



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 from health care entities.

Date	Name	Written Comment
6/19/2026	Salinas Valley Health	See Attachment #1.
6/19/2026	PIH Health	See Attachment #2.
6/19/2026	Cedars Sinai	See Attachment #3.
6/19/2026	Santa Barbara Neighborhood Clinics	See Attachment #4.
6/19/2026	Salinas Valley Health	See Attachment #5.
6/20/2026	John Muir Health	See Attachment #6.
6/22/2026	San Antonio Regional Hospital	See Attachment #7
6/22/2026	United Way Monterey County	See Attachment #8.
6/23/2026	St. Agnes Medical Center	See Attachment #9.
7/21/2026	PIH Health	See Attachment #10.
7/22/2026	Providence	See Attachment #11.
7/27/2026	Valley Children's Health	See Attachment #12.

Date	Name	Written Comment
7/28/2026	San Bernardino Mountains Community Hospital	See Attachment #13.
7/29/2026	Marian Regional Medical Center	See Attachment #14.
7/29/2026	Mercy Hospital	See Attachment #15.
7/29/2026	French Hospital Medical Center	See Attachment #16.
7/29/2026	California Hospital Medical Center	See Attachment #17.
7/29/2026	Mercy General Hospital	See Attachment #18.
7/29/2026	Mercy Medical Center Redding	See Attachment #19.
7/29/2026	Bakersfield Memorial Hospital	See Attachment #20.
7/29/2026	Northridge Hospital Medical Center	See Attachment #21.
7/29/2026	Glendale Memorial Hospital	See Attachment #22.
7/29/2026	Children's Hospital LA	See Attachment #23.
7/29/2026	Sierra Nevada Memorial Hospital	See Attachment #24.
7/30/2026	Methodist Hospital of Sacramento	See Attachment #25.
7/30/2026	Inland Empire	See Attachment #26.
7/30/2026	Dominican Hospital	See Attachment #27.
7/30/2026	Kindred Hospitals	See Attachment #28.
7/30/2026	Mercy Medical Center	See Attachment #29.

Date	Name	Written Comment
7/30/2026	Woodland Memorial Hospital	See Attachment #30.
7/30/2026	St. Joseph's Behavioral Center	See Attachment #31.
7/30/2026	St. Joseph's Medical Center	See Attachment #32.
7/30/2026	Sequoia Hospital	See Attachment #33.
7/30/2026	Mercy Medical Center Mt. Shasta	See Attachment #34.
7/30/2026	St. Elizabeth Community Hospital	See Attachment #35.
7/30/2026	St. Mary Medical Center	See Attachment #36.
7/30/2026	Mercy San Juan Medical Center	See Attachment #37.
7/30/2026	MemorialCare Health System	See Attachment #38.
7/30/2026	Palmdale Regional Medical Center and AV Edge	See Attachment #39.
7/30/2026	Mark Twain Medical Center	See Attachment #40.
7/30/2026	Mercy Hospital of Folsom	See Attachment #41.
7/31/2026	Montage Health	See Attachment #42.
7/31/2026	Scripps Health	See Attachment #43.
7/31/2026	University of California Health	See Attachment #44.
7/31/2026	Kern Medical	See Attachment #45.

Date	Name	Written Comment
7/31/2026	Loma Linda University Health	See Attachment #46.
7/31/2026	Sharp HealthCare	See Attachment #47.
7/31/2026	Washington Health	See Attachment #48.
7/31/2026	Kaiser Permanente	See Attachment #49.
7/31/2026	Dignity Health System	See Attachment #50.
7/31/2026	Mayers Memorial Health Care District	See Attachment #51.
7/31/2026	Rady's Children's Health	See Attachment #52.
8/10/2026	United Way Monterey	See Attachment #53.
8/12/2026	Sutter Medical Group	See Attachment #54.
8/18/2026	Adventist Health	See Attachment #55.
8/19/2026	Northern Inyo Healthcare District	See Attachment #56.
8/20/2026	Stanford Health Care	See Attachment #57.
8/20/2026	Montage Health	See Attachment #58.
8/20/2026	Montage Health	See Attachment #59.
8/20/2026	Kaiser Permanente	See Attachment #60.
8/20/2026	Santa Clara Valley	See Attachment #61.



June 19, 2026

VIA EMAIL

Office of Health Care Affordability
California Health and Human Services Agency
Sacramento, California

Re: Salinas Valley Health Resubmitted Data Review and Community Support Letters

Dear Members of the Office of Health Care Affordability Board:

In advance of the Office of Healthcare Affordability (OHCA) June meeting and as OHCA evaluates Salinas Valley Health's resubmitted data and considers future approaches to spending target enforcement, we want to reiterate our position as a valued safety net provider, expanding access to quality care for everyone in our region. The services we provide extend far beyond the walls of our medical center and include a broad network of primary care, specialty care, community-based programs, and preventive health initiatives that collectively serve the residents of Monterey County.

For more than seventy years, Salinas Valley Health has fulfilled a critical role as a community-owned public healthcare district. We care for a patient population with significant healthcare needs, maintain a substantial Medicare and Medi-Cal payer mix, and continue to invest in services that improve access, reduce barriers to care, and support the long-term health of our region.

As part of this submission, we are respectfully resubmitting four letters of support previously provided to OHCA by community healthcare partners and organizations. While these letters were submitted during the prior review process, we believe they remain highly relevant as OHCA considers both our updated data and the broader implications of spending target enforcement policies.

The letters reflect the perspectives of organizations and providers who work directly with the populations we serve throughout Monterey County. Their comments underscore the value Salinas Valley Health provides as a healthcare partner, referral destination, major employer and safety-net resource.

Thank you for your consideration and commitment to advancing healthcare affordability while preserving access to essential healthcare services. We appreciate the opportunity to continue working collaboratively with OHCA and look forward to the completion of your review.

Sincerely,



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

Attachments:

- Community Support Letter – Monterey County Health Department
- Community Support Letter – Santa Lucia Medical Group
- Community Support Letter – Clinica de Salud del Valle de Salinas
- Community Support Letter – Pacific Coast Pediatrics

cc: Members of the Office of Health Care Affordability Board:

Sandra Hernandez, MD
Richard Kronick, PhD
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Richard Pan, MD, MPH
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Senator John Laird
Assemblymember Dawn Addis



COUNTY OF MONTEREY HEALTH DEPARTMENT

Elsa Jimenez, Director of Health Services

Administration Animal Services Behavioral Health Clinic Services
Emergency Medical Services Environmental Health Public Administrator/Public Guardian Public Health

April 7, 2025

Office of Health Care Affordability (OHCA)
California Health and Human Services Agency
2020 W. El Camino Ave.
Sacramento, CA 95833

Dear Chair Kim Johnson and OHCA Board Members,

As Director of the County of Monterey Health Department, I am writing to express concern regarding the inclusion of Salinas Valley Health (SVH) on the Office of Health Care Affordability's (OHCA) list of high-cost hospitals currently under review. I respectfully urge OHCA to reconsider this designation considering the broader context in which SVH operates and the essential role it plays in our community.

The County Health Department operates one of the largest Federally Qualified Health Center systems in Monterey County, providing comprehensive outpatient primary healthcare services to Medi-Cal beneficiaries and uninsured residents. SVH serves as a public district health care system in one of California's regions with the most medically underserved and vulnerable populations.

Importantly, SVH acts as a referral provider for specialty care for both the County of Monterey Health Department Clinics and other Federally Qualified Health Centers (FQHCs), which primarily serve Medi-Cal, uninsured and low income residents. These community-based clinics rely on SVH for access to essential specialty services—such as oncology, endocrinology, and wound care—that are otherwise unavailable in the region. Without SVH, many of our most vulnerable residents would face significant delays or a complete lack of access to necessary care impacting their health and well-being.

Thank you for your attention to this urgent matter and for your continued commitment to improving health care affordability and equity across California and considering the broader impact your decisions have on our residents.

Sincerely,

Elsa Mendoza Jimenez, MPH
Director, County of Monterey Health Department

1270 Natividad Road, Salinas, CA 93906
Phone (831) 755-4500
www.mtyhd.org



Santa Lucia Medical Group, Inc.
Family Medicine

April 4, 2025

VIA EMAIL

Members of the Health Care Affordability Board and Chair Kim Johnson
2020 W. El Camino Avenue
Sacramento, CA 95833

RE: Opposition to Salinas Valley Health's Designation on Sector Target List

Dear OHCA Board Members and Chair Kim Johnson,

We are writing to strongly oppose the designation of Salinas Valley Health as a high-cost outlier on OHCA's sector target list. As an independent medical practice that has served the Salinas Valley since 1987, Santa Lucia Medical Group Inc. depends on the high-quality specialty care that Salinas Valley Health provides. The impact of this designation threatens not only our ability to coordinate patient care but also the broader health care access that thousands of residents rely on.

Santa Lucia Medical Group is a fully bilingual practice with providers and staff who are dedicated to serving our diverse community. We offer the full spectrum of Family Medicine and have built strong working relationships with specialists throughout the region. While we remain an independent practice that is not bound to any single funding source, we rely on Salinas Valley Health's extensive specialty network to ensure our patients receive the care they need. Restrictions imposed by OHCA's designation could lead to cuts in services, longer wait times, and a decline in access to specialty care, disproportionately harming the most vulnerable members of our community.

Beyond its role as a specialty care provider, Salinas Valley Health is deeply committed to addressing health disparities in Monterey County. The financial health of our practice does not allow Santa Lucia Medical Group to be Medicare providers, a role in our community that is addressed in part by primary care providers at Salinas Valley Health PrimeCare. Salinas Valley Health's ability to recruit primary care providers to our region and subsidize the PrimeCare providers is essential to upholding the Milbank Report goals on Primary Care spending in California.

We urge OHCA to reconsider this designation and remove Salinas Valley Health from the sector target list. Penalizing a health system that is a lifeline for so many in our community is not only unjust—it risks exacerbating existing health care inequities.

Thank you for your time and consideration.

Sincerely,

Dr. Luciano Del Toro Vargas

Santa Lucia Medical Group Inc.

Dr. Michael C. Sepulveda



Santa Lucia Medical Group, Inc.
Family Medicine

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



CSVS Administration
55 Plaza Circle, Ste. A
Salinas, CA 93901
Phone: (831) 757-8689
Fax: (831) 757-6480

CSVS Recruitment:
Doctors and Dentists
from Mexico Program
55 Plaza Circle, Ste. A
Salinas, CA 93901
Phone: (831) 757-8689
Fax: (831) 757-6480

CSVS Plaza
55 Plaza Circle, Ste. C
Salinas, CA 93901
Phone: (831) 500-6960
Fax: (831) 758-2201

CSVS Circle
950 Circle Drive
Salinas, CA 93905
Phone: (831) 757-6237
Fax: (831) 757-8458

CSVS Sanborn
219 N. Sanborn Road
Salinas, CA 93905
Phone: (831) 757-1365
Fax: (831) 757-2824

CSVS Optometry Clinic
950 Circle Drive
Salinas, CA 93905
Phone: (831) 757-1264
Fax: (831) 757-4812

CSVS North Main
2180 N. Main Street
Salinas, CA 93906
Phone: (831) 443-2190
Fax: (831) 442-3604

CSVS Alvin Dental
620 E. Alvin Dr., Ste. G
Salinas, CA 93906
Phone: (831) 444-9722
Fax: (831) 444-9723

CSVS Gonzales
126 5th Street
Gonzales, CA 93926
Phone: (831) 675-2930
Fax: (831) 675-2931

CSVS Soledad
799 Front Street
Soledad, CA 93960
Phone: (831) 678-0881
Fax: (831) 678-2803

CSVS Greenfield
808 Oak Avenue
Greenfield, CA 93927
Phone: (831) 674-5344
Fax: (831) 674-5214

CSVS King City
122 San Antonio Drive
King City, CA 93930
Phone: (831) 385-5944
Fax: (831) 385-8618

CSVS Castroville
10561 Merritt Street
Castroville, CA 95012
Phone: (831) 633-1514
Fax: (831) 633-0311

CSVS Pajaro
29-A Bishop Road
Pajaro, CA 95076
Phone: (831) 728-2505
Fax: (831) 728-2636

CSVS Seaside
1156 Fremont Blvd., Ste. 101
Seaside, CA 93955
Phone: (831) 583-9004
Fax: (831) 583-9005

CSVS Mobile Clinic
950 Circle Drive
Salinas, CA 93905
Phone: (800) 372-7993
Fax: (831) 785-2982

CSVS Outreach
430 Airport Blvd., Ste. C
Salinas, CA 93905
Phone: (866) 662-5329

Office of Health Care Affordability (OHCA)
California Health and Human Services Agency
2020 W. El Camino Ave.
Sacramento, CA 95833

Dear OHCA Board Members and Chair Kim Johnson,

I am writing to express my strong support for Salinas Valley Health (SVH) and to urge you to reconsider its designation as a high-cost hospital. As the Chief Executive Officer of Clinica de Salud del Valle de Salinas (CSVS), which has served Monterey County since 1980, I have seen firsthand the essential role SVH plays in our community.

CSVS became the first Federally Qualified Health Center (FQHC) in Monterey County in 1989. While we provide comprehensive primary care, we rely heavily on SVH for the specialty services we cannot offer. SVH is often the provider of choice for our patients when they require advanced care in areas such as cardiology, oncology, and wound care. If SVH is forced to reduce or limit services due to sector cost targets, it would significantly impact access to care for the vulnerable populations we serve—especially those working in the agriculture industry.

SVH is a vital partner in ensuring that all Monterey County residents, regardless of insurance status or ability to pay, have access to high-quality care. Penalizing SVH for the costs associated with delivering this essential care would undermine the health and well-being of our most underserved patients.

Thank you for considering the broader impact this decision would have on our community.

Sincerely,

Maximiliano Cuevas, MD, FACOG
Chief Executive Officer
Clinica de Salud del Valle de Salinas



Clinica de Salud has earned the
Joint Commission's Gold Seal of Approval™

Family Practice • Adolescent Medicine • Obstetrics and Gynecology • Preventive Medicine
Internal Medicine • Dentistry • Health Education • Community Outreach Services

www.csvs.org



260 San Jose Street, Salinas, CA 93901
Phone 831-757-8124

April 4, 2025

Members of the Office of Healthcare Affordability Board
Sent via email

RE: Opposition to Salinas Valley Health's Designation on Sector Target List

Dear OHCA Board members and Chair Kim Johnson,

I am writing to express my strong support for Salinas Valley Health and to urge you to reconsider its designation as a high-cost outlier on the sector target list. As a practicing pediatrician and part of Pacific Coast Pediatrics for the past 14 years, I have seen firsthand the essential role Salinas Valley Health plays in sustaining access to high-quality care for the families of Monterey County.

After years of proudly serving this community, I am preparing to relocate to Florida to care for my elderly parents as their health declines. While this is a personal decision I must make, I have struggled with the difficult reality that my departure would place Pacific Coast Pediatrics in an unsustainable position. Like many independent practices, we have faced mounting financial pressures, including declining reimbursement rates and rising operating costs. Without meaningful support, our ability to continue providing pediatric care to the community was at serious risk.

Fortunately, Salinas Valley Health stepped in to provide a path forward. Salinas Valley Health has agreed to integrate our pediatric providers into PrimeCare Salinas, one of its primary care clinics, ensuring that our patients will continue to receive the care they need. This transition, scheduled for May 1, 2025, would not have been possible without Salinas Valley Health's commitment to preserving access to care for all families — including those insured through Medi-Cal, which offers the lowest reimbursement rates of all payers.

Had OHCA's sector targets been in place earlier, this safety net action may not have been possible. Without Salinas Valley Health's support, my dedicated fellow pediatricians would have faced difficult choices and the families we serve would have faced devastating gaps in care. The public district health system's willingness to step in and secure continued pediatric care demonstrates the critical value it provides to our community.

I am deeply grateful to Salinas Valley Health for making it possible for our practice to survive and for ensuring that children and families in Monterey County have continued access to high-quality pediatric care. I urge OHCA to recognize the indispensable role that Salinas Valley Health plays as an integrated system and to remove it from the sector target list.

Penalizing Salinas Valley Health would put this essential community resource at risk and undermine the very goals of improving access and affordability.

Sincerely,

Christine McCuiston, MD
Pacific Coast Pediatrics



12401 Washington Blvd.
Whittier, CA 90602-1006
T: 562.698.0811

Hearing Impaired
TDD: 562.696.9267
PIHHealth.org

June 18, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

(Submitted via email to Megan Brubaker at ohca@hcai.ca.gov)

Dear Chair Johnson:

As the Office of Health Care Affordability (OHCA) board continues its discussion of spending target enforcement, PIH Health, which owns and operates PIH Health Whittier Hospital, PIH Health Good Samaritan Hospital in downtown Los Angeles, and PIH Health Downey Hospital which have a combined 1,130 licensed beds and 575,456 hospital visits per year (including inpatient admissions, outpatient visits, and Emergency Department visits); 37 medical offices; and a multispecialty medical group, must share our deep concerns about the potential process outlined to date. The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for the patients for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.

PIH Health urges the OHCA board to instead promulgate regulations that balance affordability with continued access to care by:

- Informing hospitals how their spending growth will be assessed against the target and clarifying how payer and service mix will be considered
- Basing the determination of a violation on multiple years of data to avoid the volatility of year-over-year spending swings; only multiyear assessment can reliably distinguish hospitals that genuinely exceeded their target
- Standardizing the process for explaining growth above the target, as established under the statutory waiver process
- Establishing a collaborative performance improvement process that gives hospitals a real opportunity to improve before fines are levied
- Phasing in penalty amounts and accounting for essential circumstantial factors, like investments in patient-centered care or a hospital's financial condition

PIH Health is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor, medical supply, and drug costs increased. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: consider cutting staff and services now to avoid potential penalties, or provide the care our patients need and risk fines that would compromise what little financial cushion we have.

OHCA has yet to finalize how spending will be measured, which payer and service lines will count, and what rules hospitals will be required to follow. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. One year in isolation does not give an accurate picture of PIH Health's spending trends.

Worse, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For PIH Health, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

PIH Health, Page 2

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay.
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under OBBBA.

PIH Health is committed to helping patients afford the care they need. That's why we offer financial assistance programs, medical debt forgiveness, free clinics for certain services, free vaccination programs.

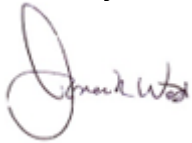
PIH Health also understands that affordability in the long term can't happen without focused efforts now. That's why we're committed to investments in community-based care, value-based contracts, quality programs, programs to address social determinants of health, and more.

Penalties at the levels proposed by OHCA would threaten PIH Health's viability, jeopardize our patients' health, and endanger the livelihoods of the 8,500+ employees who rely on us. PIH Health is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office.

In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect healthcare workforce stability. It has various tools at its disposal to do this, including adjustments to the spending targets and considering labor cost growth as a justifiable reason that an entity exceeded its spending target. PIH Health urges OHCA to treat all healthcare workers equitably and ensure that neither our frontline workers nor the hospital itself are punished for wages and benefits that grow above the spending target.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the 3.1 million residents who reside in our service areas. PIH Health appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible healthcare system for Californians.

Sincerely,



James R. West
President and Chief Executive Officer
PIH Health

cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Senator Bob Archuleta
Senator Maria Elena Durazo
Assembly Member Lisa Calderon
Assembly Member Blanca Pacheco
Assembly Member Mark Gonzalez



Peter L. Slavin, MD

President and CEO

David and Meredith Kaplan Presidential Chair

8700 Beverly Blvd.
Los Angeles, CA 90048
Direct 310-423-5711
pls@cshs.org

June 15, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process
(Submitted via email to Megan Brubaker at ohca@hcai.ca.gov)

Dear Chair Johnson and Members of the Board:

On behalf of the Cedars-Sinai Health System we write today to express serious concerns regarding the enforcement framework currently under consideration by the Office of Health Care Affordability (OHCA).

As one of California's largest health systems and home to the state's largest hospital by licensed bed count, Cedars-Sinai has a unique perspective on both the opportunities and challenges associated with improving affordability while preserving access to high-quality care. While Cedars-Sinai supports efforts to improve health care affordability and access, we are increasingly concerned that OHCA is moving toward an enforcement structure that would impose extraordinary financial burdens and penalties on hospitals based on methodologies that remain incomplete, uncertain, and disconnected from the realities of delivering care.

Such penalties will not improve affordability for patients. They will simply remove resources from organizations already confronting rising labor costs, escalating pharmaceutical expenses, inflationary pressures, workforce shortages, increasing regulatory mandates, and significant reductions in federal health care funding.

Extraordinary Financial Risk

The enforcement concepts discussed to date would authorize penalties of unprecedented magnitude, potentially reaching tens or hundreds of millions of dollars for a single hospital. These concerns are magnified by the largest federal reductions to health care funding in decades, which are already forcing hospitals throughout California to evaluate difficult operational and financial decisions. The prospect of imposing massive state penalties at the very moment hospitals are absorbing substantial federal funding losses risks further destabilizing the health care delivery system and reducing resources available for patient care.

The financial condition of California hospitals further underscores these concerns. Hospitals are uniquely constrained in their ability to respond to rising costs. Unlike many industries, hospitals generally cannot increase prices when labor, pharmaceutical, supply chain, regulatory, or other operating costs rise. At the same time, a significant portion of hospital revenue is determined by government reimbursement methodologies established by Medicare and Medi-Cal, which frequently fail to cover the actual cost of providing care. As a result, hospitals have limited ability to offset increasing expenses while continuing to invest in patient care, workforce development, medical

innovation, and community benefit programs. The imposition of substantial financial penalties in this environment would not simply reduce excess margins; it would further strain organizations already facing significant financial pressures and reduce the resources available to serve patients and communities throughout California.

Enforcement Should Not Precede Clear Rules

Most troubling, OHCA is considering enforcement before hospitals have clarity regarding how compliance will ultimately be measured. Critical questions remain unresolved, including how spending growth will be attributed, how service-line and payer-specific spending will be evaluated, what adjustments will be available, and how circumstances beyond a hospital's control will be considered. It is fundamentally unfair to subject hospitals to potentially devastating penalties before the rules themselves have been finalized and before hospitals have had a meaningful opportunity to understand what is expected of them.

Cedars-Sinai continues to believe that a punitive enforcement framework is neither necessary nor appropriate to achieve OHCA's affordability goals. However, if OHCA proceeds with enforcement, hospitals should not be judged based on historical performance during periods when key regulations, methodologies, and compliance expectations had not yet been established. Hospitals cannot reasonably be expected to comply with standards that did not yet exist.

We are also concerned by indications that OHCA may rely on a single year of data to determine compliance. Health care spending is inherently variable and can fluctuate significantly based on patient acuity, case mix, payer mix, labor market conditions, pharmaceutical costs, and other factors beyond a hospital's control. Any assessment of compliance should be based on multiple years of performance under a finalized regulatory framework and should provide hospitals sufficient time to understand expectations, implement changes, and demonstrate sustained results before penalties are considered.

The Many Drivers of Health Care Spending

The proposed framework reflects a fundamental misunderstanding of the drivers of health care spending. Hospitals do not set pharmaceutical pricing and have limited ability to influence labor market conditions, inflationary pressures, or many state and federal requirements that increase the cost of delivering care, yet hospitals appear to be OHCA's primary focus when those costs rise faster than the state's spending target.

Community Investments

Cedars-Sinai serves as a critical health care resource for patients and communities across California. Beyond providing care, we invest in workforce development, medical research, community partnerships, and initiatives that address barriers to health before they result in more serious and costly medical needs. Across our health system, these efforts expand access to care, strengthen community-based organizations, and support vulnerable populations. Cedars-Sinai is also among the largest private, non-foundation supporters of health care access and homelessness initiatives in Los Angeles County.

The extraordinary penalties currently under consideration would force hospitals to make difficult decisions regarding the allocation of limited resources. Every dollar devoted to penalties is a dollar unavailable for patient care, workforce development, medical innovation, research, and community-based programs that improve health outcomes and expand access to care. California should be encouraging hospitals to strengthen these investments, not creating enforcement mechanisms that may diminish their sustainability. An approach that diverts resources away from patients and

communities ultimately risks undermining the very affordability, equity, and population health goals OHCA was created to advance.

The Unique Role of Academic Medical Centers

For academic medical centers, the consequences are particularly concerning. Cedars-Sinai cares for some of California's sickest and most medically complex patients. We provide highly specialized services that few organizations can offer and accept referrals from across the state for patients requiring advanced care. Hospitals that care for the most complex patients, maintain specialized clinical programs, provide services that other providers cannot offer, and invest in advanced technologies, inevitably face cost structures that differ from other providers.

An enforcement framework that fails to account for these realities risks creating incentives that run directly counter to California's longstanding goal of preserving access to advanced specialty and tertiary care.

Cumulative Impact of State and Federal Policy Decisions

Perhaps most concerning, OHCA's proposal fails to account for the cumulative impact of numerous state and federal policies that are simultaneously increasing the cost of delivering care. California hospitals are being asked to:

- Comply with seismic requirements;
- Expand behavioral health capacity;
- Meet new workforce mandates;
- Implement health equity initiatives;
- Respond to growing regulatory obligations; and
- Absorb substantial reductions in federal funding.

Many of these policies reflect important public priorities, but they also carry significant costs. The state cannot continue to impose these existing requirements and new obligations on hospitals while simultaneously bringing penalty assessments when those same obligations contribute to spending growth.

Affordability Must Be Balanced with Access, Quality, and Workforce Stability

The Legislature did not create OHCA solely to reduce spending growth. It directed OHCA to balance affordability with access, quality, workforce stability, and health equity. An enforcement framework that compels hospitals to divert resources away from patient care, workforce investments, community benefit programs, clinical innovation, and specialized services would undermine those statutory obligations.

Affordability cannot be pursued in isolation from the broader health care delivery system, nor can it come at the expense of access to care.

Recommendations for a Better Path Forward

Before any penalty structure is adopted, OHCA should establish a transparent methodology, utilize multiple years of data when assessing performance, provide meaningful opportunities for corrective action, recognize factors beyond hospitals' control, and ensure that any penalties are proportionate to demonstrated and sustained noncompliance.

Hospitals should first be given the opportunity to understand the rules, explain spending growth, and implement corrective actions before being subjected to punitive financial sanctions.

California patients will not benefit if affordability policy becomes disconnected from the realities of delivering care. The Board should reject a punitive enforcement framework that threatens access to care, workforce stability, medical innovation, and the community investments that California's nonprofit hospitals make every day in schools, neighborhoods, and local organizations serving the state's most vulnerable residents. Instead, OHCA should pursue an approach that promotes accountability while preserving the resources hospitals need to care for patients, invest in their workforce, and support healthier communities throughout California.

Thank you for your consideration.

Sincerely,



Peter L. Slavin, MD
President and CEO

cc: Members of the Health Care Affordability Board:

Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Richard Pan, MD

The Honorable Adam Schiff
The Honorable Alex Padilla
The Honorable Laura Friedman
The Honorable Judy Chu
The Honorable Ted Lieu
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
The Honorable Ben Allen
The Honorable Isaac Bryan
The Honorable Rick Chavez Zbur
The Honorable Sasha Renée Pérez
The Honorable John Harabedian
The Honorable Al Muratsuchi



June 11, 2026

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

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

Dear Chair Johnson:

The Santa Barbara Neighborhood Clinic values Cottage Health as an important partner serving the healthcare needs of the South Coast region. From routine care to emergency needs, the local hospital is a pillar of our community. That's why the Santa Barbara Neighborhood Clinic is deeply concerned about how our community, including the most vulnerable patients will be impacted if the Office of Health Care Affordability (OHCA) implements aggressive, unreasonable penalties that harm patient care.

With no public hospital in Santa Barbara County, Cottage Health and its three hospitals are the largest safety net provider in the region. The level one trauma center at Santa Barbara Cottage Hospital is a crucial resource for Santa Barbara County and the neighboring counties of Ventura and San Luis Obispo. Cottage offers extensive pediatric specialty services, maternity care, including labor and delivery, and several other services that are not available elsewhere in the County.

For years, Cottage Health has partnered with the Santa Barbara Neighborhood Clinic to ensure that services are available to vulnerable patients in our community. Cottage Health has provided grant funding that has assisted SBNC in expanding space and clinic services to these patients—helping keep patients out of the emergency room. Through its direct services, community partnerships, and philanthropic investments, Cottage is a significant contributor to the health care safety net in the region.

We understand that OHCA is considering imposing multi-million-dollar penalties against hospitals, including community providers like Cottage Health. Such penalties could have significant consequences for access to care in Santa Barbara County. The community is already facing serious health care funding challenges, including the impacts of H.R. 1 and other government actions that are reducing resources available to the safety net. Additional financial strain on local hospitals would only make it harder to preserve the services that patients in the community rely on.

OHCA's affordability goals are important, and we support efforts to make health care more accessible and sustainable for Californians. However, enforcement decisions must be carefully



balanced to avoid unintentionally undermining access to critical services, particularly in communities without a public hospital.

On behalf of the Santa Barbara safety net providers, the Santa Barbara Neighborhood Clinic urges you to reject aggressive enforcement penalties against hospitals and to take a collaborative approach that protects access while improving affordability.

Sincerely,

Mahdi Ashrafian, MD, MBA
Chief Executive Officer
Santa Barbara Neighborhood Clinic

cc: Members of the Health Care Affordability Board:

Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Dr. Richard Pan

Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Honorable Senate President pro Tempore Monique Limón
Honorable Assemblymember Gregg Hart



June 19, 2026

VIA EMAIL

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

Subject: Spending Target Enforcement Framework

Dear Chair Johnson:

On behalf of Salinas Valley Health, I appreciate the opportunity to provide comments regarding the Office of Health Care Affordability's ongoing discussion of spending target enforcement.

Salinas Valley Health shares OHCA's goal of improving healthcare affordability for Californians while preserving access to high-quality care. As the Board considers future enforcement policies, we encourage an approach that is transparent, collaborative and recognizes the many factors that influence healthcare spending.

