California Hospital Association

January 24, 2025

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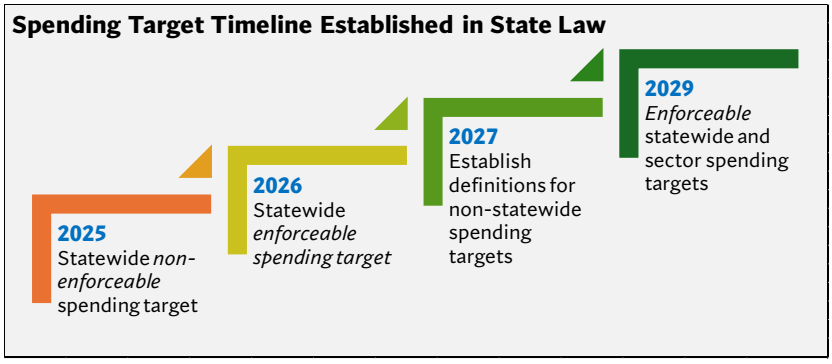
Subject: **CHA Comments for the January 2025 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

Hospitals Oppose OHCA's Rash Approach to Establishing a Hospital Sector Three Years Ahead of Schedule

At its January board meeting, OHCA appears poised to take the first official step toward the adoption of one or more hospital sector targets. Coming several years before the timeline laid out in law, this accelerated push toward implementation of sector targets contravenes clear statutory intent that OHCA and its regulated health care entities work collaboratively and learn together. As laid out in state law, focus should first be on striving to meet the state's ambitious statewide spending target, and only subsequently should OHCA move onto sectors. Equally problematic, OHCA's rush to develop sector-specific targets is occurring without the due diligence necessary to enact a sector target in a fair and data-informed manner. Accordingly, the California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, opposes the adoption of a hospital sector at this time.

State Law Intentionally Laid Out a Roadmap for Sector Target Implementation. The figure at left displays OHCA's key deadlines for implementing its spending targets under state law. While state law does provide some flexibility, the intent is clear: OHCA and its regulated entities should gain experience first under an unenforceable spending target in 2025, move to an enforceable target in 2026, take time to carefully define sector targets in 2027, and only then — with significant cushion for further thoughtful analysis — set sector targets in 2029. The current push toward sector targets is occurring not only three years ahead of schedule, but also over a period condensed from years into mere months.



OHCA Plans to Adopt Sector Targets Before Achieving Basic Milestones and Prerequisites. The potential adoption of a hospital sector definition comes just weeks into implementation of the first statewide non-enforceable spending target — and before key milestones have been met:

- **OHCA has yet to analyze or report a single year of total health care expenditure data.** OHCA's first report on statewide health care spending is due June 1, 2025, the same deadline to adopt changes to the statewide target for 2026 (this would include sector-specific targets for 2026 should OHCA choose to adopt them ahead of its statutory deadline). However, the process for adopting a sector target requires antecedent steps that would take the entirety of the next four months to complete. As such, should OHCA adopt a sector target for 2026 at any meeting prior to June, it would have to forego grounding its decisions in the comprehensive spending data the agency is tasked with collecting, analyzing, and reporting on.
- **OHCA has yet to compare segments of the health care industry on standard financial measures.** A sound process for establishing data-driven sectors and corresponding targets would include collecting and comparing comparable data across different segments of the health care industry, then making data-informed decisions. OHCA is doing the opposite. Without having looked at such data, OHCA appears poised to make initial decisions on sectors based on which segment of the health care industry happens to have historical data available. As a result, OHCA is disregarding the fact that health plans earned 40% more total net income than hospitals in 2023; that (large group) premiums for two of the largest plans (Blue Shield of California and Anthem Blue Cross) went up by 8% and 15%, respectively this year; and that branded drug prices are projected to increase by 7% in 2025. Instead, OHCA is targeting a field facing stagnant revenues, explosive cost growth, and unsustainable recent financial performance that already is resulting in pullbacks of investment, service line reductions, and full closures.
- **OHCA has yet to fairly and comprehensively evaluate the drivers of health care spending.** A prudent approach to slowing the growth of health care spending — mindful of the serious potential for unintended and tragic consequences, including patients' inability to access lifesaving care — would first carefully study the drivers of health care spending, judiciously aim to distinguish between good spending and bad, and move to address high-cost, low-value care with reasonable precision. OHCA has barely begun this task and risks pursuing cuts in spending that are incompatible with providing the level and quality of care that Californians deserve.
- **OHCA has yet to determine how hospital spending will be measured.** OHCA has yet to make final decisions on how hospital spending will be measured. In fact, its intent is to adopt a temporary methodology for one or more years, then significantly change its approach as new data become available. Accordingly, it does not have an established methodology for measuring historical spending trends, identifying higher-cost hospitals, or informing regulated entities on how their spending will prospectively be measured against their spending target. This work should be completed before adopting a sector definition or target, so that the adopted sector target is credible, and hospitals are able to properly plan for compliance.
- **OHCA has yet to assess performance against, and the reasonableness of, the statewide spending target.** The timeline on Page 1 clearly demonstrates the intent in state law to gain experience under a statewide target before moving onto sector targets. By disregarding the statutory timeline, OHCA is foregoing the opportunity to assess whether the statewide spending target is working, whether it is reasonable and unattainable, if it is driving improvements in affordability without sacrificing quality and equity, and how different segments of the health care industry are performing relative to the target.

