Department of Health Care Access and Information
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Sacramento, CA 95833
hcai.ca.gov

Health Care Affordability Board
January 2026
Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox.

Date	Name	Written Comment
1/26/2026	Unite HERE Health	**See Attachment #1**
1/27/2026	Salinas Valley Health	**See Attachment #2**
2/17/2026	Jamie Peatrowsky	I'm a California physician assistant writing in support of healthcare affordability reforms that include executive compensation accountability. While hospitals remain understaffed and patients face rising costs, many nonprofit systems pay executives millions annually. I urge OHCA to require transparency on executive pay alongside staffing ratios and patient-care investment, and to consider tying funding eligibility to workforce stability and safe staffing. True affordability must prioritize patients and frontline providers. Thank you
3/2/2026	Dr. Michael Weiss	**See Attachment #3** Good afternoon. My name is Dr. Michael Weiss, and I am a pediatrician and the VP of Population Health for Rady Children's Health, Orange County (formerly Children's Hospital of Orange County). I represent a 140,000 life all-pediatric Medi-Cal IPA under global risk with our COHS, CalOptima. We have implemented a high-risk model of care and published outcomes in Clinical Pediatrics (attached) demonstrating a 3:1 ROI by mitigating inpatient and ED costs with a care team approach. In addition, I would like to address the opportunities to enhance advanced primary care models as these serve as a promising way to reduce waste and enhance quality. For full disclosure, I am a member of the OHCA Advisory Board.
3/16/2026	Washington Health	**See Attachment #4**

Date	Name	Written Comment
3/19/2026	California Hospital Association	**See Attachment #5**
3/19/2026	Health Access California	**See Attachment #6**
3/20/2026	Justin Truong	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.
3/20/2026	John Rand	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially.
3/20/2026	Joe Leblanc	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. We run our own outdoor early childhood program and we have seen our health insurance sky rocket even with Covered California. The amount we pay is absurd as compared to our wages and we are very healthy people. Something has to change or only the wealthy will be able to afford care
3/20/2026	Susan Lea	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. As an older American living on SSA, the SSA takes $200/month from my SSA to pay for health insurance, but it is all meaningless as I cannot afford to go to the doctor or obtain the health care I actually need. Instead, I am forced to live in my car and eat next to nothing. Yes, it's great to be thin.
3/20/2026	Assemblymember Liz Ortega	**See Attachment #7**
3/20/2026	Assemblymember Alex Lee	**See Attachment #8**
3/20/2026	Kristen Beck	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care.

Date	Name	Written Comment
		Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can’t wait, we need the Board to enforce cost-growth targets with real penalties!
3/20/2026	AJ Cho	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can’t wait, we need the Board to enforce cost-growth targets with real penalties!

UNITE HERE HEALTH

January 26, 2026

Kim Johnson, Chair Health Care Affordability Board
Elizabeth Landsberg, Director Department of Health Care Access and Information
Vishaal Pegany, Deputy Director Office of Health Care Affordability Department of Health Care Access and Information

By email ohca@hcai.ca.gov

Re: Further evidence of lack of competition in Monterey County

Dear Ms. Johnson, Ms. Landsberg and Mr. Pegany:

This past November, the Office of Health Care Affordability published *An Investigative Study of Hospital Market Competition in Monterey County*, which concluded that a lack of competition is driving high hospital prices in the region. This letter provides additional information about the lack of competition in the markets for primary and urgent care—the entry points into the healthcare system that often lead to hospital-based care.

Our claims data show that 77% of our members' primary and urgent care visits, and 84% of total spending for this care, go to providers connected to hospital systems in Monterey County. In addition, providers in Montage Medical Group, MOGO, and Salinas Valley Medical Clinic are reimbursed at significantly higher rates than providers that are not part of hospital systems.

UHH covers approximately 1,100 workers and their dependents in Monterey County, a total of just over 2,200 covered lives. We sought to understand how likely our members are to receive care from higher-cost providers affiliated with the county's three hospital systems—and therefore how likely they are to be referred to those hospitals for expensive treatments and procedures.

To conduct this analysis, we reviewed claims for office and urgent care visits in Monterey County from January 1, 2024 through December 31, 2025, with claims paid through January 2, 2026. We focused on providers with more than 50 claims during this period and excluded specialists and pediatric practices. Urgent care was included because the two dominant chains, MOGO and Doctors on Duty, function as primary care providers and are frequently used by members when access to other primary care providers is limited.

The charts below show that almost 8 out of 10 visits were to a provider connected to a hospital system. Since these providers are paid higher than the market, they received 84% of the claims spend.

Billing Provider TIN	Billing Provider Office Name	Total Visits	Total Member Copay	Total Allowed	% Medicare
	Montage Providers				
264826604	Montage Medical Group	1,292	$26,588	$195,300	119%
832329260	MOGO Urgent Care	600	$16,515	$136,349	228%
471388816	Carlos Ramirez MD	435	$8,545	$47,329	81%
	Montage Subtotal	2,327	$51,648	$378,979	
	Salinas Valley Health Providers				
352401992	Salinas Valley Medical Clinic	865	$17,815	$131,862	130%
770439213	Doctors on Duty Medical Group	490	$9,995	$61,879	107%
208208956	Rolando Cabrera MD	247	$6,032	$21,687	81%
	Salinas Valley Health Subtotal	1,602	$33,842	$215,428	
	Natividad Providers				
844677834	Eloy Romero MD	51	$1,580	$5,084	79%
946000524	County of Monterey	352	$7,025	$28,218	73%
	Natividad Subtotal	403	$8,605	$33,302	
	Providers not part of Hospital Systems				
770360380	Santa Lucia Medical Group	735	$10,400	$73,123	84%
264268934	Ken Hashimoto MD	164	$3,105	$16,133	81%
942652757	Clinica de Salud del Valle de Salinas	115	$2,250	$10,843	79%
462691389	Athena Medical Group	110	$2,070	$9,793	80%
770483091	Acacia Family Medical Group	67	$1,395	$6,064	82%
941583439	Planned Parenthood	68	$1,215	$5,002	71%
	Providers not part of Hospital Systems Subtotal	1,259	$20,435	$120,957	
	TOTAL	5,591	$114,530	$748,666	

	Visits		Allowed	
	Number	**% of Total**	**Amount**	**% of Total**
Montage	2,327	42%	$378,979	51%
Salinas Valley Health	1,602	29%	$215,428	29%
Natividad	403	7%	$33,302	4%
Subtotal Providers part of Hospital Systems	**4,332**	**77%**	**$627,709**	**84%**
Subtotal Providers not part of Hospital Systems	1,259	23%	$120,957	16%
Total	5,591		$748,666	

In an effort to steer our members toward independent practices, we entered into an agreement with Santa Lucia Medical Group in Salinas in April 2025 to provide enhanced access. To encourage utilization, we eliminated copays for services at Santa Lucia and have continued to promote the practice as a high-quality, cost-effective option for care. However, due to the dominance of Montage Medical Group, we were unable to identify an independent primary care practice with sufficient capacity on the Monterey Peninsula, where the majority of our members reside. As a result, 42% of our members—and 60% of our primary care claims spending—continue to flow to the Montage system.

As noted in the OHCA report, "a significant portion of the physician workforce [in Monterey County] is either directly employed by or closely affiliated with one of the large hospital-owned medical groups…. While some independent physician practices exist in the area, all large medical groups are owned by a health system." Our data shows how little choice our members have if they want to avoid going to a provider that is connected to a hospital system.

The OHCA report also notes that "a growing body of literature shows that when health systems acquire medical groups, prices for the same services tend to increase significantly without measurable improvements in the quality of care or patient outcomes. Instead, the higher costs are due to the increased market power of the health system when negotiating with commercial insurers." Our data also shows that the costs are higher at practices connected to hospitals. This means that our members pay twice – once at the doctor's office and then again in their paychecks when there is less money left for wage increases after healthcare costs are paid.

We thank you for your continued attention to the experience of Monterey County residents in a healthcare market dominated by overpriced hospital systems.

Sincerely,

Ivana Krajcinovic
Vice President of Healthcare Delivery

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Salinas Valley HEALTH

January 27, 2026

VIA EMAIL
Members of the Office of Health Care Affordability Board
2020 W. El Camino Avenue
Sacramento, CA 95833

Dear OHCA Leadership,

We noted with interest the upcoming informational presentation to the Office of Health Care Affordability titled "Cost-Reducing Strategies: Los Angeles General Medical Center Safer@Home Program," which immediately precedes discussion of hospital sector target adjustment methodologies.

Salinas Valley Health (SVH) adopted the Safer@Home program methodology and has used it effectively to reduce hospital admissions. The SVH program, which we have discussed with leadership at Los Angeles General Medical Center, is known as Healing@Home. Attached are the results of our program to date with a focus on initial admission prevention, subsequent hospital encounters, and patient satisfaction.

