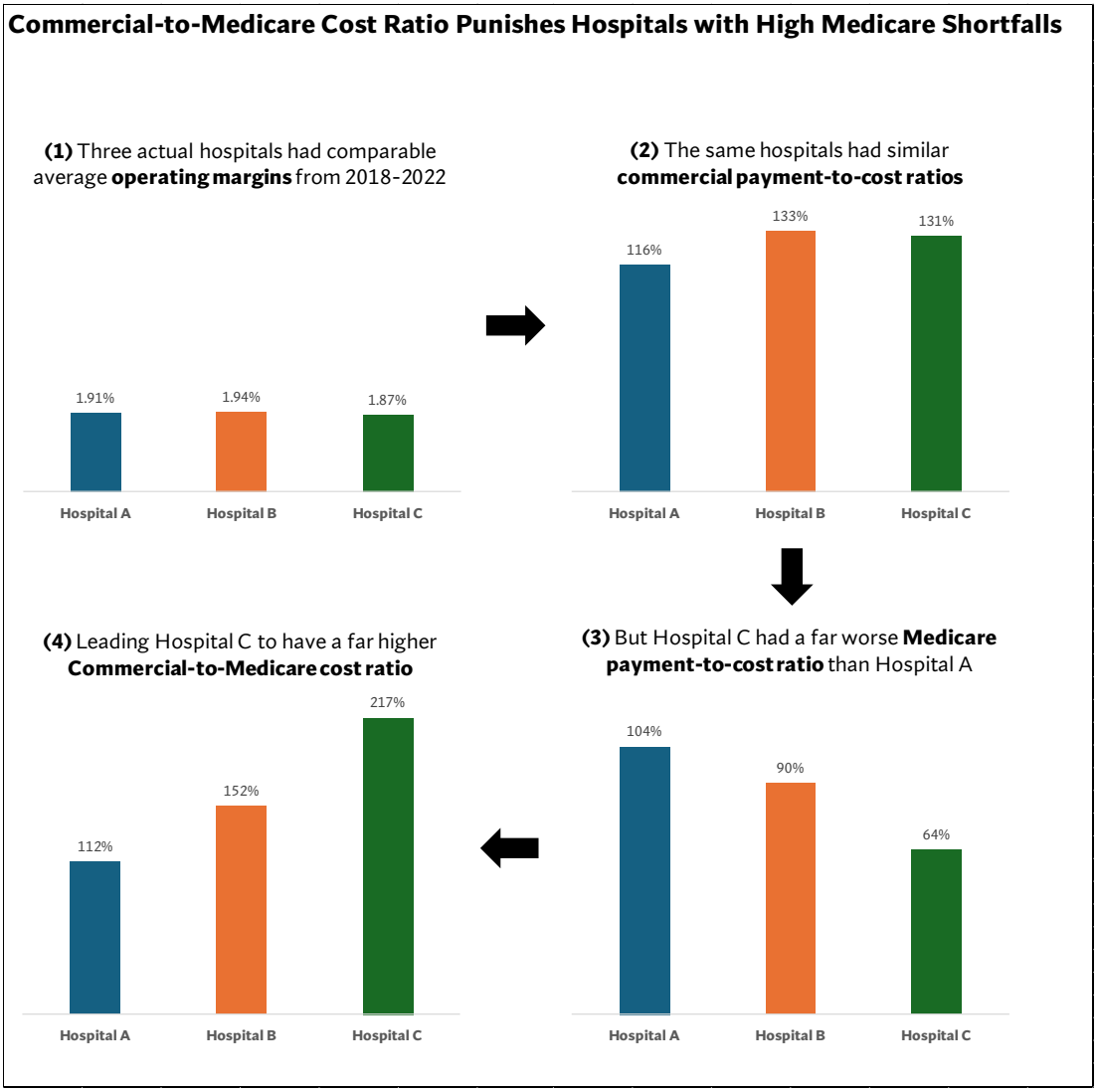
For example, Medicare graduate medical education payments are designed to cover the program's share of the cost of training new generations of health care providers. However, artificial caps put in place to restrain program spending have resulted in teaching hospitals receiving no increased funding for new physician residency positions added since 1996. This Medicare funding cap directly distorts the denominator of the commercial-to-Medicare cost ratio, since affected hospitals have a higher proportion of their Medicare expenses left unreimbursed by the Medicare program. For one hospital, this distortion is so large that it increases its commercial-to-Medicare cost ratio by an estimated 24 percentage points.

