California Hospital Association

March 20, 2025

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

Subject: **Hospitals Oppose Rash Sector Target Proposal**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

In February 2025, the Office of Health Care Affordability (OHCA) board reviewed the office's proposal to establish reduced spending targets on hospitals determined to be "high cost." As last month's conversation made clear, the proposal is rushed, based on questionable data and biased methodologies, and, if adopted, would recklessly endanger access to health care in communities across California. The California Hospital Association, on behalf of more than 400 hospitals and health systems, opposes the office's proposal and asks the board to defer any additional decisions on sector targets until myriad issues have been addressed and comprehensive consideration of sector targets is completed.

Hospital Sector Target Proposal Skips Essential Steps in the Policymaking Process

Patients Deserve a Comprehensive, Fully Considered Approach to Sector Targets. OHCA's enabling statute outlined a clear path of collaboration and learning under statewide spending growth targets, followed by careful and data-informed decisions on subdividing health care into sectors and exploring differentiated targets based on measured performance against the statewide target. With its proposal to establish unique hospital sector targets before many key steps have been completed, OHCA is choosing to diverge from the path articulated in state law. The result is a prejudicial targeting of a small set of hospitals with wholly unattainable limits on their revenue growth, without any consideration of the impacts these limits will have on these hospitals' patients and communities. Below are several of the steps OHCA is ignoring:

- **No Analysis of Comprehensive Health Care Spending Trends.** OHCA has collected, but not analyzed or reported, its comprehensive total health care expenditure (THCE) data — its principal data source on spending trends. A judicious approach would incorporate information on spending trends by service category from the THCE data into initial decisions on sectors.
- **No Consideration Given to Any Other Sector.** The lack of consideration given to the establishment of any other sector reveals a worrying partiality against the hospital field. At a minimum, OHCA could wait for the THCE data analysis to make more informed sector decisions. However, not having the THCE data is no defense, as other regulated health care entities have

reported financial data similar to hospitals' for many years — none of which has been even cursorily reviewed.

- **No Clarity on How Hospital Spending Growth Will Be Measured.** Because OHCA has not finalized a methodology for measuring hospital spending, neither hospitals nor the office itself know what the hospital sector targets mean for the affected organizations, workers, and patients.
- **No Assessment of the Reasonableness of the Statewide or Proposed Sector Targets.** Although state law affords OHCA time to assess performance against the statewide target before deciding on sector targets, OHCA's choice to move quickly disregards this key learning opportunity.

Singling Out Hospitals Strains OHCA's Impartiality and Credibility. Hospitals represent just one slice of the health care industry. Statewide, $2 out of every $3 dollars of health care spending goes to providers and payers other than hospitals. Moreover, half of California's hospitals are operating in the red and many more have margins lower than what is necessary to remain financially sustainable. And yet, OHCA is poised to adopt a hospital sector after giving no consideration to other potential sectors, prejudicially targeting a single set of providers for which data just happen to be available — despite the fact that similar data are available for other regulated entities. On top of destabilizing equitable access to high-quality hospital care, adoption of this proposal seriously challenges any appearance of impartiality on the office's part and ultimately undermines collaboration toward a shared vision of improved health care affordability.

Flawed Approach for Identifying High-Cost Hospitals Generates an Incoherent Set of Hospitals

OHCA proposes to designate hospitals as high cost if they fell in the top 15% on two financial measures for the majority of years between 2018 and 2022, following several important exclusions that together remove hospitals that accounted for nearly 20% of statewide discharges in 2022. The first measure reflects commercial inpatient reimbursement per case mix-adjusted discharge, while the second measure compares the degree to which a hospital's commercial payers reimburse its costs better than Medicare does. Both measures effectively punish hospitals for factors beyond their control, creating an arbitrary list of hospitals that happen to be high on just two of a variety of potential measures of hospitals' historical financial performance.

