April 11, 2025

Megan Brubaker
Office of Health Care Affordability
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Requests Withdrawal of Proposed Hospital Sector Spending Target Recommendations to the Board**
(Submitted via Email to Megan Brubaker)

Dear Ms. Brubaker:

California's hospitals are committed to improving affordability, access, quality, and equity in California's health care system. However, they represent just one slice of the health care industry. Statewide, $2 out of every $3 of health care spending goes to providers and payers other than hospitals. Moreover, National Health Expenditure data show a significant gap between hospitals' efficiency and that of the health care field at large. Despite the state's high cost of living, per capita spending for all health care services ranks in the middle of the pack, at 29th lowest nationally. However, when narrowed to only per capita **hospital** spending, California's rank improves 11 places — landing at 18th lowest nationally. Accounting for California's nation-leading cost of living shows that hospitals are even more efficient, outpacing most of the nation in delivering cost-effective care to patients.

Unfortunately, the Office of Health Care Affordability (OHCA) continues to ignore these and other key facts. Its February 2025 proposal to establish reduced spending targets for hospitals determined to be "high cost" is deeply flawed. It unfairly targets a single class of providers, comes before OHCA has done the necessary groundwork, relies on unsound methodologies and anomalous data, is inconsistent with key aspects of state law, and would endanger access to health care in communities across California. **For these reasons, the California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, asks OHCA to withdraw its proposal until the office has addressed these issues and conducted a far more balanced consideration of sector targets under all relevant statutory factors.**

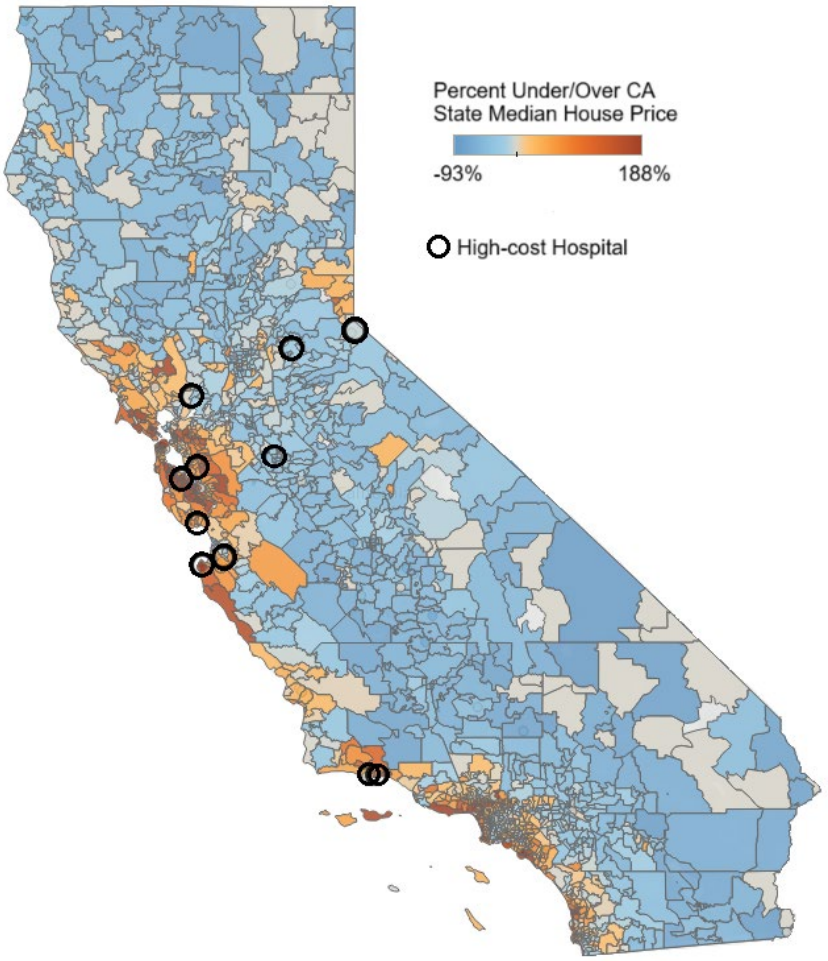
Flawed Approach for Identifying High-Cost Hospitals Leads to Illogical Results

OHCA proposes to designate hospitals as high cost if, for three out of five years between 2018 and 2022, they fell in the top 15% on two financial measures. The first measure reflects commercial inpatient reimbursement per case mix-adjusted discharge, while the second measure compares the relative cost coverage between hospitals' commercial and Medicare payers. Neither measure accounts for factors beyond hospitals' control that significantly influence their measured scores, and together generate an arbitrary list of hospitals that bear little relation to one another — other than the fact that they just happen to be high on two narrow measures that do not fully reflect the myriad factors influencing

hospital costs. Even at this late stage of the process, the office has yet to address questions about the underlying data's quality and appropriateness. Ultimately, these shortcomings are a result of OHCA moving too fast and neglecting legislatively mandated due diligence. That critical work must be completed prior to adopting policies that will profoundly impact millions of patients and workers who rely on hospitals. More detailed comments on the proposed methodologies are provided below.

Commercial Reimbursement Measure Penalizes Hospitals for Operating in High-Cost Areas and Paying Their Workers Accordingly. California is home to four of the 10 highest cost-of-living metropolitan areas in the entire country. The Bay Area and Central Coast are extraordinarily expensive places to live, even by California standards. Predictably, OHCA's commercial reimbursement measure disproportionately identifies hospitals operating in high-cost areas, with eight of the 11 listed hospitals located in just these two regions of the state. The figure to the right shows just how expensive the cost of living is in the areas containing hospitals designated as high cost. To offer competitive wages in their communities, the 11 high-cost hospitals paid nonsupervisory workers an average salary of $111,350 in 2022 — 21% higher than the $91,883 average salary paid to comparable workers at other hospitals. Adequate compensation is critical to ensuring a strong, stable workforce. To avoid penalizing hospitals simply for negotiating commercial rates that allow them to pay their workers fairly, OHCA must evaluate and incorporate adjustments that account for differences in hospitals' operating costs due to cost-of-living factors beyond their control.