Commercial-to-Medicare Payment-to-Cost Ratio Measure Punishes Hospitals with Large Medicare Shortfalls. Using Medicare benchmarking to identify high-cost hospitals is inappropriate not only in concept but also in reality, creating concrete distortions in how hospitals are assessed under OHCA's methodologies. The figure to the right shows the key distortion for all hospitals that OHCA included in its analysis: the ratio systematically over-identifies hospitals



Note: High-cost hospitals include the 23 identified by OHCA using the commercial-to-Medicare cost ratio. Data are from 2018-2022 with the same exlcusions used by OHCA.

whose Medicare payments fall short of their Medicare costs. High-cost hospitals on this measure are paid by Medicare at 60% to 70% of what it costs for them to care for their Medicare patients. Hospitals that are not high cost have Medicare shortfalls that are roughly half as large. The next figure further drives this home, looking at three **real** hospitals' financial metrics over the past five years. Each hospital had roughly equivalent operating margins and comparable commercial payment-to-cost ratios (the numerator in OHCA's measure). However, Hospital C had a far worse Medicare payment-to-cost ratio (the denominator in OHCA's measure), leading to a score on OHCA's commercial-to-Medicare payment-to-cost ratio of nearly double that of Hospital A and 40% **higher** than Hospital B's despite having **lower** operating margins and a **lower** commercial payment-to-cost ratio. Simply put, this OHCA measure punishes hospitals with the largest Medicare losses. Ultimately, Medicare's failure to accurately cover hospitals' variable patient care costs must not be compounded by serving as the basis for California's approach.



Combining Two Flawed Measures Does Not Address Their Underlying Issues. In January, OHCA board members expressed a preference for deeming hospitals as high cost if they are in the top 10% to 20% of all non-excluded hospitals on both of the measures previously described, commercial reimbursement and

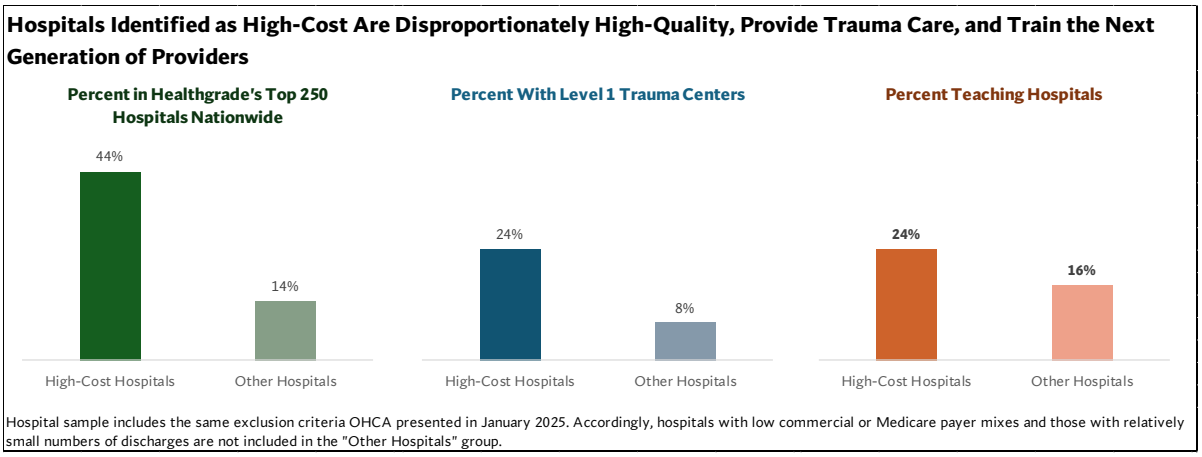
the commercial-to-Medicare payment-to-cost ratio. This approach is unsatisfactory, as the flaws in one measure do not adequately make up for those in the other. Fundamentally, the first measure fails to control for cost shifting, cross-subsidization across service lines, and differences in hospital costs. The second measure, meanwhile, largely penalizes hospitals that are forced to shift costs onto other payers due to their larger Medicare shortfalls, while failing because it benchmarks based on Medicare reimbursement policies that do not appropriately account for underlying differences in hospitals' cost of care. More work is clearly needed, not a rushed adoption of policies that will impact access to care for millions of Californians based on faulty methodologies.

