HCAi Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Health Care Affordability Board
June 2026
Public Comment

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

Date	Name	Written Comment
6/25/2026	America's Physician Groups (APG)	See Attachment #1.
7/15/2026	United Hospital Association (UHA)	See Attachment #2.
7/29/2026	California Academy of Family Physicians (CAFP)	See Attachment #3.
7/31/2026	California Hospital Association (CHA)	See Attachment #4.
7/31/2026	California Association of Health Plans (CAHP)	See Attachment #5.
7/31/2026	California Association of Public Hospitals and Health Systems (CAPH)	See Attachment #6.
7/31/2026	Private Essential Access Community Hospital (PEACH) Association	See Attachment #7.
8/5/2026	California Medical Association (CMA)	See Attachment #8.

Date	Name	Written Comment
8/10/2026	United Way Monterey County	See Attachment #9.
8/19/2026	Children's Specialty Care Coalition (CSCC)	See Attachment #10.
8/19/2026	United Auto Workers (UAW) Region 6	See Attachment #11.
8/19/2026	SEIU CA	See Attachment #12.
8/20/2026	California Association of Public Hospitals and Health Systems (CAPH)	See Attachment #13.
8/20/2026	California Hospital Association	See Attachment #14.
8/20/2026	Health Access CA	See Attachment #15.
8/20/2026	California Association of Health Plans (CAHP)	See Attachment #16.

AMERICA'S PHYSICIAN GROUPS

June 25, 2026

Kim Johnson, Chair
Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director
Office of Health Care Affordability
2020 West El Camino Avenue
Sacramento, CA 95833

Re: Recognition of Existing Affordability Infrastructure in OHCA's Progressive Enforcement Framework

Dear Chair Johnson, Director Landsberg, and Deputy Director Pegany:

On behalf of America's Physician Groups (APG), thank you for meeting on June 16th with APG and its member organizations to discuss OHCA's evolving affordability framework and the concepts presented during the Progressive Enforcement Workshop. We appreciate OHCA's willingness to engage directly with physician organizations that have anchored California's value-based care system and to solicit stakeholder input as the Office continues to refine its approach to affordability oversight and enforcement. This letter provides recommendations for the performance improvement process and suggests different standards for physician organizations that control costs and advance quality outcomes. Our central theme is that accountability must follow authority.

APG shares OHCA's commitment to improving affordability for California consumers and supports accountability mechanisms that promote high-quality, efficiency, and coordinated care. APG members collectively care for millions of Californians through risk-bearing and value-based arrangements that were specifically designed to improve quality while bending the health care cost trend. For decades, these physician organizations have accepted prospective financial accountability for patient populations through capitated and delegated payment models that align clinical decision-making, quality performance, and cost management. Both Milliman and the Berkeley Healthcare Forum have recognized and commented upon the important role this model plays in affordability.

If OHCA wants physician organizations to improve affordability, Performance Improvement Plans should focus on the tools physician organizations possess—not on spending categories controlled by hospitals, pharmaceutical manufacturers, or health plans. As OHCA continues to develop its enforcement framework, APG respectfully urges the Office to recognize a foundational principle that has guided successful value-based care arrangements for decades: **accountability must follow authority**.

California's risk-bearing physician organizations have long accepted responsibility for managing the cost and quality of care through capitated and delegated arrangements that align financial accountability with clinical decision-making. These organizations have invested substantial resources in population health management, care coordination, utilization management, quality improvement programs, and Total Cost of Care performance measurement. In many respects, California's delegated model represents one of the nation's most mature affordability strategies and has served as a proving ground for the very value-based care principles that policymakers now seek to expand throughout the health care system. The federal regulator, CCIIO, recognized the role played by such organizations and subsequently modified its approach to Medical Loss Ratio compliance under the Affordable Care Act.

Indeed, many of the activities that OHCA seeks to encourage throughout the health care system have been core features of California's delegated model for decades. Physician organizations are not merely subjects of affordability oversight; they are among the state's most established affordability mechanisms. California's risk-bearing organizations were among the earliest entities in the nation to accept prospective financial accountability for patient populations. Through capitation and delegation, these organizations have operated under fixed budgets and population-based accountability arrangements for decades. As a result, physician organizations participating in these arrangements should be viewed differently from entities whose revenue remains primarily dependent upon volume-based reimbursement and utilization-driven growth.

The distinction between statewide affordability measurement and provider accountability is particularly important for physician organizations that already operate under these advanced payment and accountability structures. APG believes that OHCA's Total Health Care Expenditures (THCE) framework serves an important purpose in measuring aggregate health care spending across California. However, a metric designed to answer the question, "How much is California spending on health care?" should not automatically be presumed to answer the separate question, "Which entity is best positioned to reduce that spending?"

THCE is an incomplete metric requiring supplemental consideration of a physician organization's total cost of care (TCOC). This distinction is highlighted by the contrast between THCE and other affordability measurement approaches, such as Total Cost of Care methodologies that have long been utilized by California physician organizations. Total Cost of Care measures are generally designed to evaluate the effectiveness of organizations in managing the resources they control. THCE, by contrast, captures spending regardless of which stakeholder controls the expenditure. Both approaches serve important purposes, but they answer fundamentally different policy questions.

The difference becomes particularly significant when OHCA considers the use of Performance Improvement Plans (PIPs) as part of its progressive enforcement framework. Many physician organizations do not possess authority over significant components of attributed spending, including hospital reimbursement rates, pharmaceutical pricing, pharmacy benefit arrangements, enrollee cost-sharing structures, and certain behavioral health expenditures administered through separate contractual arrangements. Nevertheless, those expenditures may substantially influence an organization's attributed THCE performance. Rather, the use of TCOC metrics reveals a physician organization's efficiency at mitigating avoidable hospital admissions and readmissions, their record of maintaining 95% generic prescribing and ability to coordinate care across both the medical and behavioral health spectrum.

As a practical matter, a physician organization could demonstrate strong performance in the areas it is designed to manage--including care coordination, population health management, utilization oversight, chronic disease management, and quality performance--while still exceeding a statewide spending target due to factors beyond its contractual authority or operational control that are artificially imposed under the THCE standard. In such circumstances, the organization may have few meaningful mechanisms available to reduce the spending categories responsible for the variance. A Performance Improvement Plan can only be effective when the entity subject to the plan possesses authority over the spending categories requiring improvement.

Recommendations: For this reason, APG respectfully recommends that OHCA establish a mechanism to recognize physician organizations that already operate under demonstrated affordability-focused accountability structures. Similar to adjustments that OHCA has contemplated for other categories of health care entities that incorporate collective bargaining, the Office should consider whether organizations participating in mature risk-bearing and value-based arrangements warrant modified treatment within the progressive enforcement framework.

Specifically, OHCA should consider whether an organization:

- Participates in capitated or delegated risk arrangements;
- Demonstrates performance through recognized Total Cost of Care methodologies;
- Maintains population health management and care coordination infrastructure;
- Participates in alternative payment models;
- Assumes prospective financial accountability for managing patient populations; and
- Demonstrates quality performance and utilization management capabilities.

Organizations that satisfy these criteria have already implemented many of the affordability strategies that OHCA seeks to encourage throughout the health care system. These entities should be recognized as possessing established affordability infrastructure and should be eligible for consideration of alternative compliance pathways, modified Performance Improvement Plan requirements, or other adjustments that appropriately account for their existing accountability structures.

At a minimum, APG recommends that OHCA incorporate an adjustment factor prior to finding whether a PIP process involving physician organizations is warranted. Before requiring corrective action, OHCA should identify the primary drivers of spending growth and evaluate whether the organization possesses meaningful contractual, financial, or operational authority over those expenditures. If spending growth is primarily attributable to factors such as hospital price increases, specialty pharmaceutical costs, behavioral health expenditures managed by other entities, or health plan benefit design decisions, OHCA should recognize that the physician organization may not be the stakeholder best positioned to implement corrective action.

APG further recommends that OHCA establish a rebuttable presumption that physician organizations participating in bona fide capitated or delegated-risk arrangements and demonstrating Total Cost of Care performance at or below the statewide median benchmark, or another affordability benchmark established by OHCA, have already implemented substantial affordability measures. Such organizations should be presumed to possess meaningful affordability infrastructure unless OHCA determines that controllable spending factors are materially contributing to excess expenditure growth. This approach would preserve OHCA's ability to address genuine affordability concerns while recognizing the unique

role that California's risk-bearing physician organizations already play in managing cost and improving quality.

California's delegated model has demonstrated for decades that affordability is best achieved when accountability, authority, and incentives are aligned. APG respectfully encourages OHCA to build upon this experience as it refines its progressive enforcement framework. By recognizing existing affordability infrastructure and ensuring that accountability remains aligned with operational authority, OHCA can strengthen its affordability objectives while preserving incentives that have successfully supported value-based care and cost containment in California for generations.

Thank you for your consideration of these comments. APG and its members look forward to continued collaboration with OHCA as the Office advances its important affordability mission.

Sincerely,

William J. Barcellona, Esq., MHA
Executive Vice President, Government Affairs
America's Physician Groups
wbarcellona@apg.org
(916) 606-6763

Attachment #2

United Hospital Association

July 15, 2026

Elizabeth Landsberg
Director, Office of Health Care Affordability
2020 West El Camino Avenue
Sacramento, CA 95833

RE: UHA Comments on OHCA Enforcement Framework

Dear Director Landsberg:

On behalf of the United Hospital Association (UHA), we appreciate the opportunity to comment on the Office of Health Care Affordability's (OHCA) ongoing development of its spending target enforcement framework. UHA supports the comments submitted by the California Hospital Association (CHA) and urges OHCA to carefully consider the concerns and recommendations outlined in that letter.

While hospitals share OHCA's goal of improving affordability, the process for measuring performance, evaluating compliance, and imposing enforcement actions must appropriately balance affordability goals with the equally important objectives of preserving access to care, maintaining quality, advancing equity, and supporting workforce stability. Rather than imposing excessive financial penalties that would inevitably impair hospitals' ability to care for patients, OHCA should adopt a collaborative enforcement approach that provides hospitals with a meaningful opportunity to improve spending trends.

At this stage, significant questions remain about how hospitals will be measured against the spending targets. Hospitals should not face potentially significant penalties based on methodologies that are still evolving. Before enforcement proceeds, OHCA should ensure that its measurement framework is transparent, validated, and clearly understood by the entities it regulates. In particular, OHCA should clearly communicate how spending growth will be evaluated against the target and how factors such as payer mix, service mix, patient acuity, and other operational differences will be incorporated into compliance determinations.

Equally important, the enforcement process must give hospitals a genuine opportunity to succeed rather than setting them up to fail. State law establishes a progressive enforcement structure that prioritizes technical assistance and performance improvement plans (PIPs) before monetary penalties. The Legislature clearly intended these remediation opportunities to be meaningful. Hospitals must be given adequate time to implement corrective actions, and PIPs should remain collaborative, forward-looking, and driven by the hospitals themselves, with OHCA serving an oversight role. Enforcement should focus on helping organizations achieve compliance, not creating procedural steps that inevitably lead to penalties.

OHCA should also recognize that single-year spending data are too volatile to serve as the primary basis for enforcement decisions. Year-to-year fluctuations frequently reflect measurement limitations, changes in patient acuity, service mix, or other factors that do not represent underlying pricing trends. A multiyear assessment framework would provide a more accurate and reliable picture of performance and help distinguish true outliers from statistical anomalies.

United Hospital Association

Similarly, OHCA should avoid an enforcement structure that evaluates hospitals separately across every payer category and service line. By OHCA's own analysis, this approach would have resulted in approximately 92% of hospitals exceeding the target in at least one category. A compliance framework that effectively places nearly every hospital into violation is unlikely to advance affordability goals and risks diverting substantial resources away from patient care and toward administrative processes. OHCA should adopt a more consolidated and practical approach to compliance assessment.

Finally, UHA remains deeply concerned about the magnitude of penalties under consideration. A single year of exceeding a spending target could result in penalties that reach tens or even hundreds of millions of dollars—amounts that exceed annual patient care earnings for many hospitals. Penalties of this scale would not improve affordability; they would threaten access to care by forcing reductions in services, delaying investments, and destabilizing hospitals that serve vulnerable communities.

UHA urges OHCA to adopt regulations that balance affordability with continued access to care by: providing clear guidance on how spending growth will be measured and evaluated; relying on multiyear assessments rather than single-year fluctuations; establishing a standardized process for hospitals to explain growth above the target; creating a collaborative performance improvement process that provides a meaningful opportunity for remediation; and phasing in penalties while accounting for a hospital's financial condition, investments in patient-centered care, and other relevant circumstances.

UHA appreciates OHCA's continued engagement with stakeholders and looks forward to working collaboratively toward policies that improve affordability while preserving access to high-quality care for all Californians.

Sincerely,

Janelle Blanco
Executive Director

cc: Members of the Health Care Affordability Board:
Kim Johnson
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, PhD
Dr. Richard Pan
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

July 24, 2026

Kim Johnson
Chair, Health Care Affordability Board
2020 West El Camino Ave Conference Room 900
Sacramento, CA 95833

Sent via email to OHCA@hcai.ca.gov

RE: Office of Health Care Affordability (OHCA) June 24 Board Meeting

Dear Ms. Johnson,

The California Academy of Family Physicians (CAFP) and our 11,000 family physicians, residents, and medical students thank you for considering our comments regarding recent explanations of attributed medical expenses for physician practices and enforcement of the statewide spending target presented at Office of Health Care Affordability's (OHCA) June 24 Board Meeting.

CAFP commends the Office of Health Care Affordability (OHCA) for its invaluable work promoting equitable, high-quality, and cost-efficient care and supports advancing ways to address dire affordability challenges that burden patients across California. Family physicians understand the importance of creating a financially sustainable health care system that is accessible to all. In 2023, more than half of all Californians (53 percent) reported postponing care because of the cost, many of whom also reported that delayed care led to worsening health outcomes.

CAFP is concerned about OHCA's description of attributable medical expenses for capitated physician organizations on slides 42-44 of OHCA's June 24 Board meeting presentation. The presentation notes that attributed total medical expenditure for a physician organization includes all spending for a member, regardless of the rendering clinician. This approach puts unfair risk of penalties on physician organizations that may serve high risk patient populations. Capitated primary care practices accept financial responsibility for many aspects of patient care, but they do not control every driver of total health care spending. Applying healthcare spending target penalties to expenses that fall outside a practice's operational control like pharmacy claims or emergency department utilization unfairly penalize physicians who treat patients who are medically complex or otherwise at higher risk for increased health care utilization or negative health outcomes. When spending measures include expenditures that are largely determined by external factors, the resulting penalties may not accurately reflect the quality or efficiency of the medical practice.

Pharmacy spending is a clear example. Drug costs are driven by manufacturer pricing, market shortages, patent protections, pharmacy benefit manager negotiations, and insurance formulary decisions. Physicians can make clinically appropriate prescribing

decisions, but they often have limited ability to control the prices patients or health plans ultimately pay. In many capitated arrangements, practices do not administer the pharmacy benefit and have little or no authority over formulary design or negotiated rebates. Penalizing practices for increases in pharmacy spending effectively holds them responsible for market forces beyond their control.

Similarly, emergency department spending is influenced by numerous factors outside a primary care practice's direct authority. Patient socioeconomic conditions, mental health crises, access to after-hours care, hospital admission practices, regional workforce shortages, and community resource availability all affect emergency department utilization. Although strong primary care can reduce avoidable emergency visits over time, no practice can prevent every emergency encounter or control how hospitals bill and manage patients once they present to the emergency department. Holding capitated practices accountable for all emergency department and hospital spending of their patients ignores these broader determinants of utilization.

Including uncontrollable costs in spending target calculations also creates unintended consequences. Practices may become more risk-averse when caring for medically complex or socially vulnerable populations that naturally require higher-cost medications or experience more frequent emergency care. This can undermine efforts to improve access and health equity by discouraging clinicians from serving patients with the greatest needs.

The purpose of spending targets is to encourage clinicians to improve efficiency, reduce unnecessary utilization, and deliver high-value care. These goals are best achieved when organizations are measured on costs they can meaningfully influence. A more equitable approach is to align accountability with areas where capitated practices have meaningful authority. The spending target should focus on services that practices directly manage, such as primary care, care coordination, chronic disease management, preventive services, referrals, and avoidable utilization that can reasonably be influenced through clinical interventions. Costs that are administered by separate entities or driven primarily by external market forces should either be excluded from penalty calculations, risk-adjusted appropriately, or evaluated separately using performance measures that recognize the limits of clinician control. These kinds of expenses outside of a physician practice’s control should be excluded from determining which group met the cost target or needs a performance improvement plan. Physician practices and other entities should also be able to review and appeal attributions to ensure they are protected from unfair penalties.

This approach preserves the integrity of the spending target while maintaining fairness. It continues to incentivize high-quality, efficient care without penalizing clinicians for spending they cannot realistically manage. By aligning financial accountability with actual operational control, policymakers can encourage better care delivery, support clinician participation in value-based payment models, and avoid creating incentives that may reduce access for higher-risk patients.

Thank you for the opportunity to provide input on the pathway forward for instituting equitable accountability for controlling health care spending in California. Creating incentives

for more comprehensive, coordinated, and equitable care is a significant step towards better health for Californians.

Sincerely,

Lisa Folberg, MPP
CEO, California Academy of Family Physicians

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

California Hospital Association

July 31, 2026

Elizabeth Landsberg
Director, Department of Health Care Access and Information
2020 W. El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments on Spending Target Progressive Enforcement Framework**
(Submitted via email to Megan Brubaker)

Dear Director Landsberg:

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 on OHCA's spending target measurement and enforcement frameworks. However, hospitals are deeply concerned with multiple aspects of the frameworks and urge the office and board to adopt the following essential changes:

- **Test the hospital spending methodology before it is used to assess compliance with the spending target.** The sources of volatility must be better understood, and the outpatient intensity adjustment requires close attention given the incompleteness and untested nature of the data source.
- **Assess hospital performance against the spending target on a multiyear basis.** Otherwise, hospitals will simply cycle in and out of compliance due to extreme revenue volatility that bears no relationship to their efforts to meet the spending targets.
- **Conjoin inpatient and outpatient spending into a single growth measure.** This will ensure hospitals are accountable for keeping their overall spending growth under the target and ease the office's enforcement burden.
- **Enforce only against entities that exceed the target on both their commercial and all-payer lines.** Hospitals rely on all payers to ensure their revenues cover their costs, with commercial payments making up for growing shortfalls from Medicare and Medi-Cal. The statewide and hospital sector targets must apply to all payers to account for the impacts of the One Big Beautiful Bill Act (OBBBA) and focus OHCA's enforcement resources appropriately.
- **Ensure entities have meaningful opportunities to improve their spending performance prior to the imposition of financial penalties**. OHCA must adhere to the spirit and dictates of the progressive enforcement process established by the Legislature, provide latitude for hospitals to develop and implement their own cost-reducing strategies, and afford appropriate time for performance improvement.

- **Reduce the proposed spending target penalties from their current astronomical levels.** OHCA's proposed penalties would devastate hospitals' financial condition and endanger access to care — the exact opposite of OHCA's stated goals.

Further detail on each of these concerns and recommended solutions are provided below.

Clarify How Performance Against the Spending Targets Will Be Measured

The first spending target enforcement year is now in effect — in fact, it has already concluded for the more than 150 hospitals whose fiscal year ended on or before June 30.[1] And yet, hospitals still have major unanswered questions as to how their spending will be assessed against the targets and lack confidence that OHCA's methodologies will accurately reflect year-over-year changes in the components of spending that are within their control. While OHCA's approach has positive and essential features, it has yet to be validated. These questions and concerns must be addressed to assure hospitals that their efforts to comply with OHCA's spending limits will be successful. Absent that clarity, hospitals making good-faith efforts to comply will have no assurance that they will be able to avoid enforcement. **To firmly resolve these outstanding ambiguities, the forthcoming enforcement regulations must clearly specify how OHCA will measure hospitals against the spending targets and how data reliability will be assured.**

Include Volume and Intensity Adjustments, as Currently Contemplated

OHCA has spent more than a year developing its approach for measuring hospital spending growth with the help of a dedicated workgroup. The resulting methodology has essential features that aim to prevent fluctuations in volume and service intensity from biasing determinations of whether hospitals exceeded their target. Without such volume and intensity adjustments, OHCA would discourage hospitals from serving more patients, sicker patients, and offering resource-intensive services. The 2022-23 hospital spending growth data presented by OHCA aptly demonstrate the importance of these adjustments: Median commercial outpatient spending growth flipped from negative 7% when only volume was accounted for to positive 4.2% when both volume and intensity were considered. Conversely, median Medi-Cal inpatient spending flipped from positive 1.5% to negative 1.2% when an intensity adjustment was included. **If a 3.5% spending target had applied in 2023, around 15% of hospitals would have mistakenly been identified as having met or missed the target solely due to the absence of an intensity adjustment.** OHCA must retain both the volume and intensity adjustments in its final methodology.

Further Test the Hospital Spending Methodology

While conceptually promising, more work is needed to validate OHCA's approach for measuring hospital spending, particularly with respect to how OHCA plans to estimate intensity for outpatient services. Its approach utilizes a new and incomplete data source — the Healthcare Payments Database — that only covers 20% of hospital-reported commercial outpatient visits statewide. For many hospitals, the coverage is likely even lower. The result is that OHCA will capture the spending and utilization of all commercial outpatient services, but have no insight into the resource intensity of 80% of these services. Missing just one patient

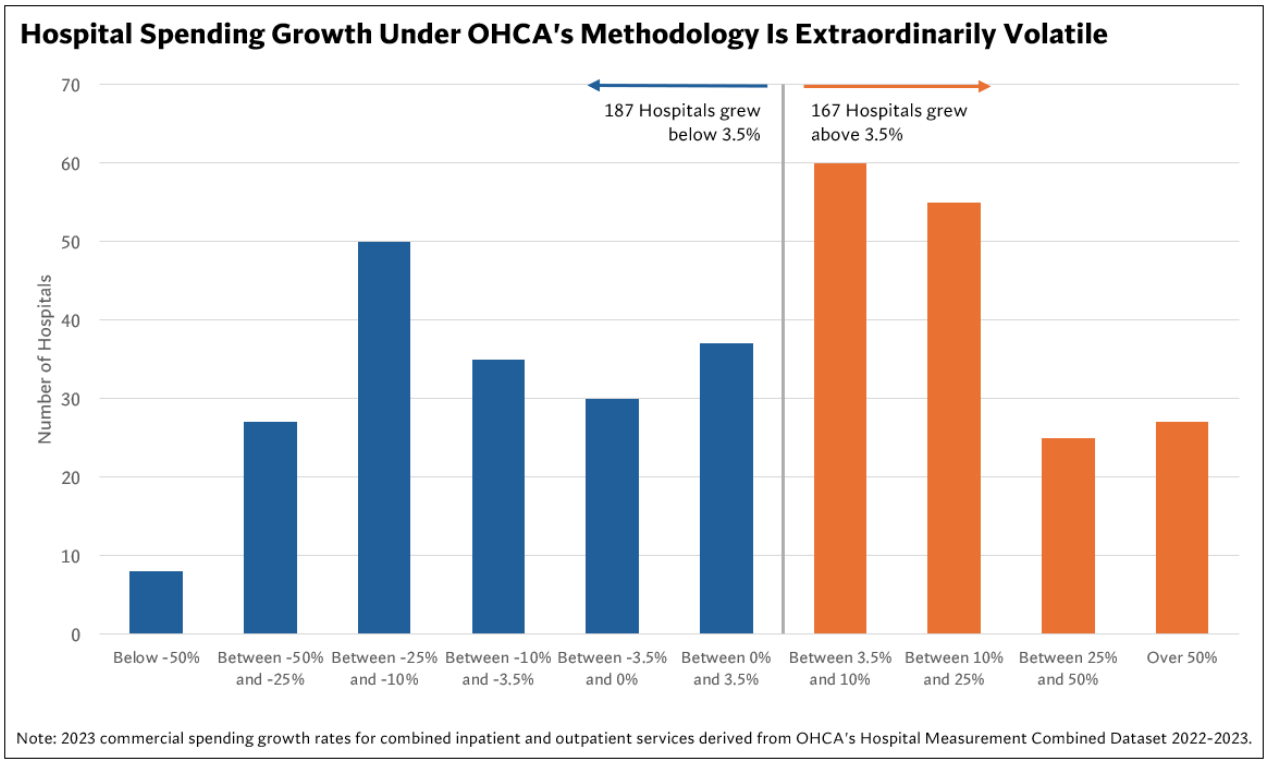
[1] OHCA has indicated it will assess hospital spending growth on a hospital fiscal, rather than calendar year, basis due to data reporting schedules.

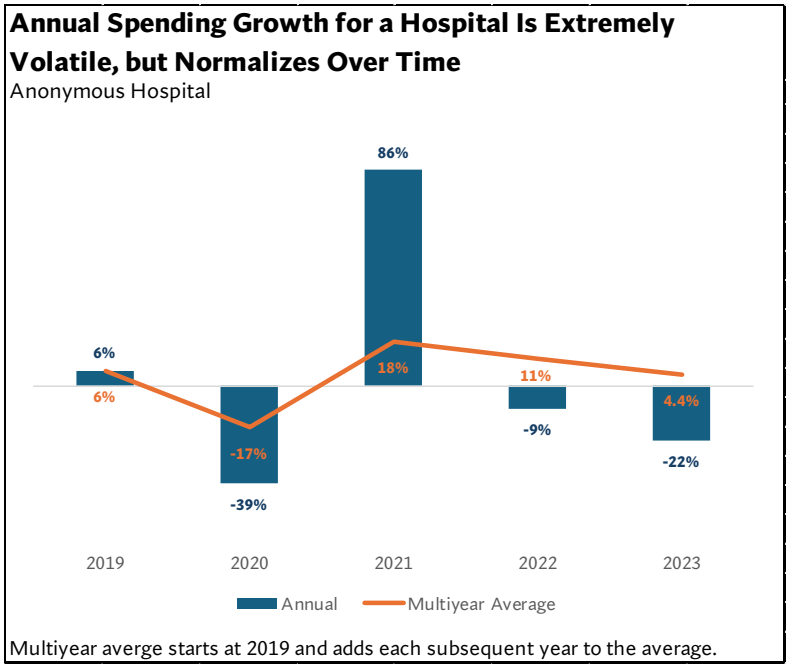
receiving a million-dollar drug infusion will inevitably bias OHCA's measurement of outpatient growth, and cause hospitals to erroneously fall subject to OHCA's onerous and unpredictable enforcement process.

Additionally, OHCA must make strides toward understanding and accounting for the extraordinary in measured hospitals spending growth before enforcement takes place. Solidifying the measurement approach up front will save OHCA from having to engage dozens or hundreds of hospitals within the initial phase of the enforcement process on justifiable reasons they exceeded their target. While improvement can be expected, the approach likely will never stamp out all unexplained volatility. OHCA will have to work closely with hospitals that exceed their target to distinguish real growth above the target from measured growth that is simply the relic of a faulty methodology.

Assess Hospital Compliance Against the Spending Targets on a Multiyear Basis

OHCA's 2022-23 hospital spending data reveal incredible volatility in individual hospitals' measured spending growth. As the figure below shows, 35 (nearly 10% of) hospitals saw annual commercial spending growth of greater than 50% or less than negative 50% between 2022 and 2023. A further 52 hospitals had growth between 25% and 50% or negative 25% and negative 50%. This volatility extends to government payers as well. Undoubtedly, these annual growth rates are not reflective, over a two-year period, of what OHCA aims to measure — the annual change in hospital unit prices. Hospitals did not receive 25% year-over-year rate increases or decreases from Medicare.