Recent analyses have demonstrated that healthcare spending growth is not driven solely by increased utilization. Changes in patient acuity, chronic disease prevalence, workforce costs, pharmaceutical expenses, and the growing complexity of care all contribute to spending trends. Any enforcement framework should account for these realities and provide providers with a meaningful opportunity to explain circumstances that may contribute to spending growth.

We respectfully encourage OHCA to:

- Utilize multiple years of data when evaluating performance against spending targets to account for year-to-year fluctuations and avoid conclusions based on isolated periods.
- Establish a clear and consistent process for providers to explain spending trends and demonstrate efforts to improve affordability.
- Prioritize performance improvement and collaboration before the imposition of financial penalties.
- Consider factors that support community access to care, including investments in workforce stability, quality improvement, population health initiatives and services that address local healthcare needs.

As a public healthcare district, Salinas Valley Health remains committed to expanding access, improving quality, advancing population health and pursuing affordability initiatives that benefit the communities we serve. We believe these goals are best achieved through a balanced approach that promotes accountability while preserving the resources necessary to care for patients.

Thank you for your consideration and for your continued engagement with providers across California. We look forward to working with OHCA to advance a healthcare system that is both affordable and accessible.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Allen Radner', is positioned above the printed name.

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

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



June 19, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

(Submitted via email to Megan Brubaker at ohca@hcai.ca.gov)

Dear Chair Johnson:

As the Office of Health Care Affordability (OHCA) board continues its discussion of spending target enforcement, John Muir Health must share our deep concerns about the potential process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for the patients for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

John Muir Health urges the OHCA board to instead promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessment can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

John Muir Health is currently experiencing labor, medical supply and drug cost growth far in excess of the 3.5% spending target. Most recently, we are facing supply shortages, which necessitate sourcing supplies from across the country after the Medline warehouse fire in Tracy on June 11. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: cut staff and services now to avoid potential penalties, or provide the care our patients need and risk fines that would wipe out what little financial cushion we have.

To adapt to the new financial environment, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), John Muir Health has reduced costs by \$300 million since 2022 through efficiency measures while maintaining quality and safety. We have been forced to make difficult decisions to close two outpatient rehabilitation locations and our Wound Care Center, while also selling our Home Health service as part of a joint venture agreement. We also face \$2 billion in

costs to meet the state's 2030 seismic compliance goals. This is on top of the \$1.2 billion we have already invested in seismic safety, including new patient care towers at our Concord and Walnut Creek Medical Centers.

And yet, our cost reduction efforts might not be enough. John Muir Health has no way of knowing, because OHCA has yet to finalize how spending will be measured, which payer and service lines will count, and what rules hospitals will be required to follow. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

John Muir Health is committed to helping patients afford the care they need. That's why we offer financial assistance programs, medical debt forgiveness, and a free Mobile Health Clinic for certain services.

John Muir Health also understands that affordability in the long term can't happen without focused efforts now. That's why in 2025 we committed more than \$200 million to community-based care to address the social determinants of health.

Penalties at the levels proposed by OHCA would threaten John Muir Health's viability, jeopardize our patients' health, jeopardize our community programs and endanger the livelihoods of the 6,800 employees who rely on us. We are the second largest private employer in Contra Costa County.

John Muir Health is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office.

In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect health care workforce stability. It has various tools at its disposal to do this, including adjustments to the spending targets and considering labor cost growth as a justifiable reason that an entity exceeded its spending target. John Muir Health urges OHCA to treat all health care workers equitably and ensure that neither our frontline workers nor John Muir Health itself are punished for wages and benefits that grow above the spending target.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Contra Costa, Alameda and Solano County residents who pass through our doors each year. John Muir Health appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

Mike Thomas
President and CEO
John Muir Health

cc: Members of the Health Care Affordability Board:

Dr. Sandra Hernández

Dr. Richard Kronick

Ian Lewis

Elizabeth Mitchell

Donald B. Moulds, PhD

Dr. Richard Pan

Elizabeth Landsberg, Director, Department of Health Care Access and Information

Vishaal Pegany, Deputy Director, Office of Health Care Affordability

Senator Tim Grayson

Assemblymember Rebecca Bauer-Kahan

Assemblymember Anamarie Avila Farias



SAN ANTONIO
REGIONAL HOSPITAL

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

(Submitted via email to Megan Brubaker at ohca@hcai.ca.gov)

Dear Chair Johnson:

As the Office of Health Care Affordability (OHCA) board continues its discussion of spending target enforcement, San Antonio Regional Hospital must share our deep concerns about the potential process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for the patients for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

San Antonio Regional Hospital (SARH) urges the OHCA board to instead promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessment can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

San Antonio Regional Hospital is currently experiencing cost growth far in excess of the 3.5% spending target. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: cut staff and services now to avoid potential penalties, or provide the care our patients need and risk fines that would wipe out what little financial cushion we have.

To adapt to the new financial environment, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- SARH has invested \$2.8M in our facility for the resources necessary to make the to meet the state's 2030 seismic compliance goals.

And yet, those efforts might not be enough. However, San Antonio Regional Hospital has no way of knowing that, because OHCA has yet to finalize how spending will be measured, which payer and service lines will count, and what rules hospitals will be required to follow. Troublingly, OHCA has



SAN ANTONIO
REGIONAL HOSPITAL

indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

Worse, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For SARH that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay.
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under OBBA.

SARH is committed to helping patients afford the care they need. That's why we offer financial assistance programs, free clinics for certain services, and community health screenings.

SARH also understands that affordability in the long term can't happen without focused efforts now. As nearby hospitals close their maternity units, SARH is stepping in to protect essential access for families. We are actively building a new maternity unit to ensure our community continues to have a safe, local place to give birth. This investment reflects our commitment to meeting critical needs even as financial pressures intensify.

Penalties at the levels proposed by OHCA would threaten SARH viability, jeopardize our patients' health, and endanger the livelihoods of the 2,500 number of workers who rely on us. SARH is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office.

In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect health care workforce stability. It has various tools at its disposal to do this, including

adjustments to the spending targets and considering labor cost growth as a justifiable reason that an entity exceeded its spending target. San Antonio Regional Hospital urges OHCA to treat all health care workers equitably and ensure that neither our frontline workers nor the hospital itself are punished for wages and benefits that grow above the spending target.



SAN ANTONIO
REGIONAL HOSPITAL

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the San Bernardino County residents who pass through our doors each year. San Antonio Regional Hospital appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

John T. Chapman
President & Chief Executive Officer
San Antonio Regional Hospital

cc: Members of the Health Care Affordability Board:

Dr. Sandra Hernández

Dr. Richard Kronick

Ian Lewis

Elizabeth Mitchell

Donald B. Moulds, PhD

Dr. Richard Pan

Elizabeth Landsberg, Director, Department of Health Care Access and Information

Vishaal Pegany, Deputy Director, Office of Health Care Affordability



June 23, 2006

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

Administration - Advocacy

1303 E. Herndon Ave.
Fresno, CA 93720
(559) 450-3000
www.samc.com

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Chair Johnson:

As the Office of Health Care Affordability (OHCA) board continues its discussion of spending target enforcement, Saint Agnes Medical Center must share our deep concerns about the potential process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for the patients for whom we care and our ability to sustain 96 years of health care services in Fresno, California. OHCA must pursue a collaborative partnered approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends as the industry faces tremendous economic headwinds.**

Saint Agnes Medical Center urges the OHCA board to instead promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only a multiyear assessment can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

While Saint Agnes Medical Center currently is not experiencing cost growth in excess of the 3.5% spending target, the outlook for future forecasting is a high-level concern. The statewide median estimated Commercial penalty of \$5 million and average of \$15 million, is something that the organization cannot bare while serving community members of which 80% are currently covered by Medi-Cal.

Last year, our labor costs grew by 31%, our medical supply costs grew 41% and our drug costs grew by 24%. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: cut staff and services now to avoid potential penalties, or provide the care our patients need and risk fines that would wipe out what little financial cushion we have.

We continue to reposition our nonprofit business to adapt to the new financial environment, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBA), and as such leaned into the following steps as part of our Mission:

- Consolidated administrative services and internal units to save on workforce costs
- Realizes that Saint Agnes may no longer have the resources necessary to make the estimated \$70 million investment in our facilities to meet the state's 2030 seismic compliance goals
- Continue to provide award winning Maternal Care for the Central Valley with no profit margin while 75% of our patients are on Medi-Cal
- Implement lean metrics across service lines and evaluate the cost of implementing new care technology as the cost of care outpaces the revenue growth.

As organizational leaders reflect on operations and the above daily, the Saint Agnes management team knows that those efforts might not be enough.

Saint Agnes Medical Center has no way of forecasting OHCA spending targets, because OHCA has yet to finalize how spending will be measured, which payer and service lines will count, and what rules hospitals will be required to follow. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

Worse, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Saint Agnes Medical Center that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay.
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under OBBA.
- Rise in the need for charitable care as community members, although working fulltime, may not qualify for Medi-Cal coverage.

Saint Agnes Medical Center also understands that affordability in the long term can't happen without focused efforts now. That's why we're committed to equitable health care that is multicultural and multilingual, investments in community-based care, inclusive value-based contracts, quality programs, addressing social determinants of health, and providing resources.



Penalties at the levels proposed by OHCA would threaten Saint Agnes Medical Center's viability, jeopardize our patients' health, and endanger the livelihoods of the 3,600 colleagues who rely on us. We remain concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office.

In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect health care workforce stability. It has various tools at its disposal to do this, including adjustments to the spending targets and considering labor cost growth as a justifiable reason that an entity exceeded its spending target. Saint Agnes Medical Center urges OHCA to treat all health care workers equitably and ensure that neither our frontline workers nor the hospital itself are punished for wages and benefits that grow above the spending target.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Fresno and Central Valley community members who pass through our doors every day. Saint Agnes Medical Center truly appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

Helen Herrera
Director, Advocacy and Health Equity
Saint Agnes Medical Center

cc: Members of the Health Care Affordability Board:

Dr. Sandra Hernández

Dr. Richard Kronick

Ian Lewis

Elizabeth Mitchell

Donald B. Moulds, PhD

Dr. Richard Pan

Elizabeth Landsberg, Director, Department of Health Care Access and Information

Vishaal Pegany, Deputy Director, Office of Health Care Affordability

Senator Anna Caballero

Senator Shannon Grove

Assemblymember Esmeralda Soria

Assemblymember David Tangipa

Assemblymember Joaquin Arambula



United Way
Monterey County

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Katy Castagna
President and CEO

June 23, 2026

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

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

Dear Chair Johnson:

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 and Salinas Valley Health in our shared mission of serving this community. From routine care to emergency needs, both 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 and Salinas Valley Health are very important to the wellbeing of our community. 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.

Sincerely,

A handwritten signature in cursive script that reads "Katy Castagna".

Katy Castagna
President and CEO

cc: Members of the Health Care Affordability Board:

Dr. Sandra Hernández

Dr. Richard Kronick

Ian Lewis

Elizabeth Mitchell

Donald B. Moulds, PhD

Dr. Richard Pan

Elizabeth Landsberg, Director, Department of Health Care Access and Information

Vishaal Pegany, Deputy Director, Office of Health Care Affordability

Assembly Speaker Robert Rivas

Senator John Laird



12401 Washington Blvd.
Whittier, CA 90602-1006
T: 562.698.0811

Hearing Impaired
TDD: 562.696.9267
PIHHealth.org

July 21, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process
(Submitted via email at ohca@hcai.ca.gov)

Dear Director Landsberg:

As the Office of Health Care Affordability (OHCA) board continues its discussion of spending target enforcement, PIH Health, which owns and operates PIH Health Whittier Hospital, PIH Health Good Samaritan Hospital in downtown Los Angeles, and PIH Health Downey Hospital which have a combined 1,130 licensed beds and 575,456 hospital visits per year (including inpatient admissions, outpatient visits, and Emergency Department visits); 37 medical offices; and a multispecialty medical group, must share our deep concerns about the potential process outlined to date. The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for the patients for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.

PIH Health urges the OHCA board to instead promulgate regulations that balance affordability with continued access to care by:

- Informing hospitals how their spending growth will be assessed against the target and clarifying how payer and service mix will be considered
- Basing the determination of a violation on multiple years of data to avoid the volatility of year-over-year spending swings; only multiyear assessment can reliably distinguish hospitals that genuinely exceeded their target
- Standardizing the process for explaining growth above the target, as established under the statutory waiver process
- Establishing a collaborative performance improvement process that gives hospitals a real opportunity to improve before fines are levied
- Phasing in penalty amounts and accounting for essential circumstantial factors, like investments in patient-centered care or a hospital's financial condition

PIH Health is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor, medical supply, and drug costs increased. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: consider cutting staff and services now to avoid potential penalties or provide the care our patients need and risk fines that would compromise what little financial cushion we have.

OHCA has yet to finalize how spending will be measured, which payer and service lines will count, and what rules hospitals will be required to follow. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. One year in isolation does not give an accurate picture of PIH Health's spending trends.

Worse, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For PIH Health, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay.
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under OBBBA.

PIH Health is committed to helping patients afford the care they need. That's why we offer financial assistance programs, medical debt forgiveness, free clinics for certain services, and free vaccination programs.

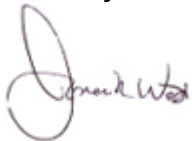
PIH Health also understands that affordability in the long term can't happen without focused efforts now. That's why we're committed to investments in community-based care, value-based contracts, quality programs, programs to address social determinants of health, and more.

Penalties at the levels proposed by OHCA would threaten PIH Health's viability, jeopardize our patients' health, and endanger the livelihoods of the 8,500+ employees who rely on us. PIH Health is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office.

In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect healthcare workforce stability. It has various tools at its disposal to do this, including adjustments to the spending targets and considering labor cost growth as a justifiable reason that an entity exceeded its spending target. PIH Health urges OHCA to treat all healthcare workers equitably and ensure that neither our frontline workers nor the hospital itself are punished for wages and benefits that grow above the spending target.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the 3.1 million residents who reside in our service areas. PIH Health appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible healthcare system for Californians.

Sincerely,



James R. West
President and Chief Executive Officer
PIH Health

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
Senator Bob Archuleta
Senator Maria Elena Durazo
Assembly Member Lisa Calderon
Assembly Member Blanca Pacheco
Assembly Member Mark Gonzalez



15480 Laguna Canyon Road
Suite 200
Irvine, CA 92618

7/16/2026

Kim Johnson, Chair

California Health Care Affordability Board
2020 W. El Camino Avenue
Sacramento, CA 95833

Re: Comments on Proposed Health Care Spending Targets

Dear Chair Johnson and Members of the Health Care Affordability Board:

On behalf of Providence, thank you for the opportunity to comment on the Office of Health Care Affordability's (OHCA) spend target workshop. We appreciate the Board's continued leadership and commitment to advancing affordability across California.

Providence shares this goal and remains committed to working collaboratively with the Board to ensure that affordability efforts are effective, sustainable, and preserve access to high-quality, equitable care.

We respectfully offer the following considerations for your continued work:

First, protecting patient access must remain central. Hospitals serving high Medi-Cal and vulnerable populations are operating under significant financial pressures. We are concerned that, without sufficient flexibility, spending targets and related enforcement mechanisms may create unintended constraints on services, delay necessary investments, and impact access to care in some communities. To ensure safety net hospitals are not disproportionately impacted, Providence respectfully requests OHCA develop a mechanism within the spending target enforcement and performance improvement plan to account for a hospital's Disproportionate Share Hospital (DSH) status, critical access hospital designation, total yearly uncompensated care burden, rural hospital status, and Health Professional Shortage Area (HPSA) designation.

Second, accounting for system-wide cost drivers is essential. Health care spending is influenced by factors such as labor costs, inflation, supply chain pressures, and pharmaceutical pricing—many of which are outside provider control. Providence is committed to expanding care to meet the needs of the communities we serve, including expanding high-acuity services often unavailable in our service areas. We respectfully request OHCA develop a mechanism to account for the hospitals that provide higher level acuity services which come with higher cost-per-patient metrics. Not accounting for acuity level will result in hospitals being forced to decide between meeting OHCA's metrics or continuing to provide high-acuity services in the community. A more comprehensive approach to reflecting these drivers would help ensure balanced accountability across the system while protecting vital services in the communities we serve.

Third, Providence is concerned that the Performance Improvement Plan (PIP) process could force hospitals to disclose proprietary information regarding current or future confidential business decisions. For example, a PIP response may require disclosing strategic initiatives or proprietary processes associated with a hospital's operations and overall costs. Because OHCA is a public entity, we are concerned that this information would be publicly available, impacting our ability to protect confidential business information. Providence respectfully requests OHCA develop a standard process to submit information in a confidential manner. We also request OHCA consider developing a process for hospitals

to proactively identify sensitive information to OHCA prior to its inclusion in any public meetings or materials.

Finally, a coordinated, system-wide strategy will be critical to achieving lasting affordability. Continued engagement across providers, payers, and other stakeholders can help ensure that policies address underlying cost drivers and avoid unintended cost shifting. Providence respectfully requests OHCA develop a collaborative system in the Spending Target Enforcement and PIP process that allows the hospital to work directly with OHCA to review any HCAi available data used to determine a hospital's costs against internal hospital or system data to ensure enforcement decisions are based on confirmed cost metrics.

Providence respectfully encourages the Board to continue refining the framework with these considerations in mind, including ensuring flexibility, transparency, and a thoughtful, implementation that safeguards patient access.

We value the Board's partnership and look forward to continued collaboration to advance shared affordability goals.

Sincerely,

A handwritten signature in black ink, reading "Lauren Driscoll". The signature is written in a cursive, flowing style.

Lauren Driscoll
South Division Chief Executive
Providence



July 22, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

(Submitted via email at ohca@hcai.ca.gov)

Dear Director Landsberg:

As the Office of Health Care Affordability (OHCA) Board continues its discussion of spending target enforcement, Valley Children's Hospital must share deep concerns about the potential process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for the children and families for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Valley Children's urges the OHCA Board to instead promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessment can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Valley Children's is currently experiencing cost growth in excess of the 3.5% spending target. From 2024 to 2025, our labor, medical supply, and pharmaceutical costs each grew by 12%. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: cut services and staff now to avoid potential penalties or provide the care our patients need and risk fines that would further limit our ability to invest in the health and well-being of our community.

To adapt to the new financial environment, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), we have deferred several plant services replacement and infrastructure projects—including boilers, chillers, air handlers, roofing, parking lots, and modernization of patient and family restrooms. These deferrals, including delays in replacing critical life-saving equipment, are due to significant cost escalation in labor and supplies, requiring us to extend project timelines and funding plans while balancing other competing organizational priorities.

Office of the President

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9300 Valley Children's Place, Madera, CA 93636 • (559) 353-3000 • valleychildrens.org

And yet, those efforts might not be enough. However, Valley Children’s has no way of knowing that, because OHCA has yet to finalize how spending will be measured, which payer and service lines will count, and what rules hospitals will be required to follow. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. As an example, Valley Children’s year-over-year data show the following:

Valley Children's Hospital FY2023 over FY2022				
Hospital Spending Growth	IP	<i>CMI</i>	OP	<i>AVI</i>
Commercial	23%	2%	10%	-7%
Medicare	-69%	184%	118%	30%
Medi-Cal	-27%	-3%	-46%	-6%

Data Source: <https://hcai.ca.gov/document/hospital-measurement-combined-dataset-2022-2023/>

One year in isolation does not give an accurate picture of Valley Children’s spending trends. Further, the acuity adjusted inpatient and outpatient commercial increases reported by OHCA are exponentially higher than Valley Children’s average commercial contract rate increases for the same time period. Equally notable, the actual Medi-Cal inpatient APR-DRG rates increased 0.3% for Valley Children’s for 2023 compared to 2022 and outpatient rates remained unchanged. Nevertheless, the approach OHCA is using to evaluate the spending growth shows substantial decreases in Medi-Cal net patient revenue for this time period.

Worse, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Valley Children’s, greater investment in one area could be offset by lower spending in another — but we would still be penalized for efforts to:

- Increase access to efficient and effective outpatient treatment, which children and their families often prefer as they’re able to get the care they need without a hospital stay.
- Align revenue increases to keep up with costs in the face of federal funding cuts under OBBBA.
- Improve the health of children and families by increasing access to primary care and supporting partnerships with community-based organizations focused on preventing illness and disease.
- Expand the workforce pipeline and enhance adoption of telehealth and other digital health tools and modalities, all focused on improving accessibility and convenience of care.
- Develop and implement new care delivery models to make care safer, more efficient, and more effective.
- Improve access to health information technology to empower patients and their families.

Valley Children’s is committed to helping patients afford the care they need. That’s why we offer a financial assistance program. Additionally, as our FY 2025 community benefit report identifies, Valley Children’s makes significant investments to improve the health of our patients and the broader community. We increase access to primary care and invest in prevention efforts with our regional partners. We have adopted new health information technology to better serve our patients, including telehealth that improves accessibility and convenience for families. We continually invest in a workforce pipeline and develop new care delivery models to make care safer, more efficient, and

effective. All of these efforts will be significantly impacted, risking the very issues OHCA has been mandated to protect.

Valley Children's also understands that affordability in the long term can't happen without focused efforts now. For example, through our Guilds Center for Community Health, we are making investments in the community to keep children healthy and well where they live, learn and play, which in the process helps prevent serious illness and the need for health care services in the future. Through our Clinical Partnership Program and Partnering for Kids Program, we are working to increase the ability of healthcare providers in local communities - in hospitals, local primary care offices and other clinical settings - to deliver pediatric care to their patients closer to home and potentially preventing the need for additional and / or more costly care in the future.

Penalties at the levels proposed by OHCA would threaten Valley Children's viability, jeopardize our patients' health, and endanger the livelihoods of the more than 740 physicians and 4,000 staff who rely on us. Valley Children's is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with OHCA.

In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect health care workforce stability. It has various tools at its disposal to do this, including adjustments to the spending targets and considering labor cost growth as a justifiable reason that an entity exceeded its spending target. Valley Children's urges OHCA to treat all health care workers equitably and ensure that neither our frontline workers nor the hospital itself are punished for wages and benefits that grow above the spending target.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for those children and families who pass through our doors each year. Valley Children's appreciates the opportunity to comment and encourages the OHCA Board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and collaborating on a more affordable and accessible health care system for children and all Californians.

Sincerely,

A handwritten signature in black ink, appearing to read "Todd A. Suntrapak", with a stylized, flowing script.

Todd A. Suntrapak
President & Chief Executive Officer

cc: Members of the Health Care Affordability Board:

Kim Johnson
Dr. Sandra Hernández
Dr. Richard Kronick

Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Dr. Richard Pan

Vishaal Pegany, Deputy Director, Office of Health Care Affordability
The Honorable Marie Alvarado-Gil, California State Senate
The Honorable Anna Caballero, California State Senate
The Honorable Shannon Grove, California State Senate
The Honorable Melissa Hurtado, California State Senate
The Honorable Juan Alanis, California State Assembly
The Honorable Joaquin Arambula, California State Assembly
The Honorable Jasmeet Bains, California State Assembly
The Honorable Stan Ellis, California State Assembly
The Honorable Jasmeet Bains, California State Assembly
The Honorable Heath Flora, California State Assembly
The Honorable Alexandra Macedo, California State Assembly
The Honorable Esmeralda Soria, California State Assembly
The Honorable David Tangipa, California State Assembly



July 28, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

(Submitted via email at ohca@hcai.ca.gov)

Dear Director Landsberg:

As the Office of Health Care Affordability (OHCA) board continues its discussion of spending target enforcement, San Bernardino Mountains Community Hospital District must share our deep concerns about the potential process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for the patients for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

San Bernardino Mountains Community Hospital District urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

San Bernardino Mountains Community Hospital District is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs grew by 12%, our medical supply costs grew 31%, and our drug costs grew by 3%. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: cut staff and services now to avoid potential penalties, or provide the care our patients need but risk fines that would wipe out what little financial cushion we have.

**29101 Hospital Road, PO Box 70, Lake Arrowhead, CA 92352
909.336.3651 | mchcares.com
San Bernardino Mountains Community Hospital District**



To adapt to the new financial environment, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), we are now seriously assessing what patient care and support functions and services can be outsourced to lower our operating costs.

And yet, those efforts might not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with San Bernardino Mountains Community Hospital District's own experience. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. Consider that for San Bernardino Mountains Community Hospital District, year-over-year data show a 13 percent increase in our operating expenses. One year in isolation does not give an accurate picture of San Bernardino Mountains Community Hospital District's spending trends.

Worse, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For San Bernardino Mountains Community Hospital District, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under OBBBA
- Complying with the seismic requirements by the 2030 deadline by incurring significant construction and remediation costs.
- Incurring new costs for new regulations like security screening 24/7 at all major hospital entrances.

San Bernardino Mountains Community Hospital District is committed to helping patients afford the care they need. That's why we offer financial assistance to those community members requiring it.

Penalties at the levels proposed by OHCA would threaten San Bernardino Mountains Community Hospital District's viability, jeopardize our patients' health, and endanger the livelihoods of the almost 300 workers who rely on us. San Bernardino Mountains Community Hospital District is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office.

In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect health care workforce stability. It has various tools at its disposal to do this, including adjustments to the spending targets and considering labor cost growth as a justifiable reason that an entity exceeds its spending target. San Bernardino Mountains Community Hospital District urges OHCA to treat all health care workers equitably and ensure that neither our frontline workers nor the hospital itself are punished for wages and benefits that grow above the spending target.



The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the San Bernardino Mountains residents who pass through our doors each year. San Bernardino Mountains Community Hospital District appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

A handwritten signature in blue ink, appearing to read "Mark Turner", is written over a light blue horizontal line.

Mark Turner, Chief Executive Officer

cc: Members of the Health Care Affordability Board:

Kim Johnson

Ian Lewis

Dr. Sandra Hernández

Donald Moulds, PhD

Dr. Richard Kronick

Dr. Richard Pan

Elizabeth Mitchell

Elizabeth Landsberg, Director, Department of Health Care Access and Information

Vishaal Pegany, Deputy Director, Office of Health Care Affordability

State Senator Rosilicie Ochoa Bogh

Assemblymember Tom Lackey



1400 E. Church Street
Santa Maria, CA 93454
direct 805-739-3100
fax 805-739-3060
dignityhealth.org/marianregional

July 29, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Marian Regional Medical Center and Arroyo Grande Community Hospital, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Marian Regional Medical Center and Arroyo Grande Community Hospital shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Marian Regional Medical Center and Arroyo Grande Community Hospital urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Marian Regional Medical Center and Arroyo Grande Community Hospital is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Marian Regional Medical Center and Arroyo Grande Community Hospital have closed/reduced Community Education that our community needs, but that is cost prohibitive.
- Marian Regional Medical Center and Arroyo Grande Community Hospital have paused/canceled investments in Community Sponsorships that are no longer possible.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Marian Regional Medical Center and Arroyo Grande Community Hospital's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Marian Regional Medical Center and Arroyo Grande Community Hospital, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

1. Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
2. Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
3. Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Marian Regional Medical Center and Arroyo Grande Community Hospital are committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$11,300,221 in patient financial assistance at cost for 23107 patients.

Penalties at the levels proposed by OHCA would threaten Marian Regional Medical Center and Arroyo Grande Community Hospital's viability, jeopardize our patients' health, and endanger the livelihoods of the XXX number of our employees who rely on us. Had the 3.5% spending

target been in place in 2023, Marian Regional Medical Center and Arroyo Grande Community Hospital would have faced a starting penalty amount of \$72,129,845 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Marian Regional Medical Center and Arroyo Grande Community Hospital are also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Santa Barbara and San Luis Obispo County residents who pass through our doors each year. Marian Regional Medical Center and Arroyo Grande Community Hospital appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Sue Andersen
President & 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
The Honorable Senator Monique Limon
The Honorable Senator John Laird



Submitted via email at ohca@hcai.ca.gov

July 29, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Mercy Hospital of Bakersfield, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Mercy Hospital shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Mercy Hospital urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Mercy Hospital is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Mercy Hospital has closed/reduced bariatric services and staffing that our community needs, but that are cost prohibitive.
- Mercy Hospital has paused/canceled donations / investments in our community that are no longer possible.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Mercy Hospital's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Mercy Hospital, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Mercy Hospital is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$4,755,384 in patient financial assistance at cost for 26,792 patients.

Penalties at the levels proposed by OHCA would threaten Mercy Hospital's viability, jeopardize our patients' health, and endanger the livelihoods of the 1,400 of our employees who rely on us. Had the 3.5% spending target been in place in 2023, Mercy Hospital would have faced a starting penalty amount of \$36,808,407 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Mercy Hospital is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Bakersfield residents who pass through our doors each year. Mercy Hospital appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

Simon Ratliff
Hospital 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

The Honorable Shannon Grove

The Honorable Stan Ellis



1400 E. Church Street
Santa Maria, CA 93454
direct 805-739-3100
fax 805-739-3060
dignityhealth.org/marianregional

July 29, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of French Hospital Medical Center, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, French Hospital Medical Center shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, French Hospital Medical Center urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

French Hospital Medical Center is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- French Hospital Medical Center have closed/reduced Community Education that our community needs, but that is cost prohibitive.
- French Hospital Medical Center have paused/canceled investments in Community Sponsorships that are no longer possible.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with French Hospital Medical Center's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For French Hospital Medical Center, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

1. Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
2. Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
3. Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

French Hospital Medical Center are committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$1,794,689 in patient financial assistance at cost for 7,630 patients.

