December 12, 2024

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Subject: **CHA Comments for the December 2024 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

The California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, appreciates the opportunity to comment ahead of the December 2024 Health Care Affordability Board meeting. The Office of Health Care Affordability (OHCA) has an historic opportunity to transform health care delivery in California, but it cannot sustainably promote affordable, high-quality, equitable care without careful deliberation, dispassionate data analysis, and meaningful input from those that deliver care to 39 million Californians. This letter offers an assessment of OHCA's proposal for measuring hospital spending, discusses the importance of encouraging investment across the full continuum of behavioral health care, and raises concerns that the push for sector targets is moving too fast and will ultimately undermine collaboration across the health care sector in fulfillment of OHCA's important mission.

Provisional Hospital Spending Methodology Is a Reasonable Start, With Opportunities for Refinement Over Time

Since April of this year, OHCA has convened the Hospital Spending and Measurement Workgroup to advise on a methodology for measuring hospitals spending. The workgroup includes representatives of hospitals, health plans, purchasers, and consumer advocates and has provided an opportunity for experts from the field to meaningfully engage in the methodology's development. The provisional methodology presented by OHCA staff at the November OHCA board meeting reflects the workgroup's collective work on this effort and is a reasonable starting point for measuring hospital spending, though there are clear opportunities for refinement. As the methodology is implemented and refined, steady and focused engagement with experts from the hospital field must continue.

OHCA's Provisional Approach Has Several Advantages. OHCA staff and the workgroup considered various approaches to measuring hospital spending over time, all of which came with positives and drawbacks. The provisional approach checks a number of important boxes:

- **The Methodology Uses a Tested, Comprehensive, and Transparent Data Source.** The provisional methodology would rely upon annual financial data that hospitals have reported to OHCA's parent department, the Department of Health Care Access and Information (HCAI), for

decades. These public reports contain the vast majority of the information OHCA needs to measure its primary variable of interest — changes in hospital spending — and can be supplemented with additional data also submitted by hospitals to HCAI at the same or similar cadence. Alternative sources of data lack several of the advantages of the existing hospital financial reports. For example, the attribution methodology used in the total health care expenditure (THCE) reports from payers would regularly assign hospital spending to hospitals other than where care was received, such as when patients receive emergency care not provided by the hospital affiliate of their medical group. While HCAI's all-payer claims database theoretically could overcome this and other challenges of the THCE data, this data source is entirely untested and — given other states' reluctance to use such data in their own spending target programs — is likely unsuited to measuring changes in aggregate health care spending over time.

- **Net Patient Revenue Is an Appropriate Measure of Hospital Spending.** OHCA intends to primarily assess hospital spending growth as the annual change in hospitals' net patient revenue, subject to certain adjustments. Net patient revenue is the best measure of hospital spending available in hospitals' financial data. First, the measure hews closely to how OHCA is tracking spending for other providers under its THCE methodology by reflecting final adjudicated payments for health care services rendered. In doing so, it excludes hospital revenues from sources beyond health care, such as parking and cafeteria revenues, leases of real property, and other business dealings beyond OHCA's jurisdiction. Moreover, net patient revenue is reported separately for the three major payer categories that OHCA is concerned with: commercial payers, Medicare, and Medicaid. Other revenue sources are generally not attributable to specific payers and are not reported accordingly.
- **The Methodology Captures Hospitals' Full Mix of Services.** Inpatient care accounted for 62% of all hospital care provided in California in 2023, with outpatient care making up the remaining 38%. OHCA's provisional methodology would capture changes in spending across both types of care, and as a result be more comprehensive than alternative approaches. However, as described below, deficiencies in capturing outpatient volumes and adjusting for outpatient case mix should be evaluated and addressed as the methodology is refined over time.
- **The Methodology Guards Against Major Perverse Incentives.** To succeed in creating a health care system that is lower cost **and** more accessible and equitable, OHCA must carefully consider the incentives its rules create. Fortunately, OHCA's provisional hospital spending methodology includes components intended to mitigate several perverse incentives that otherwise would place equitable access to care at risk, particularly for patients with the highest needs. Specifically, it measures hospital spending growth on a per-patient basis and adjusts for the enormous differences in acuity between different patients and the services that are provided.
    - **Volume Adjustment Protects Access to Care.** First, by accounting for patient volume, OHCA's provisional methodology would not penalize hospitals for seeing more patients. As a result, hospitals would remain incentivized to sustain their service lines and bed capacity and work to attract more patients through better care. The approach is comparable to OHCA's methodology for adjusting health plan and physician organization spending by their number of enrolled or assigned patients, which similarly removes the incentive for these organizations to cut their enrollment or patient panels to meet the spending target.
- **Case-Mix Adjustment Protects Patients with High Needs and Access to Complex Care.** Hospitals serve patients with enormous differences in need, some requiring short-term observation following a routine procedure and others requiring complex procedures, advanced