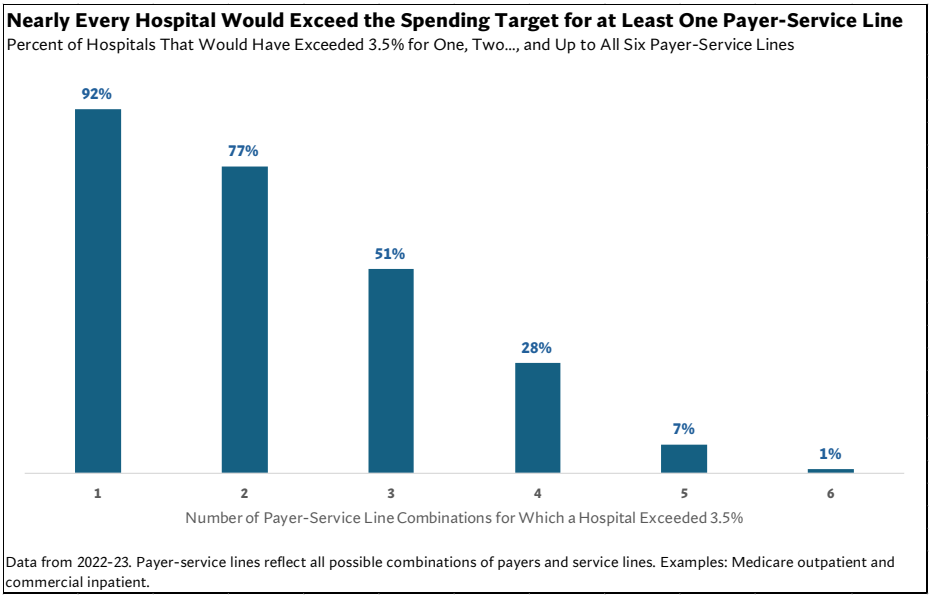


The figure on the left shows inpatient spending growth over a longer period for an individual hospital, revealing that high growth rates over a single annual growth period are **not** indicative of a sustained trend of either explosive price growth or radical price cutting. Instead, the figure shows that on a multi-year basis, the average annual growth rate normalizes to something OHCA could more meaningfully compare against the spending target. Ultimately, these data demonstrate that OHCA must measure hospital spending growth on a multiyear basis to avoid arbitrary punishment of hospitals that just happen to be in the boom cycle of their measured, **but not actual**, price growth.

Clarify What It Means to Be Accountable Against the Spending Targets

Despite having only approved statewide and overall hospital spending targets, OHCA has stated an intent to measure spending growth against the targets separately for each payer category (i.e., commercial, Medicare, and Medi-Cal) and, for hospitals, potentially separately for each service category (i.e., inpatient and outpatient). Adopting this approach would yield six distinct ways in which a hospital could be found in violation of the spending targets. As the figure below shows, had the target been in place in 2023, almost no hospital would have been safe.

OHCA would have had to initiate enforcement actions against **326 (92%) of the 356 hospitals that reported data**. It would have had to issue notice and technical assistance to and investigate the reasons why each of these 326 hospitals exceeded the target. The 326 hospitals would have had to supply extensive information justifying why, for example, their Medicare inpatient spending grew above the target — even if their overall spending growth was within the state's limits. And OHCA would have to determine the reasonableness of spending growth for each payer and service line for 326 hospitals based on no fewer than nine distinct enforcement



considerations. This would not be a prudent use of attention and resources —for OHCA or the hospitals themselves. Moreover, this approach would discourage hospitals from taking concrete and proactive steps to comply with the targets as they would still be virtually assured to violate the target for one payer-service line or another for reasons they do not control. To address barriers to efficient, fair, and appropriately targeted enforcement — and to properly inform hospitals, and other entities where applicable, of how the targets will be enforced — OHCA should codify the following policies in its forthcoming enforcement regulation package.

Conjoin Inpatient and Outpatient into A Single Measure

Hospitals are subject to the hospital spending targets established by the board. No targets have been established that apply distinctly to inpatient or outpatient services. Accordingly, hospitals must be held accountable based on all the patient care they provide. A hospital whose inpatient spending grows by 1%, outpatient spending grows by 5%, and combined total spending grows by 3% has not violated a 3.5% hospital-sector spending target — and must not be assessed as having done so. OHCA must remedy this problem by conjoining inpatient and outpatient spending in one of two ways:

- **Average the inpatient and outpatient growth rates to estimate a single measurement of growth for each hospital.** Weighting the inpatient and outpatient growth rates by service line patient revenues would account for hospitals' differing service mixes. This would streamline enforcement by limiting the number of hospitals exceeding a hypothetical 3.5% spending target on their commercial payer line in 2023 from 354 to 167 hospitals.[2]
- **Only enforce against hospitals that exceed the targets for both their inpatient and outpatient service lines.** Again, using 2023 data and considering only commercial spending growth, this would limit the scope of enforcement from 354 to 90 hospitals.

Only Enforce Against Entities That Exceed Both Their Commercial and All-Payer Spending Targets

To date, OHCA has focused on commercial health care spending growth as its key area of concern. In keeping, OHCA could simply disregard Medicare and Medi-Cal spending growth and only enforce the targets based on commercial spending growth. However, this would ignore more than 70% of the services a hospital provides, and therefore more than 70% of the payments upon which hospitals rely. Payer mix and cross subsidization, where commercial payments make up for large and growing shortfalls in payments from public payers, are fundamental features of hospital finance that cannot be ignored.

These patterns of hospitals' finance were present in OHCA's reporting on hospital spending trends in 2022 and 2023. For example, the data showed that statewide median Medicare and Medi-Cal inpatient payments were, respectively, 57% and 39% lower than commercial payments, and that statewide median reimbursement fell year-over-year for both Medicare and Medi-Cal. When the three payers are combined, the result is 0.5% annual growth in median reimbursement — far lower than each of 1) the 7% growth reported for commercial payers, 2) the state's first spending target of 3.5%, and 3) overall inflation of 3.9% in California in 2023.

Furthermore, health care coverage losses are happening now and growing due to OBBBA and other federal and state policy changes. Hundreds of thousands of residents have already dropped their Covered California coverage due to the expiration of enhanced subsidies, and millions are expected to fall off Medi-Cal coverage.

[2] 354 hospitals had data allowing for the calculation of their spending growth rates for their commercial payer line, while 356 hospitals (referenced on page 4) had data for any payer line, including for Medi-Cal and Medicare.

While reimbursement will drop, patients' care needs will not, leading to unprecedented increases in uncompensated care that hospitals do not have financial capacity to withstand.

To protect access to hospital care in the face of OBBBA's cuts and properly account for payer mix differences among hospitals, OHCA **must only initiate enforcement against hospitals that exceed their target on both their all-payer and commercial lines.** The all-payer line should account for all payments and services rendered — not only those from commercial, Medicare, and Medi-Cal — to properly capture the effects on overall reimbursement from the increase in the ranks of uninsured patients and uncompensated care.

Account for Complexity of Medi-Cal Financing

Medi-Cal financing of hospital services is bewilderingly complex. Faced with base reimbursement rates that fall far short of covering the cost of care, hospitals have been forced to "self-finance" the nonfederal share of Medi-Cal hospital expenditures to ensure they can continue caring for their communities. Self-financing comes in the form of provider taxes, intergovernmental transfers, and certified public expenditures that hospitals pay to the state or incur which are used to "draw down" federal Medicaid funding. Because hospitals incur the nonfederal share of cost, their net reimbursement equals only the federal funding. However, HCAI reports of hospital revenues include both the federal and self-financed nonfederal shares of this funding, overstating the net reimbursement hospitals receive.

In 2024, nearly half (48%) of total Medi-Cal managed care reimbursement for hospitals was self-financed — causing **total reimbursement in Medi-Cal managed care to be overstated according to HCAI financial reporting by 20% that year**.[3] Between 2022 and 2024, self-financed hospital reimbursement grew by more than $5 billion, while state-financed reimbursement grew by less than $1 billion. As a result, while payments in Medi-Cal managed care appear to have grown by 2.5% annually over this period, in truth, they grew by just 0.4% — far below the cost of caring for this population. To meet its statutory obligations under provisions such as Health and Safety Code (HSC) § 127502(d)(5) and accurately reflect the realities of Medi-Cal finance, OHCA must account for self-financing in its measurement of hospital spending growth against the targets.

Enforcement Must Be Progressive and Collaborative, Not Rushed and Punitive

As OHCA develops and promulgates formal enforcement regulations, it must conform with and expound upon the protections and processes established in state law, including but not limited to the law's clear direction that enforcement must be progressive.

Health Care Entities Must Have an Opportunity to Improve Spending Trends Under a Performance Improvement Plan (PIP)

The enforcement provisions of the California Health Care Quality and Affordability Act are unambiguous: Health care entities must have opportunities to justify and remediate their spending trends prior to any enforcement action, including the imposition of monetary penalties. HSC § 127502.5(a)) mandates that the office "enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, **allows each health care entity opportunities for remediation**, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access,

[3] Managed care is Medi-Cal's predominant delivery system, covering 94% of all Medi-Cal enrollees.

quality, equity, or workforce stability" (emphasis added).[4] State law further delineates a progressive enforcement process that starts with technical assistance, moves to (optional) public testimony, then mandatory performance improvement plans, and finally, as a last resort, monetary penalties.[5]

The Legislature did not intend the early steps of enforcement to be a "check-the-box" exercise. Rather, the process must include meaningful opportunities and adequate time for health care entities to implement cost-reducing strategies to meet the state's spending growth goals. This starts with giving entities the voluntary opportunity to put the technical assistance they receive from OHCA into action and engage in dialogue with the office on pathways to improvement. Next, it plainly requires PIPs to be forward-looking; health care entities cannot go back in time to alter prior policies, practices, or service offerings. Therefore, PIPs should apply starting in the first annual measurement period following their approval. Second, entities must be given a reasonable amount of time to implement their PIPs. The returns on many cost-reducing strategies, like primary care investments, regularly lag the upfront investments. To balance the urgency of improving affordability and the time and work involved in system improvement, the Legislature thoughtfully established that PIPs may be imposed for a period of up to three years.[6] Third, the PIPs must be self-directed. OHCA's role is to approve, not develop, the PIPs. Health care entities must have a meaningful opportunity to develop and implement their own strategies, like investing in community-based care or adopting alternative payment methodologies, to comply with their target. OHCA's role is oversight to ensure the improvement plans' goals are reached and do not have negative unintended consequences.

Spending Target Penalties May Only Be Levied After an Entity Has Failed Both Its PIP and Lawfully Established Target

California law states that, except in narrow circumstances specified in HSC § 127502.5(h)(1) for willful, egregious, or repeated noncompliance, a financial penalty may only be imposed "if the director determines that a health care entity is not compliant with an approved performance improvement plan **and** does not meet the cost target" (emphasis added).[7] This provision, among others, establishes multiple protections that must be incorporated into the forthcoming regulations.

Procedural Penalties Must Be Narrowly Tailored to Address Gross Misconduct and Set at Reasonable Levels

For the narrow instances in state law where there is egregious misconduct, OHCA has proposed procedural penalties distinct from the spending target penalties. Critically, these procedural penalties may not serve as an alternative approach to enforcement where entities' legal right to remediation is ignored and nullified. Rather, they must be narrowly tailored to the purpose established in law — addressing willful, egregious, or repeated noncompliance. OHCA's proposal oversteps these guardrails and seeks penalty limits that are out of line with comparable agencies.

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[4] Also see the Legislature's findings and declarations in HSC § 127500.5(m): "It is the intent of the Legislature in enacting this chapter that enforcement actions to address growth in per capita total health care expenditures are implemented in a progressive manner, such that health care entities are assisted to come into compliance with cost targets, including through technical assistance and performance improvement plans, before assessing administrative penalties unless there are egregious violations as specified in Section 127502.5."
[5] See HSC § 127502.5(a) and (d)(1).
[6] See HSC § 127502.5(c).
[7] See HSC § 127502.5(d)(1).

At the June OHCA board meeting, office staff presented procedural penalties as a mechanism by which OHCA could penalize entities prior to the conclusion of a PIP, including at implementation milestones within the PIP itself and for repeated failure to file an acceptable PIP. While imposing procedural penalties may be appropriate for gross misconduct like knowingly failing to provide required information, falsifying information, or repeatedly neglecting to file a PIP, extending these penalties beyond circumstances of clear bad faith or willful noncompliance is directly at odds with the statutory guardrails the Legislature established. A good-faith disagreement over what cost-reducing strategies are appropriate for an organization does not constitute egregious misconduct. Nor is it appropriate or legally sound to separately penalize an entity demonstrating a good-faith effort to implement cost-reducing strategies but where the benefits do not materialize as quickly as anticipated. In any board action and associated rulemaking, OHCA must make clear that entities are entitled to progressive enforcement of the spending targets and that procedural penalties may only be imposed in cases of unambiguously and documented egregious conduct in defiance of OHCA rules related to information sharing, data reporting, and PIP submission and implementation.

Finally, OHCA must reassess its procedural penalty amounts and revise them downward to conform to the standards of other regulators. The following table shows that OHCA's proposed procedural penalties far exceed those in comparable regulatory frameworks. Penalties for non-submission of required data in Oregon — which has the most stringent spending target program in the country — are up to $500 per day, 1/20th of the maximum per-day penalty proposed by OHCA. Massachusetts' $500,000 penalty is the maximum penalty that may be imposed for any reason. In contrast, OHCA's bifurcated proposal would authorize spending target penalties in the hundreds of millions of dollars in addition to procedural penalties at lower, but still disproportionate levels. Moreover, Massachusetts regulations make clear that penalties are only to be imposed as a last resort, in stark contrast to the framing presented at prior OHCA board meetings that procedural penalties are a means of accelerating

OHCA's Proposed Procedural Penalties Far Exceed Comparable Sanction Authorities from Other Agencies

Agency	Violation	Maximum Financial Penalty
California Office of Health Care Affordability	Health care entity fails to perform a procedural duty, such as filing a performance improvement plan or submitting information	$500,000 per violation or $10,000 per day, depending on the type of violation
Oregon Health Authority	Payer or physician organization fails to comply with data submission requirements	$400-$500 per day
Massachusetts Health Policy Commission	Payer or physician organization fails to file or implement a PIP in good faith	$500,000 per violation (per regulation, only imposed as a last resort)
California Department of Health Care Services	Managed care plan violates its state contract, fails to comply with a corrective action plan, or fails to submit timely and accurate provider network data	$25,000 for a first violation, $50,000 for the second, and $100,000 for each subsequent violation
California Department of Managed Health Care	Health plan violates the Knox-Keene Act	$25,000 per violation
California Air Resources Board	Covered entity fails to provide a timely and adequate report	$50,000 per year
California Air Resources Board	Business with over $1 billion in annual revenues fails to report its greenhouse emmissions	$500,000 per year

financial sanctions on regulated entities.[8] California's health plan regulators, the Department of Health Care Services and the Department of Managed Health Care, have limits of $25,000 per violation of similar procedural rules and requirements. Finally, while the California Air Resources Board may fine regulated entities up to $500,000 for noncompliance with its greenhouse gas reporting rules, the penalty only applies to entities with annual revenues of at least $1 billion and reflects an annual — rather than per violation — limit. In contrast, OHCA seeks authority to apply an equivalent penalty, potentially stacked multiple times within a given year, on hospitals with annual operating revenues in the low tens of millions of dollars.

OHCA May Not Assess Spending Target Penalties Based on Midyear Compliance with a PIP

The spending target is a "target percentage for the maximum **annual** increase in per capita total health care expenditures" (emphasis added).[9] This means that a spending target penalty may only be imposed after the office has determined that, in addition to being noncompliant with the PIP, the entity violated the corresponding year's spending target. **An entity cannot fail an annual target on a sub-annual basis.** Accordingly, pursuant to OHCA's underlying regulatory framework, fining an entity for noncompliance with its target based on midyear benchmarks, monitoring, and deliverables is plainly impermissible except within the narrow circumstances covered by the procedural penalties previously discussed. OHCA must give entities a year, at minimum, to comply with their PIP and associated spending target, and not rush toward punitive measures before that phase of the progressive enforcement process is complete.

PIPs That Jeopardize Access to High-Quality and Equitable Care May Not Be Imposed

To avoid unintended consequences and reinforce a holistic approach to improving affordability, the Legislature tasked OHCA with ensuring that PIPs are not implemented "in ways that are likely to erode access, quality, equity, or workforce stability."[10] This important constraint ties the hands of both the office and entities around what cost-reducing strategies may be employed. For hospitals, cutting revenues means cutting costs — costs that are concentrated in workforce recruitment and retention, facility upgrades (including those necessary to comply with state laws), and drugs and medical supplies used in patient care. Reducing hospital spending to the levels established by the spending targets may require service reductions that impair access, reduced ability to invest in quality-assurance activities, workforce reductions, and cuts to discretionary programs that address community needs. This is not what the Legislature envisioned. Flexibility will be needed for hospitals and other entities to implement cost-reducing strategies that avoid these negative impacts.

Spending Target Penalties Must Not Endanger Access to High-Quality and Equitable Care

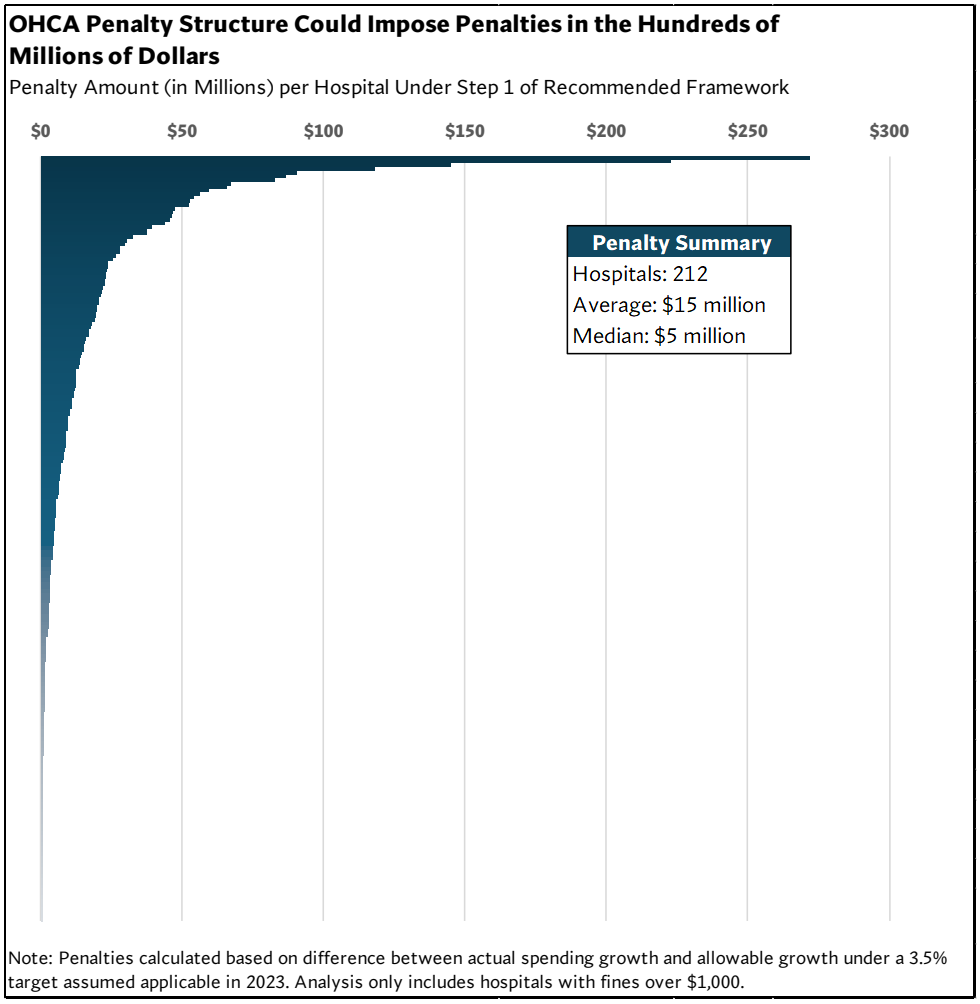
At the April board meeting, OHCA presented a two-step framework for determining the scope and range of spending target penalties for entities that fail their PIP and exceed their spending target. First, the office would set an initial amount equal to the amount by which the entity exceeded its allowable growth under its target. Then, the office would adjust that amount to account for various factors, including the nature, number,

[8] See Code of Massachusetts Regulations 958 10.15.
[9] See HSC § 127500.2(j).
[10] See HSC § 127502.5(a).

and gravity of the offenses; the entity's fiscal condition; the entity's market impact; and input from other state agencies.

OHCA's Recommended Penalty Structure Could Result in Enormous Penalties

OHCA's charge is to promote affordability without jeopardizing access to high-quality, equitable care and the stability of jobs. Unfortunately, financial penalties at the levels contemplated in OHCA's proposal would do just that and reflect the type of punitive approach to affordability the Legislature expressly disavowed. As the figure on the right shows, absent significant downward adjustments under step 2 of the framework, entities that exceed their spending target for even a single year could potentially be subject to fines in the hundreds of millions of dollars. **Had the 3.5% target been in place in 2023, the penalties would have exceeded the prior three-year cumulative total of operating earnings for 117 hospitals.** Fines of these magnitudes would threaten the viability of affected hospitals, placing access to care and health care jobs at serious risk. Enormous downward adjustments would be needed to reduce the penalties to practicable levels, rendering the process unpredictable, inscrutable, and capricious.



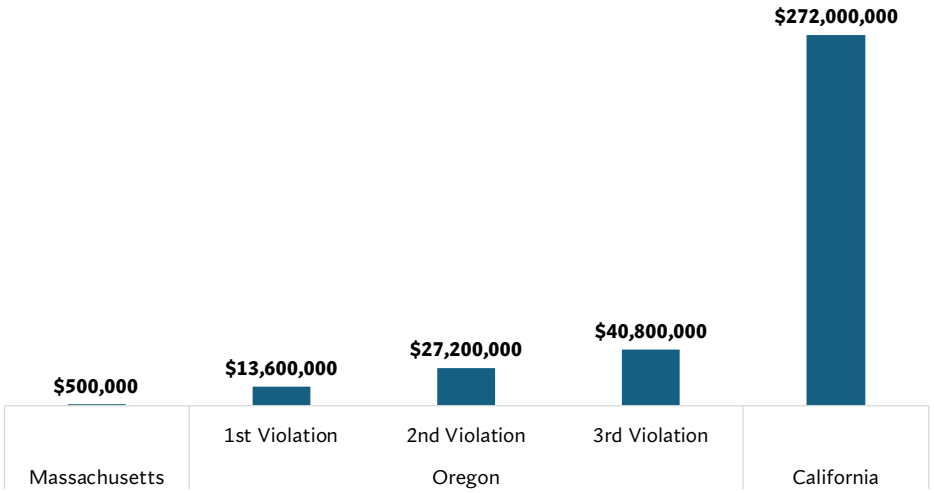
Other States Provide a Model for a More Reasonable Penalty Structure

OHCA is closely modeled after spending target programs in Massachusetts and Oregon, both of which rely on PIPs and financial penalties as their principal means of enforcement. However, the penalties in these other states vary significantly from OHCA's recommendation. In Massachusetts, the maximum financial penalty for failing to implement a PIP is $500,000. In Oregon, the financial penalty for failing to meet the state spending target starts at 5% of an entity's spending above the target (after the entity has been found to have exceeded

the target with statistical significance and without good cause in three out of five years). The penalty then increases by 5 percentage points for every additional instance of an entity exceeding the target (using the same multiyear formula). The figure on the right shows what a true outlier OHCA's recommended penalty structure could be compared to its peers, with OHCA's penalties starting at 20 times those in Oregon. OHCA should align with its peer states' penalty structures and modify its recommended framework accordingly.

California's Recommended Penalty Structure Would Be a Major Outlier

Largest Potential Financial Penalty for a Hospital Under Each State's Penalty Framework



Note: Penalties calculated based on difference between actual spending growth and allowable growth for hospitals under a 3.5% target assumed applicable in 2023. Oregon estimates apply its penalty framework to California using the 2023 hospital data. Massachusetts, by contrast, has a flat maximum penalty.

Adjustments to Initial Penalty Amounts Are Critical to Protect Access to Care

OHCA has recommended applying various adjustments to consider an individual entity's circumstances when determining final penalty amounts. Such adjustments are essential, particularly if step 1 of OHCA's penalty-setting framework is adopted, but also under a more restrained approach such as that used in Oregon. These adjustments must account for the following circumstances:

- *Hospital financial status* — To protect access to care, penalties must not undermine a hospital's ability to sustain services and remain viable. **OHCA should cap the penalty amount at a reasonable percentage of a hospital's patient care earnings.**
- *Factors beyond a hospital's control* — New mandates that raise costs, inflationary pressures, and changes in patient needs all influence a hospital's spending, despite their best attempts to remain under the spending limit. **OHCA should deduct the costs associated with these factors from the penalty.**
- *Efforts to improve access to high-quality, patient centered care* — Investments in primary and behavioral health care, for example, cost more at the outset but result in long-term savings and better health for Californians. **OHCA should deduct the costs the value of these investments from the penalty.**
- *Success in reducing spending trends until the imposition of the penalty* — **OHCA should credit an entity for any improvement in its spending performance, even if the entity has not yet met the target.**

Without these adjustments, OHCA's penalties would be unduly punitive and ultimately undermine its statutory responsibility to improve affordability while maintaining equitable access to care. While OHCA has only committed to considering the financial condition of entities when determining penalty amounts, the

latter three factors are plainly constitutive of the "nature" or "gravity" of any given offense. Specifying these factors within the regulation, alongside others as appropriate or mandated by state law, would give necessary meaning to OHCA's statutory directives and promote clarity around how OHCA's rules will be operationalized, to the benefit of both the office and regulated entities.

Conclusion

California's hospitals appreciate the opportunity to comment and look forward to continued engagement as OHCA moves toward promulgation of the spending target penalties and enforcement regulations. These rules and regulations will guide the behavior of hundreds of providers and payers; determine the breadth and scope of the office's enforcement responsibilities; guide difficult office decisions on which individual entities are subject to ever more stringent enforcement actions and which get a free pass; and, if approved in their current form, set penalties that existentially threaten the viability of hospital care across the entire state. Rulemaking must not be rushed; rather, it must deeply consider and promote all of OHCA's objectives, including the promotion of health care access, affordability, quality, equity, and workforce stability.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
David Chase
Dr. Sandra Hernández
Kim Johnson
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, PhD
Dr. Micah Owen
Dr. Richard Pan
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

California Association of Health Plans

1415 L Street, Suite 850
Sacramento, CA 95814
916.552.2910
www.calhealthplans.org

July 31, 2026

Sent via email:
ohca@hcai.ca.gov

Vishaal Pegany, Deputy Director
C.J. Howard, Assistant Deputy Director
Chris Kent, Program Specialist
Office of Health Care Affordability
2020 West El Camino Ave.
Sacramento, CA 95833

Re: Progressive Enforcement Framework and Draft Performance Improvement Plan Guidance

Dear OHCA Staff:

On behalf of the California Association of Health Plans (CAHP), we appreciate the opportunity to provide feedback on OHCA's June 8, 2026 Spending Target Progressive Enforcement Workshop and the accompanying draft Performance Improvement Plan (PIP) Guidance. We also appreciate OHCA's ongoing engagement with health plans and other stakeholders as it continues developing its spending target enforcement framework. OHCA has emphasized that the statute contemplates a progressive enforcement approach built upon technical assistance, public testimony, performance improvement plans, and ultimately, where warranted, administrative penalties. CAHP supports thoughtful implementation of this framework and appreciates OHCA's efforts to solicit stakeholder feedback before policy decisions are finalized.

