California Hospital Association

June 4, 2025

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

Subject: **Hospital Ask for Reconsideration and Reevaluation of Hospital Spending Targets and Spending Measurement**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

California's hospitals share the goals of the Office of Health Care Affordability (OHCA) to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of our more than 400 hospital members, the California Hospital Association (CHA) appreciates the opportunity to comment.

Spending Targets and Their Enforcement Must Be Revisited Now

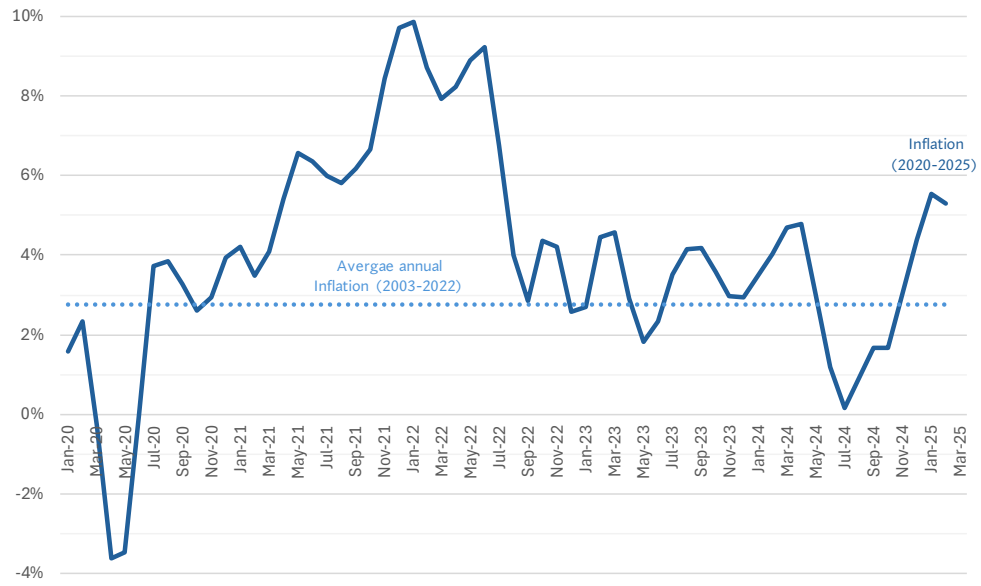
OHCA Must Reevaluate Targets in Light of Impending Federal and State Health Care Cuts. At its April 2025 meeting, the Office of Health Care Affordability (OHCA) board adopted hospital sector targets, finalizing this decision moments after hearing significant concerns about the proposal. This target was ultimately finalized three years ahead of statutory timelines, before OHCA established a methodology for measuring hospital spending, and before any meaningful analysis of the targets' impact on patient care has been conducted. Even more troublingly, it came just as devastating state and federal budget proposals are being considered. Without immediate reconsideration of both the current statewide target of 3.5% and the "high-cost" hospital target of 1.8%, hospitals across California will be forced to drastically reduce services provided, worker compensation, and staffing levels. **Hospitals urge the OHCA board to adjust these targets to account for the new challenges presented by the One Big Beautiful Bill Act and Governor Newsom's May budget revision, each of which would strip billions of dollars from California hospitals and the health care system at large.**

OHCA's enforceable spending targets will take effect just as hospitals are navigating draconian cuts to federal and state funding for California's health care delivery system. With inflation again above 5% in California, OHCA's targets are 30%-70% lower than current price level growth for all goods and services. Compounding these cuts is the federal government proposal that seeks $100 billion in cuts for Medi-Cal and Covered California over the next 10 years. The health care coverage losses alone are expected to increase uncompensated care costs for hospitals by 40%. At the same time, the governor has proposed billions more in cuts to Medi-Cal, impacting both eligibility and provider payments. **With more than 50%**

of hospitals already operating in the red, many will not survive these concurrent efforts to defund and destabilize the health care system. OHCA must ensure that its decisions do not exacerbate the disastrous effects of state and federal policies by revisiting the spending targets already established. In addition, OHCA must make clear that providers' efforts to secure adequate reimbursement in the face of unprecedented cuts in public programs are appropriate and justifiable reasons for exceeding the spending targets.