Penalties at the levels proposed by OHCA would threaten French Hospital Medical Center's viability, jeopardize our patients' health, and endanger the livelihoods of the 763 number of our employees who rely on us. Had the 3.5% spending target been in place in 2023, French Hospital Medical Center would have faced a starting penalty amount of \$631,060 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. French Hospital Medical Center are also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their

spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Santa Barbara and San Luis Obispo County residents who pass through our doors each year. French Hospital Medical Center appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Sue Andersen
President & 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
The Honorable Senator John Laird
The Honorable Senator Alex Padilla



Submitted via email at ohca@hcai.ca.gov

July 28, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Dignity Health California Hospital Medical Center (California Hospital), thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, California Hospital shares our deep concerns about the process outlined to date. The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.

Committed to a healing mission, California Hospital urges the OHCA board to promote regulations that balance affordability with continued access to care by:

- Informing hospitals how their spending growth will be assessed against the target and clarifying how payer and service mix will be considered
- Basing the determination of a violation on multiple years of data to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- Standardizing the process for explaining growth above the target, as established under the statutory waiver process
- Establishing a collaborative performance improvement process that gives hospitals a real opportunity to improve before fines are levied
- Phasing in penalty amounts and accounting for essential circumstantial factors, like investments in patient-centered care or a hospital's financial condition

California Hospital is a member of the Dignity Health California Region, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- California Hospital has needed to make a significant 80+ head count staffing reduction in force, including cuts to our inpatient pediatric service line.
- California Hospital has reduced stroke and sepsis education that our community needs, but that are cost prohibitive.
- California Hospital has canceled investments in substance use navigation, diabetic education, and health equity programming that are no longer possible.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with California Hospital's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For California Hospital, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

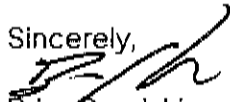
California Hospital is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$17,588,474 in patient financial assistance at cost for 13,729 patients.

Penalties at the levels proposed by OHCA would threaten California Hospital's viability, jeopardize our patients' health, and endanger the livelihoods of the 1,800 of our employees who rely on us. Had the 3.5% spending target been in place in 2023, California Hospital would have faced a starting penalty amount of \$13,393,053 on its commercial line and \$50,015,960 across all payer lines.

Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. California Hospital is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Los Angeles County residents who pass through our doors each year. California Hospital appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Brian Smolskis

Hospital President

Dignity Health California Hospital Medical Center

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

The Honorable Lola Smallwood-Cuevas

The Honorable Sade Elhawary



Submitted via email at ohca@hcai.ca.gov

July 29, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Mercy General Hospital, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Mercy General Hospital shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Mercy General Hospital urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target and clarifying how payer and service mix will be considered**
- **Basing the determination of a violation on multiple years of data to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target**
- **Standardizing the process for explaining growth above the target, as established under the statutory waiver process**
- **Establishing a collaborative performance improvement process that gives hospitals a real opportunity to improve before fines are levied**
- **Phasing in penalty amounts and accounting for essential circumstantial factors, like investments in patient-centered care or a hospital's financial condition**

Mercy General Hospital is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Mercy General Hospital has had to weigh closing key service lines our community relies on but that are no longer financially sustainable.
- Mercy General Hospital has paused investments in patient-care improvements and the replacement of aging equipment.
- Mercy General Hospital has implemented a reduction in force.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Mercy General Hospital's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Mercy General Hospital, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Mercy General Hospital is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and

discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$7,625,286 in patient financial assistance at cost for 10,003 patients.

Penalties at the levels proposed by OHCA would threaten Mercy General Hospital's viability, jeopardize our patients' health, and endanger the livelihoods of the 2,363 number of our employees who rely on us. Had the 3.5% spending target been in place in 2023, Mercy General Hospital would have faced a starting penalty amount of \$27,695,515 on its commercial line and \$50,628,734 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Mercy General Hospital is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Sacramento / Sacramento County residents who pass through our doors each year. Mercy General Hospital appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

A handwritten signature in blue ink, appearing to read "Josh C. Whidden".

Josh Whidden
Chief Financial Officer

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

The Honorable Angelique Ashby

The Honorable Maggy Krell

Submitted via email at ohca@hcai.ca.gov

July 29, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Mercy Medical Center Redding, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Mercy Medical Center Redding shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Mercy Medical Center Redding urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Mercy Medical Center Redding is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions. OHCA's hospital spending methodology produces wild results that do not correspond with Mercy Medical Center Redding's own experience.

Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Mercy Medical Center Redding, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Mercy Medical Center Redding is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$8,366,072 in patient financial assistance at cost for 11,488 patients.

Penalties at the levels proposed by OHCA would threaten Mercy Medical Center Redding's viability, jeopardize our patients' health, and endanger the livelihoods of the 2,023 employees who rely on us. Had the 3.5% spending target been in place in 2023, Mercy Medical Center Redding would have faced a starting penalty amount of \$11,217,087 on its commercial line and \$34,874,761 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Mercy Medical Center Redding is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Shasta County residents who pass through our doors each year. Mercy Medical Center Redding appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



G. Todd Smith

President

Mercy Medical Center Redding

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

The Honorable Megan Dahle

The Honorable Heather Hadwick



Submitted via email at ohca@hcai.ca.gov

July 28, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Bakersfield Memorial Hospital, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Bakersfield Memorial Hospital shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Bakersfield Memorial Hospital urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Bakersfield Memorial Hospital is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such

uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Bakersfield Memorial Hospital has closed its comprehensive burn program that our community needs, but which is cost prohibitive.
- Bakersfield Memorial Hospital has also paused and/or canceled several investments in ambulatory expansion projects that are no longer possible.
- Additional cost-cutting measures taken at Bakersfield Memorial Hospital include a reduction in force, reduction in work schedules, and other expense controls put in place as a result of the impacts from OBBBA.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Bakersfield Memorial Hospital's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Bakersfield Memorial Hospital, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Bakersfield Memorial Hospital is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$5,506,499 in patient financial assistance at cost for 29,947 patients.

Penalties at the levels proposed by OHCA would threaten Bakersfield Memorial Hospital's viability, jeopardize our patients' health, and endanger the livelihoods of the 2,100 of our employees who rely on us. Had the 3.5% spending target been in place in 2023, Bakersfield Memorial Hospital would have faced a starting penalty amount of \$39,031,209 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Bakersfield Memorial Hospital is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Kern County residents who pass through our doors each year. Bakersfield Memorial Hospital appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely, 

Ken Keller
Hospital President

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

The Honorable Melissa Hurtado

The Honorable Jasmeet Bains



Northridge Hospital Medical Center
18300 Roscoe Boulevard
Northridge, CA 91325
Direct (818) 885-5321
Fax (818) 885-5439
dignityhealth.org

Submitted via email at ohca@hcai.ca.gov

July 29, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Northridge Hospital Medical Center, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Northridge Hospital Medical Center shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Northridge Hospital Medical Center urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Northridge Hospital Medical Center is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits

has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Northridge Hospital Medical Center has closed our on-campus urgent care that helped meet our community needs, but that was cost prohibitive.
- Northridge Hospital Medical Center has also eliminated unfunded GME programs that provided training opportunities for providers in our community.
- Over the past 2 years, Northridge Hospital Medical Center has implemented 7.95% of labor efficiency savings through improved operational efficiency, centralization, and reductions in force.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Northridge Hospital Medical Center's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Northridge Hospital Medical Center, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Northridge Hospital Medical Center is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$58,895,899 in patient financial assistance at cost for 48,474 patients.

Penalties at the levels proposed by OHCA would threaten Northridge Hospital Medical Center's viability, jeopardize our patients' health, and endanger the livelihoods of the 2,159 number of our employees who rely on us. Had the 3.5% spending target been in place in 2023, Northridge Hospital Medical Center would have faced a starting penalty amount of \$6,808,073 on its commercial line and \$24,799,077 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Northridge Hospital Medical Center is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for Northridge residents who pass through our doors each year. Northridge Hospital Medical Center appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

A handwritten signature in dark ink, appearing to read "Jeremy Zoch". The signature is fluid and cursive, with the first name "Jeremy" and last name "Zoch" clearly distinguishable.

Jeremy Zoch, PhD, MHA, FACHE
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

The Honorable Caroline Menjivar

The Honorable Jesse Gabriel



Submitted via email at ohca@hcai.ca.gov

July 28, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Dignity Health Glendale Memorial Hospital and Health Center (GMHHC), thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, GMHHC shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, GMHHC urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Glendale Memorial Hospital and Health Center is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenges.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- GMHHC has not closed service lines at this time but we continue to analyze vulnerable programs like maternal child health and behavioral health for financial sustainability.
- GMHHC has not had to pause on capital investments but is heavily reliant on philanthropic support.
- We recently did a reduction in force and continually look at expenses including labor reductions.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with GMHHC's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For GMHHC, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Glendale Memorial Hospital and Health Center is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided just under \$6M in patient financial assistance at cost for 6,671 patients.

Penalties at the levels proposed by OHCA would threaten GMHHC's viability, jeopardize our patients' health, and endanger the livelihoods of our 1,000+ employees who rely on us. Had the 3.5% spending target been in place in 2023, GMHHC would have faced a starting penalty amount of \$4.1M on its commercial line and \$24.5M across all payer lines.

Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. GMHHC is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Glendale area residents who pass through our doors each year. GMHHC appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

A handwritten signature in black ink, appearing to read "Betsy Hart". The signature is fluid and cursive, with the first name "Betsy" written in a larger, more prominent script than the last name "Hart".

Betsy Hart
President

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

The Honorable Sasha Renee Perez

The Honorable Jessica Caloza



July 29, 2026

Kim Johnson, Chair
Office of Health Care Affordability (OHCA) Board
2020 W. El Camino Avenue
Sacramento, CA 95833

Re: Proposed Spending Target Enforcement Framework and Performance Improvement Plan (PIP) Process

Dear Chair Johnson:

On behalf of Children's Hospital Los Angeles (CHLA), thank you for the opportunity to provide comments on OHCA's proposed spending target enforcement framework and Performance Improvement Plan (PIP) process.

CHLA is California's largest freestanding pediatric hospital, caring for children from every county in the state. With more than 70 percent of its patients covered by Medi-Cal, CHLA serves as a safety net for families, all while providing highly specialized complex services such as transplantation, oncology, neonatal intensive care, trauma care, and rare disease treatment that are not widely available elsewhere. These unique responsibilities make CHLA fundamentally different from a typical hospital and should be reflected in OHCA's spending growth framework.

CHLA shares OHCA's commitment to healthcare affordability and accountability. However, CHLA remains concerned about the current methodology and enforcement structure, which do not adequately account for the unique realities of pediatric specialty care and could create unintended consequences for children's access to highly specialized services. These concerns are particularly significant given OHCA's proposed 3.5% spending growth target. Based on CHLA's historical performance, the organization would have exceeded the 3.5% threshold in FY 25 measurement years, including spending growth of 9.5% in FY25 vs FY24, despite ongoing cost-containment efforts.

A one-size-fits-all spending growth target does not reflect the realities of pediatric specialty care. CHLA provides the state's most complex and resource-intensive care, including organ transplantation, oncology, rare disease treatment, neonatal intensive care, trauma services, and advanced specialty programs. Year-over-year spending growth can be significantly influenced by factors outside a hospital's control, including changes in patient acuity, the introduction of new gene therapies, pharmaceutical price increases, upward workforce market pressures, and rising supply costs. In FY25, compared to FY24, CHLA experienced pharmaceutical cost inflation of 8%, medical supply cost inflation of 4%, and labor cost increases of 7.8%, all of which exceeded the proposed 3.5% spending target and were largely outside the hospital's control.



CHLA is particularly concerned that the current methodology does not adequately account for changes in patient acuity or isolate the impact of high-cost drugs and gene therapies. As California's largest pediatric referral center, even modest increases in patients requiring gene therapies, transplants, complex oncology care, and other specialized treatments can significantly affect spending growth. Gene therapy volume increased from 34 patients in FY25 to 43 patients in FY26, driving pharmaceutical costs from approximately \$54 million to \$78 million. In FY25, CHLA performed 121 pediatric transplants, including 62 bone marrow transplants, with average transplant costs exceeding \$800,000 per case and heart transplants averaging \$2 million per case. These costs reflect patient complexity and advances in pediatric medicine, not inefficiency, and a spending target that fails to account for these factors risks penalizing hospitals for providing medically necessary care to California's sickest children.

CHLA is also concerned that substantial penalties tied to annual spending growth could create perverse incentives that ultimately work against patient access. If hospitals are pressured to remain under a spending cap without adequate consideration of patient complexity and external market forces, organizations may face difficult decisions regarding service expansion, workforce investments, and access to highly specialized treatments. Such outcomes would be inconsistent with California's goal of ensuring access to high-quality care. CHLA serves over 700,000 patients annually and receives referrals from most California county hospitals, as well as other states (Nevada, Arizona, among other states) each year. As a CCS referral center, reductions in specialty service capacity would have statewide implications for pediatric access to care.

Finally, CHLA strongly supports recommendations that OHCA evaluate performance across multiple years rather than relying on a single year of spending growth data. Annual measurements alone may not accurately distinguish sustained spending trends from temporary fluctuations driven by patient acuity, emerging therapies, or other unique circumstances facing pediatric providers.

CHLA appreciates OHCA's engagement with stakeholders throughout this process and respectfully urges the Board to ensure that the final framework accounts for pediatric complexity, incorporates meaningful safeguards for access to care, and prioritizes improvement over punitive enforcement. Please contact Lindsey Berman, Associate Vice President, Policy & Government Affairs, at lberman@chla.usc.edu with any questions.

Thank you for your consideration.

Sincerely,

A handwritten signature in blue ink, appearing to read "P. Viviano".

Paul S. Viviano
President and Chief Executive Officer

July 29, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Sierra Nevada Memorial Hospital (SNMH), thank you for the opportunity to comment on the Office of Health Care Affordability's (OHCA) proposed spending growth target enforcement process. SNMH remains deeply concerned that the current framework lacks the necessary collaborative spirit to ensure long-term stability. **As proposed, exorbitant penalties would jeopardize equitable access to high-quality care, particularly for California's most vulnerable populations. We urge OHCA to adopt a collaborative enforcement model that prioritizes performance improvement over punitive measures.**

Committed to a healing mission, Sierra Nevada Memorial Hospital (SNMH) urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

SNMH is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. At SNMH, labor accounts for nearly 60% of our operating expenses, and our spending on salaries and benefits has risen by more

than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

As an example, in order to adapt to this restrictive financial environment, exacerbated by federal cuts under H.R. 1 (OBBBA), SNMH recently found it necessary to close our Home Health Agency, decreasing the resources available for care of some of the most vulnerable patients in our county.

Sadly, we can be certain that these efforts will not be enough. OHCA's current spending methodology yields results that are completely inconsistent with our operational realities and the market conditions under which we currently operate; conditions under which we will continue to operate while OHCA advances an approach which ignores these realities. Even more concerning, OHCA has indicated that it may base determinations on a single year of data, an approach that promises an incomplete and even more misleading picture of a hospital's fiscal health.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For SNMH, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

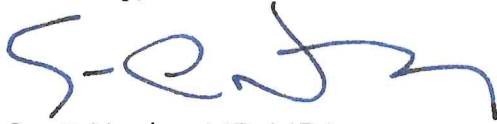
- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

SNMH remains committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$2,579,571 in patient financial assistance for 9,611 patients.

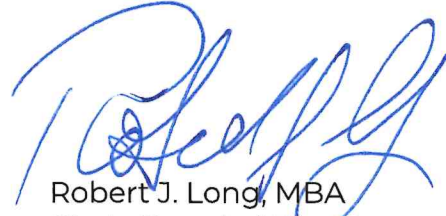
Penalties at the levels proposed by OHCA would threaten SNMH's viability, jeopardize our patients' health, and endanger the livelihoods of the 700 team members who rely on us. Had the 3.5% spending target been in place in 2023, SNMH would have faced a starting penalty amount of \$228,604 on its commercial line and \$5,745,744 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. SNMH is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The enforcement process established by OHCA will dictate our ability to serve Nevada County residents. We appreciate the opportunity to provide these recommendations and look forward to collaborating with the Office to build a sustainable, accessible healthcare system for all Californians.

Sincerely,



Scott Neeley, MD, MBA
President & CEO
Sierra Nevada Memorial Hospital
Dignity Health/Common Spirit
scott.neeley@commonspirit.org



Robert J. Long, MBA
Chair, Board of Directors
Sierra Nevada Memorial Hospital
Dignity Health/Common Spirit
boblong162@gmail.com

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
The Honorable Senator Megan Dahle
The Honorable Assemblymember Heather Hadwick



Submitted via email at ohca@hcai.ca.gov

July 28, 2026

District Office:
9250 Laguna Springs Drive
Suite 220
Elk Grove, CA 95758

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Methodist Hospital of Sacramento, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Methodist Hospital of Sacramento shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Methodist Hospital of Sacramento urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Methodist Hospital of Sacramento is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such



the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Closed our ambulatory surgery center, which our community needs, but is cost prohibitive.
- Significantly reduced capital spend
- Targeted reductions in staffing and discretionary expenditures

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Methodist Hospital of Sacramento's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Methodist Hospital of Sacramento, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Methodist Hospital of Sacramento is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$9,097,686 in patient financial assistance at cost for 9,924 patients.

Penalties at the levels proposed by OHCA would threaten Methodist's viability, jeopardize our patients' health, and endanger the livelihoods of the 1,369 number of our employees who rely on us. Had the 3.5% spending target been in place in 2023, Methodist Hospital of Sacramento would have faced a starting penalty amount of \$18,047,767 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Methodist Hospital of Sacramento is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Sacramento residents who pass through our doors each year. Methodist Hospital of Sacramento appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Phyllis Baltz

Phyllis Baltz
Hospital President

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

The Honorable Angelique Ashby

The Honorable Stephanie Nguyen



Submitted via email at ohca@hcai.ca.gov

July 28, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Dignity Health - Inland Empire (Community Hospital of San Bernardino and St. Bernardine Medical Center), thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, our two Inland Empire hospitals share our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Dignity Health - Inland Empire urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Community Hospital of San Bernardino and St. Bernardine Medical Center are members of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Dignity Health's Inland Empire Market has not closed any service lines at this time. However, we continue to evaluate vulnerable programs, including Pediatric Subacute Services and Maternal Child Health, to ensure their long-term financial and operational sustainability.
- We have also maintained our commitment to required regulatory capital investments. At the same time, current financial constraints limit our ability to expand critically needed behavioral health services in the communities we serve.
- In addition, we recently implemented a reduction in force and continue to evaluate opportunities to reduce expenses, including labor costs, while working to preserve access, quality, and essential patient care services.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Dignity Health - Inland Empire's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Dignity Health - Inland Empire, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

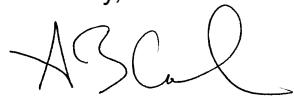
Dignity Health - Inland Empire is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, our two Inland Empire hospitals provided over \$12.1M in patient financial assistance at cost for 18,667 patients.

Penalties at the levels proposed by OHCA would threaten Dignity Health - Inland Empire's viability, jeopardize our patients' health, and endanger the livelihoods of our nearly 3,500 employees who rely on us. Had the 3.5% spending target been in place in 2023, Dignity Health - Inland Empire would have faced a starting penalty amount of \$1.4M on its commercial line and \$65.4M across all payer lines.

Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Dignity Health - Inland Empire is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the San Bernardino area residents who pass through our doors each year. Dignity Health - Inland Empire appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

A handwritten signature in black ink, appearing to read 'ABColeman', written in a cursive style.

Anthony B. Coleman, DHA
President

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

The Honorable Eloise Gomez Reyes

The Honorable James Ramos



Dignity Health™
Dominican Hospital

1555 Soquel Drive
Santa Cruz, CA 95065
direct 831.462.7700
dominicanhospital.org

Submitted via email at ohca@hcai.ca.gov

July 29, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Dignity Health Dominican Hospital, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Dominican Hospital shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Dominican Hospital urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Dominican Hospital is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals,

medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Dominican Hospital has needed to pause investments in critical equipment and capital upgrades such as end of life operating room equipment, patient to nurse communication (call light) infrastructure, and vital imaging equipment, that are no longer possible.
- Dominican Hospital has proactively implemented a comprehensive review of staffing, service lines, and scheduling practices, identifying efficiencies to ensure fiscal responsibility without compromising the exceptional patient care and safety our community expects. These strategic adjustments are designed to maintain our high standards of service delivery amidst rising operational costs and regulatory demands.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Dominican Hospital's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Dominican Hospital, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Dominican Hospital is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$5,088,244 in patient financial assistance at cost for 5,370 patients.

Penalties at the levels proposed by OHCA would threaten Dominican Hospital's viability, jeopardize our patients' health, and endanger the livelihoods of the 1,903 number of our employees who rely on us. Had the 3.5% spending target been in place in 2023, Dominican Hospital would have faced a starting penalty amount of \$19,758,230 on its commercial line and \$29,310,967 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Dominican Hospital is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Santa Cruz County residents who pass through our doors each year. Dominican Hospital appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the

Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

Christine McSweeney
President/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
The Honorable John Laird
The Honorable Dawn Addis



July 30, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process *((Submitted via email at ohca@hcai.ca.gov)*

Dear Director Landsberg:

As the Office of Health Care Affordability (OHCA) board continues its discussion of spending target enforcement, Kindred Hospitals in California must share our deep concerns about the potential process outlined to date. OHCA's spending target of 3.5% or lower is now in effect and the Office has recommended an aggressive penalty structure to which changes are critically needed. The bottom line is this: Fines at the excessively high levels proposed would be devastating to the ability to continue to provide care for the patients for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends before penalties are imposed.

At Kindred Hospitals, we are dedicated to the highest quality care through the services delivered by more than 3,000 health care workers in 13 specialized long-term acute care hospitals across California. Kindred's hospitals provide long-term acute care to medically complex patients who require continued care and extended recovery time — filling the gap between an acute care hospital and a skilled nursing facility or inpatient rehab facility.

Core Concerns

Uncontrollable Cost Growth

Kindred Hospitals in California are currently experiencing cost growth in excess of the 3.5% spending target. Labor, medical supply, and pharmaceutical costs have all risen sharply — driven by market forces, inflation, and workforce dynamics that we cannot unilaterally control. Facing such uncontrollable cost pressures at the same time OHCA places a cap on available resources forces an impossible choice: cut staff and services preemptively to avoid potential penalties or provide the care our patients need and risk fines that would threaten our financial viability.

Federal Funding Cuts Compound the Challenge

Kindred Hospitals, like hospitals across California, are already taking difficult steps to adapt to the largest federal health care funding cuts in history under the One Big Beautiful Bill Act (OBBBA). These cuts are forcing hospitals to reduce services, defer capital investments, and make other painful tradeoffs — all while still meeting the needs of their patients and communities. The state's 2030 seismic compliance requirements add further financial pressure that many hospitals will be unable to meet if OHCA enforcement proceeds as currently contemplated.

Significant Penalty Exposure Under Proposed Enforcement

The scale of exposure under OHCA's proposed penalty structure is not theoretical. Applying the 3.5% spending target retroactively to Kindred Hospitals' recent California operations, we estimate that our hospitals would have faced penalties totaling approximately \$5.4 million on its commercial lines. A fine of that magnitude — assessed against facilities that are already operating on thin margins and absorbing historic federal funding cuts under OBBBA — would inevitably force a re-evaluation of hospital operations across our California hospitals. Money directed to penalties is money that cannot be spent on patient care, workforce retention, or the facility investments the state is separately requiring of us. We raise this figure not to overstate our case, but to illustrate concretely why the enforcement framework OHCA adopts — not just the target itself — will determine whether hospitals like ours can continue to operate in the communities we serve.

Single-Year Data Is an Unreliable Basis for Enforcement

OHCA has indicated it may base enforcement determinations on only a single year of spending data. Kindred Hospitals is concerned that year-over-year spending figures are highly volatile and can be significantly distorted by one-time events, changes in patient acuity, payer mix shifts, or extraordinary circumstances entirely outside a hospital's control. Penalizing a hospital on the basis of a single anomalous year does not reflect its true spending trajectory and would produce deeply unfair outcomes. Our \$5.5 million exposure estimate underscores this point: a single-year snapshot could easily overstate or understate a hospital's true cost trajectory, making the resulting penalty arbitrary rather than a reliable measure of sustained non-compliance.

Multiple Enforcement Tracks Create Compounding Risk

OHCA has also signaled it may enforce separately across every payer and service line, creating six or more independent pathways for a hospital to violate the target. For Kindred Hospitals, this means investments that genuinely improve patient access and care efficiency in one area could trigger a penalty in another. This structure would penalize exactly the kinds of care innovations and access improvements that hospitals should be encouraged to pursue — including expanding outpatient services that patients prefer and maintaining revenue necessary to sustain operations in the face of federal cuts.

Workforce Stability Is at Risk

OHCA has a statutory duty to protect health care workforce stability. Enforcement at proposed penalty levels would directly threaten Kindred Hospital's ability to maintain a stable, high-quality workforce. Wages and benefits that grow above the spending target — particularly those governed by collective bargaining agreements — should not subject hospitals or their frontline workers to financial penalties. One-size-fits-all enforcement that disregards labor obligations would destabilize the very workforce our patients and communities depend upon.

Recommendations

Kindred urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- Providing clear guidance on how spending growth will be assessed against the target, including how payer mix, service mix, and patient acuity will be considered in any determination

- Requiring that enforcement determinations be based on multiple years of data — at minimum three years — to avoid penalizing hospitals for volatile year-over-year fluctuations that do not reflect their actual spending trends
- Standardizing and streamlining the process for explaining growth above the target, consistent with the statutory waiver process, and ensuring hospitals have a genuine opportunity to present context before any finding of violation
- Establishing a collaborative performance improvement process that gives hospitals a defined period and structured support to correct course before financial penalties are imposed
- Phasing in penalty amounts and accounting for material circumstantial factors, including investments in patient-centered care, compliance with state facility requirements, labor obligations, and a hospital's overall financial condition
- Treating labor cost growth equitably: wages and benefits above the spending target — particularly under collective bargaining agreements — should constitute a justifiable basis for exceeding the target, not a penalty trigger
- Refraining from simultaneous enforcement across multiple payer and service line categories in ways that would penalize hospitals for efficiency gains or access improvements in one area due to spending in another

Kindred Hospitals are committed to helping patients afford the care they need and to building a more sustainable health care system for the long term. We support OHCA's mission and want to work collaboratively toward shared goals. However, the enforcement framework must be fair, transparent, and grounded in the complex realities hospitals face — particularly in an environment of unprecedented federal funding cuts and rising costs.

The measurement and enforcement process OHCA establishes will directly determine whether Kindred Hospitals can continue serving the California communities that depend on us. We appreciate the opportunity to comment and strongly encourage the board to incorporate these recommendations into future rulemaking. We look forward to continued engagement as these rules are finalized and to collaborating on a more affordable and accessible health care system for all Californians.

Sincerely,

Adam Darvish

Adam Darvish
SVP Specialty Hospitals Operations, West Region Kindred Hospitals

cc: Members of the Health Care Affordability Board:

Kim Johnson
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Dr. Richard Pan

Vishaal Pegany, Deputy Director, Office of Health Care Affordability



Submitted via email at ohca@hcai.ca.gov

July 29, 2026
Elizabeth Landsberg
Director, Office of Health Care Affordability
2020 W. El Camino Ave.
Sacramento, CA 95833

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Mercy Medical Center, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Mercy Medical Center shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Mercy Medical Center urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Mercy Medical Center is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Mercy Medical Center has paused/canceled investments in the Mobile Clinic, which is a \$600K investment reliant on CCAH funding, that are no longer possible.
- Mercy Medical Center lowered salary expenses by \$5.8M through a reduction of 46 FTEs. Additionally, 7 more FTE positions were eliminated in June across essential services, such as phlebotomy, education, and surgery NSM.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Mercy Medical Center's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Mercy Medical Center, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

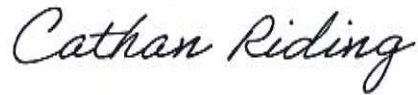
Mercy Medical Center is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$6,598,766 in patient financial assistance at cost for 34,708 patients.

Penalties at the levels proposed by OHCA would threaten the viability of hospitals, jeopardize patients' health, and endanger the livelihoods of many healthcare employees across the state. Mercy Medical Center shares the hospital community's concern that OHCA may seek to financially penalize entities before they have had a chance to improve their spending targets based on voluntary strategies. Moreover, we are worried that one-size-fits-all strategies imposed from the outside without knowledge of our distinct concerns and resources would have detrimental effects on our system's ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we all share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Merced County residents who pass through our doors each year. Mercy

Medical Center appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

A handwritten signature in cursive script that reads "Cathan Riding".

Cathan Riding
Chief Operating Officer
Account Executive

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
The Honorable Anna Caballero
The Honorable Esmeralda Z. Soria

Woodland Memorial Hospital
Hospital Administration
1325 Cottonwood Street
Woodland, CA 95695

Submitted via email at ohca@hcai.ca.gov

July 30, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Dignity Health Woodland Memorial Hospital thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Dignity Health Woodland Memorial Hospital shares our deep concerns about the process outlined to date. The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.

Committed to a healing mission, Dignity Health Woodland Memorial Hospital urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- Informing hospitals how their spending growth will be assessed against the target and clarifying how payer and service mix will be considered
- Basing the determination of a violation on multiple years of data to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- Standardizing the process for explaining growth above the target, as established under the statutory waiver process
- Establishing a collaborative performance improvement process that gives hospitals a real opportunity to improve before fines are levied
- Phasing in penalty amounts and accounting for essential circumstantial factors, like investments in patient-centered care or a hospital's financial condition

Woodland Memorial Hospital is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Dignity Health Woodland Memorial Hospital has paused/canceled investments in IT infrastructure upgrades and critical imaging replacements. In addition we've reduced our ability to invest in community projects.
- We made another reduction in force, bringing our staffing to minimum levels. Further cuts will be detrimental to our hospital and our community.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Dignity Health Woodland Memorial Hospital own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Dignity Health Woodland Memorial Hospital, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Dignity Health Woodland Memorial Hospital is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$3,936,835 in patient financial assistance at cost for 7,728 patients.

