The 2025 Hospital Landscape

California Hospital Association

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California Hospital Association

Goals of Presentation

1

Raise awareness of the hospital environment in California

2

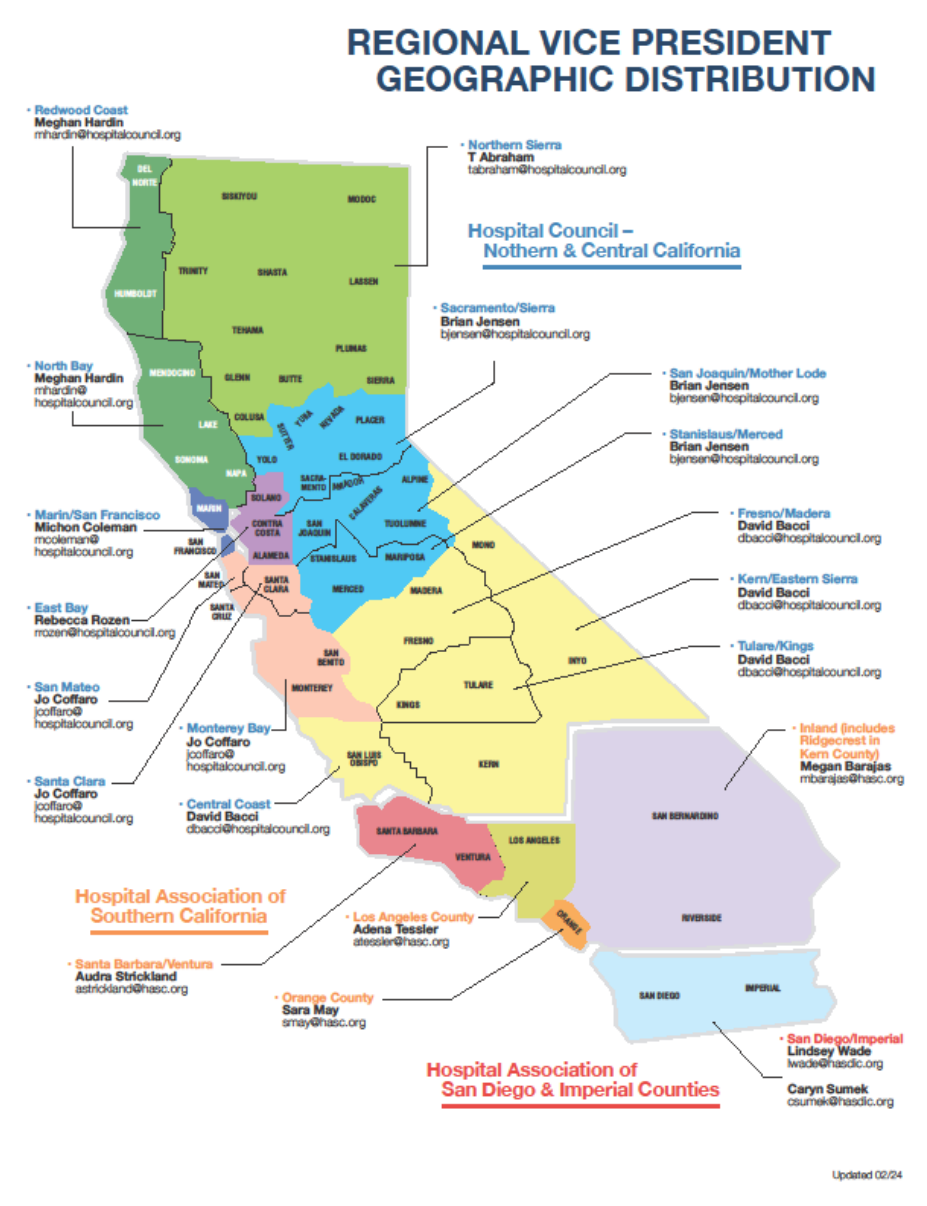
Advocate for the Board of Pharmacy to consider activation of a hospital pharmacy committee

3

Recommend the Board of Pharmacy bifurcate enforcement data in published reports i.e. The Script

- Top Corrections on Routine Pharmacy Inspections
- Top Violation Notices on Routine Pharmacy Inspections
- Quality Assurance reporting

California Hospital Association's Organization



4 Hospital Associations

CHA - California Hospital Association – Sacramento Statewide

HCNCC - Hospital Council of Northern and Central California

HASDIC - Hospital Association of San Diego and Imperial Counties

HASC - Hospital Association of Southern California

California Hospitals

439 hospitals in California

364 with Emergency Departments (EDs)