Data OHCA Relies Upon for Identifying High-Cost Hospitals Paint a Limited, Inaccurate Picture. OHCA is assessing hospital financial reports from 2018-22 to determine which hospitals are high cost — but those data are extremely limited and unreliable.

- **Data Provide a Fractional View into Hospitals' and Health Systems' Overall Finances.** OHCA's methodology evaluates individual hospitals' financial data — ignoring that the majority of the state's hospitals are either part of multi-hospital systems, financially interdependent with affiliated medical groups, or both. By looking only at individual hospitals, OHCA has failed to account for the fact that, within such hospitals and health systems, a higher-earning hospital commonly cross-subsidizes unprofitable components of the system to ensure that vital patient services remain available, even if they are not financially viable. Multiple hospitals have demonstrated this essential interdependence within hospital finance in their communications to OHCA. Nevertheless, OHCA appears poised to proceed with a hospital sector target based on a partial view of hospital and health system finances. OHCA should not proceed with hospital sector targets until it properly evaluates the scope and impacts of cross-subsidization present within health systems.
- **COVID-19 Distorted Hospitals' Financials for 3 out of the 5 Years OHCA Relies Upon.** While evaluating multiple years is appropriate given shocking year-to-year volatility in these data, the period chosen raises questions because it includes the COVID-19 pandemic. The onset of the pandemic in the spring of 2020 brought with it a collapse in elective procedures and routine care, while the next two years brought waves of acutely ill patients, emergency department and inpatient overcrowding, discharge delays, and exploding costs that far outstripped any associated increases in revenues. Despite these shocks to hospital finances — clearly indicated in HCAI and other financial reporting — OHCA seeks to use data from the COVID-19 years to determine which hospitals to penalize with low sector targets.

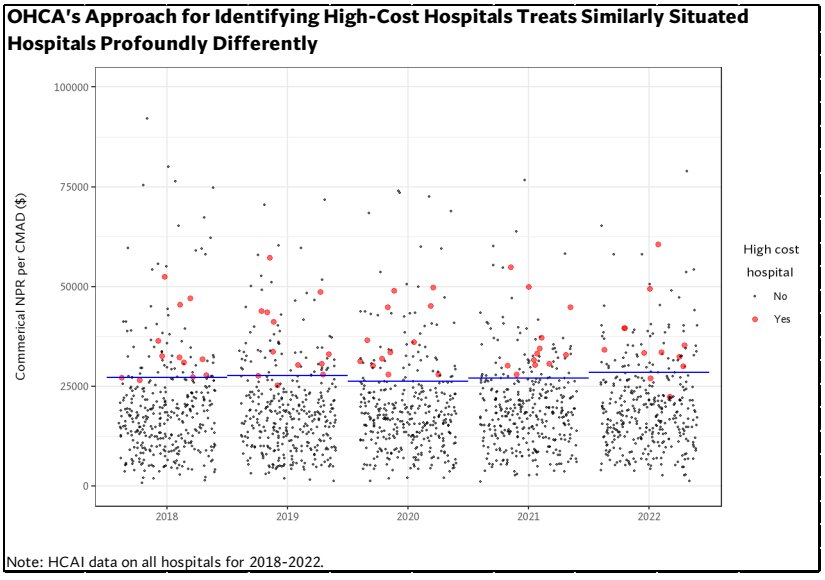
Approach Disproportionately Targets High-Quality Hospitals That Provide Complex Care and Train the Next Generation of Providers. OHCA is statutorily required to consider the quality of care a health care entity provides when considering sector targets. Yet, to date, OHCA has entirely avoided any serious analysis of hospital quality, instead simply assuming that there is no association between hospital cost and quality. However, the data simply do not bear this out. The figure below shows that 44% of the hospitals identified by OHCA as high cost are in Healthgrade's Top 250 highest quality hospitals, **nationally.** This percentage is 9 times higher than would be expected if there were no relationship

