OHCA

Office of Health Care Affordability

Department of Health Care Access and Information

# Health Care Affordability Board Meeting

December 16, 2024

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Department of Health Care Access and Information

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# Welcome, Call to Order, and Roll Call

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# Agenda

Item #1 **Welcome, Call to Order, and Roll Call**

*Secretary Kim Johnson, Chair*

Item #2 **Executive Updates**

*Elizabeth Landsberg, Director; Vishaal Pegany, Deputy Director*

Item #3 **Action Consent Item**

*Vishaal Pegany*

a) Vote to Approve November 20, 2024 Meeting Minutes

Item #4 **Informational Items**

*Margareta Brandt, Assistant Deputy Director; Debbie Lindes, Health Care Delivery System Group Manager; Vishaal Pegany; CJ Howard, Assistant Deputy Director*

a) Introduce Behavioral Health Definition and Investment Benchmark, Including Advisory Committee Feedback

b) Sector Targets, Continued from November Board Meeting

Item #5 **Public Comment**

Item #6 **Adjournment**

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# Executive Updates

Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director

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# Slide Formatting

Indicates informational items for the Board and decision items for OHCA

Indicates current or future action items for the Board

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# Public Comment

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# Action Consent Item: Vote to Approve November 20, 2024 Meeting Minutes

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# Informational Items

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# Introduce Behavioral Health Definition and Investment Benchmark, Including Advisory Committee Feedback

Margareta Brandt, Assistant Deputy Director

Debbie Lindes, Health Care Delivery System Group Manager

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# Focus Areas for Promoting High Value

| | |
|---|---|
| **APM Adoption** | • Define, measure, and report on alternative payment model adoption<br>• Set standards for APMs to be used during contracting<br>• Establish a benchmark for APM adoption |
| **Primary Care Investment** | • Define, measure, and report on primary care spending<br>• Establish a benchmark for primary care spending |
| **Behavioral Health Investment** | • Define, measure, and report on behavioral health spending<br>• Establish a benchmark for behavioral health spending |
| **Quality and Equity Measurement** | • Develop, adopt, and report performance on a single set of quality and health equity measures |
| **Workforce Stability** | • Develop and adopt standards to advance the stability of the health care workforce<br>• Monitor and report on workforce stability measures |

# Primary Care & Behavioral Health Investments

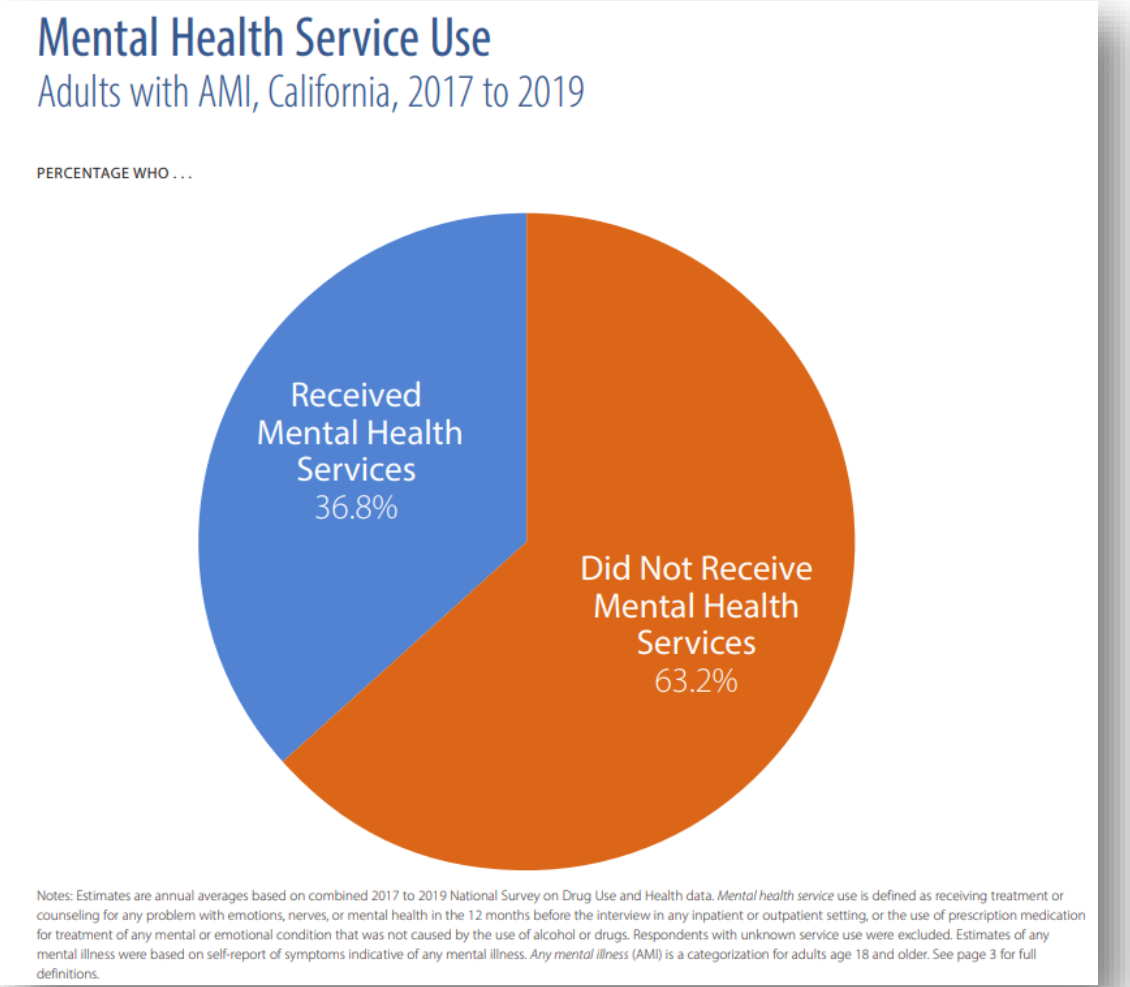
## Statutory Requirements

- Measure and promote a sustained systemwide investment in primary care and behavioral health.
- **Measure the percentage of total health care expenditures allocated to primary care and behavioral health** and set spending benchmarks that consider current and historic underfunding of primary care services.
- **Develop benchmarks** with the intent to build and sustain infrastructure and capacity and shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health.
- Promote improved outcomes for primary care and behavioral health.

# Why Behavioral Health?

- In California, nearly 32% of adults report symptoms of anxiety and/or depression. Further, almost two-thirds of California adults with mental illness reported not receiving treatment.

- Evidence indicates that effective treatment for behavioral health conditions, especially in integrated care settings, contributes to better behavioral and overall health outcomes and correlates to reduced health care costs.




California Health Care Foundation, July 2022. *Mental Health in California: Waiting for Care*. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022.pdf ; Bellon, et al. Association of Outpatient Behavioral Health Treatment with Medical and Pharmacy Costs in the First 27 Months following a New Behavioral Health Diagnosis in the US. *JAMA Network Open*. 2022;5(12):e2244644. doi:10.1001/jamanetworkopen.2022.44644; Katon, et al. Collaborative Care for Patients with Depression and Chronic Illnesses. N Engl J Med 2010;363:2611-20. https://www.nejm.org/doi/full/10.1056/nejmoa1003955; Unutzer and Katon. Long-term Cost Effects of Collaborative Care for Late-life Depression. American Journal of Managed Care Feb 2008,14(2):95-100. https://www.ajmc.com/view/feb08-2835p095-100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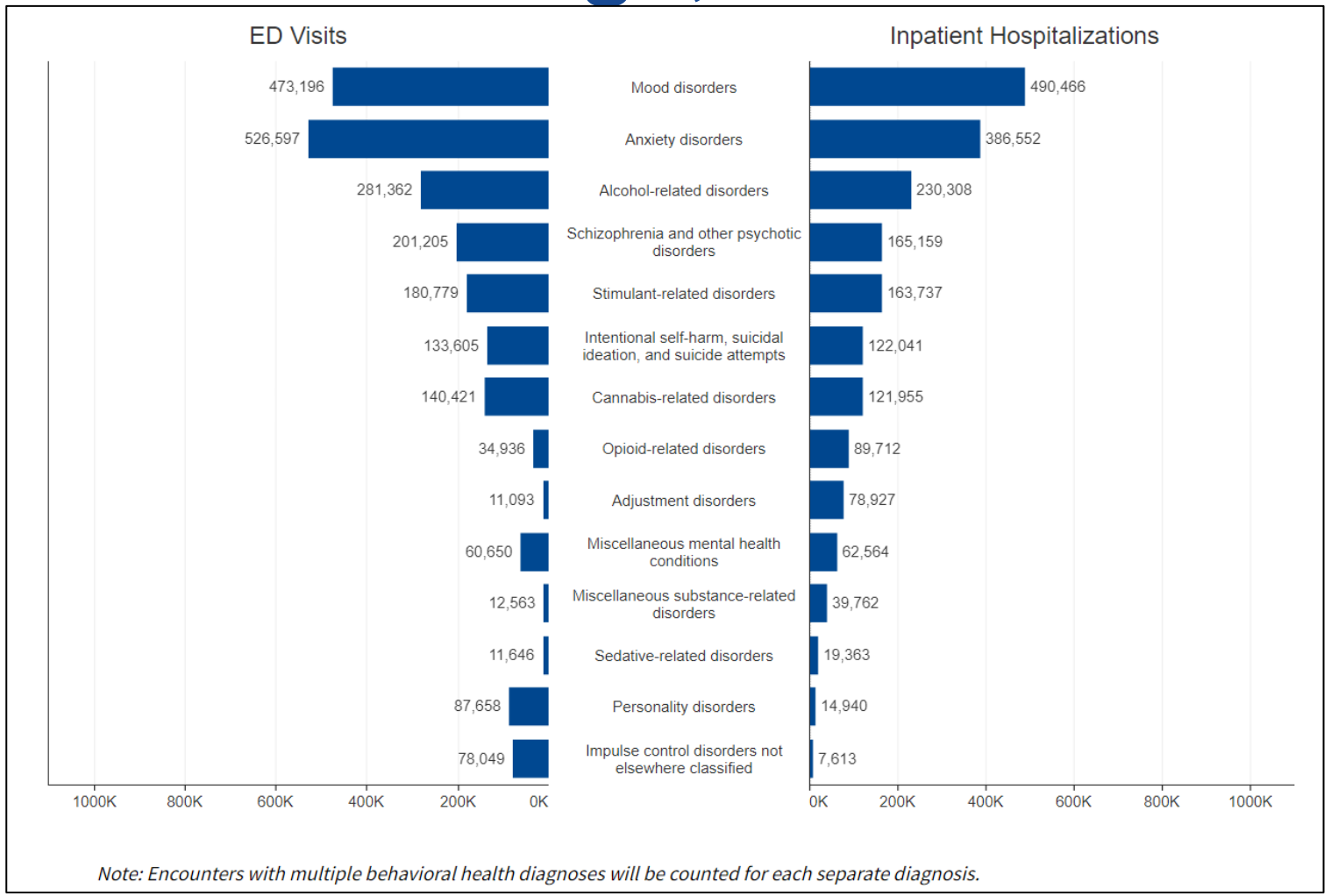
# Patient Discharge Data: Behavioral Health Diagnoses in Acute Care Settings, 2021

- Encounters for nearly 1 million emergency department visits and over 877,000 hospitalizations in California in 2021 included a mood or anxiety disorder diagnosis.
- Substance use disorders were the primary or secondary diagnosis for over 1.3 million hospitalizations and emergency department visits.