Despite this demonstrated impact, our Healing@Home initiative—along with many other actions taken by SVH to move care out of the hospital setting, including low-cost clinics, free Mobile Clinic services, reduced professional fees, outpatient imaging, and an ambulatory surgery center partnership—has been disregarded in OHCA's cost analyses. These programs are not included in the data used by OHCA and were excluded from its commissioned review of Monterey County.

While the program succeeds in avoiding inpatient admissions, it does so at a measurable financial cost to our system, principally through additional staffing, and with a reduction in commercial reimbursement.

The decision to highlight the Safer@Home program during the January meeting implicitly acknowledges that multiple approaches exist to reduce health care costs. Nevertheless, OHCA continues to evaluate affordability exclusively through the lens of commercial pricing while failing to account for the full range of system expenses, initiatives, and financial trade-offs borne by community health care systems.

Like OHCA, SVH is committed to providing affordable health care to our community. We are concerned that without a collaborative and holistic approach, these policies will result in a significant reduction in critical access and essential services.

Sincerely,

Allen Radner, MD
President/Chief Executive Officer
Salinas Valley Health

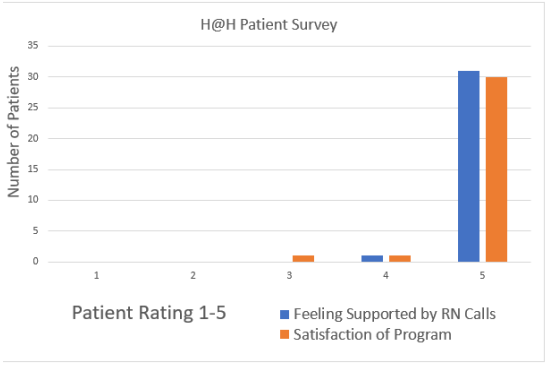
cc: Members of the Health Care Affordability Board:
David Carlisle, MD, PhD
Sandra Hernandez, MD
Richard Kronick, PhD
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Richard Pan, MD, MPH
Elizabeth Landsberg, Director of Department of Healthcare Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom

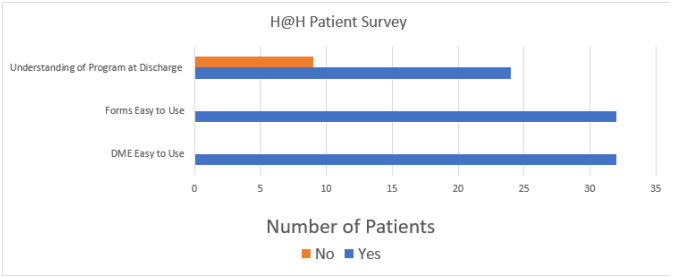
ATTACHMENT

Healing at Home Overview
Salinas Valley Health Medical Center

YTD as of Jan 17

	FY26 YTD Actuals Cellulitis	FY26 YTD Actuals UTI	FY26 YTD Actuals TOTAL
- Blue Cross Anthem	1	2	3
- Blue Shield HMO/PPO	4	4	8
- Blue Shield HMO TRIO		3	3
- Blue Shield MCSIG NONSELECT		1	1
- Blue Shield MCSIG SELECT		-	-
- Other HMO/ PPO Commercial	2	3	5
Total Commercial	7	13	20
- PRIVATE PAY	1		1
- SVMH Employees		1	1
- Other	1	1	2
Total Other	2	2	4
Total on Program for Jan 11 - Jan 17	29	51	80
- Returns to ER and DC back on program		4	4
- Return to ER and Admitted	3	2	5
Inpatient Discharge	1		1





1. After leaving the ED, did you leave having a good understanding of the program and the process? Y/N
2. On a Scale 1-5 (5 feeling very supported and 1 not feeling supported at all) how supported did you feel with the daily calls provided by the nurse?
   a. Can we ask why you rated it below 3?
3. Were the forms and tracking log easy to understand? Y/N
4. Were the supplies you were sent home with easy to use? Y/N
5. Overall on a scale 1-5 (5 being very pleased, 1 being not pleased) How pleased were you with your overall experience?

Original Article

Clinical Pediatrics
1–8

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SAGE

Effective Care Management for Children With Special Health Care Needs in the Era of Value-Based Payment

Michael A. Weiss, DO[1], Sara Marchese, MD[1], and Lishi Zhang, MS[2]

Abstract

Objectives. To evaluate the impact of a pediatric-specific care coordination program for Medicaid children with special health care needs under a fully capitated payment model and assess whether sufficient savings can be achieved to offset the cost of the care coordination program. *Methods*. 442 children with special health care needs, receiving health care under a Medicaid capitation payment program, were enrolled in a care coordination program. ED and inpatient utilization were measured for 1-year pre and post intervention. Use rates and costs for ED and inpatient services were evaluated using a Poisson random effect regression model. *Results*. There was a statistically significant reduction in ED utilization (31% reduction, $P < .0001$), inpatient admissions (38% reduction, $P = .0002$), and inpatient length of stay (34% reduction, $P = .0112$) comparing the pre and post intervention periods. Medical cost savings attributed to the reduction in ED and inpatient utilization was approximately 3 times the program costs. *Conclusions*. Enrolling children with special health care needs in a care management program was associated with a significant reduction in ED utilization, inpatient admissions, and hospital length of stay when compared with baseline expenditures. Under a fully capitated Medicaid model, the cost savings greatly exceeded the costs of the interventions. These results serve to highlight the efficacy of pediatric-specific care management programs for children with special health care needs, both clinically and economically. Such models can inform other interventions and contracting strategies to assure children receive the care they deserve in a sustainable cost model.

Keywords

pediatric care coordination, value-based payment, children with special health care needs, accountable care organizations

Introduction

In the evolving environment of accountable care and value-based payments, the importance of effective care coordination for children with special health care needs has escalated. As medical groups, hospital systems, and individual providers assume increasing levels of risk for the clinical and financial outcomes of their respective population of patients, the ability to effectively and efficiently coordinate evidence-based, high-quality care has become essential.

Under the traditional fee-for-service model, there are few incentives for care coordination programs that focus on reducing emergency department (ED) or inpatient utilization. In the fee-for-service environment, reductions in inpatient and ED utilization resulting from hospital or provider group investment in care coordination programs does not benefit the hospital or provider group who is investing in the program, but instead, it benefits the payor or managed care organization.

Alternative payment models (APMs) represent an emerging trend in which providers take different levels of "risk." APMs have been promoted under Federal policy including the Medicare Quality Payment Program, which is focused on transitioning physicians from traditional fee-for-service payment modalities toward

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population-based payment or APMs such as capitation. Hospital-based payment models, like Diagnostic Related Groups and Bundled Payments, mandate the need to proactively coordinate care and care transitions.

These payment arrangements may range from incremental payments for quality outcomes, to bundled payments for an episode of care or full risk capitation where a provider group cares for a population of patients for a fixed monthly fee. In the capitation model, the provider network retains any savings incurred but also carries the risk if the expenses exceed the monthly capitation. Under capitation, the investments in care coordination, if they result in higher quality and lower costs, provide an economic incentive to the provider group. However, little is known about the impact of these programs for pediatric patients in ED and inpatient utilization, and whether savings under a capitated model are sufficient to justify the incremental investment in care coordination.

Our hypothesis is that care management, for the appropriate population, can lead to high-quality, lower cost care in the pediatric population and that the cost of the care coordination program can be offset by the reduction in unnecessary hospital and ED utilization. The model represented here is an advanced phase of value-based payment (Medicare Category 4b—Population-based Payment), where the financial risk is borne by the medical group, hospital, and physicians. Intensive and standardized care management processes are necessary for a program to be clinically and financially successful in this payment paradigm. To support others considering developing such a model, we specifically outline staffing ratios and duties as well as the calculation of the costs and benefits of the program.

The literature is replete with examples of adult care management programs that demonstrate improved clinical and financial outcomes. Bodenheimer et al specifically focused on care coordination as one of the "10 Building Blocks of High-Performing Primary Care."[1,2] The pediatric literature is less complete and focuses primarily on care coordination at the primary care practice level.

Pordes et al[3] examined pediatric-specific care coordination models and identified 3 approaches that lead to positive clinical outcomes: (1) primary care-centric, (2) co-management-centered, and (3) episode-based. Early reviews of pediatric-specific Accountable Care Organizations (ACOs) specifically emphasize the ability to "coordinate and oversee the clinical provision of care across the continuum of health care services" as a foundational success factor.[4] Karpook and colleagues[5] identify complex care coordination as a "key component to successfully caring for children with complex medical needs. In a Commonwealth Fund White Paper from 2009, Antonelli et al[6] describe care coordination as a "critical component of the pediatric health system."