OHCA's Approach to Sector Definitions Ignores State Law. Existing law requires that sectors be developed *"in a manner that minimizes fragmentation and potential cost shifting and that encourages*

cooperation in meeting statewide and geographic region targets." No work has been done to ensure that OHCA's potential approach fulfills this requirement of state law. For example, the planned approach is likely to simply shift costs from hospitals to other providers and payers, creating earnings windfalls for health insurance companies and others even while Californians continue to struggle to pay their premiums and other costs of care.

Premature Adoption of Sector Targets Strains OHCA's Credibility and Impartiality. Adopting a hospital sector now would prejudicially target a set of providers for which data happens to be available. Not only is such an approach arbitrary, it also further debilitates a class of providers that is struggling to financially recover from the aftereffects of the worst pandemic in a century, that faces tens of billions in new costs annually from unfunded state mandates, and that is working to keep pace with increasing patient needs. In the face of every challenge, hospitals make sure their doors are open 24/7 to care for California's sickest and most vulnerable patients, including those without the ability to pay. In sum, imposing sector targets prematurely threatens successful implementation of OHCA's core functions and undermines both trust in the process and collaboration toward a shared vision of improved health care affordability for all Californians.

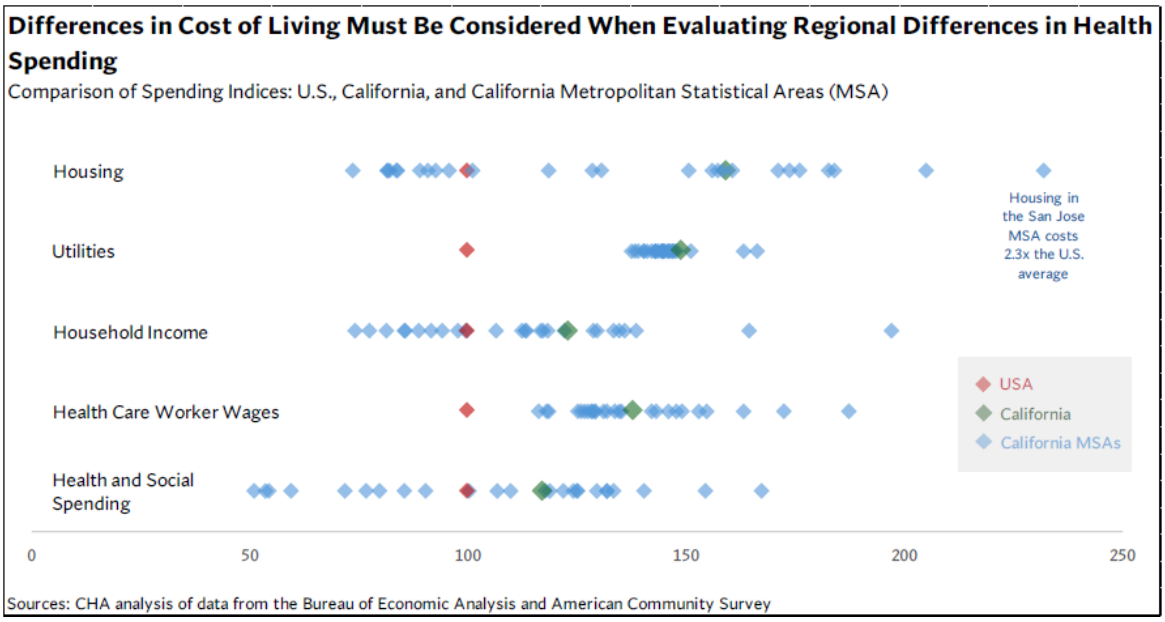
OHCA's Effort to Identify "High-Cost" Hospitals Shows How Much More Work Is Needed