*Note: Encounters with multiple behavioral health diagnoses will be counted for each separate diagnosis.*

# Investment and Payment Workgroup Members

## Providers & Provider Organizations

**Bill Barcellona, Esq., MHA**
Executive Vice President of Government Affairs, America's Physician Groups

**Lisa Folberg, MPP**
Chief Executive Officer, California Academy of Family Physicians (CAFP)

**Paula Jamison, MAA**
Senior Vice President for Population Health, AltaMed

**Amy Nguyen Howell MD, MBA, FAAFP**
Chief of the Office for Provider Advancement (OPA), Optum

**Parnika Prashasti Saxena, MD**
Chair, Government Affairs Committee, California State Association of Psychiatrists

**Catrina Reyes, Esq.**
Deputy General Counsel, California Primary Care Association (CPCA)

**Janice Rocco**
Chief of Staff, California Medical Association

## Hospitals & Health Systems

**Ash Amarnath, MD, MS-SHCD**
Chief Health Officer, California Health Care Safety Net Institute

**Kirsten Barlow, MSW**
Vice President Policy, California Hospital Association (CHA)

**Jodi Nerell, LCSW**
Director of Local Mental Heath Engagement, Sutter Health

## Health Plans

**Stephanie Berry, MA**
Government Relations Director, Elevance Health (Anthem)

**Rhonda Chabran, LCSW**
Vice President, Behavioral Health & Wellness, Kaiser Foundation Health Plan, Southern CA & HI

**Keenan Freeman, MBA**
Chief Financial Officer, Inland Empire Health Plan (IEHP)

**Nicole Stelter, PhD, LMFT**
Director of Behavioral Health, Commercial Lines of Business, Blue Shield of California

**Yagnesh Vadgama, BCBA**
Vice President of Clinical Care Services, Autism, Magellan

## Consumer Reps & Advocates

**Beth Capell, PhD**
Contract Lobbyist, Health Access California

**Jessica Cruz, MPA**
Executive Director, National Alliance on Mental Illness (NAMI) CA

**Nina Graham**
Transplant Recipient and Cancer Survivor, Patients for Primary Care

**Héctor Hernández-Delgado, Esq.**
Senior Attorney, National Health Law Program

**Cary Sanders, MPP**
Senior Policy Director, California Pan-Ethnic Health Network (CPEHN)

## Academics & SMEs

**Sarah Arnquist, MPH**
Principal Consultant, SJA Health Solutions

**Crystal Eubanks, MS-MHSc**
Vice President Care Transformation, California Quality Collaborative (CQC)

**Kevin Grumbach, MD**
Professor of Family and Community Medicine, UC San Francisco

**Reshma Gupta, MD, MSHPM**
Chief of Population Health and Accountable Care, UC Davis

**Vicky Mays, PhD**
Professor, UCLA, Dept. of Psychology and Center for Health Policy Research

**Catherine Teare, MPP**
Associate Director, Advancing People-Centered Care, California Health Care Foundation (CHCF)

## State & Private Purchasers

**Lisa Albers, MD**
Assistant Chief, Clinical Policy & Programs Division, CalPERS

**Teresa Castillo**
Chief, Program Policy Section, Medical Behavioral Health Division, Department of Health Care Services

**Jeffrey Norris, MD**
Value-Based Care Payment Branch Chief, California Department of Health Care Services (DHCS)

**Monica Soni, MD**
Chief Medical Officer, Covered California

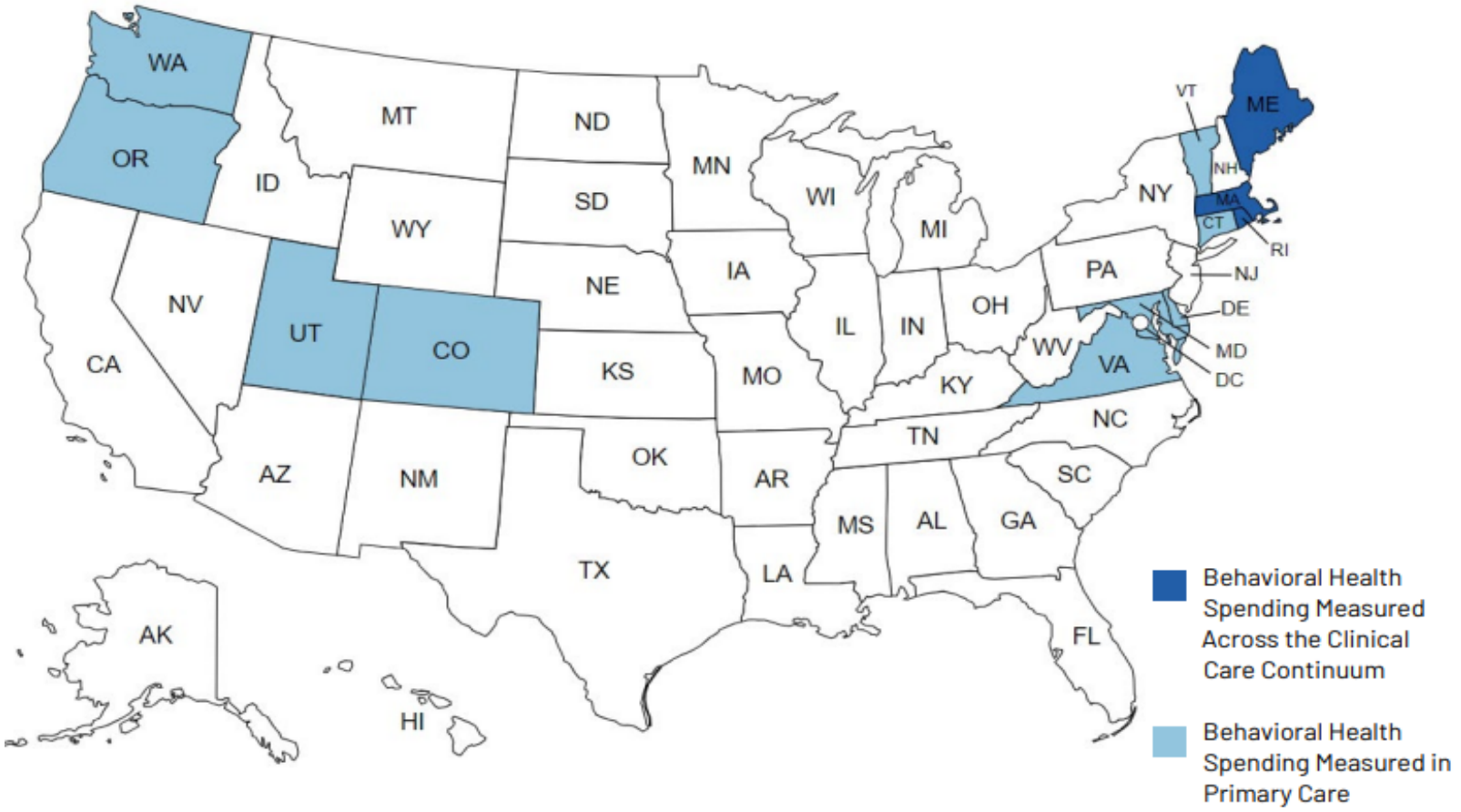
**Dan Southard**
Chief Deputy Director, Department of Managed Health Care

# Behavioral Health Spending Measurement Framework

# States Measuring Behavioral Health Clinical Spending

Nine states measure behavioral health spending as part of their efforts to measure primary care spending.

Three states measure behavioral health spending across the full care continuum (Maine, Massachusetts, and Rhode Island). This is California's mandate as well.



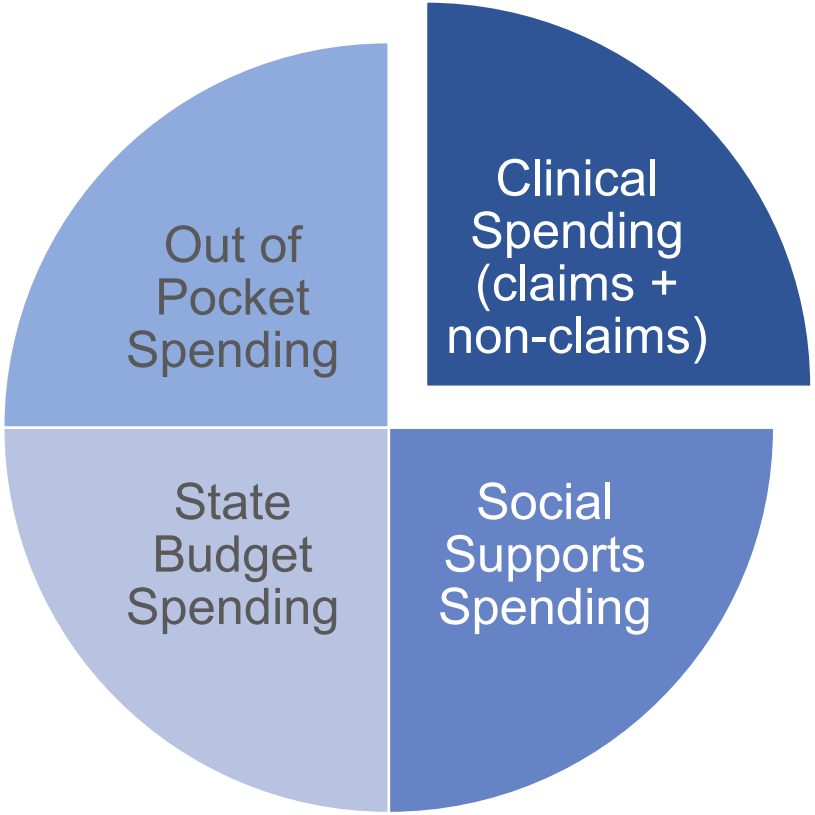

Milbank Memorial Fund (2024, April 10). *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

# Potential Use Cases for OHCA's Behavioral Health Measurement

- Measure behavioral health spending as a percentage of Total Health Care Expenditures (THCE).
- Understand spending on mental health care and substance use disorder services.
- Understand spending on behavioral health services in primary care settings.
- Understand the distribution of behavioral health spending across different types of services and care settings.
- Establish a focused benchmark for behavioral health spending that supports statewide goals and priorities.

# Data Collection and Measurement Scope

Clinical services are services provided by medical and allied health professionals to prevent, treat, and manage illness, and to preserve mental well-being across the clinical care continuum, paid via claims and non-claims payments (e.g., outpatient therapy visit, day treatment programs).