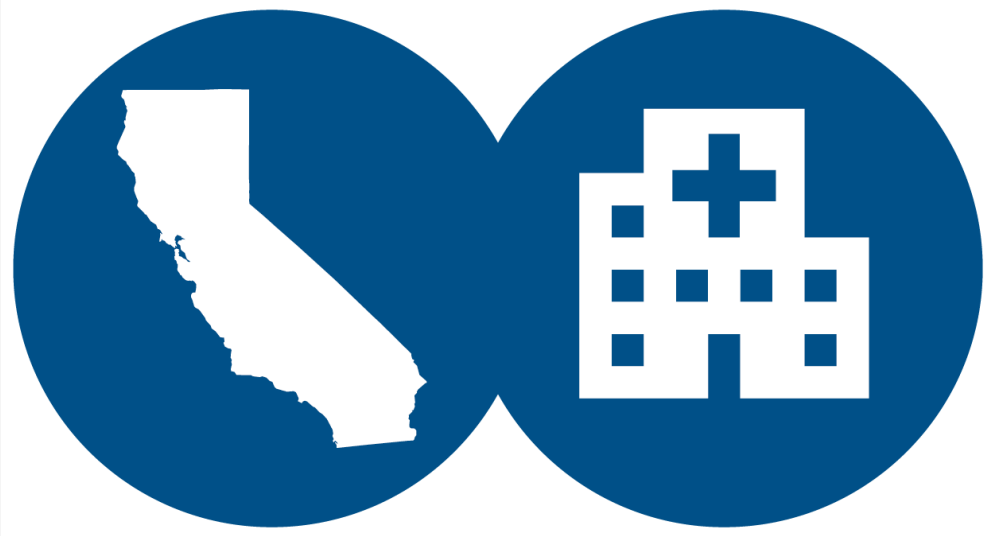
Employ over 500,000 workers – average wage $103,000 – wages grew 35% in the past 5 years

53% of hospitals are operating in the red – up from less then 30% pre-pandemic

Types of Hospitals

CALIFORNIA HOSPITAL ASSOCIATION

- **Over 450 hospitals and health systems**
- Types of Licensing Categories for Hospitals:
  - General Acute Care Hospitals (GACH)
  - Acute Psychiatric Hospitals (APH)
  - Chemical Dependency Recovery Hospitals (CDRH)
  - Specialty Hospitals – Heart, Orthopedic, Respiratory, etc.
  - State Hospitals
- Other Types of Hospitals
  - Inpatient Rehabilitation Hospitals
  - Long Term Acute Care Hospitals
  - Children's Hospitals
  - Rural Hospitals
- Federal Designations
  - Critical Access Hospitals
  - Teaching Hospitals



Types of Hospitals - Continued

Public Hospitals and Private Hospitals

Public Hospitals: County-operated or affiliated, UC hospitals, & VA Hospitals

District Hospitals: Also, public hospitals operated by a local jurisdiction/district

Private Hospitals: Investor owned or Not for Profit

Stand-Alone Hospitals and Health Systems

Stand-Alone Hospitals: Independent, not owned or operated by a health system

Health Systems: Organization that owns and operates a network of at least one or more health care facilities, like a hospital

Hospital Occupancy Overview

- Occupancy - Determines budget and staffing
    - Pre-pandemic 65%
    - Post-pandemic 90%
- Shift in occupancy
- Post-pandemic inpatients with a behavioral health diagnosis grew by 26% with chemical dependency nearly tripling – 192% increase
- Much longer lengths of stay

What's Impacting Bed Occupancy

Acuity of Patients

Delayed care during pandemic

Aging population

Access to preventative care

Delayed Discharges

Care Coordination accountability

ED Boarders – days, weeks, months

Lack of community settings – months, years

Emergency Department's Overcrowding Crisis

- **14.9 million** visits to the emergency room annually - up 25% - 11.9 million from 2020-2023
- **48% of ED** patients sought care for conditions of low or moderate complexity
- Average length of stay increased by 10% since 2019
- **538,000** patients are seen in the ER annually with behavioral health conditions

Hospital Regulating Entities

- Hospitals are regulated by multiple state departments and boards:
  - California Health and Human Services Agency (CalHHS)
    - California Department of Public Health (CDPH)
    - Department of Health Care Access and Information (HCA)
    - Department of Health Care Services (DHCS)
    - Department of Managed Health Care (DMHC)
    - Department of Insurance (DOI)
  - Business, Consumer Services & Housing Agencies (BCSH)
    - Department of Consumer Affairs (DCA)
    - Board of Pharmacy (BoP)
    - Board of Registered Nursing (BRN)
    - Medical Board of California (MBC)
  - Labor & Workforce Development Agency (LWDA)
    - Department of Industrial Relations (DIR)
    - Division of Occupation Safety and Health (Cal/OSHA)
    - Division of Workers' Compensation (DWC)