OHCA's High-Cost Hospitals Are Overwhelmingly Located in Regions with the Highest Cost of Living

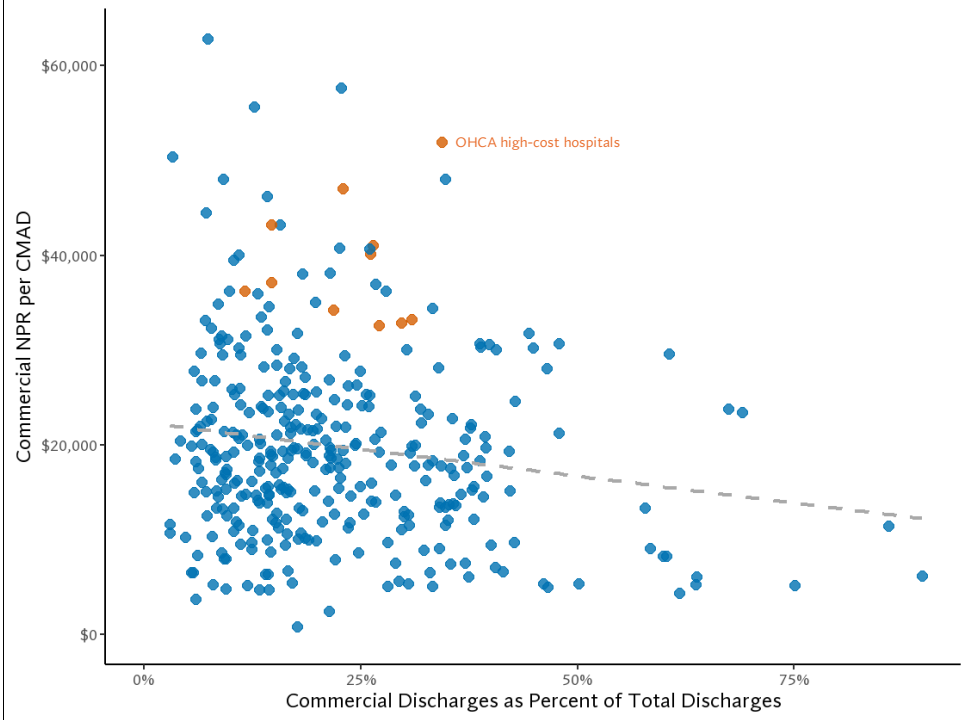


Source: American Community Survey 5-year average ending in 2023

Commercial Reimbursement Measure Myopically Focuses on a Small Subset of Patients and Services. Shortfalls in reimbursement from government payers — Medicare and Medi-Cal — force hospitals to rely on commercial payers to cover their costs. By looking only at hospitals' commercial reimbursement, the measure fails to control for the fact that some hospitals have more financially favorable payer mixes than others; hospitals without this distinct financial advantage need more revenue

per commercial patient to cover their costs. As the figure below shows, hospitals with higher commercial inpatient revenue per case mix-adjusted discharge have disproportionately small commercial payer mixes. By using this measure without any control for differences among hospitals in their payer mixes, OHCA risks penalizing hospitals for treating disproportionate shares of low-income Medi-Cal patients and elderly Medicare patients and making up their payment shortfalls the only way they can — through higher commercial payments. If hospitals were not able to recoup shortfalls in this way, the number operating at a loss (currently more than half of hospitals in California) would undoubtedly skyrocket, further eroding patients' access to care.

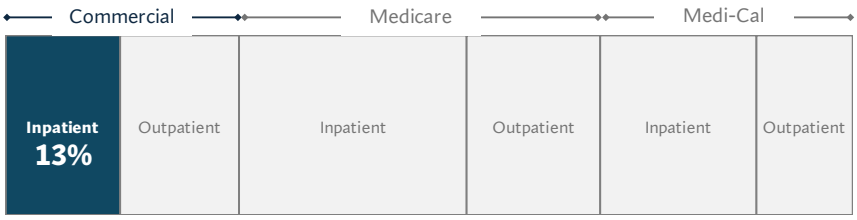
Hospitals with Higher Commercial Reimbursement Have Lower Commercial Patient Volumes



Note: Data reflect averages from the years 2018-2022 and include all hospitals not excluded from OHCA's analysis for its February 2025 high-cost hospital sector target proposal. NPR per CMAD means net patient revenue per case mix-adjusted discharge.

On top of overlooking reimbursement for 75% of the patients a typical hospital sees, OHCA's commercial reimbursement measure disregards 40% of the care hospitals provide: outpatient services. These services include emergency care, outpatient surgeries, specialty drug infusions, and other hospital services that do not require an admission. As the figure below shows, by ignoring government payers and outpatient services under this measure, OHCA is poised to determine hospitals' financial futures based on payments received for just 13% of the services provided. What's more, these payment data don't even reflect actual reported revenues, but rather an estimate (by OHCA's parent department, the Department of Health Care Access and Information) of the breakdown between hospitals' commercial revenues on the inpatient versus outpatient sides.