We support the shared objective of improving health care affordability for California consumers. At the same time, because health care spending trends are influenced by numerous factors beyond the direct control of health plans and other regulated entities, we believe additional clarification and refinement of the enforcement framework are necessary to ensure that enforcement is equitable, administrable, and aligned with OHCA's affordability goals.

In particular, the final regulations and guidance should provide clear standards, adequate confidentiality protections, meaningful opportunities for remediation, workable timelines for regulated entities acting in good faith, and safeguards to ensure that enforcement actions do not erode access, quality, equity, or workforce stability.

I. Enforcement Should Distinguish Between Costs Within and Outside of an Entity's Control

CAHP appreciates OHCA's proposal to evaluate enforcement considerations before determining whether an entity proceeds beyond technical assistance. We believe this concept is essential to the success and credibility of the spending target enforcement framework. OHCA has identified several examples of potential considerations, including population characteristics, high-cost patient outliers, investments in primary and preventive care, high-cost drugs, changes in state and federal law, and catastrophic events.

However, stakeholders would benefit from additional clarity regarding how these considerations will be evaluated and ultimately applied. During the workshop, OHCA repeatedly indicated that these considerations are intended to provide flexibility and recognize circumstances that may contribute to spending growth. At the same time, OHCA also indicated that detailed standards regarding application of these factors have not yet been developed.

CAHP respectfully requests that OHCA provide additional guidance regarding how enforcement considerations will be incorporated into spending target assessments, PIP determinations, penalty determinations, and other enforcement decisions. Greater transparency regarding these considerations would improve predictability, promote consistency across entities, and strengthen stakeholder confidence in the fairness of the enforcement process.

The regulations should describe the process for submitting additional information, the criteria OHCA will apply, the timing for OHCA's review, and the opportunity for an entity to meet and confer with OHCA before escalation. When OHCA determines that an entity should proceed beyond technical assistance, OHCA should provide a written explanation summarizing the factors considered and the reasons escalation is warranted.

In particular, OHCA should explicitly recognize significant external cost drivers that may materially affect spending growth, including:

- New state and federal coverage mandates, and other legal and regulatory requirements;
- Significant changes in state or federal program requirements;
- Changes to federal and state-imposed taxes and assessments, including modifications to the Managed Care Organization (MCO) tax structure, which may materially affect health plan expenditures;
- Drug, medical device, equipment, and emerging therapeutic cost inflation;
- Infrastructure investments;
- Workforce and labor cost increases, including organized and non-organized labor costs;
- Significant increases in patient demand for specific services; and
- Other market-wide cost pressures that materially affect health care expenditures, such as periods of inflation, supply chain shortages, and labor shortages.

Where OHCA approves spending target adjustments for providers or hospitals, including non-supervisory organized labor adjustments, OHCA should consider the downstream impact of those approved costs on contracting entities that do not control those expenditures. Consideration of these impacts will help ensure that entities are not subject to enforcement actions based on costs that result from adjustments approved elsewhere within the health care system.

These factors often operate independently of actions taken by individual health plans and should be appropriately considered within any enforcement framework.

CAHP also encourages OHCA to establish consistent standards and expectations regarding the documentation and evaluation of enforcement considerations across entity types. While entities may rely on different data sources and methodologies based on their respective business models, a common framework for assessing and substantiating enforcement considerations would promote transparency, predictability, and equitable treatment across regulated entities.

In addition, OHCA should consider quality performance, timely access, and other evidence of high-value care when determining whether an entity should proceed to further enforcement steps. Even if OHCA does not adopt a formal quality adjustment for the 2026 target, enforcement should not create incentives for entities to reduce spending in ways that could undermine access, quality, equity, or workforce stability.

II. OHCA Should Protect the Confidentiality of Nonpublic Information Submitted During the Enforcement Process

CAHP respectfully requests that OHCA adopt a clear confidentiality process for all nonpublic data, information, documents, and materials submitted during the spending target enforcement process, including those provided to participate in technical assistance, public testimony, and the entirety of the PIP process. Such submissions may include sensitive financial, actuarial, operational, contractual, labor, quality, utilization, pharmacy, governance, or strategic information. The process should encourage that candor rather than create uncertainty about public disclosure.

OHCA's proposed PIP guidance should also clarify that nonpublic information submitted through the PIP process is protected by law and should remain confidential unless disclosure is authorized under applicable statutory exceptions and procedures. The guidance should not create the impression that PIP materials are public unless an entity separately requests confidentiality.

III. Administrative Penalties Should Advance Affordability Goals Rather Than Reduce Resources Available for Patient Care

CAHP appreciates OHCA's commitment to a progressive enforcement structure and its recognition that financial penalties should represent a final enforcement step. OHCA's proposed framework appropriately contemplates technical assistance, public testimony, and performance improvement plans before penalties are considered.

However, we remain concerned that large administrative penalties may inadvertently undermine OHCA's affordability objectives if they divert resources away from care delivery, affordability initiatives, quality improvement efforts, workforce investments, or other activities that benefit consumers. The proposed approach to calculating 'initially commensurate' penalty amounts could result in penalties that are disproportionate to the circumstances giving rise to spending growth, particularly where significant external cost drivers are present.

As OHCA continues developing penalty methodologies and justification factors, we encourage the agency to carefully consider:

- The fiscal condition of entities;
- The market impact of the entity, including potential impacts on consumers and purchasers;
- Impacts on access to care;
- Existing financial pressures affecting the health care system;
- The entity's conduct and good-faith remediation efforts;
- The reasons for spending growth, including costs outside the entity's control; and
- Whether penalties are likely to advance affordability objectives in a meaningful and measurable way.

For significant enforcement determinations, OHCA should also consider providing entities an opportunity to submit additional information or request reconsideration based on material factual inaccuracies, incomplete information, or changed circumstances. Such a process would help ensure that enforcement decisions are informed by the most complete and accurate information available while promoting transparency and stakeholder confidence in the framework.

Penalties should generally be reserved for repeated or unresolved noncompliance, rather than triggered by a single performance year. A multi-year view would better distinguish an ongoing pattern from a temporary spike caused by unusual utilization, high-cost drugs, mandated benefits, labor costs, or other external pressures. It would also give entities a fair opportunity to implement corrective actions before penalties are considered.

OHCA should ensure that validated external cost drivers are meaningfully reflected in any penalty calculation methodology. We also encourage OHCA to ensure that any finalized penalty methodology reflects the broad range of circumstances that may contribute to spending growth and avoids outcomes that could unintentionally create additional affordability challenges.

Lastly, CAHP respectfully asks that OHCA ensure that any penalties collected from regulated entities are meaningfully directed back into California's health care system in a manner that advances affordability for consumers. Penalty revenue should not be treated as a general funding source disconnected from the consumer affordability concerns the enforcement framework is intended to address.

IV. OHCA Should Allow Sufficient Time for Improvement Efforts to Demonstrate Results

During the workshop, several stakeholders raised concerns regarding the timing of actions including technical assistance, performance improvement plans, and subsequent enforcement actions. OHCA noted in its workshop materials a projected timeframe of two years between a measurement period and enforcement determinations. Even though spending growth measurements are retrospective due to this time lag, OHCA should allow entities to justify the implementation of cost-management initiatives launched in between a measurement year and enforcement determinations, recognizing that these projects often require substantial operational effort and time to achieve program goals.

CAHP encourages OHCA to recognize these timing realities when evaluating entity performance against the spending target. In particular, OHCA should ensure that entities already engaged in performance

improvement activities are afforded a meaningful opportunity to demonstrate progress before additional enforcement actions are pursued.

OHCA should clarify in guidance that PIPs are intended to be forward-looking tools and should not penalize entities for performance periods they no longer have a meaningful opportunity to influence. Because spending growth measurement is retrospective, an entity may not receive notice of a target exceedance until much of the following performance year has already passed. Entities should not be penalized for intervening periods that occur before a PIP can reasonably be implemented.

Such an approach would be more consistent with OHCA's stated objective of encouraging sustainable improvement rather than solely imposing punitive consequences.

V. Technical Assistance Should Serve as a Meaningful Opportunity for Remediation

The statute contemplates technical assistance as the first step in progressive enforcement and requires that entities have opportunities for remediation. To give that step practical meaning, OHCA should treat technical assistance as a meaningful opportunity for an entity to explain spending growth, identify cost drivers, correct data issues, implement reasonable changes, and avoid unnecessary escalation.

CAHP recommends that OHCA establish a defined technical assistance period before requiring public testimony or a PIP, absent exceptional circumstances. OHCA should provide written notice of the specific concerns to be addressed, the information needed from the entity, and the criteria OHCA will use to determine whether escalation is warranted. Where an entity engages constructively and demonstrates good-faith efforts, technical assistance should be available as an off-ramp from further enforcement steps.

CAHP further encourages OHCA to formalize this review process by providing entities an opportunity to discuss preliminary findings, submit additional contextual information, and address potential concerns before a determination is made that a PIP is required.

VI. Additional Clarification Is Needed Regarding PIP Requirements and Evaluation Standards

CAHP appreciates OHCA's effort to provide draft PIP guidance and we believe stakeholder feedback at this stage is valuable. However, several elements of the draft guidance would benefit from additional clarification.

Specifically, CAHP requests additional information regarding:

- How OHCA will evaluate and weigh PIP approval criteria;
- How entities will have an opportunity to meet with OHCA to discuss preliminary findings and provide additional information before OHCA determines that a PIP is required;
- How OHCA will evaluate final compliance with a PIP;
- How OHCA will evaluate the potential for multiple or overlapping PIPs, particularly where an entity is already implementing corrective actions and has not yet had a meaningful opportunity to demonstrate progress;

- How OHCA will determine circumstances that may warrant modification of an approved PIP;
- How OHCA intends to coordinate with other regulatory agencies when proposed PIP activities implicate existing regulatory requirements; and
- How OHCA will determine the applicable spending target when a PIP spans multiple performance years with different statewide target levels.

Additional clarity on these issues would improve consistency, reduce unnecessary administrative burden, and allow entities to develop more effective and actionable improvement plans.

Conclusion

CAHP appreciates OHCA's willingness to engage directly with health plans and other stakeholders while developing this important framework. We share OHCA's commitment to improving affordability for California consumers and look forward to continuing to work collaboratively with OHCA as it refines the progressive enforcement process, PIP guidance, and related regulations.

We would welcome the opportunity to discuss these comments further and participate in future stakeholder discussions regarding enforcement policies and implementation.

Sincerely,

Anete Millers
Vice President of Legal and Regulatory Affairs
California Association of Health Plans

CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

July 31, 2026

Elizabeth Landsberg
Director, Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833

Re: Concerns with Spending Target Enforcement Framework and Financial Penalties

Dear Director Landsberg,

On behalf of the California Association of Public Hospitals and Health Systems (CAPH), I am writing to express concerns with the Office of Health Care Affordability's (OHCA's) proposed spending target enforcement framework, including the scope and range of administrative penalties and the penalty justification factors, and to encourage your consideration of several important issues during the written comment period.

California's 17 public health care systems, which include county-operated and affiliated facilities and the five University of California health systems, are the core of the state's health care safety net. County public health care systems have a mission and mandate to deliver high-quality care to all, regardless of ability to pay or insurance status, across a comprehensive range of services. Despite representing only 6% of all hospitals statewide, public health care systems provide 35% of all Medi-Cal and uninsured hospital care. They contribute over $4 billion annually to the Medi-Cal program, in place of the state's share, with many of their payments uniquely tied to quality and performance improvements. Additionally, these systems train a diverse and inclusive workforce, including nearly half of all new doctors in hospitals across the state.

We share OHCA's and the Health Care Affordability Board's goals to improve affordability and slow the growth of health care spending. However, we urge careful consideration of the enforcement policies being developed and their potential for negative impacts on the safety net. This is critically important at a time when $30 billion per year in federal funding is expected to be taken out of the Medi-Cal program.[1] Cuts like this will already push safety net providers to the brink and jeopardize services for our Medi-Cal and uninsured patients. As OHCA and the Board seek to adopt new policies regulating health care spending in

[1] Joyce, D. (2025). How massive federal cuts will create unprecedented challenges for Medi-Cal patients and providers. *California Health Care Foundation*. Available at: https://www.chcf.org/resource/how-massive-federal-cuts-will-create-unprecedented-challenges-medi-cal-patients-providers/

California, the historic changes to health coverage and funding that we are facing must be at top of mind. We urge OHCA and the Board to carefully consider the following issues as they develop and adopt the spending target enforcement framework and financial penalties:

Medi-Cal financing considerations: Most public health care systems' Medi-Cal revenues come through self-financed payments, meaning the systems themselves, not the State, provide the nonfederal share, and they receive as revenue only the federally matched (net) portion. However, many hospitals in public health care systems report the gross amount of these payments, which includes the nonfederal share they provide, in their Hospital Annual Financial Disclosure Reports. This differs from how private hospitals report supplemental funding under the Hospital Quality Assurance Fee Program, and it substantially inflates reported revenues. We are concerned that public hospitals could enter OHCA's enforcement processes based on data that overstates their revenue by not accounting for self-financing. While we appreciate OHCA staff's confirmation that the provision of a hospital's nonfederal share will be considered as a penalty justification factor, we urge the development of measurement processes that consistently and transparently account for self-financed payments so that public hospitals do not face spending target enforcement based on overestimates of their revenue.

Performance Improvement Plan (PIP) process: Under the proposed framework, entities that are required to submit PIPs have only 45 days to respond to the requirement, with the possibility of a 30-day extension. Even a mid-sized hospital is a large organization, with hundreds or thousands of employees, complex operations, and millions of dollars in annual costs. Hospitals will need more than six to ten weeks to bring together financial, operational, and clinical leadership to identify areas where sustainable changes can be made that will lead to meaningful spending reductions over the course of a multi-year PIP without affecting staffing, services, access, or quality, as would be required under the proposed framework. We recommend that OHCA lengthen the initial PIP submission period from 45 to 60 days and increase the extension window from 30 to 45 days.

Additionally, public health care systems require more guidance on how to draft a successful PIP. For hospitals, the goal of a PIP will be to reduce revenue growth to below the target rate. Most hospitals in public health care systems face very low or negative margins already, and these hospitals are facing substantial reimbursement cuts due to H.R. 1 and state budget decisions in the coming years, while labor and supply costs continue to grow. Finding ways to further reduce revenue without cutting services or staff—changes which could threaten workforce stability and access to care—may not be possible if these hospitals face spending target enforcement. Additionally, even in cases where

sustainable revenue reductions are possible, public health care systems have limited control over the volume and intensity of the services they provide and the payments that they receive. For example, the majority of patients at many public health care systems are covered by public insurance, meaning that payments for most services are already highly regulated and largely determined by federal and state agencies. Further, public health care systems' mission to provide care to all who need it regardless of ability to pay or insurance status would prevent them from committing to offering less trauma, burn, or other high-cost specialty care in order to lower revenue per discharge. We urge OHCA to provide clearer guidance on what a successful PIP could look like given the constraints facing public health care systems.

Volatility of per-year enforcement: OHCA has indicated it will enforce each performance year individually, assessing a penalty against the year that prompted enforcement. Given the significant volatility in growth rates — both negative and positive — between years, a single year viewed in isolation can present a misleading picture of an entity's underlying trend. We urge OHCA to base any determination of a violation on multiple years of data, or to incorporate a rolling-average or smoothing methodology, and to clarify how the subsequent year's baseline is adjusted after a year of large negative growth.

Proposed penalty magnitude: OHCA's proposed structure begins with an amount "initially commensurate" with an entity's failure to meet the target and then adjusts for justification factors. OHCA's own illustrative analysis of 2023 data showed "initially commensurate" penalties for public hospitals reaching $236 million, and proposed penalties could reach 125% of the initially commensurate amount at maximum. Financial penalties of this magnitude could lead to significant instability in the health care safety net, risking service line and facility closures for entities already facing historic payment cuts. As the Board takes up the range of penalties in August, we strongly encourage it to reconsider the proposed penalty structure and set a measured starting point, especially this early in the implementation of the spending target.

Enforcement is in the context of federal and state cuts: Cuts to Medi-Cal under H.R. 1 along with state budget decisions made recently could result in billions of dollars in additional annual losses for public health care systems. To stabilize revenues and prevent closures, some systems may seek Medi-Cal managed care base rate increases and/or commercial rate increases. Depending on how these flow through the measurement metrics for individual hospitals, such strategies could push a hospital's performance above the target. As just one example, we are concerned that it remains unclear how needed revenue growth like this would be accounted for during the enforcement process.

Spending target enforcement recommendations: We strongly recommend that OHCA and its Board consider alternative approaches to the penalty structure, such as what was developed in Oregon for its cost growth target program. The Oregon Health Authority (OHA), which oversees the program, is phasing in financial penalties for entities that "unreasonably exceed" its spending targets. The structure created by OHA does not assess penalties against health care entities unless they exceed the state's spending target with statistical confidence and without a valid reason for three of five years.[2] Further, the initial penalty amount is limited to only 5% of the entity's net total cost above the cost growth target over a five-year period.[3] This can progressively increase by five percentage points for additional instances of an entity failing to meet the performance requirements.[4] We encourage OHCA to consider incorporating features like this to create a reasonable starting place for financial penalties, while avoiding further financial distress and potential closures of safety net facilities and providers.

In addition, we recommend OHCA adopt clear and transparent measurement processes that account for self-financed payment structures in Medi-Cal. OHCA's enabling statute requires that "with respect to Medi-Cal, the methodology shall consider provision of nonfederal share … associated with Medi-Cal payments, such as expenditures by providers … that serve as the nonfederal share associated with Medi-Cal reimbursement."[5] While inclusion of the provision of the nonfederal share as a penalty justification factor will serve as an important backstop to ensure that public hospitals are not unduly penalized, a more precise measurement methodology would help to prevent public hospitals from entering the enforcement process based on inflated revenue estimates.

Finally, we recommend that OHCA acknowledge the role and unique financing structures of safety net providers in the penalty justification factors. At the May 2026 Board Meeting, OHCA recommended limiting the penalty justification factors to those listed in statute (§127502.5(d)(6)) without further definition. While we appreciate OHCA's aim to preserve flexibility rather than creating "one-size-fits-all" language, we urge OHCA and the Board to apply these factors in a way that genuinely protects safety net providers. For example, when considering the fiscal condition of the entity, OHCA should acknowledge that safety net providers like public health care systems face fiscal strains that may not be reflected in

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[2] Flaherty, G., & Angeles, J. (2025). Beyond public reporting: Strengthening accountability to states' cost growth targets and leveraging targets in health care oversight. *Peterson-Milbank Program for Sustainable Health Care Costs.* Available at: https://www.milbank.org/wp-content/uploads/2025/06/State-Cost-Growth-Target-Accountability_final.pdf

[3] Ibid.

[4] Ibid.

[5] CA Health and Safety Code § 127502 (2022).

a given financial measure (e.g., profits or assets) and may not have financial structures that align with these measures.

Thank you for the opportunity to comment. CAPH appreciates OHCA's engagement with stakeholders and urges the Office and Board to adopt an enforcement and penalty structure that advances affordability without compromising access to care in the health care safety net. We would welcome the opportunity to continue working with OHCA as these proposals are refined ahead of the August 2026 vote.

Sincerely,

Katie Rodriguez
Interim President & CEO
California Association of Public Hospitals and Health Systems

Cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández
Kim Johnson
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, Ph.D.
Dr. Richard Pan
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

PEACH
California's Community Safety-Net Hospitals

July 30, 2026

Office of Health Care Affordability
Department of Health Care Access and Information
2020 West El Camino Avenue
Sacramento, CA 95833

RE: Proposed Enforcement Framework

Dear Director Landsberg and Members of the Health Care Affordability Board:

The Private Essential Access Community Hospital (PEACH) Association, representing the approximately 90 community safety-net hospitals in California, appreciates the opportunity to comment on the Office of Health Care Affordability's proposed enforcement framework for health care entities. We hope to engage in a fruitful dialog moving forward where we can both share our ideas and expertise on the development of a system that can truly make healthcare more affordable for Californians.

We appreciate the webinar your team held on July 7 that provided an overview of some parts of the enforcement process and provided an opportunity for entities to ask questions. PEACH staff and members joined the call and gathered more details on the plan itself. However, we continue to have many questions about the implementation of the plan, along with numerous concerns and recommendations. We will outline those in some detail below.

PEACH would welcome the opportunity to meet directly with your team to strengthen the dialogue between OHCA and the entities it regulates. Although we appreciate the recent Zoom webinar and will strive to be thorough and clear in this memo, an in-person discussion would allow for more efficient and effective communication—particularly given the significance of the issues at stake. We will follow up with your office to identify a time for that discussion.

Overall, PEACH recommends OHCA pause its implementation efforts until critical questions regarding the data, technical assistance process, performance improvement plan process, penalty framework, and until there is a better handle on the number of Californians who will lose Medi-Cal Coverage in CY2027 and beyond

due to the provisions of HR 1. As safety net providers with 50% of their patients covered by Medi-Cal, PEACH hospitals will be heavily impacted by Medi-Cal coverage losses due to Community Engagement and Re-determination requirements. To maintain the credibility of the OHCA Board and this process, we must assure data is accurate, the process is transparent, and the program will achieve the desired outcome before substantive enforcement decisions are made.

Penalties

Unfortunately, OHCA staff did not cover any of the penalty structure during the zoom meeting held on July 7. There was no presentation of an overview of the penalty structure; no sharing of modeling that may or may not have been done on how the potential penalties would impact access to health care; no information provided on how penalties will be assessed; no opportunity for clarifying questions; and of course, no dialogue between OHCA and those entities who are at risk of penalty.

We were able to get a copy of the slides OHCA used in presenting the enforcement plan to the health plans. Using the penalty proposal outlined in that slide deck, PEACH is concerned that the penalties as currently proposed will cripple the community hospital safety net.

Using HCAI data, PEACH calculated the proposed estimated penalties using the most recent data available (2023). The 87 private Disproportionate Share Hospitals (DSH) stand to be penalized at an estimated $1,666,716,767. These same hospitals have a combined net operating margin of negative $109,374,401. The combined Medicare and Medi-Cal associated penalties would be in excess of $1B, which is causing a great deal of angst within our hospital community during a time of unprecedented Medicaid cuts resulting from HR 1.

Our concerns about the proposed Enforcement Framework stem, in part, from the reality facing California hospitals. Our members are already operating in an extraordinarily challenging financial environment, and the risk of losing access to care has never been greater. In the past three years alone, two California hospitals have closed, and 22 hospitals have been forced to close maternity units simply to remain financially viable, leaving 12 counties without maternity care. Thousands of health care workers lost their jobs in 2025 alone, and, according to an analysis by Public Citizen, more than 40 hospitals are currently at significant short-term risk of closure. Statewide, while 44% of all hospitals

are operating at a loss, 44% of the state's private DSH have had two consecutive years of negative operating margins. That is unsustainable. If California wishes to have a hospital safety net in the years to come, support is needed.

At the same time, the cost of providing care continues to rise sharply. Labor costs — the largest component of hospital spending — have increased by 51% since 2019, more than twice the rate of general inflation. For hospitals already struggling to maintain essential services and access to care, these additional losses would accelerate service reductions, workforce cuts, and hospital and clinic closures that would further erode access to care.

Currently, the OHCA Board does not have any data-driven understanding of the impact these fines could have on the health care eco-system, access to health care or the impact on the cost of health care for Californians. It seems untenable to ask the Board to make such a critical call without such information.

Recommendation: OHCA should hold another webinar with Safety Net hospitals specifically to provide an overview of the penalty plan, so that PEACH members can understand OHCA's intent. We also believe it is important for the OCHA team to hear the concerns from safety net hospitals about the impact penalties would have on access to care in their under-resourced communities and for vulnerable patient populations.

Recommendation: OHCA should not implement a penalty phase until it has completed and shared a financial model on the impact a penalty would have on community safety net hospitals and access to care. We encourage OHCA to provide an example calculation for an individual hospital to illustrate the end-to-end process and impact.

Recommendation: Before penalties are considered, OHCA should ensure that penalties are capped and phased in gradually. It should require a clear demonstration that any enforcement action will improve affordability for patients through lower premiums, reduced cost-sharing, or direct consumer benefit. In addition, OHCA should conduct and release a detailed evaluation of potential impacts on access, quality, equity, workforce stability, safety-net capacity, emergency services, and essential community programs before imposing any penalty.

Recommendation: OHCA should calculate and model what the penalty will be for each hospital using more current data as to date OHCA has only provided 2022 and 2023 periods. This will be informative for hospitals regarding their potential liability if they

exceed the targets. It may also allow them to plan effectively to potentially manage the impact on patients.

Recommendation: The outpatient data currently being used to calculate the annual hospital payment growth should not be used until examined further. The data comes from a different, non-hospital source than the rest of the data in the calculation, and it does not align with expectations. OHCA should not be using faulty data in such critical calculations. PEACH and our technical experts look forward to working with the OHCA team to work through this important data issue.

Outstanding technical questions:

1. How is OHCA treating lump sum settlements that span multiple years, but the money only hits in a single year when the settlement occurred?
2. How is OHCA factoring in denials?
3. How is OHCA factoring payer disruptions (denials, in/out of network, volume fluctuations)?
4. How is OHCA factoring in increasing overhead costs (rent, utilities, wages, supplies, etc.)? One hospital system for example had their PG&E bills increase by 13%.
5. Where do the penalty funds go?

Performance Improvement Process

PEACH is particularly interested in the "enforcement considerations" OHCA will consider when determining which entities will proceed beyond technical assistance in progressive enforcement, including a Performance Improvement Plan. We applaud the inclusion of such considerations. It demonstrates that OHCA has an understanding that so much of the cost of health care is outside of the control of hospital providers. The considerations OHCA names include patient population characteristics, high-cost patient outliers, high-cost drugs, changes in state law and impact on consumer access and affordability. This is a good start, but the list is incomplete and needs to be applied earlier in the process.

PEACH supports the use of "enforcement considerations" but believes they need to be expanded and applied further upstream as part of the determination of which entities exceed the spending target.

OHCA should consider these – and more – factors as "acceptable reasons" for cost growth. These reasons should be considered before requiring a Performance

Improvement Plan (PIP) or administering financial penalties. If a hospital's excess cost growth is justifiable under these criteria, it should be marked as acceptable in public reporting and no penalties are applied.

These reasons include the "considerations" noted above, but should also include categories of spending outside of a hospital's control and which supports the state's public policy and patient access agenda:

- **Frontline Worker Costs:** Increases in wages, benefits, and labor pressures, including workforce shortages and the challenges particularly for rural and safety net health care providers. Labor is the single largest expense for California hospitals, typically accounting for fifty to sixty percent of total operating expenses, and hospitals should not be penalized for improving benefits for current staff or recruiting new members.
- **Service Expansions:** New services or investments added to meet pressing community needs. Penalizing hospitals for creating new services can stifle vital innovation and decrease local access to care. Because healthcare is moving toward value-based, community-focused care, policies that disincentivize new community investments can leave vulnerable populations without access to critical treatments
- **Population Characteristics:** Changes in population mix, acuity, and federal policy changes like Medicaid cuts. PEACH members are committed to serving vulnerable communities and patients, but that commitment comes with a price as reimbursements are low or sometimes nonexistent and the supports these patients require to access their care are extensive and can be expensive. The patient's safety net providers care often require longer lengths of stay for the patient and disproportionate costs for the community safety-net hospitals. The social complexity of the safety net patient should be taken into consideration.
- **Behavioral Health investments:** Dedicated investments in expanding behavioral health access. Given California's behavioral health crisis, health care providers who make considerable investments in boosting services or the behavioral health workforce should be supported.
- **Macro-economic pressures:** Annual inflation rates in California range from 3.3% to 3.8% across major metropolitan areas. Inflation is clearly outside of a hospital's control but cannot be ignored.
- **Emergency Preparedness**. California hospitals have costs associated with the prevention and management of numerous natural disasters, including wildfires and earthquakes. It is in all of our best interest for hospitals to be incentive to manage these issues, with patient and staff safety and access to care in mind.