Federal Hospital Regulating Entities

- Hospitals are also regulated by federal agencies, mainly:
  - Centers for Medicare and Medicaid Services (CMS)
    - Every health care facility must be certified by CMS to care for Medicare and Medicaid patients.
  - The Drug Enforcement Administration (DEA)
  - U.S. Food and Drug Administration (FDA)
  - Accreditation Organizations – the Centers for Medicare and Medicaid Services (CMS) gives deeming authority to Joint Commission, Healthcare Facilities Accreditation Program (HFAP) and Det Norske Veritas Healthcare, Inc. (DNV) for hospitals; gives deeming authority to NCQA for Medicare Advantage health plans

Hospital Funding and Finance

The cost of care has outpaced revenues

- **31% growth in expenses**
- **27% growth in revenue**

Medi-Cal - Does not cover cost - Medi-Cal pays just 80 cents on the dollar it costs to care for patients

Medicare - Does not cover cost

Commercial Insurance - The only major payer that covers cost of care.

Other - Self–pay, TriCare, counties

Every day over half (53%) of California's hospitals lose money.

An unsustainable reimbursement structure to support a health care system responsible for 40 million people

Affordability

LABOR COSTS

Over the past five years, wages and salary expenses have increased by more than 34%, with contract labor expenses increasing 111%

POOR REIMBURSEMENT

California pays less than the cost to care for Medi-Cal patients in hospitals

NEW STATE MANDATES

New growth limits established by the Office of Health Care Affordability will restrict reimbursement for hospital care, while new minimum wage standards will increase costs

HIGHER ACUITY AND PLACEMENT CHALLENGES

Patients are arriving at hospitals sicker. This, coupled with insufficient post-acute resources, has led to increased costs and stays that are 11% longer than five years ago

By the numbers: The nation's health expenditures reached $4.9 trillion overall in 2023, a 7.5% increase from 2022. The spike in hospital spending stems mostly from Americans' increased use of hospital services and higher-intensity care, said Anne Martin, an economist with the Office of the Actuary at CMS.

Office of Health Care Affordability (OHCA)

- The Office of Health Care Affordability's Mission and Purpose

  In 2022, the California Health Care Quality and Affordability Act 1 (SB 184, Chapter 47, Statutes of 2022) established the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI). Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, OHCA's enabling statute emphasizes that it is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal.
- **Slow Spending Growth**
- **Promote High Value**
- **Assess Market Consolidation**

Throughout 2024, the Board considered sector definition and sector target setting options including geographic regions, provider category, payer and/or provider by market category, and individual health care entities.

OHCA cont'd

- The Health Care Affordability Board is a decision-making body charged with setting statewide and **sector-specific health care spending targets**, appointing a Health Care Affordability Advisory Committee, and approving key benchmarks. California Health and Human Services Agency (CalHHS) Secretary Kim Johnson is the board's chairperson.
- The Board chose to focus on hospitals and defined them as a "sector" because they account for 1/3rd of health care spending .
- The Board approved a statewide health care spending target starting at 3.5 percent for 2025 and 2026, then lowering to 3.2 percent for 2027 and 2028 and reaching 3 percent for 2029
- OHCA recommended selecting disproportionately high-cost hospitals that merit a lower target value. This approach identified 11 hospitals (4 currently operating in the **RED**) as disproportionately high-cost hospitals compared to other hospitals in the state. Target values for high-cost hospitals would start at 1.8 percent in performance year 2026 and lower to 1.6 percent in performance year 2029.
- Spending Targets = What a hospital gets paid.
- Will incentivize payers to negotiate lower reimbursement
- Hospitals will have to reduce expenses and service lines resulting in layoffs and diminished access to care.

OHCA cont.

Making health care more affordable — a priority for California hospitals — is a shared responsibility. To make a difference in the cost of care, the entire health care system — insurance companies, drug manufacturers, medical device suppliers, labor unions, governmental agencies, and others — must work together.

- Nearly two-thirds — 63% — of statewide health care spending occurs outside of hospitals; decisions around **how** and **where** to treat a patient are made by independent medical professionals and doctors- not hospitals.

- California hospitals have been working for decades to slow the rate of growth in health care spending and lower costs for patients.

- Affordable health care is a shared responsibility of the ENTIRE health care system.

OHCA cont.

Hospitals and other providers face significant headwinds. When assessing progress toward the state's affordability goals, the Office of Health Care Affordability (OHCA) has not taken into account:

- California's 65 and older population is projected to increase by 42% — and older patients' health care costs are three to five times higher than that of younger Californians.
- New lifesaving drugs and medical technologies bring hope to Californians with complex diseases or injuries but come at a high cost — sometimes millions of dollars.
- State mandates, like seismic standards and health care worker minimum wage, add billions of dollars in costs for health care providers and often come with no funding. Nearly 55% of hospitals' spending goes directly to employees — and California nurses, for example, are the highest paid nationally.