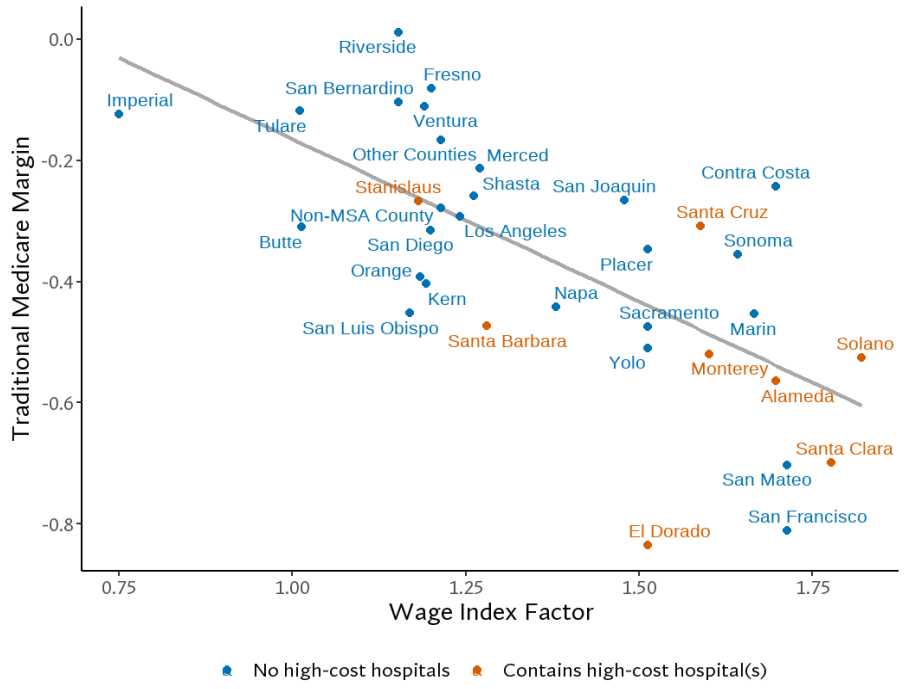
OHCA's Commercial Inpatient Revenue Measure Overlooks Reimbursement for All But 13% of the Services Hospitals Provide



Note: Reflects proportional breakdown of 2023 statewide gross patient revenue by payer and service type.

Medicare Payments Are an Inappropriate Benchmark for OHCA Target Setting. OHCA's second measure for identifying high-cost hospitals singles out those whose commercial payments cover their costs better than Medicare does. The foundational assumption is that Medicare hospital payment policies are sound and equitable — but that is not the case. Distortions and idiosyncrasies in Medicare payment policies significantly and variably

Medicare Payments Disproportionately Fail to Cover Costs in Higher-Cost Areas, as Indicated by the Area Wage Index



Note: Wage Index Factor reflects the area wage index averaged by county, weighted by traditional Medicare gross patient revenue. The margins are from pooled net patient revenues and expenses from the years 2018-2022. The methodology is based on that used in Gaudette É, Bhattacharya J. California Hospitals' Rapidly Declining Traditional Medicare Operating Margins. Forum Health Econ Policy. 2023 Mar 7;26(1):1-12. doi: 10.1515/fhep-2022-0038. PMID: 36880485.

reduce hospitals' Medicare reimbursement, often as a result of budget neutrality requirements in federal law that have the effect of redistributing funding from some hospitals to others. The figure to the left illustrates how far Medicare payments have diverged from what it costs to operate hospitals in different parts of the state. It shows the degree to which Medicare's area wage index, used to adjust hospital payments based on regional differences in hospitals' labor costs, fails to appropriately adjust payments based on underlying regional differences in the operating costs. Were the area wage index working properly, hospital margins on the traditional Medicare book of business would not have a consistent trend with the area wage index, since the area wage index-related payment adjustments would offset differences in regional costs. But there is a starkly negative trend, clearly indicating that the area wage index fails to fully compensate for the higher costs at hospitals located in more expensive areas. Differences in average salaries for nonsupervisory workers between OHCA's high-cost and other hospitals bear this out. While high-cost hospitals pay their nonsupervisory workers 21% more, their area wage index scores are just 8% higher, revealing wholly inadequate and inequitable cost coverage from Medicare payments.

A Handful of Payment Policies Cause a Significant Portion of the Medicare Funding Losses Incurred by Hospitals. A small set of distortions reduces Medicare payments to California hospitals by more than $1.3 billion annually, including:

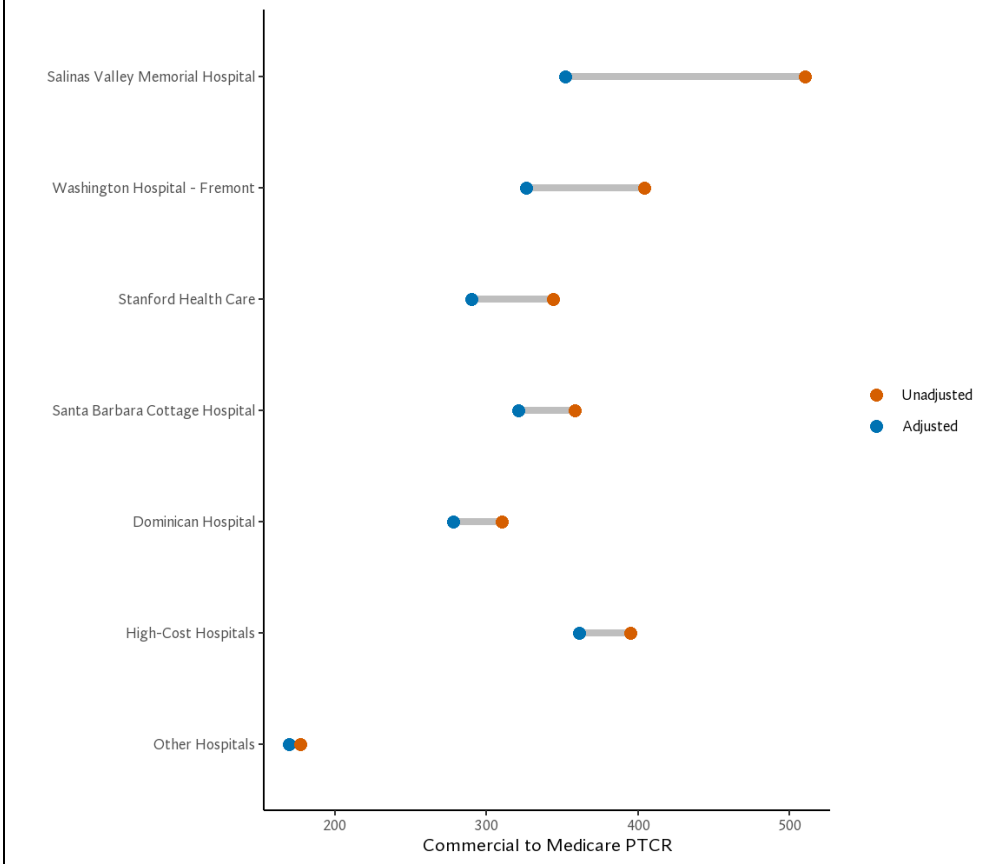
- **Occupational Mix Adjustment.** Due to nurse-staffing ratios, California hospitals employ a higher number of nurses relative to other professionals than hospitals nationally. However, for the purpose of estimating hospitals' area wage index scores, the federal government reverts the occupational mix of California's hospitals to the national average. This reduces California hospitals' Medicare payments by $435 million, with OHCA's high-cost hospitals bearing two to three times the losses of other hospitals, again distorting how hospitals score on OHCA's commercial-to-Medicare payment-to-cost ratio measure.
- **Graduate Medical Education Caps.** Medicare pays hospitals for providing graduate medical education, but the funding is generally capped at 1996 levels. As a result, California hospitals train more than 3,000 residents annually without any financial support from Medicare. One California

hospital on OHCA's high-cost list bears more than 25% of the $430 million in losses in Medicare funding due to the cap artificially boosting its commercial-to-Medicare payment-to-cost ratio score.

- **Rural Floor Adjustment.** Medicare imposes a floor on urban hospitals' wage index scores equal to the statewide rural area wage index score. In California, this policy redistributes more than $100 million in Medicare payments away from hospitals in the Bay Area, Central Coast, and greater Sacramento region to other hospitals throughout the state. Predictably, hospitals in these three regions dominate OHCA's high-cost hospital list, in part due to this redistributive component of Medicare hospital financing.

Commercial-to-Medicare Payment-to-Cost Ratio Penalizes Hospitals with Worse Medicare Reimbursement. The $1.3 billion in Medicare funding losses are not borne equitably by all California hospitals. The 11 hospitals identified by OHCA as high cost represent a mere 3% of all hospitals in the state, but collectively bear nearly $300 million (21%) of the statewide losses from these distortions in Medicare payment policies. This artificially reduces their Medicare payment-to-cost ratio (the denominator in OHCA's measure), biasing their overall score on OHCA's commercial-to-Medicare payment-to-cost ratio upward. The figure to the right shows the effects these adjustments have on several high-cost hospitals' 2022 commercial-to-Medicare payment-to-cost ratios, while also showing the disproportionate effect on OHCA's high-cost hospitals. OHCA's spending targets must account for these inequities, not compound them by imposing harsher spending targets on hospitals with the greatest reductions in Medicare payments.

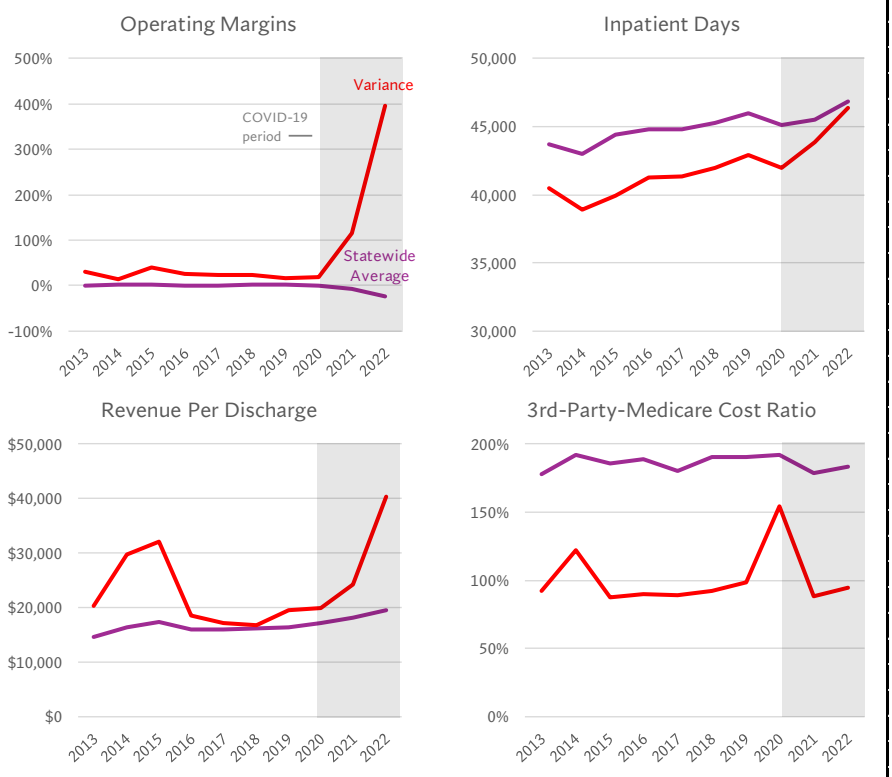
Correcting for Major Distortions in Medicare Payment Policies Substantially Reduces OHCA's High-Cost Hospitals' Scores on the Commercial-to-Medicare Payment-to-Cost Ratio (PTCR)