- **Underpayment by Government programs**. OHCA should account for underpayments from government programs like Medicaid or Medicare. Without this consideration, OHCA risks penalizing a provider merely for subsidizing state and federal programs. In addition, it allows OHCA to consider the ability-to-pay without jeopardizing access to safety net services.

Recommendation: OHCA should create a robust category of spending considerations that would be deemed acceptable reasons for hospitals to exceed the set target. The acceptable reasons for cost growth should be those documented here, including population characteristics, investments in front line workers and services that support patient care and cost factors outside of the hospitals control, in addition to the original list OHCA has presented. These acceptable reasons for growth will positively support the access to care California's safety net hospitals provide in under-resourced communities across the state.

Recommendation. PIPs should be imposed for a period of up to three years. The Legislature did not intend the early steps of enforcement to be a check-the-box exercise. Rather, the process must include meaningful opportunities and adequate time for health care entities to implement cost reducing strategies to meet the state's spending growth goals. The returns on many cost-reducing strategies, like primary care investments, regularly lag the upfront investments. This is needed to balance the urgency of improving affordability and the time and work involved in system improvement.

Recommendation. PIP selection criteria needs to be developed and transparent. OHCA has not clearly identified which hospital entities that exceed the spending targets will be required to complete a Performance Improvement Plan and which will not. Nor has OHCA explained the criteria it will use to make that determination. Without transparent, objective standards for this critical decision, the public and other key stakeholders, including the Legislature and other Departments within the Administration, cannot have confidence that the process will be applied consistently and without bias.

Outstanding technical questions:

1. What if a PIP is never approved by OHCA?
2. What regulators will OHCA consult regarding the PIP?
3. Is OHCA obligated to confer with hospitals engaging in the PIP process or is that only at the Director's discretion?

We have a shared obligation and commitment to ensure patients can access care in the communities where they live and work. As currently drafted, the OHCA enforcement policy is unclear, highly subjective, and places the hospital safety net in jeopardy. PEACH is eager to partner with you to address these concerns in a thoughtful, patient-centered approach.

Please do not hesitate to contact me or our legislative advocate, Nicette Short, at Nicette@nlshortpa.com or 916.549.2853 if you need additional information. Thank you.

Sincerely,

Anne McLeod
President and CEOPEACH – California's Community Safety-net Hospitals

CALIFORNIA MEDICAL ASSOCIATION

August 4, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833

Sent via email to **ohca@hcai.ca.gov**

Re: Proposed Performance Improvement Plan Guidance and Spending Target Progressive Enforcement

Dear Secretary Johnson:

On behalf of our over 50,000 physician and medical student members of the California Medical Association (CMA), we appreciate the opportunity to provide feedback on the California Office of Health Care Affordability's (OHCA or the Office) proposed Performance Improvement Plan (PIP) Guidance and spending target progressive enforcement process. The enforcement process is being developed by OHCA should take into consideration that neither the states with a longer history of setting spending targets, nor California data from 2023 and 2024, are in line with most health care entities being able to meet the 3-3.5% spending growth target set by OHCA for 2025-2029. Many stakeholders continue to believe that the spending targets set by OHCA will not be possible to meet without harming access to care given the increased costs to deliver medical care, including workforce costs.

CMA's Board of Trustees spent substantial time at our July 31 Board meeting discussing OHCA's proposed enforcement process and level of proposed fines for health care entities that fail to meet OHCA's spending targets. We offer the following comments and concerns to advance our shared goal of improving health care affordability for Californians while maintaining access to high-quality, equitable care. As physician organizations are directly subject to PIPs and any potential penalties under this framework, our members have a significant stake in ensuring the guidance and process are clear, workable, fair, and consistent with protecting access, quality and equitable health care delivery. We appreciate OHCA's willingness to engage with stakeholders before these proposals are finalized.

Attribution of Costs Beyond a Physician Organization's Control and Enforcement Considerations

Health & Safety Code section 127502.5(a) requires the Director to consider "the factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target." Under the attribution methodology example presented to OHCA's physician organization workshop and to the Health Care Affordability Board in June, costs, such as behavioral health specialty care

provided by another provider group, PMB pharmacy claims, and hospital ER claims will be attributed by the health plan to a physician organization even though the physician organization has no ability to negotiate, direct, or control those costs and in many instances will not even have knowledge of the changing costs such as those of PBM pharmacy claims. In fact, the only connection a medical group may have to these costs is, potentially, the financial responsibility to pay those costs to the extent those risks are delegated to the group. In many instances, a delegated group may be required to use a plan's network and rates negotiated by the plan for hospitals and specialty care networks, so the group is unlikely to have the ability to negotiate lower rates with those facilities or providers. In cases where the group is not delegated financial responsibility for these costs, they would have no visibility into, let alone control over, such care costs. A framework that attributes costs to a physician organization it cannot control adds unnecessary pressure to the practices that are least equipped to absorb it.

To the extent that OHCA decides to attribute to a physician organization costs that are beyond the control of a physician practice, those costs should be removed from consideration during your enforcement process. It is inappropriate to require a physician practice or other health care entity to draft a performance improvement plan to address costs that are beyond its control, and often beyond its line of sight. Similarly, it is misplaced and counterproductive to levy fines on a physician practice or other health care entity for costs that are beyond its control.

This problem does not end with attribution, however; it carries directly into how OHCA decides whether and how to enforce against a physician organization. Under the process outlined in the workshop materials, an entity found to have exceeded the spending growth target will have 45 days to provide additional information, including enforcement considerations such as population characteristics, high-cost patient outliers, investments in primary and preventive care, high-cost drugs, changes in state and federal law, and acts of God or catastrophic events. OHCA evaluates this information to determine whether an entity proceeds beyond technical assistance in progressive enforcement, including a PIP.

Neither the workshop materials nor the draft PIP guidance explains how OHCA will weigh these enforcement considerations, or how a physician organization is expected to raise the fact that, in addition to these factors, a meaningful share of its attributed spending is outside of its control. The enforcement considerations listed do not squarely address this issue because the examples listed reference reasons why the spending grew, but not whether the health care entity had the ability to control the spending. That gap is notable given that, as noted above, Health & Safety Code section 127502.5(a) directs the Director to consider "the extent to which each entity has control" over its cost target components. This statutory factor is not reflected anywhere in the enforcement considerations OHCA has proposed. And unlike population characteristics, high-cost outliers, and the other listed factors, which OHCA may weigh at its discretion, an entity's control over its costs is a factor that the statute requires the Director to consider.

Similarly, Section 127502, at subdivisions (f) and (g), require the Office, in consultation with the Board, to establish risk adjustment and equity adjustment methodologies for the reporting

of data and to take into account social determinants of health and other factors related to health equity. These statutory requirements were a recognition of the fact that the health and socio-economic status of a patient population materially impact the cost of providing care to that population in ways that are beyond the provider's control. They were also a recognition of the adverse outcomes to access, equity, and quality of care that would follow if the state penalized providers for treating patients with high-cost, high acuity, and chronic conditions. Those mandatory methodologies are also absent from the reporting and attribution methodologies, as well as from the Office's recommendations regarding cost target penalties.

While CMA recognizes that this enforcement guidance itself does not set or change the attribution methodology, we urge OHCA to establish costs outside of the health care entity's control as their own, separately identified factor at each relevant stage of the enforcement process. This might include having the health plan separate out attribution categories such as pharmacy claims from the costs attributed to the health care entity or allowing a physician organization to submit documentation identifying specific attributed costs it did not negotiate, direct, or otherwise control in the 45-day enforcement considerations stage, confirming that a PIP need only address the "key causes of spending growth" within a physician organization's control, and accounting for documented uncontrollable costs in OHCA's evaluation of whether a PIP is likely to bring an entity into compliance. CMA is happy to discuss further with OHCA staff about how the Office intends to handle costs attributed to a health care entity such as a medical group or physician practice that are beyond the entity's control and thus not subject to a PIP or an administrative penalty.

Spending Target Enforcement and Penalty Range

Health & Safety Code section 127502.5(a) requires the Director to enforce cost targets in a manner that "allows each health care entity opportunities for remediation." Consistent with that direction, the statute establishes a progressive enforcement sequence: technical assistance, the potential of public testimony, performance improvement plans, and only then the potential of administrative penalties for failure to meet the spending target. We appreciate this structure and its emphasis on remediation before consideration of a penalty. We are concerned, however, that OHCA's capacity to provide meaningful technical assistance may not keep pace with the number of entities likely to exceed OHCA's spending targets, particularly in these early years of enforcement. If technical assistance is limited or nonexistent in practice, physician organizations will have few genuine opportunities to develop a PIP that OHCA will approve before facing the possibility of penalties, undermining the remediation-first design the statute itself establishes.

The statute directs that if the Director determines that penalties are warranted, they be assessed "in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets," and requires the Director to consider the nature, number, and gravity of the offense, the entity's fiscal condition, and the entity's market impact in setting any penalty. OHCA's current proposal defines "initially commensurate" as the full dollar amount by which an entity's actual spending growth exceeded the target, effectively a 100 percent penalty, with a proposed

range of up to 125 percent of that amount. To illustrate the scale this methodology can produce, OHCA's own analysis of 2023 and 2024 data presented at the June Board meeting estimated that "initially commensurate" penalties for health plans alone would have ranged from $4 million to $350 million that year. Starting at, or near, the statutory ceiling in the very first year an entity could be penalized is difficult to reconcile with the statute's progressive and remediation-focused framework and leaves little room for the escalating structure the statute contemplates: an entity facing a penalty at or near the maximum in year one has nowhere left to escalate to if its performance does not improve.

This concern also connects directly to the attribution issue described above. Nothing about the statute's penalty framework requires OHCA to treat every dollar of an entity's measured excess spending as equally within that entity's control simply because a penalty calculation has been reached. If OHCA does not establish entity control as a distinct enforcement consideration at the stages described above, that gap becomes most consequential here: an entity could be penalized, dollar-for-dollar, for spending it never had the ability to control in the first place. We strongly recommend that, before finalizing any penalty amount, OHCA exclude, from the calculation of the 'initially commensurate' penalty, costs attributed to physician organizations that are documented as outside the entity's control, consistent with the express statutory requirement that the Director consider the extent of an entity's control over its cost target components. (Health & Safety Code § 127502.5(a).

Any discussions of enforcement must also take into account the current fiscal landscape for health care in California. Our concerns about administrative fines are heightened by the current environment physician practices are facing. H.R. 1 created the largest cuts to federal health care funding in our nation's history, and the federal administration has proposed regulations to cut Medicare rates paid to physicians, who, unlike other provider types, do not receive automatic annual Medicare rate increases. Medicare rate cuts will also likely translate into further cuts to Medi-Cal physician reimbursement rates as they are generally set as a percentage of Medicare. Further, physician practices, unlike larger health systems, generally do not have affiliated entities, subsidiaries, or substantial reserves to absorb reductions in government reimbursement.

As mentioned above, physician organizations have much more limited financial ability to absorb costs and revenue cuts. Imposing significant financial penalties for failure to meet the cost targets, coupled with the actions the federal government has already taken via H.R.1 and Medicare rate cuts, will likely result in fewer physician practices and reduced access to care. As the health care cuts in H.R. 1 roll out, it is advisable for OHCA to set up a reasonable penalty structure, rather than one that proposes up to 125% of the amount a health care entity has exceeded the cost target in these early years of enforcement. It will not benefit patients if OHCA imposes significant administrative penalties on health care entities that are already financially struggling to survive.

Health and Safety Code section 127502.5(b)(4) requires that the Director consult with DMHC, DHCS or the Insurance Commissioner prior to taking any enforcement action that could be inconsistent with the laws they enforce. This will serve as a protection to payers that are required to meet tangible net equity or risk-based capital reserve requirements to ensure

financial solvency. Similar attention should be paid to the financial solvency of providers, such as physician practice, a statutory factor under section 127502.5(d), before any enforcement action is undertaken. Under section 127501, paragraph (i)(1), OHCA receives audited financial reports from providers, and this may be a starting place for understanding the ability of a particular provider to sustain an administrative penalty.

We also urge OHCA to ensure the market impact factor in section 127502.5(d)(6)(C) has a meaningful, predictable effect on penalty calculations. A June 2026 Health Affairs Forefront analysis[1] found that hospital services and retail prescription drugs, not physician or professional services, account for the largest share of commercial spending growth across states with cost growth targets. The analysis in Health Affairs indicates that "Together, these two categories account for nearly 70 percent of per person commercial health spending." As CMA has long discussed with OHCA, physician practices generally lack significant market power and are not the primary cost drivers in the health care system. Given that state law requires that "The director shall consider… the market impact of the entity" to determine the penalty, OHCA's penalty structure should make clear that the Office will not levy significant fines on health care providers that do not have significant market impact. OHCA's proposed methodology lists market impact as one of several factors that "could result in an increased or decreased final penalty amount," without specifying how much weight it carries. CMA also emphasizes that a smaller penalty is warranted for an entity with little or no market power. Other states with cost targets have not imposed fines on physician organizations.

Finally, we encourage OHCA to consider that most states with cost growth target programs, including states with many years of experience, continue to see widespread cost growth that exceeds their targets. The health care cost data OHCA collected for 2023 and 2024 shows that most health care entities in California would not have met OHCA's spending growth target had it been in effect in 2024. The Medicare Economic Index, which measures inflation in physician practice operating costs, was 4.6% for 2024.[2] Given all this information, we urge OHCA to treat the early years of California's program as a period to test whether its targets are attainable without undue harm to access, quality, or equity, rather than assessing penalties calculated at or near the statutory maximum from the outset. Financial penalties are intended to change behavior. However, a penalty that exceeds a physician practice's operating earnings will not change that behavior, it will likely end the practice, whether through closure or consolidation with a larger, often higher-cost entity. Penalty amounts can be revisited and adjusted in future years as OHCA learns more about the real-world effects of imposing administrative penalties. The closure or consolidation of a physician practice cannot be undone - meaning overly aggressive early penalties risk causing exactly the kind of permanent harm to access that the statute directs OHCA to avoid. We strongly encourage OHCA to adopt an initial penalty calculation meaningfully below the statutory ceiling, reserving escalation for entities that fail to demonstrate genuine improvement over time,

[1] Michael Bailit, January Angeles, et al., HEALTH AFFAIRS, "States Are Exceeding Their Health Care Cost Growth Targets. What Does It Mean?" (June 16, 2026), https://doi.org/10.1377/forefront.20260610.549590.
[2] Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program," 88 Fed. Reg. 78818, 78885 (Nov. 16, 2023), https://www.federalregister.gov/d/2023-24184/p-640.

consistent with both the escalating structure the statute already establishes and its direction that OHCA consider each entity's fiscal condition and market impact.

Procedural Penalties, Technical Assistance

The Office seeks to establish "procedural penalties," pursuant to Health and Safety Code section 127502.5(h)(1) (referred to as "administrative penalties" in the statute), on a health care entity that fails to comply with certain requirements relating to performance improvement plans (PIPs). Bases for these penalties include, in part, up to $10,000 per day for, "repeatedly failing to file an acceptable performance improvement plan with the office."

While the statute expressly authorizes a penalty for repeatedly failing to file an acceptable PIP, we note the statute also expressly requires the Office to provide technical assistance to health care entities to assist them with compliance. (Health & Safety Code § 127502.5(a)(1) & (c)(1).) We recognize the Office may be operating under a limited bandwidth with respect to managing PIPs, especially in the early years of enforcement when it is likely that many health care entities will fail to meet the spending target.

In light of the significant administrative and procedural penalties the Office seeks to implement, and the number of health care entities expected to exceed their cost targets in the first enforcement year, CMA emphasizes the importance of providing meaningful guidance and feedback on what will be considered an acceptable PIP. Physician organizations and other health care entities should not be subjected to fines without clear and detailed feedback from the Office about what changes would be required to make a PIP acceptable. It is imperative that OHCA provide appropriate feedback when rejecting a PIP as "unacceptable" to ensure health care entities can comply with the statute without jeopardizing their practice or decreasing health care access, quality, equity, or workforce stability. (§ 127502.5(a)(1) & (c)(1).)

Thank you for your consideration of our comments. CMA appreciates the opportunity to work with OHCA on efforts to develop a spending target enforcement process that improves health care affordability for Californians while maintaining access to high-quality, equitable care. Please feel free to each out to me or Janice Rocco at jrocco@cmadocs.org should you require additional information regarding CMA's comments.

Sincerely,

René Bravo M.D.
President, California Medical Association

CC: **Elizabeth Landsberg**, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Members of the Health Care Affordability Board

Attachment #9

UNITED WAY
Monterey County

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Katy Castagna
President and CEO

August 11, 2026

Elizabeth Landsberg
Director, Office of Healthcare Affordability
2020 W. El Camino Ave.
Sacramento, CA 95833

Subject: OHCA Enforcement Must Not Jeopardize Our Community's Health
(Submitted via email to ohca@hcai.ca.gov)

Dear Director Landsberg:

United Way Monterey County(UWMC) connects people, partners, and pathways to improve lives across the County. Focused on long-term stability, United Way works alongside community partners to strengthen financial security, support early learning, and expand access to trusted resources. We work closely with our health care providers as we help to address the social determinants of health. We have deep partnerships with Montage Health, Salinas Valley Health, and Natividad in our shared mission of serving this community. From routine care to emergency needs, these hospital systems are pillars of our community. That's why United Way Monterey County is deeply concerned about how our community would be impacted if the Office of Health Care Affordability (OHCA) implements aggressive, unreasonable penalties that harm patient care.

Monterey County has a population of about 435,000 residents, 45% of whom struggle to make ends meet. UWMC provides a number of programs and services for those below the "Real Cost Measure", an estimate of the minimum income needed to meet basic needs. We depend on our local hospitals and healthcare providers for a variety of services, ranging from education and prevention to emergency services. This is foundational to the vulnerable population we serve as well as to our own workforce as an employer.

We partner with our hospitals to meet several vital community health priorities, including a shared community health needs assessment, mutual support for the 211 Information and Referral system, promoting wellness programs such as the Blue Zones project, and creating referral pathways for diabetes care and mental health supports. That work is at risk because of OHCA's current spending cap, and the jeopardy would only grow if OHCA were to impose multi-million-dollar fines on hospitals that exceed the spending cap.

OHCA's decisions now will have a ripple effect on our communities for years to come. Montage Health, Salinas Valley Health and Natividad are very important to the wellbeing of our community. No doubt the economics of measuring and comparing healthcare costs is very nuanced. Please make every effort to have a fair and equitable measurement with realistic cost targets and incentives that do not degrade the quality of our current systems. On behalf of all of our community members, United Way Monterey County urges you to take a collaborative approach that protects access while improving affordability.

Thank you for your consideration.

Sincerely,

Katy Castagna
President and CEO

cc: Members of the Health Care Affordability Board:
Kim Johnson
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, PhD
Dr. Richard Pan
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

Attachment #10

CHILDREN'S Specialty Care Coalition
Putting California's Children First

Children's Hospital Los Angeles
Medical Group

California Association
of Neonatologists

ChildNet/Specialty Medical Group
Valley Children's Hospital,
Madera

Sutter Children's Center
Sutter Medical Center, Sacramento

Children First Medical Group,
Emeryville

Rady Children's Specialists of
San Diego

Department of Pediatrics
California Pacific Medical Center
San Francisco

UCLA Mattel Children's Hospital
David Geffen School
of Medicine at UCLA

Department of Pediatrics
UC San Diego School of Medicine

Stanford Children's Health
Stanford University School
of Medicine

Department of Pediatrics
UC Davis Children's Hospital

Department of Pediatrics
UCSF Benioff Children's Hospital
UC San Francisco School of Medicine

Department of Pediatrics
UC Irvine Medical Center

Department of Pediatrics
Loma Linda University Faculty
Medical Group, Inc.

Miller Children's and Women's
Hospital Long Beach

CHOC Children's Specialists, Orange
County

Cottage Children's Medical Center -
Santa Barbara

Shriners Hospitals for Children -
Northern California

Community Regional Medical Center,
Fresno

Cedars-Sinai Guerin Children's

August 19, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833

Sent via email to ohca@hcai.ca.gov

Re: Proposed Performance Improvement Plan Guidance and Spending Target Progressive Enforcement

Dear Secretary Johnson:

On behalf of the Children's Specialty Care Coalition (CSCC), which represents 19 pediatric specialty medical groups across the state, which are either closely aligned with the freestanding children's hospitals or integrated into a larger health care system, we appreciate the opportunity to provide feedback on the California Office of Health Care Affordability's (OHCA) proposed Performance Improvement Plan (PIP) Guidance and spending target progressive enforcement process.

CSCC is dedicated to ensuring that children and youth with complex health care needs have access to equitable, timely and high-quality care. The more than 3,000 pediatric specialty care physicians we represent treat children and youth with conditions like cancer, cystic fibrosis, kidney disease, congenital heart disease, prematurity, and many other chronic and complex diseases. CSCC understands the economic challenges families across California are facing, in part due to the rising cost of health care. The enforcement framework, however, must be carefully crafted so that cost containment does not come at the expense of patient access to care and necessary medical advances to improve and prolong life.

By nature, pediatric specialists serve a high-cost population. Additionally, this care is regionalized to ensure sufficient patient volume. This translates to the state's most complex children and youth being concentrated for their care in only a select number of tertiary centers of excellence. Year-to-year, varying levels of patient acuity can skew costs. For example, if one or more children receives a newly approved gene therapy costing millions of dollars per treatment, this will drive up costs significantly. It can also save that patient's life. To that end, we recommend OHCA be very cognizant of not disincentivizing innovation for breakthrough treatments in pediatric health that could likely cause a health care entity to exceed its cost growth target. Because of the variability in the cost of treating complex pediatric patients, the enforcement framework should evaluate performance over multiple years and provide health care entities with a meaningful opportunity to explain relevant circumstances that contribute to short-term increases in spending.

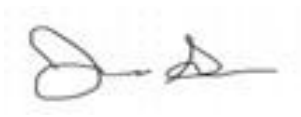
We are also concerned about the severity of the proposed penalties. Penalties of up to 125% of the amount by which a health care entity exceeds the spending target are excessive, particularly during the early years of the program. It is important to point out that OHCA is developing (PIP) Guidance against the backdrop of some very unique challenges for the pediatric specialty care network. Pediatric specialists treat a disproportionate share of Medi-Cal patients, which exceeds 70 percent at some of the state's largest children's hospitals. The unfavorable payer mix is a contributing factor to the concerning workforce trends, whereby not enough medical students are choosing to go into pediatric specialty care. For several years running, including the most recent match in 2025, a number of pediatric subspecialties had a fellowship fill rate at or below 50%, including pediatric endocrinology, nephrology, and infectious disease.[1] These trends are mirrored in California and translate into access challenges, including long wait times for appointments. Pediatric specialty medical groups are already struggling to keep up with demand and cover the cost of care, so outsized financial penalties have the potential to further deteriorate access to care.

As OHCA continues developing its enforcement regulations, CSCC urges the Board to ensure that the final framework:

(1) Evaluates performance over multiple years rather than a single year of spending growth;
(2) Allows health care entities to work collaboratively with OHCA to develop and implement performance improvement plans before imposing financial penalties.
(3) Clearly reflects California law which requires OHCA to consider whether a health care entity actually controls the costs attributed to it when enforcing spending growth targets.
(4) Ensures that any future penalties are proportionate and do not jeopardize access to essential pediatric services.

CSCC thanks the OHCA Board and staff for taking into consideration these recommendations as it crafts enforcement policies.

Sincerely,



James Stein, MD
President
Children's Specialty Care Coalition

Erin M. Kelly, MPH
Executive Director
Children's Specialty Care Coalition

[1] 2025 Medicine and Pediatric Specialties Match Results - https://www.nrmp.org/wp-content/uploads/2025/12/2025-Medicine-and-Pediatric-Specialties-MRS-Report.pdf

CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

August 20, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
2020 West El Camino Avenue, Suite 1016
Sacramento, CA 95833

Re: Concerns with Spending Target Enforcement Framework and Financial Penalties

Dear Chair Johnson,

On behalf of the California Association of Public Hospitals and Health Systems (CAPH), I am writing to express concerns with the Office of Health Care Affordability's (OHCA's) proposed spending target enforcement framework, including the scope and range of administrative penalties and the penalty justification factors, and to encourage your consideration of several important issues ahead of the August 2026 Health Care Affordability Board Meeting.

California's 17 public health care systems, which include county-operated and affiliated facilities and the five University of California health systems, are the core of the state's health care safety net. County public health care systems have a mission and mandate to deliver high-quality care to all, regardless of ability to pay or insurance status, across a comprehensive range of services. Despite representing only 6% of all hospitals statewide, public health care systems provide 35% of all Medi-Cal and uninsured hospital care. They contribute over $4 billion annually to the Medi-Cal program, in place of the state's share, with many of their payments uniquely tied to quality and performance improvements. Additionally, these systems train a diverse and inclusive workforce, including nearly half of all new doctors in hospitals across the state.

We share OHCA's and the Health Care Affordability Board's goals to improve affordability and slow the growth of health care spending. However, we urge careful consideration of the enforcement policies being developed and their potential for negative impacts on the safety net. This is critically important at a time when $30 billion per year in federal funding is expected to be taken out of the Medi-Cal program.[1] Cuts like this will already push safety net providers to the brink and jeopardize services for our Medi-Cal and uninsured patients.

[1] Joyce, D. (2025). How massive federal cuts will create unprecedented challenges for Medi-Cal patients and providers. *California Health Care Foundation*. Available at: https://www.chcf.org/resource/how-massive-federal-cuts-will-create-unprecedented-challenges-medi-cal-patients-providers/

As OHCA and the Board seek to adopt new policies regulating health care spending in California, the historic changes to health coverage and funding that we are facing must be at top of mind. We urge OHCA and the Board to carefully consider the following issues as they develop and adopt the spending target enforcement framework and financial penalties:

Medi-Cal financing considerations: Most public health care systems' Medi-Cal revenues come through self-financed payments, meaning the systems themselves, not the State, provide the nonfederal share, and they receive as revenue only the federally matched (net) portion. However, many hospitals in public health care systems report the gross amount of these payments, which includes the nonfederal share they provide, in their Hospital Annual Financial Disclosure Reports. This differs from how private hospitals report supplemental funding under the Hospital Quality Assurance Fee Program, and it substantially inflates reported revenues. We are concerned that public hospitals could enter OHCA's enforcement processes based on data that overstates their revenue by not accounting for self-financing. While we appreciate OHCA staff's confirmation that the provision of a hospital's nonfederal share will be considered as a penalty justification factor, we urge the development of measurement processes that consistently and transparently account for self-financed payments so that public hospitals do not face spending target enforcement based on overestimates of their revenue.