OHCA Must Incorporate Factors Critical to Maintaining Access and Quality into Spending Targets and Enforcement. Despite the first enforceable spending target going into effect next year, OHCA has not provided any guidance on how enforcement decisions will be made or carried out. Hospitals lack clarity on how they will be judged against the spending targets and what factors, if any, OHCA would deem as justifiable reasons for growing above the spending targets. To allow providers to plan, OHCA should establish these factors in advance, not after an enforcement period has ended. Adjustment should be directly incorporated into the spending targets for factors that can be estimated on a statewide basis. For example, in California, inflation averaged 2.8% between 2003-22, the period of median household income growth on which OHCA based the statewide spending target. Now, as Figure 1 shows, inflation is higher than 5%, nearly twice the historical level. In response, just last month, the California Department of Finance upgraded its expectations for inflation for 2025 through 2028, raising its projection by between 0.5% and 1.5% depending on the year. To account for these elevated inflation levels and ensure providers can sustain access to care and workforce stability, OHCA should adjust the spending target to account for elevated inflation expectations and other predictable macroeconomic factors affecting underlying costs in health care and beyond. The Rhode Island Health Care Cost Trends Steering Committee did just that for 2023 to 2025 to account for contemporary, atypical macroeconomic trends.

Figure 1: Inflation Is Back Above 5%, Far Higher Than Average Inflation for Historical Upon Which the Statewide Spending Target Was Based



Sources: Legislative Analyst's Office April 21, 2025 Inflation Tracker for 2020-2025 inflation and Department of Finance calendar year average inflation for 2003-2022.

To date, OHCA has introduced for consideration several factors that could justify exceeding the spending targets. These are listed in Figure 2 (on the next page), alongside additional factors that have not been considered to date. Hospitals ask that all of these factors be specifically enumerated in the regulations that further define the enforcement process, alongside a provision requiring other relevant factors not specifically enumerated be considered as appropriate.

OHCA Failed to Adequately Consider Quality, Access, and Workforce Stability When Setting Hospital Sector Targets

State law requires OHCA to incorporate various factors into its decisions on spending targets, including whether access would be sustained and quality jobs would be preserved (see provision (b)(3) of section 127502 of the Health and Safety code). In its decision on the hospital sector targets, OHCA gave cursory attention to the relationship between hospital reimbursement and quality, citing only the work of a single researcher with a single perspective. Worse, it entirely ignored the impacts of its targets on access to hospital care, health equity, or workforce stability and the availability of quality jobs.

Figure 2: Factors for Justifiable Growth Above the Spending Target

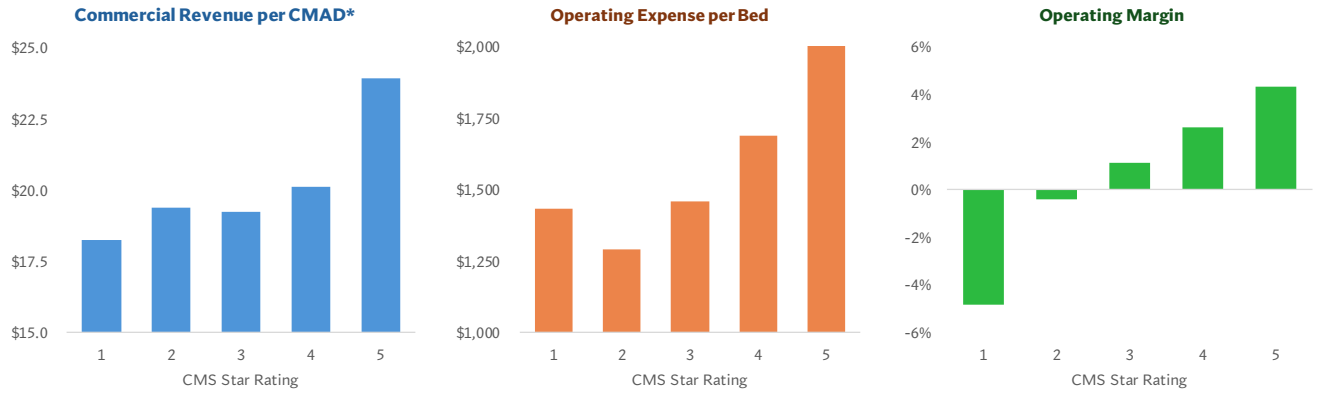
Factors OHCA Has Previously Considered
Acts of God or catastrophic events
Annual changes in age and sex of the entity's population
Changes in an entity's patient base / acuity
Changes in Medicare and Medi-Cal reimbursement
Costs associated with increased organized labor costs
Emerging and unforeseen advances in medical technology
Emerging high-cost / high-value pharmaceuticals
Investments to improve care and reduce future costs
Statutory changes impacting health care costs
Additional Factors
Changes in insurance coverage and uncompensated care
Changes in service offerings
Payment settlements and other factors that drive revenue volatility
Macroeconomic trends, including as applicable on a regional basis
Length of stay and hospital throughput
Outlier hospital stays
Overall labor cost growth
Payer mix
Regulatory changes affecting health care costs
Medical supplies and capital facility cost growth
Tariffs and other supply chain shocks