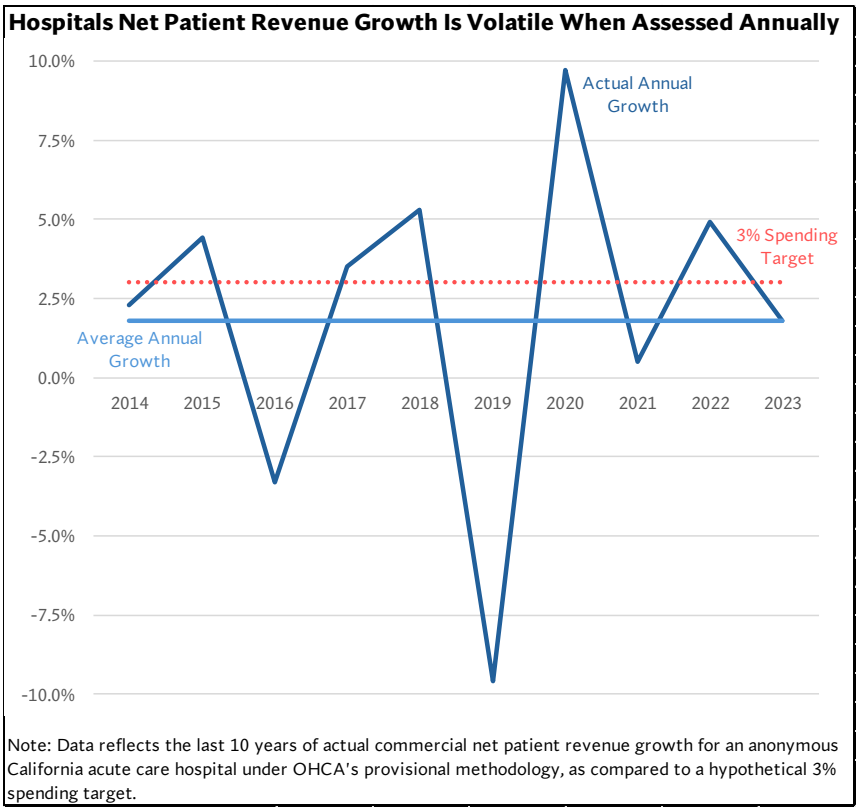
medical equipment, close observation, and prolonged stays counted in weeks, not days. By including a case-mix adjustment, hospitals would not be punished for treating patients with the highest medical needs. Similarly, different hospital services vary enormously in resource intensity. For example, heart transplants are among the most resource-intensive services that hospitals provide. Under Medicare's case-mix adjustment methodology, performing a heart transplant requires 140 times the sources of caring for a healthy newborn post-delivery, while the average length of stay for a heart transplant patient is 29 days, compared to 3 for the healthy newborn. Without case-mix adjustment, cutting heart transplant services could be the fastest route for a hospital to meet the spending target, despite resulting in the loss of life-saving care.

- **Medicare-Based Case-Mix Adjustment Is a Reasonable Starting Point; Alternatives Should Be Evaluated.** OHCA's provisional methodology would rely on the Medicare program's methodology of case-mix adjustment. Theoretically, this is a problem since Medicare's case-mix methodology is based on services used by Medicare's primarily elderly patient population. As a result, it may not appropriately account for hospital services primarily used by children and young adults, such as labor and delivery. Nevertheless, California's hospitals generally have not raised concerns with using the Medicare-based case-mix adjustment methodology, at least at the outset. Unlike other approaches, Medicare's methodology is transparent and readily available to interested users. While other approaches should continue to be evaluated, using the Medicare approach appears sufficient at this time.

The Provisional Methodology Has Deficiencies That Should Be Addressed Over Time.
While the provisional methodology has many advantages, below are several areas that OHCA must target for refinement.