Note: Five Medicare payment policies artificially reduce hospitals' Medicare payments, depressing their Medicare payment-to-cost ratios, and inflating their scores on OHCA's relative cost measure. These reductions are not born equitably among hospitals. Instead, OHCA's high-cost hospitals bear a disproportionate burden. The five Medicare payment policies are: (1) the rural floor on the area wage index, (2) an adjustment to the area wage index to revert California's occupational mix to the national average, (3) caps on graduate medical education funding, (4) Medicare disproportionate share hospital funding reductions, and (5) limits on payments for bad debt.

Identifying Hospitals as High Cost Based on Financial Performance During the Pandemic Runs Counter to State Law. OHCA has proposed using data from 2018 through 2022 to determine which hospitals are high cost, completely disregarding the fact that the worst pandemic in a century hit in March 2020. In addition to upending people's lives and livelihoods, COVID-19 severely tested health care providers' finances and operations. Routine services were canceled, patients came to hospitals with greater health needs, costs exploded, and health care workers experienced unprecedented levels of burnout. As the figure to the left shows, these anomalies show up in the financial data OHCA is using to determine which hospitals are high cost.

Hospital Finances and Patient Volumes Were Highly Volatile During the COVID-19 Period



Financial metrics are calculated using same data and methodologies used by OHCA. Accordingly, "Revenue Per Discharge" is shorthand for inpatient net patient revenue per case-mix adjusted discharge. Variance is measured using standard deviation, making it directly comparable to the statewide average.

Recognizing the abnormalities in COVID-19 years and their potential to distort historical trends, state lawmakers required that OHCA's spending target methodology *"shall provide differential treatment of the 2020 and 2021 calendar years due to the impacts of COVID-19 on health care spending and health care entities"* (Health and Safety Code Section (HSC §) 127502(d)(3)).

Identifying "high cost" hospitals by measuring hospital performance **without differentiating for those years** ignores an important and express legal requirement to appropriately account for the impacts of COVID-19 on hospital and other health care providers' financing and operations. This disregard for the statutory requirement has a material effect — four hospitals on OHCA's high-cost list only meet the qualifying criteria based on their performance in 2020 and 2021, the two years lawmakers required to receive differential treatment.

Data Anomalies Show Analysis and Adjustments Are Needed. The data OHCA is using to determine which hospitals are high cost were neither designed nor have been used for OHCA's intended administrative purpose. Unsurprisingly, even a high-level review of the data has revealed anomalies and inconsistencies both over time and across hospitals. For example:

- **Abrupt Shifts in Commercial Reimbursement.** Two hospitals' commercial inpatient reimbursement per case mix-adjusted discharge measures fell precipitously during the period

under review, reflecting commercial reimbursement rate cuts of roughly 25% and 50% or, alternatively, the correction of previously faulty data.

- **Sudden Change in Medicare Cost Coverage.** One hospital saw its commercial-to-Medicare payment-to-cost ratio more than double in a one-year period due to its Medicare payment-to-cost ratio suddenly falling in a single year from roughly 0.6 (in line with the average for the other designated high-cost hospitals) to around 0.2 (64% lower than the average for those hospitals).
- **Differences in Reported Revenues Across Hospitals.** One hospital has a unique reporting structure that requires it to combine its professional and facility revenues in reporting its patient revenue; other hospitals only report their facility revenues. This difference in reporting increases the hospital's reported revenues by an estimated 10%, biasing its scores on OHCA's measures upwards.
- **Payments from Other Payers Are Wrongly Designated as Hospital Commercial Revenues.** Hospitals' financial reports did not separate out the payments they received from commercial payers during the five-year period used by OHCA to designate high-cost hospitals. Rather, these payments are lumped together with others, including those for government programs overseen by the Department of Health Care Services (DHCS) like California Children's Services, the Child Health Disability Prevention program, the Genetically Handicapped Persons Program, and the Short-Doyle program. Including funding from these programs distorts hospitals' measured performance on at least one of OHCA's measures.

OHCA must conduct further analysis and make appropriate changes to its proposal to ensure it is based on the best possible data before taking actions that endanger the financial and operational futures of the affected hospitals. For example, OHCA must provide hospitals with the opportunity to submit updated filings to correct clear errors, as is common with other state agencies that oversee hospital finances and reporting, like the DHCS. It also must properly separate out hospitals' commercial revenue from other sources given its intent to determine which hospitals are high cost based on their commercial reimbursement levels.

OHCA's Approach Yields an Incoherent Set of Hospitals. OHCA has set out to identify the highest cost hospitals in the state that substantially contribute to high health care costs broadly. The list generated, however, obviously does not match. It includes:

- Two Medicaid disproportionate share hospitals, which serve large numbers of Medi-Cal patients — California's most vulnerable seniors, children, and low-income individuals
- Six independent hospitals, which have little to no influence on the broader health care marketplace
- Two rural hospitals, which serve crucial roles in providing care to patients who have fewer options than those in urban areas
- Three small hospitals that discharge fewer than three commercial patients per day
- Four hospitals that lost money on their operations in 2022 and three that lost money in 2023 (with 6 of the 11 hospitals having unsustainable operating margins of less than 3%)

What's more, looking beyond commercial payers to Medi-Cal, Medicare, and other payers, 9 of the 11 hospitals were below the top 20% in all-payer reimbursement per case mix-adjusted discharge in 2022. In fact, one hospital's all-payer reimbursement was in the bottom 40% of all comparable hospitals and another's was in the bottom 60%, in both cases due to their low commercial volumes and poor reimbursement from government payers. What these hospitals do have in common is a tireless

dedication to serving their communities and providing accessible, high-quality, and affordable care, including for Californians who can least afford it.