The American Academy of Pediatrics (AAP) has endorsed the need for effective pediatric-specific care coordination in multiple publications and policy statements. Specifically, the AAP states: "The pediatric community's vast experience with care coordination (is) a critical success factor for pediatric ACOs." Additionally, care coordination has been described as "an essential element of a transformed health care delivery system that encompasses optimal quality and cost outcomes."[7-9]

Multiple authors have pointed to optimal pediatric care coordination as a means to achieving the Institute for Healthcare Improvements' "Triple Aim" of improved health, improved patient experience, and lower costs. Cady et al specifically recognized pediatric care coordination as "an effective IHI Triple Aim strategy."[10] Cooley et al[11] identified care coordination as a key component of an overall strategy to reduce unnecessary hospital admissions. Coller and colleagues[12] recognized that "patients receiving home visits, care coordination, chronic care management, and cross-continuum care had fewer preventable hospitalizations."

Additional work has been done attempting to assess the cost-to-benefit ratio of care coordination and the potential savings as a result of this investment. Wong et al[13] cite the challenge with this calculation: "Children's health care benefits may take years to decades to realize a financial or health effect . . . thus the goal of identifying short- and medium-term effects that are associated with improved health over the long term." Mosquera and colleagues[14] confirmed a "comprehensive care" approach, with care coordination, reduced serious illness, and medical costs in high-risk children." The AAP Policy, "Principles of Child Healthcare Financing" also speaks to "provision of specific medical home functions such as case management, care coordination, etc."[15] Antonelli and associates were able to quantify the amount of time and the associated cost of care coordination in the primary care office setting.[16,17]

Demonstrating the clinical and financial success of care management programs is a foundational benchmark for pediatric value-based payment models. Few programs have demonstrated tangible quality and fiscal improvement in the pediatric population. We present one example of such a program.

Methods

Patient Cohort

The pediatric population represented in this study resides in Orange County, CA, where the overall rate of

uninsured children is 3.4%, slightly lower than the national average of 4.8%. A disproportionate number of Hispanic children (4.3%) are uninsured compared with Caucasian (2.6%), Asian (3.0%), and African American (1.5%) youth. Additionally, an estimated 10.8% of Orange County's children do not have a usual source of care to access when they are sick or need health advice. Nineteen percent of Orange County youth participate in food subsidies.[18] There are nearly 730 000 children, 0 to 18 years of age, in Orange County, CA, with over 300 000, or 41%, covered by the single-payer, Medicaid County Operated Healthcare System (COHS).

Payment Model

Children's Hospital of Orange County (CHOC), in partnership with the CHOC Physician's Network (CPN) Independent Practice Association, represents over 800 primary care and specialty care physicians. CPN participates in a global capitation (professional and facility fees) population-based payment program where the COHS pays a fixed per member-per month (pmpm) fee to the physician-hospital consortium to provide inpatient and ambulatory, primary, and specialty care for 150 000 Medicaid children enrolled in the CHOC network. Within this population of 150 000 children in the CHOC network exists a higher risk cohort defined as "Seniors and Persons with Disabilities." We do not care for adult patients and they are not included in this study. These children are identified by certain clinical conditions, including, but not limited to, autistic spectrum disorders, congenital syndromes, neurodevelopmental delay, cerebral palsy, mental health conditions, hematology-oncology conditions, prematurity, and complex cardiac disease (Table 1). These 4514 eligible children categorized as high risk, were stratified by the COHS to determine the order of completion of the health risk assessment (HRA). The 442 subjects in our study were the first to complete the HRA.

The COHS currently pays a pmpm care coordination fee to the physician-hospital consortium to offset some of the care coordination resource requirements.

Care Coordination Program Description

Patients are identified as eligible participants in the program based on select high-risk diagnoses (Table 1). The patient/guardian is initially contacted by a representative from the COHS, telephonically, to complete a validated, pediatric-specific HRA. Three telephonic attempts are made to complete the assessment and then, if unsuccessful, a HRA is mailed to the home of the patient. Once completed, this self-reported HRA is sent to our Health Network and we assign a Patient Care Coordinator (PCC) to the family. Each PCC is responsible for 600 families. The PCC obtains the patient's medical records from their providers and confirms the most recent well care visit and immunizations history. The PCC also contacts the patient/family telephonically to complete an Introductory Screening Tool (IST), which expands on answers from the HRA to identify any potential issues regarding access to care and other social determinants of health. Based on this secondary screen, the patient is placed into 1 of 3 categories for further care: Basic Case Management, Care Coordination, or Complex Case Management. Patients stratified into Basic Care Management receive ongoing concierge services facilitating access to care. For example, if the patient is due for well care, the PCC will assist in scheduling that appointment. Those stratified into Care Coordination or Complex Case Management receive the same concierge services enhanced by an Individual Care Plan (ICP) and Interdisciplinary Care Team (ICT). For all categories, the PCC remains the contact for the family and serves as the entry point for parent/caregiver inquiries. The PCCs are not licensed clinicians and do not independently provide medical advice.

A registered nurse (RN) then reviews the medical records, HRA, and IST to develop a preliminary ICP for each patient. The ICP includes the patient's medical and behavioral health conditions, a general case summary, community benefits/programs the patient has accessed, perceived concerns or barriers to care, and goals and interventions, including preventative services required. The PCC then schedules an ICT meeting that takes place in our care coordination offices. Invitees include the patient/family, RN care coordinator, social worker, primary care provider (PCP) or representative, specialty care providers, behavioral health providers and home health, other community program staff, school representatives, and certified interpreters. We encourage the patient's primary care physician to attend the ICT. If the patient's PCP is unable to appear, our Pediatric Medical Director attends on their behalf. Telephonic attendance is offered for all potential attendees. Prior to the meeting, the PCC sends the preliminary ICP to all invited attendees.

The ICT is an opportunity for all invitees to discuss and address any concerns or barriers to receiving coordinated, comprehensive care. The ICP is updated after the meeting to include goals, interventions, and target dates, and identification of the responsible individual for completing these goals. A Provider Summary version of the ICP is sent to the patient's PCP and Specialty Physicians, as appropriate, and a patient-friendly version is sent to the patient/family. The PCP is asked to review the ICP, sign the document, and return it to the PCC. The ICP is

Table 1. Demographics of Study Population.

Variable	Category	Mean/Frequency	SD/Percent
Age (years)		4.02	3.2
Gender	Female	158	35.8
	Male	284	64.3
Primary language	English	195	44.1
	Spanish	210	47.5
	Vietnamese	19	4.3
	Other	18	4.1
Ethnicity	Caucasian	218	49.3
	Hispanic	169	38.2
	Vietnamese	13	2.9
	African American	7	1.6
	Other	35	7.9
Primary diagnosis	Autism	163	36.9
	Congenital syndrome/chromosome abnormality	59	13.4
	Neurodevelopmental delay	46	10.4
	Cerebral palsy	44	10.0
	Mental health	25	5.7
	Oncology/hematology	22	5.0
	Prematurity	22	5.0
	Complex cardiac disease	16	3.6
	Other	45	10.0

then placed in the electronic or paper medical record of the patient for reference. After the meeting, the PCC continues to serve as a resource for the patient/family/providers to assist in scheduling appointments, facilitating access to needed care or equipment, and to connect patients to community programs, behavioral health, or other resources. The RN Care Coordinator continues to provide clinical advice, education, and connections to required specialty services, as needed. If the child is admitted to the hospital or undergoes a major event that could potentially alter the plan of care, a review of the ICP is undertaken with edits and appropriate revisions disseminated to the extended care team and the family. The HRA and ICP are updated annually. Staffing for the program is described in Table 2, and may vary based on specific acuity and geographic availability of specialty and community social services.

Results

Statistical Methods

The study population consisted of Medicaid children who were stratified to Care Coordination or Complex Case Management levels and had an ICT meeting in 2016 or 2017. The summary of demographics was provided as means (standard deviation; SD) for continuous variables or frequency (proportions) for categorical variables. A Poisson random-effect regression model, using claims data, was used to compare the rate of ED visits and inpatient admissions for the cohort of 442 children before and after ICT meeting completion with demographics (except main diagnosis) as covariates and a random intercept to account for within subject correlation. We further examined the effect modification of whether or not the parent attended the ICT meeting by a likelihood ratio test. As a post hoc analysis, a mixed regression model was used to compare the difference of average length of stay per inpatient admission before and after the ICT meeting. Time period (pre/post) and the interaction term between time period and number of inpatient admissions were treated as fixed effect and subject was fit as a random effect. Analyses were performed using SAS 9.4.

Baseline Characteristics

A total of 442 children who were both enrolled in the care management program and had an ICT meeting in 2016 or 2017 were included in the study. The mean of eligible months before and after the ICT was 10.48 months with a SD = 3.43, and 10.86 months, with SD = 3.72, respectively. The summary demographics of the patients are provided in Table 1. The mean age of the cohort was 4 years with SD = 3.17. There were 158 (35.75%) female patients and 284 (64.25%) male patients. Approximately 40% of the ICT meetings were attended by the parent(s).