Performance Improvement Plan (PIP) process: Under the proposed framework, entities that are required to submit PIPs have only 45 days to respond to the requirement, with the possibility of a 30-day extension. Even a mid-sized hospital is a large organization, with hundreds or thousands of employees, complex operations, and millions of dollars in annual costs. Hospitals will need more than six to ten weeks to bring together financial, operational, and clinical leadership to identify areas where sustainable changes can be made that will lead to meaningful spending reductions over the course of a multi-year PIP without affecting staffing, services, access, or quality, as would be required under the proposed framework. We recommend that OHCA lengthen the initial PIP submission period from 45 to 60 days and increase the extension window from 30 to 45 days.

Additionally, public health care systems require more guidance on how to draft a successful PIP. For hospitals, the goal of a PIP will be to reduce revenue growth to below the target rate. Most hospitals in public health care systems face very low or negative margins already, and these hospitals are facing substantial reimbursement cuts due to H.R. 1 and state budget decisions in the coming years, while labor and supply costs continue to grow. Finding ways to further reduce revenue without cutting services or staff—changes which could threaten workforce stability and access to care—may not be possible

if these hospitals face spending target enforcement. Additionally, even in cases where sustainable revenue reductions are possible, public health care systems have limited control over the volume and intensity of the services they provide and the payments that they receive. For example, the majority of patients at many public health care systems are covered by public insurance, meaning that payments for most services are already highly regulated and largely determined by federal and state agencies. We urge OHCA to provide clearer guidance on what a successful PIP could look like given the constraints facing public health care systems.

Nonsupervisory Organized Labor Adjustment (NOLA) process: As OHCA develops its process for adjusting spending targets to account for organized labor costs, we request that OHCA consider the issues raised in our previously submitted comments on the draft NOLA regulation and file specifications.

Our primary concern is that the level of detail and volume of data required by the draft file specifications would create a substantial new administrative burden. For example, hospitals would be required to submit detailed data on a wide range of labor cost categories for each individual employee classification code and bargaining unit across all organized labor contracts at a facility. For most hospitals, this will require the development and validation of custom reporting.

This administrative burden is compounded by the difficulty of accurately projecting such detailed labor costs two years in advance, given the inherent uncertainty of collective bargaining outcomes and the fact that many labor agreements are finalized outside the target-setting timeline. While we appreciate OHCA's clarification that there will not be a cutoff date for prospectively reporting organized labor costs, additional reporting to true up adjustments as contracts are completed would require ongoing administrative effort.

Finally, while we appreciate OHCA's efforts to create a framework for prospective labor cost adjustments, no framework for retrospective adjustments has yet been outlined. OHCA has indicated that retrospective adjustments will be applied to spending target measurement in the 2026 and 2027 performance years where the prospective adjustment process cannot be applied, but it is unclear how these adjustments will be made or what data will be used to make them. We urge OHCA to outline a clear and transparent process for applying retrospective adjustments to spending targets based on historical data.

Volatility of per-year enforcement: OHCA has indicated it will enforce each performance year individually, assessing a penalty against the year that prompted enforcement. Given the significant volatility in growth rates — both negative and positive — between years, a single year viewed in isolation can present a misleading picture of an entity's underlying

trend. We urge OHCA to base any determination of a violation on multiple years of data, or to incorporate a rolling-average or smoothing methodology, and to clarify how the subsequent year's baseline is adjusted after a year of large negative growth.

Proposed penalty magnitude: OHCA's proposed structure begins with an amount "initially commensurate" with an entity's failure to meet the target and then adjusts for justification factors. OHCA's own illustrative analysis of 2023 data showed a $230 million "initially commensurate" penalty for an individual public hospital, and penalties under the proposed framework could reach 125% of the initially commensurate amount at maximum. Financial penalties of this magnitude could lead to significant instability in the health care safety net, risking service line and facility closures for entities already facing historic payment cuts. As the Board takes up the range of penalties in August, we strongly encourage it to reconsider the proposed penalty structure and set a measured starting point, especially this early in the implementation of the spending target.

Enforcement is in the context of federal and state cuts: Cuts to Medi-Cal under H.R. 1 along with state budget decisions made recently could result in billions of dollars in additional annual losses for public health care systems. To stabilize revenues and prevent closures, some systems may seek Medi-Cal managed care base rate increases and/or commercial rate increases. Depending on how these flow through the measurement metrics for individual hospitals, such strategies could push a hospital's performance above the target. As just one example, we are concerned that it remains unclear how needed revenue growth like this would be accounted for during the enforcement process.

Spending target enforcement recommendations: We strongly recommend that OHCA and its Board consider alternative approaches to the penalty structure, such as what was developed in Oregon for its cost growth target program. The Oregon Health Authority (OHA), which oversees the program, is phasing in financial penalties for entities that "unreasonably exceed" its spending targets. The structure created by OHA does not assess penalties against health care entities unless they exceed the state's spending target with statistical confidence and without a valid reason for three of five years.[2] Further, the initial penalty amount is limited to only 5% of the entity's net total cost above the cost growth target over a five-year period.[3] This can progressively increase by five percentage points for additional instances of an entity failing to meet the performance requirements.[4] We

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[2] Flaherty, G., & Angeles, J. (2025). Beyond public reporting: Strengthening accountability to states' cost growth targets and leveraging targets in health care oversight. *Peterson-Milbank Program for Sustainable Health Care Costs*. Available at: https://www.milbank.org/wp-content/uploads/2025/06/State-Cost-Growth-Target-Accountability_final.pdf

[3] Ibid.

[4] Ibid.

encourage OHCA to consider incorporating features like this to create a reasonable starting place for financial penalties, while avoiding further financial distress and potential closures of safety net facilities and providers.

In addition, we recommend OHCA adopt clear and transparent measurement processes that account for self-financed payment structures in Medi-Cal. OHCA's enabling statute requires that "with respect to Medi-Cal, the methodology shall consider provision of nonfederal share … associated with Medi-Cal payments, such as expenditures by providers … that serve as the nonfederal share associated with Medi-Cal reimbursement."[5] While inclusion of the provision of the nonfederal share as a penalty justification factor will serve as an important backstop to ensure that public hospitals are not unduly penalized, a more precise measurement methodology would help to prevent public hospitals from entering the enforcement process based on inflated revenue estimates.

Finally, we recommend that OHCA acknowledge the role and unique financing structures of safety net providers in the penalty justification factors. At the May 2026 Board Meeting, OHCA recommended limiting the penalty justification factors to those listed in statute (§127502.5(d)(6)) without further definition. While we appreciate OHCA's aim to preserve flexibility rather than creating "one-size-fits-all" language, we urge OHCA and the Board to apply these factors in a way that genuinely protects safety net providers. For example, when considering the fiscal condition of the entity, OHCA should acknowledge that safety net providers like public health care systems face fiscal strains that may not be reflected in a given financial measure (e.g., profits or assets) and may not have financial structures that align with these measures.

Thank you for the opportunity to comment. CAPH appreciates OHCA's engagement with stakeholders and urges the Office and Board to adopt an enforcement and penalty structure that advances affordability without compromising access to care in the health care safety net.

Sincerely,

Katie Rodriguez
Interim President & CEO
California Association of Public Hospitals and Health Systems

Cc: Members of the Health Care Affordability Board:
David Chase
Sandra Hernández, MD

[5] CA Health and Safety Code § 127502 (2022).

Richard Kronick, PhD
Ian Lewis
Donald B. Moulds, PhD
Mikah Owens, MD
Richard Pan, MD

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

California Hospital Association

August 20, 2026

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

Subject: **CHA Comments for the August 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 August 2026 board meeting. **New research provides real-world evidence of the unintended negative consequences and programmatic design flaws of other states' efforts to control health care spending, which are undeniably relevant to OHCA's work.**

This letter discusses two such studies: one showing the inevitable job losses that occur when hospital spending is sharply curtailed, and the other showing the magnitudes of the disconnect between states' affordability goals and their performance due to their failures to account for real-world economic conditions. OHCA must learn from other states' experience, revise its spending targets to account for factors beyond hospitals' control, and take bold action to protect the stability of the health care delivery system and all health care jobs.

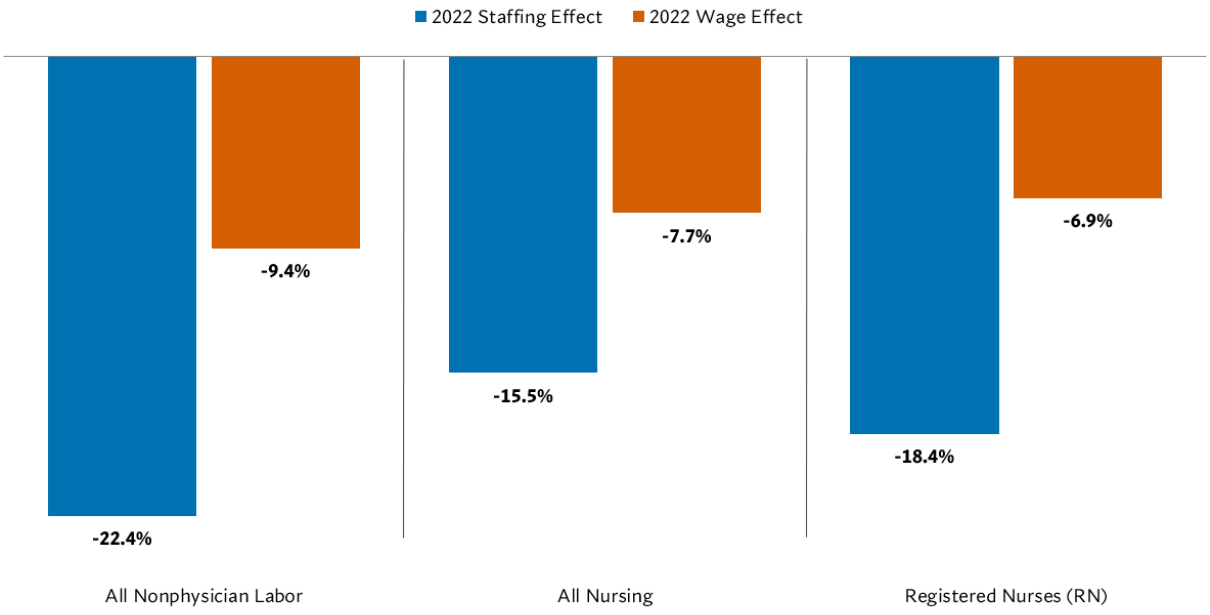
Additionally, hospitals have major concerns with OHCA's recommended spending target enforcement framework and severe penalties. CHA's comment letter on these topics — submitted in July 2026 and attached to the end of this letter — urges the board to reject OHCA's proposed penalties and adopt an approach that aligns with other states to protect, rather than threaten, access to care. Hospitals also call on OHCA and the board to codify other essential protections within the spending target enforcement framework in line with its statutory mandates.

Rhode Island's Affordability Standards Came at a Real Cost to Its Workforce

At the June 2026 meeting, OHCA highlighted Rhode Island's cost target program as a standout success, being the only cost growth target state to come in substantially under its target on average 2019-23[1]. Its success was lauded as an example of what an aggressive approach to price regulation can achieve.

The discussion failed to consider recent research showing that Rhode Island actually presents a cautionary tale of the unintended negative consequences wrought by aggressive cost controls. A recent Health Affairs study by Christopher Whaley, Daniel Arnold, and others found that Rhode Island's affordability standards — implemented in 2010 and estimated to have reduced hospital revenue by $160 million annually — led to an 18.4% reduction in registered nurse (RN) staffing per bed relative to comparison hospitals in 2022, as well as a 6.9% reduction in RN wages. Non-physician staffing, which includes nurses and all other clinical and nonclinical staff, fell by 22.4% per bed in 2022 with a 9.4% reduction in wages. Rhode Island's bed count also grew more slowly than that of comparison hospitals over the study period, meaning the per-bed figures understate the total staffing decline.

Rhode Island's Affordability Standards Result in Concerning Hospital Job and Wage Cuts



"All nonphysician labor" refers to labor for clinical and administrative activities. "Nursing" refers to clinical time from all nursing personnel. "RN" refers to clinical time from registered nurses. Effects are from 2022, the final year of the study following the affordability standards implementation in 2010. Staffing effect defined as full time equivalents (FTE) per bed; Wage effect defined as payroll per FTE.

[1] An important reason why health care spending growth in Rhode Island came in significantly under the state's spending target is that, in 2023, the state nearly doubled its target from 3.2% to 6%, making it the highest in the country. The upward adjustment was made to account for elevated inflation.

That tradeoff matters. California statute expressly tasks OHCA with protecting workforce stability in its pursuit of affordability.[2] A 22% cut in hospital staffing levels, and an over 9% cut in wages, is **exactly** the scenario the Legislature directed OHCA to avoid. Moreover, California hospitals cannot pursue the same staffing and wage reductions Rhode Island hospitals did in order to meet the state's affordability targets due to state mandates like nurse-to-patient ratios and health care worker minimum wage laws. While Rhode Island hospitals may have been able to sustain services by operating more efficiently in the face of staffing reductions and lower pay, California hospitals would have no choice but to take beds offline and eliminate services in proportion with unavoidable workforce reductions. The result: Californians would be forced to wait longer — or leave their communities entirely — to obtain life-changing and lifesaving care.

OHCA must grapple with this evidence and adapt accordingly. First, to meet its workforce stability obligations, OHCA must revise its spending targets upward to account for uncontrollable and desirable cost growth, including labor cost growth. This could be achieved, in part, by building and applying a prospective spending target adjustment for **all** labor cost growth, not only that covered by a collective bargaining agreement. In California, hospital labor costs are currently growing at 5.6% per year[3], far higher than the spending target. Hospitals also urge OHCA to recognize increased labor expenses across all workers as an acceptable justification for exceeding the target, before an entity is required to advance through the progressive enforcement process.

Universal Failure to Meet Cost Growth Targets Signals a Need to Reassess Benchmark Design

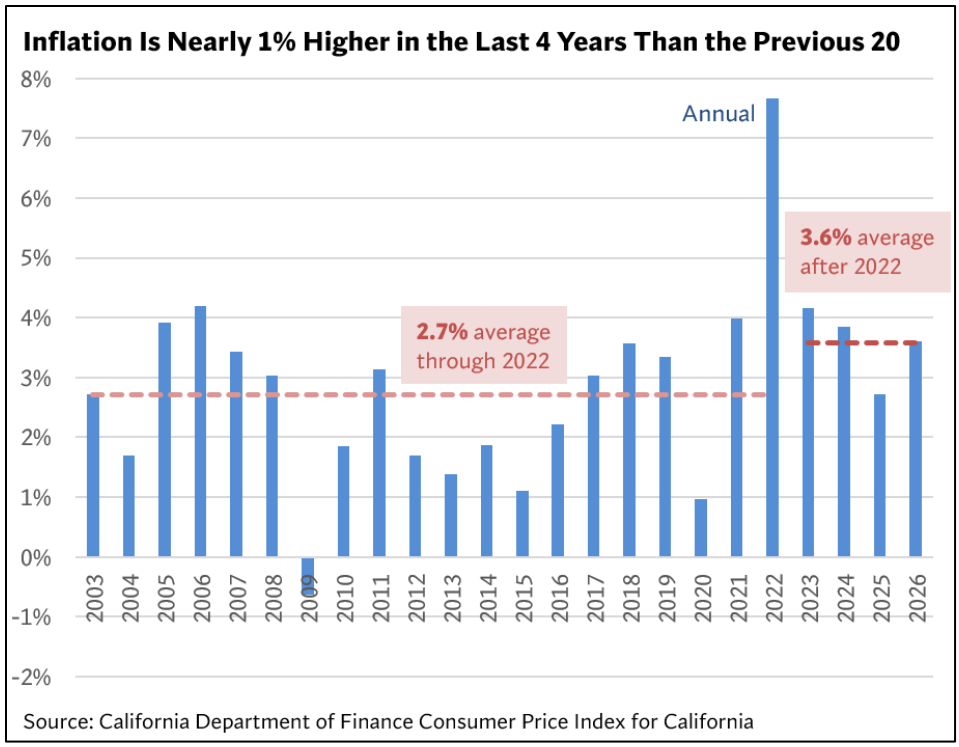
A recent *Health Affairs* opinion article, covered by OHCA at the June board meeting, found that every state with an established cost growth target exceeded it in 2023, with three states recording their highest spending growth since tracking began. States with meaningfully different cost containment strategies, enforcement powers, health care markets, and economic conditions, all landed in the same place. That convergence points to a shared problem: targets set without sufficient grounding in the actual economics of delivering care in 2026.

A subsequent *Health Affairs* research article published this month explains why. Examining six states[4], with established benchmarks for health care spending, the author found that **meeting 2022-23 targets would have required real, inflation-adjusted per capita health care spending to decline by an average of 1.6% per year.**

As the author describes, these benchmarks are set years in advance based on assumptions about inflation that mostly predate a historic 2021-23 inflation spike and elevated levels that followed. When realized

[2] Among other provisions, statute requires that OHCA's spending targets "promote the stability of the health care workforce, including the development of the future workforce, such as graduate medical education teaching, training, apprenticeships, and research." (See Health and Safety Code § 127502(c)(6).
[3] Hospital labor costs defined as average of yearly growth in sum of salary, benefits, physician professional fees, and other professional fees per adjusted discharge from the HCAI Hospital Annual Financial Reports 2019-2024.
[4]The six states included in the analysis were: Connecticut, Delaware, Massachusetts, Oregon, Rhode Island, and Washington.

inflation came in far above those assumptions, the nominal targets quietly became mandates for real spending cuts, with only one state (Rhode Island), revisiting the math. Actual inflation-adjusted spending across these six states grew only 0.7% per year over that period, below an average growth benchmark of 1.9% on an inflation-adjusted basis had inflation stayed at its historical average. However, without adjusting for inflation, spending across the states grew by 5.9% against an average benchmark of 3.4%. Thus the "failure" of all six state benchmark programs to meet their spending targets in 2023 was, in substantial part, an artifact of rigid benchmark design colliding with an economy-wide inflation shock — not evidence of runaway revenue growth.



In California, this inflation shock period led to inflation being nearly 1% higher in the past four years than it has in the previous 20. Any OHCA spending target built on the pre-2022 inflation assumption will therefore understate the true cost of maintaining hospital operations by close to a percentage point every year, based on economy-wide inflation alone. This has a direct implication for OHCA's target-setting process. A spending target that is not adjusted for inflation spikes penalizes providers for economic forces far beyond their control. That gap is not insignificant: As the research above shows, it significantly affected health system performance against the spending target programs in other states.

OHCA must change course and account for elevated inflation within the spending targets themselves. Health & Safety Code § 127502(d)(4) already directs OHCA to review a defined set of factors for adjusting spending targets, including the Consumer Price Index for urban wage earners and clerical workers, the health care employment cost index, labor costs, and trends in the price of health care technologies, among others. To date, OHCA has made no such adjustment. That failure to adjust carries straight through to OHCA's penalty framework. A spending target that is never adjusted for inflation is artificially low relative to the cost of providing care. As inflation continues to push actual hospital spending up regardless of the target's

assumptions, the gap between actual spending and that artificially low target widens. OHCA's penalty framework then calculates penalties directly from this gap, with no mechanism in the penalty framework to account for uncontrollable economic forces like historically high inflation. Before OHCA finalizes any penalty structure, it must fulfill its existing statutory obligation to build these factors into both the target-setting methodology and spending target penalty framework.

The board should not approve a penalty framework more aggressive than any other state's, built on targets the best available research shows are untethered to the economic conditions actually faced by hospitals over the past several years.

Conclusion

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

Sincerely,

Victoria Valencia
Vice President, Data Analytics

cc: Members of the Health Care Affordability Board:
David Chase
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, PhD
Dr. Mikah Owen
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

July 31, 2026

Elizabeth Landsberg
Director, Department of Health Care Access and Information
2020 W. El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments on Spending Target Progressive Enforcement Framework**
(Submitted via email to Megan Brubaker)

Dear Director Landsberg:

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 on OHCA's spending target measurement and enforcement frameworks. However, hospitals are deeply concerned with multiple aspects of the frameworks and urge the office and board to adopt the following essential changes:

- **Test the hospital spending methodology before it is used to assess compliance with the spending target.** The sources of volatility must be better understood, and the outpatient intensity adjustment requires close attention given the incompleteness and untested nature of the data source.
- **Assess hospital performance against the spending target on a multiyear basis.** Otherwise, hospitals will simply cycle in and out of compliance due to extreme revenue volatility that bears no relationship to their efforts to meet the spending targets.
- **Conjoin inpatient and outpatient spending into a single growth measure.** This will ensure hospitals are accountable for keeping their overall spending growth under the target and ease the office's enforcement burden.
- **Enforce only against entities that exceed the target on both their commercial and all-payer lines.** Hospitals rely on all payers to ensure their revenues cover their costs, with commercial payments making up for growing shortfalls from Medicare and Medi-Cal. The statewide and hospital sector targets must apply to all payers to account for the impacts of the One Big Beautiful Bill Act (OBBBA) and focus OHCA's enforcement resources appropriately.
- **Ensure entities have meaningful opportunities to improve their spending performance prior to the imposition of financial penalties**. OHCA must adhere to the spirit and dictates of the progressive enforcement process established by the Legislature, provide latitude for hospitals to develop and implement their own cost-reducing strategies, and afford appropriate time for performance improvement.

- **Reduce the proposed spending target penalties from their current astronomical levels.** OHCA's proposed penalties would devastate hospitals' financial condition and endanger access to care — the exact opposite of OHCA's stated goals.

Further detail on each of these concerns and recommended solutions are provided below.

Clarify How Performance Against the Spending Targets Will Be Measured

The first spending target enforcement year is now in effect — in fact, it has already concluded for the more than 150 hospitals whose fiscal year ended on or before June 30.[1] And yet, hospitals still have major unanswered questions as to how their spending will be assessed against the targets and lack confidence that OHCA's methodologies will accurately reflect year-over-year changes in the components of spending that are within their control. While OHCA's approach has positive and essential features, it has yet to be validated. These questions and concerns must be addressed to assure hospitals that their efforts to comply with OHCA's spending limits will be successful. Absent that clarity, hospitals making good-faith efforts to comply will have no assurance that they will be able to avoid enforcement. **To firmly resolve these outstanding ambiguities, the forthcoming enforcement regulations must clearly specify how OHCA will measure hospitals against the spending targets and how data reliability will be assured.**

Include Volume and Intensity Adjustments, as Currently Contemplated

OHCA has spent more than a year developing its approach for measuring hospital spending growth with the help of a dedicated workgroup. The resulting methodology has essential features that aim to prevent fluctuations in volume and service intensity from biasing determinations of whether hospitals exceeded their target. Without such volume and intensity adjustments, OHCA would discourage hospitals from serving more patients, sicker patients, and offering resource-intensive services. The 2022-23 hospital spending growth data presented by OHCA aptly demonstrate the importance of these adjustments: Median commercial outpatient spending growth flipped from negative 7% when only volume was accounted for to positive 4.2% when both volume and intensity were considered. Conversely, median Medi-Cal inpatient spending flipped from positive 1.5% to negative 1.2% when an intensity adjustment was included. **If a 3.5% spending target had applied in 2023, around 15% of hospitals would have mistakenly been identified as having met or missed the target solely due to the absence of an intensity adjustment.** OHCA must retain both the volume and intensity adjustments in its final methodology.

Further Test the Hospital Spending Methodology

While conceptually promising, more work is needed to validate OHCA's approach for measuring hospital spending, particularly with respect to how OHCA plans to estimate intensity for outpatient services. Its approach utilizes a new and incomplete data source — the Healthcare Payments Database — that only covers 20% of hospital-reported commercial outpatient visits statewide. For many hospitals, the coverage is likely even lower. The result is that OHCA will capture the spending and utilization of all commercial outpatient services, but have no insight into the resource intensity of 80% of these services. Missing just one patient

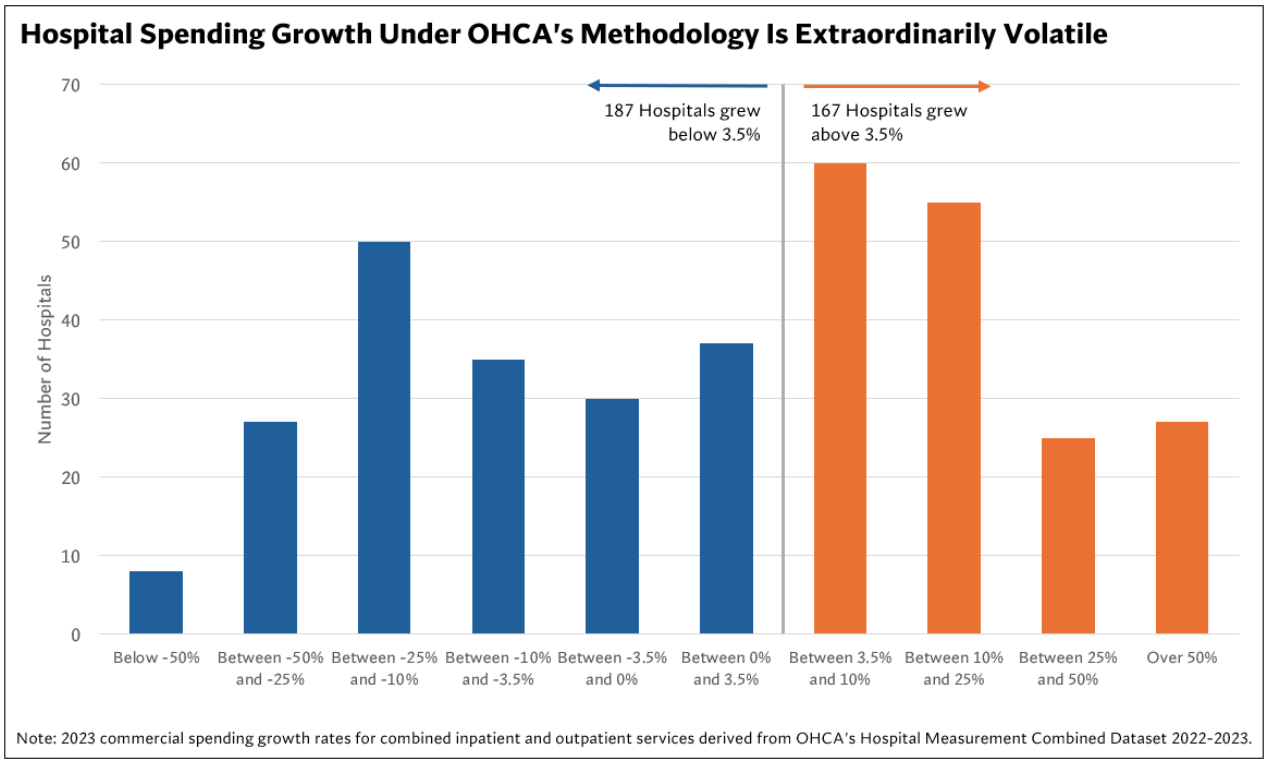
[1] OHCA has indicated it will assess hospital spending growth on a hospital fiscal, rather than calendar year, basis due to data reporting schedules.