Research on the Relationship Between CMS Star Ratings and Prices, Cited at the April Board Meeting, Has Serious Weaknesses. The RAND report led by Dr. Christopher Whaley and cited by OHCA claims there is no meaningful relationship between hospital prices and quality, based on a simple comparison of average prices across Centers for Medicare & Medicaid Services (CMS) star ratings. This conclusion is methodologically weak as it omits any statistical testing and fails to control for critical structural factors like hospital size, payer mix, or geography. While Whaley finds that there is price variation within each star rating group, his analysis stops short of asking whether financial strength supports quality performance after accounting for relevant differences among hospitals.

To test whether a model that incorporates these differences would return the same results, CHA modeled the likelihood of a hospital receiving a 4- or 5-star CMS quality rating in 2022. CHA examined mean commercial net patient revenue per case mix-adjusted discharge, operating margin, and total operating expense per bed as predictors from the 2018-22 Annual Financial Disclosure Report data, while controlling for teaching status, critical access designation, and payer mix. As Figure 3 on the next page shows, hospitals with stronger financial performance were significantly more likely to achieve high star ratings, demonstrating that hospital financial resources play an essential role in supporting quality.

Figure 3: California Hospitals With Strong Financial Performance Have Higher Quality Scores

Dollars in Thousands



*Reflects net patient revenue per case mix-adjusted discharge.

Note: CMS Star Rating data are from 2022 and financial data are 2018-2022 pooled averages from hospitals' Annual Financial Disclosure Reports. Differences in financial performance are statistically significant at the $p < 0.05$ level when comparing hospitals with a 4- or 5-Star rating to those with ratings of 3 or lower.

OHCA Selectively Cited Certain Results from a Second Study on Quality. In a second study referenced by OHCA and published in *Health Services Research,* Whaley and colleagues examine whether year-over-year increases in commercial hospital prices are associated with changes in clinical quality. They find no statistically significant effects across selected outcome measures; OHCA points to this result to conclude that "hospital price increases do not lead to clinical quality improvements." However, OHCA's presentation not only overlooks major limitations in the study's scope and methodology, but also omitted relevant results from that paper that undermines this central takeaway.

In addition to clinical measures, the paper also evaluated patient experience, measured by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. The results showed what Whaley and coauthors described as "striking" statistically significant positive associations with price increases across 7 of 10 domains. However, OHCA staff did not present these findings, leaving the board with an incomplete view of this research. Patient experience is not an optional add-on; HCAHPS scores are a core CMS quality domain. Finally, this study only looks at price **changes** over time and does not investigate how hospitals' long-term financial position may contribute to quality.

Broader Academic Literature Reveals the Importance of Financial Performance for Quality Care. OHCA's exclusive reliance on two studies from a single researcher offers a narrow and incomplete view of the evidence. In fact, multiple studies have demonstrated that hospitals with stronger financial positions are more likely to deliver higher-quality care. A 2022 scoping review covering 69 studies found that nearly half reported a positive association between hospital financial performance and quality. No studies showed a clear negative relationship. Additionally, a 2022 working paper from the National Bureau of Economic Research found that patients admitted to higher-priced hospitals had lower mortality and better outcomes. Finally, a 2022 study in the journal, *PLOS ONE*, showed hospitals that delivered higher-quality care were also more likely to demonstrate better financial performance, supporting the idea that investment in quality — when hospitals are financially capable of doing so — yields real returns.