Commercial Reimbursement Measure Myopically Focuses on a Small Subset of Patients and Services and Ignores Geographic Differences. Shortfalls in reimbursement from government payers — Medicare and Medi-Cal — lead to hospitals' reliance on commercial payers to cover costs. By looking only at hospitals' commercial reimbursement, the measure fails to control for the fact that some hospitals have more financially favorable payer mixes than others, leading disadvantaged hospitals to needing more revenue per commercial patient to cover their costs. Unsurprisingly, hospitals at the top of this measure have disproportionately small commercial payer mixes.

Additionally, outpatient services comprise 40% of the services hospitals provide. Nevertheless, OHCA's measure ignores this entire category of services — which include emergency care, outpatient surgeries, and specialty drug infusions, among other services — punishing hospitals whose inpatient care cross-subsidizes losses on the outpatient services they provide. **Ultimately, by disregarding the 40% of hospital services provided in outpatient care, and the roughly 75% of inpatient care paid for by government programs, OHCA has chosen to rely on a measure that ignores nearly 90% of the care hospitals provide.**

Finally, the measure fails to account for regional cost differences. In essence, OHCA assumes that a hospital in the Bay Area, one of the highest cost areas in the whole country, should be paid no more than a hospital in the Inland Empire, where the cost of living is considerably lower.

Commercial-to-Medicare Payment-to-Cost Ratio Penalizes Hospitals with Worse Medicare Reimbursement. OHCA's second measure for identifying high-cost hospitals singles out those whose commercial payments cover their costs better than Medicare does. The foundational assumption is that Medicare hospital payment policies are sound and equitable. Unfortunately, this is not the case. Distortions and idiosyncrasies in Medicare payment policies significantly and variably reduce hospitals' Medicare reimbursement, often as a result of budget neutrality requirements that redistribute funding from some hospitals to others. Examples include:

- A floor on the area wage index to boost payments for rural hospitals
- Adjustments to the area wage index to revert the occupational mix of California's hospitals to the national average
- Caps on funding for graduate medical education
- Medicare disproportionate share hospital funding reductions
- Limits on payments for bad debt

The above distortions reduce Medicare payments for California hospitals by over $1.3 billion annually, but are **not** borne equitably by all hospitals. Rather, the 11 hospitals (4% of all impacted hospitals) identified by OHCA as high cost collectively bear nearly $300 million (21%) of the statewide losses from these distortions in Medicare payment policies. The effect is to artificially reduce their Medicare payment-to-cost ratio (the denominator in OHCA's measure), biasing their score on OHCA's commercial-to-Medicare payment-to-cost ratio upward.

In addition to the above distortions, Medicare payment policies allow critical access hospitals (rural hospitals that meet certain conditions, like being located at a minimum distance from another hospital and having 25 beds or fewer) to receive cost-based reimbursement, theoretically ensuring their Medicare payment-to-cost ratio is close to 1. Rural hospitals that just miss the conditions for being designated as critical access hospitals, or that elect not to be based on the needs of their communities, do not have access to equally favorable Medicare reimbursement. As a result, they regularly experience major losses on their Medicare patients, biasing their score on OHCA's measure upward, and through no fault of their own, making them all the more likely to find themselves on OHCA's high-cost list.

Data Anomalies Show More Analysis Is Needed Prior to the Adoption of the Sector Targets. In February, OHCA reviewed high-cost hospitals' scores on OHCA's two measures over the five-year period under review. This uncovered several anomalies. First, two hospitals' commercial inpatient reimbursement per case mix-adjusted discharge measures fell precipitously during the period under review, potentially reflecting commercial reimbursement rate cuts of roughly 25% and 50% respectively or, alternatively, the correction of previously faulty data. Another hospital saw its commercial-to-Medicare payment-to-cost ratio more than double in a one-year period resulting from its Medicare payment-to-cost ratio suddenly falling in a single year from roughly 0.6 to around 0.2. **OHCA must conduct further analysis and make appropriate changes to its proposal before finalizing actions that endanger the financial and operational futures of the affected hospitals.**

OHCA's Approach Yields an Incoherent Set of Hospitals. OHCA's list of hospitals contains one academic medical center, two Medicaid disproportionate share hospitals, six independent hospitals, nine