At the Dec. 18 OHCA board meeting, OHCA staff presented a data analysis intended to identify high-cost hospitals throughout the state, with the purpose of potentially differentiating the spending target that applies to these high-cost hospitals. At the end of the review, both OHCA staff and board members remarked on the lack of clear and consistent patterns in the data. As the following analysis shows, we agree with that assessment. It shows just how much more work is needed to develop a defensible and rational methodology for identifying high-cost hospitals. Otherwise, OHCA risks setting different sector spending targets for different health care entities arbitrarily, creating unacceptable results that treat similarly situated hospitals differently and differently situated hospitals similarly.

Each Measure for Identifying High-Cost Hospitals Has Strengths — and Serious Weaknesses. Hospital finance is complex. As a result, no single financial measure cleanly separates high-cost hospitals from others without the need for significant contextualization. OHCA staff recognized this, putting forward multiple measures of hospital performance for consideration as options for identifying high-cost hospitals. Below are important tradeoffs to consider for each of these measures:

- **(Net patient) inpatient revenue per case mix-adjusted discharge.** This measure identifies which hospitals earn the most revenue per discharged patient, adjusted for the expected resource-intensity of their stay. A key advantage is that it considers all the major sources of direct patient revenue, regardless of whether it comes from a commercial insurer or public payer. Therefore, it accounts for the ubiquitous cross subsidization that results from some payers paying more than cost, and others paying far less. Unfortunately, it fails to control for differences in underlying operational costs between different hospitals, such as for those located in areas with higher costs of living, like the Bay Area. (The figure on the next page shows the extraordinary differences in cost of living between different regions of California.) Ultimately, using this measure to identify high-cost hospitals would punish hospitals for factors beyond their control and render them incapable of sustaining services in high-cost regions. Additionally, hospital decisions around contracting with on-call physicians — in large part driven by varying restrictions in state law — bias this measure (and others) against certain hospitals. Hospitals that employ physicians report not only facility fees in their revenues, but professional fees as well; hospitals that do not employ physicians do not report professional fee revenues. This makes the former appear higher cost

than the latter solely due to their physician employment decisions afforded by different treatment in state law.



- **Growth in inpatient Revenue per case mix-adjusted discharge.** This measure identifies which hospitals had the highest growth in their revenue over a five-year period. A key advantage is that this measure most closely corresponds to OHCA's spending target(s), which apply to entities' spending growth rather than spending levels. However, whether high growth is potentially problematic is highly dependent on its starting point. A hospital charging disproportionately low rates and experiencing a negative operating margin may need to increase its revenues faster than other hospitals simply to survive. Targeting such a hospital with an inequitably lower spending target could leave it incapable of negotiating sustainable rates with payers and only increase its chances of closing or reducing services.
- **Operating margins.** This measure shows the extent to which a hospital's underlying operational revenues are keeping up with its expenses, rendering it a sustainable organization. High margins could reveal an opportunity for lower future revenue growth without as much risk of reductions in access or quality. However, using this measure to set stricter spending targets could simply penalize more efficient hospitals. Additionally, the measure is biased against hospitals that disproportionately cross-subsidize non-hospital services with expenditures that fall outside of the requirements of hospitals' financial reports, such as those that financially support their affiliated medical groups. Finally, the accounting practices of hospital systems make this a suboptimal measure for all but independent hospitals. For example, within systems, operating expenses (part of the calculation to determine operating margins) can vary depending on how a system apportions shared expenses to individual hospitals under its umbrella.
- **3rd party-to-Medicare cost ratio.** This measure aims to compare cost coverage between hospitals' commercial and Medicare payers. A higher ratio means commercial payers cover hospital's costs to a greater degree. There are distinct advantages of this approach, namely that it accounts for some of the differences in operational costs between hospitals, such as those located in high-cost regions and those that provide medical education. Nevertheless, it has major shortcomings, most notably by assuming the reasonableness of Medicare payment policies. Recent research casts doubt on the validity of this assumption, revealing that underpayment in

Medicare fee for service (FFS) is much greater for California hospitals located in high-cost regions.[1] According to the referenced 2023 study, a California hospital with a Medicare area wage index of 1.2 can expect to lose 25 cents on every dollar of care it provides to a Medicare FFS patient. However, a hospital with an area wage index of 1.8 can expect to lose around 60 cents for each dollar of care. (Medicare measures regional differences in hospital costs using the area wage index.) As the figure above demonstrates, this deficiency in Medicare payment policy inevitably makes a hospital that is disproportionately undercompensated by Medicare appear significantly higher cost under the 3rd party-to-Medicare cost ratio measure than another hospital, even if the two have equal operating margins. Accordingly, using this ratio to identify high-cost hospitals for spending target purposes would punish hospitals simply for having poor Medicare reimbursement and additional factors beyond their control. Ultimately, it would make operating in California's high cost-of-living regions only more challenging.