Penalties at the levels proposed by OHCA would threaten the viability of hospitals, jeopardize patients' health, and endanger the livelihoods of many healthcare employees across the state. Dignity Health Woodland Memorial Hospital shares the hospital community's concern that OHCA may seek to financially penalize entities before they have had a chance to improve their spending targets based on voluntary strategies. Moreover, we are worried that one-size-fits-all strategies imposed from the outside without knowledge of our distinct concerns and resources would have detrimental effects on our system's ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we all share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Yolo, Solano & Colusa County residents who pass through our doors each year. Dignity Health Woodland Memorial Hospital appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Gena Bravo
Hospital President

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
The Honorable Christopher Cabaldon
The Honorable Assembly Majority Leader Aguiar-Curry



Submitted via email at ohca@hcai.ca.gov

July 28, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of St. Joseph's Medical Behavioral Health Center, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, St. Joseph's Medical Behavioral Health Center shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, St. Joseph's Medical Behavioral Health Center urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

St. Joseph's Medical Behavioral Health Center is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such

uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- St. Joseph's Behavioral Health Center has reduced staffing, potentially impacting our ability to meet the community needs. .

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with St. Joseph's Medical Behavioral Health Center's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For St. Joseph's Medical Behavioral Health Center, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

St. Joseph's Medical Behavioral Health Center is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$227,264 in patient financial assistance at cost for 123 patients.

Penalties at the levels proposed by OHCA would threaten St. Joseph's Behavioral Health Center's viability, jeopardize our patients' health, and endanger the livelihoods of the 169 employees who rely on us. Had the 3.5% spending target been in place in 2023, St. Joseph's Behavioral Health Center would have faced a starting penalty amount of \$888,078 on its commercial line and \$2,669,654 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. St. Joseph's Behavioral Health Center is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the St. Joseph's Behavioral Health Center residents who pass through our doors each year. St. Joseph's Behavioral Health Center appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



David Ziolkowski
President & CEO, St. Joseph's Medical Center

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

The Honorable Jerry McNerney

The Honorable Rhodesia Ransom

The Honorable Josh Harder



St. Joseph's Medical Center
Administration
1800 North California Street
Stockton, CA 95204

Direct 209.467.6512
Fax 209.461.3299
dignityhealth.org

Submitted via email at ohca@hcai.ca.gov

July 28, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of St. Joseph's Medical Center, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, St. Joseph's Medical Center shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, St. Joseph's Medical Center urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

St. Joseph's Medical Center is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such

uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- St. Joseph's Medical Center has eliminated Pediatric Home Health services that our community needs, but that are cost prohibitive.
- St. Joseph's Medical Center has postponed investments in Primary Care physician buildings that are no longer possible.
- St. Joseph's Medical Center has reduced staffing in several clinical areas, potentially impacting our ability to meet community needs.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with St. Joseph's Medical Center's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For St. Joseph's Medical Center, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

St. Joseph's Medical Center is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$9,128,258 in patient financial assistance at cost for 18,008 patients.

Penalties at the levels proposed by OHCA would threaten St. Joseph's Medical Center's viability, jeopardize our patients' health, and endanger the livelihoods of the 3,116 employees who rely on us. Had the 3.5% spending target been in place in 2023, St. Joseph's Medical Center would have faced a starting penalty amount of \$9,271,744 on its commercial line and \$46,499,879 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. St. Joseph's Medical Center is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the St. Joseph's Medical Center residents who pass through our doors each year. St. Joseph's Medical Center appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



David Ziolkowski
President & CEO, St. Joseph's Medical Center

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

The Honorable Jerry McNerney

The Honorable Rhodesia Ransom

The Honorable Josh Harder



Submitted via email at ohca@hcai.ca.gov

July 30, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Sequoia Hospital, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Sequoia Hospital shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Sequoia Hospital urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Sequoia Hospital is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits

has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Sequoia Hospital, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Sequoia Hospital is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$3,385,690 in patient financial assistance at cost for 6517 patients.

Penalties at the levels proposed by OHCA would threaten Sequoia Hospital's viability, jeopardize our patients' health, and endanger the livelihoods of the 900+ number of our employees who rely on us. Had the 3.5% spending target been in place in 2023, Sequoia Hospital would have faced a starting penalty amount of \$962,298 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Sequoia Hospital is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Redwood City, San Mateo County residents who pass through our doors each year. Sequoia Hospital appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Christine McSweeney, MBA, FACHE
President

Sequoia Hospital

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

The Honorable Josh Becker

The Honorable Diane Papan



Submitted via email at ohca@hcai.ca.gov

July 29, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Mercy Medical Center Mt. Shasta, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Mercy Medical Center Mt. Shasta shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Mercy Medical Center Mt. Shasta urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Mercy Medical Center Mt. Shasta is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions. OHCA's hospital spending methodology produces wild results that do not correspond with Mercy Medical Center Mt. Shasta's own experience.

Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Mercy Medical Center Mt. Shasta, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Mercy Medical Center Mt. Shasta is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$1,607,533 in patient financial assistance at cost for 3,575 patients.

Penalties at the levels proposed by OHCA would threaten Mercy Medical Center Mt. Shasta's viability, jeopardize our patients' health, and endanger the livelihoods of the 309 employees who rely on us. Had the 3.5% spending target been in place in 2023, Mercy Medical Center Mt. Shasta would have faced a starting penalty amount of \$2,669,257 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Mercy Medical Center Mt. Shasta is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Siskiyou County residents who pass through our doors each year. Mercy Medical Center Mt. Shasta appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Rodger Page
President

Dignity Health- North State Market &
Mercy Medical Center Mt. Shasta
St. Elizabeth Community Hospital

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
The Honorable Megan Dahle
The Honorable Heather Hadwick



Dignity Health®

St. Elizabeth Community Hospital

Submitted via email at ohca@hcai.ca.gov

July 29, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of St. Elizabeth Community Hospital, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, St. Elizabeth Community Hospital shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, St. Elizabeth Community Hospital urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

St. Elizabeth Community Hospital is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions. OHCA's hospital spending methodology produces wild results that do not correspond with St. Elizabeth Community Hospital's own experience.

Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For St. Elizabeth Community Hospital, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

St. Elizabeth Community Hospital is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$3,397,645 in patient financial assistance at cost for 9,877 patients.

Penalties at the levels proposed by OHCA would threaten St. Elizabeth Community Hospital's viability, jeopardize our patients' health, and endanger the livelihoods of the 602 employees who rely on us. Had the 3.5% spending target been in place in 2023, St. Elizabeth Community Hospital would have faced a starting penalty amount of \$2,583,565 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. St. Elizabeth Community Hospital is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Tehama County residents who pass through our doors each year. St. Elizabeth Community Hospital appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Rodger Page

President

Dignity Health- North State Market &

Mercy Medical Center Mt. Shasta

St. Elizabeth Community Hospital

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

The Honorable Megan Dahle

The Honorable James Gallagher

St. Mary Medical Center
1050 Linden Ave
Long Beach, CA 90813
www.stmarymedicalcenter.org

July 30, 2026

Submitted via email at ohca@hcai.ca.gov

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of St. Mary Medical Center, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, St. Mary Medical Center shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, St. Mary Medical Center urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered.
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target.

St. Mary Medical Center
1050 Linden Ave
Long Beach, CA 90813
www.stmarymedicalcenter.org

- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process.
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied.
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition.

St. Mary Medical Center is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- St. Mary Medical Center recently experienced a reduction in force affecting service lines and community impact.
- St. Mary Medical Center uses careful planning for efficiency, focusing on financial prudence and optimizing available resources.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with St. Mary Medical Center's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

St. Mary Medical Center
1050 Linden Ave
Long Beach, CA 90813
www.stmarymedicalcenter.org

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For St. Mary Medical Center, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay.
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap.

St. Mary Medical Center is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$68,843,327 in patient financial assistance at cost for 71,959 patients.

Penalties at the levels proposed by OHCA would threaten St. Mary Medical Center's viability, jeopardize our patients' health, and endanger the livelihoods of the 1,600 number of our employees who rely on us. Had the 3.5% spending target been in place in 2023, it would have faced a starting penalty amount of \$1,933,199 on its commercial line and \$15,634,775 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. St. Mary Medical Center is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Long Beach in the County of Los Angeles residents who pass through our doors each year. St. Mary Medical Center appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to

St. Mary Medical Center
1050 Linden Ave
Long Beach, CA 90813
www.stmarymedicalcenter.org

working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Carolyn Caldwell, FACHE
Hospital 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
The Honorable Lena Gonzales
The Honorable Josh Lowenthal



Submitted via email at ohca@hcai.ca.gov

July 31, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Mercy San Juan Medical Center, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Mercy San Juan Medical Center shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Mercy San Juan Medical Center urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Mercy San Juan Medical Center is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such

uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Mercy San Juan Medical Center has significantly reduced or eliminated various essential community services, because the cost has become too prohibitive. This includes Hyperbaric Oxygen Therapy (HBOT), the Sleep Disorder Center, and the Hospital Outpatient Surgery Center, forcing vulnerable patients to seek care elsewhere and delaying vital treatments. Furthermore, the closure of the Perinatal Diabetic Clinic deprives expectant mothers and their babies of a critical community need, leaving them with reduced access to specialized care
- Mercy San Juan has also delayed or postponed the capital investments in critical areas like the Family Birth Center, Emergency Room updates, and replacements for aging diagnostic equipment.
- Mercy San Juan Medical Center eliminated/terminated 18 FTEs worth of positions in the last year and consolidated 67 FTEs worth of labor with forced labor standard reductions all due to financial pressures of operating this hospital at a loss.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Mercy San Juan Medical Center's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Mercy San Juan Medical Center, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

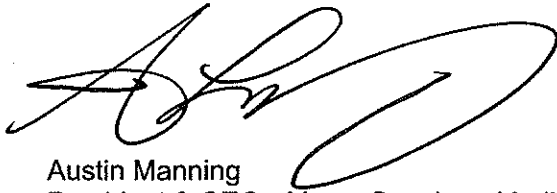
Mercy San Juan Medical Center is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$18,364,550 in patient financial assistance at cost for 13,155 patients.

Penalties at the levels proposed by OHCA would threaten Mercy San Juan Medical Center's viability, jeopardize our patients' health, and endanger the livelihoods of the 2,928 of our employees who rely on us. Had the 3.5% spending target been in place in 2023, Mercy San Juan Medical Center would have faced a starting penalty amount of \$15,021,900 on its commercial line and \$41,699,389 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Mercy San Juan Medical Center is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Carmichael, Sacramento County residents who pass through our doors

each year. Mercy San Juan Medical Center appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

A handwritten signature in black ink, appearing to read 'AM', with a large, sweeping loop at the end.

Austin Manning
President & CEO - Mercy San Juan Medical Center

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

The Honorable Rodger Neillo

The Honorable Josh Hoover

July 30, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Submitted via email: Attn: Megan Brubaker at OHCA@hcai.ca.gov

Dear Director Landsberg:

I am writing on behalf of MemorialCare, a nonprofit, integrated health care delivery system located in both Los Angeles and Orange Counties that has four hospitals and over 220 community-based ambulatory sites of care to provide our deep concerns on the current proposals to date for establishing hospital spending target enforcement process. **The proposed exorbitant fines at the levels proposed would be simply disastrous for the patients for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

With the passage of the Affordable Care Act (ACA), driving affordability and quality through value-based care has been MemorialCare's priority to move from volume to value. MemorialCare makes sure that patients receive the right care, at the right place and at the right time based on clinical criteria – and, as important, at the lowest cost. The system's leadership and board of directors have supported a model to increase healthcare quality and access, while decreasing per capita costs, which has been at the forefront of the system's clinical and business strategies.

For these reasons, MemorialCare shares the Office of Health Care Affordability (OHCA) goals to improve affordability and access to high-quality health care. Remember, making health care more affordable requires thoughtful, long-term planning. For example, a comprehensive focus on growing alternative payment models of care in hospitals and health systems has the potential to lead to long-term cost savings but requires significant up-front investments and reorganization of delivery models. Allowing for an opportunity to develop and implement these improvements will allow hospitals and health care systems to transform towards models of care that support timely access to high-quality and affordable patient-centered care.

At the February 2024 OHCA Board meeting, MemorialCare presented to the board on "cost-reducing strategies" under the alternative payment model agenda item. We shared our ten-year journey predicated on the implementation of the ACA in reducing total cost of care in healthcare through investments in accessible community-based practice sites and innovative value-based models of care. However, as pointed out by board member Dr. Richard Pan, he asked if MemorialCare could "squeeze anymore savings, having done so much already in bending the cost curve" and "if we could meet this proposed 3% spending target". And we stated at the meeting, it would be unlikely we could meet the proposed 3% spending target, since we have invested in many of the tools to reduce the cost of care for health plans, employers, and patients for ten years.

Since the 2024 OHCA Board meeting, the enforceable spending target of 3.5% has been set for 2026, and even with that slight adjustment our system would not be able to meet this target, and therefore subject to excessive financial penalties. As a result, our hospital system would be unfairly penalized for having reduced total cost care for years. **Therefore, the combined impact of California's first statewide spending target at 3.5% and now proposed enforcement methodology falls short of achieving the OHCA goals to improve access and affordability for patient care long term. For these reasons, we respectfully ask you to consider a new structure for enforcement and penalties.**

MemorialCare urges the OHCA to consider regulations that balance affordability with continued access to care by:

- Informing hospitals how their spending growth will be assessed against the target and clarifying how payer and service mix will be considered.
- Basing the determination of a violation on multiple years of data to avoid the volatility of year-over-year spending swings; only multiyear assessment can reliably distinguish hospitals that genuinely exceeded their target.
- Standardizing the process for explaining growth above the target, as established under the statutory waiver process.
- Establishing a collaborative performance improvement process that gives hospitals a real opportunity to improve before fines are levied.
- Phasing in penalty amounts and accounting for essential circumstantial factors, like investments in patient-centered care or a hospital's financial condition.

And yet, those efforts might not be enough. However, MemorialCare has no way of knowing that, because OHCA has yet to finalize how spending will be measured, which payer and service lines will count, and what rules hospitals will be required to follow. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. One year in isolation does not give an accurate picture of each of our four distinct MemorialCare hospital spending trends, which includes a free-standing children's hospital.

Even worse for our system, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving our four hospitals six separate ways to violate the target. **OHCA is moving ahead to fast on an enforcement process without considering the chaotic environment health systems are currently operating in with looming Federal Medicaid cuts impacting the state and our hospitals, while all under the backdrop of the continued inflationary cost drivers on labor, drugs and medical supplies that we have no control over.**

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to provide the same level of services to our community. MemorialCare appreciates the opportunity to comment and encourages the OHCA staff to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Thank you for the opportunity to comment, and we look forward to continuing to work with both OHCA staff and board members to address affordability in healthcare for Californians. If you have any additional questions, please contact me at kpugh@memorialcare.org.

Sincerely,



Kristen L. Pugh, MPA
Vice President, Advocacy & Government Relations
MemorialCare Health System

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

Assemblymember Cottie Petrie Norris
Senator Tom Umberg



July 27, 2026

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

Subject: OHCA Must Adopt a Balanced and Collaborative Enforcement Process

Dear Director Landsberg,

On behalf of **Palmdale Regional Medical Center (PRMC)**, I write to express our significant concerns regarding the Office of Health Care Affordability's proposed spending target enforcement framework. While we share OHCA's goal of improving health care affordability for California residents, we are concerned that the proposed enforcement approach could have unintended consequences that negatively affect patient access to care, workforce stability, and the long-term sustainability of essential hospital services.

As one of the primary providers of acute care, emergency services, and specialty care in the Antelope Valley, PRMC serves a diverse population that includes many low-income, underserved, and medically complex patients. The realities facing hospitals today include escalating labor expenses, rising pharmaceutical costs, increasing supply chain costs, growing regulatory requirements, and reductions in reimbursement that continue to strain hospital operations.

PRMC urges OHCA to adopt regulations that balance affordability objectives with the need to preserve access to high-quality care by:

- Clearly defining how hospital spending growth will be measured and how payer mix, patient acuity, and service line complexity will be considered.
- Evaluating performance over multiple years rather than relying on a single year of spending data, which can be significantly affected by extraordinary events and operational fluctuations.
- Establishing a consistent process that allows hospitals to explain circumstances contributing to spending growth above established targets.
- Providing hospitals with a meaningful performance improvement period before financial penalties are imposed.

- Considering financial condition, community need, and investments in patient care when determining any enforcement actions or penalties.

Hospitals throughout California are currently facing unprecedented financial pressures. At PRMC, ongoing increases in labor, medical supply, pharmaceutical, and technology costs have substantially outpaced historical growth rates. These expenses are often outside of a hospital's direct control but are necessary to maintain safe staffing levels, ensure regulatory compliance, and provide high-quality patient care.

We are particularly concerned that substantial financial penalties could force hospitals to delay investments in workforce development, facility improvements, service expansion, and community health programs. Such outcomes would ultimately undermine the very goals of improving affordability, access, and health outcomes that OHCA seeks to advance.

PRMC has consistently invested in initiatives that improve patient outcomes and reduce long-term health care costs, including:

- Expanding access to emergency medicine services.
- Establishing residency programs to train primary care physicians to provide needed care in the community.
- Investing in technology for quality improvement and patient safety initiatives.

These investments often require significant up-front expenditures but are necessary for organizational transformation needed for hospitals to better care for patients. We believe affordability initiatives should encourage innovation and collaboration rather than create financial risks that could compromise patient care.

Palmdale Regional Medical Center remains committed to working collaboratively with OHCA and other stakeholders to develop policies that advance affordability while preserving access to essential health care services for residents throughout the Antelope Valley and surrounding communities. Thank you for your consideration of these concerns and recommendations.

Sincerely,



Nana Deeb
Chief Executive Officer
Palmdale Regional Medical Center



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

Assemblymember Tom Lackey

Senator Suzette Valladares



July 14th, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

Antelope Valley Economic Development & Growth Enterprise (AV EDGE) knows firsthand the importance of our local hospital, Southwest Healthcare, when it comes to our community's health. From routine care to emergency needs, our local hospital is a pillar of our community. **That's why AV EDGE 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.**

AV EDGE is an organization that devotes itself to facilitating business growth and opportunity within our 3,000 square mile region of Antelope Valley. Therefore, we believe our local hospitals are important to our community. AV EDGE is a pro-growth, pro-business coalition committed to advancing the economic and healthcare vitality of our region. By working together with other community leaders, local government, and supporting hospitals like this one, we make a significant impact on the lives of residents.

We partner with our hospital to meet several vital community health priorities, including needs and gap assessment, workforce development pathways, and economic development projects to expand the availability and access in our underserved community. 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. On behalf of the 496,000 residents we serve, AV EDGE urges you to take a collaborative approach that protects access while improving affordability.

If you have any questions or need additional information, please contact drew@avedgeca.org or by calling our office at 661-441-2957.

Sincerely,

A blue ink signature of Drew Mercy.

DREW MERCY
Executive Director

cc: Members of the Health Care Affordability Board:

Kim Johnson
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, PhD
Dr. Richard Pan
Vishaal Pegany, Deputy Director, Office of Health Care Affordability



Submitted via email at ohca@hcai.ca.gov

July 30, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Mark Twain Medical Center, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Mark Twain Medical Center shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Mark Twain Medical Center urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Mark Twain Medical Center is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Mark Twain Medical Center, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Mark Twain Medical Center is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$1,055,025 in patient financial assistance at cost for 8,437 patients.

Penalties at the levels proposed by OHCA would threaten Mark Twain Medical Center's viability, jeopardize our patients' health, and endanger the livelihoods of the 350 +number of our employees who rely on us. Had the 3.5% spending target been in place in 2023, Mark Twain Medical Center would have faced starting penalties across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Mark Twain Medical Center is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Calaveras County residents who pass through our doors each year. Mark Twain Medical Center appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

Doug Archer
President/CEO
Mark Twain Medical Center

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

The Honorable Marie Alvarado Gill



Submitted via email at ohca@hcai.ca.gov

July 30, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Mercy Hospital of Folsom, thank you for the opportunity to provide comments about the Office of Health Care Affordability (OHCA)'s spending growth target enforcement process. As the OHCA board continues its discussion, Mercy Hospital of Folsom shares our deep concerns about the process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for California, gravely limiting equitable access to high-quality care in communities throughout the state, especially for the most vulnerable. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Committed to a healing mission, Mercy Hospital of Folsom urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Mercy Hospital of Folsom is a member of Dignity Health California, the largest provider of Medi-Cal services in the state providing more than 800,000 inpatient days and 1.2 million outpatient visits. Even after all supplemental payments and the provider fee, Dignity Health California loses annually, on average, more than half a billion dollars in unpaid costs. To think we could be fined on that service line is incredulous, unjust and will result in a destabilized safety net across the state.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals,

medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills are forcing challenging decisions.

To adapt to the new financial environment, including the largest health care cuts in history from H.R. 1, the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- Mercy Hospital of Folsom has significantly reduced or eliminated various essential community services, because the cost has become too prohibitive. This includes Outpatient Infusion services, emergent spine and hand surgery call, music therapy,
- Mercy Hospital of Folsom has also delayed or postponed the capital investments in critical areas like the expansion of our existing hospital campus, upgrading of radiology equipment (MRI, CT, Nuclear Medicine, MRI), generator updates, and a critical OR expansion.
- Mercy Hospital of Folsom eliminated/terminated 25 FTEs worth of positions in the last year due to forced labor standard reductions all due to financial pressures.

And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Mercy Hospital of Folsom's own experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Mercy Hospital of Folsom, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Mercy Hospital of Folsom is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250 percent of the federal poverty level (FPL) and discounted, medically necessary care up to 500 percent of the FPL. In fiscal year 2025, the hospital provided \$4,307,611 in patient financial assistance at cost for 7,112 patients.

Penalties at the levels proposed by OHCA would threaten Mercy Hospital of Folsom's viability, jeopardize our patients' health, and endanger the livelihoods of the 2,928 of our employees who rely on us. Had the 3.5% spending target been in place in 2023, Mercy Hospital of Folsom would have faced a starting penalty amount of \$244,797 on its commercial line and \$3,769,182 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Mercy Hospital of Folsom is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would without knowledge of our distinct concerns and resources have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as maintain a stable workforce — priorities we share with the Office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Folsom, Sacramento County residents who pass through our doors each year. Mercy Hospital of Folsom appreciates the opportunity to comment and encourages the OHCA



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A member of CommonSpirit

board to incorporate these recommendations into future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

Lisa Hausmann
President & CEO - Mercy Hospital of Folsom

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
The Honorable Rodger Neillo
The Honorable Josh Hoover



Community Hospital
of the Monterey Peninsula
Montage Health

July 31, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process
(Submitted via email at ohca@hcai.ca.gov)

Dear Director Landsberg:

As the Office of Health Care Affordability (OHCA) board continues its discussion of spending target enforcement, Community Hospital of Monterey Peninsula (CHOMP) must share our deep concerns about the potential process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for the patients for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

CHOMP urges the OHCA board to instead promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessment can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

CHOMP is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs and physician fees grew by 10.1%, our medical supply costs grew 8.3% and our drug costs grew by 4.7%. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: cut staff and services now to avoid potential penalties, or provide the care our patients need and risk fines that would wipe out what little financial cushion we have.

To adapt to the new financial environment, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- CHOMP has put two major capital projects on hold: a new parking structure and tower addition at the hospital. These projects were intended to support increased patient access to care and improve the patient/visitor experience at our facility.
- CHOMP will not have the resources necessary to make the \$12 million investment in our facilities to meet the state's 2030 seismic compliance goals, in addition to the \$40 million in life safety projects included in our capital plan to maintain our facilities.
- With 76% of our labor costs falling outside of collective bargaining agreements and thus subject to OHCA's cap, CHOMP will be required to cut jobs.

And yet, those efforts might not be enough. However, CHOMP has no way of knowing that, because OHCA has yet to finalize how spending will be measured, which payer and service lines will count, and what rules hospitals will be required to follow. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. Consider that for CHOMP, year-over-year data show an average 9.2% expense trend with the annual trend by year of: 7.0% in 2021, 12.0% in 2022, 14.5% in 2023, 2.1% in 2024 and 10.6% in 2025. One year in isolation does not give an accurate picture of CHOMP's spending trends.

Worse, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For CHOMP, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay.
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under OBBA.
- It's important to note that **CHOMP's payer mix is 80% governmental** so the majority of our reimbursement is fixed, non-negotiable and falls below the actual cost of care.

CHOMP is committed to helping patients afford the care they need. That's why we offer financial assistance programs, medical debt forgiveness, free clinics for certain services, free vaccination programs. In 2025, we provided community benefit services totaling \$228 million; these are free or subsidized programs that focused on building health communities, health education and wellness, improving access to primary and specialty care.

CHOMP also understands that affordability in the long term can't happen without focused efforts now. That's why we're committed to significant annual commitment of funds for grants to nonprofit organizations and multi-agency collaborative organizations in support of health assessment and improvement projects within our service area. In 2025, CHOMP awarded a total over \$1 million in 96 grants to 89 organizations.

Penalties at the levels proposed by OHCA would threaten CHOMP's viability, jeopardize our patients' health, and endanger the livelihoods of the 3,000 workers who rely on us. CHOMP is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office.

In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect health care workforce stability. It has various tools at its disposal to do this, including adjustments to the spending targets and considering labor cost growth as a justifiable reason that an entity exceeded its spending target. CHOMP urges OHCA to treat all health care workers equitably and ensure that neither our frontline workers nor the hospital itself are punished for wages and benefits that grow above the spending target.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Monterey Peninsula residents who pass through our doors each year. CHOMP appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Alicia M. Maitland
Chief Financial Officer
Montage Health

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



Amber J. Ter-Vrugt
Assistant Vice President, Government
Relations & Community Benefit
Office of the President
Scripps Health

4555 Executive Drive
San Diego, CA 92121
Tel 858-678-6893

July 31, 2026

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

Submitted Electronically: ohca@hcai.ca.gov

Re: Proposed Office of Health Care Affordability (OHCA) Penalty Framework and Enforcement Process

Dear Director Landsberg:

On behalf of Scripps Health (Scripps), we respectfully urge the Office of Health Care Affordability (OHCA) to reject the proposed penalty and enforcement framework in its current form and replace it with a methodology that prioritizes meaningful Performance Improvement Plans (PIP) and accounts for current economic realities, including Medicare and Medi-Cal funding shortfalls, rising operating costs, unfunded legislative mandates, and increasing uncompensated care.

Specifically, Scripps urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- Acknowledging errors in the data and methodologies, and work with providers to develop methodology grounded in real-world experience that achieves its intended goals without creating harmful unintended consequences.
- Developing safe harbor policies to create certainty in the process for providers.
- Developing explicit waivers in the penalty framework and enforcement process to account for cost drivers that are outside of provider's control.

- Informing hospitals how spending growth will be assessed against the target and clarifying how payer and service mix will be considered.
- Basing the determination of a violation on multiple years of data to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target.
- Standardizing the process for explaining growth above the target, as established under the statutory waiver process.
- Establishing a collaborative performance improvement process that gives hospitals a real opportunity to improve before fines are levied.
- Phasing in penalty amounts and accounting for essential circumstantial factors, like investments in patient-centered care or a hospital's financial condition.

Scripps supports the goal of improving health care affordability, and we are working toward that goal every day for the benefit of our community and the patients we serve.

We are creating value in meaningful and measurable ways.

For example, Scripps developed a direct-to-employer relationship with Qualcomm. By streamlining that relationship, we improved the member experience. Just as important, the savings generated through this model are realized by patients and Qualcomm. This is a practical example of a patient-centered affordability strategy that we are venturing.

Our efforts to create value are not limited to commercially insured patients. Scripps has established an advanced care clinic that provides high-touch outpatient care for medically complex and vulnerable patients, including individuals with limited or no ability to pay. This model helps reduce admissions and readmissions by caring for patients in a more appropriate outpatient setting. Likewise, through the Good Medicine program that affiliates with Scripps, physicians provide follow-up care in patients' homes after discharge, when appropriate. Although these services are not fully reimbursed, they are the right thing to do and have helped reduce emergency department visits and readmissions.

Scripps is also driving efficiency through value-based purchasing, operational improvements, and supply cost reduction initiatives. We have implemented targeted efforts to improve operating room efficiency and throughput, optimize technology, avoid unnecessary capital purchases, and reduce waste through disciplined vendor management and physician leadership. We continue to expand access through extended primary care hours, weekend services, and additional express care options.

These efforts are possible because of our workforce. Scripps has been recognized by *Fortune* as one of the nation's top health care employers for the sixth consecutive year, ranking No. 8 out of 50. In addition, 93 percent of Scripps employees say Scripps is a great place to work, compared with 57 percent at a typical U.S.-based company. We have invested heavily in employee retention and reduced reliance on contract labor because stable, experienced teams improve care and lower costs. But there is a limit to how much can be squeezed out of the system through internal efficiencies alone, and we have reached that point.

That is why the proposed enforcement framework is so concerning. Hospitals must be given a real opportunity to succeed, not set up to fail. State law requires meaningful opportunities for remediation before penalties are imposed, and OHCA should honor that intent through a collaborative, provider-driven Performance Improvement Plan (PIP) process focused on improvement rather than punishment.

Affordability cannot be separated from access. Hospitals are facing rising labor, utility, regulatory, and uncompensated care costs that are often outside their control. Further, while we comply with Corporate Practice of Medicine laws and do not employ physicians, required costs for contracts and related physician services are also rising for everything from primary care to anesthesiology. We must pay these increases in accordance with federal and state laws and do not control the market issues driving these price increases.

If labor costs rise by 5 percent while providers are expected to keep total expense growth below OHCA's target, the pressure inevitably falls on staffing and services unless those cost drivers are appropriately recognized. Labor costs should be considered by OHCA irrespective of whether they arise from collective bargaining or broader market conditions. The same is true for utility costs, new state mandates, and other externally imposed expenses.