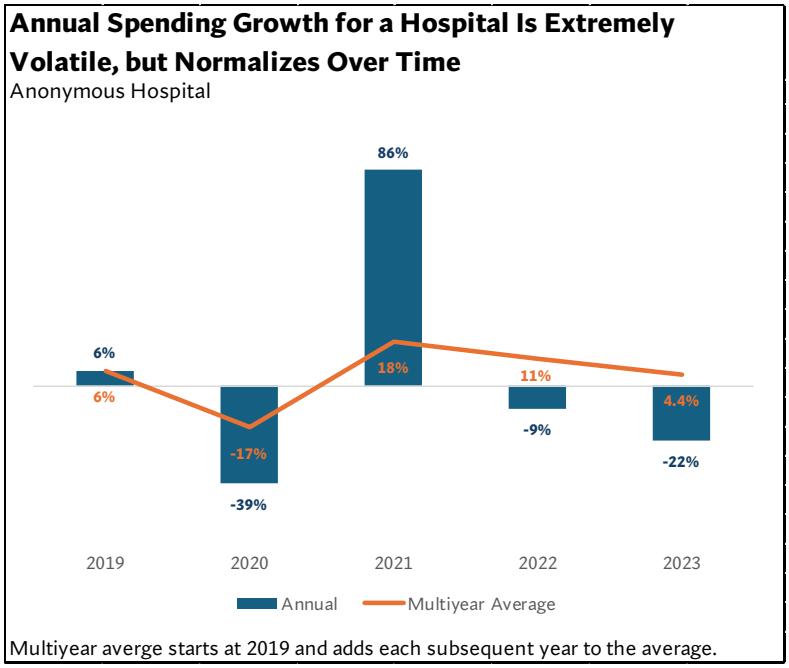
receiving a million-dollar drug infusion will inevitably bias OHCA's measurement of outpatient growth, and cause hospitals to erroneously fall subject to OHCA's onerous and unpredictable enforcement process.

Additionally, OHCA must make strides toward understanding and accounting for the extraordinary in measured hospitals spending growth before enforcement takes place. Solidifying the measurement approach up front will save OHCA from having to engage dozens or hundreds of hospitals within the initial phase of the enforcement process on justifiable reasons they exceeded their target. While improvement can be expected, the approach likely will never stamp out all unexplained volatility. OHCA will have to work closely with hospitals that exceed their target to distinguish real growth above the target from measured growth that is simply the relic of a faulty methodology.

Assess Hospital Compliance Against the Spending Targets on a Multiyear Basis

OHCA's 2022-23 hospital spending data reveal incredible volatility in individual hospitals' measured spending growth. As the figure below shows, 35 (nearly 10% of) hospitals saw annual commercial spending growth of greater than 50% or less than negative 50% between 2022 and 2023. A further 52 hospitals had growth between 25% and 50% or negative 25% and negative 50%. This volatility extends to government payers as well. Undoubtedly, these annual growth rates are not reflective, over a two-year period, of what OHCA aims to measure — the annual change in hospital unit prices. Hospitals did not receive 25% year-over-year rate increases or decreases from Medicare.



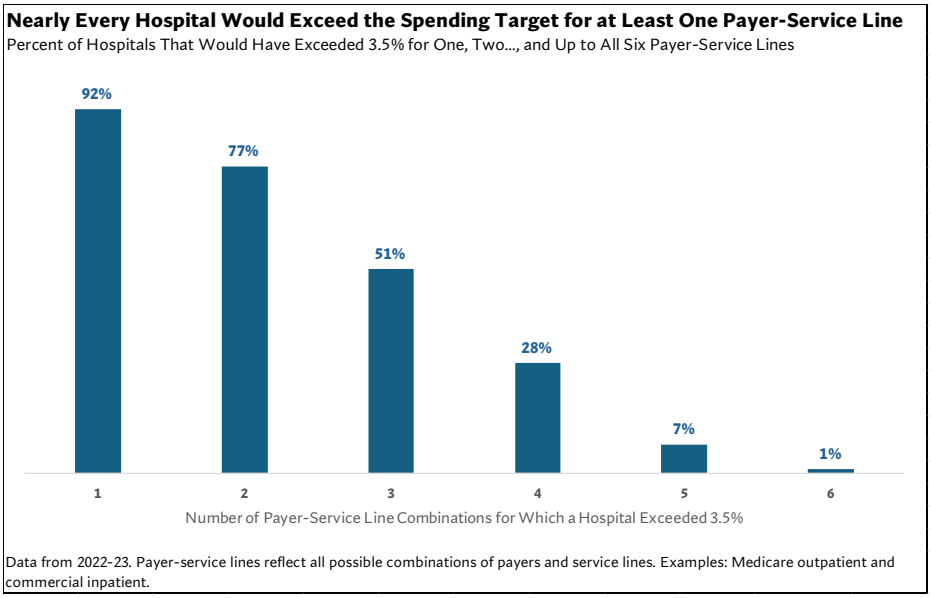


The figure on the left shows inpatient spending growth over a longer period for an individual hospital, revealing that high growth rates over a single annual growth period are **not** indicative of a sustained trend of either explosive price growth or radical price cutting. Instead, the figure shows that on a multi-year basis, the average annual growth rate normalizes to something OHCA could more meaningfully compare against the spending target. Ultimately, these data demonstrate that OHCA must measure hospital spending growth on a multiyear basis to avoid arbitrary punishment of hospitals that just happen to be in the boom cycle of their measured, **but not actual**, price growth.

Clarify What It Means to Be Accountable Against the Spending Targets

Despite having only approved statewide and overall hospital spending targets, OHCA has stated an intent to measure spending growth against the targets separately for each payer category (i.e., commercial, Medicare, and Medi-Cal) and, for hospitals, potentially separately for each service category (i.e., inpatient and outpatient). Adopting this approach would yield six distinct ways in which a hospital could be found in violation of the spending targets. As the figure below shows, had the target been in place in 2023, almost no hospital would have been safe.

OHCA would have had to initiate enforcement actions against **326 (92%) of the 356 hospitals that reported data**. It would have had to issue notice and technical assistance to and investigate the reasons why each of these 326 hospitals exceeded the target. The 326 hospitals would have had to supply extensive information justifying why, for example, their Medicare inpatient spending grew above the target — even if their overall spending growth was within the state's limits. And OHCA would have to determine the reasonableness of spending growth for each payer and service line for 326 hospitals based on no fewer than nine distinct enforcement



considerations. This would not be a prudent use of attention and resources —for OHCA or the hospitals themselves. Moreover, this approach would discourage hospitals from taking concrete and proactive steps to comply with the targets as they would still be virtually assured to violate the target for one payer-service line or another for reasons they do not control. To address barriers to efficient, fair, and appropriately targeted enforcement — and to properly inform hospitals, and other entities where applicable, of how the targets will be enforced — OHCA should codify the following policies in its forthcoming enforcement regulation package.

Conjoin Inpatient and Outpatient into A Single Measure

Hospitals are subject to the hospital spending targets established by the board. No targets have been established that apply distinctly to inpatient or outpatient services. Accordingly, hospitals must be held accountable based on all the patient care they provide. A hospital whose inpatient spending grows by 1%, outpatient spending grows by 5%, and combined total spending grows by 3% has not violated a 3.5% hospital-sector spending target — and must not be assessed as having done so. OHCA must remedy this problem by conjoining inpatient and outpatient spending in one of two ways:

- **Average the inpatient and outpatient growth rates to estimate a single measurement of growth for each hospital.** Weighting the inpatient and outpatient growth rates by service line patient revenues would account for hospitals' differing service mixes. This would streamline enforcement by limiting the number of hospitals exceeding a hypothetical 3.5% spending target on their commercial payer line in 2023 from 354 to 167 hospitals.[2]
- **Only enforce against hospitals that exceed the targets for both their inpatient and outpatient service lines.** Again, using 2023 data and considering only commercial spending growth, this would limit the scope of enforcement from 354 to 90 hospitals.

Only Enforce Against Entities That Exceed Both Their Commercial and All-Payer Spending Targets

To date, OHCA has focused on commercial health care spending growth as its key area of concern. In keeping, OHCA could simply disregard Medicare and Medi-Cal spending growth and only enforce the targets based on commercial spending growth. However, this would ignore more than 70% of the services a hospital provides, and therefore more than 70% of the payments upon which hospitals rely. Payer mix and cross subsidization, where commercial payments make up for large and growing shortfalls in payments from public payers, are fundamental features of hospital finance that cannot be ignored.

These patterns of hospitals' finance were present in OHCA's reporting on hospital spending trends in 2022 and 2023. For example, the data showed that statewide median Medicare and Medi-Cal inpatient payments were, respectively, 57% and 39% lower than commercial payments, and that statewide median reimbursement fell year-over-year for both Medicare and Medi-Cal. When the three payers are combined, the result is 0.5% annual growth in median reimbursement — far lower than each of 1) the 7% growth reported for commercial payers, 2) the state's first spending target of 3.5%, and 3) overall inflation of 3.9% in California in 2023.

Furthermore, health care coverage losses are happening now and growing due to OBBBA and other federal and state policy changes. Hundreds of thousands of residents have already dropped their Covered California coverage due to the expiration of enhanced subsidies, and millions are expected to fall off Medi-Cal coverage.

[2] 354 hospitals had data allowing for the calculation of their spending growth rates for their commercial payer line, while 356 hospitals (referenced on page 4) had data for any payer line, including for Medi-Cal and Medicare.

While reimbursement will drop, patients' care needs will not, leading to unprecedented increases in uncompensated care that hospitals do not have financial capacity to withstand.

To protect access to hospital care in the face of OBBBA's cuts and properly account for payer mix differences among hospitals, OHCA **must only initiate enforcement against hospitals that exceed their target on both their all-payer and commercial lines.** The all-payer line should account for all payments and services rendered — not only those from commercial, Medicare, and Medi-Cal — to properly capture the effects on overall reimbursement from the increase in the ranks of uninsured patients and uncompensated care.

Account for Complexity of Medi-Cal Financing

Medi-Cal financing of hospital services is bewilderingly complex. Faced with base reimbursement rates that fall far short of covering the cost of care, hospitals have been forced to "self-finance" the nonfederal share of Medi-Cal hospital expenditures to ensure they can continue caring for their communities. Self-financing comes in the form of provider taxes, intergovernmental transfers, and certified public expenditures that hospitals pay to the state or incur which are used to "draw down" federal Medicaid funding. Because hospitals incur the nonfederal share of cost, their net reimbursement equals only the federal funding. However, HCAI reports of hospital revenues include both the federal and self-financed nonfederal shares of this funding, overstating the net reimbursement hospitals receive.

In 2024, nearly half (48%) of total Medi-Cal managed care reimbursement for hospitals was self-financed — causing **total reimbursement in Medi-Cal managed care to be overstated according to HCAI financial reporting by 20% that year**.[3] Between 2022 and 2024, self-financed hospital reimbursement grew by more than $5 billion, while state-financed reimbursement grew by less than $1 billion. As a result, while payments in Medi-Cal managed care appear to have grown by 2.5% annually over this period, in truth, they grew by just 0.4% — far below the cost of caring for this population. To meet its statutory obligations under provisions such as Health and Safety Code (HSC) § 127502(d)(5) and accurately reflect the realities of Medi-Cal finance, OHCA must account for self-financing in its measurement of hospital spending growth against the targets.

Enforcement Must Be Progressive and Collaborative, Not Rushed and Punitive

As OHCA develops and promulgates formal enforcement regulations, it must conform with and expound upon the protections and processes established in state law, including but not limited to the law's clear direction that enforcement must be progressive.

Health Care Entities Must Have an Opportunity to Improve Spending Trends Under a Performance Improvement Plan (PIP)

The enforcement provisions of the California Health Care Quality and Affordability Act are unambiguous: Health care entities must have opportunities to justify and remediate their spending trends prior to any enforcement action, including the imposition of monetary penalties. HSC § 127502.5(a)) mandates that the office "enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, **allows each health care entity opportunities for remediation**, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access,

[3] Managed care is Medi-Cal's predominant delivery system, covering 94% of all Medi-Cal enrollees.

quality, equity, or workforce stability" (emphasis added).[4] State law further delineates a progressive enforcement process that starts with technical assistance, moves to (optional) public testimony, then mandatory performance improvement plans, and finally, as a last resort, monetary penalties.[5]

The Legislature did not intend the early steps of enforcement to be a "check-the-box" exercise. Rather, the process must include meaningful opportunities and adequate time for health care entities to implement cost-reducing strategies to meet the state's spending growth goals. This starts with giving entities the voluntary opportunity to put the technical assistance they receive from OHCA into action and engage in dialogue with the office on pathways to improvement. Next, it plainly requires PIPs to be forward-looking; health care entities cannot go back in time to alter prior policies, practices, or service offerings. Therefore, PIPs should apply starting in the first annual measurement period following their approval. Second, entities must be given a reasonable amount of time to implement their PIPs. The returns on many cost-reducing strategies, like primary care investments, regularly lag the upfront investments. To balance the urgency of improving affordability and the time and work involved in system improvement, the Legislature thoughtfully established that PIPs may be imposed for a period of up to three years.[6] Third, the PIPs must be self-directed. OHCA's role is to approve, not develop, the PIPs. Health care entities must have a meaningful opportunity to develop and implement their own strategies, like investing in community-based care or adopting alternative payment methodologies, to comply with their target. OHCA's role is oversight to ensure the improvement plans' goals are reached and do not have negative unintended consequences.

Spending Target Penalties May Only Be Levied After an Entity Has Failed Both Its PIP and Lawfully Established Target

California law states that, except in narrow circumstances specified in HSC § 127502.5(h)(1) for willful, egregious, or repeated noncompliance, a financial penalty may only be imposed "if the director determines that a health care entity is not compliant with an approved performance improvement plan **and** does not meet the cost target" (emphasis added).[7] This provision, among others, establishes multiple protections that must be incorporated into the forthcoming regulations.

Procedural Penalties Must Be Narrowly Tailored to Address Gross Misconduct and Set at Reasonable Levels

For the narrow instances in state law where there is egregious misconduct, OHCA has proposed procedural penalties distinct from the spending target penalties. Critically, these procedural penalties may not serve as an alternative approach to enforcement where entities' legal right to remediation is ignored and nullified. Rather, they must be narrowly tailored to the purpose established in law — addressing willful, egregious, or repeated noncompliance. OHCA's proposal oversteps these guardrails and seeks penalty limits that are out of line with comparable agencies.

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[4] Also see the Legislature's findings and declarations in HSC § 127500.5(m): "It is the intent of the Legislature in enacting this chapter that enforcement actions to address growth in per capita total health care expenditures are implemented in a progressive manner, such that health care entities are assisted to come into compliance with cost targets, including through technical assistance and performance improvement plans, before assessing administrative penalties unless there are egregious violations as specified in Section 127502.5."
[5] See HSC § 127502.5(a) and (d)(1).
[6] See HSC § 127502.5(c).
[7] See HSC § 127502.5(d)(1).

At the June OHCA board meeting, office staff presented procedural penalties as a mechanism by which OHCA could penalize entities prior to the conclusion of a PIP, including at implementation milestones within the PIP itself and for repeated failure to file an acceptable PIP. While imposing procedural penalties may be appropriate for gross misconduct like knowingly failing to provide required information, falsifying information, or repeatedly neglecting to file a PIP, extending these penalties beyond circumstances of clear bad faith or willful noncompliance is directly at odds with the statutory guardrails the Legislature established. A good-faith disagreement over what cost-reducing strategies are appropriate for an organization does not constitute egregious misconduct. Nor is it appropriate or legally sound to separately penalize an entity demonstrating a good-faith effort to implement cost-reducing strategies but where the benefits do not materialize as quickly as anticipated. In any board action and associated rulemaking, OHCA must make clear that entities are entitled to progressive enforcement of the spending targets and that procedural penalties may only be imposed in cases of unambiguously and documented egregious conduct in defiance of OHCA rules related to information sharing, data reporting, and PIP submission and implementation.

Finally, OHCA must reassess its procedural penalty amounts and revise them downward to conform to the standards of other regulators. The following table shows that OHCA's proposed procedural penalties far exceed those in comparable regulatory frameworks. Penalties for non-submission of required data in Oregon — which has the most stringent spending target program in the country — are up to $500 per day, 1/20th of the maximum per-day penalty proposed by OHCA. Massachusetts' $500,000 penalty is the maximum penalty that may be imposed for any reason. In contrast, OHCA's bifurcated proposal would authorize spending target penalties in the hundreds of millions of dollars in addition to procedural penalties at lower, but still disproportionate levels. Moreover, Massachusetts regulations make clear that penalties are only to be imposed as a last resort, in stark contrast to the framing presented at prior OHCA board meetings that procedural penalties are a means of accelerating

OHCA's Proposed Procedural Penalties Far Exceed Comparable Sanction Authorities from Other Agencies

Agency	Violation	Maximum Financial Penalty
California Office of Health Care Affordability	Health care entity fails to perform a procedural duty, such as filing a performance improvement plan or submitting information	$500,000 per violation or $10,000 per day, depending on the type of violation
Oregon Health Authority	Payer or physician organization fails to comply with data submission requirements	$400-$500 per day
Massachusetts Health Policy Commission	Payer or physician organization fails to file or implement a PIP in good faith	$500,000 per violation (per regulation, only imposed as a last resort)
California Department of Health Care Services	Managed care plan violates its state contract, fails to comply with a corrective action plan, or fails to submit timely and accurate provider network data	$25,000 for a first violation, $50,000 for the second, and $100,000 for each subsequent violation
California Department of Managed Health Care	Health plan violates the Knox-Keene Act	$25,000 per violation
California Air Resources Board	Covered entity fails to provide a timely and adequate report	$50,000 per year
California Air Resources Board	Business with over $1 billion in annual revenues fails to report its greenhouse emmissions	$500,000 per year

financial sanctions on regulated entities.[8] California's health plan regulators, the Department of Health Care Services and the Department of Managed Health Care, have limits of $25,000 per violation of similar procedural rules and requirements. Finally, while the California Air Resources Board may fine regulated entities up to $500,000 for noncompliance with its greenhouse gas reporting rules, the penalty only applies to entities with annual revenues of at least $1 billion and reflects an annual — rather than per violation — limit. In contrast, OHCA seeks authority to apply an equivalent penalty, potentially stacked multiple times within a given year, on hospitals with annual operating revenues in the low tens of millions of dollars.

OHCA May Not Assess Spending Target Penalties Based on Midyear Compliance with a PIP

The spending target is a "target percentage for the maximum **annual** increase in per capita total health care expenditures" (emphasis added).[9] This means that a spending target penalty may only be imposed after the office has determined that, in addition to being noncompliant with the PIP, the entity violated the corresponding year's spending target. **An entity cannot fail an annual target on a sub-annual basis.** Accordingly, pursuant to OHCA's underlying regulatory framework, fining an entity for noncompliance with its target based on midyear benchmarks, monitoring, and deliverables is plainly impermissible except within the narrow circumstances covered by the procedural penalties previously discussed. OHCA must give entities a year, at minimum, to comply with their PIP and associated spending target, and not rush toward punitive measures before that phase of the progressive enforcement process is complete.

PIPs That Jeopardize Access to High-Quality and Equitable Care May Not Be Imposed

To avoid unintended consequences and reinforce a holistic approach to improving affordability, the Legislature tasked OHCA with ensuring that PIPs are not implemented "in ways that are likely to erode access, quality, equity, or workforce stability."[10] This important constraint ties the hands of both the office and entities around what cost-reducing strategies may be employed. For hospitals, cutting revenues means cutting costs — costs that are concentrated in workforce recruitment and retention, facility upgrades (including those necessary to comply with state laws), and drugs and medical supplies used in patient care. Reducing hospital spending to the levels established by the spending targets may require service reductions that impair access, reduced ability to invest in quality-assurance activities, workforce reductions, and cuts to discretionary programs that address community needs. This is not what the Legislature envisioned. Flexibility will be needed for hospitals and other entities to implement cost-reducing strategies that avoid these negative impacts.

Spending Target Penalties Must Not Endanger Access to High-Quality and Equitable Care

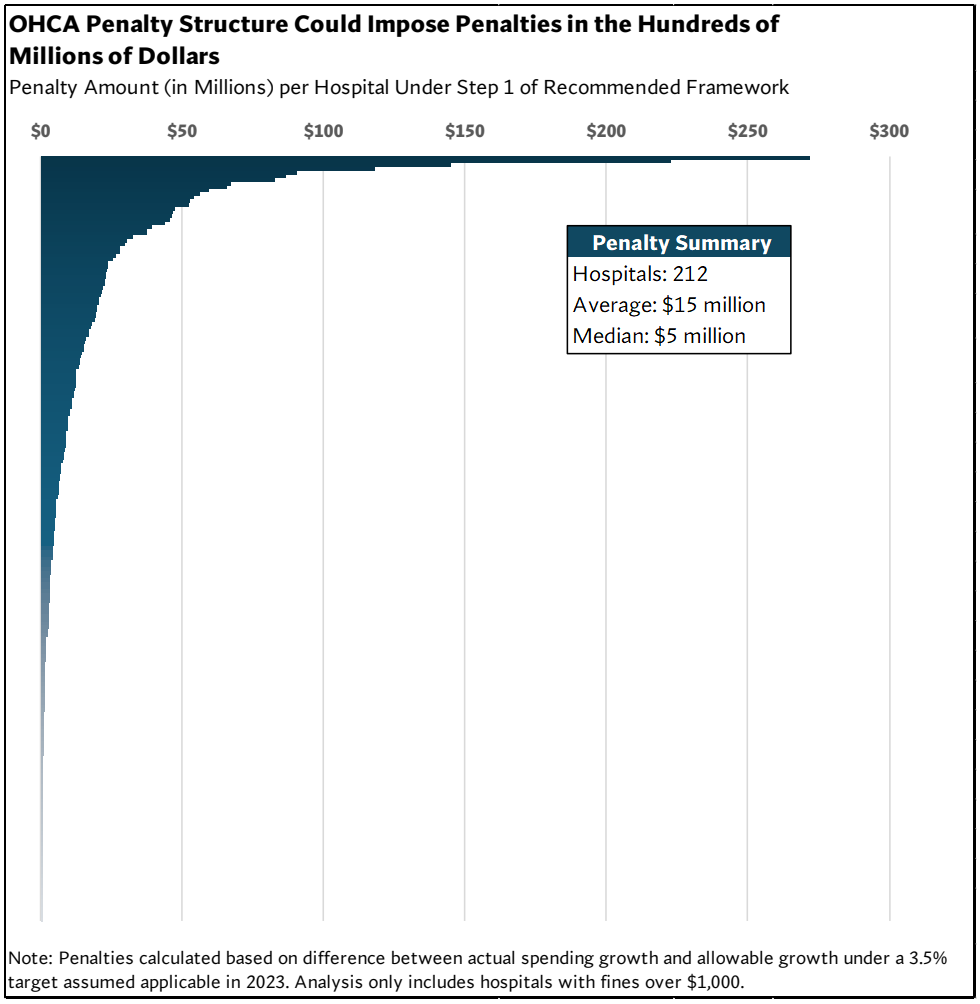
At the April board meeting, OHCA presented a two-step framework for determining the scope and range of spending target penalties for entities that fail their PIP and exceed their spending target. First, the office would set an initial amount equal to the amount by which the entity exceeded its allowable growth under its target. Then, the office would adjust that amount to account for various factors, including the nature, number,

[8] See Code of Massachusetts Regulations 958 10.15.
[9] See HSC § 127500.2(j).
[10] See HSC § 127502.5(a).

and gravity of the offenses; the entity's fiscal condition; the entity's market impact; and input from other state agencies.

OHCA's Recommended Penalty Structure Could Result in Enormous Penalties

OHCA's charge is to promote affordability without jeopardizing access to high-quality, equitable care and the stability of jobs. Unfortunately, financial penalties at the levels contemplated in OHCA's proposal would do just that and reflect the type of punitive approach to affordability the Legislature expressly disavowed. As the figure on the right shows, absent significant downward adjustments under step 2 of the framework, entities that exceed their spending target for even a single year could potentially be subject to fines in the hundreds of millions of dollars. **Had the 3.5% target been in place in 2023, the penalties would have exceeded the prior three-year cumulative total of operating earnings for 117 hospitals.** Fines of these magnitudes would threaten the viability of affected hospitals, placing access to care and health care jobs at serious risk. Enormous downward adjustments would be needed to reduce the penalties to practicable levels, rendering the process unpredictable, inscrutable, and capricious.



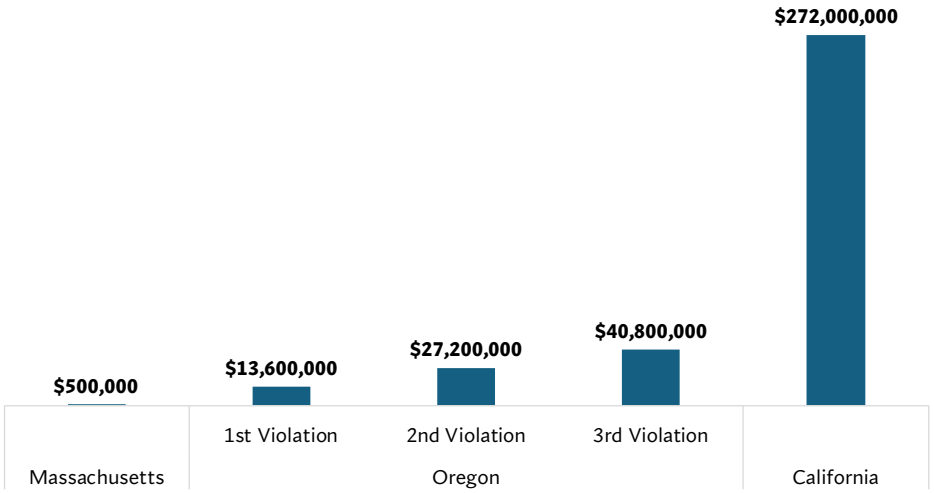
Other States Provide a Model for a More Reasonable Penalty Structure

OHCA is closely modeled after spending target programs in Massachusetts and Oregon, both of which rely on PIPs and financial penalties as their principal means of enforcement. However, the penalties in these other states vary significantly from OHCA's recommendation. In Massachusetts, the maximum financial penalty for failing to implement a PIP is $500,000. In Oregon, the financial penalty for failing to meet the state spending target starts at 5% of an entity's spending above the target (after the entity has been found to have exceeded

the target with statistical significance and without good cause in three out of five years). The penalty then increases by 5 percentage points for every additional instance of an entity exceeding the target (using the same multiyear formula). The figure on the right shows what a true outlier OHCA's recommended penalty structure could be compared to its peers, with OHCA's penalties starting at 20 times those in Oregon. OHCA should align with its peer states' penalty structures and modify its recommended framework accordingly.

California's Recommended Penalty Structure Would Be a Major Outlier

Largest Potential Financial Penalty for a Hospital Under Each State's Penalty Framework



Note: Penalties calculated based on difference between actual spending growth and allowable growth for hospitals under a 3.5% target assumed applicable in 2023. Oregon estimates apply its penalty framework to California using the 2023 hospital data. Massachusetts, by contrast, has a flat maximum penalty.

Adjustments to Initial Penalty Amounts Are Critical to Protect Access to Care

OHCA has recommended applying various adjustments to consider an individual entity's circumstances when determining final penalty amounts. Such adjustments are essential, particularly if step 1 of OHCA's penalty-setting framework is adopted, but also under a more restrained approach such as that used in Oregon. These adjustments must account for the following circumstances:

- *Hospital financial status* — To protect access to care, penalties must not undermine a hospital's ability to sustain services and remain viable. **OHCA should cap the penalty amount at a reasonable percentage of a hospital's patient care earnings.**
- *Factors beyond a hospital's control* — New mandates that raise costs, inflationary pressures, and changes in patient needs all influence a hospital's spending, despite their best attempts to remain under the spending limit. **OHCA should deduct the costs associated with these factors from the penalty.**
- *Efforts to improve access to high-quality, patient centered care* — Investments in primary and behavioral health care, for example, cost more at the outset but result in long-term savings and better health for Californians. **OHCA should deduct the costs the value of these investments from the penalty.**
- *Success in reducing spending trends until the imposition of the penalty* — **OHCA should credit an entity for any improvement in its spending performance, even if the entity has not yet met the target.**

Without these adjustments, OHCA's penalties would be unduly punitive and ultimately undermine its statutory responsibility to improve affordability while maintaining equitable access to care. While OHCA has only committed to considering the financial condition of entities when determining penalty amounts, the

latter three factors are plainly constitutive of the "nature" or "gravity" of any given offense. Specifying these factors within the regulation, alongside others as appropriate or mandated by state law, would give necessary meaning to OHCA's statutory directives and promote clarity around how OHCA's rules will be operationalized, to the benefit of both the office and regulated entities.