3rd Party-to-Medicare Cost Ratio Punishes Hospitals Whose Medicare Reimbursement Is Relatively Poor

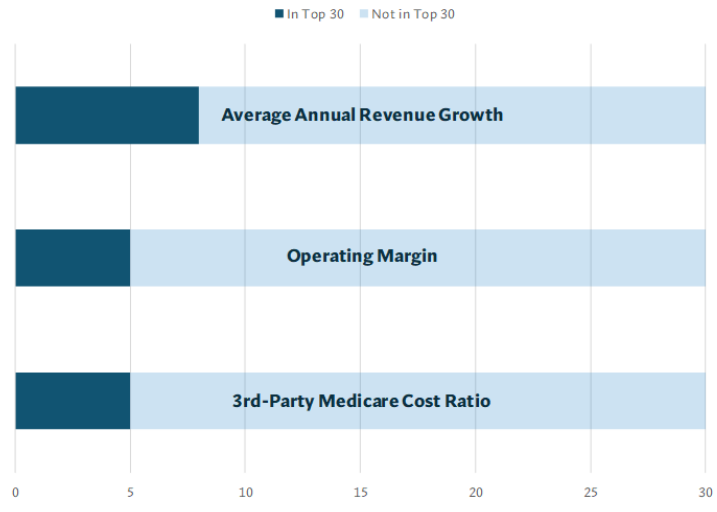
	Hospital in Low-Cost Region			Hospital in High-Cost Region		
	Revenue	Cost	Profit/Loss	Revenue	Cost	Profit/Loss
Medi-Cal	$5,000	$6,000	-$1,000	$5,000	$6,000	-$1,000
Medicare	$5,000	$6,667	-$1,667	$5,000	$12,500	-$7,500
3rd Party	$10,000	$5,000	$5,000	$25,244	$12,622	$12,622
Totals	*$20,000*	*$17,667*	*$2,333*	*$35,244*	*$31,122*	*$4,122*
Operating Margin		**12%**			**12%**	
3rd-Party-to-Medicare Cost Ratio		**267%**			**500%**	

Note: Examples reflect hypothetical hospitals with equal operating margins and equal reimbursement-to cost ratios for 3rd-party and Medi-Cal payers. The only material difference is the shortfall in Medicare reimbursement relative to cost, with the hospital in a low-cost region facing a 25% Medicare shortfall and the hospital in the high-cost region facing 60% Medicare shortfall (consistent with the estimates in the referenced research).

Measures Do Not Agree on Which Hospitals Are High Cost. In addition to each measure having idiosyncratic shortcomings, OHCA's attempt to identify high-cost hospitals using four distinct measures yielded wildly inconsistent results, failing to provide a data-informed answer on which hospitals to potentially target with a lower spending target. The following figure summarizes this striking lack of agreement between the measures, revealing that a hospital in the top 30 in terms of revenue per discharge (including OHCA's suggested exclusions) is highly unlikely to fall in the top 30 on any of the other measure. In fact, the inconsistency in hospitals' performance on these measures is so great that among the hospitals in the top 30 of revenue per discharge, roughly half experienced negative average operating margins during the full five-year period analyzed by OHCA. Thus, using this or a similar measure to identify which hospitals to apply a lower sector spending target to risks seriously undermining these hospitals' financial viability. The figure on the next