Table 2. Program Staffing (Core Team Members).

Position	Education and Certification	Full-Time Equivalent	Role
Patient Care Coordinator (PCC)	High school diploma; AA Preferred	1.0 per 600 patients	Patient/family liaison. Facilitates care and communicates with family on an ongoing basis. Conducts the Introduction Screening Tool (secondary screen), leads ICT meetings.
RN Care Manager	Pediatric RN	1.0 per 9 PCCs	Supervises and provides education to PCCs, offers medical advice to families (when appropriate), prepares ICPs, interacts with specialty case managers and physicians.
Medical Director	Board-certified pediatrician with case management and quality improvement experience	0.25 per 9 PCCs	Final approval of all ICPs, attends ICT meetings, and coordinates care with primary and specialty care physicians.
Licensed Clinical Social Worker	Certified licensed clinical social worker	0.5 per 9 PCCs	Attends ICT meetings, addresses social determinants of health, family safety, and connects families to community resources.

Abbreviations: ICT, interdisciplinary care team; RN, registered nurse.

Pre-Post Comparisons on ED Visits and Inpatient Admissions for the Cohort of 442 Children

Overall, the rate of ED visits and inpatient admissions were 114 and 169 per 1000 member months prior to ICT, and 78 and 110 per 1000 member months after ICT, respectively. In the Poisson random effect regression model, the ED visit rate was 31% lower in the post-ICT period than prior with Incidence rate ratio (IRR) of pre versus post = 0.69 (95% confidence interval [CI] = 0.60-0.79; $P < .0001$; Table 3A) after controlling for age, gender, language, ethnicity, and parent attendance and accounting for within subject correlation. The inpatient admission rate was 38% lower in post-ICT period than prior with IRR of pre versus post = 0.62 (95% CI = 0.48-0.79; $P = .0002$; Table 3B). Over-dispersion was not observed in the 2 models (scale parameter = 0.86 for emergency room [ER] visits and 0.55 for inpatient admissions). We further examined effect modification of parent ICT attendance by a likelihood ratio test. Parent attendance at the ICT failed to modify the effect of ICT on either ER visits or inpatient admissions ($P = .8642$ for ER visits and .4817 for inpatient admissions).

Post Hoc Analysis on Bed Days

There were 100 subjects who required inpatient admissions prior or subsequent to the ICT meeting. Among these subjects, the average length of stay per inpatient admission was found to be significantly longer before the ICT than after the ICT meeting ($P = .0112$). The average length of stay per inpatient admission prior to the ICT was 9.59 days, and the average length of stay after the ICT was 6.32 days, a 34% reduction in length of stay post-ICT.

The overall base cost of the program is approximately $13.76 per member per month (Table 4). However, the demonstrated savings in ED and inpatient utilization, in our population-based payment system, is approximately 3 times the program costs, $42.04 per member per month, allowing the opportunity to reinvest in additional quality improvement activities. The calculation of savings is derived from the reductions in ED and inpatient stays and the associated cost aversion related to those services in our population-based payment system.

Discussion

In implementing this intervention, we applied the strategic tenets of care coordination to a population of children with special health care needs and demonstrated, as a proxy for quality, significant reductions in ED and inpatient utilization. This program was created in the context of a population-based payment environment requiring demonstrable cost efficiency.

We have shown that a care coordination program focused on a relatively small cohort of high-risk children was associated with a significant reduction in ED and inpatient utilization across the entire population studied. Additionally, if the children were hospitalized, inpatient length of stay was significantly shorter than prior to the intervention. While the costs of the program exceeded the amount budgeted within a total capitation funds flow, the financial benefits from cost savings more than adequately covered the program costs.

Table 3. Results of Poisson Random Effect Regression Model Analysis.

(A) Inpatient Admissions

Variable	Category	IRR (95% CI)	*P*
ICT	Completed	0.62 (0.48-0.79)	.0002
Age (years)		0.95 (0.88-1.02)	.1665
Gender	Female	Reference	
	Male	1.07 (0.68-1.70)	.7673
Language	English	Reference	
	Spanish	0.89 (0.54-1.45)	.6384
	Vietnamese	2.43 (0.79-7.48)	.1218
	Other	1.21 (0.36-4.04)	.7616
Ethnicity	Caucasian	Reference	
	Hispanic	1.29 (0.79-2.10)	.3157
	Vietnamese	0.31 (0.05-1.84)	.1995
	African American	4.83 (1.22-19.21)	.0257
	Other	1.22 (0.50-3.01)	.6633
Parent attended ICT meeting	No	Reference	
	Yes	0.87 (0.55-1.37)	.5404

(B) Emergency Department Visits

Variable	Category	IRR (95% CI)	*P*
ICT	Completed	0.69 (0.60-0.79)	<.0001
Age (years)		0.94 (0.90-0.98)	.0032
Gender	Female	Reference	
	Male	0.81 (0.63-1.03)	.0893
Language	English	0.9041	.9041
	Spanish	1.02 (0.78-1.32)	.9041
	Vietnamese	1.40 (0.71-2.75)	.3276
	Other	0.86 (0.42-1.75)	.6715
Ethnicity	Caucasian	Reference	
	Hispanic	1.15 (0.89-1.50)	.2876
	Vietnamese	0.38 (0.15-0.96)	.0425
	African-American	0.89 (0.32-2.48)	.8248
	Other	0.83 (0.50-1.40)	.4925
Parent attended ICT meeting	No	Reference	
	Yes	0.93 (0.73-1.19)	.5819

Abbreviations: CI, confidence interval; ICT, Interdisciplinary Care Team; IRR, Incidence Rate Ratio.

Table 4. Annual Program Costs.

Average monthly membership	4514
Team FTE count	10
Labor costs	$543 619
Overhead	$201 874
Total cost	$745 493
Cost pmpm (for the 4515 children)	$13.76

Abbreviations: FTE, full-time equivalent; pmpm, per member-per month.

The engagement of organizational leadership, who supported our approach in the paradigm of the Triple Aim, was essential to development and implementation of this program. Instrumental to the demonstrated success was the ability to accurately attribute patients to specific primary and specialty care providers to ensure care continuity. Bodenheimer et al reference "empanelment" as a key to population health care coordination and we confirmed this as a key driver.[1] The other key attributes of the program include the following:

- The ability to risk stratify the patients to guide appropriate resource allocation and interventions.
- Specific assignment of nonlicensed, lay-person staff to assist the families in navigating the complex health care system (PCCs) and the creation of ongoing relationships.

- The patient and family engagement facilitated by the HRA and IST completion, as well as the ICT Meeting and ongoing dialogue with our team.
- Our overall team-based approach with clinical and nonclinical personnel collaborating on multiple challenges facing these families: medical, social determinants, access, and so on.
- The ability to review timely, patient-specific data, including inpatient and ED utilization, HEDIS quality metrics, well child care compliance, and immunization completion rates to guide our individualized interventions.

It bears further mention that the relationship component of programs like ours is often under-emphasized but actually creates the greatest opportunity for success. The families who came to our office to attend ICT Meetings were extremely grateful to have a consolidated team of professionals addressing their entire spectrum of needs. The trust developed in these sessions, whether in-person or telephonic, created an environment where the families felt comfortable and remained engaged and proactive.

Interestingly, we demonstrated that the physical or telephonic attendance of the parent or guardian at the ICT was not a predictor of positive outcomes. One could hypothesize that the act of gathering the care team serves a positive function, as does the completion of the HRA and pre-ICT interview where parental concerns are recorded. Even if the parent failed to attend the ICT, the PCC continued to serve in the concierge role for the family.

Areas for further refinement of the program certainly exist. We acknowledge that having families physically attend the ICT meetings, while empirically beneficial, places undue financial and logistic burden on them. As a result, we are piloting a telehealth approach whereby patients can access the ICT via video and audio smartphone utilizing HIPPA-compliant technology. We also recognize that while having the actual primary care physician attend the ICT is ideal, it is unrealistic to believe that busy providers will be able to leave the office to attend. This is another opportunity for telehealth enhancements. Last, although we received tremendous subjective positive feedback on the program from patients, families, and clinicians, we did not conduct a pre and post formal, objective satisfaction survey. This has now been incorporated for future study.

Study Limitations

As with many analyses of care management efficacy, there were limitations to this study. The use of reduced ED visits and inpatient admissions to represent quality of care, although beneficial, could be challenged. Because there is inconsistency in health plan continuous eligibility in this population, our comparison is at the member-eligible months level rather than a continuous period of time. Although the study is a year-over-year comparison of the same cohort, serving as its own control, there remains the possibility that seasonal or year-to-year variation in disease prevalence (ie, respiratory syncytial virus, influenza) could play a role in frequency of ED visits and inpatient admission, independent of our intervention. Utilization and expenses may also regress to the mean over time as was demonstrated by the incidence rate of ED visits and inpatient admissions decreasing about 5% for every advancing year of age based on the results of Poisson models (Table 3). The children were, obviously, getting older between the pre and post ICT period; therefore, a small portion of rate reduction of pre-post ICT on ED visits and inpatient admissions could be attributed to the increase in age. Additionally, the population included here is a subset (442) of the overall population of patients eligible for the program (4514). There is the possibility of biased selection for inclusion of those families who are more highly engaged, as demonstrated by their completion of the initial HRA.