between cost and quality, as has been presented in testimony to OHCA's board. Absent a relationship, 5% of OHCA's high-cost hospitals would be predicted to fall in Healthgrade's Top 250 list. While it is clear that California's hospitals outperform other hospitals nationally in terms of being extremely high quality, the figure above also shows that OHCA's high-cost hospitals are disproportionately recognized within California for the quality of care they provide. There are other differences between OHCA's high-cost hospitals and others that also must be considered before proceeding to targets. As shown in the figure, OHCA's high-cost hospitals are 3 times as likely as other California hospitals to operate level 1 trauma centers, and disproportionately serve as major teaching centers for the next generation of providers. Ultimately, this clearly indicates that OHCA is not adequately controlling for salient differences among hospitals in its attempt to identify hospitals that are unjustifiably high cost.



Method for Distinguishing High-Cost Hospitals Would Treat Similarly Situated Hospitals Profoundly Differently. OHCA is poised to subject hospitals with similar financial metrics to profoundly different spending targets, due to the inclusion of arbitrary exclusion factors and an arbitrary cutoff value. The exclusionary factors include:

- Ignoring hospitals for which comprehensive data is not yet available in lieu of waiting, in certain instances, for these data to become available
- Removing hospitals with low commercial and Medicare payer mixes
- Eliminating hospitals with discharge numbers below the statewide average

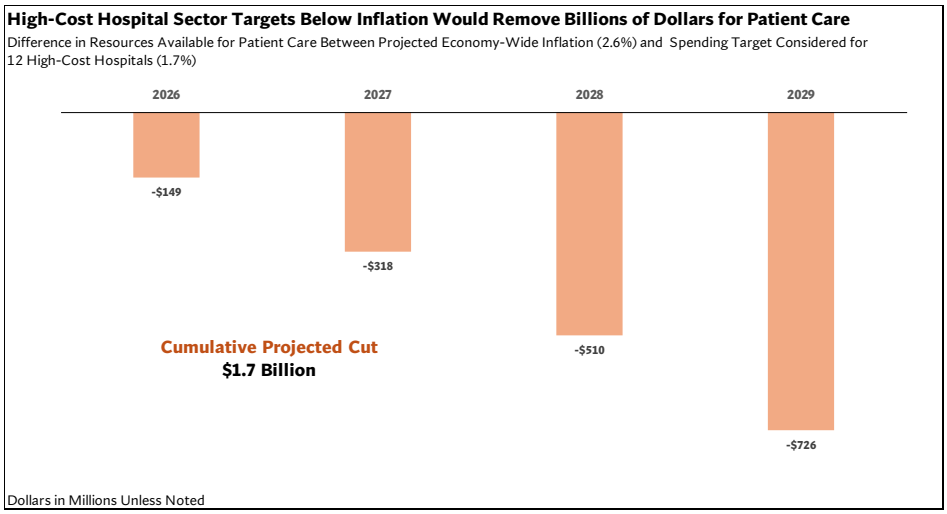


Then, OHCA deems hospitals as high cost if they are above the 80th percentile in at least 3 out of 5 years on one of two measures of costs. As the figure to the right shows, this

approach singles out a minority of hospitals above OHCA's arbitrary percentile cutoff. Moreover, using a percentile cutoff approach fails to distinguish between hospitals that are true outliers from those that merely happen to be at the top of the distribution. For methodological decisions as important as this, OHCA should show its background work, including sensitivity analyses detailing why the exact thresholds of 80% and 3 out of 5 are deemed appropriate.