Measures for Identifying High-Cost Hospitals Disagree Far More Often Than Not

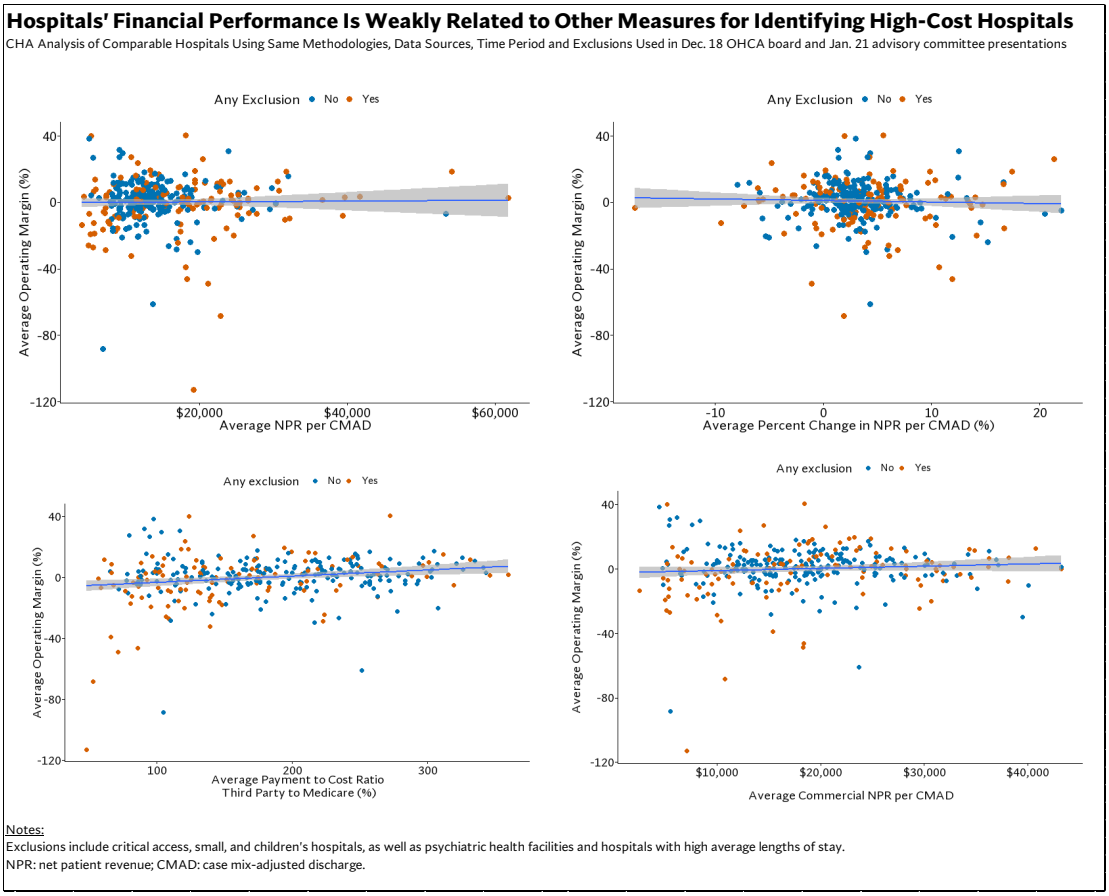
Count of Hospitals That Appear in Top 30 by Measure by Comparison to Hospitals in Top 30 in Inpatient Revenue Per Case-Mix-Adjusted Discharge



Source: Data are from OHCA's Data Review of California Hospitals from the Dec. 16, 2024 Health Care Affordability Board Meeting, specifically slides 56-57 that compare hospitals with OHCA's suggested exclusions.

[1] 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.

page shows the weak relationships between operating margin and the other financial measures reviewed by OHCA's board and advisory committee for all comparable hospitals (not simply the top 30 hospitals), while the appendix shows the remaining relationships among the measures for all comparable hospitals.



Exclusions Require a Sound Rationale. At the Dec. 18 board meeting, OHCA presented a number of hospital characteristics and suggested excluding hospitals with a subset of these characteristics from its list(s) of high-cost hospitals. The table on the next page compares the set of hospital characteristics reviewed by OHCA, those suggested to qualify hospitals for exclusion, and a wider set of additional relevant hospital characteristics that were not considered. While exclusions based on hospital characteristics may be warranted, OHCA has not provided a compelling rationale for why its chosen set of exclusions is reasonable and better than a wide variety of alternatives. Below are just several of the thorny issues that must be addressed prior to establishing a list of characteristics that exclude certain hospitals from negative adjustments to their spending targets.

Numeric Cutoffs Could Result in Similar Hospitals Facing Radically Differently Sector Targets. OHCA has suggested excluding small hospitals with fewer than 100 beds and hospitals with average lengths of stay longer than 20 days from its list of high-cost hospitals. Why these specific thresholds were chosen is unclear — and both could result in similarly situated hospitals above and below the thresholds receiving radically different sector targets. Take, for example, hospitals with average lengths of stay just above and below the 20-day threshold. The former, which would qualify for exclusion, had average operating margins of negative 2.2% between 2018 and 2022; nonqualifying hospitals had average operating margins of negative 2.4%.