- Initial focus on clinical services and health care payers (e.g., commercial and Medicare Advantage)
- Possibility of using supplemental data sources to capture spending from other categories in the future

Adapted from: Milbank Memorial Fund (2024, April 10). *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

# Measuring Behavioral Health Investment

**Numerator**

Claims-based payments for behavioral health + Non-claims-based payments for behavioral health = Total behavioral health investment

**Denominator**

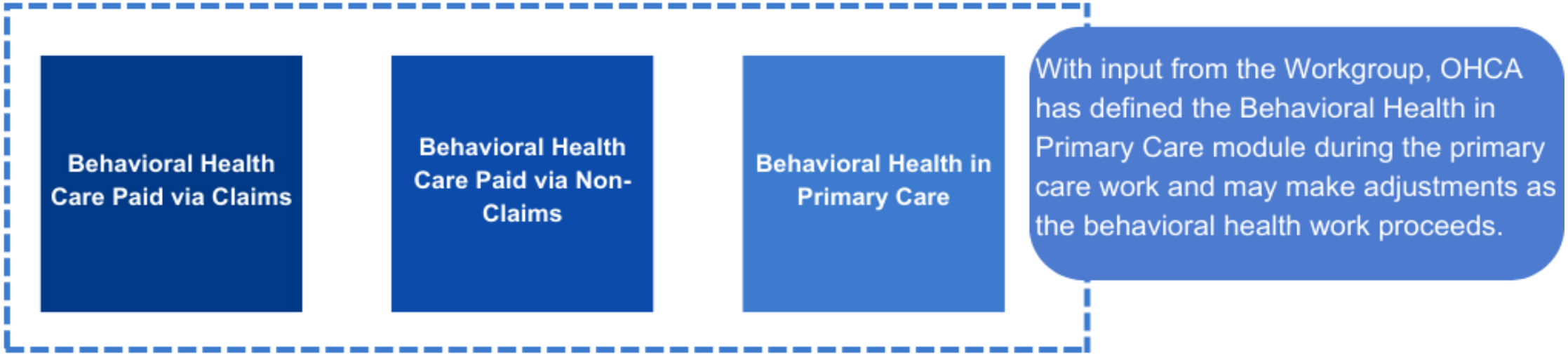
Total claims-based payments + Total non-claims-based payments = Total medical expense

X 100% = Behavioral health investment as a % of total medical expense

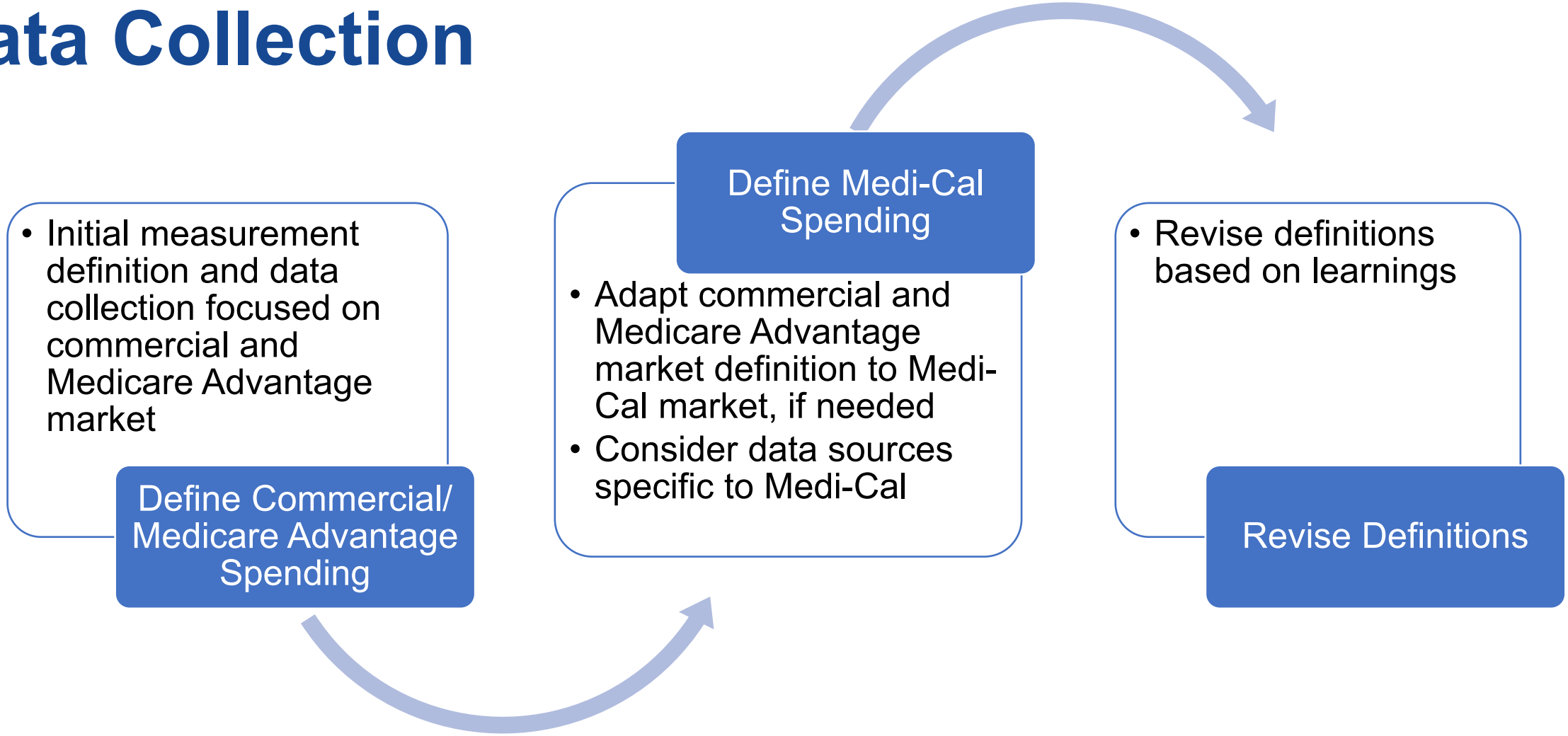
Note: The numerator will include patient out-of-pocket responsibility for behavioral health services obtained through the plan i.e., services for which a claim or encounter was generated. The denominator will include pharmacy spending and all patient out-of-pocket responsibility for services obtained through the plan.

# Three Recommended Modules for Behavioral Health Spending Measurement

OHCA proposes to use three modules to measure behavioral health spending, following the approach for measuring primary care spending. Behavioral health in primary care will be measured separately so it can be included in analyses of behavioral health or primary care spending.



# Proposed Phased Approach to Behavioral Health Spending Measurement Definition and Data Collection



# Other State Approaches to Defining Behavioral Health

States develop behavioral health definitions to support data collection and measurement, reporting, all-payers claims databases analyses, and to inform state policy.

| Behavioral Health Spend Definition | Restrict by Diagnosis | Categorize Services by Care Setting | Limit to Certain Provider Types |
|---|---|---|---|
| Milbank Memorial Fund | ✓ | ✓ | |
| Maine | ✓ | | |
| Massachusetts | ✓ | ✓ | |
| Rhode Island | ✓ | | |

Milbank Memorial Fund (2024, April 10). *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

# High-Level Considerations and Trade Offs

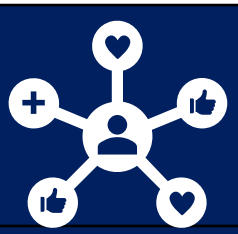
| Key Decision | Considerations | Related Decisions |
|---|---|---|
| **Restrict by Diagnosis** | Necessary to:<br>• Measure substance use disorder (SUD) and mental health (MH) separately<br>• Capture spend by non-behavioral health clinicians (e.g., PCPs) and in non-behavioral health care settings (e.g., ED, acute care hospitals) due to broad service codes<br>• Support a benchmark focused on specific diagnoses | • Which diagnoses to include?<br>• Include primary diagnosis or more?<br>• Filter by diagnosis in the same way across all providers/facilities? |
| **Categorize Services by Care Setting** | Necessary to:<br>• Understand spend by care setting (e.g., inpatient, outpatient)<br>• Support a benchmark focused on certain care settings | • Which care settings to include?<br>• Which services to include?<br>• How to treat behavioral health in primary care? |
| **Limit to Certain Provider Types** | • Excludes some behavioral health spend<br>• With categorization, could support understanding spend by certain provider types<br>• Necessary to support a benchmark focused on certain providers | • Which types of providers to include?<br>• Limit to certain providers for all care settings or only primary care? |

# OHCA Data Sources for Measuring Behavioral Health Investment

- OHCA will collect the data to measure behavioral health spending as part of its Total Health Care Expenditures (THCE) data collection efforts; THCE data submissions capture payments by payers and patients for covered behavioral health services.
- Behavioral health spending data will include claims and non-claims payments, which will be categorized using the Expanded Framework.
- OHCA will provide definitions, technical specifications, and technical assistance to support submitters accurately allocating payments to behavioral health, particularly for non-claims payment categories.
- OHCA is planning for initial behavioral health data collection and measurement efforts to focus on the commercial and Medicare Advantage populations.

# Behavioral Health Investment Benchmark

# Proposed Goals for Improved Behavioral Health Care

|  |  |  |  |  |
|---|---|---|---|---|
| **Accessible** | **Comprehensive** | **Coordinated** | **Equitable** | **High Quality** |
| • Providers and services are available when and where needed<br>• Culturally responsive and linguistically concordant<br>• Affordable | • Services across the continuum<br>• More treatment in community and ambulatory settings, reduced need in emergency departments and correctional facilities | • Services integrated across behavioral health settings and with primary care<br>• Attentive and responsive to health-related social needs | • Reduced disparities in utilization and outcomes<br>• Reduced misinformation, stigma, and discrimination | • Improved behavioral health and overall health outcomes<br>• Low frustration, high satisfaction |

Adapted from: CalHHS (2023 March). *Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts*. https://www.chhs.ca.gov/wp-content/uploads/2023/03/CalHHS-Behavioral-Health-Roadmap-_-ADA-03.02.23.pdf

# OHCA's Role in Improving Behavioral Health Outcomes

## Systemwide Behavioral Health Goals

Behavioral health care that is:

- Accessible
- Comprehensive
- Coordinated
- Equitable
- High Quality

**Motivate**

## California Stakeholder Actions

- Identify and support higher value care
- Build and sustain infrastructure and capacity
- Promote behavioral health integration with primary care and social and public health services
- Reduce disparities

**Resulting In**

**Supports**

## OHCA's Behavioral Health Workstream

- Promote sustained systemwide investment in behavioral health
- **Measure and report** the percentage of total health care expenditures. allocated to behavioral health care
- Set focused **spending benchmarks** to support improved behavioral health outcomes
- Conduct analysis

# Examples of How OHCA Can Support Better Behavioral Health Outcomes

**Measure mental health spending and substance use disorder spending separately**

Show how spending differs; compare to need as represented in prevalence data (from other sources)

**Measure spending across service and treatment categories (e.g., primary care, outpatient, emergency/ observation, inpatient)**

Highlight goal to rebalance care toward prevention and outpatient care

**Set spending benchmarks that focus on specific populations, services, or care settings**

Motivate positive change towards meeting goals of an improved behavioral health system

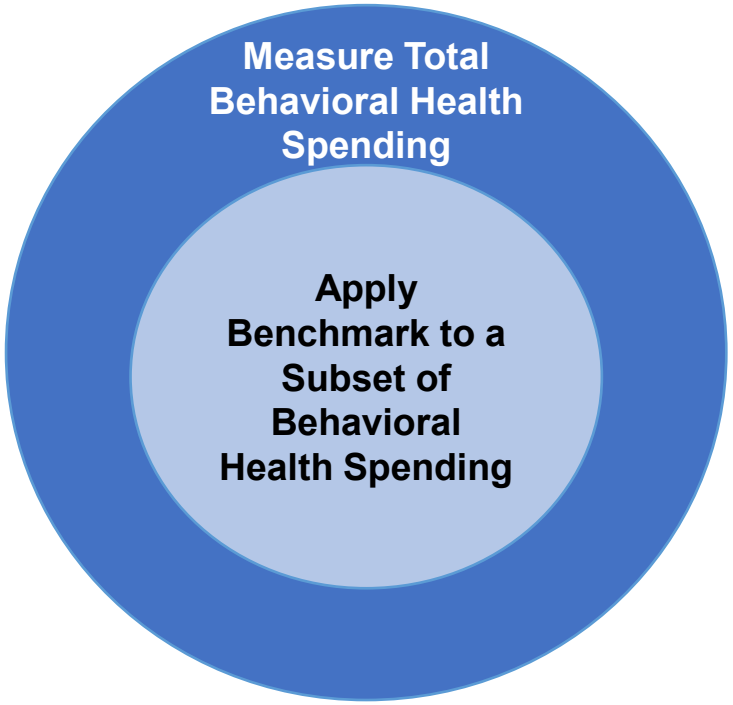
# Key Decisions for Measuring Behavioral Health Spending and Benchmark Setting

- Determine priorities for measuring behavioral health spending
- Consider need for a phased approach
- Define approach to claims payments: diagnoses, services, care settings, providers
- Define approach to non-claims payments
- Define benchmark focus – conditions, care settings, population
- Define benchmark structure and timing

# Broad Measurement, Focused Benchmark

- **Measurement:** OHCA will be measuring total behavioral health spending as a percentage of total health care expenditures.
- **Benchmark**: OHCA proposes that the behavioral health investment benchmark applies to a subset of behavioral health care spend.