Conclusion

As health care payment reform continues to evolve and greater numbers of patients are covered by population-based payments, the ability to coordinate care, improve quality, and lower costs will become more and more vital. Programs like ours, where quality outcomes, as measured by reduced needs for ED and inpatient care, are accompanied by a tangible positive economic outcome, can further inform pediatricians regarding the components necessary to be successful in this changing paradigm. Models, like the one described, can inform other clinical interventions and contracting strategies to assure children receive appropriate and effective care coordination. If we can demonstrate the value proposition for payers, both governmental and private sector, of investing in care management programs, the ability to bring pediatric-specific care coordination to our most vulnerable children will be greatly enhanced.

Acknowledgments

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Author Contributions

MAW authored the Introduction and Literature Review while SM provided the information regarding the Care Coordination Program. LZ authored the Methodology and Results sections

of the manuscript. Both MAW and SM authored the Discussion and Conclusion sections.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Washington Health

March 16, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
2020 West El Camino Avenue
Sacramento, CA 95833

Subject: **Removal of Washington Health from the OHCA High-Cost Hospital Outlier List**
(Submitted via email to Megan Brubaker)

Dear Chair Johnson:

I write today to request that the Health Care Affordability Board remove Washington Health (WH) from the high-cost outlier hospital list. Based on the recent resubmission of our financial data to the HCAI Hospital Annual Financial Disclosure Report (HAFDR), we no longer qualify for inclusion on this list. This data was not changed in the aggregate but was only re-categorized based on industry standards.

It is my understanding that the Health Care Affordability Board does not have a policy in place for formally considering data resubmissions from hospitals. I strongly urge the OHCA board to adopt such a policy, in the interest of fairness and transparency. When an institution submits clarified or corrected financial data demonstrating that it does not qualify for inclusion on the high-cost hospital list, then it must be promptly reviewed and removed at the earliest opportunity.

Over the past several months, Washington Health has resubmitted our HAFDR data to HCAI for the years 2021 through 2024. Working with a third-party consultant, we came to understand that we had been misinterpreting the reporting categories for data submissions to HCAI. Revenues associated with WH's self-insured health plan had been incorrectly categorized in HAFDR. After resubmitting the data, WH met with HCAI staff to explain the changes and the rationale requiring resubmission, and HCAI validated and accepted the resubmitted data. Importantly, this resubmission did not involve any change to the underlying financial data. Rather, it reflects a more accurate, industry-standard classification of the same data across the appropriate reporting categories.

As we explained to the OHCA staff, when we used the methodology adopted by OHCA to identify high-cost hospitals, we found that for 2021 through 2024 Washington Health did not exceed the 85th percentile for commercial inpatient net patient revenue. As a result, we do not meet OHCA's own criteria for inclusion on the high-cost hospital list, and we should be taken off the list as soon as possible.

2000 Mowry Avenue
Fremont, CA 94538
510.797.1111

www.washingtonhealth.com

As an independent District hospital, Washington Health is proud to provide high-quality healthcare to all patients, regardless of their ability to pay. Not being owned by a large health care system and having a publicly elected board means that we are accountable locally to the residents of our community. But it also means that we have limited resources dedicated to regulatory filings.

Now that Washington Health has submitted a reclassified set of data to HCAI that accurately reflects our financial picture, it is incumbent upon OHCA to recalculate the metrics for the high-cost outlier hospital list and remove WH when you validate that we no longer meet the criteria for inclusion on the list. There is no justification for maintaining our listing, and everyday Washington Health remains on this list misleads the public and ultimately undermines the principles of transparency and fairness.

We appreciate your attention to this matter and look forward to your response.

Sincerely,

Kimberly Hartz
Chief Executive Officer
Washington Health

Cc: Members of the Health Care Affordability Board:
Sandra Hernandez, MD
Richard Kronick, Ph.D.
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Richard Pan, MD
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Senator Dr. Aisha Wahab
Assemblymember Alex Lee
Assemblymember Liz Ortega

California Hospital Association

March 19, 2026

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

Subject: **CHA Comments for the March 2026 OHCA Board Meeting**
(Submitted via Email to Megan Brubaker)

Dear Chair Johnson:

California's hospitals share the Office of Health Care Affordability's (OHCA's) goal to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of nearly 400 hospitals, the California Hospital Association (CHA) appreciates the opportunity to comment ahead of OHCA's March 2026 board meeting.

To Protect Access to Care, OHCA Should Incorporate Additional Factors into Its Enforcement Decisions

Over the past year, OHCA has discussed and sought feedback from stakeholders on the spending target enforcement process. One area of focus has been how to waive or cease enforcement for regulated entities whose spending grew faster than the target for justifiable reasons. OHCA has stated that it will not implement a waiver process, noting that such a process would not allow for enough "flexibility." Rather, OHCA would rely on the Department of Health Care Access and Information (HCAI) director's discretion to determine which entities should move through the progressive steps of enforcement. CHA continues to urge OHCA to reconsider this decision and instead implement a waiver process to provide regulated entities with a standardized, transparent, and legally authorized opportunity to engage with the office on the factors that drove their spending growth.

OHCA has stated that enforcement decisions by the director would be based on a set of "enforcement considerations." To date, OHCA has introduced nine potential factors that are broadly reasonable. When enumerating these factors in regulation, OHCA should clarify that these factors include certain constituent elements that are critical for protecting access to high-quality hospital care.

- **Extend "Investments in Primary and Preventive Care" to other investments in patient-centered care.** Achieving the health care system of tomorrow requires investment, such as bringing on new behavioral health beds, establishing new ambulatory care sites as an alternative to inpatient care,

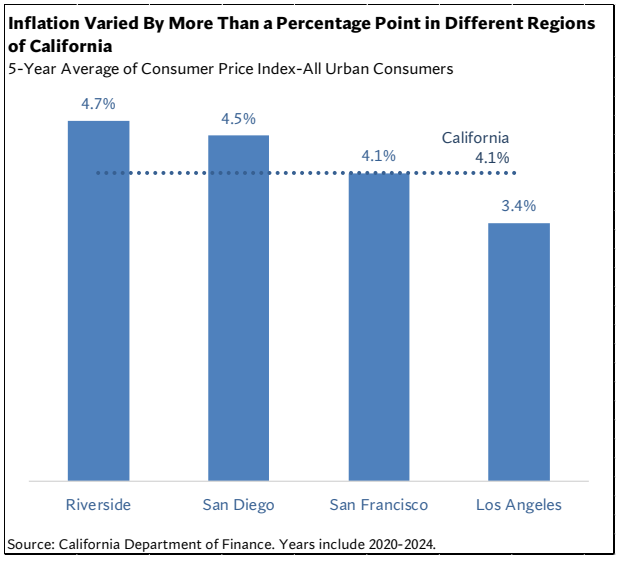
updating out-of-date diagnostic equipment, introducing the latest genomic and information technologies, or expanding much-needed specialty care services. These types of investments improve patient care and outcomes, and are necessary to meet the needs of an aging population. To avoid creating a chilling effect on these important investments, OHCA must clarify that they will be considered potentially justifiable reasons for exceeding the spending targets.

- **Incorporate payer mix as a component of population characteristics, entity baseline costs, and changes in state and federal law.** Patients' source of coverage is a key driver for both their care needs (e.g., a senior on Medicare often requiring different care than a newborn on Medi-Cal) and the reimbursement a provider receives. For California hospitals, Medicare and Medi-Cal pay only $0.83, on average, for every dollar in costs. Payments from commercial payers help offset these shortfalls, but still don't cover the full loss for many hospitals. (This is an important reason why more than 40% of California hospitals operate at a loss, losing money each day providing patient care.) The health care cuts enacted by the One Big Beautiful Bill Act (OBBBA) will reduce access and coverage for children and families on Medi-Cal and Covered California. Moreover, California is entering an unprecedented era of demographic change where 22% of Californians will be 65 or older by 2040 (compared to 14% in 2020), resulting in hundreds of thousands of additional Medicare enrollees. These coverage and demographic changes mean that uncompensated care and payment shortfalls from government payers will only grow, endangering the viability of hospital services across the state. Variation in hospitals' commercial payments correlates to their shortfalls in Medi-Cal and Medicare reimbursement, which results in hospitals mistakenly looking costly when only commercial reimbursement is considered; when all payers are taken into account, the hospital proves to be considerably less costly. To prevent penalizing hospitals that care for greater numbers of Medicare and Medicaid patients, OHCA should commit in advance to incorporating payer mix into the population characteristics, entity baseline costs, and changes in state and federal law enforcement considerations.
- **Consider providers' financial conditions as part of entity baseline costs.** Health care throughout the state is under threat. The OBBBA will eliminate coverage for nearly 2 million Californians and reduce payments for Medi-Cal providers already paid below cost. Dozens of hospitals statewide are at short-to-medium term risk of closure. Last year alone, hospitals and health systems eliminated more than 3,000 jobs (a number that is nearly 50% higher than average for the last five years). To remain viable over the next several years, hospitals will be forced to cut their expenses through force reductions or service lines cuts or take steps to increase their revenues, which could result in them exceeding the targets. OHCA must consider an entity's baseline financial condition when assessing its performance against the targets.