Cost pressures outside our control and mandated by legislative bodies continue to mount and must also be considered.

For example, the One Big Beautiful Bill (OBBBA) resulted in the largest cut in Medicaid in the programs' 60-year history. This is expected to increase uncompensated care associated with coverage losses facing Californians and will have severe financial implications for Scripps and the communities we serve.

In another example, changes made by the legislature to the State's Managed Care Organization (MCO) tax in this budget cycle are expected to add more than **\$8.50 per member per month**, or approximately a **1.5 percent** rate increase on affected health insurance products. At the same time, providers are being asked to operate under cost growth caps near **3.2 percent**.

Further, new safety-related mandates like **Assembly Bill 2975 (AB 2975) that will go into effect in 2027**, though well-intentioned, carry significant operating and capital costs to our system at more than \$4 million annually.

These are just a few examples of cost pressures outside our control mandated by legislative bodies.

We also respectfully request that OHCA take into account the impact of payer disputes and related litigation. Providers are often forced to pursue underpayments through lengthy legal proceedings and may recover amounts rightfully owed months or years later. Under the proposed framework, those delayed recoveries could distort financial reporting and unfairly subject providers to penalties.

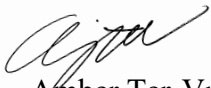
In closing, Scripps urges OHCA to adopt a more balanced, transparent, and workable approach—one that advances affordability while protecting quality and access to care. A provider-driven remediation model, grounded in real-world cost pressures and focused on

sustainable improvement, would better serve California patients and communities than the proposed punitive framework.

The proposed penalties are also out of step with those adopted in other states and are severe enough to threaten care delivery. Penalties of this magnitude should not rest on an unfinished methodological foundation. By OHCA's own data, **92 percent of hospitals would have been in violation in 2023**. That strongly suggests a problem with the framework itself, not with the field. A model that would classify nearly the entire hospital sector as noncompliant is not calibrated to advance success.

Thank you for your consideration. Please do not hesitate to contact me at ter-vrugt.amber@scrippshealth.org if you have any questions or would like to discuss this matter further.

Sincerely,



Amber Ter-Vrugt
AVP, Government Relations and Community Benefit

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
San Diego Legislative Delegation



University of California Health
1111 Franklin Street
Oakland, CA 94607

universityofcalifornia.health

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July 31, 2026

Elizabeth Landsberg
Director, Department of Health Care Access and Information
2020 W. El Camino Ave., Suite 1016
Sacramento, CA 95833

Submitted electronically via email to ohca@hcai.ca.gov.

**Subject: Hospital Spending Measurement, Enforcement Policies,
and Penalty Design**

Dear Director Landsberg,

We appreciate Office of Health Care Affordability staff offering the recent hospital workshop on July 7, 2026, covering spending target measurement, progressive enforcement, and Performance Improvement Plans (PIPs). On behalf of the University of California (UC) Health, I am writing to provide feedback on the information provided in the presentation and offer recommendations for OHCA's consideration. This letter supplements written comments submitted to OHCA on June 18, 2026.

UC Health and its six academic health centers and 21 health professional schools are part of California's public health care system and form the core of the state's health care safety net. UC Health's mission is to improve the health and well-being of all people living in California now and in the future by educating and training the inclusive workforce of tomorrow, delivering exceptional and equitable care, and discovering life-saving treatments and cures.

Spending Measurement

Retain volume and service intensity adjustments. UC Health appreciates OHCA's efforts to distinguish spending growth from changes in the number and complexity of patients served. These adjustments are essential to avoid disadvantaging hospitals that care for more patients, treat higher-acuity populations, or provide resource-intensive services. We encourage OHCA to retain these features in the final methodology.

Continue validating spending measurement methodology and use a multiyear view.

OHCA should continue testing its outpatient methodology, including the use of the Healthcare Payments Database, against hospital-reported data and should provide a meaningful opportunity for hospitals to identify material data or intensity issues. Because annual results can be highly volatile, performance should be assessed over multiple years or through an appropriate smoothing methodology before an entity advances through enforcement.

Enforcement Process

Provide clear and transparent enforcement criteria. Regulations implementing the enforcement process should clearly explain how OHCA will enforce across multiple payer and service-line measures, how hospitals will be selected for deeper stages of progressive enforcement, and how reasonable explanations for spending growth will be considered. When advancing an entity to deeper stages of progressive enforcement, OHCA should provide a data-based rationale so that similarly situated entities are treated consistently, and the process is grounded in the application of objective standards.

Evaluate overall hospital performance. OHCA should combine inpatient and outpatient results through a weighted measure rather than assessing the categories independently. Similarly, enforcement should consider commercial and all-payer performance together and should not be triggered solely by a single payer-service line. This approach would better reflect the full scope of hospital services and the effects of public program payment changes and changes in uncompensated care.

Account for public hospital Medi-Cal financing. California's public hospitals, including UC and county systems, finance the nonfederal share of a significant amount of Medi-Cal payments through intergovernmental transfers and certified public expenditures. Because reported revenue may include both federal funds and the hospitals' own contributions, gross figures can overstate the net reimbursement available to support care. OHCA should make appropriate methodological adjustments so public hospitals are assessed on a comparable basis to other providers.

Ensure performance improvement plans provide a meaningful opportunity to improve. PIPs should be forward-looking, begin with the first full measurement year after approval, and allow sufficient time for operational changes to take effect. OHCA should establish clear standards for PIP approval, evaluation, and successful completion while preserving an entity's ability to select strategies appropriate to its circumstances. Further, PIPs should be focused on actions and outcomes that are realistically achievable.

Penalties

Adopt a balanced initial penalty methodology. UC Health appreciates OHCA's proposed two-step process in which relevant circumstances are considered before a final penalty is

determined. However, defining the initial penalty as the full dollar difference between actual and allowable spending growth would result in the application of a purely mathematical formula that fails to provide a balanced and individualized assessment of the situation at hand and could overly bias the final assessed penalty. OHCA should consider measured alternatives, such as penalty ranges, graduated tiers, or reasonable maximum amounts. The initial calculation should be a starting point for individualized review, not a presumptive final result.

Apply adjustment factors transparently and consistently and minimize unintended consequences. Penalties should reflect the circumstances of each case, including federal and state mandates and policy changes, macroeconomic conditions, workforce and supply costs, and other factors outside an entity's reasonable control. OHCA should also recognize good-faith PIP implementation, measurable improvement, prior compliance, and investments in primary care, behavioral health, workforce development, and population health. Clear criteria will promote fairness while preserving appropriate discretion. Penalties should support compliance without undermining the services and investments OHCA's framework is intended to preserve.

Consider the public benefits provided by UC's academic health centers. UC's tripartite mission of education, research, and public service translates directly into substantial public benefits provided through our academic medical centers. In fiscal year 2024-25, UC's academic medical centers provided an estimated \$4.7 billion in uncompensated care and more than \$1 billion in support to UC Schools of Medicine to train California's physician workforce. OHCA should consider the extent to which penalties could impair these public benefits, including access to high-quality care regardless of ability to pay, workforce development, and biomedical research.

We appreciate the Board's consideration of UC Health's unique role as California's public academic health system. UC Health remains committed to working collaboratively with OHCA and other stakeholders to advance affordability while preserving accessible, equitable, high-quality care for all Californians.

Sincerely,



Tam M. Ma
Associate Vice President
Health Policy and Regulatory Affairs

Cc: Members of the Health Care Affordability Board
Kim Johnson
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis

Director Landsberg

July 31, 2026

Page 4

Donald B. Moulds, Ph. D.

Dr. Richard Pan

Dr. Micah Owen

David Chase

Vishaal Pegany, Deputy Director, Office of Health Care Affordability

K. Jones, Assistant Secretary, California Health and Human Services Agency

Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom



Via Email at ohca@hcai.ca.gov

July 31, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process)

Dear Director Landsberg:

As the Office of Health Care Affordability (OHCA) board continues its discussion of spending target enforcement, Kern Medical must share our deep concerns about the potential process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for the patients for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Kern Medical urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Kern Medical is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs grew over seven percent and our medical supply costs, including pharmaceuticals, grew eight percent. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: cut staff and services to avoid potential penalties or provide the care our patients need but risk fines that would wipe out what little financial cushion we have.

Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. Consider that for Kern Medical, our total expenses have increased an average of eight percent per year for the last three years. One year in isolation does not give an accurate picture of Kern Medical's spending trends.

Worse, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Kern Medical, that means greater investment in one

area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under OBBBA

Kern Medical is one of California's designated public safety net hospitals and is committed to helping patients afford the care they need. That's why we offer programs including financial assistance, free clinics for certain services, and free vaccination programs.

Kern Medical also understands that affordability in the long term can't happen without focused efforts now. That's why our organization continuously invests in community-based care, value-based contracts, quality programs, programs to address social determinants of health, and other ways you're working to drive down costs.

Penalties at the levels proposed by OHCA would threaten Kern Medical's viability, jeopardize our patients' health, and endanger the livelihoods of the 2,500 number of workers who rely on us plus the 250 physicians training at our hospital with the aim to keep many of them here to serve our vulnerable population. Had the 3.5 percent spending target been in place in 2023, Kern Medical would have faced a starting penalty amount across all its service lines. Such a fine would inevitably require re-evaluations of service and staffing levels, thereby threatening care in our communities. Kern Medical is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office.

The measurement and enforcement process that OHCA establishes will directly impact whether we can continue to be there for Kern County residents who pass through our doors each year. Kern Medical appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Scott Thygerson
Chief Executive Officer

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
Senator Shannon Grove, Senate District 12
Senator Melissa Hurtado, Senate District 16
Assemblymember Dr. Jasmeet Bains, Assembly District 35
Assemblymember Stan Ellis, Assembly District 32



LOMA LINDA UNIVERSITY
HEALTH

July 31, 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:

On behalf of Loma Linda University Health, I appreciate the opportunity to comment on the Office of Health Care Affordability's proposed enforcement framework for health care entities.

Loma Linda University Health (LLUH) is a leading academic health system serving the Inland Empire and surrounding communities. Our system includes six hospitals, including the region's only children's hospital, eight professional schools, more than 1,100 faculty physicians, and a comprehensive outpatient network. LLUH provides more than 1.5 million patient visits annually and serves as a major regional referral center, safety-net provider, and Level I trauma center for a region encompassing more than one-quarter of California's landmass.

While we share OHCA's goal of making health care more affordable for Californians, we are concerned that this policy fails to address the cost drivers of health care cost growth and does nothing to reduce the cost of care to patients. Furthermore, implementing a penalty structure that begins with the full amount by which an entity exceeds the target would be significantly punitive and will impede access to health care across California.

California's health care delivery system is already facing significant operational and financial pressures, including workforce shortages, inflation, rising pharmaceutical and supply costs, cybersecurity and emergency preparedness requirements, and chronic underpayment in government programs. Imposing financial penalties on hospitals and health systems for cost growth driven by factors beyond our control would divert critical resources away from patient care, workforce investments, access to services, and community benefit programs, without any assurance that patients would experience lower premiums, deductibles, or out-of-pocket costs.

Hospitals and health systems cannot absorb large, open-ended financial penalties without consequences. Every dollar paid in penalties is a dollar that cannot be invested in recruiting and retaining essential caregivers, including nurses, physicians, and behavioral health clinicians; maintaining emergency department capacity; expanding access to primary and specialty care services; advancing quality and patient safety initiatives; or sustaining essential but chronically underfunded services, such as obstetric and maternity care.

The risk is even greater for Loma Linda University Health and other hospitals serving a high proportion of Medi-Cal, Medicare, safety-net, and high-acuity populations. Approximately 76% of the patients we serve rely on Medicare or Medi-Cal coverage, making us particularly vulnerable to policies that further strain provider resources while reimbursement rates continue to lag behind the actual cost of providing care. We experience cost growth because we treat patients with greater clinical complexity, face rising costs for life-saving pharmaceuticals and medical supplies that are beyond our control, and are subject to state and federal regulatory requirements that increase operating expenses. A penalty framework that treats cost growth primarily as a failure of financial discipline rather than a reflection of patient needs and market realities will ultimately lead to reduced services, longer wait times, and diminished access to care in communities that already face significant barriers.

The proposed OHCA framework would impose penalties beginning at the full amount by which an entity exceeds the cost growth target and could increase those penalties further over time. This is not simply an accountability tool; at the levels proposed, these penalties would function as destabilizing sanctions. California faces some of the nation's most complex health care delivery challenges, including high labor costs, significant geographic variation, seismic and capital requirements, under-resourced rural and safety-net communities, and substantial reliance on Medi-Cal reimbursement. These realities make California's hospital system particularly vulnerable to punitive financial penalties.

We respectfully urge OHCA to reconsider the proposed penalty framework and adopt a more measured approach that protects patients and preserves access to care. California should not adopt one of the most punitive cost growth enforcement models in the country without clear evidence that it will make care more affordable for patients. Affordability is essential, but it cannot be achieved by destabilizing the providers and hospitals on which patients depend for their care.

If you need additional information, please do not hesitate to contact me or our legislative advocate, Nicette Short, at Nicette@nlshortpa.com or 916-549-2853.

Sincerely,



Shandra Secor
Vice President, Government Relations
Loma Linda University Health

A Seventh-day Adventist Organization
LOMA LINDA UNIVERSITY HEALTH
11234 Anderson Street, Loma Linda, California 92354
909-558-5371

Loma Linda University Health includes Loma Linda University's eight professional schools, Loma Linda University Medical Center's six hospitals — including The Dennis and Carol Troesh Medical Campus, which opened in August 2021, housing the new adult hospital and Children's Hospital expansion — and more than 1,100 faculty physicians located in the Inland Empire of Southern California. Established in 1905, Loma Linda University Health is a global leader in education, research and clinical care. It offers over 100 academic programs and provides quality health care to over 40,000 inpatients and 1.5 million outpatients each year. A Seventh-day Adventist organization, Loma Linda University Health is a faith-based health system with a mission "to continue the teaching and healing ministry of Jesus Christ."



July 31, 2026

Elizabeth Landsberg
Director, Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833
(Submitted via email to ohca@hcai.ca.gov)

SUBJECT: Sharp HealthCare Comments on Proposed Spending Target Enforcement and Penalty Framework

Dear Chair Johnson and Members of the Health Care Affordability Board:

Sharp HealthCare (“Sharp”) is a nonprofit, integrated health care delivery system based in San Diego, California, serving nearly one third of the 3.3 million residents of San Diego County across five acute care hospitals, five specialty hospitals, three affiliated medical groups, and a regional nonprofit health plan. Sharp is San Diego’s largest health care provider, its largest private employer with approximately 22,000 team members, and the region’s largest Medi-Cal provider. We proudly share the Office of Health Care Affordability’s (“OHCA”) goal of a more affordable, accessible, equitable, and high-quality health care system for all Californians.

We are grateful for the recent, productive engagement between Sharp and OHCA leaders and appreciated the opportunity for the dialogue directly. Sharp intends to submit additional follow-up materials for OHCA’s consideration, including further detail on the issues we discussed.

For the purposes of this comment period, however, we write to reiterate the concerns Sharp has raised previously and to urge OHCA to reject the currently proposed enforcement framework and penalty structure.

As stated in our previous comments, the enforcement process as proposed sets hospitals up to fail—relying on unclear measurement processes, built on data that has yet to be validated, and applying overly broad violation criteria—and then attaches disproportionate, punitive fines to that flawed foundation.

Consistent with our prior comments, we respectfully urge the Board to:

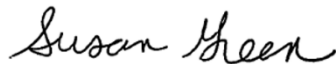
- Reject the proposed enforcement and penalty structure, under which penalties would begin at the full dollar amount by which a hospital exceeded its target—potentially exceeding \$100 million for a single hospital in a single year, and be adjusted at the Director’s discretion—fines of this magnitude would be devastating to hospitals’ ability to maintain essential services, forcing reductions or eliminations of critical care, and directly reducing access to care for the vulnerable patients and communities who depend on it most;

- Validate its measurement methodology and correct the flawed violation criteria before any enforcement determinations are made, so that normal, year-over-year volatility across individual payer and service-line categories is not mistaken for a genuine failure to meet the target;
- Address its statutory obligation to promote alternative payment models (APMs) when measuring hospital spend by incorporating APM consideration within the regulatory framework, in alignment with OHCA's statutory requirement to promote "the shift from payments based on fee-for-service to alternative payment models" (Health & Safety Code § 127504); without APM consideration within the enforcement framework, OHCA will penalize hospitals like Sharp that have most successfully advanced the very models OHCA is charged with advancing;
- Recognize the realities hospitals face—including unprecedented federal and state funding cuts, rising expenses outside the hospital's control, and the essential safety-net services that penalties of this magnitude would jeopardize; and
- Decline to finalize enforcement on an accelerated timeline, and instead release the complete, integrated enforcement framework for full public comment before any vote on penalties.

Sharp remains committed to working with OHCA to achieve a shared goal of a more affordable, accessible, and equitable health care system. But these goals must be grounded in a framework that is fair, transparent, validated, and workable—one that gives hospitals a genuine opportunity to succeed rather than setting them up to fail.

We appreciate OHCA's continued engagement, look forward to providing our supplemental materials, and welcome the opportunity to continue this dialogue.

Respectfully submitted,



Susan Green
Executive Vice President & Chief Financial Officer
Sharp HealthCare
Susan.Green@sharp.com

cc: Kim Johnson, Chair, Health Care Affordability Board
Megan Brubaker, OHCA Board Liaison

Attached:

- Sharp HealthCare OHCA Comment Letter, June 18, 2026
- Susan Green public comments at Health Care Advisory Board Meeting, June 24, 2026
- Sharp HealthCare NOLA Regs Comment Letter, July 13, 2026
-



June 18, 2026

Kim Johnson
Chair, Health Care Affordability Board
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833
(Submitted via Email to ohca@hcai.ca.gov)

SUBJECT: Sharp HealthCare Opposition to OHCA's Proposed Penalty Framework for Spending Targets

Dear Chair Johnson and Members of the Health Care Affordability Board:

Sharp HealthCare (“Sharp”) is a nonprofit, integrated health care delivery system based in San Diego, California, serving nearly one million of the 3.3 million San Diego County residents across four acute care hospitals, three specialty hospitals, three affiliated medical groups, and a regional health plan. On July 1, 2026, Sharp will take over operations of Tri-City Medical Center (“TCMC”) under a long-term lease agreement approved by the voters of the Tri-City Health Care District on June 2, 2026.

As San Diego's largest health care provider, and the region's largest Medi-Cal provider, Sharp shares the Office of Health Care Affordability's (“OHCA”) goal of creating a more affordable, accessible, equitable, and high-quality health care system for all Californians. We appreciate the opportunity to submit comments on OHCA's proposed enforcement mechanisms and financial penalties for entities that exceed the spending growth targets.

Sharp is aligned with the comments submitted by the California Hospital Association (“CHA”) regarding the methodological approach for assessing hospitals performance against targets, adjustment factors for such assessments and opposition to the proposed penalties, as outlined in the “CHA Comments for the May 2026 OCHA Board Meeting” submitted to OHCA on May 21, 2026.

Sharp respectfully opposes the penalty framework currently under consideration by OHCA. While we support the principle of health care cost accountability, the proposed enforcement framework and penalties are disproportionate, premature, and risk inflicting serious harm on patient access, workforce stability, and the financial viability of hospitals across California — including safety-net and community providers that serve our most vulnerable populations.

I. Proposed Penalties are Disproportionate and Unprecedented

OHCA has recommended a financial penalty framework that would calculate penalties based on the full dollar difference between a hospital's actual spending growth and the allowed growth under the spending target, with upward adjustments for repeated noncompliance. These proposed penalties are wildly out of step with what other states have implemented. Massachusetts — the state most frequently cited as the model for California's approach — does not impose financial penalties on providers for exceeding health care cost growth benchmarks. Instead, Massachusetts relies on a collaborative Performance Improvement Plan PIP

process that gives providers a meaningful opportunity to reduce spending over time. California should follow this precedent and modify its enforcement structure to emphasize collaboration and establish reasonable penalties to avoid destabilizing the very health care system OHCA is charged with protecting.

II. Spending Targets are Based on Outdated Economic Data and Unrealistically Low

The statewide spending growth target of 3.5% for 2025–2026 was derived from the average growth rate of California median household income over a 20-year period ending in 2022. However, since the target was set, two additional years of data have become available revealing that actual median household income growth has been approximately 8.6% — nearly three times the rate OHCA assumed when setting the spending targets. The Governor's proposed 2026–27 budget projects average wages and personal income to grow by 4.3% and 4.6%, between 2025 and 2029, respectively.

With California inflation again exceeding 5%, OHCA's spending targets are 30%–70% below current price-level growth for all goods and services. Setting enforcement penalties against targets that are fundamentally disconnected from economic reality is neither fair nor sound policy.

III. Federal and State Funding Cuts Make Compliance Unattainable

OHCA's enforceable spending targets will take effect at precisely the moment hospitals are facing unprecedented reductions in both federal and state funding. The One Big Beautiful Bill Act (“H.R. 1”), signed into law on July 4, 2025, enacted nearly \$1 trillion in cuts to Medicaid — the largest funding reduction in the program's 60-year history. In California, H.R. 1 is expected to cut approximately \$30 billion per year in federal funding from Medi-Cal and could cause up to 3.4 million Californians to lose their health care coverage. The Governor's May budget revision proposes additional billions in Medi-Cal reductions affecting both eligibility and provider payments. Together, these coverage losses are expected to increase uncompensated care costs for California hospitals by approximately 40%.

The impact of H.R. 1 on Sharp is both direct and severe. Sharp is the largest Medi-Cal provider in San Diego County, caring for approximately 35% of the region's total Medi-Cal population, more than any other provider in the market. Medi-Cal reimburses less than 70% of the cost of care, and in fiscal year 2025, Sharp's uncompensated medical care services — including the unreimbursed costs of Medi-Cal, Medicare, and charity care — totaled more than \$742 million.

H.R. 1's restrictions on provider tax rates and its cap on state-directed payments at Medicare levels will further erode the supplemental funding mechanisms California has relied upon to sustain hospital reimbursement. New work requirements and more frequent eligibility redeterminations are projected to cause up to 1.4 million Californians to lose Medi-Cal coverage by mid-2028, driving a surge in uninsured patients who will continue to present at our hospitals for care — care that Sharp is obligated and committed to provide, but for which it will receive no reimbursement.

Imposing additional penalties on top of these devastating funding cuts would push many hospitals — particularly those serving underserved communities — to cut or eliminate services, and in some cases, toward financial insolvency. OHCA must ensure its enforcement actions do not compound the destabilizing effects of federal and state fiscal policies.

IV. Penalties Will Harm Patient Access, Quality, and Equity

Penalties at the levels proposed by OHCA undermine hospitals' viability, jeopardize patients' health, and endanger the livelihoods of health care workers and will result in the reduction of critical services like behavioral health, preventative care, and access to pre-natal services for the vulnerable patients Sharp serves across the San Diego region.

Based on OHCA's Hospital Measurement Combined Dataset for 2022–2023, the total commercial penalty amount for Sharp's hospitals alone would exceed \$59 million if penalties were assessed as currently proposed. A penalty of that magnitude would be deeply destabilizing for a system like Sharp — where every dollar of margin is reinvested into patient care, workforce, and community benefit. For smaller and rural hospitals operating on even thinner margins, proportionally similar penalties would be even more devastating, leading to service reductions, layoffs, and facility closures across the state.

Patients would be forced to travel farther for care, face longer wait times, experience more overcrowding in emergency departments, and lose access to critical services including maternity care, cancer treatment, mental health services, and surgical care. These consequences fall disproportionately on the most vulnerable Californians — low-income families, communities of color, rural residents, and those who depend on safety-net hospitals, like Sharp Chula Vista Medical Center (“SCVMC”) and Sharp Grossmont Hospital (“SGH”).

Sharp serves as a critical safety-net provider for San Diego County’s most vulnerable populations. SCVMC operates the only labor and delivery unit in San Diego County’s South Bay, as other hospitals have closed their units over the past several years. SCVMC is also one of only two hospitals that receives ambulance transports for patient emergencies at the international border with Mexico. SCVMC routinely provides emergency and inpatient care to undocumented and uninsured individuals — a patient population that will only grow as federal and state policy changes restrict Medi-Cal eligibility and freeze new enrollment for state-only funded beneficiaries. Imposing financial penalties on a safety-net system already absorbing the costs of caring for these patients is fundamentally incompatible with California’s stated commitment to health care coverage and access.

SGH in La Mesa, California, operates one of the busiest emergency departments in California and the US ([77 hospitals with the most ED visits in 2025 - Becker's Hospital Review | Healthcare News & Analysis](#)). SGH serves as a safety net for patients in both East County San Diego and Imperial County, as the nearest hospital to the east - El Centro Regional Medical Center – is more than 100 miles away.

Sharp’s role in serving Medi-Cal and underserved patients underscores the stakes. Sharp serves more Medi-Cal patients than any other provider in San Diego County, and in FY 2025, Sharp’s total uncompensated care exceeded \$742 million. Penalizing a system that absorbs this level of uncompensated care will not lower costs — it will erode the capacity to deliver it.

OHCA's proposed fines will not lower the cost of care; they will reduce hospitals' ability to sustain vital services, resulting in reduced access to care and longer wait times — particularly in communities with the fewest alternatives.

V. State Law Requires Transparent Processes and Meaningful Remediation Before Penalties

The California Health Care Quality and Affordability Act (Health & Safety Code § 127500 et seq.) established a progressive enforcement framework that requires meaningful opportunities for remediation before financial penalties may be imposed. This includes notification, clear criteria, and waiver processes to justify excess spending, technical assistance from OHCA, and the development of performance improvement plans. OHCA must honor the legislative intent by ensuring the PIP process is collaborative, forward-looking, and hospital-driven — not a procedural formality on the path to punitive fines. The enforcement process must give hospitals a genuine opportunity to succeed, not set them up to fail.

Specifically, for remediation and enforcement, Sharp urges the Board to:

- Ensure that PIPs are developed collaboratively with hospital input and reflect the unique circumstances of each institution, including its payer mix, patient population, and community role.
- Provide hospitals with adequate time — a minimum of three years — to implement PIPs before any penalty assessment.
- Set clear, transparent criteria for what constitutes justifiable reasons for exceeding spending targets — including investments in response to changes in federal or state law — and establish a formal waiver process for hospitals to justify spending growth above the target.
- Recognize that providers' efforts to secure adequate reimbursement in the face of unprecedented public program cuts are appropriate and justifiable reasons for exceeding spending targets.

VI. OHCA Disproportionately Targets Hospitals While Ignoring Other Cost Drivers

Hospitals are one part of the health care system, yet OHCA's enforcement framework places disproportionate emphasis on them. Major drivers of spending growth also include rising drug costs, increasing insurance premiums, administrative burden, and health plan practices. An effective and equitable enforcement approach should hold all parts of the health care system accountable, including health plans, pharmacy benefit managers, and pharmaceutical manufacturers, rather than focusing primarily on hospitals, which are central to care delivery in California communities.

VII. The Penalty Framework Was Developed Without First Establishing Foundational Methodology for Evaluation

Despite the first enforceable spending target going into effect in January 2026, OHCA has not yet finalized or published draft regulations governing the enforcement process. We are more than halfway through the first enforcement year and OHCA has failed to provide clarity on how hospitals will be measured against the spending targets, what methodologies will be used, and what factors OHCA will consider for justifiable expenses above target.

For example, the California Health Care Quality and Affordability Act (Health & Safety Code § 127500 et seq.) requires that OHCA promote the "shift from payments based on fee-for-service to alternative payment models that provide financial incentive for equitable high-quality and cost-efficient care." While OHCA has established alternative payment methodology ("APM") goals and benchmarks for health plans, OHCA has not addressed how hospital utilization of APMs will be factored into spend target methodology or the enforcement and penalty framework.

Sharp's primary focus is on each patient's health and outcomes. Population health is the core framework for how we approach patient care and reimbursement. Sharp adopted the capitated reimbursement model more than 30 years ago, building upon that foundation to drive positive patient outcomes and high-quality care at low costs. Capitation accounts for approximately 26% of Sharp hospital revenues and is a critical component of successful population health management in alignment with the alternative payment models outlined in statute.

Hospitals operating under capitated, risk-based, or other alternative payment arrangements – like Sharp – are fundamentally different from providers paid solely through fee-for-service because they assume financial accountability for managing the total cost and quality of care across a population. In that context, spending levels and year-over-year growth can reflect care redesign, upstream investment, risk transfer, and shifts in where services are delivered, rather than inefficiency or excessive pricing.

If OHCA fails to account for hospital APM utilization, it risks penalizing hospitals that are already advancing the statutory goal of moving California toward more equitable, high-quality, and cost-efficient care. At a minimum, OHCA should explain how a hospital's APM participation will be measured, how APM-related revenue and expenditures will be treated in spending assessments, and how APM adoption will be weighed in measuring the hospital against spending target.

Additionally, OHCA has not established a standardized and transparent process for hospitals to explain justifiable spending growth above the target, despite the California Health Care Quality and Affordability Act's requirement for clear criteria and processes regarding justifiable growth and risk adjustment methodologies. Instead, hospitals are left without defined standards, timelines, documentation requirements, or a formal pathway for demonstrating when higher spending reflects legitimate circumstances such as changes in federal or state law, shifts in payer mix, new service obligations, workforce pressures, or necessary investments to preserve access and quality.

That omission is not a procedural technicality; it is central to whether the enforcement framework is fair, workable, and consistent with legislative intent. Hospitals operate in an environment shaped by factors often outside their control, including new mandates that increase costs, public program underpayment, coverage losses, labor shortages, inflationary pressures, and changing patient acuity and service needs. Even where hospitals make good-faith efforts to remain below the spending target, those external forces can materially drive spending growth. OHCA should therefore establish a clear and transparent process for identifying those justifiable cost drivers and deduct the costs associated with them from any penalty calculation. A consistent and transparent justification process is critical to due process, fair enforcement, and protecting patient access to care.