Northern California hospitals, and two rural hospitals. Two hospitals had an average daily patient census smaller than 13 in 2022, with a third seeing just 43 patients in inpatient beds on any given day. Although, by OHCA's design, the 11 hospitals have high commercial reimbursement, their average all-payer inpatient reimbursement per case mix-adjusted discharge is just around the 75th percentile, 10 percentage points lower than OHCA's chosen threshold for designating a hospital as high cost on its measures. In fact, one hospital's all-payer reimbursement was in the bottom 40% of all comparable hospitals statewide in 2022. Four hospitals lost money on their operations in 2022, with one recently reporting it has barely more than 14 days cash on hand to support its operations. Several hospitals report using their hospital margins to sustain professional services in their communities, due to the latter being reimbursed at a loss. Ultimately, these surprising attributes show that OHCA has fallen short of identifying a set of hospitals with unjustifiably high costs, and that significantly more work is needed before moving forward.

Proposed Sector Targets Would Decimate Hospital Care, Without Any Commensurate Benefit to Patients

Adoption of Sub-Inflationary Targets Would Endanger Access to Care and Violate OHCA's Multipronged Mission. OHCA has proposed sector targets of between 1.6% and 1.8% annually on hospitals designated as high cost. Such targets are as low as 35% below projected inflation for all goods and services, burdening affected hospitals with the task of sustaining patient care in the face of real cuts to their allowable revenue growth. Making matters worse, hospital costs are not currently growing at economy-wide inflation. According to Kaufman Hall, western states' hospital costs are currently growing at 6% for labor, 8% for supplies like personal protective equipment, and 10% for drugs. The proposed high-cost hospital sector targets are 70% to 80% lower than the recent cost growth for these essential inputs. Such targets would have to be met with draconian cuts to the affected hospitals' workforces and service lines, as well as abandonment of investments to expand access to high-quality care — unavoidable actions all in conflict with OHCA's statutory mandate to promote affordability while maintaining access to quality care.

Negative Impacts of Proposed Targets Would Not Be Nullified by Selective Enforcement on the Back End. OHCA staff have promised to practice discretion and not aggressively enforce the sector targets in circumstances where excess growth is beyond the hospital's control. Unfortunately, the uncertain possibility of being forgiven at a later date for excess spending growth is not sufficient to avoid the devastating consequences of the sector targets under discussion. First, the designated hospitals would face major reputational consequences, causing patients, including those on Medicare and Medi-Cal, to seek care elsewhere. Second, health insurance companies would immediately pressure hospitals to accept rate increases at the insufficient sector target level. There would be no good option for hospitals: Those that accept the insufficient rate increases would inevitably be forced to make real cuts in patient care. Those that cannot accept the offered rates would undoubtedly face contract terminations — as recently experienced in San Diego, where thousands of patients lost their usual source of care. Third and finally, the targets will chill investment aimed at improving access to high-quality care, as hospitals will have no assurance that the increased revenues funding these investments will not be taken away on the back end due to violation of the aggressive targets.

The Rash Adoption of Draconian Hospital Sector Targets Would Compound the Harms of Pending Federal Funding Cuts. Federal policymakers are currently considering proposals to drastically cut funding for vital health care programs. Particularly at risk is the Medicaid program and enhanced premium support for those with individual market coverage. California's health care programs are

especially vulnerable. Medi-Cal covers nearly 15 million Californians (more than a third of the state's population) and is sustained by $118 billion in federal funding. The cuts currently under consideration could remove tens of billions of dollars in federal funding from California's health care system, which the state could not backfill given its own precarious budget situation. This means cuts to coverage, benefits, and provider rates are on the horizon, with potential to turn a merely challenging financial environment, wherein more than half of California's hospitals already operate in the red, into a full-blown crisis. Compounding federal funding threats with unconscionably low sector targets would make it certain that hospital services would be cut, workers laid off, and access to care curtailed for millions of Californians. Making highly consequential decisions on sector spending targets prior to these potentially catastrophic federal actions would demonstrate a profound disregard for OHCA's statutory mission to sustain and promote access to high-quality, equitable care.

Conclusion

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

Sincerely,

Ben Johnson
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