Importantly, OHCA should also incorporate additional factors that account for key drivers of health care spending to balance access, quality, equity, and workforce stability with affordability. The factors recommended below would allow for a more comprehensive assessment of whether entities justifiably exceeded the target:

- **Macroeconomic trends:** OHCA's adoption of the spending target is based on median household income growth of a 20-year historical period that does not reflect current economic trends. Inflation in California during this period averaged just 2.8%, compared to an average inflation growth of 4.1% in the past five calendar years (from 2020-24) per the California Department of Finance tracker. Meanwhile, global trade

uncertainty and tariffs have increased costs for the supplies hospitals rely on to provide care. According to Kaufman Hall, western states' year-over-year hospital costs per day from 2024 to 2025 increased at 13% for supplies, like personal protective equipment, and pharmaceuticals. Moreover, trends in the cost of doing business vary for hospitals in different regions of the state — sometimes by as much as 1.3 percentage points, as illustrated in the figure at right. To avoid punishing entities due to global unrest-induced supply shocks and other economic trends far beyond their control, OHCA should consider macroeconomic trends during enforcement.



- **Labor costs.** Labor costs make up 55-60% of hospitals' total operating costs and are growing rapidly. Over just the past year, these expenses have increased by 6%. While OHCA's governing statute contains a provision expressly authorizing it to adjust the spending target for actual or projected organized labor costs (See Health & Safety Code127501.4(j)(2)), state law provides flexibility as to how OHCA considers other labor costs when assessing entities' performance against the targets. To reflect the reality that bargained and non-bargained wages often grow in concert and prevent inequitable treatment of hundreds of thousands of health care workers, OHCA must consider **all** labor cost growth as an enforcement consideration.
- **Other reasonable causes.** While the additional factors above should cover several reasons an entity may justifiably exceed the spending target, there may be other factors that cannot be predicted in advance that may also contribute to an entity's excess — but justifiable — growth. In regulation, OHCA should specify that the director may consider additional, non-enumerated factors in enforcement decisions.

Avoidable Emergency Department Use Reflects Broader Access Constraints

In June 2025, HCAI released an analysis using data from the Healthcare Payments Database showing that potentially avoidable emergency department (ED) visit rates vary widely across California and are consistently highest for Medi-Cal enrollees, at approximately 47-65 visits per 1,000 member-years across regions, compared to 14-19 for commercial enrollees. This pattern is reflected on a national scale in a study of Medicaid patients that also shows higher ED utilization compared to commercial patients, driven by higher rates of reported barriers to timely access to primary care and worse continuity of care.[1]

When Medi-Cal beneficiaries struggle to access primary care and other preventive care due to limited availability, long wait times, and after-hours constraints, EDs are an appealing option: open at all hours, appointment-free, and accepting of all patients. However, that means that patients are often seeking care in a more costly setting and are sicker by the time they seek care, requiring more intensive treatment. Ultimately,

[1] Cheung, P. T., Wiler, J. L., Lowe, R. A., & Ginde, A. A. (2012). National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries. *Annals of emergency medicine*, *60*(1), 4–10.e2. https://doi.org/10.1016/j.annemergmed.2012.01.035

the alarming disparity between Medi-Cal and commercial patients in their avoidable ED visit rates points to the importance of expanding access to primary care for Medi-Cal beneficiaries.

Conclusion

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

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency

HEALTH ACCESS CALIFORNIA

March 19, 2026

The Honorable Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability
Health Care Access and Information Department

2020 W. El Camino Ave, Ste. 1200
Sacramento, CA

Re: March 2026 Health Care Affordability Board Meeting

Dear Ms. Johnson, Ms. Landsberg, and Mr. Pegany,

Health Access, the statewide health care consumer advocacy coalition committed to quality, affordable care for all Californians, seeks public accountability for the enforcement process, offers comments on the labelling of penalties as well as the scope and range, the limits on administrative costs and profits for health plans and insurers, and possible application of rate review and medical loss ratio requirements to providers as well as plans.

Executive summary:

- Performance improvement plans should be a tool for health system transformation toward the vision of lower costs, improved outcomes and increased equity at both the provider and plan levels.
- At every step of the enforcement process, public transparency and accountability are needed to reinforce progress toward lower costs and higher value.
- The OHCA law includes three different types of penalties: the penalty for exceeding the growth target, penalties for obstructing OHCA's work, and a third penalty specific to health plans and insurers related to administrative costs and profits.
- An illustration of the penalty to overhead and profits for plans or insurers that exceed the spending growth target.
- A discussion of extending rate review and the medical loss ratio that apply now to plans and insurers to providers.
- The OHCA enterprise rests on data and we offer comments on several specific data issues.

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Performance Improvement Plans as a Tool for Larger Health System Transformation

The vision behind the OHCA statute is about transforming the health care system to lower costs while improving outcomes and equity. Equity should be improved through both greater affordability which benefits communities of color the most as well as a shift toward primary care and behavioral health that is culturally appropriate and anchored in the community.

Hospitals and Hospital Systems

The most effective and practical way to accomplish this transformation of the health care system is at the level of hospital or health systems. Here Health Access proposes that the Office use performance improvement plans (PIPs) approved by OHCA to further the work of transforming the larger health system by allowing hospitals that exceed the spending target to reduce spending for the entity subject to the target by increasing reliance on primary care and community-oriented behavioral health services whether those services are provided by affiliates, subsidiaries or other entities subject to the control, governance, or financial control of the hospital or the larger hospital system of which that hospital is an element in addition to mitigating price increases for hospital inpatient and outpatient care.

This will work under existing California law:

- **First**, the hospital must document legal control or governance of the affiliate or subsidiary, to the satisfaction of the OHCA staff.
- **Second**, the hospital must demonstrate how the improvements occurred in the practical dollars and cents of financial accounting.
- **Third**, the hospital demonstrates how these efforts improve access, equity, and quality for consumers while projecting cost savings to payers through more care that is more cost-effective for consumers and other purchasers and less care that is downstream and costly.
- **Finally**, these efforts must be accompanied by the hospital facility subject to the target reducing the rate of growth in hospital revenues, both inpatient and outpatient. One approach would be for the hospital itself to slow growth in pricing of hospital services. Another example could be a hospital that participates in the 340B program ceasing to extract exorbitant profits from the 340B program. Given the existing California law, this step of slowing the rate of year-over-year growth in hospital revenues is necessary to bring the hospital entity into compliance with the growth target for the licensed hospital. Without this step, the hospital can continue to exceed the year-over-year growth target without consequences.

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Health Plans and Insurers

Health plans and insurers present a different set of challenges and opportunities for transforming the health system. Here the question is whether health plans and insurers are prioritizing primary care and community-based behavioral health while continuing to comply with the many consumer protections on timely access to the full range of medically necessary care, including specialty care and hospital care, while negotiating provider contracts in which the health plan demonstrates that it took the OHCA targets into account in slowing cost growth. The premise of OHCA is that plans and insurers will do all of that. After all, if the plans and insurers don't negotiate based on cost and quality, what's the use of a health plan or insurer? Why not just have a single payer system like Canada or Britain and eliminate the middle man? Or at least rely on more stringently regulated non-profit health insurers like France or Germany or other European nations[1]?

The role of health plans continues to evolve. To the extent that health plans and insurers like United and Blue Shield own or control physician organizations, a performance improvement plan for the plan could take that into account. Doing that would require working through the implications for the patients attributed to other contracting physician organizations.

If a health plan owns or controls or is otherwise merged with a pharmacy benefit manager (PBM), then that arrangement should demonstrably benefit consumers and other purchasers through slower cost growth for prescription drugs and not exclusively to the benefit of shareholders and management of the entity. Health Access looks forward to working with OHCA staff as they develop a methodology for holding plans accountable for their various roles in managing health care costs and quality for Californians.