- **Provisional Approach Does Not Account for Differences in *Outpatient* Service Mix and Patient Acuity**. OHCA's provisional approach for case-mix adjustment looks exclusively at hospitals' mix of **inpatient** services and patients, assigns an associated case-mix index score, and then extends that inpatient case-mix index score to the outpatient side. The methodology cannot distinguish between the resource intensity of an emergency department visit to treat a minor wound and an outpatient hip replacement or cancer drug infusion. As a result, large but appropriate changes in hospitals' outpatient service mix could artificially boost their measured growth numbers and cause them to miss the spending target. Unfortunately, there are no readily available approaches available to address this known shortcoming. As the methodology for measuring hospitals spending continues to be refined, OHCA and its dedicated workgroup should prioritize identifying and evaluating alternative approaches to outpatient case-mix adjustment.
- **Case-Mix Index Does Not Appropriately Capture Outlier Cases.** While the case-mix index appropriately captures differences in resource intensity and patient acuity in most cases, it fails to accurately capture the most expensive stays. For example, it does well to differentiate the resource intensity of caring for a patient needing a one-night hospital stay from another needing a four-night stay. However, it falls far short of appropriately capturing the resources needed to care for a patient that stays weeks or months in the hospital, a trend that, unfortunately, is growing increasingly common. OHCA must identify ways to control for such outlier stays as it refines its hospital spending measurement approach going forward.
- **OHCA Must Account for Significant Annual Volatility in Hospital Spending.** Despite the inclusion of adjustments for volume and case mix, year-over-year volatility in hospital spending, as measured under the provisional methodology, is enormous. The figure on the next page demonstrates this using real data for an anonymous California hospital. It shows that over the last decade, its average annual growth in net patient revenue was far below OHCA's (eventual)

spending target of 3%. However, it still would have violated the spending target in 5 out of 10 years. Unfortunately, such volatility is the norm rather than the exception. This means that, to appropriately assess which hospitals had spending growth beyond the spending target, OHCA will have to evaluate growth on a multiyear basis or employ statistical testing that controls for this underlying volatility.



Behavioral Health Investment Benchmark Must Encourage Improved Access Across the Full Continuum of Care.

Behavioral health care is in crisis in California. Insufficient access to care spans the entire continuum of care, from navigation and peer services to therapy, medication-assisted treatment, intensive outpatient services, inpatient psychiatric care, and long-term nursing and supportive care. For inpatient care, a 2021 RAND study found that California was short nearly 5,000 psychiatric beds. The need to invest in the full continuum has been consistently recognized across the major recent efforts to reform California's system of behavioral health care:

- The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-Connect) aims to *"strengthen the continuum of mental health services for Medi-Cal beneficiaries living with serious mental illness,"* including by ensuring greater access to residential and inpatient treatment and unlocking new federal Medicaid funding.
- The Behavioral Health Continuum Infrastructure Program (BHCIP) is providing billions of dollars to support the construction, acquisition, or expansion of additional treatment capacity, including for residential facilities adding 2,601 beds and 128 outpatient facilities, adding 281,146 slots to the state's outpatient service capacity.
- The Behavioral Health Services Act (Proposition 1, 2024) builds on BHCIP, providing billions of dollars more in funding to expand behavioral health treatment, residential care, and supportive housing for Californians with the highest need.
- Senate Bill 855 (2020), which amended the state's laws to require health plans and insurers to cover behavioral health care at parity with other covered benefits, was written to address inequities in coverage the full range of behavioral health care.
- The California Health and Human Services Agency's Behavioral Health Crisis Continuum Plan from May 2023 … stated that the behavioral health "*continuum is only complete when connected to more intensive services that can be accessed when medically necessary, and from which people will exit and return to the community where recovery and resiliency support will be critical. This idea of a*

"continuum of care" applies broadly to all levels of care but can be specifically examined from the lens of a complete crisis system."

In establishing its methodology for measuring behavioral health spending and setting an investment goal, OHCA must support — not be at cross purposes with — these broader state efforts to create a complete system of care capable of meeting all Californians' behavioral health care needs. To do so, the behavioral health investment benchmark must include all medically appropriate care settings for which increased access is needed.