Categorical Attributes Mask Underlying Variation in Service Delivery, Leading to Potentially Unjustified Differences in Treatment from OHCA. Patterns of hospital service delivery are incredibly diverse. Psychiatric hospitals do not exclusively provide psychiatric inpatient care. Children's hospitals are not the only ones to provide specialized children's services. Academic medical centers are a minority of teaching hospitals. Public hospitals are not the only disproportionate share Medi-Cal providers. Moreover, licensing decisions by hospitals complicate what attributes, revenues, and costs get applied to a single "hospital" or spread out among multiple hospitals in their financial filings. Nevertheless, the categories used by OHCA aim to strictly delimit hospitals across categorical distinctions that do not truly or fully exist, such as when distinguishing between psychiatric hospitals and general acute hospitals that provide significant psychiatric care. To this end, OHCA must take care not to adopt rules based on false distinctions that do not appropriately capture differences in care delivery.

Unclear How OHCA Chose Which Characteristics Qualify Hospitals for Exclusion from its List of High-Cost Hospitals

Hospital Types	Identified	Excluded
Cancer treatment centers		
Children's	Yes	Yes
Critical access	Yes	Yes
Designated public	Yes	
District and municipal		
Disproportionate share		
Free	Yes	Yes
Fully integrated delivery system	Yes	Yes
Independent		
Investor-owned		
Long-term stay facilities	Yes	Yes
Maternity care		
Not-for-profit		
Psychiatric health facilities	Yes	Yes
Psychiatric	Yes	
Quaternary care		
Rehabilitation		
Research		
Rural		
Small facilities	Yes	Yes
Specialty	Yes	
State	Yes	Yes
Teaching	Yes	
Trauma centers		

Comparison of various hospital characteristics, those identified by OHCA in its Dec. 18 board presentation, and those suggested to exclude hospitals from being a high-cost hospital

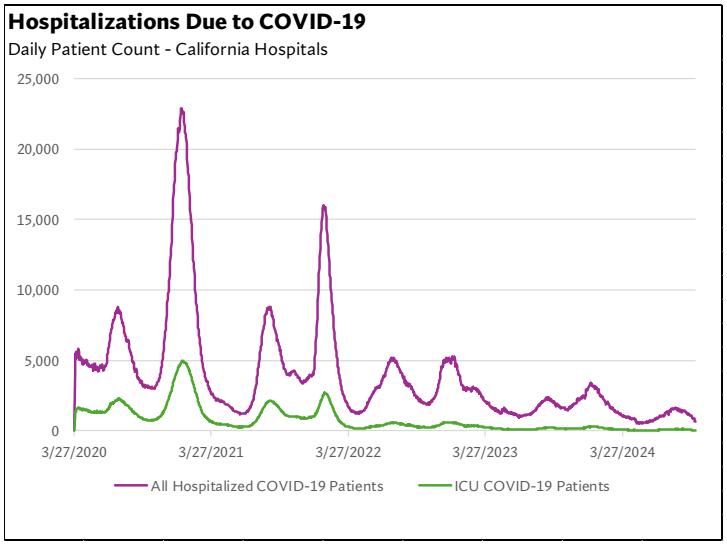
Rural Hospitals Should Be Considered for Exclusion, in Addition to Critical Access Hospitals. Critical access hospitals represent a subset of rural hospitals with a special designation and reimbursement methodology from Medicare. OHCA has recommended excluding critical access hospitals from its list of high-cost hospitals. While protecting the state's 38 critical access hospitals is absolutely essential, rural hospitals are generally highly vulnerable to closures and service line reductions. OHCA should provide a clear rationale for why the broader set of rural hospitals are not recommended for exclusion.

Isolating High-Cost Hospitals Exceeding an Arbitrary Cutoff Would Subject Similarly Performing Hospitals to Potentially Hugely Different Spending Targets. OHCA's Dec. 18 slides used top-30 cutoffs on four financial measures to isolate high-cost hospitals. This binary approach above and below the top 30 risks treating nearly identically situated hospitals differently. As the table below shows, this could result in a hospital with inpatient revenue per (case mix-adjusted)

Hospitals Right Above and Below An Arbitrary Top-30 Cutoff Could Be Treated Very Differently