Public Accountability for the Enforcement Process

Health Access recommends that each step of the enforcement process be public and subject to public accountability through public comments to the department and the Board. This includes the following:

- Step One: setting, and adjusting, growth targets: this is public and has been subject to extensive public comment.
- Step Two: Public notice that an entity has exceeded the target at the time the entity receives initial notice of exceeding the target. (In some states, the state and the entity negotiate secretly at this stage. California should learn from this, not replicate it.)
- Step Three: Office's determination whether to proceed with enforcement, including any "enforcement considerations".

[1] Post-Brexit Britain is not always considered part of Europe.

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- Step Four: Office to provide public notice of the extent to which the target is exceeded and any technical assistance. Steps three and four may be combined.
- Step Five: Written or verbal public testimony.
- Step Six: Public disclosure of the draft "performance improvement plan" followed by public disclosure of approved plan as well as public reporting of monitoring of progress, if any, in addressing that plan by the entity to slow the growth of spending.
- Step Seven: Spending growth target penalties: administrative penalties for exceeding the target to be publicized to local and statewide media.

Ideally, no penalty is ever issued because every entity meets the growth target and no entity proceeds to progressive enforcement. But at each step along the way of progressive enforcement, each entity should be subject to public accountability and the opportunity for public comment.

Penalties and Progressive Enforcement: Different Penalties, Different Labels

The OHCA law includes three different types of administrative penalties:

1. "The spending target penalty": the penalty for an entity that exceeds the growth target.
    - For this penalty, progressive enforcement applies.
2. "Obstruction of OHCA requirements": another category of penalty for an entity that "knowingly" or "willfully" obstructs the requirements of the OHCA program
    - Examples of the second type of penalty include
        - The very modest data submission penalty that is already in place.
        - If an entity fails to submit a performance improvement plan
        - If an entity fails to implement a performance improvement plan.
        - An entity knowingly falsifies information or fails to submit required information.
    - Every penalty in this category requires that the entity act "knowingly" or "willfully". "Knowingly" and "willfully" are meaningful legal standards known to the courts.
    - For this category of penalty, the requirements of progressive enforcement do NOT apply. Reading these penalties as requiring progressive enforcement would make nonsense of the law since most of these penalties deal with obstruction of compliance, such as failure to provide information or failure to submit a performance improvement plan.
3. A third category of penalty capping administrative costs and overhead of health plans and insurers that exceed the target. This is discussed at greater length below.

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Limiting Administrative Costs and Profits for Health Plans and Insurers that Exceed the Target

The OHCA law contains an unusual provision which helps to explain the unusual coalition which supported the creation of the Office of Health Care Affordability:

> 127502 (h) (2) The targets established for a payer's administrative costs and profits under this subdivision may be subject to annual adjustment, but shall not increase to the extent the costs for the medical care portion of the medical loss ratio exceed a target.

Translated this means that if the claims and nonclaims spending paid by health plans and insurers for hospital services, professional services, outpatient prescription drugs and other covered benefits grow more than the target of 3.5% for 2026, then the administrative overhead and profit of the health plan or insurer shall not increase in the subsequent year.

This is a mild punishment for the plan by capping administrative costs and profits at the level of the prior year's administration and profits. This penalty was designed to create an incentive for health plans and insurers to bargain effectively with providers and drug manufacturers based on cost and quality, something that OHCA was intended to incentivize.

Here's an illustrative example:

- Health Plan X THCE for 2025=$20 billion, spending target=3.5%
    - THCE includes 15% administrative costs and profits=$3 billion
- Health Plan X THCE for 2026=$22 billion
    - Permissible increase in THCE year over year=$20.7 billion
    - Health Plan X exceeds the spending target by $1.3 billion.
    - Administrative costs and profits without OHCA law=15% of $22 billion=$3.3 billion
    - But administrative costs and profits for Health Plan X are frozen at $3 billion because the plan exceeded the spending target.
- In addition, OHCA has the ability to enforce the spending target through progressive enforcement, up to and including commensurate penalties.

We say it is a mild penalty for health plans and insurers because in this example, it amounts to $0.3 billion, the difference between $3 billion in plan profits and administrative overhead and $3.3 billion while consumers and other purchasers pay $1.3 billion more in premiums than they should have paid under the target.

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Table 1. Illustrative Example:
Impact of Freezing Administrative Costs and Profits for a Health Plan

	2025 Base Year	**2026 Target (3.5%)**	**2026 Example**	**Example versus Target**
"Total" Health Care Expenditures	$20.0 billion	$20.7 billion	$22.0 billion	+$1.3 billion
Administrative Costs and Profit (15% of THCE)	$ 3.0 billion	$ 3.1 billion	$ 3.3 billion	NA
Penalty: Limit administrative costs/profits to prior year amount	NA	NA	$ 3.0 billion for admin and profits	-$0.3 billion penalty by limiting admin costs/profits

The law also requires OHCA to consult with DMHC and CDI to assure that plans remain financially solvent and able to comply with rate review requirements. If imposing the lower limits on plan administrative costs and profits endangers solvency, then OHCA can work with its sister state agencies to assure plan solvency. DMHC and CDI, like other insurance regulators, routinely monitor reserves to ensure solvency as one element of the rate review process[2].

Medical Loss Ratio Requirements and Rate Review: Just Insurers and Health Plans? Or Providers as Well?

Medical loss ratio requirements and the rate review process for health plans and insurers create transparency and accountability around the administrative overhead and profit of health plans and insurers[3]. The rate review process helps protect consumers from unjustified or "unreasonable" rate increases, including both premiums and cost sharing. The medical loss ratio requires a health plan or insurer to spend 80% of its premium on clinical care in the individual and small group markets and 85% in the large group market[4]. However, how those 80%-85% of premium dollars are used is largely determined by hospitals, hospital systems, and large physician organizations, not the health plan or insurer. The hospital, health system or large physician organization

[2] We note that in most recent reviews of financial solvency, all health plans had ample financial solvency and some had reserves that were excessive, exceeding not just 500% of tangible net equity (TNE), the statutory threshold,, but 1,000% of TNE.
[3] Kaiser Family Foundation. (n.d.). *Explaining health care reform: Medical loss ratio (MLR).*https://www.kff.org/affordable-care-act/explaining-health-care-reform-medical-loss-ratio-mlr/; California Department of Managed Health Care. (n.d.). *Rate review process.*https://www.dmhc.ca.gov/DataResearch/PremiumRateReview/RateReviewProcess.aspx
[4] Health and Safety Code Section 1367.003 and Insurance Code Section 10112.25

determines how much goes towards direct patient care versus administrative costs or profits of the provider[5] , not the health plan or insurer.

Consumers and other purchasers do not know how much of their premium dollar is eaten up by overhead and profits of hospitals and health systems or large physician organizations and how much goes to hands-on patient care. Consumers and purchasers depend on the explanations of health plans and insurers about whether premium increases are reasonable or justifiable, despite the primary drivers of premium increases being hospitals, health systems and large physician organizations, as well as outpatient prescription drug costs.[6]

Just as the medical loss ratio requirement for health plans and insurers ensures that health plans and insurers devote a defined share of premiums to paying providers, and rate review ensures that premiums themselves are not unjustified or unreasonable, a similar framework could be applied to hospitals, hospital systems, and large physician organizations to guarantee that no less than a set ratio of their revenue is directed towards patient care and that the rates of those providers are justified and reasonable. Right now, consumers only have these protections on the insurance side, but no comparable safeguards exist on the provider side. Establishing medical loss ratio requirements and rate review at the provider level would create accountability across the entire health system, not just for insurers and health plans, ensuring that consumers' dollars go to care, not unnecessary administrative costs and profit. A recent analysis by the California Health Care Foundation found that 25% of the spending in health care “provides no value to patients” and much of that is administrative overhead and profits at the provider level due to administrative waste and unfair pricing, both at the provider level and the plan/insurer level.[7] But there is no state-level reporting or standards for administrative overhead or profits retained by providers, unlike insurers and plans which are subject to both transparency and a cap on profits and overhead.

Inpatient and outpatient hospital services make up the largest share of premium dollars at 37%, and professional services, largely physicians, amount to another 25%[8]. Yet the information needed to differentiate administrative costs and profits of providers from the real cost of delivering care to patients is not reported to HCAI or other state agencies. Hospitals, health systems and large physician organizations determine how much goes towards hands-on clinical care and how much goes to overhead and profits.

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[5] For non-profit entities, we refer to revenues in excess of expenditures as profits. Clinical care should make up the overwhelming majority of spending, whether it is a hospital, a clinic, a health system, a large physician organization or a health plan or insurer.

[6] California Department of Health Care Access and Information. *Baseline Report: Health Care Spending — Trends in California, 2022–2023*. 5 June 2025, hcai.ca.gov/wp-content/uploads/2025/06/Baseline-Report-Health-Care-Spending-Growth-Trends-in-California-2.pdf.

[7] https://www.chcf.org/resource/why-health-care-is-so-expensive/

[8] California Department of Health Care Access and Information. *Baseline Report: Health Care Spending — Trends in California, 2022–2023*. 5 June 2025, hcai.ca.gov/wp-content/uploads/2025/06/Baseline-Report-Health-Care-Spending-Growth-Trends-in-California-2.pdf.