Proposed Targets for High-Cost Hospitals Are Inconsistent with State Law and Would Jeopardize Access to Quality Care and Workforce Stability

OHCA Lacks Authority to Adjust Sector Targets as Proposed. State law establishes several authorities under which OHCA may impose spending targets on one or more health care entities. These include:

- **The statewide target**, applicable to all regulated health care entities (HSC § 127502(a))
- **Sector targets**, specific targets by health care sector, which may include fully integrated delivery systems, geographic regions, and individual health care entities (HSC § 127502(b)(1))
- **Targets adjusted by sector** (HSC § 127502(b)(2))
- **Adjusted targets for high- and low-quality providers**, targets adjusted downward "for health care entities that deliver high-cost care that is not commensurate with improvements in care," and vice versa (HSC § 127502(d)(6)(A))
- **Labor cost-adjusted targets**, accounting for actual or projected nonsupervisory employee organized labor costs (HSC § 127502(d)(7))
- **Individual entity sector targets**, based on an entity's status as a high-cost outlier (HSC § 127502(e)(1)).

In January 2025, OHCA's board assented to staff's recommendation to (1) define all hospitals as a single sector and (2) adjust the target for all or a specified subset of hospitals within the hospital sector. OHCA cited HSC § 127502(b)(2) as its legal authority to proceed as recommended. This provision states:

> *"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." **(emphasis added)***

While OHCA's cited legal authority allows it to adjust targets **by** sector, it has proposed to adjust targets and apply differential standards **within** a single prospective sector. Related provisions in the enabling statute all conform with the above language, only allowing OHCA to establish or adjust targets **by** sector. While there are arguably exceptions under specified conditions where OHCA has authority to impose different targets within the same sector (see, HSC § 127502[d][6][A],allowing adjustment of targets upward or downward based on the level of quality improvement, and HSC § 127502[d][7], requiring target adjustments to account for nonsupervisory employee organized labor costs), neither of those scenarios are applicable to the immediate high-cost hospital proposal.

Instead, when setting a target for a high-cost entity that is different from the statewide or sector target that would otherwise apply, HSC § 127502(e) contemplates accomplishing that only through adoption of a sector definition comprised of that individual health care entity, to which uniquely established or adjusted targets could be applied based on the entity's status as a high-cost outlier or to encourage the entity to serve populations with greater health risks. The requisite use of one target per defined sector, outside the potential exceptions noted above, is further supported by HSC § 127502(*l*)(2)(D), which requires OHCA to "specify which single sector target is applicable if a health care entity falls within two or more sectors." **As a result of exceeding its statutory authority, OHCA must withdraw its hospital sector target proposal and return with an alternative consistent with its enabling statute.**

OHCA's Proposed Sector Target Value for 2026 Doesn't Align with Methodology, Potentially Due to Premature Rounding. OHCA's method for determining high-cost hospitals' sector target values is to derive a relativity score based on how much more costly this set of hospitals is on OHCA's two measures, compared to other hospitals. Then, OHCA divides the statewide spending target by this relativity score. This approach lacks a sound foundation by misapplying a within-year measure of hospital costliness to an across-year measure of hospitals' cost growth over time. In addition, as described later, it fails to consider whether the resulting target values are attainable, sustainable, and protective of access to care. On top of all these shortcomings, the starting value of the sector target is a full decimal point lower than expected according to the data and methodology presented at the February 2025 board meeting. Rather than resulting in a 1.8% value, CHA's replication of OHCA's presented methodology returns a 1.9% value — a seemingly small difference, but with major financial implications. OHCA's lower-than-expected value is likely due to premature rounding of the relativity scores, rather than waiting until the final calculation to round to the desired, single decimal point.