The Legislature Has Raised Concerns that Sector Targets Will Endanger Access to Quality Care, Workforce Stability, and Hospital Operations

OHCA's fast-paced adoption of the hospital sector spending target has led the Legislature to seek additional information and insight into its actions. Most recently on April 30, 2025, members from both houses of the Legislature sent a letter about the statewide and hospital sector spending targets to California Department of Health and Human Services Secretary and OHCA board chair Kim Johnson. The letter requested information on OHCA's analyses of the spending targets and their impacts on health care access, quality care, and workforce stability. It further asks how OHCA will ensure that hospitals are not driven to a financial crisis in adhering to the sub-inflationary spending target. These are critical questions that hospitals share and have raised with OHCA.

At the May Senate subcommittee budget hearing, legislators raised further questions after they were "concerned" to learn that the spending targets did not take into account cost drivers such as inflation and state mandates (e.g., seismic and the health care minimum wage) and that there is no clear way to determine whether the spending targets will result in lower health insurance premiums to consumers. Of note, legislators contend that OHCA's spending targets do not reflect the operational reality hospitals face in keeping up with rising costs and new state mandates, all while maintaining a workforce that meets the needs of providing high-quality care to all Californians.

The creation of OHCA was a joint effort between the Administration and the Legislature. OHCA has a responsibility to meaningfully address the concerns and questions raised by the Legislature. CHA urges OHCA to abide by statutory requirements and additional relevant considerations in its pursuit of improving affordability, a goal that hospitals share.

Provisional Approach for Measuring Hospital Spending Raises Important Questions

At the April 2025 board meeting, OHCA introduced a substantially revised approach to measuring hospital spending. While the approach for measuring inpatient spending was unchanged from when OHCA last convened its Hospital Spending and Measurement Workgroup or discussed the matter with the board, staff presented an entirely new approach for measuring outpatient spending. Rather than bootstrapping measured outpatient spending based on known measures of inpatient spending, OHCA's new approach would separately measure outpatient spending as outpatient revenue per intensity-adjusted visit. This measure would be created by marrying hospital reported financial and utilization data and a new and untested data source — the Healthcare Payments Database (HPD) — with which OHCA would estimate each hospital's outpatient intensity adjustment score. While the approach has conceptual appeal in that it accounts for service volumes and intensity, it also raises several fundamental concerns:

- **No Expert Feedback –** It appears OHCA has settled on a methodology without first consulting the workgroup OHCA created specifically for this purpose. As such, experts in hospital financing did not have any opportunity to review and provide feedback on the provisional methodology prior to even preliminary decisions being made.
- **An Untested Approach –** Calculating the outpatient intensity adjustment with the HPD relies on a new and emerging data source that has never been used for this purpose. While hospitals have some experience with the ambulatory payment classification system, CHA has yet to identify a hospital with experience using the enhanced ambulatory patient groups (EAPGs) methodology. As such, OHCA's preferred methodology for creating an outpatient intensity adjustment appears to be entirely unfamiliar and untested in California. While OHCA shared that Medi-Cal uses EAPGs, it is unknown when or where this is the case as the Department of Health Care Services,

Medi-Cal's administrator, uses a fee schedule to pay for outpatient services on a per-service/procedure basis, rather than using EAPGs.

- **Marrying Multiple Data Sources Introduces Complications –** Unlike the methodology for inpatient spending measurement, OHCA's outpatient methodology combines hospital- and payer-reported data. This introduces various challenges. For example, hospital-reported data include all hospital visits, whereas a substantial proportion of these visits will be missing from the HPD data due, in large part, to the fact that reporting for self-insured is voluntary. According to data from the California Health Care Foundation, the self-insured reflect 15%-20% of all insured Californians and 30% of the commercially insured (OHCA's primary population of interest). Such levels of incompleteness in the HPD raises questions about the reliability and accuracy of the outpatient intensity adjustments; these must be addressed prior to implementation.
- **No Assurance of Transparency –** OHCA's enabling legislation requires that any adopted risk adjustment methodologies be transparent to the public (see provision (f)(1) of Health and Safety Code Section 127502). However, claim-level HPD data are not generally available to the public except through specific requests and is subject to various conditions (such as are necessary to protect patient privacy). If OHCA is to use these data for the purpose of measuring hospital performance against the spending target, the office must find a way to ensure that the underlying data and methodology can be validated by regulated entities.

California's hospitals appreciate the opportunity to comment and look forward to continued engagement toward our shared goals of promoting affordability, access, quality, and equity in California's health care system.

Sincerely,

Ben Johnson
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