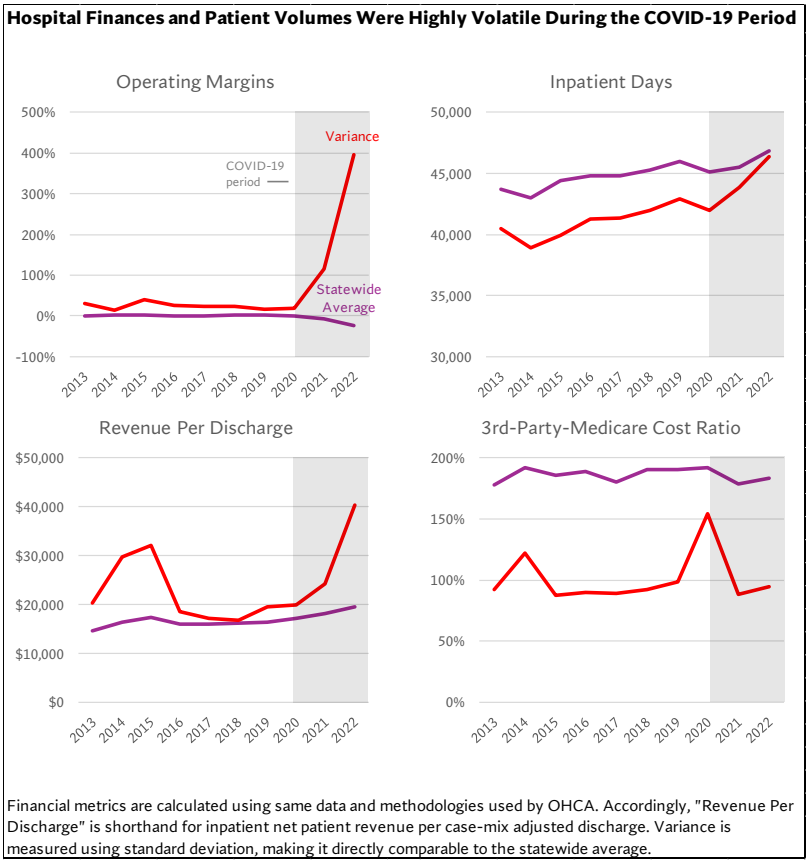
	30th-Ranked Hospital	31st-Ranked Hospital	Percent Difference
Net Patient Revenue Per Discharge	$26,580	$26,570	0.04%
Average Annual Growth	11.9%	11.8%	0.1%
Operating Margin	15.1%	15.0%	0.1%
3rd Party-to-Medicare Cost Ratio	299.5%	296.5%	3%

Source: CHA's analysis of hospital financial data for the years 2018-2022. Percent differences for the latter three variables are shown as percentage point differences since they are comparing percent-based measures.



discharges that is 0.04% higher than their next closest peer being subject to a radically different spending target. Moreover, identifying that hospital as having 0.04% higher revenue per discharge would depend heavily on measurement decisions and realities, such as the most recent year in which data are available and how many years are aggregated together to smooth the variation, rather than fundamental differences between the hospitals above and below the cutoff.

Including the COVID-19 Pandemic Years in Data for Identifying High-Cost Hospitals Introduces Serious Distortions. Between 2020 and 2022, the world experienced the worst pandemic in a century. California's hospitals stepped up, weathered unprecedented patient volume and workforce stability and safety challenges, and ultimately saved thousands of lives. The figure above shows the data on COVID-19 hospitalizations. At its two highest daily peaks in 2021 and 2022, nearly 23,000 and over 16,000 COVID-19 patients, respectively, were being treated in California's hospitals, reflecting at its worst roughly 60% of the daily census for statewide general acute beds. While routine services were canceled, sicker patients needing longer stays and more complex care overwhelmed hospitals' already stretched workforces. Costs went up enormously, while reimbursements became increasingly volatile and stagnant. Ultimately, as the figure to the right shows, these were anything but typical years for hospital operations and their finances. And yet, OHCA is seeking to potentially make sector target decisions based on these three highly irregular COVID-19 years. This would ultimately bias their measures and punish hospitals for factors far beyond their control.