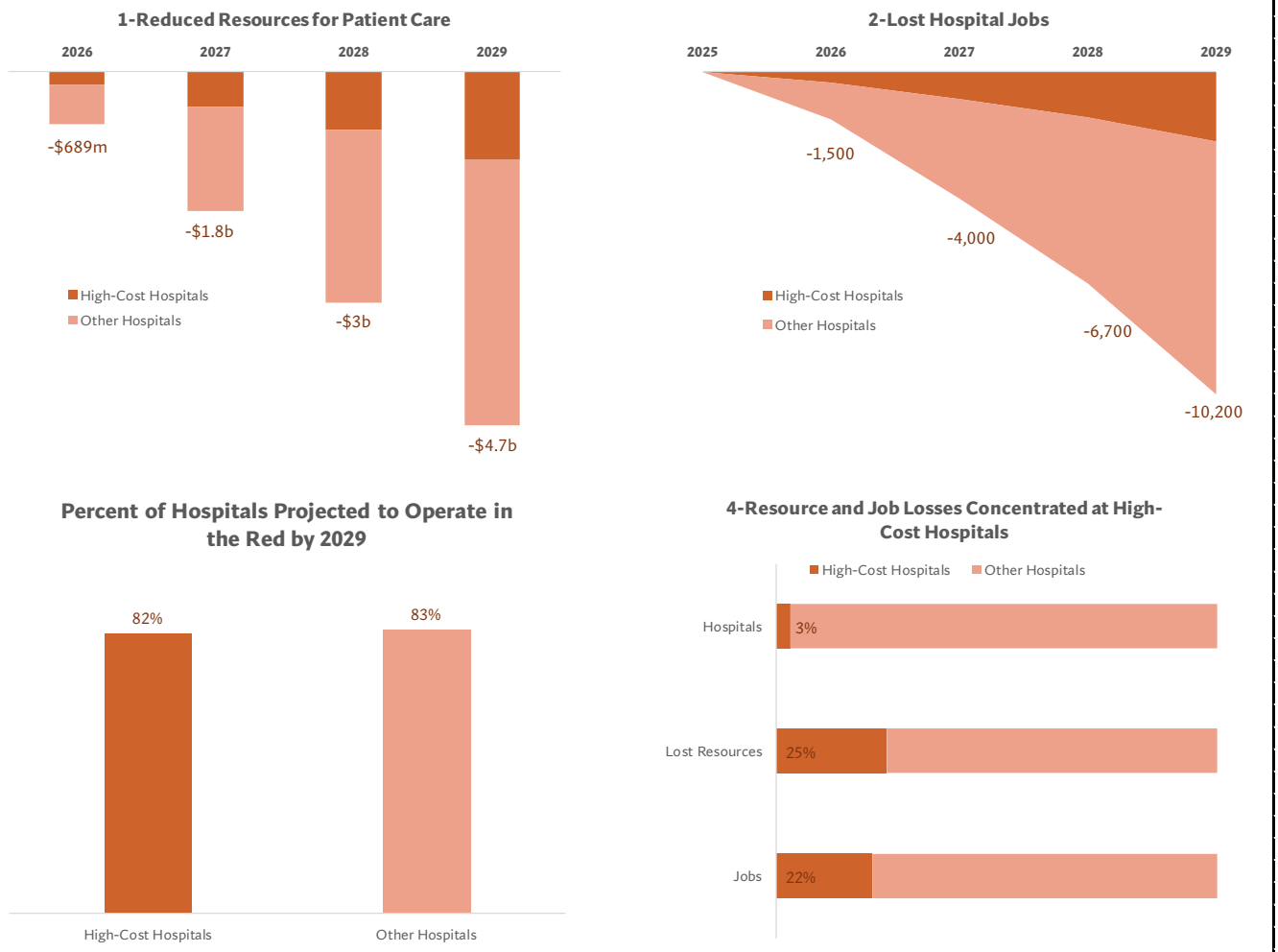
On Their Own, Proposed Sector Target Values Would Decimate Access to High-Quality, Equitable Care and Workforce Stability. OHCA has proposed sector targets of between 1.6% and 1.8% annually on hospitals designated as high cost. Such targets are 35% below projected inflation for all goods and services — even before factoring in the impact new tariffs will have on pricing for medical devices, pharmaceuticals, and other supplies hospitals need. This means real, inflation-adjusted cuts in hospital resources are coming, with real consequences for patients and health care workers.

What's worse, this understates the true magnitude of the proposed cuts given the current extraordinary cost growth pressure hospitals are facing. According to Kaufman Hall, western states' hospital costs are currently growing at 6% for labor, 8% for supplies like personal protective equipment, and 10% for drugs. The proposed high-cost hospital sector targets are 70% to 80% lower than the recent cost growth for these essential inputs. Such targets could only be met with draconian cuts to the affected hospitals' workforces and service lines, as well as the abandonment of investments to expand access to high-quality care.

The figure on the next page drives home the catastrophic effects of OHCA's proposed high-cost hospital sector target, in combination with the statewide target, on hospital care in the current inflationary environment. The figure compares projected revenue under the spending targets (starting at 1.8% for hospitals designated as high cost and 3.5% for other hospitals) and what is expected given recent trends. **The end result: nearly $5 billion diverted from patient care by 2029, more than 10,000 lost jobs, and 83% of California's hospitals operating in the red.** These consequences would overwhelmingly fall on the high-cost hospitals; despite the proposed 11 hospitals representing just 3% of statewide hospitals, they would bear 25% of the losses in resources and 22% of the resulting job eliminations. Hospitals would be forced to take drastic actions to reduce services and workforce, or risk closing entirely. This would devastate the health and well-being of local communities.

Hospital Sector Targets Would Endanger Hospital Care in California, Especially in Areas with Hospitals Designated as High Cost

Projected Impact of the Statewide and Proposed Sector Targets on Hospital Resources, Jobs, Financial Sustainability



Notes:

Panel 1: Hospital resources are defined as net patient revenue. Lost resources reflect the difference between recent historical growth in net patient revenue and growth allowed under the spending targets.

Panel 2: Job losses are projected based on the expectation that hospitals scale down their workforces proportionate to their lost revenues.

Panel 3: Hospital operating margins are projected as the difference between allowable revenue growth under the spending targets and projected expense growth using recent historical trends.

Panel 4: Uses the definitions and terms defined above to show that despite making up a small portion (3%) of all hospitals in the state, OHCA's high-cost hospitals would bear enormously disproportionate negative consequences due to their reduced targets.

Negative Impacts of Proposed Targets Would Not Be Nullified by Selective Enforcement on the Back End. OHCA staff have promised to practice discretion and not aggressively enforce the sector targets in circumstances where excess growth is beyond the hospital's control. Unfortunately, the mere possibility of being forgiven at a later date for excess spending growth does not offer the security needed to avoid the devastating consequences of the sector targets under discussion. First, the designated hospitals would face major reputational consequences, causing patients — including those on Medicare and Medi-Cal — to seek care elsewhere. Second, health insurance companies would immediately pressure hospitals to accept rate increases at the insufficient sector target level. Hospitals would be left with no good options: those that accept the insufficient rate increases would inevitably be forced to make real cuts in patient care, while those that cannot accept the offered rates would undoubtedly face contract

terminations (this recently played out in San Diego, where thousands of patients lost their usual source of care because of an insurer's efforts to push inadequate rates on a local hospital). Third, the targets would stifle investment aimed at improving access to high-quality care, as affected hospitals will have no assurance that the increased revenues funding these investments will not be taken away on the back end due to violation of the aggressive targets.