Conclusion

California's hospitals appreciate the opportunity to comment and look forward to continued engagement as OHCA moves toward promulgation of the spending target penalties and enforcement regulations. These rules and regulations will guide the behavior of hundreds of providers and payers; determine the breadth and scope of the office's enforcement responsibilities; guide difficult office decisions on which individual entities are subject to ever more stringent enforcement actions and which get a free pass; and, if approved in their current form, set penalties that existentially threaten the viability of hospital care across the entire state. Rulemaking must not be rushed; rather, it must deeply consider and promote all of OHCA's objectives, including the promotion of health care access, affordability, quality, equity, and workforce stability.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
David Chase
Dr. Sandra Hernández
Kim Johnson
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, PhD
Dr. Micah Owen
Dr. Richard Pan
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

California Association of Health Plans

1415 L Street, Suite 850
Sacramento, CA 95814
916.552.2910
www.calhealthplans.org

August 20, 2026

Sent via email:
ohca@hcai.ca.gov

Kim Johnson, Chair
Elizabeth Landsberg, Director
Vishaal Pegany, Deputy Director
Office of Health Care Affordability
2020 West El Camino Ave.
Sacramento, CA 95833

Re: Spending Target Enforcement, Penalty Framework, and the Need to Account for Real-World Affordability Pressures

Dear Chair Johnson, Director Landsberg, Deputy Director Pegany, and OHCA Board Members:

On behalf of the California Association of Health Plans (CAHP), we appreciate the opportunity to provide comments in advance of the August 26, 2026 Health Care Affordability Board meeting. The agenda for this meeting includes potential Board action on spending target administrative penalty scope, range, and justification factors, as well as procedural penalty scope, range, and justification factors. It also includes continued discussion of spending target enforcement, public transparency of enforcement, draft Performance Improvement Plan (PIP) guidance, and the nonsupervisory organized labor adjustment (NOLA) and data collection regulations. Given the significance of these items, CAHP respectfully urges the Board to carefully evaluate whether the enforcement framework currently under consideration will actually advance affordability for consumers and purchasers, or whether it risks adding new costs, friction, and instability to an already strained health care system.

We share OHCA's goal of improving affordability for California consumers. Health plans are committed to slowing health care cost growth and supporting a more sustainable system. However, OHCA's spending target enforcement framework cannot be designed in isolation from the real-world cost pressures that are being layered onto the same system OHCA is seeking to make more affordable. As CAHP explained in our July 31 comments on OHCA's progressive enforcement framework and draft PIP guidance, health care spending trends are affected by numerous factors outside the direct control of health plans and other regulated entities, including new state and federal mandates, taxes and assessments, workforce and labor costs, high-cost drugs and emerging therapies, infrastructure investments, increased service demand, inflation, supply chain pressures, and other market-wide cost drivers. An enforcement framework that does not meaningfully account for these realities will not produce affordability. It will only punish entities for costs they cannot fully control.

As of the submission of this letter on Thursday, August 20, 2026, OHCA has yet to formally publish in writing an updated and complete framework that it intends to present to the Board for a potential vote. Instead, stakeholders have been required to piece together OHCA's evolving concepts from a series of Board meetings, Advisory Committee meetings, workgroups, draft guidance documents, and presentations.

This fragmented approach makes it difficult for stakeholders to fully understand OHCA's latest proposals, evaluate how the various components interact, and provide meaningful feedback.

To facilitate transparency and ensure that the Board and stakeholders have a complete understanding of the framework under consideration, **CAHP respectfully recommends that the Board not vote on penalty scope, range, or justification factors until stakeholders have access to a single, consolidated explanation of OHCA's proposed enforcement framework.** Such a document should clearly describe the enforcement process, statutory authorities, implementation timeline past fall 2026, proposed regulations and guidance, areas of agency discretion, and how the various components of the framework fit together.

To ensure that the spending target framework advances affordability without creating unintended consequences, CAHP respectfully encourages the Board to consider the following principles as it evaluates the proposed penalty structure, enforcement framework, and related implementation decisions.

I. OHCA Should Not Vote on Penalty Framework Elements Without Clear Standards for How External Cost Drivers Will Be Evaluated

Before approving the proposed spending target penalty scope, range, or justification factors, the Board should ensure that OHCA has established clear, administrable standards for evaluating whether spending growth is attributable to factors within or outside an entity's control. OHCA has acknowledged that enforcement considerations may include factors such as population characteristics, high-cost patient outliers, investments in primary and preventive care, high-cost drugs, changes in state and federal law, and catastrophic events. However, CAHP remains concerned that the current framework does not provide sufficient clarity on how those considerations will actually affect decisions to escalate beyond technical assistance, require a PIP, assess penalties, or adjust penalty amounts.

This lack of clarity matters because the Board is now being asked to consider penalty structures before the regulated community has a clear understanding of how OHCA will distinguish between avoidable spending growth and spending growth driven by law, public policy, labor markets, taxes, inflation, or other external forces. Without that distinction, the framework risks treating very different circumstances as though they are the same. For example, an entity that exceeds a target because of avoidable inefficiency should not be evaluated in the same manner as an entity whose costs increase because state policy requires it to cover new mandated benefits, absorb new taxes, implement new reporting systems, comply with workforce requirements, or pay higher contracted rates resulting from labor adjustments approved elsewhere in the system.

CAHP respectfully urges the Board to direct OHCA to define, in regulation or formal guidance, the process for submitting contextual information, the criteria OHCA will use to evaluate that information, the timing for review, and the opportunity for an entity to meet and confer before escalation. When OHCA determines that an entity should proceed beyond technical assistance, OHCA should provide a written explanation summarizing the factors considered and the reasons escalation is warranted. The Board should not approve a penalty framework that relies on future discretionary flexibility while leaving regulated entities without lasting standards that will apply consistently across administrations and future Board compositions.

CAHP would also like to reiterate feedback provided to OHCA in CAHP's July 13 letter commenting on the draft NOLA regulations regarding providing additional clarity and transparency of the process. Specifically, CAHP asks that the Board direct OHCA to capture in both the NOLA and forthcoming enforcement regulations that entities are not required to submit prospective labor costs to facilitate a labor costs adjustment and can alternatively submit actual costs during the enforcement considerations process.

II. Penalties Must Be Designed to Improve Affordability, Not Merely Punish Health Care Entities

The Board's discussion of penalties has understandably focused on deterrence. However, as OHCA staff have publicly shared, deterrence alone is not the statutory objective. The purpose of the spending target framework is to improve affordability for consumers and purchasers. CAHP remains concerned that exceptionally large penalties, especially if calculated only as a function of excess spending above the target and not balanced with the need for entities to invest their finances in sustainable affordability programs, may reduce resources available for affordability initiatives, care delivery, quality improvement, consumer support, network investment, and system stabilization in a way that erodes access, quality, equity, or workforce stability.

OHCA's June presentation materials described an approach in which penalties begin with an "initially commensurate" amount based on the difference between actual spending growth and spending growth had the entity met the target, with potential adjustments based on statutory penalty justification factors. The same materials also described a recommended maximum penalty range of up to 125 percent of initially commensurate excess spending growth.

CAHP urges the Board to ask a threshold question before approving any penalty range: how will these penalties lower costs for consumers and purchasers? If penalty dollars are removed from the health care system without a clear, transparent mechanism to return value to consumers and purchasers, the framework risks becoming punitive rather than corrective, outside the bounds of statutory guardrails and at the expense of meaningful affordability reforms. CAHP's July 31 comments urged OHCA to ensure that penalties collected from regulated entities are meaningfully directed back into California's health care system in a manner that advances affordability for consumers, and are not treated as a general funding source disconnected from the affordability concerns the framework is intended to address.

This is not a theoretical concern. If a health plan, hospital, physician organization, or other entity is assessed a significant penalty, those dollars must come from somewhere. A penalty that weakens an entity's fiscal condition, reduces resources available for consumer-facing investments, or increases pressure elsewhere in the system may ultimately undermine affordability rather than improve it. The Board should not approve penalty ranges without also insisting on a clear policy for how penalty funds will be used to deliver measurable affordability benefits to consumers and purchasers.

III. OHCA Should Reject the Assumption That Penalties Are Simply a "Cost of Doing Business"

CAHP is concerned by recurring suggestions that entities may treat penalties as a routine "cost of doing business." That assumption is unsupported and dangerous. Health plans operate in highly regulated markets where premium increases are subject to rate review, benefit obligations are set by law, administrative costs include significant required expenditures, and affordability pressures directly affect enrollment and market

stability. Health plans cannot simply absorb unlimited new costs or pass them through without consequences. If premiums rise too sharply, consumers and employers may reduce coverage, move to self-funded arrangements, or exit the market entirely.

The same dynamic applies more broadly across the health care system. Hospitals and physician organizations also face cost pressures that may affect access, workforce stability, and service availability. If the enforcement framework assumes that penalties can be imposed without downstream consequences, it risks ignoring the basic economic reality that new costs imposed on health care entities will eventually affect consumers, purchasers, employers, providers, or the stability of coverage and care delivery.

IV. The Enforcement Framework Should Foster Systemwide Collaboration, Not Conflict

CAHP urges the Board to consider how the proposed spending target enforcement framework may affect relationships across the health care system. The spending target applies across sectors, but no single sector fully controls all of the costs that flow through the system. Plans negotiate with providers, providers negotiate labor contracts, policymakers enact mandates, manufacturers set drug prices, regulators impose reporting requirements, and purchasers make coverage decisions. If OHCA's framework is not carefully designed, it could unintentionally incentivize each part of the system to blame another for spending target performance rather than encouraging shared accountability for underlying cost drivers.

This concern is especially relevant to the PIP framework. PIPs should not become a mechanism that pits plans and providers against each other or encourages regulated entities to shift costs, assign blame, or use the spending target as leverage in already complex contracting negotiations. Instead, PIPs should be structured to foster collaboration where spending growth is driven by shared, systemwide factors. OHCA should consider whether PIP guidance can expressly encourage joint problem-solving among affected entities, particularly where spending growth results from provider pricing, labor adjustments, high-cost pharmaceuticals, mandated benefits, regulatory requirements, or other cost drivers that cannot be solved by one entity acting alone.

We recognize that plans and providers will continue to have significant disagreements over reimbursement, market power, consolidation, and contracting. However, those disagreements should not obscure an important point: many cost pressures now affecting affordability are policy-driven or systemwide. An enforcement framework that encourages plans and providers to fight over who is responsible for missing a target will not improve affordability. **A framework that requires OHCA to identify and evaluate the underlying cost drivers, and to support collaborative corrective action where appropriate, has a far better chance of producing savings for consumers and purchasers.**

V. OHCA Must Account for the Cumulative Impact of State-Imposed Costs, Mandates, Taxes, and Labor Requirements

CAHP strongly recommends that OHCA evaluate affordability in cumulative terms. Too often, affordability discussions treat each new policy requirement as if it operates independently: one mandate here, one tax there, one labor adjustment, one reporting requirement, one benchmark, one data file, one enforcement obligation. But health plans, providers, employers, and consumers experience those requirements cumulatively. The relevant question is not whether any single policy appears manageable in isolation. The

relevant question is whether the total stack of state-imposed obligations can be absorbed by the industry while also meeting increasingly aggressive spending targets.

This cumulative burden is not hypothetical. Recent federal policy changes, including provisions of the One Big Beautiful Bill Act, further illustrate how external governmental actions may affect costs, utilization, coverage, reimbursement, and uncompensated care in ways that vary substantially across entities. CAHP has previously urged OHCA to recognize external cost drivers such as new mandates, changes in state and federal program requirements, state and federal taxes and assessments, drug and device cost inflation, infrastructure investments, labor costs, and market-wide inflationary pressures. We are also concerned about stakeholder perspectives that may argue for narrow interpretations of mandate costs, such as focusing only on the direct cost of a covered service while ignoring downstream utilization, implementation, high-risk pregnancies, neonatal intensive care, provider capacity, administrative setup, and other associated cost impacts. A narrow view of mandate costs will undoubtedly minimize the true affordability impact of state policy decisions.

The Managed Care Organization (MCO) tax is another example. If state-imposed taxes increase premiums or expenditures, OHCA should not treat those costs as ordinary discretionary spending by plans. Likewise, if OHCA approves nonsupervisory organized labor adjustments for providers or hospitals, those approved cost increases may ultimately appear in negotiated rates and affect payer expenditures. OHCA should not approve provider-side adjustments and then disregard the downstream impact of those same costs when evaluating payer performance. CAHP's July 31 comments specifically urged OHCA to consider downstream impacts where it approves spending target adjustments for providers or hospitals, including nonsupervisory organized labor adjustments.

VI. Administrative Costs and Profits Must Be Presented with Full Context

To reiterate an important theme from our April 2026 public comments, CAHP also urges OHCA to refine how it presents payer administrative costs and profits. OHCA's June presentation described Total Health Care Expenditures as including Total Medical Expense plus Total Non-Medical Expense, with Total Non-Medical Expense including broker commissions, federal and state taxes and fees, general administrative expenses, and health plan and insurer profits. OHCA's June materials also show that, in the fully insured commercial market, general administrative costs, commissions, taxes and fees, and profit are presented together as non-medical spending.

That distinction is critical. Public discussion of "administrative costs and profits" can easily suggest that all non-medical expense is discretionary overhead, which would be inaccurate. Taxes, fees, regulatory assessments, compliance obligations, reporting requirements, fraud prevention, customer service, claims administration, data submissions, and other required functions are part of the cost of operating in a regulated market. If OHCA presents these figures at a high level without explaining what is included, the Board and the public may draw oversimplified conclusions about health plan behavior and affordability drivers.

As OHCA moves toward enforcement, this issue becomes even more important. If taxes, fees, mandates, and regulatory obligations are embedded in administrative cost categories, then those categories cannot be treated as evidence of discretionary cost growth without careful analysis. **CAHP urges OHCA to provide**

clear definitions, methodology, data limitations, and explanatory context whenever payer financial data is used to inform Board discussion, enforcement policy, or public reporting.

VII. Technical Assistance Must Be a Meaningful Off-Ramp, Not a Procedural Formality

The statute emphasizes "progressive" enforcement, but that structure has practical meaning only if technical assistance serves as a meaningful opportunity for remediation and to inform PIPs. CAHP's July 31 comments urged OHCA to establish a defined technical assistance period before requiring public testimony or a PIP, absent exceptional circumstances. OHCA should provide written notice of the specific concerns to be addressed, identify the information needed from the entity, and explain the criteria OHCA will use to determine whether escalation is warranted. If an entity engages constructively, explains cost drivers, corrects data issues, and implements reasonable changes, technical assistance should function as a genuine off-ramp from further enforcement.

This is particularly important because spending growth measurement is retrospective. Entities may not receive notice of a target exceedance until much of a later performance year has already passed. A framework that penalizes entities for periods they no longer have a meaningful opportunity to influence is inconsistent with the stated objective of sustainable performance improvement. PIPs should be forward-looking tools that allow entities to identify root causes, implement corrective action, and demonstrate progress over a workable period of time.

VIII. PIP Guidance Must Include Clear Standards, Confidentiality Protections, and Workable Timelines

CAHP appreciates OHCA's development of draft PIP guidance, but additional clarity is needed before the Board approves penalty structures that will depend heavily on PIP compliance. OHCA should define how PIP approval criteria will be evaluated, how final compliance will be assessed, how multiple or overlapping PIPs will be handled, when PIP modifications may be warranted, how OHCA will coordinate with other regulators, and how spending targets will apply when a PIP spans multiple performance years.

In addition, OHCA must affirmatively protect nonpublic information submitted during the enforcement process. Technical assistance and PIP discussions may require entities to submit sensitive financial, actuarial, operational, contractual, labor, quality, utilization, pharmacy, governance, or strategic information. If entities are uncertain whether those materials will remain confidential, the process will discourage candor and undermine OHCA's ability to understand the actual drivers of spending growth. CAHP urges OHCA to adopt a clear confidentiality process that establishes a presumption that nonpublic information submitted during enforcement considerations, technical assistance, public testimony, and the PIP process is confidential, and that such treatment follows the information if shared with another regulator.

IX. The Board Should Not Approve Penalty Scope and Range Without Understanding Their Practical, Real-World Consequences

The OHCA Board is being asked to consider penalty structures that may risk compromising its statutory obligations and have profound implications for affordability, access, market stability, and consumer costs. CAHP respectfully urges the Board not to approve penalty scope, range, or justification factors unless the

Board is confident that the framework will distinguish controllable from uncontrollable costs, meaningfully account for external cost drivers, preserve access and quality, protect confidential information, provide due process, and ensure that any penalties collected are used to improve affordability for consumers and purchasers.

This is not only a technical implementation question; it is central to whether the spending target framework will achieve its intended purpose. California will not improve affordability by creating a system that encourages each sector to point to another for spending target performance, nor will affordability be improved by treating penalties as the primary solution to cost growth while overlooking the broader economic and policy environment in which regulated entities operate. A sustainable affordability framework should encourage meaningful improvement, preserve access and quality, and address the underlying drivers of spending growth in a way that promotes accountability across the system.

CAHP supports accountability and shares OHCA's goal of improving affordability for California consumers. However, accountability must be fair, transparent, forward-looking, and grounded in economic reality. Before voting on penalty scope, range, or justification factors, CAHP respectfully urges the Board to ensure that OHCA's enforcement framework advances affordability without destabilizing coverage, access, or care delivery. We appreciate OHCA's continued engagement and would welcome the opportunity to work with OHCA staff and the Board to refine the progressive enforcement framework, PIP guidance, penalty methodology, and related regulations in a way that advances affordability for consumers and the health care system overall.

Sincerely,

Anete Millers
Vice President of Legal and Regulatory Affairs
California Association of Health Plans

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August 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

California Department of Health Care Access and Information
2020 W. El Camino Ave, Ste. 1200
Sacramento, CA

Re: August 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, offers comments and recommendations on the enforcement process, penalties for exceeding the spending target and procedural penalties as well as proposed cost and market impact review (CMIR) regulations.

Executive Summary

Health Access recommends:

- Public transparency throughout the enforcement process, from initial notice of exceeding the target to technical assistance and performance improvement plans and finally to penalties.
- Commensurate, dollar-for-dollar penalties for an entity that exceeds the spending target consistent with California law, and necessary to limit the damage done by exorbitant health care costs for consumers.
- Recognition of penalty adjustment factors, including nature and gravity of offense, fiscal condition of entity, and Medi-Cal match

1127 11th Street | Suite 925 | Sacramento, CA 95814 health-access.org

as well as appropriate inclusion of documented, quantified enforcement considerations.
- Consideration of mandates, old and new, in the context of other programs and laws, both state and federal.

In addition, as the organizational sponsor of AB 1415 (Bonta), Health Access mostly supports the proposed regulations to implement it, with the important proviso that the definition of management services organizations (MSOs) should be revised, consistent with AB 1415.

I. Growth Target Enforcement: From Target to Notice to Penalties

Enforcement Process: Multiple Steps, Transparency Sought at Each Step

The governing section on the enforcement process focuses on "compliance with the targets" and "remediation".

> **Health and Safety Code 127502.5.**
> (a) The director shall enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, allows each health care entity opportunities for remediation, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability.

The enforcement process has been transparent from the initial public vote to set the targets and should continue to be transparent at each step of enforcement. Transparency should enhance compliance while providing "opportunities for remediation".

The enforcement process began in 2023 with a public vote by the Board setting the cost growth target based on median family income. These targets apply to health care entities, including health plans and insurers as well as hospitals, large physician organizations and other health care entities. Any subsequent adjustments to a target for an individual entity, a category of entities or all entities also requires action by the Board in a public vote after a public process and timeline delineated in statute.

The second step in the enforcement process is the collection of data from health plans and hospitals as well as attributing costs to large physician organizations. Again, the rules for data collection are publicly available and were subject to public discussion and vote during Board meetings and the Advisory Committee. Each health plan or hospital produces data about each of their own organizations after the target year. Because of this, a health plan or hospital has the ability to know whether or not their own entity exceeded the growth target for the target year before the Office of Health Care Affordability and certainly before the broader public.

The third step is OHCA analyzing data to determine whether an entity exceeded the target by market segment and if so, by how much. Was it a little? Was it a lot? What does the look by market segment tell us? The law recognizes that different entities play different roles in different market segments. Data made public on an entity-specific basis is important to assess market impact, whether the entity is a hospital, a plan or a large physician organization. Some health plans do lots of Medi-Cal managed care and little commercial business while others are significant players in commercial coverage purchased by consumers and employers but have less market impact in Medi-Cal managed care. Does the entity do lots of Medicare? Or a little? Is it a large nonprofit hospital with lots of Medicare patients but a disproportionately small share of Medi-Cal patients?

Health Access supports the decision to analyze and report cost growth by market segment and strongly opposes blending measurement of the commercial market segment with all market segments. Medicare, Medi-Cal and commercial market segments serve different populations with different benefit packages, different cost sharing, different market rules, and importantly, different process for payment rates. Both Medicare and Medi-Cal payment rates are set by government rules while the commercial market segment has much higher costs per patient without commensurately greater benefit to consumers. OHCA exists to provide public scrutiny across all three market segments.

In the fourth step, OHCA will notify an entity if it has exceeded the cost target. The law:

> (b) Prior to taking any enforcement action, the office shall do all of the following:

(1) Notify the health care entity that it has exceeded the health care cost target.
(2) Give the health care entity not less than 45 days to respond and provide additional data, including information in support of a waiver described in subdivision (i).
(3) If the office determines that the additional data and information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target, the office may modify its findings, as appropriate.[1]

The notification that an entity exceeded the target should be public at the time notice is provided to the entity. In a real sense, the enforcement process begins in earnest when an entity receives the notice that it exceeded the growth target. The fact that an entity exceeded the target indicates that the entity has failed to comply with the law to control costs for consumers and other purchasers. The law speaks to "remediation" and coming into compliance with the target: by law, exceeding the target means that the entity erred and the "burden" is on the entity to "demonstrate" that the entity can "explain all or a portion of the entity's cost growth in excess of the target". The motivation to do right and play by the rules should encourage entities of all types to attempt to meet the cost growth target for the year.

The fifth step in the law is that the entity may submit additional data for review by OHCA staff. In the words of the law, this step is about whether "the information meets the burden established by the office to explain all or a portion of the entity's cost growth in excess of the applicable target". At this juncture, the entity may disclose data errors or corrections. The entity may also offer "enforcement considerations" about factors "outside the control" of the entity, rather than factors within the control of the entity.

Health Access asks for public transparency at each stage of this key step:

- If an entity has data errors or corrections that are large enough to impact whether it exceeds the target (something which has already occurred), that fact should be public along with an explanation of what was corrected.
- Public disclosure of "enforcement considerations" is important. Health Access has written extensively about the revenue generated by about half of all California hospitals from the 340B program: the first question OHCA should ask when an entity asserts high drug costs is whether the entity benefited from the 340B program? Other reasons for exceeding the target

[1] Health and Safety Code 127502.5 (b)

would benefit from similar scrutiny. For example, if an entity asserts that the target or enforcement of the target should be adjusted for organized labor costs, do they actually have a collective bargaining agreement consistent with the asserted costs?

- Public disclosure of "enforcement considerations" should provide sufficient time for interested parties to offer public comment. Public comment may illuminate important enforcement considerations.
- If the data corrections or enforcement considerations are sufficient to "meet the burden" to explain the cost growth above the target in whole or in part, then that fact should be publicly stated. Again, such assertions by the entity should be documented and the impact on compliance quantified. General hand waving about inflation or labor costs or other factors should not be sufficient.

The law provides clarity on what happens after this step before enforcement proceeds:

> Commensurate with the health care entity's offense or violation, the director *may* take the following progressive enforcement actions:[2]

At this stage, the OHCA staff determines whether to proceed with further enforcement steps or not. That decision on whether to proceed should also be public because it is of great consequence not only for the affected entity but also for other similarly situated entities and for consumers and other purchasers of care and coverage. Once further enforcement is triggered, each additional step is at the discretion of the director. If the entity uses the opportunity for "remediation" to come into compliance with the growth target, then no further enforcement is required.

The sixth step in the enforcement process is "technical assistance". This is required by law. It may vary by type of entity such as health plan or large physician organization and may range from general information to one-on-one discussions. This is not management consulting or detailed directions to the entity by the OHCA staff. Health Access supports as consistent with the law the staff recommendation not to require implementation of technical assistance before proceeding to other enforcement. Whether technical assistance is provided and a general sense of what it entails should also be public.

[2] Health and Safety Code 127502.5 (a), emphasis added.

In the seventh step, the Director may compel public testimony from an entity which exceeded the target. The public testimony may be written, verbal or both. Health Access notes that there is already extensive public comment by entities subject to the target. By law, such compelled testimony is public. By law, it is at the discretion of the Director.

Step eight is one of the most consequential steps in the sequence of enforcement: OHCA can require an entity to develop and submit a "performance improvement plan". This plan to correct the failure of the entity to meet the growth target is subject to approval by the HCAI Director. But the burden is on the entity to develop a plan specific to its circumstances that will bring it back into compliance with the growth target without eroding access, quality, equity or workforce stability. In other states, few entities have been subject to performance improvement plans. Health Access seeks public notice:

- At the time an entity is told that it must develop a performance improvement plan.
- When the entity submits the plan, and before the Director approves it so that stakeholders may comment.
    - Health Access recognizes that some information in a performance improvement plan may be not otherwise publicly available or "business proprietary" information that would inform competitors and that the law appropriately recognizes these narrow circumstances.
    - Information that is otherwise publicly available should be made public.
- When a plan to correct course is approved, the law requires a detailed summary of that plan to be made public[3].
- At each milestone, a public update on progress toward compliance.
- Upon completion of the plan.

Performance improvement plans may be as brief as some months or as long as up to three years. Health Access supports the concept of "stacking" annual performance improvement plans for up to three years in order to encourage more prompt improvement in meeting the cost growth target if it proves operationally feasible.

While the performance improvement plan is a single step in the enforcement process, in practice the plan, its development, approval and implementation involve multiple steps. In our observation, other states have varied in what is public when.

[3] Health and Safety Code 127502.5 (c) (2)

Our recommendations are aimed at continuing OHCA's emerging tradition of public transparency.

Step	Action	Public? When?
1.	Growth target set for years 2025-2029	Public Board Vote to Adopt April 2023. May be adjusted for 2028 or 2029.
2.	Data collection from plans and hospitals and about large physician organizations	• Annually for prior year, reported in spring of next year • 2025 data collected in 2026, reported publicly early 2027, • Health plan, hospital each submits own data and knows likely results
3.	Data analysis by OHCA staff	• Entity-specific results should be public in summary form
4.	OHCA notifies entity if it exceeded growth target	• Public at the time of notice to entity.
5.	Entity that exceeded target may provide additional data, to correct data submission or offer explanation of factors outside the control of the entity; these are "enforcement considerations".	• Transparency of possible enforcement considerations • Allow sufficient time for public comment • Data errors/corrections: public • If data corrections or enforcement considerations "meet the burden" established by the Office, public notice. If not, public notice.
6.	OHCA determines whether to proceed with further enforcement.	Public notice at time entity is notified whether enforcement will proceed or not.
7.	OHCA to provide "technical assistance": this may be general by type of entity (health plan, hospital, doctor group) or 1:1. No requirement for entity to implement or comply with TA.	Transparency about type of technical assistance by entity and level of detail: generalized? One on one?
8.	OHCA may (or may not) compel public testimony by entity.	By definition, public.