**Spending Included**



# Example: Rhode Island Behavioral Health Investment Benchmark

The Rhode Island Office of the Health Insurance Commissioner (OHIC)'s **behavioral health spending obligation** focuses on community-based behavioral health care for commercial fully-insured children and adolescents, ages 0-18.

**Spending obligation (benchmark):**

- In 2025, carriers must increase per member, per month spending on community-based behavioral health care for target population to 200% of baseline (defined as calendar year 2022 spending).
- After 2025, carriers must have annual expenditures on community-based behavioral health care for the target population at the market average as determined by OHIC.
- Includes claims and non-claims spending for community-based behavioral health care.
- Applies to spending for residents of Rhode Island who receive care from providers located in Rhode Island.
- If carriers do not reach the benchmark, they will be subject to penalties determined by the Commissioner.

# Tentative Timeline for Behavioral Health Work

Between meetings, OHCA will revise draft behavioral health definitions and investment benchmarks based on feedback.

| | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 | Apr 25 | May 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Workgroup** | X | X | X | X | X | X | X | X | X | X | X |
| **Advisory Committee** | | | | X | | | X | | X | | |
| **Board** | | | | | | X | X | X | | X | ✓ |

X Provide Feedback ✓ Board Approval

# October Advisory Committee Feedback

- Suggestion to engage additional stakeholders, such as: clinical professional organization representatives, behavioral health providers not in managerial roles, emergency medical services personnel, and people with lived experiences.
- Questions on how diagnosis codes will be used to measure behavioral health care.
- Discussion of Behavioral Health in Primary Care module:
  - Questions about how it will be defined.
  - Availability of primary care clinicians trained to provide behavioral health services is a concern.
  - Care management and care team infrastructure may not be adequate to support need.
- Prevention is important – not all is through the health care system.
- More behavioral health spend, such as through institutional care, does not necessarily mean better outcomes.
- Important to capture behavioral health spend via telehealth and spend under capitation.
- Access to care is critical with focus on therapy, peer support, wrap around services, etc.
- Affordability should be a goal for measuring and benchmarking, especially out-of-plan spending

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# Public Comment

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# Sector Targets

Vishaal Pegany, Deputy Director
CJ Howard, Assistant Deputy Director

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# Sector Target Implementation

The general process for establishing sector targets is a two-step process.

1. The Board **defines** sector(s)
    a) The Board votes on sector(s) definition(s)
    b) The Office promulgates regulations defining the sector(s)

2. The Board **establishes sector target(s) value(s)** annually
    a) The Office recommends sector target(s) value(s) by March 1 in the year preceding the performance year (e.g., by March 1, 2025 for performance year 2026)
    b) The Board approves sector target(s) value(s) by June 1 in the year preceding the performance year
    c) The Board may approve multi-year sector targets

Today's discussion will focus primarily on step 1. The Office will return to the Board to address Step 2 as soon as January 2025.

# Board Discussion Recap

# Hospitals Sector Board Discussion Recap

In November, the Board discussed potential attributes of facilities that may warrant special consideration when establishing a sector and sector target for disproportionately high-cost hospitals.

The attributes discussed included: Critical Access, Small, Psychiatric, Children's, Teaching/Academic Medical Center, Specialty, State, County, and Long-Term Stay.

Board members broadly suggested that many of these attributes may warrant distinct consideration, or even exclusion, when defining a hospital sector and establishing sector targets for hospitals.

Members suggested the following:

- Factoring in geography/rural areas to any hospital sector target.
- Since State and County Hospitals rely minimally on commercial payment, and in many cases are funded in whole or in part by state and local appropriations, they may not warrant a lower spending target value.
- Psychiatric Hospitals are funded differently by Medicare, so may warrant distinct treatment.
- Children's Hospitals receive very little Medicare funding, and some may have different billing practices.
- Long-Term Stay and Specialty Hospitals are likely a heterogeneous group, where some may warrant distinct treatment or consideration while others may not.
- Critical Access Hospitals and Small Hospitals, depending upon how they are defined, may not warrant lower targets.
- Most Teaching Hospitals and academic medical centers likely do not warrant distinct treatment.
- A review of hospital data by facility attributes and several financial metrics.

# Data Review of California Hospitals

# Hospitals in California

Based on discussions with the Board, the following data in this section shows the Top 30 hospitals for each of four financial metrics from 2018-2022.* These are a select and illustrative set of metrics for the Board's review and analysis. They are not meant to convey a methodology or recommendation on how to define a hospital sector or establish sector targets:

- Spending: Average Inpatient Net Patient Revenue (NPR) Per Case Mix Adjusted Discharge (CMAD)
- Growth: Average Annual Growth Per Inpatient NPR Per CMAD
- Profitability: Average Operating Margin
- Price: Average Payment to Cost Third Party to Medicare Ratio

The first section shows the Top 30 hospitals for each metric without any potential exclusions.

The second section shows the Top 30 hospitals for each financial metric with the following exclusions:

- Critical Access Hospitals
- Psychiatric Health Facilities
- State Hospitals
- Long-Term Stay Hospitals (more than 20 days)
- Small Hospitals (less than 100 licensed beds)
- Children's Hospitals
- Kaiser Hospitals (part of a FIDS)

* Data reported by hospitals for financial metrics may not include all years.

# Definitions of Metrics

- **Inpatient Net Patient Revenue (NPR) Per Case Mix Adjusted Discharge (CMAD)**: the amount of money a hospital generates for inpatient services, excluding charity care, bad debt, and contractual allowances adjusted by the number of hospitalizations to account for inpatient volume and inpatient intensity of services.
- **Annual Growth Per Inpatient NPR Per CMAD:** the year-over-year change in the amount of money a hospital generates per unit for inpatient services, excluding charity care, bad debt, and contractual allowances adjusted by the number of hospitalizations to account for inpatient volume and inpatient intensity of services.
- **Operating Margin**: the net income from operations divided by total operating revenue (net patient revenue plus other operating revenue). This ratio indicates the percentage of net patient revenue that remains as income after operating expenses have been deducted.
- **Payment to Cost Third Party to Medicare Ratio**: Medicare and Third-Party net patient revenue divided by Medicare and Third-party costs. This ratio compares the amount a third-party payer pays for a medical service compared to what Medicare would pay for the same service, showing how much more or less the third party pays relative to Medicare's standard rate for that service.

Note: Net Patient Revenue consists of the actual amount of revenue received from patients and third-party payers after subtracting the deductions from revenue from the sum of gross patient revenue and capitation premium revenue.

# Definitions of Facility Attributes

- **Critical Access Hospital:** CAHs represent a separate provider type with their own Medicare Conditions of Participation (CoP) as well as a separate payment method. The CoPs for CAHs are listed in the "Code of Federal Regulations" at 42 CFR 485 subpart F.
- **Small Facility:** For this analysis, OHCA defines Small Facilities as those Hospitals with less than 100 licensed beds.
- **Psychiatric Hospital:** The designation of a psychiatric hospital is self-reported in the HCAI financial reporting. These hospitals provide a preponderance of psychiatric services.
- **Psychiatric Health Facility (PHF):** a health facility, licensed by the State Department of Health Care Services, that provides 24-hour inpatient care for people with mental health disorders or other persons described in the Welfare and Institutions Code.
- **Children's Hospital:** The designation of a Children's Hospital is self-reported in HCAI data. There are likely facilities that specialize in or focus on care for children that do not self-identify as a Children's Hospital.
- **Teaching Hospital:** HCAI identifies teaching hospitals based primarily on the American Medical Association's Graduate Medical Education (GME) Directory.

Centers for Medicare & Medicaid. Critical Access Hospitals. Retrieved December 10, 2024, from https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals; Health and Safety Code § 1250.2 (a)(1); HCAI Hospital Annual Financial Data, Selected Data File Documentation For Report Periods Ended on or After June 30, 2004; California Health Facilities Commission, Hospital peer grouping for efficiency comparison (1982).

# Definitions of Facility Attributes

- **Specialty Hospital:** There is not a statutory definition of what constitutes a specialty hospital. Examples of care provided by specialty hospitals may include rehabilitation, cancer treatment, heart surgery, addiction recovery, respiratory care, neurological services, long-term care, orthopedic surgery, and mental health care.
- **Designated Public Hospital (Public):** Facilities defined as "Designated Public Hospitals" per Welfare and Institutions Code (WIC) § 14181.10.* There may be other county or predominantly county run hospitals that are not included in this definition.
- **State Hospital:** Hospitals that provide mental and behavioral health services to patients referred by a county court, a prison, or a parole board as defined in WIC § 4100.
- **Long Stay Facility:** For this analysis, OHCA defines Long-Stay Facilities as those Hospitals with an average length of stay greater than 20 days.
- **Fully Integrated Delivery System Hospitals:** Hospitals that are part of a fully integrated delivery system as defined in Health and Safety Code § 127500.2 (h).

* WIC § 14184.10 authorized a Medi-Cal demonstration project and defines facilities as designated public hospitals.
Sources: HCAI Hospital Annual Financial Data, Selected Data File Documentation For Report Periods Ended on or After June 30, 2004; WIC § 4100; California Health Facilities Commission, Hospital peer grouping for efficiency comparison (1982); Health and Safety Code § 127500.2 (h).

# Review of Hospital Data Metrics

# Key Takeaways: Review of Metrics Without Specified Exclusions (2018-2022)

| Financial Metric (2018-2022) | Top 30 Range (High to Low) | Statewide Median (Without Exclusions) |
|---|---|---|
| Average Inpatient NPR Per CMAD | $402K to $28K | $12,791 |
| Average Annual Growth in Inpatient NPR Per CMAD | 79% to 15% | 3% |
| Average Operating Margin | 41% to 15% | 1% |
| Average Payment to Cost Third Party to Medicare Ratio | 857% to 300% | 180% |

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

# Top 15 Average Inpatient NPR Per CMAD Without Specified Exclusions (2018-2022)

| | Hospital | County | Critical Access | Small | Child | Teach | Spec | Psych | State | Public | Long Stay | Average Inpatient NPR per CMAD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Children's Healthcare Organization of Northern CA - Pediatric Hospital | Santa Clara | N | Y | N | N | N | N | N | N | Y | $402,481 |
| 2 | Laguna Honda Hospital and Rehabilitation Center | San Francisco | N | N | N | N | N | N | N | N | Y | $136,200 |
| 3 | Totally Kids Rehabilitation Hospital | San Bernardino | N | Y | Y | N | Y | N | N | N | Y | $136,086 |
| 4 | Joyce Eisenberg Keefer Medical Center | Los Angeles | N | N | N | N | N | Y | N | N | Y | $134,932 |
| 5 | Motion Picture and Television Hospital | Los Angeles | N | N | N | N | N | N | N | N | Y | $99,305 |
| 6 | Surprise Valley Community Hospital | Modoc | Y | Y | N | N | N | N | N | N | Y | $89,990 |
| 7 | Catalina Island Medical Center | Los Angeles | Y | Y | N | N | N | N | N | N | Y | $83,903 |
| 8 | Healthbridge Children's Hospital - Orange | Orange | N | Y | N | N | N | N | N | N | Y | $81,517 |
| 9 | Star View Adolescent (PHF) | Los Angeles | N | Y | N | N | N | Y | N | N | Y | $67,188 |
| 10 | Lucile Salter Packard Children's Hospital at Stanford | Santa Clara | N | N | Y | Y | N | N | N | N | N | $60,867 |
| 11 | La Casa Psychiatric Health Facility | Los Angeles | N | Y | N | N | N | Y | N | N | Y | $59,470 |
| 12 | Eastern Plumas Health Care | Plumas | Y | Y | N | N | N | N | N | N | Y | $55,954 |
| 13 | LAC/Rancho Los Amigos National Rehabilitation Center | Los Angeles | N | N | N | N | N | N | N | Y | N | $54,042 |
| 14 | Jewish Home | San Francisco | N | N | N | N | N | Y | N | N | Y | $52,726 |
| 15 | Mayers Memorial Hospital | Shasta | Y | N | N | N | N | N | N | N | Y | $46,623 |