Sector Target Values Under Consideration Would Threaten Hospitals' Capacity to Provide High-Quality Care

Sub-Inflationary Targets Would Decimate Hospitals' Ability to Sustain Services and Their Workforces. OHCA presented sector spending target options of between 1.7% and 1.9% for hospitals designated as high cost. Such low potential spending targets would predictably and unacceptably endanger patient care. They are as low as 35% below projected inflation for all goods and services, therefore reflecting a real cut in resources. Affected hospitals would not be able to sustain their workforces, afford drugs and supplies, maintain their facilities, or continue to financially support essential community services and quality improvement activities that lose money every day but are critical to supporting their communities' well-being. In fact, even the above inflationary comparison understates the draconian implications of the presented sector target values given recent growth in the costs of fundamental inputs into patient care. A recent analysis of financial data for hospitals in the western United States showed that costs are currently growing at 6% for labor, 8% for supplies like personal protective equipment, and 10% for drugs. A 1.7% target is 70% to 80% lower than the recent cost growth for these essential inputs — demonstrating a complete lack of sustainability in the high-cost sector targets OHCA is considering.



Sector Targets Would Further Destabilize Already Struggling Hospitals. Of the 34 hospitals identified as high cost by OHCA on either of its measures, 13 (almost 40%) lost money on their operations over the five-year period OHCA analyzed. Even when limited to the 12 hospitals identified by both measures as high cost, three (25%) lost money on their operations. Imposing a drastically deficient sector target on these struggling hospitals would endanger their ability to sustain their services, jeopardizing life-saving care for the patients that rely on them.

OHCA Risks Compounding the Harms of Federal Efforts to Defund California's Health Care System

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

Support Patients, Not Insurance Company Profits

While OHCA is singling out hospitals with unattainably low sector targets at far less than general inflation, health insurance companies are increasing consumer premiums by 10% or more annually. State agencies like the California Public Employees' Retirement System (CalPERS) recently offered one of the state's highest-cost health insurance companies a premium increase 40% higher than OHCA's statewide spending target, just as OHCA appears poised to impose spending targets on select hospitals that are roughly 50% lower than the statewide target. Furthermore, OHCA has provided no assurance that any lower spending targets imposed on hospitals would be passed to consumers in the form of lower premiums and cost sharing, rather than simply being retained by payers as higher profits. No commensurate adjustments to payers' targets are being considered, leaving it unclear who will benefit from OHCA's targeting of a small set of providers. Before proceeding, OHCA should clearly state why it is not striving to ensure any strict targets on providers translate into savings for the California residents who pay billions of dollars in premiums to health insurance companies every year.

Conclusion

Hospitals Recommend an Alternative Path for OHCA: A Sound Process to Ensure Buy-In and Avoid Catastrophic Consequences for Patients. California's hospitals are deeply concerned that OHCA's rush to adopt sector targets has failed to follow a sound process or allowed due consideration of relevant factors and stakeholder input. Ultimately, these failures undermine the office's credibility, making the achievement of OHCA's broadly shared goals only more challenging. California's hospitals recommend an alternative path:

- Review total health care expenditure data first so that the office's decisions are informed by comprehensive spending data itself

- Learn from early implementation and develop policies accordingly, rather than setting sector targets three years ahead of schedule
- Inform regulated entities of how to conform with state rules prior to setting stringent targets, so they may better comply with their unique sector targets
- Evaluate the potential unintended consequences of its policies before imposing them, so that patients are not hurt by the imposition of ill-conceived policies

Ultimately, hospitals ask for a sound process, deliberation that incorporates the voices of regulated entities, and judicious and well-considered decisions that demonstrate deep understanding of the health care system. The process for setting sector targets has not met these basic standards to date, but there still is time for OHCA to reverse course and improve the process through which it decides the fate of millions of Californians.

California's hospitals appreciate the opportunity to comment and look forward to continued engagement to improve OHCA's approach so that it best serves Californians.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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