This lack of transparency undermines the credibility of the enforcement program and deprives hospitals of the information they need to make good-faith efforts to comply. Sharp echoes CHA's comments and recommendations regarding methodology and adjustment factors for assessing hospitals against spending targets ("CHA Comments for the May 2026 OCHA Board Meeting" submitted to OHCA on May 21, 2026).

VIII. Recommendations

Sharp urges the Health Care Affordability Board to reject the proposed penalty framework in its current form and instead adopt an enforcement approach that is fair, transparent, and grounded in the realities facing California's hospitals. Specifically, we recommend the Board:

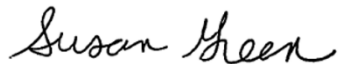
1. Withdraw the proposed penalty methodology and replace it with a remediation-first framework that prioritizes technical assistance and performance improvement plans over punitive fines.
2. Recalculate the statewide spending growth target using current economic conditions, including updated median household income data, inflation, wage growth, and labor cost trends.
3. Incorporate federal and state Medi-Cal funding shortfalls, reductions, coverage losses, and resulting uncompensated care into any assessment of hospital performance and suspend penalties where those factors materially affect hospital compliance.
4. Adopt an explicit access protection standard that bars any penalty or remediation measure that would reduce essential services, weaken workforce capacity, or worsen health equity.
5. Implement the full progressive enforcement process required by statute by providing meaningful technical assistance, collaborative performance improvement plans, and at least three years for remediation before any penalty is considered.

6. Apply affordability enforcement across all major drivers of health care spending, including health plans, pharmaceutical manufacturers, and pharmacy benefit managers, rather than concentrating penalties on hospitals.
7. Publish draft enforcement regulations for a full public comment period with clear, actionable justifiable costs above the target.

The measurement and enforcement framework OHCA adopts will directly affect Sharp's ability to maintain access to care, sustain essential services, and serve the nearly one million San Diego County residents who receive their care with Sharp each year.

Sharp remains committed to working with OHCA to achieve the shared goal of a more affordable, accessible, and equitable health care system. However, we cannot support an enforcement framework that threatens the very access and quality of care that Californians depend on. We look forward to working with OHCA on these rules and collaborating on a more affordable and accessible health care system for Californians.

Respectfully submitted,



Susan Green
Executive Vice President & Chief Financial Officer
Sharp HealthCare
Susan.Green@sharp.com

cc: Elizabeth Landsberg, Director, OHCA
Megan Brubaker, OHCA Board Liaison
Chris Howard, CEO, Sharp HealthCare

Chair Johnson, Director Landsberg, Members of the Board — thank you.

I'm Susan Green, Chief Financial Officer of Sharp HealthCare, San Diego's largest health care provider and the County's largest Medi-Cal provider.

Let me be direct: **the penalty framework before you will not make care more affordable. It will make care less available.**

I don't say that from theory — I say it from experience.

Before joining Sharp in 2024, I spent over a decade in Massachusetts finance leadership, including at Tufts Medicine, from the day the Health Policy Commission was created in 2012. I lived every year of the cost growth benchmark — the model OHCA cites.

So hear this clearly: **what California is proposing is not the Massachusetts model. It is something far more punitive.**

- In Massachusetts, the **maximum penalty is \$500,000** — and only for failing to implement a Performance Improvement Plan, not for exceeding the benchmark.
- In **14 years, Massachusetts has never imposed that penalty on a single hospital.**
- OHCA's proposal would calculate penalties on the **full dollar difference** between actual and allowed growth — uncapped, and escalating. For Sharp alone, that's **over \$59 million.**

That is not a stricter version of Massachusetts. It is a **fundamentally different regime** — and Massachusetts itself is proof that **even the restrained version leaves health systems in crisis:**

- FY2024 median operating margin for Massachusetts acute care hospitals: **negative 2%.** Only 39% finished in the black.
- Tufts Medicine — where I served — lost **\$171 million in one year**, on top of \$399 million the year before, with multiple rounds of layoffs.
- Steward Health Care **declared bankruptcy in 2024** — two hospitals closed permanently.
- In 2025, the Legislature rushed through a **\$234 million emergency bailout of hospitals**, on top of \$417 million the year before.

California now proposes to leapfrog that penalty structure by orders of magnitude — at the exact moment hospitals face **nearly \$1 trillion in federal Medicaid cuts under H.R. 1**, billions more in Medi-Cal reductions, and up to **3.4 million Californians losing coverage**.

Meanwhile, Sharp absorbed **\$742 million in uncompensated care last year**, operates the only labor and delivery unit in San Diego's South Bay, receives patient transports directly from the U.S.–Mexico border, and serves **35% of the County's Medi-Cal population**.

A \$59 million penalty doesn't lower costs — it erodes the capacity to deliver care.

My ask is straightforward: **align California's penalty structure with the proportionality and remediation-first approach that has defined Massachusetts** — collaboration, performance improvement plans with time to succeed, and penalties that are bounded, predictable, and reserved for failure to engage. Not fines calculated on the full spending differential that will close units, eliminate services, and push safety-net hospitals toward insolvency.

I have seen what financial destabilization does to hospitals — and it is the most vulnerable communities who bear the heaviest burden.

Sharp is committed to working with OHCA to achieve real affordability. **But affordability means nothing if there is no hospital left to provide the care.**

Thank you.



July 13, 2026

Kim Johnson
Chair, Health Care Affordability Board
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833
(Submitted via Email to ohca@hcai.ca.gov)

SUBJECT: Sharp HealthCare Comments Re: Proposed Nonsupervisory Organized Labor Adjustment (NOLA) Emergency Regulations

Dear Chair Johnson and Members of the Health Care Affordability Board:

Sharp HealthCare (“Sharp”) is a nonprofit, integrated health care delivery system based in San Diego, California, serving nearly one million of the 3.3 million San Diego County residents across five acute care hospitals, five specialty hospitals, three affiliated medical groups, and a regional non-profit health plan. Sharp employs approximately 21,500 team members and is party to multiple collective bargaining agreements across several bargaining units.

As San Diego’s largest health care provider and largest Medi-Cal provider, Sharp proudly shares the Office of Health Care Affordability’s (“OHCA”) goal of a more affordable, accessible, equitable, and high-quality health care system for all Californians. We appreciate the opportunity to submit informal comments on the proposed Nonsupervisory Organized Labor Adjustment (“NOLA”) emergency regulations issued on June 23, 2026.

Sharp fully supports the principle of health care cost accountability. However, as drafted, the NOLA regulations are structurally incompatible with how hospitals actually incur labor costs, are inconsistent with OHCA’s statutory duty to protect workforce stability for all healthcare workers, and — when layered onto OHCA’s proposed penalty framework — would produce arbitrary, punitive, and economically distortive outcomes. If not substantially revised, the NOLA process will fail as a meaningful adjustment mechanism and will actively harm the very workers and patients OHCA is charged with protecting.

I. The 15-Month Advance Submission Deadline Is Arbitrary, Speculative, and Disconnected from How Hospitals Incur Labor Costs

The proposed regulations require hospitals to file NOLA petitions fifteen (15) months in advance of a program year. This timeline is fundamentally incompatible with the operational, contractual, and economic realities of running a California health system.

Collective bargaining agreements (“CBAs”) are negotiated on staggered cycles and are varied in length. Sharp — like most California health systems — is party to multiple CBAs with different unions (including, UNAC/SPNN, CNA, and SEIU-UHW), each with independent expiration dates that do not align with a single 15-month look-ahead window. It is impossible to reliably project wage impacts for a program year when the CBA itself may not yet be open, in negotiation, or ratified.

Additionally, the 15-month window fails to account for the many non-labor cost pressures hospitals absorb outside their control — pharmaceuticals, medical supplies, utilities, and technology costs — that OHCA’s penalty framework does not otherwise adjust for. By limiting the adjustment to one narrow slice of cost growth, OHCA creates an internally inconsistent enforcement regime that treats one category of cost pressure as adjustable while ignoring all others.

Critically, the regulations provide no mechanism for retrospective true-up, mid-year amendment, or emergency adjustment. This is inconsistent with peer-state models and with the statute’s own recognition of “labor costs” as an adjustment factor (Health & Safety Code § 127502(d)).

Recommendation: OHCA should (a) permit petitions to be filed up to and including the program year, (b) authorize retrospective true-up petitions after CBAs are ratified, and (c) permit multi-year rolling adjustments that reflect the actual cadence of hospital labor bargaining.

II. Limiting the Adjustment to Organized Labor Alone Discriminates Against Non-Represented Healthcare Workers and Violates OHCA’s Statutory Duty to Protect All Workforce Stability

Health & Safety Code § 127502 requires OHCA to promote affordability while “maintain[ing] quality, equity, and workforce stability.” The statute lists “labor costs” — not “organized labor costs” — as an adjustment factor. By narrowing the NOLA adjustment to nonsupervisory organized labor alone, OHCA is legislating a policy choice the statute does not authorize and that arbitrarily divides the healthcare workforce.

According to U.S. Bureau of Labor Statistics data cited by the California Hospital Association, 56% of hospital spending goes to labor, and clinical and administrative supervisory payroll accounts for less than 7% of hospital payroll. The vast majority of Sharp’s approximately 21,500 employees are nonsupervisory — but a substantial share are not covered by a collective bargaining agreement. Under the proposed regulations, wage increases for these non-represented nonsupervisory employees — technicians, respiratory therapists, patient-care assistants, environmental services staff, food services, and countless others — receive no adjustment consideration whatsoever.

This creates three predictable and harmful outcomes:

1. **Wage compression and pay inequity.** When union-negotiated wage increases are shielded from penalty exposure, but corresponding non-represented wage adjustments are not, hospitals will face powerful financial incentives to suppress wages for non-represented workers. This directly contradicts California’s stated commitment to healthcare workforce equity.
2. **Distortion of collective bargaining.** The regulation creates an asymmetric incentive for unionization that intrudes on federally regulated labor relations and inserts state affordability policy into private-sector bargaining dynamics — a role the Legislature did not assign to OHCA.
3. **Undermining SB 525.** California’s healthcare minimum wage law (SB 525) mandates a phased minimum wage schedule that increases wages for many non-represented workers on a fixed statutory timeline. Excluding those legislatively mandated increases from any adjustment mechanism penalizes hospitals for complying with state law.

Recommendation: OHCA must expand the adjustment framework to cover all healthcare workforce cost increases — including (i) non-represented nonsupervisory wage adjustments made in response to, or in parallel with, organized labor negotiations, (ii) increases mandated by SB 525 and other statutory wage floors, and (iii) increases driven by California’s minimum nurse-to-patient staffing ratios and other state-mandated staffing requirements.

III. The NOLA Process Fails to Account for Mid-Cycle, Emergency, and Successor-CBA Wage Increases

The 15-month advance filing window cannot accommodate the way CBAs are actually negotiated and executed. Ratification dates slip. Successor CBAs are often executed months — or years — after the prior contract expires and include retroactive wage adjustments. Mid-cycle reopeners, market wage adjustments, and premium pay for surge staffing during public health emergencies (as California hospitals experienced during COVID-19 and subsequent respiratory surges) are common and unavoidable.

Without a mid-cycle amendment or retrospective true-up pathway, hospitals will be exposed to substantial and unwarranted penalties for wage increases they had no reasonable ability to forecast at the time of filing and no reasonable way to avoid. Under OHCA’s proposed penalty framework — which calculates initial penalties equal to the full dollar variance from the spending target — a single unforeseen CBA ratification could generate penalties in the tens of millions of dollars for Sharp alone, even where the underlying wage increases were legally required, market-driven, or necessary to prevent a strike.

The predictable behavioral response by health systems will be artificial wage growth suppression across the entire workforce, undermining recruitment and retention at precisely the moment California is confronting a documented healthcare workforce shortage, an aging population, and unprecedented federal Medicaid reductions under H.R. 1.

Recommendation: OHCA should permit (a) mid-program-year NOLA amendments upon CBA ratification or reopener execution, (b) retrospective NOLA true-up petitions filed in conjunction with CBA related wage increases, and (c) an emergency adjustment pathway for surge staffing costs incurred during declared public health emergencies.

IV. The Petition Process Must Recognize Legislatively Mandated Labor Cost Drivers Beyond Collective Bargaining

California hospitals operate under an unusually dense set of state-mandated labor cost drivers, including (i) SB 525’s healthcare minimum wage schedule, (ii) mandatory nurse-to-patient staffing ratios under Title 22, (iii) meal and rest break requirements enforced by the Division of Labor Standards Enforcement, and (iv) workforce training and safety mandates. None of these cost drivers are the product of collective bargaining, yet all materially increase hospital labor spending in ways OHCA has no other mechanism to adjust for.

The current NOLA proposal implicitly treats state-mandated wage increases as “controllable” — they are not. Penalizing hospitals for costs the Legislature itself imposed is neither fair nor consistent with the statutory scheme.

Recommendation: The NOLA — or a companion adjustment mechanism — must expressly include state-mandated wage and staffing cost increases as eligible adjustment factors, regardless of whether those costs flow through a collective bargaining agreement.

V. The NOLA Framework Should Not Be Finalized in Isolation from OHCA’s Broader Enforcement, Waiver, and Methodology Regulations

OHCA has not yet published draft regulations for spending-target measurement methodology, the waiver process for justifiable spending growth, or the progressive enforcement framework. Finalizing NOLA in isolation — before the underlying measurement and enforcement rules are in place — deprives hospitals of the ability to assess how NOLA interacts with those regimes and forecloses meaningful public comment on the framework as a whole.

Sharp echoes and incorporates by reference our prior comment letters as well as the California Hospital Association’s April and June 2026 comment letters urging OHCA to (a) develop multi-year, all-payer measurement methodologies before finalizing enforcement, (b) establish a formal, transparent waiver process for justifiable spending growth, and (c) ensure penalty amounts are proportionate, predictable, and capped to prevent hospital insolvency.

Recommendation: OHCA should defer final action on NOLA until the measurement methodology, waiver process, and penalty framework have been released, publicly commented on, and finalized as an integrated regulatory package.

VI. Sharp’s Specific Concerns and the Real-World Consequences of an Inadequate NOLA Framework

Sharp is San Diego County’s largest employer of healthcare workers and largest Medi-Cal provider. In FY 2025, Sharp’s uncompensated care exceeded \$742 million, and Sharp reinvests every dollar of margin into patient care, workforce, and community benefit. Under OHCA’s proposed penalty framework, Sharp faces potential single-year commercial penalties exceeding \$59 million based on the 2022–2023 Hospital Measurement Combined Dataset.

Following a June 2026 vote of the public, Sharp assumed operational control of the Sharp Tri-City Medical Center on July 1, 2026, under a long-term administrative lease agreement. As a result, Sharp has inherited additional collective bargaining relationships, new operational cost structures, and integration-related labor costs that the current NOLA framework has no mechanism to address.

Sharp Chula Vista Medical Center — one of only two hospitals receiving ambulance transports from the U.S.–Mexico border and operator of the only labor and delivery unit in the South Bay — and Sharp Grossmont Hospital — one of the busiest emergency departments in California and the United States — are exactly the kinds of safety-net facilities that OHCA’s own statute directs the Board to protect. A NOLA process that excludes the majority of the workforce and cannot accommodate real-world CBA timing will directly compromise Sharp’s ability to sustain these essential services.

VII. Summary of Recommendations

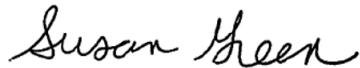
- Extend and restructure the NOLA filing window to permit petitions filed within the program year, retrospective true-ups after CBA ratification, and multi-year rolling adjustments.
- Expand the definition of eligible labor costs to include non-represented nonsupervisory wage increases made in parallel with organized labor negotiations, and increases driven by SB 525, minimum staffing ratios, and other state-mandated labor obligations.
- Add a mid-cycle amendment and emergency adjustment pathway for successor CBAs, reopeners, and surge staffing during declared public health emergencies.

- Defer final action on the NOLA regulations until they can be reviewed alongside OHCA's measurement methodology, waiver process, and progressive enforcement framework.
- Adopt an explicit workforce-stability protection standard, consistent with Health & Safety Code § 127502, that bars any NOLA denial or enforcement action that would compromise recruitment, retention, or wage equity across the healthcare workforce.

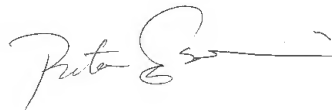
The measurement and enforcement framework OHCA adopts — including the NOLA procedures — will directly affect Sharp's ability to maintain access to care, sustain essential services, and serve the nearly one million San Diego County residents who receive their care with Sharp each year. As currently drafted, the NOLA regulations would penalize hospitals for wage increases they cannot forecast, would drive wage compression and inequity across the non-represented workforce, would ignore legislatively mandated labor costs, and would insert OHCA into private-sector collective bargaining in ways the statute does not authorize. Sharp respectfully urges the Board to substantially revise the NOLA framework consistent with the recommendations above.

Sharp remains committed to working with OHCA to achieve a shared goal of a more affordable, accessible, and equitable health care system, and we look forward to continued engagement on these regulations and the broader enforcement framework.

Respectfully,



Susan Green
EVP & Chief Financial Officer
Sharp HealthCare
Susan.Green@sharp.com



Rita Essaian
EVP & Chief People Officer
Sharp HealthCare
Rita.Essaian@sharp.com

cc: Elizabeth Landsberg, Director, OHCA
Megan Brubaker, OHCA Board Liaison
Chris Howard, CEO, Sharp HealthCare



July 31, 2026

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

Subject: OHCA Must Establish a Thoughtful, Reasonable Enforcement Process

(Submitted via email at ohca@hcai.ca.gov)

Dear Director Landsberg:

As the Office of Health Care Affordability board continues its discussion of spending target enforcement, Washington Health must share our deep concerns about the potential process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be simply disastrous for the patients for whom we provide care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Washington Health urges the OHCA board to promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target** and clarifying how payer and service mix will be considered
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

Washington Health (WH) is currently experiencing cost growth far in excess of OHCA's proposed spending target. Last year, our labor costs grew by 10.3%, our medical supply costs grew 8.4%, and our drug costs grew by 7.7%. Facing such uncontrollable cost growth at the same time as OHCA is putting a cap on the resources we will have to pay our bills is forcing challenging decisions: cut staff and services now to avoid potential penalties, or continue providing the care our patients need and risk fines that could result in a reduction of services and staff in the future.

Furthermore, OHCA's hospital spending methodology produces wild results that do not correspond with Washington Health's own experience. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be misleading as many hospitals experience

year-over-year spending volatility. For WH, our total operating expenses increased 21.8% in FY23, decreased 5.1% in FY24 and then increased 10.8% in FY25. Looking at one year in isolation does not give an accurate picture of Washington Health's spending trend.

Washington Health is committed to helping patients afford the care they need. That's why we offer care without charge to all patients who meet criteria spelled out in our Charity Care Policy. In FY25, WH recorded \$3 million in foregone charges related to charity care. In FY25, the provision for medical debt forgiveness was \$45.2 million. In addition to the charity care WH provides, the estimated cost of care for medically indigent patients that was not covered by Medi-Cal and Medi-Cal managed care programs was estimated at \$88 million in FY25. And the cost of uncompensated care provided to Medicare and Medicare managed care patients exceeded \$175.8 million for the same year.

Washington Health understands that affordability in the long term can't happen without focused efforts now. That's why we're committed to Value-based care (VBC) that reduces costs for patients by shifting the focus from the quantity of services to the quality and outcomes of care.

For over a decade, WH has promoted consumer value and long-term affordability by participating in multiple VBC programs:

- Since 2016, Washington Health has been a top performing hospital in California's DHCS's PRIME (Public Hospital Redesign and Incentives in Medi-Cal) & QIP (Quality Incentive Pool) programs. These programs serve California's most vulnerable consumers, reduce disparities, improve health outcomes, and reduce unnecessary costs for consumers and taxpayers.
- In 2023, Washington Health and Alameda County Behavioral Health Services launched the first ever hospital-based IHOT (In-Home Outreach Team) to serve consumers that access the ED for substance use and mental health. Appropriately managing behavioral health care lowers hospital admissions and emergency room use—two major cost drivers for consumers and taxpayers.
- Washington Health participates in multiple other VBC's, including:
 - CMS's TEAMS model, which holds hospitals accountable for coordinating care and managing costs for surgical care.
 - Multiple local and payor VBC programs, including programs with Alameda Alliance for Health, United Health Care, Hill Physicians, and Blue Cross of CA.
 - Washington Health is also leading the formation of a Clinically Integrated Network (CIN) in our community. CIN's coordinate care across primary care, specialists, and post-acute providers, can reduce duplicative services, avoid avoidable hospital visits, and prevent costly complications.

Penalties at the levels proposed by OHCA would threaten Washington Health's viability, jeopardize our patients' health, and endanger the livelihoods of the 2,231 workers we employ. Had the spending target been in place in 2023, Washington Health would have faced a starting penalty amount of \$7.6 million on its commercial line and \$26.5 million across all payer lines. Fines of these magnitudes would inevitably pose a huge threat to independent community health systems such as Washington Health and produce consequences that are fundamentally inconsistent with OHCA's mission to

improve affordability and access. Every dollar diverted to excessive penalties is a dollar that cannot be invested in patient care, physician recruitment, workforce development, advanced technology, trauma services, behavioral health, and other critical community programs.

Faced with financial sanctions of this scale, Washington would have little choice but to reduce investments in essential services, placing local access to care at risk and requiring many of our residents to travel outside their community for treatment. More broadly, these penalties could accelerate the consolidation of healthcare into larger systems by undermining the financial sustainability of independent providers. Ironically, the result would be fewer local healthcare options, reduced access to local affordable, high-quality care, and increased costs and travel burdens for the very patients OHCA is seeking to protect.

Washington Health is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best, and we are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the 343,000 Southern Alameda County residents whom we serve. Washington Health appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible health care system for all Californians.

Sincerely,



Kimberly Hartz
CEO, Washington Health

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
Senator Dr. Aisha Wahab
Assemblymember Alex Lee
Assemblymember Liz Ortega



July 31, 2026

Vishaal Pegany
Deputy Director, Office of Health Care Affordability
Department of Health Care Access and Information
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833

Sent via email:
OHCA@hcai.ca.gov

Subject: Comments on Proposed Spending Target Progressive Enforcement Regulations and Performance Improvement Plan (PIP) Guidance

Dear Mr. Pegany,

Kaiser Permanente (KP) appreciates the opportunity to comment on the Office of Health Care Affordability's (OHCA) proposed spending target progressive enforcement proposals and related Performance Improvement Plan (PIP) guidance.

We support OHCA's goal of improving affordability for California consumers and purchasers while preserving access, quality, equity, and workforce stability. As OHCA develops the enforcement framework for the statewide spending target, it is critical that the regulations and related guidance provide adequate confidentiality protection, clear and consistent standards, meaningful opportunities for remediation, workable timelines for regulated entities acting in good faith, and avoid penalties that erode access, quality, equity, or workforce stability.

Accordingly, we have provided feedback and respectfully request revisions to the proposals and guidance as follows:

I. OHCA must protect the confidentiality of all nonpublic data and information submitted during all stages of the enforcement process.

OHCA is obligated to protect the confidentiality of all nonpublic data, information, documents, and materials submitted during the spending target enforcement process and must adopt a confidentiality framework that is clearly captured in regulation and related guidance. Confidentiality protection is particularly important because the enforcement process may involve public OHCA Board discussions, public testimony, public reporting, and publication of information related to Performance Improvement Plans (PIPs).

The confidentiality framework should apply to all data, information, documents, and materials submitted to OHCA during spending target enforcement, whether submitted voluntarily or in response to an OHCA request. This should include information submitted to explain spending growth, request or support

adjustments, respond to enforcement considerations, participate in technical assistance (TA), develop or modify a PIP, provide PIP progress reports, submit final PIP materials, or respond to a proposed penalty.

We strongly recommend that OHCA revise the draft PIP guidance document shared with industry members to reflect the California Health Care Quality and Affordability Act's (hereinafter "Act") confidentiality provisions. The guidance should not create a presumption that PIP materials are public unless confidentiality is requested. Instead, it should clarify that nonpublic information submitted through the PIP process is protected by law and will remain confidential unless disclosure is authorized under specific statutory exceptions and procedures. A clear confidentiality framework that reflects the requirements of the Act will allow and incentivize regulated entities to provide meaningful information to OHCA without risking inappropriate disclosure of sensitive financial, actuarial, operational, labor, contractual, quality, governance, or strategic information.

II. OHCA should establish transparent and consistent standards for the enforcement process.

A. OHCA should provide clear standards for how enforcement considerations will be evaluated and applied.

OHCA has identified several enforcement considerations, including 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. While we support OHCA's decision not to treat this list as exhaustive, we urge OHCA to formally expand the factors that will be evaluated in the regulations and related guidance. OHCA should include additional factors which have been raised by OHCA Board and Advisory Committee members, including changes in mandated benefits, changes in taxes related to healthcare or other administrative requirements, macroeconomic factors such as periods of inflation, supply chain shortages, labor shortages and associated costs, high-cost medical devices, equipment, and emerging therapeutics, infrastructure investments, and significant increases in patient demand for specific services.

OHCA should also provide more transparency regarding how enforcement considerations will be evaluated. 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. OHCA should also provide written explanations when it determines that an entity should proceed beyond technical assistance (TA), including a summary of the factors considered and the reasons for escalation.

B. OHCA should clarify how entities will be selected for progressive enforcement steps.

While the Act gives OHCA discretion to determine which entities are subject to enforcement actions, it provides guidance in Section 127502.5(a) that should be incorporated into regulations and related guidance to ensure a fair and transparent process. Criteria such as performance relative to target(s), market share, entity size, spending volume, historical performance, or market impact should be transparent and consistently applied.

Market share should not be used as a proxy for culpability or bad faith. Larger entities may have more complete data, broader patient populations, greater exposure to high-cost patients and high-cost drugs, and more significant obligations related to access, quality, equity, workforce stability, and public program participation. OHCA should not select entities for escalation based on size or market share alone without first evaluating the drivers of spending growth, performance relative to peers, historical performance, and the entity's good-faith efforts to improve affordability.

- C. Calculation of administrative penalties and application of penalty justification factors must be fair and transparent.

OHCA should also include transparent decision-making criteria and written explanations before escalation or penalty assessment to avoid unfair or inconsistent treatment. OHCA should also further clarify beyond the statutory language how it will evaluate statutory penalty justification factors, including fiscal condition and market impact. Any assessment of penalties must be applied consistently across entities and tied to an entity's conduct, the reasons for its spending growth, its good-faith remediation efforts, and its compliance with any approved PIP—not based on size or scale.

III. OHCA should clarify key enforcement considerations, including labor costs and quality.

- A. OHCA should only consider actual labor costs and clarify in regulation that entities can submit them for consideration during enforcement considerations without condition.

KP would like to reiterate our comments submitted to OHCA on June 11, 2026, in response to the proposed nonsupervisory organized labor adjustment (“NOLA”) regulations, urging OHCA to apply labor costs based on actual negotiated costs, not projections, in order to protect the collective bargaining process and better serve OHCA's NOLA policy to apply verifiable data.

We also ask that OHCA clarify in the progressive enforcement process regulations and related guidance the critical information that was shared by OHCA Staff at the July Advisory Committee. Specifically, OHCA stated that regulated entities may supply actual labor costs during the enforcement considerations process and that regulated entities that do not submit a prospective adjustment request do not waive the opportunity for consideration of actual labor costs during the enforcement considerations process.

OHCA should specify in regulation that entities may also submit non-organized labor costs during the enforcement considerations process to account for the costs entities bear to support all labor. This aligns with the intent of the Act to improve affordability but not at the expense of the workforce.

OHCA should also clarify that labor organizations have a very limited role in the labor adjustment/considerations process. OHCA's process should protect a regulated entity's confidential bargaining, financial, operational, and personnel information. Regulated entities must remain responsible for certifying their own cost data, and OHCA should establish a structured process for resolving disputes without requiring public disclosure of sensitive information.

- B. Quality performance and timely access should be a factor in whether an entity proceeds to enforcement.

Even though OHCA has decided not to pursue a quality adjustment for the 2026 target, OHCA should include high quality performance and compliance with timely access standards as factors in determining whether an entity proceeds to enforcement steps. OHCA is permitted by the Act to consider a variety of data sources and should use that flexibility to evaluate whether an entity's spending growth supports the Act's goals of preserving access, quality, equity, and workforce stability. High quality performance, timely access compliance, and demonstrable investments in care delivery should be relevant to whether escalation is warranted.

IV. Technical assistance (TA) should serve as a meaningful step for entities acting in good faith.

The Act identifies TA as the first step in progressive enforcement and requires that OHCA allow health care entities opportunities for remediation. To give that step practical meaning and comply with the Act, OHCA should treat TA as a real opportunity for an entity to explain spending growth, identify drivers, correct data issues, implement reasonable changes, and avoid unnecessary escalation.

The regulations should establish a defined TA period before escalation, absent exceptional circumstances. OHCA should also 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, TA should be available as an off-ramp from public testimony or PIP requirements. TA should not function merely as a procedural step that occurs in parallel with, or immediately before, escalation. A meaningful TA process will better support OHCA's affordability goals by encouraging collaboration, early resolution, and targeted improvement.

V. Public testimony should be reserved for repeated, unexplained, or bad-faith noncompliance with the spending target(s).

OHCA should limit compelled public testimony to entities whose performance is an outlier relative to peers, that fail to cooperate or exhibit bad-faith noncompliance. Public testimony can carry significant reputational consequences and may require discussion of complex, sensitive, or confidential information in a public setting. It should not be used as an early-stage enforcement tool and should be handled in private meetings with the Board whenever possible, particularly where an entity is participating in TA, providing information to OHCA, or otherwise acting in good faith.