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

# Top 16-30 Average Inpatient NPR Per CMAD Without Specified Exclusions (2018-2022)

| | Hospital | County | Critical Access | Small | Child | Teach | Spec | Psych | State | Public | Long Stay | Average Inpatient NPR per CMAD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | San Diego County Psychiatric Hospital | San Diego | N | N | N | N | N | Y | N | N | Y | $40,659 |
| 17 | Kindred Hospital - San Francisco Bay Area | Alameda | N | Y | N | N | N | N | N | N | Y | $39,391 |
| 18 | Southern Inyo Hospital | Inyo | Y | Y | N | N | N | N | N | N | Y | $38,036 |
| 19 | Kentfield Hospital | Marin | N | N | N | N | Y | N | N | N | Y | $36,490 |
| 20 | Seneca Healthcare District | Plumas | Y | Y | N | N | N | N | N | N | Y | $35,601 |
| 21 | San Mateo Medical Center | San Mateo | N | N | N | N | N | N | N | Y | Y | $35,191 |
| 22 | Glenn Medical Center | Glenn | Y | Y | N | N | N | N | N | N | Y | $34,762 |
| 23 | California Rehabilitation Institute | Los Angeles | N | N | N | N | Y | N | N | N | N | $31,950 |
| 24 | Resnick Neuropsychiatric Hospital at UCLA | Los Angeles | N | Y | N | N | N | Y | N | N | N | $31,240 |
| 25 | Kindred Hospital - Brea | Orange | N | Y | N | N | N | N | N | N | Y | $30,750 |
| 26 | Vibra Hospital of Sacramento | Sacramento | N | Y | N | N | Y | N | N | N | Y | $30,616 |
| 27 | Trinity Hospital | Trinity | Y | Y | N | N | N | N | N | N | Y | $30,531 |
| 28 | Kindred Hospital - Paramount | Los Angeles | N | N | N | N | N | N | N | N | Y | $30,311 |
| 29 | Contra Costa Regional Medical Center | Contra Costa | N | N | N | N | N | N | N | Y | N | $29,654 |
| 30 | UCSF Medical Center | San Francisco | N | N | N | Y | N | N | N | Y | N | $28,658 |

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

# Top 15 Average Annual Growth in Inpatient NPR Per CMAD Without Specified Exclusions (2018-2022)

| | Hospital | County | Critical Access | Small | Child | Teach | Spec | Psych | State | Public | Long Stay | Average Annual Growth per Inpatient NPR per CMAD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Sonoma Specialty Hospital | Sonoma | N | Y | N | N | N | N | N | N | Y | 79% |
| 2 | Providence St. Jude Medical Center | Orange | N | N | N | N | N | N | N | N | N | 66% |
| 3 | Glenn Medical Center | Glenn | Y | Y | N | N | N | N | N | N | Y | 61% |
| 4 | Alameda Hospital | Alameda | N | N | N | N | N | N | N | Y | Y | 50% |
| 5 | Marie Green Psychiatric Center (PHF) | Merced | N | Y | N | N | N | Y | N | N | N | 37% |
| 6 | Telecare Riverside County Psychiatric Health Facility (PHF) | Riverside | N | Y | N | N | N | Y | N | N | N | 35% |
| 7 | Children's Healthcare Organization of Northern Ca - Pediatric Hospital | Santa Clara | N | Y | N | N | N | N | N | N | Y | 34% |
| 8 | Southern Inyo Hospital | Inyo | Y | Y | N | N | N | N | N | N | Y | 33% |
| 9 | Sutter Surgical Hospital - North Valley | Sutter | N | Y | N | N | N | N | N | N | N | 24% |
| 10 | Healthbridge Children's Hospital - Orange | Orange | N | Y | N | N | N | N | N | N | Y | 23% |
| 11 | Highland Hospital | Alameda | N | N | N | N | N | N | N | Y | N | 23% |
| 12 | Joyce Eisenberg Keefer Medical Center | Los Angeles | N | N | N | N | N | Y | N | N | Y | 22% |
| 13 | La Casa Psychiatric Health Facility (PHF) | Los Angeles | N | Y | N | N | N | Y | N | N | Y | 22% |
| 14 | Ventura County Medical Center | Ventura | N | N | N | N | N | N | N | Y | N | 22% |
| 15 | Casa Palmera Care Center, LLC | San Diego | N | Y | N | N | Y | N | N | N | Y | 21% |

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

# Top 16-30 Average Annual Growth in Inpatient NPR Per CMAD Without Specified Exclusions (2018-2022)

| | Hospital | County | Critical Access | Small | Child | Teach | Spec | Psych | State | Public | Long Stay | Average Annual Growth per Inpatient NPR per CMAD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | LAC/Rancho Los Amigos National Rehabilitation Center | Los Angeles | N | N | N | N | N | N | N | Y | N | 19% |
| 17 | Laguna Honda Hospital and Rehabilitation Center | San Francisco | N | N | N | N | N | N | N | N | Y | 19% |
| 18 | Palomar Rehabilitation Institute | San Diego | N | Y | N | N | Y | N | N | N | N | 17% |
| 19 | Jerold Phelps Community Hospital | Humboldt | Y | Y | N | N | N | N | N | N | Y | 17% |
| 20 | Gateways Hospital and Mental Health Center | Los Angeles | N | Y | N | N | N | Y | N | N | Y | 17% |
| 21 | Trinity Hospital | Trinity | Y | Y | N | N | N | N | N | N | Y | 16% |
| 22 | Sempervirens (PHF) | Humboldt | N | Y | N | N | N | Y | N | N | N | 16% |
| 23 | San Luis Obispo County (PHF) | San Luis Obispo | N | Y | N | N | N | Y | N | N | N | 16% |
| 24 | Hi-desert Medical Center | San Bernardino | N | N | N | N | N | N | N | N | N | 15% |
| 25 | Crestwood (PHF)- Bakersfield | Kern | N | Y | N | N | N | Y | N | N | N | 15% |
| 26 | Ridgecrest Regional Hospital | Kern | Y | N | N | N | N | N | N | N | N | 15% |
| 27 | College Medical Center | Los Angeles | N | N | N | N | N | N | N | N | N | 15% |
| 28 | Crestwood (PHF) - San Jose | Santa Clara | N | Y | N | N | N | Y | N | N | Y | 15% |
| 29 | George L. Mee Memorial Hospital | Monterey | Y | Y | N | N | N | N | N | N | Y | 15% |
| 30 | Seneca Healthcare District | Plumas | Y | Y | N | N | N | N | N | N | Y | 15% |

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

# Top 15 Average Operating Margin Without Specified Exclusions (2018-2022)

| | Hospital | County | Critical Access | Small | Child | Teach | Spec | Psych | State | Public | Long Stay | Average Operating Margin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Merritt Peralta Institute Chemical Dependency Recovery Hospital | Alameda | N | Y | N | N | Y | N | N | N | N | 41% |
| 2 | BHC Alhambra Hospital | Los Angeles | N | Y | N | N | N | Y | N | N | N | 40% |
| 3 | Canyon Ridge Hospital | San Bernardino | N | N | N | N | N | Y | N | N | N | 39% |
| 4 | Sierra Vista Hospital | Sacramento | N | N | N | N | N | Y | N | N | N | 32% |
| 5 | College Hospital Costa Mesa | Orange | N | N | N | N | N | Y | N | N | N | 31% |
| 6 | Fremont Hospital | Alameda | N | N | N | N | N | Y | N | N | N | 30% |
| 7 | Heritage Oaks Hospital | Sacramento | N | N | N | N | N | Y | N | N | N | 28% |
| 8 | Hoag Orthopedic Institute | Orange | N | Y | N | N | Y | N | N | N | N | 27% |
| 9 | Del Amo Hospital | Los Angeles | N | N | N | N | N | Y | N | N | N | 27% |
| 10 | Casa Palmera Care Center, LLC | San Diego | N | Y | N | N | Y | N | N | N | Y | 26% |
| 11 | San Jose Behavioral Health | Santa Clara | N | Y | N | N | N | Y | N | N | N | 24% |
| 12 | Crestwood (PHF) - San Jose | Santa Clara | N | Y | N | N | N | Y | N | N | Y | 21% |
| 13 | USC Kenneth Norris Jr. Cancer Hospital | Los Angeles | N | Y | N | N | Y | N | N | N | N | 20% |
| 14 | Memorial Hospital Los Banos | Merced | N | Y | N | N | N | N | N | N | N | 19% |
| 15 | Children's Hospital at Mission | Orange | N | Y | Y | N | N | N | N | N | N | 19% |

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

# Top 16-30 Average Operating Margin Without Specified Exclusions (2018-2022)

| | Hospital | County | Critical Access | Small | Child | Teach | Spec | Psych | State | Public | Long Stay | Average Operating Margin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Eastern Plumas Health Care | Plumas | Y | Y | N | N | N | N | N | N | Y | 19% |
| 17 | Trinity Hospital | Trinity | Y | Y | N | N | N | N | N | N | Y | 19% |
| 18 | Goleta Valley Cottage Hospital | Santa Barbara | N | Y | N | N | N | N | N | N | N | 18% |
| 19 | Mercy Hospital - Folsom | Sacramento | N | N | N | N | N | N | N | N | N | 18% |
| 20 | Scripps Green Hospital | San Diego | N | N | N | N | Y | N | N | N | N | 18% |
| 21 | Crestwood (PHF) – Carmichael | Sacramento | N | Y | N | N | N | Y | N | N | N | 18% |
| 22 | Salinas Valley Memorial Hospital | Monterey | N | N | N | N | N | N | N | N | N | 18% |
| 23 | Los Robles Hospital and Medical Center | Ventura | N | N | N | N | N | N | N | N | N | 17% |
| 24 | Good Samaritan Hospital - San Jose | Santa Clara | N | N | N | N | N | N | N | N | N | 17% |
| 25 | Desert Valley Hospital | San Bernardino | N | N | N | N | N | N | N | N | N | 16% |
| 26 | Santa Ynez Valley Cottage Hospital | Santa Barbara | Y | Y | N | N | N | N | N | N | N | 16% |
| 27 | California Rehabilitation Institute | Los Angeles | N | N | N | N | Y | N | N | N | N | 16% |
| 28 | Los Angeles Community Hospital | Los Angeles | N | N | N | N | N | N | N | N | N | 16% |
| 29 | Scripps Memorial Hospital - La Jolla | San Diego | N | N | N | N | N | N | N | N | N | 16% |
| 30 | Aurora San Diego | San Diego | N | N | N | N | N | Y | N | N | N | 15% |