OHCA cont.

To improve health care affordability while protecting health care access and improving equity, OHCA must work with hospitals and other providers to advance meaningful change.

- Reform at this scale must reflect the differences between “good” spending — such as needed investments in behavioral health and primary care — and spending that unnecessarily adds to costs, such as high pharmaceutical costs and insurer-driven discharge delays.
- Health care providers must be able to invest in programs that make their communities healthier, so patients can be treated **before** their conditions become serious and more expensive.
- OHCA must ensure that any savings generated through its work are passed on to consumers in the form of reduced premiums and out-of-pocket expenses, rather than greater profits for insurance companies (profit for the six largest national health insurers was $47 billion in 2023).

OCHA cont.

OHCA **has no** jurisdiction over pharmaceutical companies, manufactures, wholesalers or retail pharmacies.

OHCA **has** jurisdiction over hospitals and their pharmacy operations.

Hospitals, the California Legislature and HCAI are working diligently to lower health care costs. Every additional requirement a hospital must fulfill raises costs, which runs counter to this shared goal. These considerations must be balanced when creating new laws and regulations.

Any proposed new laws or regulations impacting hospital expenditures , including unfunded mandates will be critically analyzed.

CHA and the hospitals community is invested in protecting access not diminishing access because **patients deserve affordable health care that doesn't sacrifice quality, equity, or access.**

Top 10 Things To Know About California Hospitals

California Hospital Association

- California is **4th** in the nation for life expectancy.
- California has the **lowest maternal mortality rate** in the country.
- California hospitals treated nearly **3.7 million** Medi-Cal patients in 2022.
- People visited hospital emergency departments **14 million** times.
- Hospitals employ close to **520,000 workers** and generate over **$345 billion** in economic activity.
- There were over **400,000 births** in California hospitals in 2022.
- Wages for hospital workers have **grown 28%** in the past five years.
- Hospitals with EDs must provide a medical screening evaluation to any patient requesting.
- California hospitals train over **11,000 doctors** a year.
- **1 in 4** Californians receives care at a hospital.

Pharmacy Distinct Roles in Care Delivery

Hospital Pharmacy

Integrated into inpatient clinical care

Manages sterile compounding, IVs, high-risk medications

Involved in direct patient interventions

Retail Pharmacy

Dispenses outpatient medications

Limited clinical context

Less access to full patient history

Pharmacy Distinct Roles in Care Delivery - continued

Medical safety depends on setting appropriate standards

Hospital and retail pharmacies operate in fundamentally different ways

Board of Pharmacy must clearly differentiate rules between and amongst settings

Enforcement & Accountability

Accountability should align with scope and practice setting

Enforcement must recognize different safety thresholds and workflows

Oversight with tailored law, regulations, and guidance for each setting

Pharmacists Practicing Within Hospital/Health System Pharmacies

Collaborate with interdisciplinary teams to ensure safe and effective use of medications

Work within the electronic medical record to optimize and monitor all medication therapies

Serve as a vital member within the emergency response team to provide medication recommendations and support during hospital emergency codes

Therapeutics Decision Making – Uses evidence-based medication guidelines and develops order sets

Clinical Decision Support – Formulary & utilization management,

Direct Patient Care – Medication history, clinical evaluation of admission reason(s) and demographics, pharmacy dosing and therapy management, therapy monitoring, discharge medication evaluation

Pharmacy Medication Operations – Procurement, storage, dispensing, compounding, distribution

Oversight Challenges Without Differentiation

- Applying "one-size-fits-all" rules causes gaps
- Risk of over/under-regulating retail or hospital pharmacy practice
- Lack of clarity leads to inconsistent compliance/enforcement
- Inhibits innovation in both settings

Board of Pharmacy's Role

- Need for Structural Separation – Hospital vs. Retail

  - Set clear, separate standards for hospital vs. retail pharmacies
  - Encourage compliance through setting-specific guidance
  - Involve hospital clinical pharmacists in hospital policy development
  - Inspection protocols and report must match setting
  - Current ambiguity creates legal and operational risk

Proposed Recommendations

Create separate regulatory tracks

Develop setting-specific training

Appoint hospital pharmacy experts to board committees

Conclusion

Hospital and retail pharmacies both safeguard public health

Regulations must reflect operational and risk differences

The Board of Pharmacy must lead with clear, enforceable, differentiated guidance, regulations, and laws

Align rules with risk, scope, and setting

Call to Action

Advocate for the Board of Pharmacy to consider activation of a hospital pharmacy committee to the Board.

Recommend the Board of Pharmacy bifurcate enforcement data in published reports i.e. The Script

Top Corrections on Routine Pharmacy Inspections

Top Violation Notices on Routine Pharmacy Inspections

Quality Assurance reporting

Thank You

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