The regulations should specify criteria for requiring public testimony and should provide the entity with advance notice, an opportunity to submit written context, and confidentiality protections before any public testimony is scheduled. Public testimony should be used only where necessary to further the purposes of the enforcement framework and should not substitute for a careful evaluation of enforcement considerations.

VI. Performance Improvement Plan (PIP) requirements must be feasible and reasonable.

A. OHCA should not pursue multiple overlapping PIPs.

OHCA should avoid multiple overlapping PIPs across performance years where the same cost drivers or corrective actions are involved. If OHCA applies the enforcement process separately for each performance year, entities may face overlapping enforcement processes, inconsistent milestones, duplicative reporting, and potentially separate penalties for related drivers of spending growth.

OHCA should include in the regulations and related guidance a presumption in favor of consolidated PIPs where performance years, spending drivers, or corrective actions overlap. A consolidated PIP could address multiple performance years or recurring drivers more effectively while reducing administrative burden and avoiding inconsistent or duplicative obligations.

B. PIPs should be forward-looking and explicitly hold entities harmless for periods that are outside of their control.

OHCA should specify in regulation and in the related guidance that PIP standards and requirements must be geared toward impacting future spending growth to ensure that PIPs are effective and non-

punitive. OHCA Staff, the OHCA Board, and Advisory Committee members have remarked on this principle in public meetings, and it should be formalized into the framework.

In a similar vein, given that entities are unable to impact spending trends for the year directly following the performance year that is the subject of a PIP, OHCA should specify in regulations and related guidance that entities will be held harmless for the year occurring between the year the PIP was initiated and the start of the PIP. For example, by the time an entity has submitted their 2026 Total Medical Expenditures (TME) data to OHCA, most of 2027 will have passed. Entities required to complete a PIP based on 2026 performance should not be penalized for their 2027 performance.

C. OHCA must provide a reasonable PIP submission timeline.

The proposed 45-day PIP submission timeline, with one optional 30-day extension, is not sufficient for complex entities. A meaningful PIP may require root-cause analysis, data validation, actuarial review, clinical and operational planning, labor analysis, financial modeling, legal review, executive approval, and coordination across multiple business units and regulated entities.

OHCA should extend the standard PIP submission timeline to at least 90 days and allow additional extensions for good cause. This additional time will improve the quality, feasibility, and accountability of PIPs and reduce the likelihood that entities submit incomplete or unrealistic plans simply to meet an abbreviated deadline.

D. Entities should not face administrative penalties for failure to meet mid-PIP milestones.

OHCA should not assess penalties for failure to meet mid-PIP milestones where an entity is working in good faith to come into compliance with the spending targets. PIPs are intended to support sustainable improvement, which may require implementation over time and adjustment as new information becomes available.

Mid-PIP milestones should be used to monitor progress, identify barriers, and support course correction—not to trigger penalties against entities that are actively implementing an approved plan in good faith. Assessing penalties after such a short period of time does not allow entities reasonable opportunity for remediation as required by the Act.

VII. OHCA should clarify how it will interact with other regulators.

OHCA should clarify when and how it will confer with other regulators during the enforcement process. PIP commitments or enforcement issues may overlap with requirements overseen by the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Covered California, CalPERS, the Department of Insurance (CDI), CMS, and other state or federal agencies.

Before independently consulting with another regulator about entity-specific information, OHCA should provide the regulated entity with notice and sufficient time to identify overlapping commitments, legal obligations, confidentiality concerns, or potential conflicts. This will help ensure that OHCA has accurate context and that any interagency consultation is informed by the regulated entity's existing obligations.

Confidential treatment should apply to all information deemed confidential, and that confidentiality should be recognized and adhered to by other state agencies. OHCA should not share confidential information with other agencies unless appropriate protections are in place and the entity has been informed of the scope and purpose of the disclosure.

VIII. OHCA should revise its administrative penalty framework to align with its statutory obligations and protect consumers.

A. Penalties should be assessed only after repeated noncompliance with the targets.

OHCA should assess penalties only where an entity has exceeded a spending target for multiple years, such as three out of five performance years, consistent with Oregon’s model. A multi-year standard would allow OHCA to take a more reasonable and holistic view of spending trends and account for the efforts an entity has taken to reduce costs.

A single-year exceedance may reflect temporary or anomalous factors, such as high-cost patient outliers, high-cost drugs, public program changes, state-mandated benefits, labor costs, or other external pressures. A multi-year standard would better distinguish persistent noncompliance from isolated or explainable variation and would better align with the penalty framework and goals of enforcement.

Additionally, assessing penalties without giving entities a meaningful opportunity to modify practices and determine how to reduce costs in line with good policy runs afoul of OHCA’s obligation to provide entities with opportunity for remediation before penalizing them.

B. The Act does not require OHCA to set a penalty floor equal to an “initially commensurate” amount.

OHCA should not treat the “initially commensurate” concept as a mandatory penalty floor. The Act does not compel OHCA to set the minimum penalty at an amount that is initially commensurate with the failure to meet the target. OHCA has discretion to develop a penalty framework that is reasonable, proportionate, and consistent with its statutory obligations to improve affordability while avoiding actions that erode access, quality, equity, or workforce stability.

C. The “initially commensurate” amount should be reduced by costs recognized by OHCA during enforcement considerations.

OHCA’s measurement for “initially commensurate” should be based on the amount by which the entity exceeded the target after subtracting costs OHCA recognizes during enforcement considerations (as defined more broadly per the comments above). Entities should not be penalized for costs that OHCA has determined are relevant to whether enforcement should proceed. If OHCA relies on certain costs or factors to determine that spending growth was explainable, justified, or outside the entity’s control, those same costs or factors should also reduce the penalty calculation.

D. Excessive penalties would undermine OHCA’s affordability goals and run afoul of statutory obligations.

An excessive “initially commensurate” penalty would be an unjust and destructive blow to entities already working to meet spending targets and improve affordability for consumers. Such penalties would be contrary to OHCA’s statutory purpose of reducing the cost of health care and inconsistent with OHCA’s statutory obligation not to take enforcement actions that erode access, quality, equity, or workforce stability. Penalties should also not disadvantage or allow insured companies to be less competitive against self-funded.

Penalties should be used as a last resort for repeated, unexplained, or bad-faith noncompliance—not as an automatic or punitive response to spending growth that may be driven by factors outside an

entity's control. OHCA should also not stack penalties for multiple years of noncompliance as doing so would be punitive and further prevent entities from meeting future targets.

For comparison, Oregon has established a tiered escalation structure for its penalty framework – starting with 5% of the net total cost above the target for the first violation, increasing by 5% per additional year of violation. Oregon also factors in an entity's cost reductions between performance years when calculating the net total penalty amount. This approach, coupled with a penalty assessment only subsequent to a multi-year review, allows entities to more strategically target actual cost drivers and make sustainable adjustments to practices, while avoiding unjust penalties that destabilize the entity and healthcare market.

We also note that administrative penalties assessed by OHCA are to be deposited into the "Health Care Affordability Fund." OHCA should clarify how those funds will be used and 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.

KP appreciates OHCA's continued engagement with stakeholders as it develops the spending target enforcement framework and the opportunity to share feedback. The final regulations and guidance should support affordability while providing clear standards, protecting confidential information, allowing meaningful remediation, and preserving access, quality, equity, and workforce stability.

We respectfully request that OHCA revise the proposals and guidance to incorporate the recommendations described above. We look forward to continued engagement with OHCA on these important issues.

Sincerely,

A handwritten signature in blue ink that reads "Deborah Espinal". The signature is fluid and cursive, with the first name and last name clearly distinguishable.

Deborah Espinal, Ph.D.
Vice President, Enterprise Regulatory Services
Policy and Regulatory Affairs

cc: Elizabeth Landsberg, Director, Department of Health Care Access and Information



Submitted via email at ohca@hcai.ca.gov

July 31, 2026

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

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process

Dear Director Landsberg:

On behalf of Dignity Health and in addition to the comments provided by our 28 California hospitals, thank you for the opportunity to provide comments about the Office of Health Care Affordability's (OHCA) spending growth target enforcement process. As the OHCA board continues its discussion, Dignity Health wants to share our deep concerns about the process outlined to date. The fines, at the exorbitant levels being considered by the Office, would eliminate our ability to meet community and capital demands, including seismic compliance. We implore the board to step back and reconsider the impact of the penalty structure on access to care and the sustainability and fiscal solvency of health care in California.

As the largest Medi-Cal provider, just last year we had more than 800,000 inpatient days and 1.2 million outpatient visits. This commitment comes at a cost. After all supplemental payments, including the provider fee, **we lost nearly half a billion dollars – at cost.**

- Medi-Cal reimbursements don't fully cover cost, and they vary greatly from year to year based on when the provider fee is approved. **To be fined for Medi-Cal rate changes is just wrong.**
- Additionally, Medicare Fee for Service (FFS) rates are set by the federal government and most Medicare Advantage rates are a percentage of FFS. **Why would OHCA consider governmental rate changes as being punishable by fines?**

In fiscal year 2023, Dignity's:

- Total revenue was \$11.7 billion excluding COVID-era FEMA payments;
- Our operating loss was \$170 million; and
- Our EBITDA was \$400 million – resulting in net income of \$50 million

Using OHCA's structure, we calculated that the total all-payer penalty would be \$631 million, which is nearly 6% of our revenue. And even if you take just the calculated commercial penalty of \$117 million – these unreasonable penalties **would debilitate our system and require reductions in workforce and service lines, and possibly cause entire hospital closures.**

Dignity Health reiterates what we have shared many times with the Office, even when we have asked for technical assistance and used Office provided data sets, we cannot replicate the OHCA data outcomes. How can we be moving forward with penalties without full transparency to providers as to the data or calculations?

The OHCA Hospital Spending Workgroup had on multiple occasions, for both the inpatient calculations and the outpatient calculations, requested that OHCA perform scenario testing on those calculations to confirm no bias or outlier issues would be present, and to validate that the intensity adjustments (CMI for inpatient, and APC weighting for outpatient) had the desired impact. We are concerned that since OHCA did not go through with those calculation scenarios, which is best practice, OHCA/HCAI has materially overlooked significant issues in the development of the spending calculations.

Additionally, the spending calculations treat inpatient and outpatient separately, with no formula for combining the two calculations, nor weighting the spending between inpatient and outpatient. Again, this is not how hospitals operate, nor how contracting between health insurers and hospitals works. In fact, hospital and insurer contract negotiations often result in parties agreeing to move dollars between services and across inpatient and outpatient to address administrative issues or strategic needs of either party, even if the overall value of the contract/payments remain the same. The Hospital Spending Workgroup had requested OHCA/HCAI pressure test the spending calculations for these types of scenarios, but OHCA/HCAI did not abide by such requests.

It is Dignity Health's recommendation that the Hospital Spending Workgroup be reconvened, the calculations revised, modified, and thoroughly tested before going live.

Our system is currently experiencing cost growth far in excess of the 3.5% spending target. Healthcare realities show up in a far more complex context than what hospitals can directly control. Workforce shortages and mandatory minimum wages are driving up labor costs significantly. Labor accounts for more than 54% of our operating expenses, and our spending on salaries and benefits has risen by more than 20.2% in the past five years. In addition, the prices of pharmaceuticals, medical supplies, and advanced technologies have increased by nearly 10% annually. Facing such uncontrollable cost growth, at the same time that OHCA is putting a lid on the resources we have to pay our bills, is forcing challenging decisions.

We as a system have already made difficult decisions in response to H.R. 1 (the One Big Beautiful Bill). We have consolidated services, closed clinics, and reduced our workforce by several hundred employees. And yet, these efforts will not be enough. OHCA's hospital spending methodology produces wild results that do not correspond with Dignity Health's experience. Disconcertingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For Dignity Health that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they're able to get the care they need without a hospital stay
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under H.R. 1.
- Investments in physician recruitment to enhance access and other meaningful improvements for patients but that would put our hospital at risk for exceeding the cap

Dignity Health is committed to helping patients afford the care they need. That's why we offer free, medically necessary care up to 250% of the federal poverty level (FPL) and discounted,

medically necessary care up to 500% of the FPL. Additionally, we provide nearly 10% of the services provided statewide by Medi-Cal. We have been proud to partner with the State of California in providing access to the most vulnerable in our State. And for all of that commitment, we now face penalties that threaten our viability which will clearly impact our 56,000 employees and the communities we serve.

We encourage the OHCA board to pause, require staff to scenario test the data, and model the true impact of the fines to the viability of providers. We believe incorporating these recommendations into future rulemaking is critical to the future success of the program. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,



Shelly L Schlenker
EVP, Chief Advocacy Officer

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

Chief Executive Officer
Ryan Harris



Board of Directors
Jeanne Utterback, President
Abe Hathaway, Vice President
Tami Vestal-Humphry, Treasurer
Lester Cufaude, Director
James Ferguson, Director

July 31, 2026

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

Subject: Comments on OHCA Spending Target Enforcement Framework
(Submitted via email at ohca@hcai.ca.gov)

Dear Director Landsberg:

On behalf of Mayers Memorial Healthcare District, thank you for the opportunity to provide comments as the Office of Health Care Affordability (OHCA) continues its work to develop a spending target enforcement framework. We appreciate OHCA's commitment to improving health care affordability for Californians and share the goal of ensuring patients have access to high-quality, sustainable care.

As the Board considers its enforcement approach, we respectfully encourage OHCA to adopt a framework that recognizes the unique challenges facing hospitals—particularly rural providers—and emphasizes collaboration and performance improvement before financial penalties are imposed. For small rural hospitals such as Mayers Memorial Healthcare District, significant financial penalties could have unintended consequences for patient access to care and the long-term sustainability of essential health services.

We respectfully urge the OHCA Board to adopt regulations that balance affordability objectives with preserving access to care by:

- Clearly communicating how spending growth will be evaluated against the spending target, including how payer mix and service mix will be considered.
- Using multiple years of data when determining compliance with spending targets to account for normal year-to-year variability and better identify sustained spending trends.
- Standardizing the process for hospitals to explain spending growth through the statutory waiver process.
- Establishing a collaborative performance improvement process that provides hospitals a meaningful opportunity to address spending trends before financial penalties are considered.
- Phasing in penalties and accounting for important contextual factors, including investments in patient-centered care, infrastructure needs, and an organization's financial condition.

Like many hospitals across California, Mayers Memorial Healthcare District is experiencing cost increases that significantly exceed the current 3.5% spending target. During the past year, labor costs increased by approximately 4%, medical supply costs increased by 5%, and pharmaceutical expenses increased by 38%. These cost pressures are largely outside our control and continue to outpace reimbursement growth.

As a result, rural hospitals are faced with extraordinarily difficult decisions. We must balance the need to remain financially sustainable with our responsibility to maintain access to essential health care services for our communities. We are concerned that an enforcement framework relying primarily on financial penalties could unintentionally force hospitals to reduce services or delay needed investments in order to avoid future penalties.

These concerns are particularly significant for Critical Access Hospitals. Rural hospitals operate under fundamentally different financial and operational conditions than larger urban health systems. We maintain emergency services, laboratory, imaging, pharmacy, ambulance, and other essential services around the clock despite relatively low patient volumes. High fixed operating costs, limited workforce availability, long travel distances, dependence on governmental payers, and limited negotiating leverage with suppliers all contribute to spending patterns that differ substantially from those of larger organizations. Recruitment, retention, temporary staffing, housing, and transportation expenses are often necessary simply to ensure continued access to care.

These structural realities are largely beyond the control of rural providers but have a direct impact on annual spending growth. We respectfully encourage OHCA to ensure that its enforcement methodology adequately reflects these unique circumstances so that efforts to improve affordability do not inadvertently reduce access to care in rural communities.

Mayers Memorial Healthcare District has already taken significant steps to responsibly manage costs and improve efficiency, particularly in light of ongoing financial pressures, including the substantial federal health care funding reductions associated with the One Big Beautiful Bill Act (OBBBA). These efforts include:

- Canceling a planned construction project to replace our acute care wing, which would have addressed seismic compliance requirements and expanded surgical services.
- Carefully evaluating staffing levels and service lines, recognizing that our workforce costs fall outside collective bargaining agreements and are therefore subject to OHCA's spending methodology.
- Transitioning to a different group purchasing organization (GPO) to reduce supply and pharmaceutical expenses, despite the limited purchasing leverage available to rural hospitals.
- Moving employee health insurance to a self-funded model after premium increases in the fully insured market became unsustainable.

While these initiatives demonstrate our commitment to cost stewardship, we remain concerned that they may not be sufficient under the proposed methodology.

We also respectfully encourage OHCA to consider the limitations of relying on a single year of data for enforcement decisions. Our own experience illustrates how annual fluctuations can produce results that do not accurately reflect long-term spending trends. For example, year-over-year data for Mayers Memorial Healthcare District shows a 49% reduction in Commercial Inpatient Net Patient Revenue per case-mix-adjusted discharge alongside a 21% increase in Commercial Outpatient Net Patient Revenue per case-mix-adjusted discharge. Evaluating either measure independently over a single year provides an incomplete picture of our overall performance.

Similarly, we are concerned about the possibility of separate enforcement across multiple payer categories and service lines. Evaluating each category independently could create situations where appropriate investments in one area are not recognized by offsetting efficiencies achieved elsewhere within the organization. For example, hospitals may appropriately experience spending growth as they:

- Expand access to outpatient services that improve patient convenience and reduce the need for inpatient hospitalization.
- Maintain revenues necessary to offset rising operating costs and reductions in federal funding under OBBBA.
- Invest in programs and services that improve patient outcomes and strengthen access to care in underserved communities.

We respectfully encourage OHCA to adopt an approach that evaluates an organization's overall performance rather than isolated components that may not accurately represent the full picture.

Mayers Memorial Healthcare District remains deeply committed to improving affordability for our patients. In addition to providing essential health care services, we maintain Charity Care and Discount Payment Programs that provided more than \$773,000 in financial assistance during the past year.

We appreciate OHCA's interest in partnering with providers to improve affordability across California's health care system. We believe that a collaborative enforcement framework—one that emphasizes transparency, flexibility, and opportunities for improvement before penalties are imposed—will better support the shared goals of affordability, access, quality, and long-term sustainability.

The decisions made through this rulemaking process will have a direct impact on our ability to continue serving residents throughout portions of Shasta, Lassen, and Modoc Counties. We respectfully ask the Board to consider the unique realities facing rural providers as it finalizes these regulations.

Thank you for your consideration of these comments and for the opportunity to participate in this important discussion. We look forward to continuing to work with OHCA to advance policies that promote both affordable and accessible health care for all Californians.

Sincerely,

Jessica DeCoito

Jessica DeCoito
Chief Operations Officer
Mayers Memorial Healthcare District

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 30, 2026

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

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

Rady Children's Health appreciates the opportunity to comment on the Office of Health Care Affordability's proposed enforcement framework for health care entities. Rady Children's Health is a premier pediatric healthcare system that unites the expertise of Children's Hospital of Orange County and Rady Children's Hospital San Diego. With three hospitals, a growing network of primary and specialty care centers spanning six counties, and two of the region's Level 1 pediatric trauma centers, Rady Children's Health is a trusted partner for families seeking safe, high-quality care.

Rady Children's Health is proud of its commitment to serving families in Southern California, providing care for the sickest and most medically complex infants, children, and adolescents. Nearly 60% of our patients are covered by Medicaid, making us the primary pediatric safety net provider in the region.

While we share OHCA's goal of making health care more affordable for Californians, we are concerned that this policy fails to address the cost drivers of health care cost growth and does nothing to reduce the cost of care to patients. Furthermore, we continue to have concerns that the data being used to calculate spending growth is not tailored to the pediatric patients that we serve.

California's health care delivery system is already under severe operational and financial pressure from workforce shortages, inflation, rising pharmaceutical and supply costs, cyber and emergency preparedness needs, unfunded infrastructure mandates, and persistent underpayment in government programs. In addition to these ongoing cost pressures, safety net hospitals like Rady Children's Health will be at the forefront of the challenges imposed by HR 1, including caring for the newly uninsured Californians.

Imposing exorbitant financial penalties on hospitals and health systems for cost growth that is driven by factors outside their control would remove resources from patient care, staffing, access, and community benefit investments without guaranteeing any reduction in premiums, deductibles, or out-of-pocket costs for patients.

Hospitals and health systems cannot absorb large, open-ended penalties without consequences. Every dollar paid as a penalty is a dollar unavailable to recruit and retain essential caregivers like nurses, physicians, and behavioral health clinicians; maintain emergency department capacity; expand access to primary care and specialty services; invest in quality and safety improvements; or sustain services that are underfunded but essential to the community, like obstetrics and maternity care.

The risk is even more extreme for Rady Children's Health and other hospitals serving a high proportion of Medi-Cal, safety-net, and high-acuity populations. We experience cost growth because we treat patients with greater clinical complexity, face cost increases for life-saving pharmaceuticals and other items outside of our control and are governed by state and federal regulatory requirements that raise operating costs. A penalty framework that treats cost growth primarily as a failure of discipline rather than a reflection of patient needs and market conditions will force reductions in services, longer waiting times, and diminished access in communities that already face barriers to care.

The OHCA proposed framework would start issuing penalties calculated at the full amount by which an entity exceeds the target and then potentially increase that amount. This is not an accountability tool. Penalties at the amount health providers would face are devastating sanctions, because California faces the nation's most complex health care delivery challenges. High labor costs, broad geographic variation, seismic and capital obligations, under-resourced rural and safety-net communities and significant reliance on Medi-Cal reimbursement are just a few of the factors that make California a particularly fragile and vulnerable hospital ecosystem.

Finally, we are concerned that the data sets OHCA uses to calculate spending growth do not adequately reflect the unique characteristics of the pediatric population we serve. Children with complex medical needs may experience higher acuity, longer lengths of stay, and more resource-intensive treatment plans. To produce an accurate assessment, OHCA's data should account for the specific resources required to deliver high-quality pediatric care. Without pediatric-specific and appropriate data, spending growth calculations may mischaracterize the cost of caring for these patients.

We respectfully urge OHCA to reconsider the proposed penalty framework and adopt a more measured approach that protects patients and preserves access to care. California should not adopt the most punitive cost growth target enforcement model in the country without clear evidence that it will make care more affordable for patients. Affordability is essential, but it cannot be achieved by destabilizing the providers patients rely on for emergency, inpatient, outpatient, behavioral health, primary care, and specialty services. We urge OHCA to revise the proposed framework prior to implementation.

We remain committed to working collaboratively with OHCA to develop meaningful solutions that improve the issues of health care cost affordability while preserving access to high-quality care. We hope OHCA is open to a true partnership with providers and that together, we can work to develop approaches that address cost pressures without undermining the services upon which patients and families rely.

If you would like any additional information, please reach out to me or our Sacramento advocate, Nicette Short at nicette@nlshortpa.com or 916.549.2853.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jena Jensen', with a stylized, cursive script.

Jena Jensen

Vice President, Chief Advocacy
& Public Policy Officer



OFFICERS

August 11, 2026

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Chair

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

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STAFF

Katy Castagna
President and CEO

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



August 13, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
Department of Health Care Access and Information
2020 We El Camino Ave, 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 Sutter Medical Group, A California Corporation, I 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.

Sutter Medical Group (SMG), like most foundation-associated groups in California, is contracted by a health care entity (in our case Sutter Health) to provide clinical services. We receive funding to compensate our physicians and other clinicians for these clinical services through that contract. We do no independent billing or have other material sources of revenue. We play no role in negotiating contracts with insurers, PBMs, or outside medical organizations which might provide specialized care to Sutter patients. We do not set prices for services or negotiate over the costs of supplies, pharmaceuticals or vaccines. We do not have clinical staff or capital assets. We do not control emergency department, hospital, lab or imaging charges.

Health & Safety Code section 127502.5(a) requires consideration of "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." SMG has no control over the factors listed above, and they should be removed from consideration as applies to an evaluation and enforcement process related to medical groups in our situation. Furthermore, regarding a Performance Improvement Plan, SMG does not have access to the kind of data regarding these components of a cost target to be able to even complete a report.

Thank you for consideration of these comments. We look forward to further clarity on the guidelines related to groups such as ours and to working with OHCA on rational targets and processes that improve health care affordability while maintaining access to high-quality, equitable care. Please feel free to reach out directly should you seek more information on the nature of the financial relationship and accountabilities of SMG.

Sincerely,

Michael Conroy MD

Michael Conroy MD, FACP
President and CEO, Sutter Medical Group
2700 Gateway Oaks Drive
Sacramento, CA 95833
Michael.conroy@sutterhealth.org
C (831) 869-6702



Adventist Health
One Adventist Health Way
Roseville, CA 95661
AdventistHealth.org

August 18, 2026

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

RE: Proposed Financial Penalty Framework for Exceeding the Cost Growth Target

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

Thank you for the opportunity to comment on the Office of Health Care Affordability's proposed financial penalty framework for health care entities that exceed the cost growth target after completing a performance improvement plan. We share OHCA's goal of making health care more affordable for Californians. This policy fails to address the cost drivers of health care cost growth and does nothing to reduce the cost of care to patients. Furthermore, implementing a penalty structure that begins with the full amount by which an entity exceeds the target, and then allowing that amount to be adjusted upward, would be significantly punitive and will harm all Californians.

California's health care delivery system is already under severe operational and financial pressure from workforce shortages, inflation, rising pharmaceutical and supply costs, seismic and capital requirements, cyber and emergency preparedness needs, and persistent underpayment in government programs. Imposing financial penalties on hospitals and health systems for cost growth that is driven by factors outside their control would remove resources from patient care, staffing, access, and community benefit investments without guaranteeing any reduction in premiums, deductibles, or out-of-pocket costs for patients.

Based on OHCA's proposed methodology, Adventist Health estimates the financial impact of these penalties could be \$381 million in the first year. Diverting resources of this magnitude away from patient care would significantly impair our ability to invest in workforce recruitment and retention, maintain access to essential services, meet facility and technology requirements, and support the communities that depend on our hospitals and clinics.

Hospitals and health systems cannot absorb large, open-ended penalties without consequences. Every dollar paid as a penalty is a dollar unavailable to recruit and retain essential caregivers like nurses, physicians, and behavioral health clinicians; maintain emergency department capacity;

expand access to primary care and specialty services; invest in quality and safety improvements; or sustain services that are underfunded but essential to the community, like obstetrics and maternity care.

The risk is even more extreme for hospitals serving a high proportion of Medi-Cal, Medicare, rural, safety-net, and high-acuity populations like Adventist Health. We experience cost growth because we treat patients with greater clinical complexity, maintain standby capacity for emergencies, operate services that are not profitable but are medically necessary, and comply with state and federal requirements that increase operating costs. A penalty framework that treats cost growth primarily as a failure of discipline rather than a reflection of patient needs and market conditions will force reductions in services, longer wait times, and diminished access in communities that already face barriers to care.

The proposed framework also does not directly solve the affordability problem patients experience. Californians struggle with premiums, deductibles, co-insurance, prescription drug costs, delayed care, and medical debt. Penalizing providers does not ensure that commercial insurers will lower premiums or reduce patient cost-sharing. Without a mechanism requiring savings to be passed through to consumers, financial penalties will weaken the health care delivery system while leaving patients' bills unchanged.

Eight states currently operate cost growth target programs: California, Connecticut, Delaware, Massachusetts, New Jersey, Oregon, Rhode Island, and Washington. Across these states, the experience to date has been mixed. Multiple states with several years of data have missed their targets in recent years, including Connecticut, Delaware, Massachusetts, Oregon, Rhode Island, and New Jersey. A 2026 JAMA Network Open study evaluating spending growth benchmarks in the eight states found no evidence that benchmark programs were associated with lower hospital prices and premium results were mixed with no evidence of sustained reductions over time. Rhode Island was the only state showing a statistically significant outpatient price reduction. Rhode Island is the only state that takes into account service categories. In short, the available evidence does not show that general benchmark penalties translate into affordability relief for patients.

Oregon is the clearest comparison because it is the only other state with financial penalties tied to a cost growth target. Oregon does not impose penalties for a single year of exceeding the target. Instead, an entity must exceed the target with statistical confidence and without an acceptable reason in at least three out of five calendar years within a market before a penalty may apply. Oregon also requires consideration of reasonable cause, and its penalties are phased as a percentage of the net cost above and below the target over the five-year period: 5 percent for the first penalty, 10 percent for the second, and 15 percent for the third, with escalation over time. Oregon's 2026-2030 target was also increased from the scheduled 3.0 percent to 3.75 percent after stakeholder review, recognizing the need for a target that reflects real-world economic conditions.

By contrast, California's proposed framework would start with the full amount by which an entity exceeds the target and then potentially increase that amount. This is not an accountability tool. Penalties at the amount health systems would face is a destabilizing sanction because California faces the nation's most complex health care delivery challenges, including high labor costs, broad

geographic variation, seismic and capital obligations, under-resourced rural and safety-net communities, and significant reliance on Medi-Cal reimbursement.

We respectfully urge OHCA to reconsider the proposed penalty framework and adopt a more measured approach that protects patients and preserves access to care. At a minimum, any enforcement framework should:

- Require multiple years of sustained, statistically significant target exceedance before any penalty is considered.
- Provide robust exceptions for reasonable causes, including patient acuity, utilization changes, labor shortages, inflation, workforce costs, state and federal policy changes, emergency preparedness, public health emergencies, and underpayment by government programs.
- If a penalty is considered, ensure that penalties are capped and phased in gradually.
- Require a clear demonstration that any enforcement action will improve affordability for patients through lower premiums, reduced cost-sharing, or direct consumer benefit.
- Evaluate potential impacts on access, quality, equity, workforce stability, rural care, safety-net capacity, emergency services, and essential community programs before imposing any penalty.
- Coordinate cost growth accountability across all sectors of the health care system, including health plans, pharmaceutical costs, administrative costs, and benefit design, rather than concentrating financial risk on providers.