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

# Top 15 Average Payment to Cost Third Party to Medicare Ratio Without Specified Exclusions (2018-2022)

| | Hospital | County | Critical Access | Small | Child | Teach | Spec | Psych | State | Public | Long Stay | Average Payment to Cost Third Party to Medicare Ratio |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Monterey Park Hospital | Los Angeles | N | N | N | N | N | N | N | N | N | 857% |
| 2 | Barton Memorial Hospital | El Dorado | N | N | N | N | N | N | N | N | N | 799% |
| 3 | Southern Inyo Hospital | Inyo | Y | Y | N | N | N | N | N | N | Y | 489% |
| 4 | Salinas Valley Memorial Hospital | Monterey | N | N | N | N | N | N | N | N | N | 476% |
| 5 | Orange County Global Medical Center | Orange | N | N | N | N | N | N | N | N | N | 404% |
| 6 | Goleta Valley Cottage Hospital | Santa Barbara | N | Y | N | N | N | N | N | N | N | 382% |
| 7 | Mercy Hospital - Folsom | Sacramento | N | N | N | N | N | N | N | N | N | 382% |
| 8 | Doctors Hospital of Manteca | San Joaquin | N | Y | N | N | N | N | N | N | N | 381% |
| 9 | Children's Hospital Los Angeles | Los Angeles | N | N | Y | Y | N | N | N | N | N | 376% |
| 10 | Barstow Community Hospital | San Bernardino | N | Y | N | N | N | N | N | N | N | 370% |
| 11 | Mercy Medical Center - Merced | Merced | N | N | N | N | N | N | N | N | N | 362% |
| 12 | Washington Hospital - Fremont | Alameda | N | N | N | N | N | N | N | N | N | 358% |
| 13 | Novato Community Hospital | Marin | N | Y | N | N | N | N | N | N | N | 356% |
| 14 | Community Hospital of The Monterey Peninsula | Monterey | N | N | N | N | N | N | N | N | N | 352% |
| 15 | Emanuel Medical Center | Stanislaus | N | N | N | N | N | N | N | N | N | 351% |

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

# Top 16-30 Average Payment to Cost Third Party to Medicare Ratio Without Specified Exclusions (2018-2022)

| | Hospital | County | Critical Access | Small | Child | Teach | Spec | Psych | State | Public | Long Stay | Average Payment to Cost Third Party to Medicare Ratio |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Watsonville Community Hospital | Santa Cruz | N | N | N | N | N | N | N | N | N | 348% |
| 17 | L.A. Downtown Medical Center | Los Angeles | N | N | N | N | N | N | N | N | N | 347% |
| 18 | Doctors Medical Center - Modesto | Stanislaus | N | N | N | N | N | N | N | N | N | 347% |
| 19 | Stanford Health Care | Santa Clara | N | N | N | Y | N | N | N | N | N | 339% |
| 20 | Sutter Tracy Community Hospital | San Joaquin | N | Y | N | N | N | N | N | N | N | 338% |
| 21 | Dominican Hospital | Santa Cruz | N | N | N | N | N | N | N | N | N | 330% |
| 22 | Marin General Hospital | Marin | N | N | N | N | N | N | N | N | N | 329% |
| 23 | Petaluma Valley Hospital | Sonoma | N | Y | N | N | N | N | N | N | N | 320% |
| 24 | Sharp McDonald Center | San Diego | N | Y | N | N | Y | N | N | N | N | 309% |
| 25 | Memorial Hospital Modesto | Stanislaus | N | N | N | N | N | N | N | N | N | 307% |
| 26 | Sutter Amador Hospital | Amador | N | Y | N | N | N | N | N | N | N | 306% |
| 27 | Santa Barbara Cottage Hospital | Santa Barbara | N | N | N | Y | N | N | N | N | N | 305% |
| 28 | Stanford Health Care Tri-Valley | Alameda | N | N | N | N | N | N | N | N | N | 302% |
| 29 | Los Robles Hospital and Medical Center | Ventura | N | N | N | N | N | N | N | N | N | 301% |
| 30 | Sierra Nevada Memorial Hospital | Nevada | N | N | N | N | N | N | N | N | N | 300% |

The acronym “PHF” stands for licensed Psychiatric Health Facility. The column label “Psych” means a hospital self-reports as a psychiatric hospital.
Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data.

# Review of Hospital Metrics Removing Specified Facilities

# Hospital Analysis with Specified Exclusions

Based on feedback from the Board, OHCA presents the following Top 30 data excluding hospitals with the following attributes: Critical Access Hospitals, Children's Hospitals, Psychiatric Health Facilities, Small Hospitals (<100 beds), and Long-Term Stay Hospitals (>20 days).

**Key takeaways include:**

| Financial Metric (2018-2022) | Top 30 Range (High to Low) | Statewide Median (With Exclusions) |
|---|---|---|
| Average Inpatient NPR Per CMAD | $54K to $18K | $12,647 |
| Average Annual Growth in Inpatient NPR Per CMAD | 66% to 8% | 3% |
| Average Operating Margin | 39% to 12% | 2% |
| Average Payment to Cost Third Party to Medicare Ratio | 857% to 276% | 198% |

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

# Top 15 Average Inpatient NPR Per CMAD With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

| | Hospital | County | Teaching/ AMC | Specialty | Psych | Public | Average Inpatient NPR per CMAD | Average Annual Growth per Inpatient NPR per CMAD | Average Operating Margin | Average Payment to Cost Third Party to Medicare Ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | LAC/Rancho Los Amigos National Rehabilitation Center | Los Angeles | N | N | N | Y | $54,042 | 19% | -7% | 144% |
| 2 | California Rehabilitation Institute | Los Angeles | N | Y | N | N | $31,950 | 0% | 16% | 197% |
| 3 | Contra Costa Regional Medical Center | Contra Costa | N | N | N | Y | $29,654 | 2% | -4% | 120% |
| 4 | UCSF Medical Center | San Francisco | Y | N | N | Y | $28,658 | 3% | 0% | 238% |
| 5 | Stanford Health Care | Santa Clara | Y | N | N | N | $28,288 | 4% | 9% | 339% |
| 6 | Foothill Regional Medical Center | Orange | N | N | N | N | $26,170 | 3% | -5% | 82% |
| 7 | Alhambra Hospital Medical Center | Los Angeles | N | N | N | N | $26,031 | 8% | 4% | 109% |
| 8 | University of California Davis Medical Center | Sacramento | Y | N | N | Y | $25,870 | 3% | 6% | 237% |
| 9 | City of Hope Helford Clinical Research Hospital | Los Angeles | N | Y | N | N | $25,584 | 0% | -3% | 174% |
| 10 | Ronald Reagan UCLA Medical Center | Los Angeles | Y | N | N | Y | $25,395 | 2% | 6% | 142% |
| 11 | Santa Clara Valley Medical Center | Santa Clara | Y | N | N | Y | $25,319 | 3% | -10% | 146% |
| 12 | College Hospital Costa Mesa | Orange | N | N | Y | N | $24,736 | 14% | 31% | 117% |
| 13 | Highland Hospital | Alameda | N | N | N | Y | $23,901 | 23% | -16% | 191% |
| 14 | Northbay Medical Center | Solano | N | N | N | N | $23,497 | 0% | 1% | 271% |
| 15 | John Muir Medical Center - Walnut Creek | Contra Costa | N | N | N | N | $21,904 | 4% | 9% | 102% |

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

# Top 16-30 Average Inpatient NPR Per CMAD With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

| | Hospital | County | Teaching/ AMC | Specialty | Psych | Public | Average Inpatient NPR per CMAD | Average Annual Growth per Inpatient NPR per CMAD | Average Operating Margin | Average Payment to Cost Third Party to Medicare Ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| 16 | California Pacific Medical Center - Van Ness Campus | San Francisco | N | N | N | N | $21,759 | 5% | -4% | 253% |
| 17 | El Camino Health | Santa Clara | N | N | N | N | $21,693 | 3% | 13% | 283% |
| 18 | Cedars-Sinai Medical Center | Los Angeles | Y | N | N | N | $21,663 | 3% | 9% | 278% |
| 19 | Zuckerberg San Francisco General Hospital & Trauma Center | San Francisco | Y | N | N | Y | $21,267 | 4% | -30% | 218% |
| 20 | Alta Bates Summit Medical Center - Alta Bates Campus | Alameda | N | N | N | N | $20,920 | 3% | -3% | 256% |
| 21 | Keck Hospital of USC | Los Angeles | Y | N | N | N | $20,718 | 7% | -3% | 180% |
| 22 | LAC/Harbor - UCLA Medical Center | Los Angeles | Y | N | N | Y | $19,863 | 12% | -12% | 94% |
| 23 | Adventist Health Delano | Kern | N | N | N | N | $19,530 | 5% | -14% | 125% |
| 24 | Washington Hospital - Fremont | Alameda | N | N | N | N | $19,448 | 2% | 0% | 358% |
| 25 | East Los Angeles Doctor's Hospital | Los Angeles | N | N | N | N | $19,406 | 4% | 8% | 114% |
| 26 | Sacramento Behavioral Healthcare Hospital, LLC | Sacramento | N | N | Y | N | $19,118 | N/A | -1771% | 114% |
| 27 | Community Hospital of The Monterey Peninsula | Monterey | N | N | N | N | $19,104 | 2% | 12% | 352% |
| 28 | LAC/Olive View - UCLA Medical Center | Los Angeles | Y | N | N | Y | $18,948 | 12% | -24% | 140% |
| 29 | Good Samaritan Hospital - San Jose | Santa Clara | N | N | N | N | $18,699 | 0% | 17% | 232% |
| 30 | Valley Presbyterian Hospital | Los Angeles | N | N | N | N | $18,663 | 7% | 5% | 108% |

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

# Top 15 Average Annual Growth in Inpatient NPR Per CMAD With Exclusions (2018-2022)

Key: Rank top 15 ■ Rank 16-30 □

| | Hospital | County | Teaching/ AMC | Specialty | Psych | Public | Average Annual Growth per Inpatient NPR per CMAD | Average Inpatient NPR per CMAD | Average Operating Margin | Average Payment to Cost Third Party to Medicare Ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Providence St. Jude Medical Center | Orange | N | N | N | N | 66% | $9,327 | 4% | 136% |
| 2 | Highland Hospital | Alameda | N | N | N | Y | 23% | $23,901 | -16% | 191% |
| 3 | Ventura County Medical Center | Ventura | N | N | N | Y | 22% | $15,894 | -5% | 101% |
| 4 | LAC/Rancho Los Amigos National Rehabilitation Center | Los Angeles | N | N | N | Y | 19% | $54,042 | -7% | 144% |
| 5 | Hi-Desert Medical Center | San Bernardino | N | N | N | N | 15% | $15,425 | 5% | 118% |
| 6 | College Medical Center | Los Angeles | N | N | N | N | 15% | $12,499 | 13% | 123% |
| 7 | College Hospital Costa Mesa | Orange | N | N | Y | N | 14% | $24,736 | 31% | 117% |
| 8 | Aurora Las Encinas Hospital | Los Angeles | N | N | Y | N | 13% | $6,411 | 3% | 92% |
| 9 | Loma Linda University Medical Center - Murrieta | Riverside | N | N | N | N | 13% | $10,047 | -9% | 116% |
| 10 | Arrowhead Regional Medical Center | San Bernardino | Y | N | N | Y | 12% | $12,384 | -21% | 199% |
| 11 | Aurora San Diego | San Diego | N | N | Y | N | 12% | $10,995 | 15% | 102% |
| 12 | LAC/Harbor - UCLA Medical Center | Los Angeles | Y | N | N | Y | 12% | $19,863 | -12% | 94% |
| 13 | LAC/Olive View - UCLA Medical Center | Los Angeles | Y | N | N | Y | 12% | $18,948 | -24% | 140% |
| 14 | Hollywood Presbyterian Medical Center | Los Angeles | N | N | N | N | 11% | $14,763 | 6% | 102% |
| 15 | Paradise Valley Hospital | San Diego | N | N | N | N | 10% | $10,766 | 4% | 119% |