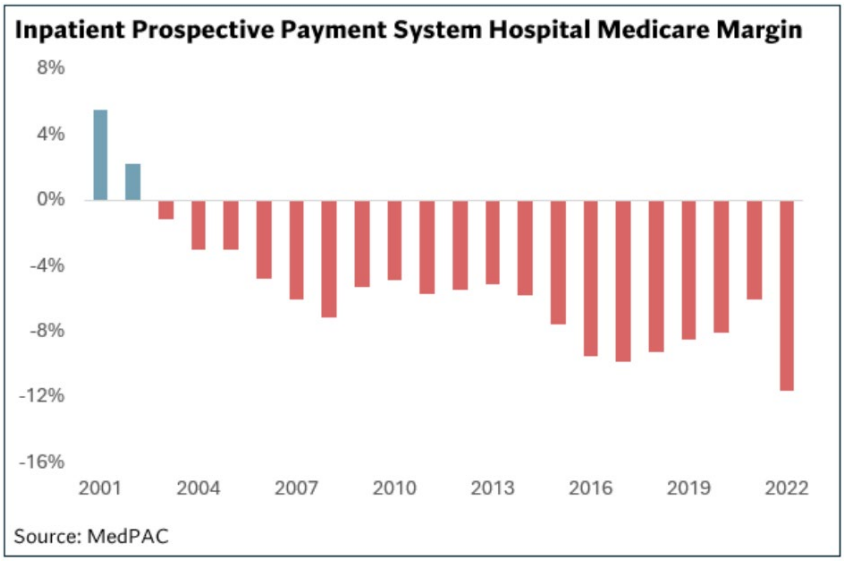
Learning Needed Before Moving Toward Sector Targets

Consideration of Sector Targets Is Premature. The November board meeting continued the discussion on sector targets, focusing on options for differentiating between "high- and low-cost" hospitals for the purpose of differentiating their spending targets. This effort is premature, coming **before** OHCA has:

- Finalized a methodology for measuring hospital spending growth
- Measured or reported statewide or hospital baseline spending growth
- Implemented the state's first spending target
- Set any rules for enforcement
- Meaningfully and impartially analyzed the drivers of health care spending
- Considered whether payers should be allowed to retain savings from lower sector targets on providers in the form of higher earnings
- Fulfilled the requirements of statute on the development of sector targets, including to *"minimize fragmentation and potential cost shifting and that encourages cooperation in meeting statewide and geographic region targets"*[1]

Deficiencies in Medicare Hospital Payment Policies Raise Many Questions About Using Medicare Payments as the Baseline Comparison. An OHCA board member suggested that one way to identify relatively high-cost hospitals is to compare hospitals' commercial reimbursement levels to what Medicare pays them. Unfortunately, growing deficiencies in Medicare payment policy make such an approach increasingly problematic.

- **Medicare Payments Are Becoming Increasingly Insufficient.** Medicare payments for hospital services are updated annually to account for the inflation. However, as the figure on the right shows, due to inadequate inflationary updates, Medicare payment levels are falling farther and farther short of covering hospitals costs in caring for Medicare patients. In fact, these updates have proven so inadequate in recent years that, for federal fiscal year 2024, the Medicare Payment Advisory Committee went so



[1] Health and Safety Code Section 127502(l)(2)(C).

far as to recommend an update 1.5 percentage points higher than required by federal law. The growing failure of Medicare to cover the cost of hospital care calls into question whether OHCA should look to the federal program to guide its assessments of the appropriateness of hospital payments in the commercial market.

- **Deficiencies in Medicare Payment Policies Make Hospitals in High-Cost Areas Inappropriately Appear to Be High Cost.** Comparing hospitals' commercial reimbursement levels to Medicare is further complicated by the fact that hospitals in high-cost areas are increasingly disadvantaged by Medicare payment policies. Research from Stanford and the University of Southern California reveals that Medicare underpayment is much greater for California hospitals located in high-cost regions, as opposed to low-cost regions.[2] For example, while fee-for-service Medicare paid California hospitals in regions with low area wage index scores at close to cost in 2019, it underpaid hospitals with high area wage index scores by upwards of 50% or even 75%. This deficiency in Medicare payment policy inevitably makes hospitals in areas that are disproportionately undercompensated by Medicare appear more expensive, despite their higher commercial rates being necessary to sustain their operations. Accordingly, comparing commercial payments to Medicare benchmark rates would mislead due to deficiencies in how the underlying benchmark rates are determined. Significantly more evaluation is needed before using Medicare payment levels to identify high- and low-cost hospitals.

Conclusion

OHCA has an opportunity to transform health care delivery in California. Meeting this opportunity will require the careful balancing of tradeoffs, evolution as OHCA continues to learn more, and collaboration across the health care sector in pursuit of our shared goals of improved affordability, access, quality, and equity. CHA encourages OHCA to proceed reflectively, with due consideration of the impacts its decisions will have for the 39 million Californians who rely on the state's health care delivery system for their health, lives, and livelihoods.

Sincerely,

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[2] 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.