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

Conclusion

Adopting one or more sector targets now, long before its statutory deadlines and before OHCA has performed its basic due diligence, would be wholly premature. It demonstrates partiality versus one segment of the health care field — the only segment OHCA has investigated in any depth. It comes at a time when Californians need more and better health care — investments in behavioral health, more access to primary care services, and a greater emphasis on equitable outcomes — and as hospitals

struggle just to stay afloat. Imminent federal attempts to defund California's already fragile health care delivery system could turn an already challenging situation into catastrophe for hospitals, their workers, and their patients. CHA opposes the creation of a hospital sector at this time.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
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Dr. Sandra Hernández
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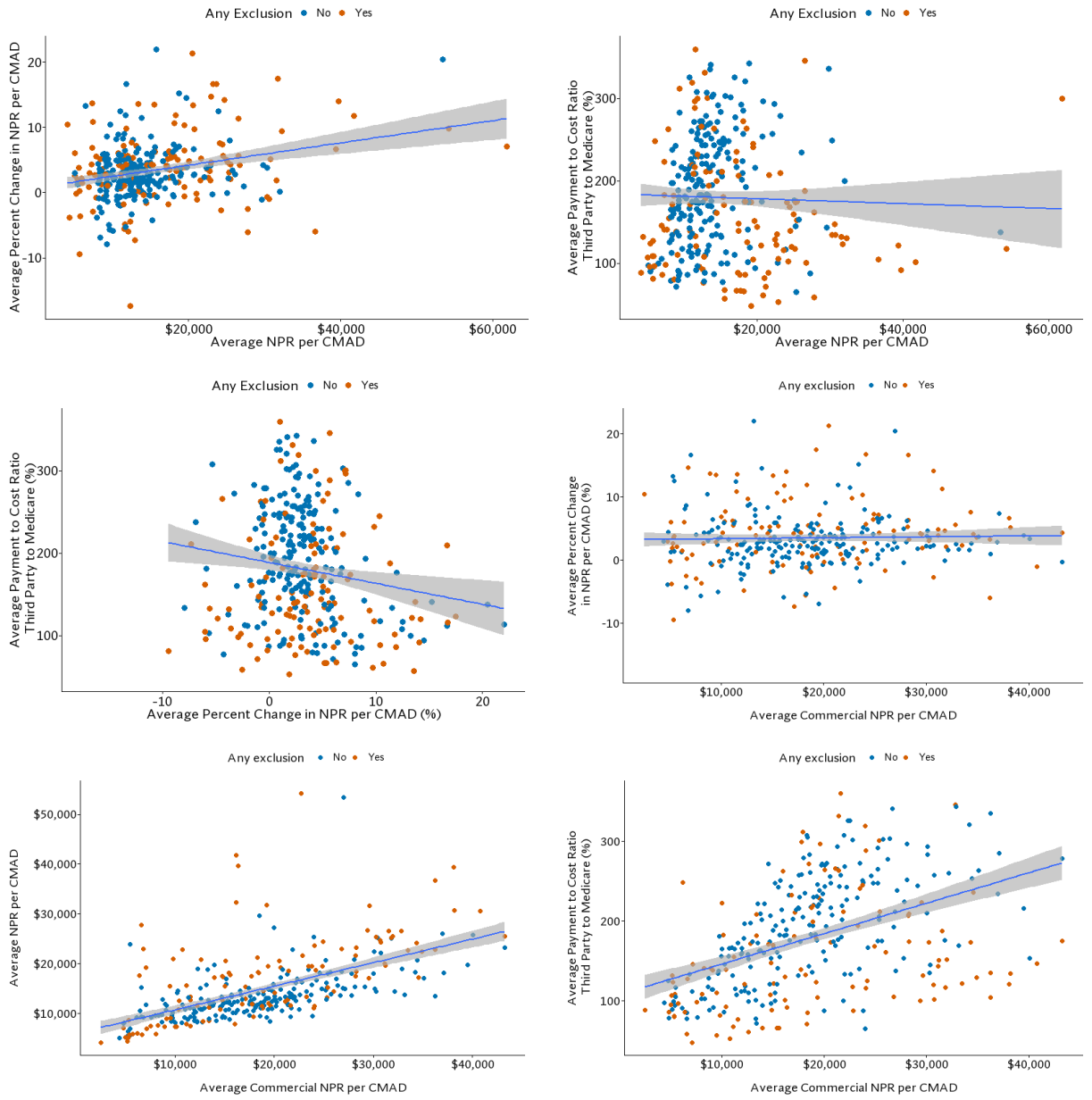
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency

Appendix Figure

Data Analysis Reveals Weak, Inconsistent, and Counterintuitive Relationships Among Measures Used by OHCA to Identify High-Cost Hospitals

CHA Analysis of Comparable Hospitals Using Same Methodologies, Data Sources, Time Period and Exclusions Used in OHCA's Dec. 18 board and Jan. 21 advisory committee presentations



Notes:

Exclusions include critical access, small, and children's hospitals, as well as psychiatric health facilities and hospitals with high average lengths of stay.

NPR: net patient revenue; CMAD: case mix-adjusted discharge.