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

# Top 16-30 Average Annual Growth in Inpatient NPR Per CMAD With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

| | Hospital | County | Teaching/ AMC | Specialty | Psych | Public | Average Annual Growth per Inpatient NPR per CMAD | Average Inpatient NPR per CMAD | Average Operating Margin | Average Payment to Cost Third Party to Medicare Ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Adventist Health St. Helena | Napa | N | N | N | N | 10% | $11,958 | -4% | 198% |
| 17 | Lompoc Valley Medical Center | Santa Barbara | N | N | N | N | 9% | $14,554 | -1% | 97% |
| 18 | Methodist Hospital of Southern California | Los Angeles | N | N | N | N | 8% | $10,874 | -1% | 134% |
| 19 | Southern California Hospital at Hollywood | Los Angeles | N | N | N | N | 8% | $11,344 | -2% | 251% |
| 20 | Alhambra Hospital Medical Center | Los Angeles | N | N | N | N | 8% | $26,031 | 4% | 109% |
| 21 | Marshall Medical Center | El Dorado | N | N | N | N | 8% | $17,024 | 2% | 288% |
| 22 | Palomar Medical Center Poway | San Diego | N | N | N | N | 8% | $14,011 | 1% | 174% |
| 23 | Providence Mission Hospital | Orange | N | N | N | N | 8% | $12,051 | 1% | 196% |
| 24 | Providence St. Joseph Hospital | Orange | N | N | N | N | 8% | $13,511 | -3% | 94% |
| 25 | USC Verdugo Hills Hospital | Los Angeles | N | N | N | N | 8% | $9,433 | -5% | 88% |
| 26 | College Hospital | Los Angeles | N | N | Y | N | 8% | $12,422 | 2% | 113% |
| 27 | Eden Medical Center | Alameda | N | N | N | N | 8% | $15,668 | 5% | 293% |
| 28 | Provdence St. Mary Medical Center | San Bernardino | N | N | N | N | 8% | $10,413 | 4% | 253% |
| 29 | Valley Presbyterian Hospital | Los Angeles | N | N | N | N | 7% | $18,663 | 5% | 108% |
| 30 | Keck Hospital of USC | Los Angeles | Y | N | N | N | 7% | $20,718 | -3% | 180% |

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

# Top 15 Average Operating Margin With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

| | Hospital | County | Teaching/ AMC | Specialty | Psych | Public | Average Operating Margin | Average Inpatient NPR per CMAD | Average Annual Growth per Inpatient NPR per CMAD | Average Payment to Cost Third Party to Medicare Ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Canyon Ridge Hospital | San Bernardino | N | N | Y | N | 39% | $5,259 | 3% | 99% |
| 2 | Sierra Vista Hospital | Sacramento | N | N | Y | N | 32% | $9,166 | 1% | 94% |
| 3 | College Hospital Costa Mesa | Orange | N | N | Y | N | 31% | $24,736 | 14% | 117% |
| 4 | Fremont Hospital | Alameda | N | N | Y | N | 30% | $9,624 | 4% | 104% |
| 5 | Heritage Oaks Hospital | Sacramento | N | N | Y | N | 28% | $9,231 | 4% | 77% |
| 6 | Del Amo Hospital | Los Angeles | N | N | Y | N | 27% | $5,598 | 1% | 108% |
| 7 | Mercy Hospital - Folsom | Sacramento | N | N | N | N | 18% | $13,672 | 2% | 382% |
| 8 | Scripps Green Hospital | San Diego | N | Y | N | N | 18% | $12,585 | 4% | 146% |
| 9 | Salinas Valley Memorial Hospital | Monterey | N | N | N | N | 18% | $17,886 | 0% | 476% |
| 10 | Los Robles Hospital and Medical Center | Ventura | N | N | N | N | 17% | $13,788 | 4% | 301% |
| 11 | Good Samaritan Hospital - San Jose | Santa Clara | N | N | N | N | 17% | $18,699 | 0% | 232% |
| 12 | Desert Valley Hospital | San Bernardino | N | N | N | N | 16% | $8,444 | 0% | 206% |
| 13 | California Rehabilitation Institute | Los Angeles | N | Y | N | N | 16% | $31,950 | 0% | 197% |
| 14 | Los Angeles Community Hospital | Los Angeles | N | N | N | N | 16% | $11,738 | 7% | 103% |
| 15 | Scripps Memorial Hospital - La Jolla | San Diego | N | N | N | N | 16% | $14,263 | 1% | 242% |

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

# Top 16-30 Average Operating Margin With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

| | Hospital | County | Teaching/ AMC | Specialty | Psych | Public | Average Operating Margin | Average Inpatient NPR per CMAD | Average Annual Growth per Inpatient NPR per CMAD | Average Payment to Cost Third Party to Medicare Ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Aurora San Diego | San Diego | N | N | Y | N | 15% | $10,995 | 12% | 102% |
| 17 | Desert Regional Medical Center | Riverside | N | N | N | N | 15% | $15,139 | 5% | 249% |
| 18 | Memorial Hospital of Gardena | Los Angeles | N | N | N | N | 14% | $14,772 | 6% | 150% |
| 19 | Sharp Memorial Hospital | San Diego | N | N | N | N | 14% | $12,062 | 4% | 256% |
| 20 | Whittier Hospital Medical Center | Los Angeles | N | N | N | N | 13% | $10,765 | 4% | 176% |
| 21 | Emanuel Medical Center | Stanislaus | N | N | N | N | 13% | $10,234 | 4% | 351% |
| 22 | San Ramon Regional Medical Center | Contra Costa | N | N | N | N | 13% | $15,491 | 0% | 213% |
| 23 | Sutter Roseville Medical Center | Placer | N | N | N | N | 13% | $15,538 | 1% | 249% |
| 24 | El Camino Health | Santa Clara | N | N | N | N | 13% | $21,693 | 3% | 283% |
| 25 | College Medical Center | Los Angeles | N | N | N | N | 13% | $12,499 | 15% | 123% |
| 26 | Southwest Healthcare System - Murrieta | Riverside | N | N | N | N | 12% | $9,335 | 0% | 191% |
| 27 | Adventist Health Hanford | Kings | N | N | N | N | 12% | $10,911 | 3% | 223% |
| 28 | Monterey Park Hospital | Los Angeles | N | N | N | N | 12% | $12,223 | -1% | 857% |
| 29 | Placentia Linda Hospital | Orange | N | N | N | N | 12% | $8,420 | -1% | 266% |
| 30 | Community Hospital of The Monterey Peninsula | Monterey | N | N | N | N | 12% | $19,104 | 2% | 352% |

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

# Top 15 Average Payment to Cost Third Party to Medicare Ratio With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

| | Hospital | County | Teaching/ AMC | Specialty | Psych | Public | Average Payment to Cost Third Party to Medicare Ratio | Average Inpatient NPR per CMAD | Average Annual Growth per Inpatient NPR per CMAD | Average Operating Margin |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Monterey Park Hospital | Los Angeles | N | N | N | N | 857% | $12,223 | -1% | 12% |
| 2 | Barton Memorial Hospital | El Dorado | N | N | N | N | 799% | $18,094 | -2% | 6% |
| 3 | Salinas Valley Memorial Hospital | Monterey | N | N | N | N | 476% | $17,886 | 0% | 18% |
| 4 | Orange County Global Medical Center | Orange | N | N | N | N | 404% | $10,076 | -2% | -4% |
| 5 | Mercy Hospital - Folsom | Sacramento | N | N | N | N | 382% | $13,672 | 2% | 18% |
| 6 | Mercy Medical Center - Merced | Merced | N | N | N | N | 362% | $13,210 | 2% | 7% |
| 7 | Washington Hospital - Fremont | Alameda | N | N | N | N | 358% | $19,448 | 2% | 0% |
| 8 | Community Hospital of The Monterey Peninsula | Monterey | N | N | N | N | 352% | $19,104 | 2% | 12% |
| 9 | Emanuel Medical Center | Stanislaus | N | N | N | N | 351% | $10,234 | 4% | 13% |
| 10 | Watsonville Community Hospital | Santa Cruz | N | N | N | N | 348% | $12,119 | -6% | -22% |
| 11 | L.A. Downtown Medical Center | Los Angeles | N | N | N | N | 347% | $9,211 | -2% | -2% |
| 12 | Doctors Medical Center - Modesto | Stanislaus | N | N | N | N | 347% | $13,456 | 1% | 11% |
| 13 | Stanford Health Care | Santa Clara | Y | N | N | N | 339% | $28,288 | 4% | 9% |
| 14 | Dominican Hospital | Santa Cruz | N | N | N | N | 330% | $17,652 | 2% | 9% |
| 15 | Marin General Hospital | Marin | N | N | N | N | 329% | $16,291 | 2% | 6% |

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

# Top 16-30 Average Payment to Cost Third Party to Medicare Ratio With Exclusions (2018-2022)

Key: Rank top 15 Rank 16-30

| | Hospital | County | Teaching/ AMC | Specialty | Psych | Public | Average Payment to Cost Third Party to Medicare Ratio | Average Inpatient NPR per CMAD | Average Annual Growth per Inpatient NPR per CMAD | Average Operating Margin |
|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Memorial Hospital Modesto | Stanislaus | N | N | N | N | 307% | $12,649 | 3% | 9% |
| 17 | Santa Barbara Cottage Hospital | Santa Barbara | Y | N | N | N | 305% | $18,420 | 2% | 3% |
| 18 | Stanford Health Care Tri-Valley | Alameda | N | N | N | N | 302% | $15,418 | 6% | 3% |
| 19 | Los Robles Hospital and Medical Center | Ventura | N | N | N | N | 301% | $13,788 | 4% | 17% |
| 20 | Sierra Nevada Memorial Hospital | Nevada | N | N | N | N | 300% | $13,286 | 2% | 0% |
| 21 | Alta Bates Summit Medical Center - Summit Hawthorne | Alameda | N | N | N | N | 294% | $14,451 | 5% | -4% |
| 22 | Eden Medical Center | Alameda | N | N | N | N | 293% | $15,668 | 8% | 5% |
| 23 | Marshall Medical Center | El Dorado | N | N | N | N | 288% | $17,024 | 8% | 2% |
| 24 | Mills-peninsula Medical Center | San Mateo | N | N | N | N | 284% | $15,266 | 2% | 4% |
| 25 | El Camino Health | Santa Clara | N | N | N | N | 283% | $21,693 | 3% | 13% |
| 26 | Providence Santa Rosa Memorial Hospital | Sonoma | N | N | N | N | 279% | $15,313 | 3% | 4% |
| 27 | Tenet Health Central Coast Twin Cities Community Hospital | San Luis Obispo | N | N | N | N | 278% | $12,576 | 4% | 11% |
| 28 | Cedars-Sinai Medical Center | Los Angeles | Y | N | N | N | 278% | $21,663 | 3% | 9% |
| 29 | Methodist Hospital - Sacramento | Sacramento | N | N | N | N | 276% | $14,939 | 2% | -4% |
| 30 | Sequoia Hospital | San Mateo | N | N | N | N | 276% | $17,072 | 2% | -2% |

Source: OHCA and Freedman Health Care analysis of HCAI Hospital Annual Financial Data

# Sector Definition and Target Setting Options

# Defining Other Sectors

In response to Board requests, the Office has identified options for the Board's consideration to address disproportionately high-cost hospitals. In November, the Board expressed interest in potentially defining other sectors based on geographic region, medical group/provider organizations, and market category. Based on timing and data availability, the Office has limited the scope of today's discussion to defining a potential hospital sector.

Statute requires the Board to define initial sectors on or before October 1, 2027, and that the setting of different targets by health care sector is informed by historical cost and other relevant supplemental data. To define a sector and establish targets for performance year 2026, the Board would need to establish sector definitions, and the Office would need to recommend target values on or before March 1, 2025.

The Office has limited data to inform the establishment of potential sectors beyond Hospitals.