Combining Proposed Sector Targets and Looming Federal and State Funding Cuts Would Unnecessarily Imperil Care. Federal policymakers are currently considering proposals to drastically cut funding for vital health care programs, potentially by tens of billions of dollars annually. Meanwhile, the state's already precarious budget situation on its own could necessitate significant cuts to health care programs and unquestionably forestalls the state's ability to backfill lost federal funding. Medi-Cal and Covered California are uniquely at risk. Millions of Californians could lose coverage, causing newly uninsured Californians to seek care in hospital emergency departments in droves; benefits and provider rates are similarly exposed to potential cuts. This would turn an already challenging financial environment, wherein more than half of California's hospitals operate in the red, into a full-blown crisis. Compounding federal funding threats and potential state budget solutions with unconscionably low sector targets would all but guarantee the dire consequences the Legislature sought to avoid when it initially created OHCA: cuts in hospital services, if not outright closures; chilling effect on investments; jobs lost; and reduced access to care for millions of Californians. Highly consequential decisions on sector spending targets must consider these potentially catastrophic policy changes for government health care programs. Finalizing a proposal before state and federal decisions are made would demonstrate a troubling disregard for OHCA's statutory mission to sustain and promote access to high-quality, equitable care. OHCA must take stock of the looming cuts to federal and state health care program funding before imposing even more aggressive targets than the statewide target currently in place.

OHCA Has Provided No Assurance That Patients Would Benefit from Sector Targets. OHCA has yet to propose a plan to ensure that the reduced 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. While payers contracting with the high-cost hospitals would benefit from limiting the growth of payments in 2026 to 1.8%, these payers' targets would remain at the statewide level, generating a margin for payers to use as they see fit, including for administration and profits. A comprehensive approach to sector targets could take this into account and ensure that commensurate adjustments are applied to payer targets to ensure that Californians actually benefit from differentiated provider targets OHCA is imposing.

Sector Target Proposal Is Inconsistent with the Letter and Spirit of State Law in Failing to Consider All Relevant Statutory Factors. In creating OHCA, state lawmakers clearly sought to prevent pure cost cutting at the expense of other goals for the state's health care system. Instead, they mandated OHCA proceed in a balanced fashion to

> *"improve the affordability, quality, equity, efficiency, access, and value of health care service delivery"* (HSC § 127500(c)).

Aside from the legislative intent, the spending target provisions in statute provide the same direction, requiring that all spending targets

> *"promote the goal of improved affordability for consumers and purchasers of health care, while maintaining quality and equitable care, including consideration of the impact on persons with disabilities and chronic illness"* (HSC § 127502(c)(5)).

This requirement to balance affordability with other equally important factors is specifically imported to the adoption of sector targets, stating they

> *"shall be informed by… consideration of access, quality, equity, and health care workforce stability and quality jobs"* (HSC § 127502(b)(3)).

Further, the enabling statute requires consideration of other factors in addition to or supplementing these overarching goals, including:

- HSC § 127502(c)(5): Targets must promote the stability of the health care workforce, both present and in the future
- HSC § 127502(d)(3): Target methodology must provide differential treatment of COVID years
- HSC § 127502(d)(4): Target methodology must allow for consideration of a host of factors impacting costs including but not limited to health care employment cost index, provider payer mix, state or local mandates, and federal/state policy changes
- HSC § 127502(d)(5): Target methodology must consider the level of hospital self-financing associated with Medi-Cal payments
- HSC § 127502(e): Target methodology for an individual health care entity sector must allow for treatment as a high-cost outlier while encouraging the entity to service populations with greater health risks taking into account patient mix and geographic costs
- HSC § 127502(*l*)(2)(C): Sector targets must be developed in a manner that minimizes fragmentation and potential cost shifting, and that encourages cooperation in meeting targets

Despite the clear requirements in state law that these various goals for California's health care system be protected and meaningfully considered in the setting of spending targets, OHCA has performed no analysis or review of the potential consequences of its hospital sector proposal on access, quality, equity, or workforce stability. Similarly, OHCA has ignored or given merely cursory attention to these other legislatively mandated considerations in rushing to finalize its flawed proposal. Thus, OHCA has fallen short in its duty to adequately consider all the relevant statutory factors and demonstrate a rational connection between those and the targets embodied in its proposal. Most alarmingly, OHCA has provided no assurance that the exact consequences the Legislature sought to avoid would not inevitably follow the strict cost-cutting nature of the proposed sector targets. In light of recent hospital expense growth, alongside further imminent cost increases due to tariffs, other economic challenges, and looming federal/state budget actions, it is essential for OHCA to perform its due diligence to ensure that access to high-quality, equitable care is protected under its spending targets.

California's Hospitals Ask OHCA to Withdraw Its Proposal and Maintain the Statewide Spending Target for All Regulated Entities

OHCA's proposed hospital sector targets are three years ahead of the statutory timeline, are inconsistent with various requirements in state law, are based on data and methodologies with known shortcomings, and would jeopardize access to hospital care in communities across the state. The proposal has come before OHCA has given consideration to any other sector, evaluated the sustainability of the statewide spending target, or done the necessary groundwork to assure California's patients that its sector targets will maintain access to care, quality, and workforce stability. For these reasons, California's hospitals respectfully ask OHCA to withdraw its proposal and defer action until the above antecedent steps can be completed.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
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