California should not adopt the most punitive cost growth target enforcement model in the country without clear evidence that it will make care more affordable for patients. Affordability is essential, but it cannot be achieved by destabilizing the providers patients rely on for emergency, inpatient, outpatient, behavioral health, primary care, and specialty services. We urge OHCA to revise the proposed framework.

Sincerely,



Kerry L. Heinrich
President and Chief Executive Officer

CC: Office of the Governor, Deputy Cabinet Secretary Richard Figueroa
Director of the Department of Health Care Services Michelle Baass





August 19, 2026

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

RE: NIHD Comments on Spending Target Progressive Enforcement Framework

Dear Chair Johnson:

NIHD supports the state's goal of making health care more affordable for Californians and recognizes the importance of accountability in controlling health care spending. However, affordability cannot be pursued in isolation from access, quality, workforce stability, and the financial sustainability of the hospitals upon which California communities depend. This is particularly important for rural hospitals, where significant financial penalties can have a disproportionate effect on the availability of local health care services.

The 3.5% spending target must also be considered in the context of the actual cost pressures hospitals face simply to maintain existing services. In 2025, NIHD provided employees with a 2.5% annual wage increase in addition to a 2.5% cost-of-living adjustment. For employees receiving both adjustments, this represented an approximately 5% increase in base wages — already greater than the 3.5% statewide spending growth target — before accounting for increases in employee benefits or other operating expenses. These workforce investments are necessary for NIHD to remain competitive in recruiting and retaining qualified health care professionals in a rural community.

These concerns are particularly relevant as NIHD plans for the future of health care in our community. NIHD is in the early planning stages of a significant investment in local health care infrastructure, including the development of a new Rural Health Clinic and medical office building. Our existing facilities and space limitations increasingly constrain our ability to expand services, accommodate specialists, and meet evolving community needs. NIHD is evaluating service-line and utilization data, including services for which patients currently travel outside the area, to identify opportunities to bring needed care closer to home. The project will require substantial investment, supported through a combination of grant funding, community and philanthropic support, and District resources.

The goal is not simply to construct a new building. It is to create the capacity necessary to expand needed services, provide modern technology and equipment, and allow more patients to receive high-quality care in their own community. An affordability framework should not place hospitals in the position of choosing between making responsible investments in workforce, infrastructure, equipment, and expanded access to care and avoiding potentially significant financial penalties.

NIHD also believes enforcement must provide hospitals with a meaningful opportunity to improve before financial penalties are imposed. Technical assistance and performance improvement plans should allow

sufficient time and flexibility to identify the causes of spending growth, implement appropriate corrective strategies, demonstrate improvement, and work collaboratively with OHCA toward compliance.

NIHD respectfully urges the Health Care Affordability Board not to approve the proposed enforcement framework in its current form. California can advance health care affordability without compromising access to care, workforce stability, necessary investments in infrastructure and technology, the ability to expand needed services, or the quality of patient care. For rural communities like ours, maintaining this balance is critical to ensuring a sustainable health care system that can continue to meet the needs of the communities we serve.

Sincerely,

A handwritten signature in cursive script that reads "Christian Wallis".

Christian Wallis, CEO

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514
(760) 873-2109
christian.wallis@nih.org



August 20, 2026

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

Subject: Physician concerns on OHCA enforcement framework

(Submitted via email to Megan Brubaker at ohca@hcai.ca.gov)

Dear Chair Johnson:

On behalf of Stanford Health Care, an OHCA-designated “high-cost” hospital, we appreciate the opportunity to comment on OHCA’s spending target measurement and enforcement frameworks. However, we 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.**
Even as a large health care delivery system, we would not be immune to how detrimental OHCA's proposed penalties would have on our financial condition. We are concerned that the proposed penalty levels would endanger access to care — the exact opposite of OHCA's stated goals. Excessive penalties could also force hospitals and physician practices to reduce services, consolidate or close, ultimately reducing patient access to care, squeezing our capacity to continue providing tertiary and quaternary complex-level care.

Thank you for your consideration.

Sincerely,

A handwritten signature in dark ink, reading "Jason J Hill". The signature is written in a cursive, slightly informal style.

Jason Joseph Hill
Chief Government & Community Affairs Officer
Associate Vice President
Stanford Health Care



August 20, 2026

Mr. David Chase
Member, Board of Directors
Office of Health Care Affordability
2020 W. El Camino Ave.
Sacramento, CA 95833

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process
(Submitted via email at ohca@hcai.ca.gov)

Dear Mr. Chase:

As a new member of the Office of Health Care Affordability (OHCA) board, I wanted to write directly to convey our concerns that have been expressed, but seemingly not seriously considered, by the OHCA board. In sum, Montage Health/Community Hospital of the Monterey Peninsula (CHOMP) agrees that the cost of healthcare nationally, and in California, is too high. We are also more than willing to be a part of the solution to this issue and continue to take significant steps to this end. Additionally, the OHCA board steadfastly refuses to consider the overall cost of the care that we provide to residents throughout Monterey County for which there is no reimbursement. 80% of our patient population is covered by governmental insurance programs (Medi-Cal or Medicare) and the reimbursement we receive from these programs does not cover the actual cost of care, leading to financial shortfalls. This high percentage of patients covered by governmental programs is outsized compared with most other healthcare systems, and places a large burden on the commercially insured patients we care for to balance the shortfalls from governmental reimbursement programs. Additionally, our community population health programs, our physician practice (Montage Medical Group), our Medicare Advantage plan (Aspire Health), and many other programs under Montage Health are loss leaders for the organization, but are critical to the overall care of our community.

In sum, we strongly object to the notion that focusing on one small aspect of the overall cost of healthcare in California—the commercial reimbursement rates of seven hospitals—is an appropriate tactic without considering the impact of other stakeholders contributing to those high costs (insurers, pharmaceutical industry, medical device manufacturers, medical supply companies, etc.) The high costs of our healthcare system are a complex issue, and approaches to address those costs require nuanced, balanced actions considering all of the stakeholders within the industry. Instead, OHCA has refused to acknowledge that complexity and has marched forward with flawed actions that will worsen the affordability, quality, equity, efficiency, access, and value of healthcare service delivery in California.



As this body continues its discussion of spending target enforcement, we must share our deep concerns about the potential process outlined to date. **The bottom line is this: Exorbitant fines at the levels proposed would be disastrous for the patients for whom we care. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

CHOMP urges the OHCA board to instead promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target and clarifying how payer and service mix will be considered**
- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessment can reliably distinguish hospitals that genuinely exceeded their target
- **Standardizing the process for explaining growth above the target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors**, like investments in patient-centered care or a hospital's financial condition

CHOMP is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs and physician fees grew by 10.1%, our medical supply costs grew 8.3% and our drug costs grew by 4.7%. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions including staffing and service availability.

To adapt to the new financial environment, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

- CHOMP has put two major capital projects on hold: a new parking structure and tower addition at the hospital. These projects were intended to support increased patient access to care and improve the patient/visitor experience at our facility.
- CHOMP will not have the resources necessary to make the \$12 million investment in our facilities to meet the state's 2030 seismic compliance goals, in addition to the \$40 million in life safety projects included in our capital plan to maintain our facilities.
- With 76% of our labor costs falling outside of collective bargaining agreements and thus subject to OHCA's cap, CHOMP is facing difficult decisions regarding our workforce

And yet, those efforts might not be enough. However, CHOMP has no way of knowing that, because OHCA has yet to finalize how spending will be measured, which payer and service lines will count, and what rules hospitals will be required to follow. Troublingly, OHCA has



indicated that it will base its determinations on only a single year of data, which may be woefully misleading. Consider that for CHOMP, year-over-year data show an average 9.2% expense trend with the annual trend by year of: 7.0% in 2021, 12.0% in 2022, 14.5% in 2023, 2.1% in 2024 and 10.6% in 2025. One year in isolation does not give an accurate picture of CHOMP's spending trends.

Worse, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For CHOMP, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they are able to get the care they need without a hospital stay.
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under the OBBBA. (Again, it is important to note that **CHOMP's payer mix is 80% governmental** so the majority of our reimbursement is fixed, non-negotiable and falls below the actual cost of care.)

CHOMP is committed to helping patients afford the care they need. That is why we offer financial assistance programs, medical debt forgiveness, free clinics for certain services, and free vaccination programs. In 2025, we provided community benefit services totaling \$228 million; these are free or subsidized programs that focused on building health communities, health education and wellness, improving access to primary and specialty care.

CHOMP also understands that affordability in the long term cannot happen without focused efforts now. That is why we're committed to significant annual commitment of funds for grants to nonprofit organizations and multi-agency collaborative organizations in support of health assessment and improvement projects within our service area. In 2025, CHOMP awarded a total of over \$1 million in 96 grants to 89 organizations.

Penalties at the levels proposed by OHCA would threaten CHOMP's viability, jeopardize our patients' health, and endanger the livelihoods of the 3,000 workers who rely on us. CHOMP is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office. In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect health care workforce stability. It has various tools at its disposal to do this, including adjustments to the spending targets and considering labor cost growth as a justifiable reason that an entity exceeded its spending target. CHOMP urges OHCA to treat all health care workers equitably and ensure that neither our frontline workers nor the hospital itself are punished for wages and benefits that grow above the spending target.



The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Monterey Peninsula residents who pass through our doors each year. CHOMP appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

A handwritten signature in blue ink, appearing to read "M. McDermott".

Michael McDermott, MD, MBA
President and Chief Executive Officer

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



August 20, 2026

Dr. Mikah Owen
Member, Board of Directors
Office of Health Care Affordability
2020 W. El Camino Ave.
Sacramento, CA 95833

Subject: OHCA Must Establish Thoughtful, Reasonable Enforcement Process
(Submitted via email at ohca@hcai.ca.gov)

Dear Dr. Owen:

As a new member of the Office of Health Care Affordability (OHCA) board, I wanted to write directly to convey our concerns that have been expressed, but seemingly not seriously considered, by the OHCA board. In sum, Montage Health/Community Hospital of the Monterey Peninsula (CHOMP) agrees that the cost of healthcare nationally, and in California, is too high. We are also more than willing to be a part of the solution to this issue and continue to take significant steps to this end. Additionally, the OHCA board steadfastly refuses to consider the overall cost of the care that we provide to residents throughout Monterey County for which there is no reimbursement. 80% of our patient population is covered by governmental insurance programs (Medi-Cal or Medicare) and the reimbursement we receive from these programs does not cover the actual cost of care, leading to financial shortfalls. This high percentage of patients covered by governmental programs is outsized compared with most other healthcare systems, and places a large burden on the commercially insured patients we care for to balance the shortfalls from governmental reimbursement programs. Additionally, our community population health programs, our physician practice (Montage Medical Group), our Medicare Advantage plan (Aspire Health), and many other programs under Montage Health are loss leaders for the organization, but are critical to the overall care of our community.

In sum, we strongly object to the notion that focusing on one small aspect of the overall cost of healthcare in California—the commercial reimbursement rates of seven hospitals—is an appropriate tactic without considering the impact of other stakeholders contributing to those high costs (insurers, pharmaceutical industry, medical device manufacturers, medical supply companies, etc.) The high costs of our healthcare system are a complex issue, and approaches to address those costs require nuanced, balanced actions considering all of the stakeholders within the industry. Instead, OHCA has refused to acknowledge that complexity and has marched forward with flawed actions that will worsen the affordability, quality, equity, efficiency, access, and value of healthcare service delivery in California.



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CHOMP urges the OHCA board to instead promulgate regulations that balance affordability with continued access to care by:

- **Informing hospitals how their spending growth will be assessed against the target and clarifying how payer and service mix will be considered**
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To adapt to the new financial environment, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), we have taken the following steps:

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- With 76% of our labor costs falling outside of collective bargaining agreements and thus subject to OHCA's cap, CHOMP is facing difficult decisions regarding our workforce

And yet, those efforts might not be enough. However, CHOMP has no way of knowing that, because OHCA has yet to finalize how spending will be measured, which payer and service lines will count, and what rules hospitals will be required to follow. Troublingly, OHCA has



indicated that it will base its determinations on only a single year of data, which may be woefully misleading. Consider that for CHOMP, year-over-year data show an average 9.2% expense trend with the annual trend by year of: 7.0% in 2021, 12.0% in 2022, 14.5% in 2023, 2.1% in 2024 and 10.6% in 2025. One year in isolation does not give an accurate picture of CHOMP's spending trends.

Worse, OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. For CHOMP, that means greater investment in one area could be offset by lower spending in another — but we would still be penalized for work and conditions like:

- Increasing access to efficient and effective outpatient treatment, which patients often prefer as they are able to get the care they need without a hospital stay.
- Maintaining revenue increases to keep up with costs in the face of federal funding cuts under the OBBBA. (Again, it is important to note that **CHOMP's payer mix is 80% governmental** so the majority of our reimbursement is fixed, non-negotiable and falls below the actual cost of care.)

CHOMP is committed to helping patients afford the care they need. That is why we offer financial assistance programs, medical debt forgiveness, free clinics for certain services, and free vaccination programs. In 2025, we provided community benefit services totaling \$228 million; these are free or subsidized programs that focused on building health communities, health education and wellness, improving access to primary and specialty care.

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Penalties at the levels proposed by OHCA would threaten CHOMP's viability, jeopardize our patients' health, and endanger the livelihoods of the 3,000 workers who rely on us. CHOMP is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce — priorities we share with the office. In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect health care workforce stability. It has various tools at its disposal to do this, including adjustments to the spending targets and considering labor cost growth as a justifiable reason that an entity exceeded its spending target. CHOMP urges OHCA to treat all health care workers equitably and ensure that neither our frontline workers nor the hospital itself are punished for wages and benefits that grow above the spending target.



The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the Monterey Peninsula residents who pass through our doors each year. CHOMP appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We look forward to working with the office as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

A handwritten signature in blue ink, appearing to read "M. McDermott".

Michael McDermott, MD, MBA
President and Chief Executive Officer

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



August 20, 2026

Sent by email to: OHCA@HCAI.CA.Gov

Honorable Members of the Health Care Affordability Board
Office of Health Care Affordability
Department of Health Care Access and Information
2020 West El Camino Avenue
Sacramento, California 95833

Re: Proposed NOLA Regulations and Progressive Enforcement Framework

Dear Chair Johnson and Members of the Health Care Affordability Board:

Kaiser Permanente (“KP”) appreciates the opportunity to provide comments regarding the Office of Health Care Affordability’s (“OHCA”) proposed Nonsupervisory Organized Labor Adjustment (“NOLA”) Regulations and progressive enforcement framework.

We recognize that the Health Care Affordability Board has a central role in establishing California’s health care affordability framework. The Board establishes statewide and sector-specific health care spending targets and approves key methodologies and benchmarks. Importantly for the issues addressed in this letter, the Board is also responsible for approving the scope and range of administrative penalties and the penalty-justification factors that govern the application of penalties. OHCA, through its Director, is responsible for implementing and enforcing the statutory cost targets and the Board-approved framework. Cal. Health & Safety Code § 127501.11.

Accordingly, KP respectfully urges the Board to ensure that the final framework reflects the statutory objectives of promoting affordability while preserving and promoting the equally important statutory objectives of advancing quality, access, equity, and workforce stability. The enforcement framework should reflect a balanced approach that recognizes the interrelationship among these goals, and must also provide a fair, transparent, predictable, and proportionate process for regulated entities. In particular, the framework should distinguish between circumstances that explain or mitigate missing a spending target and conduct that warrants escalating enforcement. Before approving the final scope and range of penalties, the Board should ensure that the corresponding enforcement standards and mitigating circumstances are clearly defined.

I. NOLA Regulations

KP understands that OHCA is revising the NOLA Regulations in response to stakeholder feedback and to clarify and codify their requirements. KP shares OHCA's goal of ensuring that the regulations are clear, actionable, and achievable for regulated entities.

A. Actual Versus Prospective Labor Cost Adjustments

KP appreciates OHCA's verbal clarification that regulated entities may submit actual labor costs during the enforcement consideration process, rather than being limited to prospective labor costs submitted before the target year.

KP understands that OHCA intends to clarify this point in the forthcoming enforcement regulations. We respectfully request that the same clarification be included in the NOLA regulations so that an entity reviewing either regulation will understand that it may submit actual labor costs based on existing labor contracts.

We further request that both the NOLA and enforcement regulations expressly provide that an entity's decision not to seek prospective adjustment does not waive its ability to present actual labor costs during the enforcement consideration process. This clarification is important because actual labor costs will not be known until after contracts are negotiated.

B. Labor Organization Submissions

KP appreciates OHCA's verbal clarification that labor organizations may not submit labor adjustment requests on behalf of a regulated entity or validate an entity's financial data without the entity's consent.

KP respectfully requests that the NOLA regulations state this requirement expressly. To avoid ambiguity, the regulations should make clear that OHCA will not accept a labor submission on behalf of a regulated entity unless the regulated entity has authorized or consented to the submission.

C. Confidentiality

KP continues to have concerns regarding the confidentiality protections contemplated by the NOLA regulations.

First, the process as proposed places an unnecessary burden on regulated entities by requiring them to affirmatively request confidential treatment, provide a basis for the request, and demonstrate how the information has been maintained as confidential. KP respectfully recommends that the regulations instead establish a presumption that non-public information submitted to OHCA is confidential, except for information that is already publicly available. This approach would simplify the submission process, establish a clearer rule for regulated entities, and facilitate efficient review by OHCA staff.

Additionally, KP is concerned that information for which confidential treatment has been granted could subsequently be shared with other governmental agencies without adequate notice or protection. KP respectfully urges OHCA to provide advance notice before sharing information for which confidential treatment has been granted and ensure that any confidentiality protections accompany the information when it is shared with another governmental agency.

II. Progressive Enforcement Framework

The statutory framework is intended to provide regulated entities with opportunities to understand and address the factors contributing to spending growth before financial penalties are imposed.

The Board's role is particularly important here. The Legislature vested the Board with responsibility for establishing the enforcement framework, including the scope and range of administrative penalties, penalty-justification factors, and related standards governing enforcement. While OHCA staff and the Director are responsible for implementing and applying that framework in individual cases, the Board's decisions will determine the degree of flexibility available to account for mitigating circumstances, distinguish among different forms of noncompliance, and ensure that enforcement advances affordability while preserving quality, access, equity, and workforce stability.

A. Penalty Calculation and Range

KP understands that there would be two distinct opportunities to account for circumstances affecting an entity's spending performance. First, after an entity is notified that it exceeded its target, the entity would have 45 days to submit information supporting adjustments based on labor costs and circumstances outside its control. Second, during the penalty-justification phase, OHCA would consider factors including the nature, number, and gravity of the relevant offenses in determining the appropriate (or any) penalty.

Our understanding was that these penalty-justification factors could mitigate the initially commensurate penalty amount and potentially result in a penalty substantially below the initial amount. The materials released in advance of the August Board meeting, however, describe a formal penalty range of 100–125 percent of the initially commensurate amount.

Because the Board is responsible for establishing the scope and range of penalties that may ultimately be imposed, KP respectfully asks the Board to ensure that it has sufficient information regarding how mitigating circumstances, penalty-justification factors, and enforcement considerations will actually operate before approving a final penalty framework. The Board's decision will shape the discretion available to the Director and OHCA staff when applying the framework in individual enforcement proceedings.

A financial penalty should be reasonable and proportionate and should account for circumstances that materially affect an entity's ability to control spending growth. These circumstances may include, among others:

- mandated benefits and other requirements imposed by state or federal law;
- inflation;
- labor and supply costs;
- high-cost drugs and patients;
- infrastructure investments;
- increased demand for services; and
- other circumstances outside the entity's reasonable control.

The framework should also recognize positive performance in areas that are central to the broader objectives of the health care affordability program, including quality, access, equity, workforce stability, and affordability initiatives.

KP respectfully encourages the Board to consider whether a multi-year approach would produce a more reliable and equitable measure of performance rather than relying principally on a single year's spending growth. Spending can experience significant year-to-year volatility for reasons outside an entity's control. A framework that considers multiyear spending trends would better distinguish persistent performance concerns from temporary fluctuations.

Other jurisdictions, such as Oregon, have adopted approaches that recognize the limitations of single-year measurements and the risk to the health care system of significant, disproportionate penalties. KP encourages OHCA to consider approaches as the Board evaluates the appropriate penalty framework.

B. Progressive Enforcement Must Provide a Meaningful Opportunity for Remediation

KP supports a progressive enforcement model that gives entities a meaningful opportunity to understand the drivers of spending growth and take corrective action before financial penalties are imposed.

The regulations should therefore clearly describe the full chronology of progressive enforcement, including:

- what is required of an entity at each stage;
- the criteria OHCA will use to determine whether an entity progresses to the next stage;
- the circumstances under which technical assistance or a Performance Improvement Plan ("PIP") may resolve the matter without further enforcement; and
- how and when OHCA will formally close an enforcement process.

This clarity is necessary not only for regulated entities to understand their obligations and opportunities for remediation, but also for the Board to evaluate whether the proposed penalty scope, range, and justification factors are appropriate. Before establishing the final penalty framework, the Board should ensure that regulated entities have clear notice regarding how OHCA will evaluate mitigating circumstances, determine whether escalation is warranted, and apply enforcement considerations throughout the progressive enforcement process. A penalty framework should not depend on future discretionary judgments without corresponding standards that promote transparency, consistency, and predictability.

C. Selection of Entities for Progressive Enforcement and Enforcement Considerations

KP urges OHCA to established a clear framework or formula for determining which entities that exceed a spending target will proceed through progressive enforcement and to ensure the forthcoming regulations provide clarity and transparency regarding how the framework will operate.

Specifically, the regulations should clearly identify:

- the criteria that will determine which entities proceed through each stage of progressive enforcement and how those criteria will be applied consistently;

- where in the progressive enforcement process OHCA will evaluate enforcement considerations;
- how entities should present information concerning factors outside their control, including labor costs, mandated benefits, inflation, supply costs, high-cost drugs and patients, infrastructure investments, increased demand, and other relevant circumstances; and
- how OHCA will account for positive performance relating to quality, access, equity, workforce stability, and affordability.

KP also believes that an entity's performance over multiple years provides important context. The most significant enforcement measures should be reserved for repeated, unexplained, or bad-faith noncompliance rather than a single-year target miss and/or target miss attributable to temporary or external circumstances.

D. Interim PIP Milestones and "Bad Faith"

KP respectfully urges the Board to ensure that interim PIP milestones function as tools for measuring progress and supporting corrective action rather than as automatic triggers for financial penalties. Consistent with the principles of progressive enforcement, the framework should clearly distinguish between circumstances that warrant refinement of a PIP and circumstances that justify administrative sanctions. The Board's determination regarding penalty scope and justification factors should preserve sufficient flexibility for the Director to evaluate an entity's overall compliance efforts, remediation progress, and implementation challenges before imposing penalties. The regulations should also clearly define any "bad faith" standard and explain how that standard will be applied.

As the Board considers the scope and range of administrative penalties and the penalty-justification factors, KP respectfully asks the Board to ensure that the overall framework is transparent, predictable, proportionate, and consistent with the statutory design of progressive enforcement. Clear standards are needed throughout the process, including technical assistance, public testimony, PIPs, remediation efforts, and penalty determinations. Regulated entities should understand the criteria that govern escalation, the opportunities to present relevant information, and how OHCA will evaluate mitigating circumstances and other enforcement considerations.

III. PIP Implementation

Effective PIPs require sufficient time for entities to identify the drivers of spending growth, implement corrective actions, and demonstrate measurable results. Because spending growth is often assessed retrospectively and many costs are established well in advance of a performance year, entities should not be evaluated based on periods during which they did not have a meaningful opportunity to influence performance.

Technical assistance and PIPs should function as meaningful opportunities to improve performance, rather than simply procedural prerequisites to public testimony or financial penalties.

KP therefore respectfully asks OHCA and the Board to consider:

- consolidating overlapping PIPs where appropriate;
- structuring PIPs prospectively so that entities are evaluated on periods during which they can reasonably affect performance;
- holding entities harmless for periods before they have had a reasonable opportunity to implement required changes;

- extending the PIP submission period to at least 90 days; and
- reserving public testimony and financial penalties for repeated, unexplained, or bad-faith noncompliance rather than a single-year target miss attributable to external or temporary factors.

IV. Conclusion

Kaiser Permanente supports OHCA's overarching objective of improving health care affordability and recognizes the importance of establishing a meaningful and effective framework for addressing excessive health care cost growth.

At the same time, the effectiveness and credibility of the program will depend on whether regulated entities have clear rules, meaningful opportunities to explain circumstances affecting their performance, and a progressive enforcement process that appropriately distinguishes between circumstances outside an entity's control and conduct warranting financial penalties.

As the Board exercises its responsibility to establish the enforcement framework and the permissible scope and range of administrative penalties, KP respectfully asks the Board to ensure that the standards it adopts provide adequate flexibility for the Director and OHCA staff to distinguish between isolated target misses, external cost pressures, good-faith remediation efforts, and repeated or continuing noncompliance.

KP appreciates the Board's consideration of these issues and OHCA's continued engagement with stakeholders. We look forward to continuing to work collaboratively with OHCA and the Board as the NOLA and progressive enforcement regulations are developed and finalized.

Sincerely,



Deborah Espinal
Vice President
Policy and Regulatory Affairs
Kaiser Permanente



Administration
777 Turner Drive
San Jose, CA 95128

(408) 885-4010
www.SCVH.org

August 17, 2026

Secretary Kim Johnson
Chair, Health Care Affordability Board
2020 El Camino Avenue, Suite 1016
Sacramento, CA 95833
OHCA@hcai.ca.gov

Subject: Comments for August 2026 Health Care Affordability Board Meeting

Dear Chair Johnson,

Santa Clara Valley Healthcare appreciates the opportunity to provide additional comment on the Office of Health Care Affordability's proposed financial penalties for spending target performance.

As you know, Santa Clara Valley Healthcare operates the largest public healthcare system in Northern California, serving 460,000 unique patients every two years through our four (4) hospitals and 15 comprehensive health centers and is expecting utilization to increase as community members lose coverage due to HR 1 and related eligibility changes to state-only Medi-Cal coverage.

Our integrated healthcare delivery system provides a comprehensive array of primary, specialty and tertiary care, including:

- Over 60 adult and pediatric specialties and subspecialties,
- Level 1 and 2 adult trauma and Level 2 pediatric trauma services,
- Regional Burn Center,
- The Sobrato Cancer Center, and
- Our Rehabilitation Center which earned national recognition as one of U.S. News & World Report's 2026–2027 [Top 10 Best Hospitals for Rehabilitation](#).

Our system has grown significantly over the decade as the County purchased O'Connor Hospital and St. Louise Regional Medical Center out of bankruptcy in 2019 and in 2025 purchased Regional Medical Center from the Hospital Corporation of America after it closed its maternity and trauma services and downgraded stroke and STEMI-services. Furthermore, over the past four (4) years, our County Health System opened four (4) new Health Centers, offering primary, specialty and urgent care, to meet the growing demand for services, particularly in previously underserved areas of Santa Clara County. We await federal approval to open a new Health Center on the San Jose/Campbell border.

Santa Clara Valley Healthcare is the predominant provider of care to patients who rely on Medi-Cal

for health coverage. Our Health System provides the majority of all Medi-Cal hospital days for those living in Santa Clara County and continues to serve as the safety net for Medicare and Medi-Cal patients requiring specialty services.

Santa Clara Valley Healthcare takes seriously our mission to provide high-quality, compassionate care to all residents regardless of socio-economic status or ability to pay. We share the goals of the Office of Health Care Affordability (OHCA) to improve affordability for patients and slow the growth of health care spending.

As our community increasingly relies on our system, it is critical that our County Health System not be penalized for efforts to secure the revenue necessary to maintain the services our community needs as federal and state funding are cut, creating a \$1 billion loss in revenue by Fiscal Year 2029. Addressing losses this large require increasing revenues or changes to service lines that will negatively impact access to care – outcomes contrary to OHCA's goals.

It is from that lens that we offer the following comments and concur with the points raised in the California Association of Public Hospitals' July 31, 2026 comments to your Board. 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:

- Public hospitals and healthcare systems Medi-Cal revenues come through self-financed payments, meaning we provide the nonfederal share and receive only the federally matched (net) portion as revenue. However, many hospitals in public health care systems report the gross amount of these payments, which includes the nonfederal share we provide, in 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 revenue by not accounting for self-financing. Moreover, 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.
- Under the proposed framework, those organizations that are required to submit PIPs have only 45 days to respond to the requirement, with the possibility of a 30-day extension. 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 at least 60 days and increase the extension window from 30 to at least 45 days. The short timeframe proposed would not allow sufficient time to understand if the data is correct, then develop meaningful change.

- 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.
- OHCA's proposed penalty structure begins with an amount "initially commensurate" with a hospital's failure to meet the target and then adjusts for justification factors. OHCA's analysis of 2023 data showed "initially commensurate" penalties for public hospitals reaching \$236 million and showed that proposed penalties could reach 125% of the initially commensurate amount at maximum. Financial penalties of this magnitude would cause significant instability in the health care safety net, risking service line and facility closures for public hospitals already facing historic payment cuts. As the Board considered penalties, we strongly encourage reconsideration of the proposed penalty structure and set a measured starting point, especially this early in the implementation of the spending target.

With the magnitude of funding losses our Health System faces, we are taking every action possible to develop budget solutions and efficiencies, including eliminating 200 positions in February, with another 64.5 positions in July 1. Such budget solutions are not enough to fill the gap, so we will be faced with increasing revenue and scaling back services, to maintain access to care for patients. The proposed penalty structure could further destabilize public healthcare systems like ours, putting care at risk for the communities we serve.

Given these concerns and the changing healthcare landscape, Santa Clara urges the Office of Health Care Affordability and Health Care Affordability Board to consider the points raised above and make changes that would allow public healthcare systems like Santa Clara Valley Healthcare to continue providing high-quality, comprehensive care without sacrificing services to pay penalties.

Sincerely,

Signed by:



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Paul E. Lorenz

Chief Executive Officer

Santa Clara Valley Healthcare