- **Physician Organizations**: The Office has very limited data on Total Medical Expense growth attributed to physician organizations. The Office is developing strategies to improve physician organization reporting.
- **Geographic Regions**: The Office has limited data on regional Total Medical Expenditure growth to inform defining appropriate geographic regions. Additional annual data reporting and supplemental data sets will be informative to defining geographic sectors in future years.
- **Market Category Sectors**: Additional data reporting and analysis of California's cost growth trends may inform defining market category sectors and target values.

Defining an initial hospital sector will not preclude the board from adding or defining geographic, market category, physician organization, or other sectors in the future.

# Hospital Sector Options

Based on discussions with the Board, the Office has developed options to enable the Board to establish sector targets to address high-cost hospitals.

These options focus on how to define and establish sectors; the Office can return in subsequent meetings with options on establishing the sector target value(s).

1. Wait to establish sector targets for performance year 2027 or later.
2. Define the Community Hospital of the Monterey Peninsula (CHOMP), Salinas Valley Memorial Hospital, and Natividad Medical Center as a sector and establish target(s) for those facilities.
3. Establish a sector based on facility attributes and financial measures.
4. Define all hospitals as a sector and adjust the sector target for select facilities.

# Hospital Sector Options

1. **Wait to establish sector targets for performance year 2027 or later.**

***Approach Summary:***

The Board could decide to wait to establish sector targets for performance year 2027 for high-cost hospitals, which means that OHCA would propose sector targets in winter/spring of the year preceding the applicable performance year.

***Statute:***

Health and Safety Code (HSC) § 127502 (I)(2)(A): On or before October 1, 2027, the board shall define initial health care sectors, which may include geographic regions and individual health care entities, as appropriate, except fully integrated delivery systems, considering factors such as delivery system characteristics. Sectors may be further defined over time.

# Hospital Sector Options

1. **Wait to establish sector targets for performance year 2027 or later.**

***Considerations:***

- All facilities are subject to the statewide spending target.
- For many facilities, the statewide spending target will be a reduction in spending growth compared with historical trends.
- Waiting to develop a hospital sector target allows the Office to direct attention to other efforts, such as physician organization attribution and spending target enforcement.

***Implementation:***

The Office and Board will continue to analyze existing data and evaluate approaches to implementing sector targets, including high-cost hospitals.

# Hospital Sector Options

**2. Define CHOMP, Salinas Valley Memorial Hospital, and Natividad Medical Center as a sector and establish target(s) for those facilities.**

***Approach Summary:***

The Board would define the three Monterey facilities as a sector and establish target(s) for them.

***Statute:***

- HSC § 127502 (b)(1): The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.
- HSC § 127502 (b)(2): 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.

# Hospital Sector Options

**2. Define CHOMP, Salinas Valley Memorial Hospital, and Natividad Medical Center as a sector and establish target(s) for those facilities.**

***Considerations:***

- This approach is narrowly tailored to address the high-cost of three hospitals that have been brought to the Board's attention.
- Defining such a narrow sector would limit the Board's ability to later adjust the spending target to only these facilities because the statute only allows adjustments when warranted to account for the baseline costs in comparison to other health care entities in the health care sector and geographic region.
- The Board would still be able to adjust the target of each facility.
- Stakeholders might challenge why these three facilities are defined as a single sector, when data show that there are other high-cost hospitals.

***Implementation:***

- The Board would vote to define the three hospitals as a sector at a future board meeting.
- The Office would draft and seek to implement regulations defining the sector.
- The Office would return to the Board with options for establishing target value(s) for the sector.

# Hospital Sector Options

## 3. Establish a sector based on facility attributes and financial measures.

### *Approach Summary:*

The Board could define a high-cost hospital sector that includes a subset of hospitals based on facilities that are disproportionately high cost, define potential inclusion and/or exclusion criteria based on financial metrics and facility attributes, and establish target(s) for those facilities.

### *Statute:*

- HSC § 127502 (b)(1): The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.
- HSC § 127502 (b)(2): 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.
- HSC § 127502 (b)(3): The setting of different targets by health care sector…shall be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs pursuant to § 127506.

# Hospital Sector Options

## 3. Establish a sector based on facility attributes and financial measures.

### *Considerations:*

- The Board would need to decide which metrics should be used to determine which facilities would be included or excluded in the sector.
- Not all attributes that may warrant inclusion or exclusion (e.g., Children's Hospitals, Public Hospitals) are readily identifiable or defined in statute or regulation, and many are self-reported.
- The Board may need to develop definitions for these facility attributes, and potentially how financial measures would be operationalized in the definition because the definitions would be in regulations.
- This approach may unintentionally include or exclude entities that may not warrant a target different from than the statewide target.
- This approach would require additional time to develop and implement and the Office would not be able to implement sector definition regulations and recommend target values for Performance Year 2026.

### *Implementation:*

- The Office would continue to work with the Board on developing a process, based on financial measures and facility attributes, for defining hospitals that would be included in the sector definition.
- Once the process for defining included hospitals is agreed upon, the Office would seek to promulgate regulations and return to the Board with options for establishing target(s) for the sector.

# Hospital Sector Options

## 4. Define all hospitals as a sector and adjust the sector target for select facilities.

### *Approach Summary*

The Board could define all hospitals as a sector. If established as a sector, hospitals would be subject to the statewide target unless and until the Board adjusts the target for all or a specific subset of hospitals within the sector.

### *Statute*

- HSC § 127502 (b)(1): The board shall establish specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. The board shall define health care sectors, which may include geographic regions and individual health care entities, as appropriate, except for fully integrated delivery systems, and the office shall promulgate regulations accordingly.
- HSC § 127502 (b)(2): 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.*
- HSC § 127502 (b)(3): The setting of different targets by health care sector…shall be informed by historical cost data and other relevant supplemental data, such as financial data on health care entities submitted to state agencies and the Health Care Payments Data Program, as well as consideration of access, quality, equity, and health care workforce stability and quality jobs pursuant to § 127506.

# Hospital Sector Options

**4. Define all hospitals as a sector and adjust the sector target for select facilities.**

***Considerations:***

- Allows the Board to consider the unique attributes of each facility and adjust cost targets of individual hospitals to account for baseline costs in comparison to other hospitals in the sector and geographic region.
- Enables the Board to strategically modify, tailor, and adapt its use of the sector target tool to promote consumer affordability.
- This approach would not limit the Board from adding additional sectors in the future (e.g., geographic).
- Enables the Board to adjust targets for all or a select portion of the hospitals in the sector annually.
- The approach for measuring and reporting hospital performance against the spending target will be different from health plans and other provider types that rely upon attributed TME growth; establishing hospitals as their own sector aligns with how they are measured differently.
- This option could be implemented to enable adjusting of sector targets as soon as performance year 2026.

# Hospital Sector Options

**4. Define all hospitals as a sector and adjust the sector target for select facilities.**

***Implementation:***

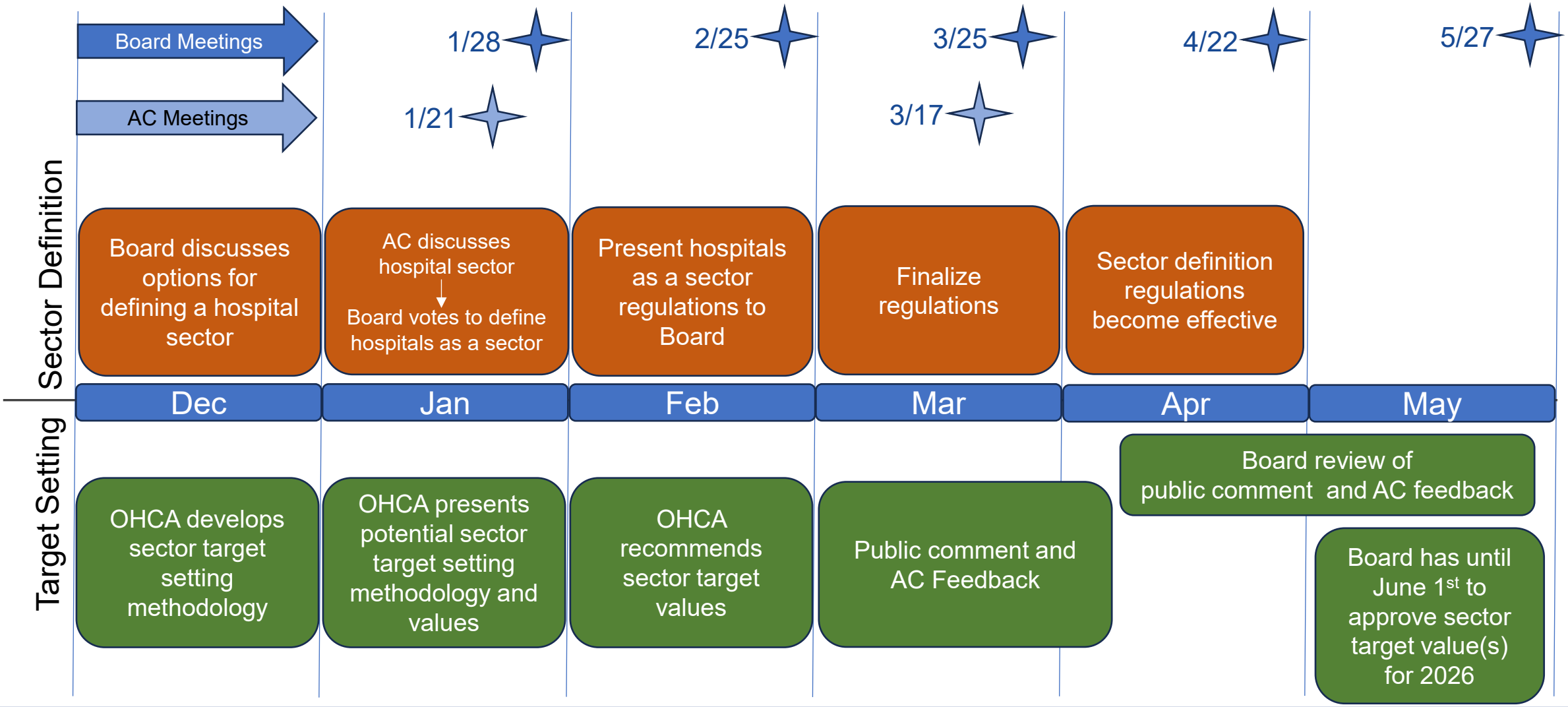
- **January 2025:**
  - The Office would present sector definition options to the Advisory Committee for their feedback.
  - The Board would vote to define hospitals as a sector.

- **February 2025:**
  - The Office would draft regulations with the approved sector definition, present to Board, and then seek OAL approval.
  - The Office would make recommendation for a sector target value(s) and present to Board.

- **February to April 2025**
  - The Board would discuss appropriate hospitals to adjust the sector target for and the sector target value.
  - The Office would present proposed target value(s) to the Advisory Committee for their feedback.

- **April 2025 to May 2025:**
  - The Board would be able to vote on sector target value and any adjustments for selected hospitals 45 days after the Office's proposed targets are discussed at the February board meeting.

# Sector Target Implementation Milestones



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# Recommendation

If the Board intends to proceed with sector targets effective for calendar year 2026, OHCA recommends implementing Option 4.

Option 4 will provide the Board with the ability to consider the details and attributes of each hospital prior to implementing a target value that differs from the statewide spending target. This option enables the Board to respond timely to facilities with spending trends that do not advance consumer affordability.

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# Public Comment

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# General Public Comment

Written public comment can be emailed to:

ohca@hcai.ca.gov

To ensure that written public comment is included in the posted board materials, e-mail your comments at least 3 business days prior to the meeting.

HCAI

Department of Health Care Access and Information

# Next Board Meeting:
# January 28, 2024
## 10:00 a.m.

## Location:
## May Lee State Office Complex
## 651 Bannon St.
## Auditorium, Room 300
## Sacramento, CA  95811

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# Adjournment

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