9.	Performance improvement plan	• Notice when an entity has been told to develop a PIP • Public notice and summary when an entity submits a draft PIP to permit public comment prior to approval • Detailed summary of PIP once approved as required by law. • Public update at each milestone • Public update on completion.
10.	Financial penalty commensurate with amount by which exceeded target, subject to adjustment factors specified in law.	• Commensurate amount public. • Any adjustment factors public. • Penalty owed should be public—and date of payment.

Growth Target Financial Penalties:
Addressing The Injustice of Exorbitantly High Health Care Costs

Only after the many steps in the enforcement process and only if an entity has failed to comply with its performance improvement plan is an entity subject to a potential financial penalty for exceeding the growth target.

> **Health and Safety Code 127502.5** (d) (1) If the director determines that a health care entity is not compliant with an approved performance improvement plan and does not meet the cost target, the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target. An entity that has fully complied with an approved performance improvement plan by the deadline established by the office shall not be assessed administrative penalties. However, the director may require a modification to the performance improvement plan until the cost target is met.

Health Access supports commensurate penalties as consistent with California law and opposes penalties that are one-twentieth this amount or even less and that are instead based on laws in other states. The Governor and Legislature deliberately chose to give the Director the authority to impose substantial and meaningful penalties in order to cause health plans, hospitals, and large physician organizations

to change their business model and move toward the triple aim of lower costs combined with improved outcomes and greater equity.

What is exorbitant is the harm done today to consumers and other purchasers by high health care costs. A recent employer survey found that employer coverage in California will cost as much as a small car, about $30,000 a year for family coverage[4]. If consistent with prior years, family share of coverage would be about $9,000 and the deductible $4,800, almost $5,000, for a total of $14,000. This is money that could go into wages, lessening income inequality. Without effective enforcement and meaningful penalties, the harm to consumers will only compound over time.

No wonder more than half of California consumers go without care because of high health care costs. This is wrong in every sense: it is bad health policy because people skip needed care and get worse. It worsens inequity because the cost hits hardest those with the least resources. It is unethical for a hospital to spend more on executive compensation than charity care—and use its market power to insist on commercial payments that are three or four times what Medicare would pay for the same care at the same hospital[5]. Surely twice what Medicare pays would be sufficient if the goal was fairness and access to care.

The injustices inflicted on California consumers by high health care costs drives Health Access' support for strong, commensurate penalties combined with effective enforcement and transparency throughout the enforcement process, from the initial notice that an entity exceeded the target to any financial penalties.

Penalty Adjustment Factors: Nature, Gravity of Offense, Entity Fiscal Condition, Medi-Cal Match, and Enforcement Considerations

Health Access acknowledges that the law provides for "adjustment factors" for the penalty for exceeding the cost growth target. These include:

- The nature, number and gravity of the offenses.
- The fiscal condition of the entity, which under the law includes consideration of any system or larger entity as well as any subsidiaries or affiliates controlled by the entity such as clinics, foundations, or other care settings.
- The market impact of the entity: even relatively small entities can exert substantial market power. This is the lesson of "surprise medical bills".

[4] https://www.latimes.com/business/story/2026-07-16/california-employer-health-premiums-will-cost-as-much-as-new-car-in-2027
[5] https://health-access.org/high-hospital-costs-in-santa-barbara-county/

- Medi-Cal match considerations. The law details numerous aspects of the Medi-Cal match, such as the hospital provider tax or the use of county funds for nonfederal share of Medicaid match.

The law also provides for penalties that escalate beyond the commensurate amount of exceeding the target for repeated failure to meet the target. This helps to answer the concern voiced by Board members that an entity will feel free to exceed the target because it can rebase its spending to a higher level during the lengthy period of months or years which is needed to collect data and engage in progressive enforcement.

Health Access earlier voiced concern that adjusting the spending target penalty for enforcement considerations amounted to double-counting (or double-discounting) the enforcement considerations. The enforcement considerations arise in the period immediately after the entity has been notified that it exceeded the target. These considerations, such as a disproportionate number of very high-cost patients or disproportionate use of high-cost drugs (without the benefit of the revenue-enhancing aspects of the 340B program), affect whether an entity proceeds further through the stages of enforcement. Such enforcement considerations would also factor into the calculation of the "commensurate penalty". The "commensurate" amount is the amount by which an entity exceeded the target. But an "enforcement consideration" that is based on a factor outside the control of the entity may explain part of the excess growth.

With respect to escalating penalties for an entity that is repeatedly noncompliant with performance improvement plans[6], staff has proposed that these penalties may range up to 125% or 150% of the commensurate amount. We recognize that this proposal reflects the role of the Board in determining the "range" of penalties. We remain concerned that this may be insufficient to deter a genuinely bad actor. We have had experience with each of these: entities that put profits ahead of patients; entities that knowingly failed to meet staffing requirements by a factor of ten; entities that fail to plan to comply with seismic safety requirements, risking lives of their patients and the community; and entities so certain of their righteousness that consumers go without needed behavioral health in a timely manner.

We are pleased that the law requires commensurate penalties and allows for escalating penalties. The excess profits that entities stand to gain by exceeding the targets, or delaying or obfuscating steps of the enforcement process, represent a

[6] Health and Safety Code 127502.5 (d) (5).

significant incentive for covered entities. If an entity fails to meet the target, consumers are the ones left paying the price. Commensurate penalties were designed to counter-balance the profit incentive and therefore must have the ability to escalate and adapt to remain effective. We are not certain what is sufficient to change behavior given the adamant resistance of so many entities to recognizing the damage their high health care costs are doing today to the health of Californians. In that context, we worry that 125% may not be sufficient.

Procedural Penalties: Knowingly or Willfully Failing to Meet Process Requirements

The law governing the Office also includes penalties for knowingly or willfully failing to report information or accurate data, failing to file a performance improvement plan, repeatedly failing to implement a plan, or falsifying information. "Knowingly", "willfully" and "repeatedly" are standards that have legal meaning that require evidence to demonstrate.

One set of penalties already adopted by the Board under these provisions of law deals with the failure of health plans or insurers to timely submit "total health care expenditure" data. Other examples of "willfully failing to report complete and accurate data" may occur in the future, necessitating further action on penalties for those failures.

The Office staff have proposed penalties of $10,000 per day for some of these violations and for two categories of one-time penalties of $500,000 for one-time failures. Health Access recommends that penalties be meted out on a per-violation basis, rather than a per-entity basis. For example, an entity could knowingly falsify multiple sets of information: that in our view would merit multiple procedural penalties. Similarly, an entity could "knowingly fail to provide information required by the office" several times or more than one set of information. The director should retain the authority to issue multiple penalties in such situations.

Enforcement Considerations: Mandates: Old and New

The OHCA statute provides that the Board and staff consider newly imposed mandates that affect entities subject to the growth target. The cost impacts, if any, should be quantified and documented, preferably by independent analyses[7]. Newspaper clips and generalized assertions are not sufficient to quantify impacts.

[7] An independent analysis is not funded or controlled by the entity subject to the new costs.

Health Access recognizes that some new state or federal mandates increase health care costs. Some costs increase over time while others will diminish as a proportion of "total health care expenditures" or hospital revenues. Enforcement considerations that excuse enforcement in whole or in part, including those that involve mandates should be rare, well documented and both quantifiable and with the impact quantified. We encourage skepticism about the use of "enforcement considerations" to address mandates.

A longstanding mandate: hospital seismic requirements

In 1972, after the Sylmar quake collapsed newly built hospitals, California law was changed to require newly built hospital buildings to be seismically sound.

In 1994, after several quakes damaged or collapsed hospital buildings that predated 1972, the law was updated to require two stages of seismic requirements: first, that hospital buildings no longer be at risk of collapse in a major earthquake. Virtually every hospital building in California now meets this standard. This standard does not require a hospital to be fully functional after a quake. A hospital that meets this standard would not be expected to have electricity or lights or water or even functioning elevators. Engineers expect that one of four hospital buildings would need to be promptly evacuated. Patients and workers would live but the hospital building could not provide care or even remain open.

The second standard due to go into full effect in 2030 requires hospitals to be operational after a major quake. Most Californians probably assume that hospitals can provide care after a major quake.[8]. As of 2026, almost 3,200 of the over 3,300 California hospital buildings have met the structural requirements or filed plans to do so prior to 2030. As of 2026, only about half of the buildings have met the nonstructural performance requirements[9].

Hospital seismic safety has been an expectation in California for over *fifty* years. The current requirements have been in place for over *thirty years*, longer than the standard homeowner mortgage. If a homeowner can be expected to pay off her mortgage in thirty years, hospitals can be expected to meet major capital costs in that time, if they plan prudently and are committed to patient safety and serving

[8] Assembly Health analysis, SB 1432 (Caballero), June 25, 2024. As of 2024, a majority of hospital buildings had met the structural requirements, but few had met the nonstructural performance requirements for such operational needs as electricity and water.
[9] Background for AB 2131. Not published.

their communities. Health Access opposes any enforcement consideration for this longstanding mandate.

Infertility requirements: Only for the Large Group Segment of Commercial Coverage

In 2024, SB 729 (Menjivar) added coverage of infertility treatments to state-regulated coverage purchased by large employers, known as large group coverage. This mandate was enacted in 2024 and took effect July 1, 2025. It impacts half the first year of the OHCA targets and is built into the base of spending for the years 2026-2029.

The analysis by the California Health Benefits Review program of this legislation estimated the increase in expenditures to be about 0.12% in year 1 and about 0.2% for the 8.1 million Californians in this market segment in year 2.[10] Since the coverage mandate does not apply to state-regulated individual and small group coverage and since it is only half year coverage in 2025, the impact on commercial coverage to less than 0.03%-0.04% in 2025 and slightly over 0.1% in 2026 for the overall commercial market segment.

Given the very modest impact of this benefit mandate in 2025 and ongoing, health plans and insurers should be able to absorb it by reducing profits, overhead and reserves.

MCO Tax: A New Mandate

The recently enacted state budget includes a revised Medicaid Managed Care Organization Tax that applies the same tax rate of $8.85 per enrollee per month to both Medi-Cal managed care plans and state-regulated commercial managed care plans and invests the federal match received from this tax into the Medi-Cal program. If the premium for family coverage will cost California employers $30,000 in 2027, then the added cost of the MCO tax is slightly more than 1% of the premium, and a smaller proportion of "total health care expenditures" which includes cost sharing.

[10] SB 729 Infertility Abbreviated Analysis Final_revised 0420.pdf. Scenario 2 applies: 2023-2024 | California Health Benefits Review Program. Coverage estimates: Sources of Health Insurance in California Large group enrollment is about 63% of the 12.9 million Californians in non-CalPERS, state-regulation coverage.

Health Access notes that the tax rate of $8.85 is a flat amount, so the percentage impact on commercial premiums and cost sharing will decline over the years it is expected to be in effect.

Health Access also notes that the MCO tax is subject to approval by the federal government which has not yet been granted.

Health care costs are already too high. Health Access offers recommendations to avoid further worsening these exorbitantly high health care costs by passing through the MCO tax to consumers and other purchasers:

- As a first step, the MCO tax should be taken out of profits, shareholder payouts, and reserves to the maximum extent possible in order to preserve the goal of more affordable care.
- Second, any adjustment or consideration should be limited only to entities that pay the MCO tax, DMHC-regulated health plans in the commercial market segment. If need be, such entities could be defined as a "sector" within the meaning of the law, just as hospitals have been.
- Third, Health Access opposes waivers of enforcement for health plans that exceed the target in part because of the MCO tax. The MCO tax while significant is nowhere near 3% of THCE. Again, the impact should be quantified and should reflect the net after profits, shareholder payouts, and reductions in excessive reserves.

Enforcement Considerations: High-Cost Drugs?

In prior correspondence, we have commented on the 340B program which about half of all California hospitals participate in. It creates a revenue stream for hospitals that in some cases, such as the University of California, amounts to billions of dollars in revenues annually. A recent Health Affairs piece found:

> For hospitals eligible for 340(B) discounts, each Keytruda patient was associated with $102,680 in annual revenue, measured through insurer reimbursement, after organizational, patient, and market factors were adjusted for. Each Keytruda patient was associated with $67,825 in revenue at noneligible hospitals and $3,094 in revenue at physician practices[11].

The article's title, "Profitability of Infused Biologics", speaks to the reason we are skeptical about high-cost drugs (or high-cost patients) as an enforcement consideration without further, entity-specific detail. This article also speaks to site-

[11] James C. Robinson, Ari Koruskov, Mark Thomson, Christopher M. Whaley, https://www.healthaffairs.org/doi/10.1377/hlthaff.2026.00334. August 3, 2026

neutral payments as a way to control health care costs without impairing quality or outcomes.

II. Updated Cost and Market Impact Regulations

As the sponsor of AB 1415 (Bonta, Chapter 641 of 2025), Health Access supports OHCA's efforts to implement the law and improve transparency for transactions involving private equity groups, hedge funds in health care, and management services organizations (MSOs). As the enactment of AB 1415 recognized, these three types of entities have had a growing footprint in health care and impact on consumers, with little regulation and transparency.

Private equity has been a growing presence in health care transactions for a decade. Between 2019 and 2023, private equity acquisitions of health care providers in California totaled $4.31 billion, roughly a third of all health care deals but these transactions had little or no scrutiny at the state or federal level[12]. AB 1415 brings sunlight to these transactions and the evaluation of the impacts on consumers. This transparency is important, especially given the research that these transactions can lead to higher prices, dangerous health outcomes, worse access to care, and financial outcomes for the health care entity being acquired[13].

Comprehensive Threshold for Private Equity Transactions Ensures Transparency of Complex Transactions

OHCA's proposed regulations on private equity transactions provide helpful further detail consistent with the statute. We especially appreciate the detailed inclusion of the impacts of private equity transactions in health care in Section 97435 and the threshold including any types of control or impacts described. As our colleagues at the Private Equity Stakeholder Project point out, private equity control can appear through many tactics including debt or liability positions, governance rights, management agreements, fee arrangements and more[14]. The proposed regulations

[12] Christopher Cai, Zirui Song https://www.chcf.org/resource/2024/05/07/private-equity-in-health-care-prevalence-impact-and-policy-options-for-california-and-the-u-s/#related-links-and-downloads. May, 7, 2024

[13] Richard M. Scheffler, Laura Alexander, Brent D. Fulton, Daniel R. Arnold, Ola Abdelhadi https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf. July 10, 2023; Sneha Kannan, Joseph Dov Bruch, Zirui Song https://jamanetwork.com/journals/jama/fullarticle/2813379. December 26, 2023; David Blumenthal https://www.commonwealthfund.org/publications/explainer/2023/nov/private-equity-role-health-care. November 17, 2023

[14] See Private Equity Stakeholders Project's comments on the May 2026 proposed amendments to California Code of Regulations, Title 22, Division 7, Chapter 11.5, Article 1.

ensure there is transparency of the complex types of transactions and their impact on consumers.

Transparency of Real Estate Investment Trusts and Leasebacks Protects Consumers

Health Access supports the inclusion of the use of real estate investment trusts (REITs) and real estate leaseback arrangements. Their inclusion is consistent with AB 1415. Transparency of these transactions is critical to protecting consumers from the negative impacts we've seen from this private equity strategy primarily used in skilled nursing home and hospital transactions. In both situations, the firm sells the real estate of the health care entity. These arrangements can significantly affect financial stability, access to care, and operations.

Two examples:

- In July of 2019, Prospect sold the real estate of its California, Connecticut, and Pennsylvania hospitals in a sale-leaseback transaction into a Trust for $1.55 billion. The transaction left Prospect with fewer assets, and Prospect ultimately filed for bankruptcy in 2025[15].
- Similarly, the use of sale-leasebacks played a role in Steward Health Care's bankruptcy. Steward sold its Massachusetts properties for $1.25 billion 2016 to a Trust. The agreement included annual rent increases, which each hospital was responsible for paying. The increased leasing obligations raised Steward's operating costs and contributed to worsening financial pressures. Steward fell behind on accounts payable to vendors, who repossessed needed medical equipment. The loss of this equipment was linked to adverse patient outcomes, including a patient dying[16].

These examples illustrate the negative impacts of Real Estate Investment Trust (REIT) for consumers and why they were included in AB 1415 and support their inclusion in the regulation.

[15] Mary Bugbee https://pestakeholder.org/news/steward-health-cares-bankruptcy-one-year-later/#_edn115. May 6, 2025.
[16] Wasan M Kumar https://hmpi.org/2024/06/19/steward-health-a-cautionary-tale/. June 11, 2024

Avoiding Gaps in Oversight by Narrowing MSO Definition

We reiterate our recommendation to modify the definition of management services organizations (MSOs) to ensure that it captures the range of MSO structures that can impact consumers and the health care market and that the law permits.

Existing law already limits what is captured to MSOs that provide services that can affect health care prices and quality through provider rate negotiation and revenue cycle management. The proposed regulation further limits what is being captured within the definition of MSOs by requiring certain MSOs to have two or more relationships with physician organizations before they fall within the regulatory definition. This threshold could exclude MSOs that have substantial influence over a physician organization. We recommend changing this threshold to *"one or more physician organizations or a hospital"* to ensure that captive MSOs are captured. Captive MSOs are often used by private equity or other investment arrangements to provide capital to physician organizations that amount to control while complying with California's corporate practice of medicine restrictions. Without this change, CMIRs could miss some transactions with potential impacts on consumers.

Expanding CMIR Oversight to Capture Private Equity Withdrawals

Health Access recommends that the regulations capture transactions in which a private equity group withdraws funding or control from a health care entity. The risks associated with private equity involvement do not arise only when capital enters a health care entity. The withdrawal of control or financial support can negatively affect an entity's financial stability and its ability to continue providing services at all and can even collapse the entity.

Financial instability can ultimately affect consumers due to efforts to increase revenue by increasing prices, reducing unprofitable services or closures, decreases in quality of care and workforce deductions. The collapse of Steward Health Care illustrates the importance of examining the full financial relationship between private equity investors and health care entities, including the extraction and withdrawal of financial resources.

Financial Distress Should Not Eliminate Transparency

Transparency and review are particularly important when a financially vulnerable health care entity enters a transaction that could significantly affect its long-term financial stability or the availability of services in its community.

The existing cost and market impact regulations already recognize the need to move quickly when financial distress threatens continued access to care by including an expedited review process for transactions involving severe financial distress, significant reductions in critical health care services, or other urgent circumstances. Rather than exempting or excluding these transactions from review, the expedited process appropriately captures and balances the need for timely financing with OHCA's responsibility to understand the transaction's potential effects on consumers and communities.

Conclusion

Health Access seeks public transparency throughout the enforcement process and supports commensurate, dollar-for-dollar penalties to address exorbitant costs for consumers and other purchasers. We recognize that the law includes various adjustment factors for penalties. As the sponsor of AB 1415 (Bonta), we largely support the proposed regulations revised Cost and Market Impact Reviews, while seeking a definition of management services organizations (MSOs) more consistent with the statute.

Thank you for your consideration of these recommendations,

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 Secretary, Office of the Governor, Attn.:

Paula Villescaz
Robert Rivas, Speaker, California Assembly, Attn.: Rosielyn Pulmano
Monique Limón, President Pro Tempore, California State Senate, Attn.: Marjorie Swartz
Mary Watanabe, Director, Department of Managed Health Care
Michelle Baass, Director, Department of Health Care Services
Assemblymember Mia Bonta, Chair, Assembly Health Committee, Attn.: Lisa Murawski
Dr. Akilah Weber Pierson, Chair, Senate Health Committee, Attn.: Teri Boughton
Brent Houser, Deputy Secretary, California Health and Human Services Agency, Attn.: Darci Delgado
Senator Caroline Menjivar, 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

Attachment #11

Mike Miller
Director
Victor Quiroz
Assistant Director

Region 6

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA - UAW

6500 S. ROSEMEAD BLVD.
PICO RIVERA, CA 90660-3532
PHONE: (562) 801-1500

Dear OCHA Board members,

On behalf of the United Auto Workers (UAW) Region 6, representing over 100,000 active and retired members in the state of California, I write in strong support for the enforcement of cost-growth targets with real penalties.

We support the proposal for commensurate penalties that are dollar for dollar the amount spent over the target and the proposed expanded possible range of penalties for repeat or intentional offenders. Strong penalties are needed to ensure big hospitals and insurers slow spending growth and meet the targets.

High healthcare costs hurt working people. We need the Board to enforce cost-growth targets with real penalties!

Michael J. Miller

Michael Miller
Director, UAW Region 6

MM:at
opeiu494afl-cio

SEIU CALIFORNIA

UNITE. FIGHT. WIN.

August 19, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
2020 West El Camino Avenue, Suite 1016
Sacramento, CA 95833

Submitted via OHCA@hcai.ca.gov

Re: August 2026 Health Care Affordability Board Meeting

Dear Chair Johnson,

On behalf of SEIU California's 750,000 members and their families, I am writing to express our recommendations to strengthen OHCA enforcement and performance improvement plans. These regulations are both urgent and important. We have appreciated the staff's diligent work to develop thoughtful proposals regarding enforcement of the spending growth targets in a way that balances administrative burden on OHCA with the need to ensure compliance and also ensure that entities do not implement performance improvement plans in ways that are likely to erode access, quality, equity, or workforce stability. Our comments below reflect a strong interest in transparency and public engagement throughout the enforcement process. We also appreciate the ongoing work to robustly implement AB 1415 and the nonsupervisory labor cost adjustment provisions in statute. We encourage OHCA staff and the board to move forward quickly with both of those workstreams.

Transparency and Public Engagement

While we recognize that some parts of the enforcement process will be held confidential and potentially conducted in closed sessions of the Board, we encourage OHCA to prioritize transparency and public engagement when possible. In the paragraphs below we outline our expectations for public testimony, stakeholder participation, and public availability of technical assistance and performance improvement plans:

Public testimony and stakeholder participation in the enforcement process

We encourage OHCA to see stakeholders, including unions representing workers at regulated entities, as sources of collaboration and information during the enforcement stage. In particular, there are stakeholders who will be able to speak to actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target. Such engagement is also consistent with OHCA's

regulatory framework as outlined in HSC 127502.5.(a)), which clearly states the director shall review information and other relevant data from additional sources.

We ask OHCA to make the identities of entities exceeding the spending growth target public at the time that the entity is notified and create a pathway for accepting input from stakeholders regarding actions by the entity that have eroded, or are likely to erode, access, quality, equity, or workforce stability, factors that contribute to spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target.

Publicly post technical assistance

As referenced above, to foster stakeholder participation and maximize public transparency, we urge OHCA to make public, as early in the process as is deemed appropriate, all technical assistance that is provided to entities. Other CalHHS departments provide a clear model and past practice for doing this. In the same way that All Facility Letters made public by CDPH and All Plan Letters made public by DMHC and DHCS are useful to other stakeholders, OHCA technical assistance letters provided to entities regarding their failure to meet the spending growth target will be broadly useful to other stakeholders. Such technical assistance can help researchers, policymakers, and advocates understand the factors that contributed to categories of entities failing to meet the spending growth target and how OHCA is interpreting those factors with regard to enforcement of the spending growth target.

Performance improvement plans and plan monitoring

We strongly support the statutory intention of using performance improvement plans (PIP) to guide entities into compliance with the spending growth targets. It is key to the progressive enforcement actions outlined in statute, and a core component of the foundational agreement between stakeholders, the legislature, and administration that grounded OHCA's establishment.

We encourage OHCA to make public a detailed summary of any proposed performance improvement plan or the entire proposed performance improvement plan (excluding any information deemed confidential) so that stakeholders with relevant information will be able to bring that information to the staff and Board prior to approval of the performance improvement plan.

We also encourage OHCA to make public a detailed summary of the approved performance improvement plan or the entire approved performance improvement plan (excluding any information deemed confidential) so that employees at entities on a performance improvement plan will be able to determine whether actions taken by the entity are part of the performance improvement plan or are independent business decisions unrelated to the performance improvement plan. This is particularly critical to prevent performance improvement plans from being implemented in ways that are likely to erode access, quality, equity, or workforce stability. Other stakeholders including organizations advocating on behalf of patients and consumers, local government, other health care entities serving the same community similarly have a strong interest in understanding any performance improvement plans and how they will be implemented by the entity.

Similar to posting of technical assistance, there is past precedent and examples in state government for such public transparency for improvement plans like the OHCA PIP. As an example, we would look at The California Dept. of Justice on how they use their website to make publicly available information regarding nonprofit health facility transactions and conditional approvals of mergers. For the same reasons, we encourage OHCA to offer periodic public updates as it monitors entities for compliance with performance improvement plans and to provide a public update at the end of a performance improvement plan or when a plan is modified. Similarly, CDPH, per federal requirement, posts healthcare facility inspection reports and plans for correction.

Administrative and Procedural Penalties

SEIU CA supports strong administrative and procedural penalties that will drive entities toward compliance.

Administrative penalties

With regards to administrative penalties, commensurate, dollar-for-dollar penalties are a reasonable starting place that is consistent with statute, and we appreciate staff's recognition that penalties should be allowed to go higher than dollar-for-dollar in cases with aggravating or exacerbating factors.

Procedural penalties

We also believe that procedural penalties hold a clear and important role in supporting implementation and cooperation from entities subject to the spending growth targets. The spending growth targets are only effective if entities comply with the procedural steps necessary to implement the law. To be effective, procedural penalties should be substantial enough to be a meaningful deterrent to noncompliance, increase with repeated violations (either per day or per violation, depending on the type of violation), and be made public in a timely manner.

AB 1415 Implementation

SEIU CA, a strong supporter of AB 1415 (Chaptered, 2025), appreciated the diligent work of staff on implementing regulations. In particular, it is critical that the managed service organization (MSO) definition is in keeping with AB 1415 to guarantee the improved transaction transparency envisioned by the bill is fully achieved. Specifically, SEIU CA supports the inclusion of the use of real estate investment trusts (REITs) and real estate leaseback arrangements.

Nonsupervisory Organized Labor Adjustment Implementation

We appreciate the ongoing staff work to ensure that the nonsupervisory organized labor adjustment (NOLA) process is ready to be implemented in time for prospective adjustments for the 2027 measurement year. We look forward to seeing the next versions of the draft regulations and the Request File Specifications Document. We hope that the next versions will clarify that the union is a valid submitter and ensure that there is early and open communication between OHCA, the entity, and the union regarding NOLA submissions.

SEIU CA, a champion of health care transparency and affordability, believed in the potential, transformative role of the Office of Health Care Affordability (OHCA) long before its activity began. We are heartened by the work of OHCA to date. As you review these comments, and make appropriate adjustments, we urge OHCA to stay the course on these critical enforcement and performance improvement-related policies and protocols to guarantee meaningful and timely implementation. We appreciate OHCA's engagement with stakeholders and welcome further conversation, where helpful, on our feedback contained in this letter.

Sincerely,

Beth Malinowski
Government Relations Advocate
SEIU California

cc:
Members, Health Care Affordability Board
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
CJ Howard, Assistant Deputy Director, Office of Health Care Affordability