Consumers and purchasers have no way of knowing what is spent on patient care and what goes to profits and overhead. A provider-level medical loss ratio requirement and rate review would directly address this gap by establishing clear expectations for how healthcare dollars should be spent.

Several other states collect medical loss ratio information for nursing homes and California has considered legislation in this area[9]. Massachusetts, New York, and New Jersey have all extended medical loss ratio style accountability into care settings by requiring nursing homes to disclose their spending on direct care, administrative overhead, and profit. New Jersey's AB 4482, passed in 2020, requires facilities to ensure that a set proportion of their revenue goes toward direct care, and mandates rebates when the entity fails to meet this threshold, directly protecting residents.[10] Similarly, California has also considered both legislation to require reporting of medical loss ratios for physician organizations regulated as risk bearing organizations and recently for community clinics.[11]

Data Issues: "Total" Health Care Expenditures

Health Access reviewed the data submission guide for payers to submit "total" health care expenditures. We acknowledge that as with any new data set, improvements should occur over time.

Should the Medicaid provider tax on hospitals, known as the "hospital quality assurance fee" (HQAF) be counted as part of revenue? The actual net revenue received by each hospital from the HQAF is not publicly available, instead being sequestered in an off-the-books arrangement in a private foundation. The Biden Administration attempted to make public these actual amounts but to date, to the best of our knowledge, California has not yet done so. Also, the current HCAI hospital financial reporting makes reporting of HQAF revenue both voluntary and unstandardized. Unless the data is both accurate and publicly reported in full, Health Access has serious doubts about its inclusion.

Discussion continues about the definition of behavioral health spending and whether to limit capture of behavioral health spending to only those claims for which behavioral health is the primary diagnosis or should also include claims where behavioral health is a secondary diagnosis for which care may have been provided[12]. One of the many challenges of measuring behavioral health spending is minimizing double counting. It

[9] AB 1537 (Wood) of 2023.

[10] https://pub.njleg.gov/bills/2020/AL20/89_.HTM#:~:text=into%20the%20agreement.-,i.,of%20this%20section%5D1%20.; https://www.mass.gov/lists/direct-care-cost-quotient-dcc-q-reports

[11] AB 616 (Rodriguez) of 2023 on reporting MLR for RBOs and AB 1113 (Mark Gonzalez) of 2025 on community clinic MLRs.

[12] https://hcai.ca.gov/wp-content/uploads/2025/08/OHCA-Proposed-Behavioral-Health-Definition_2025.08.04-1.pdf

may be correct that behavioral health care occurs during an office visit with a physician, an emergency room visit, or hospital stay where the primary diagnosis is a physical health need. Conversely, during outpatient emergency care or inpatient hospital stays where the primary diagnosis is mental health or substance abuse treatment, physical health needs are often addressed as well. Also, there are known and documented challenges with lack of coding of secondary diagnoses. The practicalities of avoiding double counting and recognizing the limits of coding persuade us that use of a primary diagnosis of behavioral health needs seems appropriate. We, of course, remain open to further discussion and learning over time.

Conclusion

Health Access appreciates consideration of these comments.

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Executive Director

CC:
Members, Health Care Affordability Board
Richard Figueroa, Deputy Cabinet Secretary, Office of the Governor
Christine Aurre, Legislative Affairs, Office of the Governor, Attn.: Paula Villescaz
Robert Rivas, Speaker, California Assembly, Attn.: Rosielyn Pulmano
Mike McGuire, President Pro Tempore, California State Senate, Attn.: Marjorie Swartz
Mary Watanabe, Director, Department of Managed Health Care
Michelle Baass, Director, Department of Health Care Service
Assemblymember Mia Bonta, Chair, Assembly Health Committee, Attn.: Lisa Murawski
Senator Caroline Menjivar, Chair, Senate Health Committee, Attn.: Teri Boughton
Brendan McCarthy, Deputy Secretary, California Health and Human Services Agency, Attn.: Darci Delgado
Dr. Akilah Weber Pierson, Chair Senate Budget Subcommittee 3 on Health and Human Services, Attn.: Scott Ogus
Dawn Addis, Chair, Assembly Budget Subcommittee 1 on Health, attn.: Patrick Le
Josephine Figuroa, Deputy Commissioner, California Department of Insurance

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Attachment #7

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LIZ ORTEGA
ASSEMBLYMEMBER, TWENTIETH DISTRICT

COMMITTEES
CHAIR, LABOR AND EMPLOYMENT
ARTS, ENTERTAINMENT, SPORTS, AND TOURISM
BUDGET
INSURANCE
PRIVACY AND CONSUMER PROTECTION
BUDGET SUBCOMMITTEE NO. 5 ON STATE ADMINISTRATION

March 20, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
2020 West El Camino Avenue
Sacramento, CA 95833

Subject: Removal of Washington Health from the OHCA High-Cost Hospital Outlier List

Dear Chair Johnson:

I write today to urge that the Office of Health Care Affordability (OHCA) Board remove Washington Health (WH) from the high-cost outlier hospital list as soon as possible. Based on WH's recent resubmission of its financial data to the California Department of Health Care Access and Information (HCAI), Washington Health's CEO Kimberly Hartz has told me that WH no longer qualifies for inclusion on this list and should be removed without delay.

The 20th California Assembly District, which I represent, and Washington Township Health Care District, which governs WH, share a significant portion of Southern Alameda County. As a public hospital, WH plays a key role in providing safety-net healthcare services to all residents in my district. Now that WH had demonstrated it does not belong on this list, you have an obligation to remove the health system at the earliest opportunity.

My understanding is that WH's previous HCAI data submission wrongly categorized revenue associated with its self-insured health plan and Medicare Advantage plans. The resubmission of revenue data corrects this mistake and now reflects a more accurate, industry-standard classification across reporting categories. WH has been fully transparent throughout the process of resubmitting the data, meeting with HCAI staff to explain the changes and rationale requiring resubmission. HCAI has validated and accepted the resubmitted data.

WH has also met with OHCA staff and explained that replicating OHCA's own methodology the health system does not meet the criteria for inclusion on the high-cost hospital list. Now that WH has submitted a reclassified set of data to HCAI that accurately reflects our financial picture, it is incumbent upon OHCA to recalculate the metrics for the high-cost outlier hospital list and remove WH when you validate that they no longer meet the criteria for inclusion on the list. There is no justification for maintaining WH's listing, and every day that WH remains on this list misleads the public and ultimately undermines the principles of transparency and fairness.

We appreciate your attention to this matter and look forward to your response.

Sincerely,

LIZ ORTEGA
Assemblymember, 20th District

Cc: Members of the Office of Health Care Affordability Board:
Sandra Hernandez, MD
Richard Kronick, Ph.D.
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Richard Pan, MD
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

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March 20, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
2020 West El Camino Avenue
Sacramento, CA 95833

Subject: Removal of Washington Health from the OHCA High-Cost Hospital Outlier List
(Submitted via email to Megan Brubaker)

Dear Chair Johnson:

I write today to strongly urge that the Office of Health Care Affordability (OHCA) Board review Washington Health's (WH) placement on the high-cost outlier hospital list as soon as possible. Based on the health system's recent resubmission of financial data to Health Care Access and Information (HCAI), it appears that WH no longer qualifies for inclusion on this list. If the financial data submitted supports this finding, I am writing to request that WH is removed from this list without delay.

The 24th California Assembly District, which I represent, and Washington Township Health Care District, which governs WH, share a significant portion of Southern Alameda County together. As a public hospital, WH plays a key role in providing safety-net healthcare services to all residents in my district.

My understanding is that WH's previous HCAI data submission wrongly categorized revenue associated with its self-insured health plan and Medicare Advantage plans. The resubmission of revenue data corrects this mistake and now reflects a more accurate, industry-standard classification across reporting categories. WH has been fully transparent throughout the process of resubmitting the data, meeting with HCAI staff to explain the changes and rationale requiring resubmission. HCAI has validated and accepted the resubmitted data.

WH has also met with OHCA staff and explained that when replicating OHCA's own methodology, they did not meet the criteria for inclusion on the high-cost hospital list. Now that WH has submitted a reclassified set of data to HCAI that accurately reflects their financial picture, it is incumbent upon OHCA to recalculate the metrics for the high-cost outlier hospital list and remove WH when you validate that they no longer meet the criteria for inclusion on the list. Every day that WH remains on this list misleads the public and ultimately undermines the principles of transparency and fairness.

We appreciate your attention to this matter and look forward to your response.

Sincerely,

Assemblymember Alex Lee
California 24th Assembly District

Cc: Members of the Office of Health Care Affordability Board:
Sandra Hernandez, MD
Richard Kronick, Ph.D.
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Richard Pan, MD
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability