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

Health Care Affordability Board
May 2026
Public Comment

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

Date	Name	Written Comment
5/22/2026	Brenda Rojas	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/22/2026	Kit Bear	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, I have to delay or ration care, or make difficult decisions about what to prioritize financially. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/22/2026	Washington Health	See Attachment #1.
5/23/2026	Henry Rosenfeld	Californians like my 33 year old son who has a chronic illness face high costs of living, and cannot afford the ever-escalating price of health care. Because of these expenses, he has to delay or ration care, or make difficult decisions about what to prioritize financially for himself, his wife and four year old daughter. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/23/2026	Abby Bernstein	Californians like myself face high costs of living, and cannot afford the ever-escalating price of health care. I don't want unbearable medical debt. I don't want my friends and neighbors to face unbearable medical debt. One friend moved to another country

Date	Name	Written Comment
		so that she could afford treatment for her multiple sclerosis. This is appalling. Consumers can't wait, we need the Board to enforce cost-growth targets with real penalties!
5/29/2026	Ronit Corry	Health care should be a right, not a privilege for the rich! The government is supposed to protect us, not allow companies to take advantage of us. I cannot afford the high price of healthcare. I should not have to choose between healthcare or paying my bills and eating, should I? Especially in the richest country in the world! Please do something about this!!!
6/5/2026	Kern Medical	See Attachment #2.
6/5/2026	Joan Hartmann, Third District Supervisor, County of Santa Barbara	See Attachment #3.
6/8/2026	California Association of Health Plans	See Attachment #4.
6/9/2026	Santa Barbara South Coast Chamber of Commerce	See Attachment #5.
6/11/2026	Sierra View Medical Center	See Attachment #6.
6/11/2026	Marshall Medical	See Attachment #7.
6/15/2026	Mary Casillas, Hazel Hawkins Memorial	See Attachment #8.
6/15/2026	Livermore Valley Chamber of Commerce	See Attachment #9
6/15/2026	NorthBay Health	See Attachment #10.
6/15/2026	CenCal Health	See Attachment #11.
6/15/2026	San Mateo County Economic	See Attachment #12.

Date	Name	Written Comment
	Development Association	
6/16/2026	Pomona Valley Hospital Medical Center	See Attachment #13.
6/16/2026	Andrew Guarni, Hoag Memorial Hospital	The enforcement process established by the Office of Health Care Affordability (OHCA) must improve affordability while protecting access to care. To do that, OHCA must: • Inform hospitals how their spending growth will be assessed against the target and clarify how payer and service mix will be considered. • Base 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 targets. • Standardize the process for explaining growth above the target, as established under the statutory waiver process. • Establish a collaborative performance improvement process that gives hospitals a real opportunity to improve before fines are levied. • Phase in penalty amounts and account for essential circumstantial factors, like investments in patient-centered care or a hospital's financial condition. Instead, OHCA is seeking massive penalties that won't make care more affordable — they'll simply undermine the entire system of care. • A single year of exceeding the target could trigger penalties in the tens or hundreds of millions of dollars — more than many hospitals even earn from patient care. • For , a penalty of that magnitude would mean: [share how your organization might attempt to absorb multi-million-dollar fines, if even possible]. • Thoughtful enforcement that relies on collaboration between OHCA and hospitals is the only way to ensure that patients' access to care is not diminished as hospitals navigate performance improvement. • The One Big Beautiful Bill Act is the largest health care cut in American history. OHCA must act now to protect access to care, including how it enforces the spending targets. The

Date	Name	Written Comment
		current enforcement process is not sustainable and sets hospitals up to fail through unclear measurement processes, overly broad “violation” criteria, and financially crippling fines. • Halfway through the first enforcement year, hospitals have little clarity on how their performance will be measured. The methodology is not yet validated, the data are incomplete, and the rules are not codified. • What’s more, OHCA’s approach of enforcing separately across every payer and service line sets up six separate ways to violate the target. The result: Using OHCA's own data, 92% of hospitals would have been in violation in 2023. • This is hardly the foundation upon which to base exorbitant fines, and yet that’s exactly the path OHCA has pursued. Thank you for your consideration.
6/16/2026	Casa Colina Hospital	See Attachment #14.
6/17/2026	Mountain View Chamber of Commerce	See Attachment #15.
6/17/2026	Valley Children’s Hospital	See Attachment #16.
6/17/2026	Stanford Medicine Children’s Health	See Attachment #17.
6/17/2026	Chamber of San Mateo County	See Attachment #18.
6/17/2026	Pleasanton Chamber of Commerce	See Attachment #19.
6/17/2026	United Hospital Association	See Attachment #20.
6/17/2026	County of Santa Barbara	See Attachment #21.
6/17/2026	Ridgecrest Regional Hospital	See Attachment #22.

Date	Name	Written Comment
6/17/2026	Monterey Bay Economic Partnership	See Attachment #23.
6/17/2026	Stanford Health Care	See Attachment #24.
6/17/2026	Stanford Health Care Tri-Valley	See Attachment #25.
6/18/2026	Kindred Hospital	See Attachment #26.
6/18/2026	Cottage Health	See Attachment #27.
6/18/2026	California Hospital Association	See Attachment #28.
6/18/2026	Adventist Health	See Attachment #29.
6/18/2026	Health Access California	See Attachment #30.
6/18/2026	Pebble Beach Company	See Attachment #31.
6/18/2026	Glendora Hospital	See Attachment #32.
6/18/2026	College Hospital Costa Mesa	See Attachment #33.
6/18/2026	College Medical Center	See Attachment #34.
6/18/2026	Dublin Chamber of Commerce	See Attachment #35.
6/18/2026	California Association of Public Hospitals and Health Systems	See Attachment #36.
6/18/2026	Washington Health	See Attachment #37.
6/18/2026	California Children's Hospital Association	See Attachment #38.
6/18/2026	Roy Lee, Santa Barabara County	See Attachment #39.

Date	Name	Written Comment
	Supervisor, First District	
6/18/2026	Sharp HealthCare	See Attachment #40.
6/18/2026	Sutter Health	See Attachment #41.
6/18/2026	Children's Specialty Care Coalition	See Attachment #42.
6/18/2026	College Hospital Cerritos	See Attachment #43.
6/18/2026	Santa Clara Valley Healthcare	See Attachment #44.
6/18/2026	MemorialCare	See Attachment #45.
6/18/2026	University of California Health	See Attachment #46.
6/18/2026	Mountains Community Hospital	See Attachment #47.
6/18/2026	Hoag Hospital	See Attachment #48.
6/18/2026	Montage Health/CHOMP	See Attachment #49.
6/18/2026	District Hospital Leadership Forum	See Attachment #50.

?rr_afkclr!/

Washington Health

May 22, 2026

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

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

Dear Chair Johnson:

At the March meeting of the Health Care Affordability Board, board members concurred with the staff's recommendation not to remove Washington Health (WH) from the high-cost outlier list, despite substantial evidence demonstrating that Washington Health no longer meets the criteria for inclusion and should be removed at the earliest opportunity.

Washington Health has taken extensive, proactive steps to validate this position. We resubmitted our HCAI Hospital Annual Financial Disclosure Report (HAFDR), met twice with OHCA staff, and received formal validation and acceptance of our revised data from HCAI. Based on these actions, we reasonably anticipated that OHCA staff would rerun the target adjustment analysis and recommend Washington Health's removal from the list. Instead, staff recommended that no updated analysis be conducted for hospitals that resubmitted data, and the Board subsequently declined to take action, despite the fact that Washington Health no longer qualifies for inclusion on the high-cost outlier list.

As a result, it now appears that Washington Health will remain on the list until well into 2027, pending OHCA's future review cycle. This delay is not a neutral administrative matter. It is causing ongoing reputational and financial harm to Washington Health, misleading the public about the health system's cost profile, and impairing the institution's standing in the marketplace.

Accordingly, while the Board has chosen not to remove Washington Health from the list at this time, we respectfully request that OHCA publicly acknowledge in writing at a future board meeting that Washington Hospital no longer meets the criteria for inclusion and will be removed at the earliest opportunity, consistent with statutory and procedural requirements.

We believe such a statement would represent an important step towards correcting public perception and reinforcing the principles of fairness, accuracy, and transparency that should guide this process.

2000 Mowry Avenue
Fremont, CA 94538
510.797.1111

www.washingtonhealth.com

Washington Health is an independent, public health care district serving all the residents of southern Alameda County, regardless of their ability to pay. Our continued inclusion on this high-cost outlier list is negatively affecting our reputation and is impairing our ability to negotiate with payors. We respectfully ask OHCA to mitigate this ongoing harm through a clear public acknowledgment of our current status.

Thank you for your attention to this matter. We appreciate your consideration and look forward to your response.

Sincerely,

Kimberly Hartz
Chief Executive Officer
Washington Health

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

KernMedical | 160 YEARS Health for Life.

June 5, 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, 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 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

Kern Medical is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our salary expenses grew by 12%, benefits expenses increased by 9%, our medical supply costs grew 11%, and our total expenses increased 9%. 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 potentially challenging decisions that will result in terrible impacts to staff, services, patient access, and our community at large. We are only projecting a 0.2% net income margin this coming year. How can OHCA contemplate potential penalties and fines that will wipe out what little financial cushion we have?

In addition to the rapidly increasing costs at Kern Medical, we face the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA). Our hospital operates efficiently and we are disciplined with managing our costs with our staff productivity and expense ratios performing within industry standards.

Our efforts to maintain positive margins may not be enough because Kern Medical has no way of knowing how to plan 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 Kern Medical, over the last 10 years our total annual expenses have increased 4% to 12% each year. To recap our last five fiscal years, our total expenses have increased as follows:

- FY2021: 8%
- FY2022: 4%
- FY2023: 6%
- FY2024: 6%
- FY2025: 9%

One year in isolation does not give an accurate picture of Kern Medical's or any hospital'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.
- Information technology investments far exceed OHCA's cost targets and many IT costs remain unknown with the coming of AI.

Kern Medical is committed to helping patients afford the care they need, especially at one of California's designated public safety net hospitals caring for the most vulnerable. That's why we offer financial assistance programs, a sliding fee scale, and other programs to assist our patients and improve access to care in our underserved community.

Kern Medical also understands that affordability in the long term can't happen without focused efforts now. That's why we're committing investments in community-based care, from our primary care clinics, shelter-based medicine, mobile clinics, value-based contracts, quality programs, and programs to address social determinants of health. All these are part of our efforts to support our patients, community, and manage our costs in a disciplined manner.

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 staff who rely on us as their employer. 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.

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. Kern Medical 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 all of Kern County's 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:
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 Shannon Grove, Senate District 12
Senator Melissa Hurtado, Senate District 16
Assemblymember Stan Ellis, Assembly District 32
Assemblymember Dr. Jasmeet Bains, State Assembly District 35

Attachment #3

JOAN HARTMANN
Third District Supervisor

County Administration Building
105 East Anapamu Street
Santa Barbara, California 93101
Telephone: (805) 568-2192

COUNTY OF SANTA BARBARA

SENT VIA EMAIL

June 5, 2026

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

Subject: Office of Health Care Affordability (OHCA) Enforcement Must Not Jeopardize Our Community's Health

Dear Chair Johnson:

I write to express my concern about the potential community impacts of enforcement actions or penalties by the Office of Health Care Affordability against Santa Barbara Cottage Health.

Santa Barbara Cottage Hospital, Goleta Valley Cottage Hospital, and Santa Ynez Valley Cottage Hospital comprise the Cottage Health system and are critical health care providers for our region. With no public hospital in Santa Barbara County, Cottage Health serves as the primary hospital system for a significant portion of our county. Residents depend on Cottage Health every day, and especially in emergencies.

Santa Barbara Cottage Hospital's Level I Trauma Center is a vital regional resource, serving patients not only from Santa Barbara County, but also from neighboring Ventura and San Luis Obispo Counties. Cottage Health also provides extensive pediatric specialty services, maternity care, labor and delivery, and other critical health services that are not available elsewhere in the County. In the rural Santa Ynez Valley, which I proudly represent, Santa Ynez Valley Cottage Hospital, with its 11 beds and small emergency department, provides essential emergency care for residents and visitors who would otherwise face significant travel times during urgent medical situations.

Cottage Health invests in the future of our regional health care workforce through training programs for new doctors, nurses, and other health care professionals. These programs are essential to maintaining access to care, supporting our local economy, and sustaining the high-quality, professional health care services our residents rely on.

Cottage Health also operates in one of the most expensive regions in California, where high real estate costs and the overall cost of living create substantial challenges for recruiting and retaining a skilled health care workforce. Cottage must compete with much larger health care systems across the state and country for physicians, nurses, technicians, and other essential professionals. In response, Cottage has been a leader among hospital systems in developing innovative support for its workforce, including housing and childcare assistance. These kinds of investments strengthen patient care, support workforce stability, and should be recognized as part of the broader community value Cottage provides.

Cottage Health's contributions extend well beyond the walls of its hospitals. Through its direct services, community partnerships, and philanthropic investments, Cottage is a significant contributor to the health care safety net in our region. Santa Barbara County is a community of great resources, but also deep disparities. It is no secret that wealth gaps in our county are substantial, and without the safety net role Cottage plays, those gaps would be even more pronounced in terms of access to health care.

Gina Fischer
Chief of Staff
gfischer@countyofsb.org

Alma Hernández
District Representative
ahernandez@countyofsb.org

Meighan Dietenhofer
District Representative
mdietenhofer@countyofsb.org

Slava Kuznyetsov
Administrative Assistant
slavak@countyofsb.org

I understand that OHCA is considering the imposition of multi-million-dollar penalties against hospitals, including community hospitals like Cottage Health. Such penalties could have significant consequences for access to care in Santa Barbara County. Our 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 our residents rely on.

OHCA's affordability goals are important, and I support efforts to make health care more accessible and sustainable for Californians. However, enforcement decisions must be carefully calibrated so they do not unintentionally undermine access to critical services, especially in communities without a public hospital.

On behalf of Santa Barbara County and the residents we serve, I respectfully urge OHCA to take a reasonable approach that protects patient care while advancing the shared goal of health care affordability.

Sincerely,

Joan Hartmann
Third District Supervisor
Vice Chair of the Board of Supervisors
County of Santa Barbara

cc: Hon. Senate President pro Tempore Monique Limón, 21st District, California State Senate
Hon. Assemblymember Gregg Hart, 37th District, California State Assembly

California Association of Health Plans

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

June 5, 2026

Sent via email:
ohca@hcai.ca.gov

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

Re: Impact of Proposed Managed Care Organization (MCO) Tax on Health Care Affordability and Spending Target Implementation

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

On behalf of the California Association of Health Plans (CAHP), we appreciate the opportunity to engage with OHCA as as the state continues to advance its affordability framework. We recognize OHCA's critical role in promoting sustainable cost growth and ensuring that Californians have access to affordable coverage.

We are writing to highlight significant concerns regarding the Governor's proposed Managed Care Organization (MCO) Tax and its intersection with OHCA's spending target framework, cost data, and enforcement model.

I. Magnitude of the MCO Tax and Affordability Impacts

The proposed MCO Tax would create a material increase in underlying health care costs of $1.5 billion a year. As we noted in our recent public comments at the May 27th OHCA Board meeting, this would place direct upward pressure on premiums in the individual, small group, and large group markets, affecting employers, families, and other purchasers already struggling with affordability pressures. A working family of four would pay more than $400 a year. For employers, those pressures may contribute to reduced participation in fully insured products and increased movement toward self-funded arrangements, particularly among price-sensitive purchasers. These concerns link directly to the affordability objectives that OHCA is charged with advancing.

II. Interaction with OHCA Spending Targets and Enforcement

The proposal also creates a serious tension with OHCA's spending target framework. Plans are already subject to spending growth targets and, increasingly, scrutiny through OHCA's enforcement process. If enacted, the MCO Tax would require plans to absorb a substantial new state-imposed cost beginning in 2027, while at the same time remaining accountable for limiting total expenditure growth. Without explicit recognition of this tax within OHCA's framework, plans may face conflicting policy expectations—on the one hand, incorporating the tax into premiums, and on the other, being measured against spending targets that do not account for the resulting increase.

III. Importance of Cross-Agency Alignment

We also believe the MCO Tax proposal highlights the importance of cross-agency alignment. The tax sits at the intersection of multiple state policy and regulatory structures, including DMHC oversight, DHCS financing, Covered California affordability concerns, and OHCA's spending target implementation. If each entity proceeds without coordination, plans may face incompatible regulatory signals and heightened compliance risk. For that reason, we respectfully urge OHCA to work closely with sister agencies to ensure that state-imposed cost increases such as the MCO Tax are reflected consistently and appropriately across affordability, rate review, and spending target frameworks. At a minimum, OHCA should clarify how such externally driven cost increases will be treated in future performance assessments, performance improvement plans, and enforcement determinations.

IV. Cost Driver Transparency

As OHCA continues to build out its affordability framework, we believe it will be important to ensure that payer cost and financial data are interpreted in full context. As we noted in our recent public comments to the Board, discussions around administrative costs and profits are often presented at a high level but can obscure the underlying components that make up those figures, including taxes, regulatory compliance, and reporting obligations in addition to core administrative functions. If the MCO Tax proceeds, it will only heighten the importance of distinguishing between externally driven cost burdens and discretionary spending choices when evaluating payer performance, especially since this massive tax would count as "administrative" costs. We respectfully encourage continued transparency in OHCA's methodology and a clear accounting of how new cost drivers such as the MCO Tax are reflected in both data presentation and enforcement policy.

V. Conclusion

We appreciate the Board's continued attention to issues affecting affordability and access. However, if the MCO Tax passes and is implemented, we respectfully request that the spending targets for the corresponding effective years of this tax be adjusted to account for its impact on total health care expenditures.

Sincerely,

Charles Bacchi
President & CEO

SANTA BARBARA
SOUTH COAST
CHAMBER OF COMMERCE
FROM GOLETA TO CARPINTERIA

805.967.2500
SBSCChamber.com
Mailing Address: 5662 Calle Real #204, Goleta CA 93117
Visitor Center: 120F State Street, Santa Barbara CA 93101

June 9, 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 South Coast Chamber of Commerce values Cottage Health as an important leader 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 South Coast Chamber of Commerce is deeply concerned about how our community, including employers and businesses 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. And with its 11 beds and small emergency room, Santa Ynez Valley Cottage Hospital offers crucial emergency services to the rural Santa Ynez Valley. Without these hospitals, our residents will have to travel far from home for healthcare.

Cottage Health also invests in the future of the regional health care workforce through training programs for new doctors, nurses, and other health care professionals. These programs are essential to maintaining access to care, supporting the local economy, and serving as a pipeline to well-paying jobs for our region. Cottage supports its workforce (and access to healthcare) through innovative programs such as workforce housing and childcare assistance. These kinds of investments strengthen patient care, support workforce stability and community health. Without these programs, it would be even more difficult to retain healthcare workers in Santa Barbara.

Cottage Health's contributions extend well beyond the walls of its hospitals. Through its direct services, community partnerships, and philanthropic investments, Cottage is a significant contributor to the health care safety net in our region. Cottage provides significant charity and discounted care and offers a wide variety of community health programs that benefit the most vulnerable.

SANTA BARBARA
SOUTH COAST
CHAMBER OF COMMERCE
FROM GOLETA TO CARPINTERIA

805.967.2500
SBSCChamber.com
Mailing Address: 5662 Calle Real #204, Goleta CA 93117
Visitor Center: 120F State Street, Santa Barbara CA 93101

We understand that OHCA is considering imposing multi-million-dollar penalties against hospitals, including community providers like Cottage Health. These penalties will hurt access to care in Santa Barbara County. If OHCA levies financial penalties on Cottage Health, health care services will certainly be impacted. Our community is already facing serious health care funding challenges, including cuts from H.R. 1 and other government actions that are reducing resources available to the safety net. Additional financial strain on local hospitals will only make it harder to preserve the services that patients in our 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.

OHCA's decisions now will have a ripple effect on our communities for years to come. On behalf of the Santa Barbara business community, the Santa Barbara South Coast Chamber of Commerce urges you to reject aggressive enforcement penalties against hospitals.

Sincerely,

KRISTEN MILLER | President & CEO
SANTA BARBARA SOUTH COAST CHAMBER OF COMMERCE
(805) 967-2500 | Kristen@SBSCChamber.com

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

SIERRA VIEW
MEDICAL CENTER

?rr_af k c l r !4

June 10, 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:

On behalf of Sierra View Medical Center, I am writing to express our concerns regarding the Office of Health Care Affordability's proposed spending target enforcement framework.

While we support the goal of improving health care affordability, we are concerned that the enforcement approach currently under consideration may create unintended consequences for hospitals and the communities they serve. Significant financial penalties, particularly when applied without sufficient flexibility and collaboration, could undermine the ability of health care organizations to respond to evolving patient needs and maintain access to essential services.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the 170,000+ Porterville and surrounding community residents who pass through our doors each year. Sierra View 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.

SIERRA VIEW
MEDICAL CENTER

We also urge the OCHA Board to ensure that any enforcement process accounts for the unique circumstances facing hospitals and recognizes the importance of preserving access to quality care, workforce stability, and long-term organizational sustainability.

Sierra View Medical Center remains committed to delivering high-quality, affordable care to our community and looks forward to working constructively with OHCA as the regulatory framework continues to develop.

Thank you for your consideration.

Sincerely,

Donna Hefner

Chief Executive Officer

Sierra View 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 Melissa Hurtado, California State Senate District 16
Assemblywoman Macedo, California State Assembly District 33
Congressman David Valadao, California 22nd Congressional District
Congressman Vince Fong, California 20th Congressional District

June 15, 2026

Kim Johnson, Chair
Office of 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, Marshall is compelled to share our grave 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 community. We urge OHCA to pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.

Marshall 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
- **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

Marshall is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs grew by 10%, our medical supply costs grew 9%, and our drug costs grew by 5%. From 2021 to 2025, our cost growth has been extraordinary: labor costs grew by 27%, our medical supply costs grew 46%, and our drug costs grew by 65%!

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. As part of our initiative to reduce our salary/benefit expenses, we have identified a reduction of 39 FTEs across the organization, including 3 executive positions, and are consolidating other executive functions.

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:

- Marshall has paused or canceled investments in many community projects, such as a local, collaborative healthy living initiative;

- Since Marshall's resources are limited to make the $40 million investment in our facilities to complete the state's 2030 seismic compliance, we are asking our local voters to support facility modernization with a new tax;
- Marshall is contracting out certain department functions to further reduce labor costs;
- Our employees have participated in work reduction days, taking PTO immediately rather than banking their well-earned days off; and
- We have ceased our employee pension plan.

And yet, those efforts might not be enough. But Marshall 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 will be gravely misleading. Our year-over-year expense increases noted above illustrate the volatility that makes any single year of data irrelevant. One year in isolation does not give an accurate picture of Marshall's spending trends, nor could any one year accurately reflect any hospital's cost trend.

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 Marshall, 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. Ambulatory care is a critical strategy to drive down overall healthcare costs – it makes no sense to penalize the very care that serves to reduce the high cost of hospital care in the future.
- Investments in outreach and programs that keep our highest-cost patients out of the hospital though proactive care management.

Marshall is committed to helping patients afford the care they need. For example, that's why we have structured our newest drop-in clinic as a physician clinic, reducing co-pays and costs for patients and insurers. We offer financial assistance programs, medical debt forgiveness, free clinics for certain services, and free vaccination programs.

Marshall also understands that affordability in the long term can't happen without focused efforts now. That's why we're committed to investing in preventive care and working closely with our ACO partners to continue to drive the most efficient use of healthcare dollars.

Yet penalties at the levels proposed by OHCA would threaten Marshall's viability, jeopardize our patients' health, and endanger the livelihoods of the 1,500 workers who rely on us, not to speak of the economic devastation in our county were Marshall to fail. Marshall 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. Marshall 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 150,000 El Dorado County residents who rely on us to be there. Marshall 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. As always, we welcome a site visit from the OHCA staff and Board to share our challenges and opportunities and share data that may be relevant to your understanding.

Sincerely,

Siri Nelson

Siri Nelson, President and Chief Executive Officer

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 Marie Alvarado-Gil
Assemblymember Joe Patterson

?rr_afkclr !6

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, Hazel Hawkins Memorial 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.**

Hazel Hawkins Memorial Hospital 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

Hazel Hawkins Memorial Hospital is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs grew by **8.6%**, our medical supply costs and drug costs grew by **17.4%** combined. 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:

- Hazel Hawkins Memorial Hospital no longer has the resources necessary to make the $30 to $50 million investment in our facilities to meet the state's 2030 seismic compliance goals.
- Hazel Hawkins Memorial Hospital is having to delay capital expenditures and projects from $5 to $20 million in addition to the seismic compliance goals.

And yet, those efforts might not be enough. However, Hazel Hawkins Memorial 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

indicated that it will base its determinations on only a single year of data, which may be woefully misleading. Consider that for Hazel Hawkins Memorial Hospital, year-over-year total expenditures less depreciation have increased by **10%**. One year in isolation does not give an accurate picture of Hazel Hawkins Memorial Hospital's spending trends.

Worse, OHCA has also indicated it may consider separate enforcement across every payor and service line, giving hospitals six separate ways to violate the target. For Hazel Hawkins 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 OBBBA.
- Not investing in high-cost areas of treatment that would result in meaningful improvements for patients, but would put our hospital at risk of exceeding the cap.

Hazel Hawkins Memorial Hospital is committed to helping patients afford the care they need. That's why we offer charity care and financial assistance programs, medical debt forgiveness, and free vaccination programs. The hospital's bad debt and charity care expenses have increase by **5%** and **63.7%** respectively.

Hazel Hawkins Memorial Hospital 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 partnering with other health care providers.

Penalties at the levels proposed by OHCA would threaten Hazel Hawkins Memorial Hospital's viability, jeopardize our patients' health, and endanger the livelihoods of the over **700** employees who rely on us. Hazel Hawkins 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 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. Hazel Hawkins Memorial 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.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the cities of Hollister, San Juan Bautista and all other San Benito County residents who pass through our doors each year. Hazel Hawkins 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,

Name: Mary Casillas
Title: CEO
Organization: San Benito Health Care District

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
Robert Rivas, Speaker of the Assembly
John Laird, Senator

Livermore Valley
CHAMBER of COMMERCE

June 15, 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:

Livermore Valley Chamber of Commerce knows firsthand the importance of our San Francisco Bay Area's local hospitals 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 Livermore Valley Chamber of Commerce 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.**

Our mission is to enhance the business community and quality of life in the Livermore Valley through strategic advocacy, visionary leadership, innovative programs, valuable connections and partnerships. We partner with our local and regional hospitals to meet several vital community health priorities, including community centric webinars, educational programs and maintaining a sense of health safety. 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 85,000 residents we serve, Livermore Valley Chamber of Commerce urges you to take a collaborative approach that protects access while improving affordability.

Sincerely,

Sherri Souza
CEO/President
Livermore Valley Chamber of Commerce
2157 First St.
Livermore, CA 94550
925-447-1606

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
California Senator Jerry McNerney
Assembly Member Rebecca Bauer-Kahan
California Senator Aisha Wahab

?rr_af k c l r ! / .

4500 Business Center Dr.
Fairfield, CA 94534
NorthBay.org

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 discussions regarding spending target enforcement, the NorthBay Health System respectfully submits the following concerns and recommendations about the potential process outlined to date. While we support OHCA's goal of improving health care affordability for Californians, the enforcement framework currently under consideration risks producing unintended consequences that could undermine patient access, workforce stability, and the financial sustainability of community-based health care providers. Most concerning is the potential for substantial financial penalties to be imposed before hospitals have been provided with a meaningful opportunity to improve performance. **Exorbitant fines at the levels proposed would divert critical resources away from patient care rather than advancing affordability.**

NorthBay Health urges the OHCA board to adopt regulations that balance affordability objectives with continued access to high-quality care by:

- **Clearly defining how spending growth will be assessed against the established targets** 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 providers to explain spending growth above target**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before financial penalties are considered, fines are levied
- **Phasing in penalty amounts and accounting for essential circumstantial factors,** including investments in patient-centered care, workforce needs, or a hospital's financial condition

NorthBay Health is currently experiencing cost growth far more than the 3.5% spending target. Last fiscal year (2025), our labor costs increased by 8.5%, our medical supply costs increased by 10.9%, and our pharmaceutical expenses increased by 29.2%. These increases are largely driven by market forces and external factors beyond the control of individual health systems.

At the same time, providers face significant financial pressures stemming from reductions in federal health care funding, including those enacted through the One Big Beautiful Bill Act (OBBBA).

As a result, NorthBay Health has already undertaken difficult measures to adapt to this evolving financial landscape, including:

- Closing our psychiatric, home health and hospice programs despite ongoing community need for these services.
- Deferring approximately $30 million in facility investments necessary to meet the state's 2030 seismic compliance requirements.
- Evaluating workforce reductions in response to escalating labor costs and spending constraints.

Despite these actions, NorthBay Health remains unable to accurately assess its future compliance status because key elements of OHCA's enforcement methodology remain unresolved. Providers still lack clarity regarding how spending will be measured, which payer categories and service lines will be evaluated, and how compliance determinations will ultimately be made. Particularly concerning is OHCA's indication that compliance will be evaluated using only a single year of spending data, which may be woefully misleading. Considering that between 2020 and 2025 for NorthBay Health, the average increase in employment and supply costs was 6.7%. While one year only saw a 2.6% increase, the others varied between 4.2% and 9.5% which is materially higher than OHCA's annual 3% target. Evaluating a single year in isolation does not accurately reflect the organization's long-term spending trajectory and could result in penalties based on temporary fluctuations rather than sustained performance.

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 NorthBay 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. The framework could discourage investments that ultimately improve affordability and patient outcomes, including:

- Expanding access to outpatient services, 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.

Expanding clinical sites across Solano, Yolo and Napa counties to reduce travel burdens and improve patient access to care.

These investments improve community health and often reduce long-term health care costs. However, if associated expenditures are treated solely as spending growth without consideration of their value and impact, providers may be forced to delay or abandon initiatives that benefit patients. NorthBay Health remains deeply committed to affordability and access. Each year, we spend $4 million in charity care, $2.5 million in care of the indigent population and an additional $215 million in Medi-Cal related medical services. In 2025 alone, more than37,500 unique patients benefited from these programs.

NorthBay Health also understands that affordability in the long term can't happen without focused efforts now. That's why we invest approximately $28 million annually on community benefit programs designed to address the underlying drivers of poor health outcomes. These efforts include support for mental health initiatives, homelessness reduction programs, and substance use treatment services.

NorthBay Health created the "health care Lyft Option program which covers the cost of patients' transport to and from their appointments. This investment reduces the overall cost of healthcare by ensuring those who are in financial need can access the healthcare they need to stay healthy.

Penalties at the levels proposed by OHCA would threaten NorthBay Health's viability, jeopardize our patients' health, and endanger the livelihoods of the nearly 2,400 employees who rely on us. NorthBay 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.

OHCA also has a statutory obligation to protect health care workforce stability. The Board should utilize the tools available to it – including spending targets adjustments and recognition of labor cost growth as a legitimate factor contributing to spending increases. NorthBay Health 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 ultimately adopted by OHCA will have a direct impact on whether we can continue to be there for the Solano, Yolo & Napa County residents who pass through our doors each year. We respectfully urge the Board to adopt a transparent, balanced, and collaborative approach that promotes affordability while preserving access to care, workforce stability, and the long-term sustainability of California's health care delivery system.

Thank you for the opportunity to provide these comments. We look forward to working with the office as these rules are finalized and to continued collaboration in building a more affordable and accessible health care system for all Californians.

Sincerely,

Mark Behl
President and CEO
NorthBay 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
Assemblywoman Lori Wilson, Eleventh Assembly District
Assemblywoman Cecilia Aguiar-Curry, Fourth Assembly District
Senator Christopher Cabaldon, Third Senate District

CenCal HEALTH®
Local. Quality. Healthcare.

June 15, 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:

CenCal Health values Cottage Health as an important partner serving the healthcare needs of the Central Coast region. From routine care to emergency needs, the local hospital is a pillar of our community. That is why CenCal Health is deeply concerned about how our community, and our most vulnerable residents, will be impacted if the Office of Health Care Affordability (OHCA) implements aggressive, unreasonable penalties against hospitals.

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 (SBCH) 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.

CenCal Health is the oldest Medicaid managed care program of its kind in the country. We are a County Organized Health System which contracts with the state to administer Medi-Cal benefits through local healthcare providers in Santa Barbara and San Luis Obispo counties, including the Cottage Health hospitals (SBCH, Goleta Valley Cottage Hospital and Santa Ynez Valley Cottage Hospital). In addition to providing Medi-Cal benefits to patients served by these hospitals, CenCal Health has partnered with Cottage Health to develop innovative programs to proactively serve the health and well-being of the most vulnerable in our community.

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 members we serve in the Santa Barbara and San Luis Obispo communities, CenCal Health urges you to reject aggressive enforcement penalties against hospitals and to take a collaborative approach that protects access while improving affordability.

CenCal HEALTH®
Local. Quality. Healthcare.

Sincerely,

Marina Owen
Chief Executive Officer
CenCal 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
Honorable Senate President pro Tempore Monique Limón
Honorable Assemblymember Gregg Hart

June 17, 2026

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

RE: OHCA Enforcement Process

Dear Chair Johnson,

For seven decades, the San Mateo County Economic Development Association (SAMCEDA) has been a leading voice for the economic engine that is San Mateo County. SAMCEDA believes in the power of a strong economy driven by an appreciation of what that engine provides to our ecosystem on the Peninsula.

By working with employers of all sizes and industries, engaging with our public sector and our elected leadership, recognizing that we have 21 individual jurisdictions (20 cities and one county) and collaborating and communicating with the Chambers of Commerce, non-profit organizations and our educational institutions, SAMCEDA tackles the most difficult challenges through goal-oriented solutions.

As a regional business organization committed to improving health care affordability for California employers, workers, and families, we encourage the Office of Health Care Affordability (OHCA) to adopt a thoughtful and collaborative enforcement process before imposing penalties for spending target performance.

While businesses share OHCA's goal of slowing health care cost growth, enforcement based on incomplete rules and/or single-year data could unintentionally penalize providers for appropriate investments in access, workforce stability, innovation, and high-quality care.

We encourage the OHCA Board to provide clear standards, consider multi-year trends and relevant context, and allow meaningful performance improvement opportunities before fines are assessed. A balanced approach will better support affordability while preserving access to care for Californians.

Sincerely,

Rosanne Foust
President & CEO, SAMCEDA

?rr_afkclr!/1

POMONA VALLEY HOSPITAL
MEDICAL CENTER

June 16, 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, Pomona Valley Hospital Medical Center (PVHMC) 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.**

PVHMC 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

PVHMC is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs grew by 4% despite a wage freeze, our medical supply costs grew 7%, and our drug costs grew by 6%. 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:

- Without additional funding support, Pomona Valley Hospital Medical Center lacks the resources necessary to make the estimated $151 million investment required to comply with California's 2030 seismic standards, placing significant strain on the hospital's long-term financial sustainability.
- With 65% of our labor costs falling outside of collective bargaining agreements and thus subject to OHCA's cap, PVHMC has had to cut 265 jobs to date.

And yet, those efforts might not be enough. However, Pomona Valley Hospital Medical Center 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 Pomona Valley Hospital Medical Center, year-over-year there was an 18% increase in insurance and yet an overall 3% decrease in professional fees. One year in isolation does not give an accurate picture of PVHMC'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 PVHMC, 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.

Pomona Valley Hospital Medical Center is committed to helping patients afford the care they need, regardless of their ability to pay. Through our financial assistance and charity care programs, eligible patients receive free or discounted medically necessary care, helping to reduce financial barriers to treatment. We also provide a wide range of free and low-cost community services, including health screenings, vaccinations, disease prevention programs, health education classes, support groups, transportation assistance, medication support, and care navigation services. In fiscal year 2025 alone, PVHMC provided an estimated $88.9 million in community benefits, including charity care, unreimbursed care, subsidized health services, community health improvement programs, and other initiatives designed to improve access to care and support the health of our community. Through these investments, PVHMC helps thousands of individuals and families obtain needed healthcare services while reducing the financial burden associated with receiving care.

Pomona Valley Hospital Medical Center also understands that affordability in the long term can't happen without focused efforts now. That's why we continue to invest in community-based care, preventive health services, and programs that improve access to care before health conditions become more serious and costly. Through initiatives such as our mobile health services, community health education programs, nurse navigation services, food insecurity partnerships, and expanded access to primary and specialty care, we are addressing the social and economic factors that impact health outcomes. We are also committed to quality improvement, patient safety, and care coordination efforts that

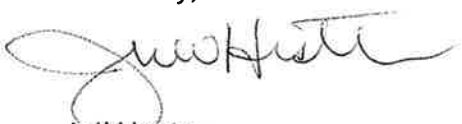
reduce avoidable hospitalizations and emergency department visits while ensuring patients receive the right care in the right setting. These investments help improve the health of our community while supporting a more sustainable and affordable healthcare system for the future.

Penalties at the levels proposed by OHCA would threaten PVHMC's viability, jeopardize our patients' health, and endanger the livelihoods of the 3,800+ number of workers who rely on us. PVHMC 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.

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. PVHMC 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 tens of thousands of residents who pass through our doors each year. Pomona Valley 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,



Juli Hester
Chief Financial Officer
Pomona Valley Hospital 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
Susan Rubio, State Senator District 22

CASA COLINA
Hospital and Centers for Healthcare

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, Casa Colina Hospital and Centers for Healthcare 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 serve as well as the hospitals who support our community. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Casa Colina Hospital 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

Casa Colina Hospital is currently experiencing cost growth in excess of the 3.5% spending target. Last year, our labor costs grew by 4.8%, our medical supply costs grew 4.5%, and our drug costs grew by 4.3%. In addition, the state of California, via SB 525, is mandating minimum wages for healthcare workers at bi-annual increases that far exceeds 3.5%.

255 East Bonita Avenue
P.O. Box 6001
Pomona, CA 91769-6001

Phone 909/596-7733 or 800/926-5462
Fax 909/593-0153
Email care@casacolina.org

www.casacolina.org

CASA COLINA
Hospital and Centers for Healthcare

Facing such uncontrollable cost growth at the same time as OHCA is putting constraints on the resources we have to pay our bills is forcing challenging decisions for all California hospitals: either cut staff and services now to avoid potential penalties, or provide the care our patients need and risk fines that could cause some hospitals to close.

Casa Colina Hospital has no way of knowing the implications that we will endure, 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 a hospital's true spending trends.

OHCA has also indicated it may consider separate enforcement across every payer and service line, giving hospitals six separate ways to violate the target. That means that even if a hospital reduced spending in one area in order to provide a greater investment in another, they still could be penalized.

Casa Colina Hospital is committed to helping patients afford the care they need. That's why we offer financial assistance programs, Charity Care, free clinics for certain services, and free vaccination programs.

Penalties at the levels proposed by OHCA would threaten many California hospitals, jeopardize patients' health, and endanger the livelihoods of our 1,200 workers and the hundreds of thousands of healthcare workers across the state. Casa Colina 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 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.

255 East Bonita Avenue
P.O. Box 6001
Pomona, CA 91769-6001

Phone 909/596-7733 or 800/926-5462
Fax 909/593-0153
Email care@casacolina.org

www.casacolina.org

CASA COLINA
Hospital and Centers for Healthcare

Casa Colina 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.

Casa Colina 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,

Kelly M. Linden
President and CEO
Casa Colina Hospital and Centers for Healthcare

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
Susan Rubio, State Senate District 22
Michelle Rodriguez, State Assembly District 53

255 East Bonita Avenue
P.O. Box 6001
Pomona, CA 91769-6001

Phone 909/596-7733 or 800/926-5462
Fax 909/593-0153
Email care@casacolina.org

www.casacolina.org

MOUNTAIN VIEW
CHAMBER OF COMMERCE

June 16, 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

Dear Chair Johnson:

I am writing to express concern about the Office of Healthcare Affordability (OHCA)'s enforcement process.

The Mountain View Chamber of Commerce is a regional business organization committed to improving health care affordability for California employers, workers, and families. We are also fortunate to have four renowned healthcare institutions - Stanford Hospital, El Camino Health, Kaiser Permanente, and Sutter Health - based in our city and serving our greater region. From routine care to emergency needs to community engagement, our local hospitals are at the core of our health and well being.

On behalf of our community, we urge OHCA to adopt a thoughtful and collaborative enforcement process before imposing penalties on providers who exceed the spending cap. While businesses share OHCA's goal of slowing health care cost growth, enforcement based on incomplete rules and/or single-year data could unintentionally penalize providers for appropriate investments in access, workforce stability, innovation, and high-quality care. Aggressive penalties can harm patient care, which is the worst possible outcome.

We encourage the OHCA Board to reconsider the spending cap, and to provide clear standards, consider multi-year trends and relevant context, and allow meaningful performance improvement opportunities before fines are assessed. A more realistic, balanced approach will better support affordability while preserving access to care for all Californians.

Thank you for your consideration.

Sincerely,

Peter Katz, President & CEO
Mountain View Chamber of Commerce

Valley Children's HEALTHCARE

June 16, 2026

Kim Johnson
Chair, Office of 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, 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
Valley Children's | HOSPITAL | MEDICAL GROUP | HOME CARE | FOUNDATION

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	*CMI*	OP	*AVI*
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,

Todd A. Suntrapak
President & Chief Executive Officer

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
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

Stanford MEDICINE
Children's Health

4700 Bohannon Drive
1st Floor
Mail Code: 5524, Office 147
Menlo Park, CA 94025
(650) 497-8277

June 17, 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, Stanford Medicine Children's Health writes to convey concerns with the potential process outlined to date. Exorbitant fines at the levels proposed would negatively impact our capacity to care for our most complex and specialty maternal and pediatric patients. We hope OHCA pursues a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.

Stanford Medicine Children's 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 violation determinations on multi-year data to 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 critical contextual factors, like investments in patient-centered care or a hospital's financial condition

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. We are also concerned that OHCA has indicated that it will base its determinations on only a single year of data, which can be deeply misleading. One year in isolation does not give an accurate picture of California hospitals' 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. Under this model, we could be penalized even when our overall spending is controlled. For example, positive developments could be punished, such as:

- 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.
- Meeting the increasing demand for uncompensated care — especially in our emergency department — which strains our bed capacity.
- Investing in innovation and research for advanced technology to improve patient health outcomes.

As an academic medical center, our maternal and pediatric patients are often more complex and require more intensive, expensive care than patient cases typically available at a community hospital. Federal funding helps offset some of our research and graduate medical education (GME) costs. However, we bear most of the operational expenses for our academic medical center, resulting in a financial loss that we consider a vital investment in our community, medical education, and research. In fiscal year 2024-2025, we invested more than $38 million in health professions education, supporting our resident physicians, fellows, medical students, and trainees in nursing and allied health.

Stanford Medicine Children's Health is committed to helping our complex maternal and pediatric patients afford the care they need. We also understand that affordability in the long term cannot happen without focused efforts today, which is one reason we remain committed to community-based investments in access to primary care, economic stability, social and emotional health, and maternal and infant health.

We are deeply concerned that OHCA's proposed penalties will stifle medical breakthroughs and jeopardize these vital community and professional investments. Penalizing entities without first giving them a meaningful opportunity to improve their spending trends is counterproductive. We know our health system best, and we are worried that one-size-fits-all strategies imposed would detrimentally impact our ability to sustain access to high-quality, equitable care, a priority 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 consideration of labor cost growth as a justifiable reason that an entity exceeded its spending target. We urge OHCA to treat all health care workers equitably and ensure that neither our frontline workers nor hospitals are punished for wages and benefits that grow above the spending target.

Stanford MEDICINE
Children's Health

Stanford Medicine Children's Health appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We also strongly encourage the OHCA Board to review the compelling data and recommendations in the California Hospital Association's comment letter submitted on May 21, 2026. We look forward to working with you as these rules are finalized and to collaborating on a more affordable and accessible health care system for Californians.

Sincerely,

Michele Lew
Senior Vice President, Chief Government Relations Officer

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
The Honorable Josh Becker
The Honorable Marc Berman

CHAMBER
SAN MATEO COUNTY

ELEVATING BUSINESS.
ENGAGING COMMUNITY.
EMPOWERING THE FUTURE.

June 16, 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:

Chamber San Mateo County knows firsthand the importance of our local nonprofit hospitals, Stanford Health Care, Stanford Medicine Children's Health, Kaiser Permanente, Sutter Health and Sequoia Hospital, when it comes to our community's health. From routine care to emergency needs, our local hospitals are pillars of our community. That's why Chamber San Mateo 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.

Chamber San Mateo County advocates for more than 1,000 businesses that represent 175,000 residents and 100,000 employees across Redwood City, San Carlos, Belmont, Menlo Park, and communities throughout San Mateo County. Chamber San Mateo County is action-oriented, collaborative, and focused on results. We bring together business, government, education, labor, and community leaders to address the issues that shape our region's future, including healthcare, transportation, housing, workforce development, economic vitality, and effective public policy. Our mission is simple: to be a trusted voice for growth, innovation, problem-solving, and an exceptional quality of life for everyone who lives and works in San Mateo County.

We partner with our hospitals to meet several vital community health priorities, including timely access to care and economic stability. That work is at risk because of OHCA's current spending caps, and the jeopardy would only grow if OHCA were to impose multi-million-dollar fines on hospitals that exceed the spending caps.

OHCA's decisions now will have a ripple effect on our communities for years to come. On behalf of the 175,000 residents we serve, Chamber San Mateo County urges you to take a collaborative approach that protects access while improving affordability.

Sincerely,

Amy Buckmaster
President & CEO
Chamber San Mateo County

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
State Senator Josh Becker
Assemblymember Marc Berman
Assemblymember Diane Papan

?rr_af kclr !/7

June 17, 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)

Dear Chair Johnson:

The Pleasanton Chamber of Commerce knows firsthand the importance of our San Francisco Bay Area's local hospitals 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 the Pleasanton Chamber 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.

The Pleasanton Chamber of Commerce's mission is to help businesses start, grow, and thrive. We support initiatives that strengthen our workforce, expand economic opportunity, and enhance the long-term vitality of our business community and region. We partner with our local and regional hospitals to meet several vital community health priorities, including strengthening healthcare workforce pipelines, advancing community wellness initiatives, expanding access to quality care, and ensuring our region remains a healthy place to live, work, and do business. 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 over 80,000 residents we serve, The Pleasanton Chamber of Commerce urges you to take a collaborative approach that protects access while improving affordability.

Sincerely,

Yianna Theodorou
President/CEO

Attachment #20

United Hospital Association

June 15, 2026

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

RE: UHA Comments on OHCA Enforcement Framework

Dear Chair Johnson:

On behalf of the United Hospital Association (UHA), we appreciate the opportunity to comment on the Office of Health Care Affordability's (OHCA) ongoing development of its spending target enforcement framework. UHA supports the comments submitted by the California Hospital Association (CHA) and urges OHCA to carefully consider the concerns and recommendations outlined in that letter. While hospitals share OHCA's goal of improving affordability, the process for measuring performance, evaluating compliance, and imposing enforcement actions must appropriately balance affordability goals with the equally important objectives of preserving access to care, maintaining quality, advancing equity, and supporting workforce stability.

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

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

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

Similarly, OHCA should avoid an enforcement structure that evaluates hospitals separately across every payer category and service line. By OHCA's own analysis, this approach

would have resulted in approximately 92% of hospitals exceeding the target in at least one category. A compliance framework that effectively places nearly every hospital into violation is unlikely to advance affordability goals and risks diverting substantial resources away from patient care and toward administrative processes. OHCA should adopt a more consolidated and practical approach to compliance assessment.

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

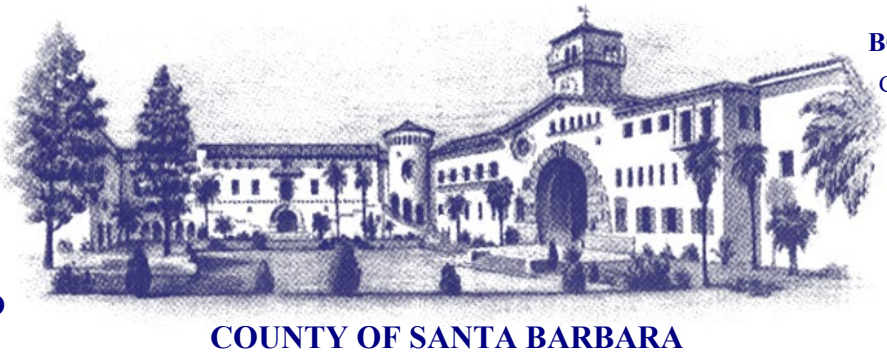
UHA urges OHCA to adopt regulations that balance affordability with continued access to care by: providing clear guidance on how spending growth will be measured and evaluated; relying on multiyear assessments rather than single-year fluctuations; establishing a standardized process for hospitals to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

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

Sincerely,

Janelle Blanco
Executive Director

cc: Members of the Health Care Affordability Board:
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



COUNTY OF SANTA BARBARA

BOARD OF SUPERVISORS
County Administration Building
105 East Anapamu Street
Santa Barbara, CA 93101
Telephone: (805) 568-2190
www.countyofsb.org

June 17, 2026

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

RE: Comment on Proposed OHCA Health Care Spending Target and Associated Enforcement
(Submitted via email to Megan Brubaker at ohca@hcai.ca.gov)

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

On behalf of the Board of Supervisors in the County of Santa Barbara, I write to express our considerable concerns regarding the Office of Health Care Affordability's upcoming action on the proposed enforcement mechanism associated with the previously adopted statewide health care spending target agendized for its June 26, 2026 meeting. Our local hospitals – Santa Barbara Cottage Hospital, Goleta Valley Cottage Hospital, and Santa Ynez Valley Cottage Hospital – provide essential services to our community. Santa Barbara County residents depend on Cottage Health for their health care, particularly in emergencies and other critical situations. We urge OHCA to reconsider the potential impacts of the significant financial penalties on our community and the patients we serve.

With no public hospital in Santa Barbara County, Cottage Health and its three hospitals serve as the backbone of our local health care safety net. The Level I Trauma Center at Santa Barbara Cottage Hospital is a critical resource not only for Santa Barbara County, but also for neighboring Ventura and San Luis Obispo Counties. Cottage provides extensive pediatric specialty services, maternity and labor and delivery care, and numerous other services that are not available elsewhere in the County. Santa Ynez Valley Cottage Hospital, despite its small size, provides vital emergency services to residents of the rural Santa Ynez Valley. Cottage Health also invests heavily in training the next generation of physicians, nurses, and other health care professionals, supporting both access to care and the local economy.

The County is particularly concerned that OHCA's proposal could result in multi-million-dollar penalties for hospitals – including the Cottage system – that already are facing significant financial pressures. Such penalties would inevitably reduce resources available for patient care, workforce investments, service expansion, and community health programs. In a region that depends heavily on a single hospital system for access to specialty, emergency, trauma, and maternity care, any reduction in hospital resources has direct implications for patient access and community health.

Hospitals face cost pressures that are fundamentally different from those experienced in other sectors of the health care system. Labor costs, pharmaceutical expenses, medical supplies, technology investments, emergency preparedness requirements, seismic compliance obligations, and growing demand for increasingly complex care continue to rise regardless of statewide spending targets. Hospitals cannot simply reduce these costs without affecting patient care.

These concerns are especially acute given the significant uncertainty surrounding federal health care funding and the anticipated impacts of H.R. 1. The County is closely monitoring state budget discussions regarding funding for individuals who may lose health coverage as a result of federal policy changes. Depending on the outcome of those discussions, counties and local hospitals may face increased pressure to ensure continued access to care for vulnerable populations. In Santa Barbara County, where there is no public hospital system, the financial stability of Cottage Health will be particularly important to maintaining access to care for both uninsured residents and the broader community. At a time when hospitals may be called upon to shoulder greater responsibility for caring for vulnerable populations, policies that further weaken hospital finances risk undermining the very access to care our communities depend upon.

While the County of Santa Barbara is highly sensitive to health care affordability challenges and strongly supports efforts to reduce cost burdens for patients and families, OHCA's spending target proposal and the potential for associated penalties is overly rigid and fails to adequately account for the realities facing community hospitals. The proposal threatens the long-term sustainability of our local hospitals, our health care workforce, and the safety-net services upon which residents throughout the region rely.

The County's perspective is grounded in our long-standing commitment to supporting access to quality health care services, particularly preventive, emergency, and safety-net services for uninsured and underinsured residents. We are concerned that the practical effect of OHCA's proposal could undermine both the County's and our hospital partners' ability to meet the health care needs of our community.

On behalf of the County of Santa Barbara and the residents we serve, we urge OHCA to pursue affordability in a manner that does not simultaneously undermine the hospitals communities rely upon when they are sick, injured, in labor, or in crisis. Thank you for considering the County's perspective.

Sincerely,

Elizabeth Espinosa
Legislative Advocate

cc: The Honorable Monique Limón, Senate President pro Tempore
The Honorable Gregg Hart, Member of the Assembly

?rr_afkclr!00

Ridgecrest
REGIONAL HOSPITAL

June 17, 2026

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

Dear Chair Johnson:

As the Office of Health Care Affordability (OHCA) board continues its discussion of spending target enforcement, I must share on behalf of Ridgecrest Regional Hospital and the remote high desert community we serve my concerns about the potential process outlined to date. While I can understand the need to create efficiencies in healthcare, the exorbitant fine levels proposed threatens access to care in our geographically isolated area, where patients have no other options for care.

Large urban hospitals and those affiliated with a healthcare system operate at scales where trends can be more accurately projected and resources can more effectively amortize the costs of operations. But Ridgecrest Regional Hospital has a limited patient pool (about 40,000 including communities in the surrounding areas), many of which would have to travel 90 to 120 miles away for alternative options for care. But small populations still see unpredictable healthcare emergencies that cannot be planned for.

In the absence of specificity for small and remote hospitals like ours, we can only evaluate based on the same penalties for exceeding 3.5 percent cost caps outlined in the by OHCA. It is much more difficult for hospitals like Ridgecrest Regional Hospital to recruit and retain qualified providers, which creates a burden that cannot be adequately amortized at low volumes. For example, we are facing a 5.5 percent increase to salaries and benefits, without adding services, just to keep up with the market. Physician compensation will see an estimated 7 percent annual increase. Other anticipated cost increases include 5 percent for supplies, 7 percent for insurance and 8 percent for utilities. These increases are based on the labor market, supply and demand, and other factors beyond our control. Adding to our current financial struggles a $15 million penalty (estimate for hospitals with more than one violation) would not improve service for our community, it would only make it more impossible to deliver.

In 2024 RRH made the excruciating decision to suspend labor and delivery services as part of a multi-pronged approach to weather a fiscal crisis. We are one of the few hospitals in California that have resumed this essential service, but the penalty schedule outlined puts

not only labor and delivery but ALL critical service lines at risk if RRH is slapped with a fine.

Through one-time financial assistance from the Department of Defense, RRH has been able to reopen labor and delivery. But we continue to search for new revenues to sustain essential operations as the costs for delivering care continues to outpace the government and private insurance reimbursements.

Communities like ours have lost hospitals, clinics, and other services in recent years. We have retained ours by being highly responsive to the unpredictable demands and creating strategic partnerships with stakeholders in our county, state, and nation. But this fragile new stability could be entirely upended by a punitive plan that does very little to improve access and resources to our remote community.

Ridgecrest Regional Hospital closed 2018 with a modest profit, to be reinvested into our capital expenses. No one could have planned for the earthquakes in 2019, which damaged our seismically compliant structure and carried huge opportunity costs for lucrative services. Then we were hit with COVID in 2020, which brought similar demands for lifesaving investment while hobbling our ability to deliver procedures that help keep us in the black. In 2025 we were able to close out a four-year recovery plan with another modest gain. However, none of this would have been possible if without taking into consideration the volatility of year-over-year spending swings. OHCA must take factors like these into account when creating new guardrails within which hospitals must operate.

Healthcare expenditures for small, rural hospitals are more dependent on external factors outside of our control or influence, not on hospital leadership. We do not create our cost environment, we are merely subject to these outside pressures and required to exist within it. Ridgecrest Regional Hospital takes seriously its legal mandate to operate with fiscal responsibility and resourcefulness, but that should not threaten our ethical responsibility to provide access to continuous care the patients in our outlying areas rely on.

Sincerely,

James Suver, CEO/President
Ridgecrest Regional Hospital

Monterey Bay
ECONOMIC PARTNERSHIP

June 17, 2026

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

Subject: Balancing Health Care Affordability with Community Health Needs

Submitted via email to ohca@hcai.ca.gov

Dear Chair Johnson:

Monterey Bay Economic Partnership (MBEP) appreciates the Office of Health Care Affordability's efforts to address the important challenge of health care affordability for California residents. We recognize that healthcare costs affect families, employers, and communities throughout the state, and we support balanced approaches that improve affordability while maintaining access to high-quality care.

As a regional, cross-sector membership organization serving Monterey, San Benito, and Santa Cruz Counties, MBEP works closely with employers, educational institutions, local governments, nonprofit organizations, and healthcare providers to advance economic vitality and community well-being throughout the region. Access to quality healthcare is an essential component of a healthy workforce, strong communities, and a resilient regional economy.

In the Monterey Bay region, healthcare providers are among the largest employers and most important community institutions, serving as anchors for workforce development, public health, emergency preparedness, and regional resilience. Ensuring continued access to high-quality healthcare services is important not only for residents but also for the long-term economic vitality and competitiveness of our region.

We understand the importance of addressing healthcare affordability and recognize the concerns raised about healthcare costs. At the same time, we encourage careful consideration of any actions that could inadvertently affect healthcare access, workforce capacity, community benefit programs, or other services relied upon by residents throughout our region.

Hospitals and healthcare systems play a critical role not only in delivering care, but also in supporting workforce development, community health initiatives, emergency preparedness, medical education, and regional economic stability. Decisions that affect the financial capacity of

healthcare providers can have impacts that extend well beyond the walls of a hospital and into the broader community.

Our concern is not with the goal of affordability itself, but with ensuring that affordability strategies are implemented in a manner that preserves access to care, maintains essential community services, supports healthcare workforce capacity, and protects community benefit programs that residents rely upon.

We encourage OHCA to continue working collaboratively with the California Hospital Association, healthcare providers, community organizations, employers, and other stakeholders to identify solutions that advance affordability while preserving access, quality, innovation, and community health outcomes. We believe California can pursue affordability goals while also ensuring that communities continue to benefit from strong and sustainable healthcare systems.

Thank you for your consideration and for your continued work on behalf of California's communities.

Sincerely,

Tahra Goraya
President and CEO
Monterey Bay Economic Partnership (MBEP)

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

Stanford MEDICINE Health Care

June 17, 2026

Kim Johnson
Chair, Health Care Affordability Board
2020 W. El Camino Avenue,
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, Stanford Health Care shares deep concerns with the potential process outlined to date. **Exorbitant fines at the levels proposed would certainly impact our capacity to care for our most complex and specialty patients. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Stanford Health Care 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 violation determinations on multi-year data** to 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 critical contextual factors,** like investments in patient-centered care or a hospital's financial condition

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 can be deeply misleading. One year in isolation does not give an accurate picture of California hospitals' 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. Under this model, we could be penalized even when our overall spending is controlled. For example, positive developments could be punished, such as:

- 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.
- Meeting the increasing demand for uncompensated care — especially in our emergency department — which strains our bed capacity.
- Investments in innovation and research for advanced technology to improve patient health outcomes.
- Forcing us to delay investments needed to meet the state's 2030 seismic compliance deadline.

Moreover, Stanford Health Care is one of a handful of hospitals identified as "high-cost" by the OHCA Board. As an academic medical center, our patients are more complex and require more intensive, expensive care than patient cases typically available at a community hospital. Federal funding and Medicare help offset some of our research and graduate medical education (GME) costs. However, we bear most of the operational expenses for our academic medical center, resulting in a financial loss that we consider a vital investment in our community, medical education, and research. In Fiscal Year 2024-2025, we invested over $207 million in health professions education, supporting our resident physicians, fellows, medical students, and trainees in nursing and allied health.

Stanford Health Care is committed to helping patients afford the care they need. We also understand that affordability in the long term can't happen without focused efforts now. That's why we are committed to community-based investments in behavioral health services, social services for patients experiencing homelessness, and food and income security. Our investments also fund a sexual assault response team, patient financial advocacy, and other patient wellness programs such as cancer survivorship. Additionally, we partner with Federally Qualified Health Centers (FQHCs), community-based hospitals, and other medical practices to offer free Stanford Medicine specialty second-opinion services. We also subsidize Stanford Life Flight, which provides fast and reliable transport solutions for critically ill and injured patients, not just to Stanford Medicine locations, but also to hospitals from the Oregon border to Kern and Santa Barbara Counties.

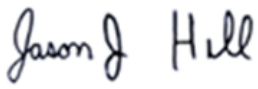
We are deeply concerned that OHCA's proposed penalties will stifle medical breakthroughs and jeopardize these vital community and professional investments. Penalizing entities without first giving them a meaningful opportunity to improve their spending trends is counterproductive. We know our health system best, and we are worried that one-size-fits-all strategies imposed would detrimentally impact 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. We urge 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.

Stanford Health Care appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We also strongly encourage the OHCA Board to review the compelling data and recommendations in the California Hospital Association's comment letter submitted on May 21, 2026. 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,



Jason Joseph Hill
Chief Government & Community Affairs Officer
Associate Vice President
Stanford Health Care

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
The Honorable Josh Becker
The Honorable Marc Berman

Stanford MEDICINE
Health Care
Tri-Valley

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, Stanford Health Care Tri-Valley shares deep concerns with the potential process outlined to date. **Exorbitant fines at the levels proposed would certainly impact our capacity to care for our most complex and specialty patients. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

Stanford Health Care Tri-Valley 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 violation determinations on multi-year data** to 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 critical contextual factors,** like investments in patient-centered care or a hospital's financial condition

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 can be deeply misleading. One year in isolation

does not give an accurate picture of California hospitals' 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. Under this model, we could be penalized even when our overall spending is controlled. For example, positive developments could be punished, such as:

- 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.
- Meeting the increasing demand for uncompensated care — especially in our emergency department — which strains our bed capacity.
- Investments in innovation and research for advanced technology to improve patient health outcomes.
- Forcing us to delay investments needed to meet the state's 2030 seismic compliance deadline.

Stanford Health Care Tri-Valley is committed to helping patients afford the care they need. We also understand that affordability in the long term can't happen without focused efforts now. That's why we are committed to community-based investments in behavioral health services, social services for patients experiencing homelessness, and food and income security.

We are deeply concerned that OHCA's proposed penalties will stifle medical breakthroughs and jeopardize these vital community and professional investments. Penalizing entities without first giving them a meaningful opportunity to improve their spending trends is counterproductive. We know our health system best, and we are worried that one-size-fits-all strategies imposed would detrimentally impact 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. We urge 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.

Stanford Health Care Tri-Valley appreciates the opportunity to comment and encourages the OHCA board to incorporate these recommendations into future rulemaking. We also strongly encourage the OHCA Board to review the compelling data and recommendations in the California Hospital Association's comment letter submitted on May 21, 2026. 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,

Denise Bouillerce
Senior Director, Government & Community Relations
Stanford Health Care Tri-Valley

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
The Honorable Jerry McNerney
The Honorable Rebecca Bauer Kahan

Kindred Hospitals

June 17, 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, 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, is 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.

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.

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.

<u>Recommendations</u>

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:

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

Cottage Health
GOLETA VALLEY | SANTA BARBARA | SANTA YNEZ VALLEY

Post Office Box 689
400 West Pueblo Street
Santa Barbara, CA 93102-0689
p: 805-682-7111
w: CottageHealth.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:

Thank you for the opportunity to provide comments on the proposed enforcement regime for Hospital Sector Spending Targets pending before the Office of Health Care Affordability ("OHCA") Board. Cottage Health has deep concerns about the proposal that OHCA is considering, particularly potential fines and penalties that could be levied against hospitals. In 2028, Cottage Health estimates losing approximately $40M in funding due to changes in insurance coverage, enrollment and work requirements driven by H.R. 1. Spending Target penalties will add more pressure on our already thin operating margins and will force us to close services which will reduce access to care. Instead of financial penalties, Cottage Health urges OHCA to adopt a collaborative approach to enforcement that gives hospitals a meaningful opportunity to improve affordability without putting healthcare services at risk.

I. Who We Are

Cottage Health operates three hospitals and two medical centers: Santa Barbara Cottage Hospital (SBCH), Goleta Valley Cottage Hospital (GVCH), Santa Ynez Valley Cottage Hospital (an 11-bed critical access hospital), Cottage Rehabilitation Hospital and Cottage Children's Medical Center. We are a non-profit health system serving California's Central Coast, headquartered in Santa Barbara County where there is no county hospital. As a result, our hospitals are the safety net provider for all of Santa Barbara County. These hospitals offer 55+ specialty services, including services which are under-reimbursed (and operate at a loss) such as psychiatry, pediatrics and labor and delivery.

Our Santa Barbara Cottage Hospital is a level-1 trauma center with the only pediatric ICU in Santa Barbara County. These services operate at a loss. In a county with no public hospital, access to Cottage Health's emergency rooms is essential to the region—we have more than 93,000 emergency room visits each year.

Government payers are the largest payers for all Cottage Health facilities. Approximately 73% of our hospital revenue is derived from government payers, with 20%+ coming from Medi-Cal. **Medicare reimbursement covers 65% of the costs** of care and **Medi-Cal covers just 38%**. Each year, our costs of delivering services to Medicare beneficiaries exceed Medicare reimbursement at SBCH by **$150 million** and GVCH losses on Medicare are approaching **$20 million annually**. Without commercial reimbursement to fill the gaps, it is not possible for SBCH and GVCH to provide a broad spectrum of high-quality services to the community.

With this imbalanced payer mix, Cottage Health hospitals operate with narrow to non-existent operating margins. Due to factors outside our control, operational expenses at Cottage Health hospitals easily outpace the 3.5% Hospital Spending Target each year. Last year for example, our labor costs grew by 4.8% and medical supply and drug costs increased by 7% (our drug costs in the first four months of this year are $3.6M above all of 2025). Without the ability to raise revenue to fund these cost increases, we will be forced to make tough choices that will impact the communities we serve.

Patient Access Support

Cottage Health is committed to helping patients afford the care they need and offers generous programs for free and discounted care. In the past three years, Cottage Health has provided more than **$43 million** in free and discounted care. Our Financial Assistance Policy provides discounts to patients **at or below 700% of the federal poverty limit**, which exceeds the state requirement to provide discounts to patients at 400% FPL. If we limited financial assistance to the state requirement (patients at or below 400% FPL) our charity care spending would be reduced by **$7.2 million**.

We also offer payment plans, allowing patients up to 90 months to address their medical bills. Our most common payment plan is 17 months, with an average monthly payment of $134. We also devote resources to helping patients finds coverage, funding three FTEs dedicated to patient eligibility and coverage assistance. They explore every avenue of available coverage for our patients.

Santa Barbara Cottage Hospital also spends approximately **$7.7 million each year** on Population Health programs providing food, shelter and other support for patients who are at risk for homelessness, need social support such as food, housing and transportation, or who experience health inequities. We also provide significant grant funding each year to the Santa Barbara Neighborhood Clinic which provides outpatient services to low-income residents.

Low-Cost Access Points

As the sole community provider in Southern Santa Barbara County, Cottage Health has invested significant resources to offer access to low-cost services throughout the Central Coast. These include 13 Urgent Care Centers (with average visit price of $200); the nation's first Spanish-language virtual care platform offering visits for $29; and employing 17 new primary care providers. None of these services generate positive margin; they are low-cost access points that serve our community. For example, our Urgent Care Centers provided 155,000 visits in 2025 at a loss of **$4.9 million.** Cottage Health subsidizes primary care at an annual loss of **$9.6 million**.

Workforce Investments

Cottage Health is proud to offer competitive wages and benefits to recruit and retain our high-quality workforce. Due to the high cost of living, recruiting and retaining healthcare workers in Santa Barbara County is incredibly challenging. Santa Barbara County is the 16th most expensive labor market out of 400 metropolitan areas nationwide. In 2025, our employees received average increases of 4.8%, at an annual cost of $25 million. If Santa Barbara Cottage Hospital was held to the 1.8% Spending Target, we could not fund increases at this level.

Funding market wages and benefits isn't our only workforce challenge. According to the Economic Research Institute, Santa Barbara is the 41st most expensive city in the United States and the 27th most expensive in California. https://www.erieri.com/cost-of-living/united-states/california/santa-barbara. The median home price in Santa Barbara in 2023 was $2.25 million and $1.57 million in Goleta. The housing market is so challenging that we devote significant resources to support our employees' housing needs, including downpayment assistance and employer-subsidized housing. If Spending Target Penalties were adopted, it's unlikely we could continue funding these programs.

II. Spending Target Enforcement

We understand that OHCA is considering an enforcement regime that includes levying financial penalties against hospitals. We believe that such an approach will undermine stability of healthcare services in our region. Instead of levying financial penalties against hospitals, Cottage 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 low-cost access points, under-reimbursed services or a hospital's financial condition

Impact of the Hospital Sector Target

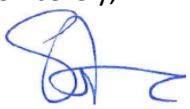
Cottage Health is reviewing its operations to determine how it would respond if financial penalties are implemented (**initial estimates show potential penalties of $13-28 million**). If so, there is no doubt that changes would need to be made to service mix, quality, access and workforce. At an average cost of FTE of $174,200, a reduction of $13 million would equate to 77 FTEs. We simply

could not continue to operate in the same way with revenue that is less than the costs of providing care.

Cottage Health is also concerned that OHCA may seek to financially penalize hospitals before they have had the chance to improve spending trends voluntarily. Any enforcement strategy should involve collaboration with affected hospitals and open dialogue about, and consideration of, the drivers of inflation. In addition to establishing a fair and collaborative enforcement process, OHCA has a statutory duty to protect health care workforce stability. As discussed above, financial penalties will adversely affect our operations and workforce. We urge OHCA to adjust the spending targets to reflect labor cost growth as a justifiable reason for exceeding spending targets. Cottage Health urges OHCA to treat all health care workers (organized and non-organized) 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 enforcement process that OHCA establishes will directly impact whether we can continue to be there for the Central Coast residents (and visitors) who pass through our doors each year. Cottage 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,



Stacy Bratcher
SVP and Chief Legal Officer
Cottage 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
The Honorable Monique Limón, Senate President pro Tempore
The Honorable Gregg Hart, Member of the Assembly

California Hospital Association

June 18, 2026

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

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

Dear Chair Johnson:

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

OHCA Board Must Ensure Penalties Do Not Jeopardize Access to Care

OHCA has proposed penalties that start at the full amount by which a health care entity exceeded its spending target. For hospitals, this framework would generate penalties in the tens or hundreds of millions of dollars for a single year's violation — a starting point twenty times higher than in Oregon, the state currently operating the most aggressive spending target penalty regime in the country. The consequences would be devastating: Of the more than 200 hospitals that could have been penalized had the 3.5% spending target been in effect in 2023, more than half would have faced initial penalties exceeding their cumulative three-year (2021-23) operating earnings. If forced to absorb penalties of this magnitude, hospitals would have no choice but to cut services, reduce staff, or close outright — easily foreseeable outcomes that would directly contradict OHCA's statutory mandate to promote access, quality, equity, and workforce stability alongside affordability.

The Legislature Expressly Delegated Authority to Set the "Scope and Range" of Penalties to the Board

It has been argued that penalties must equal the amount by which an entity exceeded the target, at least prior to the application of any entity-specific adjustments. That position rests on a fundamental misreading of the relevant statutes. If the Legislature had intended a specific penalty formula or defined minimum penalty amounts, it would have prescribed it. **It did not.** Instead, the Legislature expressly delegated to the board the authority to establish "the scope and range of administrative penalties and the penalty justification factors for

assessing penalties."[1] Such delegation is meaningful only if the board has genuine discretion to construct a penalty structure that is not mechanically predetermined by what is in fact an initial penalty ceiling established by law.

The board should exercise this authority by looking to peer state models and adopting a penalty framework that is proportionate, predictable, and transparent — one that credibly encourages compliance without threatening the financial viability of hospitals on which millions of Californians rely. That framework must include reasonable penalty ceilings and express requirements on the director to apply adjustment factors that account for entity-specific mitigating factors, as described below. Oregon's framework — which begins penalties at 5% of the amount by which spending exceeded the target and escalates for repeated noncompliance — provides a working model that is dramatically more defensible than OHCA's current approach and would still create meaningful compliance incentives. **The board has ample statutory authority to adopt a balanced penalty framework — and should do so.**

OHCA Director's Role Is to Apply the Board's Enforcement Framework, and Account for Various Mitigating Factors

Once the board has established the penalty framework, the director would apply it to the specific facts of each entity found in violation of the target and its performance improvement plan. Critically, before finalizing any penalty amount, the director is required by statute to consider:

> "(A) The nature, number, and gravity of the offenses.
> (B) The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.
> (C) The market impact of the entity."[2]

These are entity-specific judgments about culpability, financial capacity, and systemic importance that — within the board's established framework — modify penalty amounts based on the relevant entity's fiscal condition, limited control over cost drivers, and other factors. As stated in CHA's May 2026 letter, to protect access to care at the same time as promoting improved affordability, the director must also incorporate adjustments to an individual entity's penalty to account for factors beyond a hospital's control; efforts to improve access to high-quality, patient centered care; and improved performance relative to the state's spending goals.

OHCA's Proposed Cost and Market Impact Review Regulations Must Conform with Legislative Text and Avoid Unintended Consequences

OHCA has proposed changes to its Material Change Transactions and Pre-Transaction Review Regulations to implement Assembly Bill (AB) 1415 (Statutes of 2025). In various respects, the proposed rules conflict with the letter and intent of AB 1415, would upend standard and beneficial business practices, and would threaten

[1] Health and Safety Code § 127501.11(b)(2).
[2] Health and Safety Code § 127502.5(d)(6).

collaborations needed to sustain access to care in an increasingly unstable environment. To align the proposed regulations with statutory authority and prevent avoidable and widespread negative impacts on California's patients and providers, hospitals ask OHCA to make the following revisions:

- Do not include entities that "own, operate or control a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license" in the definition of **"health care entities"** because there is no statutory authority in AB 1415 or elsewhere to define these entities as such. Rather, the Legislature has clearly deemed such entities to be **"noticing entities"** that are subject to the noticing entity requirements.
- Categorically exclude from the definition of a "management services organization" (MSO) all entities that own, control, are controlled by, or are under common control with one or more hospitals, to align with statutory authority.
- Revise Section 97435(c)(10) to align with the existing established criteria for health care entity transactions that involve a transfer of control, responsibility, or governance of a health care entity in Section 97435(e). Section 97435(c)(10), which defines certain MSO transactions as material change transactions, is too broad and will substantially delay or stymie even ordinary course MSO arrangements that do not have any material impact on the control, operations, or governance of MSOs or health care entities.
- Revise Section 97435(c)(9) to only capture transactions involving hedge funds and private equity that could actually result in a change of control, responsibility, or governance of a health care entity or MSO by making use of the established criteria for health care entity transactions that involve a transfer of control, responsibility, or governance of a health care entity in Section 97435(e). Section 97435(c)(9), which defines certain private equity group or hedge fund transactions as material change transactions, is too broad and will likely chill or delay the ability of distressed hospitals and other health care entities to find necessary capital, regardless of whether or not the private equity group or hedge fund retains any actual authority or control over the operations or assets of the health care entity or MSO.
- Expand the "usual course" and "common control" exceptions to also apply to noticing entity transactions. OHCA has previously stated that these types of transactions are not material in nature.
- Delete Section 97435(c)(11) covering real estate leasebacks in its entirety. This provision is too broad and captures common and de minimis arrangements. The other circumstances listed in Section 97435(c) that require filing would cover any arrangements that rise to material level of concern.
- Expand confidentiality protections to: (1) include additional transaction documents containing sensitive information, (2) deem sensitive information otherwise provided to OHCA as confidential, and (3) extend non-disclosure requirements to confidential information shared with the Attorney General.
- Expressly eliminate duplicative reporting obligations in the proposed regulations as required by AB 1415.

CHA's detailed comments on the proposed regulations, submitted on June 11, 2026, are attached to this letter.

OHCA Must Acknowledge the Relationship Between Hospitals' Financial Resources and Their Ability to Sustain High-Quality Care

At the May 2026 board meeting, OHCA presented its recommendation to make no adjustments to health care entities' spending targets based on their performance on their measured quality. Instead, OHCA proposes to

wait and revisit the issue within two years, citing data immaturity and the ongoing rollout of quality measurement programs at other state agencies. While, at this time, CHA raises no concerns with OHCA's recommendation, hospitals remain concerned with OHCA's repeated assertion that research demonstrates "minimal to no link" between health care cost and quality, which was a partial justification for that decision. That conclusion rests on weak evidence, contradicts a substantial body of peer-reviewed literature, and should not become the analytical baseline for future spending target adjustment or enforcement decisions. CHA detailed the significant methodological limitations of the Whaley research OHCA has relied upon, and the broader literature that supports a positive financial-quality relationship, in its June 2025 letter to the board.

One point bears particular emphasis given OHCA's continued reliance on the Percent of Medicare versus Centers for Medicare & Medicaid Services (CMS) star rating plot at the May 2026 meeting. This analysis, published by RAND and cited repeatedly by OHCA, only goes skin-deep: a simple unadjusted distribution of CA hospital prices within each star rating category, with no regression analysis, and no controls for hospital type, teaching status, payer mix, case mix, or geography. Notably, even the study's own authors characterize this analysis as "incomplete for several reasons," cautioning that their approach does not account for the full range of factors that drive quality differences among hospitals. That methodological caveat was not presented to the board. Additionally, the study excludes cancer hospitals, children's hospitals, long-term care hospitals, and inpatient rehabilitation facilities, all hospital types that are subject to OHCA's spending targets, thus further undermining its relevance as a foundation for California enforcement policy. A descriptive plot with unacknowledged limitations, drawn from a sample that excludes entire categories of OHCA-regulated hospitals, is not an adequate evidentiary basis for concluding that no meaningful relationship exists between hospital financial strength and quality of care.

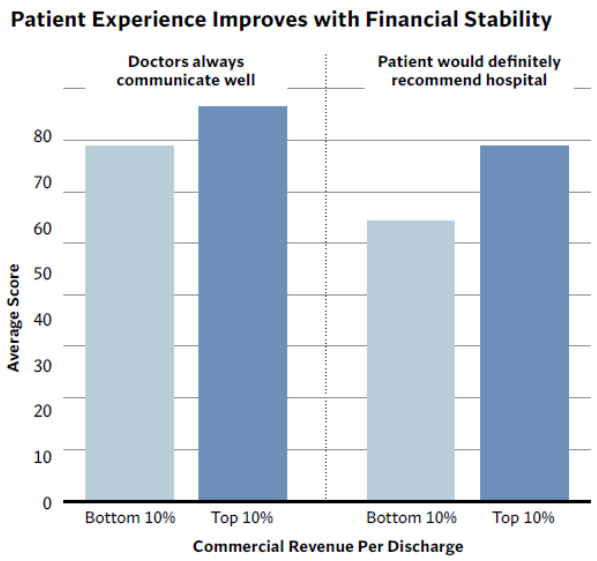
CHA's own California-specific analysis addresses these exact limitations. Using Annual Financial Disclosure Report data from 2018–22 and a regression model controlling for teaching status, critical access designation, and payer mix, CHA estimated the likelihood of a hospital receiving a 4- or 5-star CMS rating based on its financial performance. Hospitals with stronger operating margins, higher commercial revenue per case mix-adjusted discharge, and greater operating expense per bed were significantly more likely to achieve high star ratings. Hospitals in the top 10% for financial strength had a median CMS star rating a full star higher than those in the bottom 10%.

Separately, a regression model analysis of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data from 2017–2023 found statistically significant positive associations between commercial revenue per case-mix adjusted discharge and six patient experience domains.

Patients' Experience Depends on a Hospital's Resources

On the nationally recognized *Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)* of hospitalized patients, one of the most widely used and reputable measures of patient experience, patients at financially stable hospitals are more likely to report:

- **Staff always explain medicines**
- **They would definitely recommend hospital**
- **They understand their care when they leave the hospital**
- **They are given information about recovery at home**
- **Nurses always communicate well**
- **Doctors always communicate well**



Source: "Strong Hospital Finances Mean Higher-Quality Care," California Hospital Association, 2025

While OHCA's approach of waiting until the data and methodology are ready before applying a quality adjustment is understandable, OHCA should not continue to assert that there is "minimal to no link" between cost and quality and should not rely on that assertion as justification for the delay. When the data are ready, the process of quality adjustment to the spending targets should begin with an honest assessment of the full body of evidence — not a predetermined conclusion that the evidence does not support.

Conclusion

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

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

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

Attachment

California Hospital Association

June 11, 2026

Megan Brubaker
Department of Health Care Access and Information
Office of Health Care Affordability
2020 W. El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments on Proposed Revisions to Material Change Transactions and Pre-Transaction Review Regulations to Implement Assembly Bill 1415**

Dear Ms. Brubaker:

The California Hospital Association (CHA), on behalf of nearly 400 hospital and health system members, thanks the Office of Health Care Affordability (OHCA) for the opportunity to comment on proposed changes to the Cost and Market Impact Review (CMIR) regulations, intended to implement Assembly Bill (AB) 1415 (Statutes of 2025). Hospitals appreciate OHCA's commitment to a public process by providing advance notice and consideration of stakeholder feedback. **However, hospitals have significant substantive concerns about the regulations and request various changes to align the proposed rules with the letter and intent of AB 1415, prevent standard and beneficial business practices from being upended, and protect access to care in an increasingly unstable environment.**

The proposed expansion of OHCA's market oversight authority comes as patient care in California is under threat. The One Big Beautiful Bill Act (OBBBA) enacted the deepest Medi-Cal coverage and payment cuts in the program's history. Even before these cuts are felt, nearly half of hospitals are operating at a loss — and the 40 hospitals with the worst financial performance had average operating margins of **negative 39%** in 2024. In "The Big Ugly Threat to Safety Net Hospitals," Public Citizen found that 83 California hospitals are at heightened risk of closing, cutting services, or laying off staff.

Collaboration — whether through wholesale purchases and affiliations, timely investments, or obtaining outside help with daily operations — is a critical lifeline for hospitals in financial distress. Unfortunately, the proposed regulations would substantially narrow these pathways to financial recovery and undermine access to care in communities throughout California.

To ensure the proposed regulations not only align with statutory authority, but also prevent avoidable and widespread negative impacts on California's health care providers and their patients, hospitals ask that OHCA revise its regulations to:

- Not include entities that "own, operate or control a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license" in the definition of **"health care entities"** because there is no statutory authority in AB 1415 or elsewhere to define these entities as such. Rather, the Legislature has clearly deemed such entities to be **"noticing entities"** that are subject to the noticing entity requirements.
- Categorically exclude from the definition of a "management services organization" (MSO) all entities that own, control, are controlled by, or are under common control with one or more hospitals, to align with statutory authority.
- Revise Section 97435(c)(10) to align with the existing established criteria for health care entity transactions that involve a transfer of control, responsibility, or governance of a health care entity in Section 97435(e). Section 97435(c)(10), which defines certain MSO transactions as material change transactions, is too broad and will substantially delay or stymie even ordinary course MSO arrangements that do not have any material impact on the control, operations, or governance of MSOs or health care entities.
- Revise Section 97435(c)(9) to only capture transactions involving hedge funds and private equity that could actually result in a change of control, responsibility, or governance of a health care entity or MSO by making use of the established criteria for health care entity transactions that involve a transfer of control, responsibility, or governance of a health care entity in Section 97435(e). Section 97435(c)(9), which defines certain private equity group or hedge fund transactions as material change transactions, is too broad and will likely chill or delay the ability of distressed hospitals and other health care entities to find necessary capital, regardless of whether or not the private equity group or hedge fund retains any actual authority or control over the operations or assets of the health care entity or MSO.
- Expand the "usual course" and "common control" exceptions to also apply to noticing entity transactions. OHCA has previously stated that these types of transactions are not material in nature.
- Delete Section 97435(c)(11) covering real estate leasebacks in its entirety. This provision is too broad and captures common and de minimis arrangements. The other circumstances listed in Section 97435(c) that require filing would cover any arrangements that rise to material level of concern.
- Expand confidentiality protections to: (1) include additional transaction documents containing sensitive information, (2) deem sensitive information otherwise provided to OHCA as confidential, and (3) extend non-disclosure requirements to confidential information shared with the Attorney General.
- Expressly eliminate duplicative reporting obligations in the proposed regulations as required by AB 1415.

More details about each recommendation are provided below. CHA would also welcome the opportunity to discuss these matters further with OHCA.

An Entity That Owns, Operates, or Controls a Provider May Not Be Defined as a "Health Care Entity"

AB 1415 introduced (1) a separate "noticing entity" category, as defined in Health & Safety Code § 127507(h), that includes "an entity that owns, operates, or controls a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license" and (2) separately defines the types of material transactions for which a "noticing entity" must provide notice. Importantly, AB 1415 did not revise or otherwise alter the existing statutory definition of "health care entity" found at Health & Safety Code § 127500.2(k) — which does not include an "entity that owns, operates, or controls a provider."

By contrast, the proposed regulations treat entities that own, operate, or control a provider as both a "noticing entity" and a "health care entity" pursuant to the revised definition of "health care entity" found at Section 97431(g) of the proposed regulations. This would subject such entities to health care entity filing requirements. Including such entities within the definition of "health care entity" clearly exceeds statutory authority, eliminates the clear statutory distinction between health care entities and noticing entities, and improperly imposes all the thresholds and filing duties of a "health care entity" on entities that own, operate, or control a provider. Accordingly, in this regard, the proposed regulations frustrate clear statutory intent to separately address the notice obligations of such entities through the "noticing entity" requirements, rather than through the "health care entity" notice obligations.

Proposed Resolution

OHCA should align the proposed regulations with AB 1415 by deleting Section 97431(g)(4) so that "an entity that owns, operates, or controls a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license" is not considered a "health care entity."

Categorically Exclude from the MSO Definition All Entities That Own One or More Hospitals

The proposed regulations define an MSO in Section 97431(k) to refer to "entities, as described in [Health & Safety Code § 127500.2(o)] that are additionally at least one of the following:

(1) Owned by a **hospital** (emphasis added) and have two or more physician organizations as clients or affiliates;
(2) Employ the physician-owner of, or otherwise have an agreement with the physician-owner that defines the services to be provided and compensation for such services with, one or more physician organizations;
(3) Share directors, officers, investors, or other natural persons with the ability to exercise control with respect to a health care entity; or
(4) Affiliated with at least two of the following:
    (A) A health plan;
    (B) Two or more physician organizations; or
    (C) A **hospital**." (emphasis added)

By contrast, Health & Safety Code § 127500.2(o) clearly states that an MSO "does not include entities that own one or more health facilities, as defined in subdivision (a) or (b) of Section 1250" (referring to entities that own one or more general acute care hospitals or psychiatric hospitals).

CHA appreciates OHCA's efforts to narrow the types of entities that may qualify as an MSO under the proposed regulations by limiting MSOs to only those entities that meet certain additional criteria. However, the proposed regulations' MSO definition exceeds statutory authority by including MSOs that are owned by a hospital, something clearly excluded under Health & Safety Code § 127500.2(o).

Additionally, in nearly all cases, an entity that owns a hospital will also share directors, officers, investors, or other natural persons that have the ability to exercise control with respect to a health care entity, since a general acute care or psychiatric hospital is itself a type of health care entity. This means that **any** entity that both (1) owns a general acute care or psychiatric hospital, and (2) provides certain management and administrative support services to the hospital or other providers — an almost universal occurrence — will be swept up in the proposed regulations' definition of an MSO. This is exactly why the Legislature revised prior drafts of AB 1415 that referenced "health systems" to remove all such references, and instead elected to expressly state in the final AB 1415 language that MSOs do not include entities that own one or more general acute care hospitals or psychiatric hospitals.

Proposed Resolution

The definition of MSO found in Section 97431(k) of the proposed regulations should be revised to clearly exclude any entity that owns, controls, is controlled by, or is under common control with one or more health facilities, as defined in subdivision (a) or (b) of Health & Safety Code § 1250, regardless of whether it meets one or more of the criteria set forth in Section 97431(k)(1) through (4).

Criteria for Transactions Involving MSOs Have No Materiality Thresholds and Will Adversely Impact the Ability of MSOs and Health Care Entities to Enter into Ordinary Arrangements

Section 97435(c)(10) in the proposed regulations defines a "material change transaction" subject to notice to include transactions involving an MSO that does one of the following:

(A) Results in an MSO providing management and administrative support services for a health care entity satisfying Section 97435(b)(1);
(B) Result in an MSO providing management and administrative support services for two or more providers that collectively generate $10 million annually from California patients; or
(C) Involves a transfer of control, responsibility or governance, in whole or in part, of the MSO, as defined in Section 97435(e), or a change in 25% or more of the MSO's ownership.

This material change circumstance is too broad and, as drafted, would subject ordinary course management and administrative support transactions to the notice obligations, regardless of whether the transactions involve any transfer of the assets or operations of a health care entity or MSO. Notably, Section 97435(c)(10)(A) and (B) do not include any limiting threshold. That is, **any** transaction involving **any** MSO that results in the MSO providing management and administrative support services to a qualifying health care entity, or two or more qualifying health care providers, would be subject to OHCA's notice obligations, regardless of whether the transaction gives the MSO any control over the health care entity's or providers' assets, operations, or governance. As written, the proposed regulations would increase costs and substantially

delay the ability of MSOs and qualifying health care entities to enter into the most ordinary course management and administrative support service arrangements, including for minor transactions and the provision of limited administrative support activities that have no material market impacts. Providers not seeking a change in ownership but who need help with administrative and management functions would effectively lose their ability to expeditiously and reliably contract for these services, making them more likely to close outright while nullifying opportunities to improve administrative efficiencies. For these reasons, significant changes are needed.

Proposed Resolution

Section 97435(c)(10) should be revised to capture only those transactions that could actually result in a change of control, responsibility, or governance of a health care entity or MSO. Specifically, OHCA should delete Sections 97435(c)(10)(A) and (B) in their entirety, and Section 97435(c)(10)(C) should be revised to apply to transfers of control, responsibility, or governance of an MSO or health care entity, making use of OHCA's existing materiality standard.

Provisions Delineating "Material" Transactions Involving a Private Equity Group or Hedge Fund Would Chill Distressed Health Care Entities' Ability to Raise Capital

AB 1415 requires that a noticing entity notify OHCA of certain transactions that do either of the following: (1) sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a **material amount** of the health care entity's or MSO's assets to one or more entities; or (2) transfer control, responsibility, or governance of a **material amount** of the assets or operations of the health care entity or MSO to one or more entities [Health & Safety Code § 127507(c)(2)]. This noticing obligation is nearly identical to the existing noticing obligations of health care entities. Yet, the proposed regulations define a "material change transaction" so broadly as to sweep up ordinary course and passive investment transactions that do not involve a material amount of the assets or operations of the health care entity or MSO.

First, Section 97435(c)(9)(A) defines a "material change transaction" to include a transaction involving a private equity group or hedge fund that "results in the private equity group or hedge fund holding 5% or more of the assets, equity, debt, or liabilities of a health care entity satisfying [Section 97435(b)(1), (2), or (3)] or a management services organization[,]" including "groups of investors, private equity firms, or hedge funds investing collectively hold 5% of the assets or equity of the health care entity[.]" The 5% threshold is substantially lower than the standard applicable to health care entities in the existing regulations, where a change of control, responsibility, or governance of a health care entity is defined in reference to a transfer of 25% or more of the voting power of the members of the governing body of a health care entity. This means that under the proposed regulations, a noticed transaction would include passive investment transactions that do not impact or alter the control of a health care entity or MSO.

Second, Section 97435(c)(9)(B) is ostensibly an even broader circumstance than the 5% threshold in Section 97435(c)(9)(A), which renders Section 97435(c)(9)(A) superfluous. Notably, Section 97435(c)(9)(B) pertains to transactions involving a private equity group or hedge fund that "results in the acquisition of assets, equity, debts, or liabilities of a health care entity satisfying [Section 97435(b)(1), (2), or (3)] or a management services organization," but without any minimum materiality threshold. Section 97435(c)(9)(B) also includes a list of

eight control indicia, but notably, these indicia are introduced by the clause "including, but not limited to" suggesting the listed indicia are merely illustrative, rather than limited. A literal interpretation means that **any** transaction wherein a private equity group or hedge fund acquires **any** assets, equity, debts or liabilities of a qualifying health care entity or MSO could constitute a material change transaction.

Even if Section 97435(c)(9)(B) were limited to those transactions that meet one or more of the listed eight control indicia, certain of the listed control indicia still cast too wide of a net and would sweep in common and ordinary course arrangements that have no impact on the ownership or control of a health care entity or MSO. For example, the control indicia would capture even routine transactions resulting in the charging of a nominal fee to the health care entity or MSO, regardless of whether the private equity group or hedge fund retains any actual authority or control over the operations or assets of the health care entity or MSO.

Amid unprecedented funding cuts at the federal and state level, health care entities need flexibility to move quickly and secure financing in order to keep their doors open and ensure patients in their community continue to have access to quality care. The proposed regulations would make it much more difficult and costly for distressed hospitals and other health care entities to raise much-needed capital, and could further turn investors away from the California health care market altogether. OHCA must balance its interest in reviewing an expanded set of transactions with the imperative to sustain access, for which investment is critically needed. To do this, it must focus only on those transactions that actually change the control of health care entities or MSOs.

Proposed Resolution

Section 97435(c)(9) should be revised to capture only those transactions that could actually result in a change of control, responsibility, or governance of a health care entity or MSO. OHCA has already established criteria for health care entity transactions that involve a transfer of control, responsibility, or governance of a health care entity in Section 97435(e).

As OHCA previously noted in its Findings of Emergency and Notice of Proposed Emergency Regulations, dated November 2023 (the "**Emergency Findings**"), it previously drafted Section 97435(e) to establish the "tipping point" for materiality as to when a transfer of control could affect affordability, access, and equity. Notably, OHCA comments in the Emergency Findings that it originally contemplated establishing a 10% threshold for transfer of voting power that constitutes a material transfer of control pursuant to Section 97435(e)(1), but decided on the existing 25% threshold as the appropriate tipping point for materiality. OHCA noted that it further adopted Section 97435(e)(2), categorizing transfers of supermajority rights, veto rights, and similar provisions based on the Attorney General regulations found in 11 Cal. Code Regs. § 999.5. Accordingly, OHCA has already determined that Section 97435(e) appropriately identifies the threshold in which a transaction becomes sufficiently material to constitute a transfer of control that could affect affordability, access, and equity and which warrants further scrutiny. OHCA should, therefore, revise Section 97435(c)(9) to align with the same criteria set forth in Section 97435(e).

Extend to Noticing Entities the Exception for Transactions in the Usual and Regular Course of Business and Common Control

In OHCA's Emergency Findings for its initial regulations, it stated that exceptions are "necessary to define those transactions that require the filing of a notice," in reference to the statutory requirement for OHCA to focus on only those transactions that involve a **material amount** of the assets or operations of a health care entity. OHCA stated:

"The Office also enumerates transactions that are ***not material****, such as those in the day-to-day, usual and regular course of business, and situations that amount to internal adjustments or restructurings . . . [t]his is necessary to minimize the Office's burden from receiving notices of transactions that would not typically trigger health care consolidation concerns."* (emphasis added)

However, OHCA did not revise the "ordinary course" and "common control" exceptions to the definition of a material change transaction found in its existing regulations to also apply to noticing entities. Specifically, Section 97431(l) of the proposed regulations state that a "material change transaction" does not include: "(1) transactions in the usual and regular course of business of the **health care entity**, meaning those that are typical in the day-to-day operations of the health care entity; and (2) situations in which the **health care entity** directly, or indirectly through one or more intermediaries, already controls, is controlled by, or is under common control with, all parties to the transaction, such as a corporate restructuring" (emphasis added).

Although AB 1415 includes the same operative language — for OHCA to receive notice of noticing entity transactions that involve a **material amount** of the assets or operations of a health care entity or MSO — the proposed regulations fail to extend these same exceptions to MSO transactions that are either in the usual and regular course of business or that pertain only to internal adjustments or restructurings. The same logic enumerated in OHCA's prior Emergency Findings should be applied to ordinary course transactions and internal restructurings of MSOs.

Moreover, as noted previously, given the broad MSO definition and the extent to which Section 97435(c)(10) would seemingly capture any management and administrative support arrangement between the MSO and a qualifying health care entity, extending these exceptions to MSO transactions is necessary to focus resources and attention on transactions that are most likely to have a material impact, and to reduce the burden on health care entities and MSOs to notify OHCA of transactions that are not material.

Proposed Resolution

OHCA should revise Section 97431(l) of the proposed regulations to exempt from the notice obligations transactions that are in the MSO's usual and regular course of business, as well as transactions where the MSO directly or indirectly through one or more intermediaries, already controls, is controlled by, or is under common control with, all parties to the transaction.

Provisions Covering Real Estate Sale-Leaseback Arrangements Are Too Broad

The proposed regulations include a "material change transaction" circumstance targeted at real estate transactions for the first time. Section 97435(c)(11) proposes to define a "material change transaction" to

include transactions that result in the sale or transfer of real estate where a health care entity provides health care services: (A) to an entity other than the entity acquiring the health care entity or its direct parent; and (B) the surviving health care entity will be required to lease or pay rent for the real estate.

While hospitals appreciate that OHCA acknowledges that transactions where the health care entity or its direct parent acquires the real estate do not warrant scrutiny, Section 97435(c)(11) as proposed by OHCA still captures usual, customary, inappreciable transactions that should not raise concerns. This shortcoming stems from the lack of a materiality threshold for transactions that include leasebacks. As a consequence, under the proposed regulations, notice would have to be provided and OHCA would have to review all such transactions that have a qualified submitter, no matter how small the agreement is or whether it would impact the market. For example, health care entities routinely sign professional services agreements with small physician groups — often with only a couple of physicians — and offer to take over the group's lease. Often, this occurs as the physicians near retirement, and allows the health care entity to maintain services at the same location when otherwise the office would close. Going forward, such agreements, which protect access to care, would cease to exist if subject to CMIR requirements.

Proposed Resolution

Delete Section 97435(c)(11) in its entirety. The other circumstances requiring filing specified in Section 97435(c) would adequately cover leaseback arrangements that would have an appreciable impact on the health care market.

Certain Confidentiality Provisions Reflect an Improvement, but Changes to Protect Sensitive Information Are Needed

Confidentiality protections are essential to protect competitively sensitive information from being released into the public domain, which could not only sink a proposed transaction, but also increase health care costs to the extent third parties find that they are being paid comparatively less. The proposed regulations make various changes to the rules and process governing the confidentiality of information provided to OHCA. For example, the updated rules deem certain documents confidential, including stock purchase agreements, compensation documents, contract rates, transaction valuation documentation, and unredacted résumés. This change is appropriate given the competitively sensitive nature of the information contained in these documents, but does not extend to all the documents containing sensitive information required to be submitted under Section 97438(c).

While the documents listed above would be deemed confidential, the related information otherwise provided to OHCA would have to be determined confidential on a case-by-case basis — adding unnecessary uncertainty and workload to the review process.

Finally, the regulations permit disclosure of confidential information to the Attorney General. However, there are no protections ensuring that the Attorney General keep this same information confidential.

Proposed Resolution

To comprehensively protect documents that by nature contain confidential information, OHCA should deem confidential all the documents submitted pursuant to Section 97438(c). OHCA should further specify that competitively sensitive information otherwise submitted, including but not limited to the price of the transaction, stock valuations, compensation amounts, contracted rates, and detailed resume information, shall be deemed confidential. OHCA should also add a provision to limit disclosure by the Attorney General of any confidential information shared, whether through an interagency agreement or other means.

Tolling Based on Third-Party Information Requests Would Create Unwarranted Uncertainty and Delays

OHCA proposes changes to Section 97440 to allow OHCA's review timelines to be tolled while awaiting information from third parties that are not participants in the transaction under review. Third parties are entirely outside the control of the submitter. Submitters cannot compel a third party to respond to OHCA's requests, cannot accelerate the pace of a third party's production of information, and cannot anticipate how long a third-party review may take. Allowing open-ended tolling based on third-party information requests would expose compliant submitters to indefinite extensions of the review period through no fault of their own, creating profound uncertainty regarding transaction timing, operational planning, financing, and regulatory approvals from other agencies.

For hospitals and health systems already operating in financial distress — the very entities most likely to be engaged in time-sensitive transactions necessary to preserve access to care — this uncertainty is not merely an inconvenience. An indeterminate review timeline would cause financing to fall through, require renegotiation of transaction terms, or cause a potential partner to walk away entirely. The practical effect could be to make beneficial transactions impossible to complete, threatening patient access to care in vulnerable communities.

Proposed Resolution

OHCA should revise Section 97440 to eliminate tolling of the 45-day and 60-day review periods based on information requests directed to third parties. Tolling should be limited to periods during which OHCA is awaiting information or documents from the submitter itself, or during periods of parallel review by another state or federal agency whose findings may directly affect OHCA's determination.

Proposed Regulations Fail to Eliminate Duplicative Reporting Obligations, as Required by AB 1415

AB 1415 requires OHCA to adopt regulations to eliminate duplicative reporting if a noticing entity or health care entity is required to submit notice under more than one subdivision *[see* Health & Safety Code § 127507(c)(2)(C)]. However, the proposed regulations fail to include any such regulation and, as currently drafted, an entity that is both a noticing entity and a health care entity would need to file two separate notices pertaining to their involvement in the same transaction.

The information and documentation required to be included as part of the notices to OHCA are extensive, particularly under the proposed regulations. There is no question that the process of an entity completing the analysis as to whether it needs to file a notice or submission, and then compiling all required information and documentation for such notice, is time-consuming, costly, and burdensome.

Proposed Resolution

OHCA should expressly include a provision in the proposed regulations that eliminates duplicative reporting obligations in cases where a noticing entity or health care entity is required to submit notice to OHCA under more than one subdivision, as required by AB 1415.

Conclusion

CHA has significant concerns with the proposed regulations as currently drafted, and urges OHCA to incorporate these requested revisions in final regulations. Hospitals appreciate the opportunity to comment on these important regulations and would welcome further discussion.

Sincerely,

Lois J Richardson

Lois Richardson
Vice President, Legal Counsel

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

Adventist Health
One Adventist Health Way
Roseville, CA 95661
AdventistHealth.org

June 17, 20216

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.

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

HEALTH ACCESS CALIFORNIA

June 18, 2026

The Honorable Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Health Care Access and Information Department

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

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

Re: June 2026 Health Care Affordability Board Meeting

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

Health Access, the statewide health care consumer advocacy coalition committed to quality, affordable care for all Californians, offers comments on OHCA's spending target penalties, enforcement of the spending target, and equity adjustment for payers. Our comments focus on ensuring that enforcement remains effective and centered around consumer affordability. Health Access supports strong accountability for spending increases that exceed the growth target.

Executive Summary:

- Health Access supports commensurate, dollar-for-dollar penalties, consistent with California law.
- Health Access recognizes that financial penalties for exceeding the spending target are the culmination of a lengthy, multi-step enforcement process.
- Health Access supports enforcement, including performance improvement plans and adjusting cost targets for an entity, to rebase spending by a specific entity to the intended target level, to prevent an entity from rebasing to a higher level of spending.

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

- Health Access opposes measuring spending combined across Medicare, Medi-Cal, and commercial market segments. Doing so would obscure increases in spending in each segment.
- Health Access supports measuring spending across multiple years rather than year over year to address volatility.
- Impacts of H.R. 1 and charity care.
- With respect to the enforcement framework,
    - We propose imposing penalties for an entity that fails to meet milestones in an agreed-upon performance improvement plan as "repeatedly" failing to implement that plan.
    - We support "stacking" year by year performance improvement plans.
    - We suggest that the range and scope of penalty for obstruction of a performance improvement plan, through failing to file one or to comply with one, the penalty should be commensurate with the amount by which the entity exceeded the spending target.
- Health Access offers further comments on equity adjustment for payer spending target methodology and supports revisiting the framework.

1. Spending Target Penalties

A. Spending Target Penalties Consistent with California Law: Commensurate with the Dollar Amount in Excess of the Target

Health Access supports commensurate, dollar-for-dollar financial penalties for exceeding the spending target as consistent with California law.[1] Commensurate penalties are proportional to the failure to meet the spending target and the impact that rising costs have had on consumers and other purchasers. Proposals to model the spending target penalties on the laws enacted in other states such as Oregon or Massachusetts lack statutory authority under California law. Health Access notes that studies of growth target programs in other states, including Massachusetts as well as others, found that because of the lack of accountability mechanisms, the effectiveness of the growth target programs waned over time.[2] Based on these studies, we conclude that California law has greater potential to slow cost growth because of its more effective enforcement mechanisms, culminating with possible commensurate financial penalties for exceeding the growth target.

[1] Health and Safety Code 127502.5 (d)(1)
[2] https://www.mathematica.org/publications/the-massachusetts-health-care-cost-growth-benchmark-and-accountability-mechanisms-stakeholder# and https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2845326

California law also provides that for repeated failure of an entity to comply with a performance improvement plan the Director may assess escalating penalties that *exceed* the commensurate penalties in (d) (1).[3] This provision for escalating penalties makes clear the intent of the Legislature and the Governor to impose strong penalties for exceeding the spending target.

Health Access opposes smaller or capped penalties both because this approach lacks statutory authority and because smaller or capped penalties do not encourage entities to correct behavior by making the change necessary to meet the growth target.

B. Lengthy Enforcement Process Before Financial Penalty considers Factors Outside the Control of the Entity at Early Stages

Possible financial penalties for exceeding the spending target culminate a lengthy enforcement process with multiple steps:

- The process of enforcement began with setting the spending target for the years 2025-2029 in 2024.
- In the next step, after the end of a target year, each health plan or each hospital reports its own data on its own spending[4].
- The determination of whether the entity exceeded the target is the next step.
    - At this early stage in this enforcement process, "enforcement considerations" involving factors outside the control of the entity may apply if those factors result in the entity exceeding the target and are determined to be outside the control of the entity.
    - External factors such as high-cost drugs, H.R. 1 impacts, or change in utilization patterns need to be assessed both for impact on spending and the ability of the entity to control costs. For example, high-cost drugs have a different impact for a hospital that participates in the 340B program than one that does not.
- Technical assistance follows and then public testimony, written or verbal.
- Performance improvement plans to correct a failure to comply with the target may follow. These plans may last months or up to three years.
- Only after all these steps can the Director consider imposing financial penalties for exceeding the cost growth target. By this point, entities will have had years to plan for compliance with the state spending targets.

[3] Health and Safety Code 127502.5 (d) (5)
[4] For large physician organizations, the methodology is still being developed.

This enforcement framework provides notice, requires general technical assistance and then a performance improvement plan developed by the entity itself before the Director assesses a financial penalty. External factors outside the control of the entity are considered early in the process rather than during the penalty phase.

C. Adjustment Factors for Spending Target Penalty: California Law

Health Access supports basing any adjustment to the initially commensurate penalty for exceeding the spending target on the factors listed in California law[5]:

- The nature, number, and gravity of the offenses.
- The fiscal condition of the entity, including any affiliates or subsidiaries as well as an entity that controls, governs, or has financial control of the entity.
- The market impact of the entity.

This structure for adjusting spending target penalties requires the Director to consider the entity's financial capacity, including revenues, reserves, profits, assets, affiliates, and market impact to determine whether the initially commensurate penalty should be adjusted. This two-step process in the law keeps penalties proportionate to the impact exceeding the spending target had on consumers and other purchasers while it prevents destabilizing an entity with limited financial resources. Conversely, this approach also assures that entities with substantial reserves or system-level support cannot rely on external factors as justification for exceeding the spending target.

D. Adjustment Factors Lacking Statutory Authority

Health Access opposes factors to adjust the spending target penalty which lack statutory authority in California law. These include:

- Capping the penalty amount at earnings from patient care: there is no statutory basis for this. Instead, the law speaks to the financial capacity of the entity writ large.
- Deducting costs outside the control of the entity from the penalty amount is not consistent with state law. Instead, such "enforcement considerations" are reviewed earlier in the enforcement process when the determination that the entity has exceeded the target is made. Deducting such costs during the penalty phase may amount to double counting or double exempting from enforcement.

[5] Health and Safety Code 12502.5 (d) (6).

- In Health Access' view, investments in primary care and behavioral health are appropriate considerations as part of the performance improvement plan. Unfortunately, existing law imposes the duty to comply with the spending target, and penalties for exceeding it, on the entity itself, not on the larger system of which an individual hospital might be one piece. Similar statutory constraints apply for health plans, large physician organizations, and other health care entities.

2. Enforcement of the Spending Target

A. Rebasing to the Target Level

One question the Board has rightly been asking is whether the entity will benefit from failing to meet the spending target by rebasing its spending to a higher level which will compound over time. In taking action on high-cost hospitals, the Board has already determined that there are a few entities which begin at an unacceptably high base of spending, that is, a base of spending roughly twice what other entities spend per patient or per enrollee. The action the Board took to address such excessively high spending was to set a lower spending target. The Board might take a similar approach for entities that exceed the spending target by requiring them to meet a lower spending target in the future.

Another approach is to require a performance improvement plan to restore spending by the entity to the level it would have been if the entity had not exceeded the spending target. The goal of a performance improvement plan should be to restore spending by an entity to the level it would have been if the entity had initially complied with the growth target and continued to comply over the subsequent period until the end of the enforcement process. If an entity exceeded the spending target for 2026, the data will not be reported until 2027 or 2028 (depending on the entity type) and the enforcement process extends beyond that. Allowing the entity to front-load spending encourages entities to rebase to a higher level of spending because of the cumulative and compounding benefit to the entity. The enforcement process, culminating in a spending target penalty, if any, should deter such behavior. An illustrative example using average spending per patient or per enrollee beginning at $10,000 per patient or enrollee:

Illustrative Example – *Avg. Spending per Patient/Enrollee*	Entity A *(Historical Cost Growth – 10% per year)*	Entity B *(Historical Cost Growth – 3.5% per year)*
2025	$10,000	$10,000
2026	$11,000	$10,350
2027	$12,100	$10,712
2028	$13,310	$11,087
2029	$14,641	$11,475

After only five years, the period of the initial OHCA targets, the average spending per patient or enrollee is almost $3,200 higher at 10% annual growth than 3.5%. The benefit is considerable.

The Board should consider both approaches, a lower spending target and an effective performance improvement plan, since these are not mutually exclusive.

B. Measure cost growth by market segment, not across segments.

Health Access continues to support measuring cost growth by market segment, specifically measuring cost growth separately for each of Medicare, Medi-Cal, and commercial markets. Aggregating measurement across all three market segments has multiple flaws:

- It conceals cost growth, particularly for commercial coverage.
- It ignores the different rate-setting approaches for each market segment.
- It obscures the different market dynamics for each.
- It overlooks the differing benefit packages for each market segment.
- And it undoes an important equity adjustment element of the growth target methodology in which Medi-Cal is distinguished by the income of its enrollees while Medicare beneficiaries are distinguished in terms of social risk by age and disability.
- Finally, it allows entities to avoid accountability for cost growth in each of the market segments.

Measuring cost growth by market segment, separating out Medicare, Medi-Cal and commercial growth permits:

- Purchasers, both public and private, to track growth in their market segment more accurately.
- Differences in rate setting methodology and benefit packages among the different market segments.
- Consistency with the statutory requirement to consider an equity adjustment to the spending target methodology.
- Accountability of each entity for cost growth in each of the three market segments.

Consumers do not benefit from entities offsetting spending across market segments. Aggregating across market segments does not allow OHCA to understand the root cause of spending growth. This is not consistent with the legislature's intent when establishing OHCA; the goal is to curb cost growth, not to allow entities to redistribute that growth among purchasers.

C. Multi-Year Measurement to Address Year-to-Year Volatility

Health Access supports using multi-year measurement to evaluate spending target performance to account for year-to-year volatility in various spending measures, including THCE and hospital revenues as well as measures such as equity performance. Evaluating performance over multiple years, such as three out of five years, is consistent with the approach taken by the Board and the Office with respect to very high-cost hospitals. It reflects the data on five years of hospital profits presented at the May 2026 Board meeting in which data for 2022 may be a low-end outlier. It is consistent with recommendations of various experts we have consulted and builds on existing data collection which has collected multiple years of data.

D. Charity Care and Other H.R. 1 Impacts on Spending

California's healthcare affordability crisis did not begin with recent state and federal budget cuts to health care, and those cuts alone do not explain persistently high health care costs over time. While the implementation of H.R. 1 is projected to result in a greater uninsured population, including an estimated 1.3 million losing Medi-Cal coverage by 2029-2030 and more losing coverage from Covered

California[6], an increase in the uninsured population does not justify shifting costs onto commercial payers.

Historically, spending growth in California's commercial market has mostly been driven by increases in prices, and not uncompensated care.[7] California hospitals now spend roughly 1% of revenue on charity care, with many hospitals spending far less. The amount of revenue invested in charity care is too modest to justify persistent increases in commercial prices. As Health Access said previously, hospital charity care should be an enforcement consideration only if a hospital can document that 1) it provided additional charity care above the levels prior to H.R. 1, 2) provided free care with no expectation of payment and no medical debt imposed on consumers, 3) priced care to the uninsured and underinsured consistent with California's Hospital Fair Pricing Act of 2006 and 4) exceeded the target because it provided increased charity care.

Other H. R. 1 impacts reduce hospital revenues, such as the cuts to state-directed Medi-Cal payments. These make it less likely that a hospital will exceed the growth target, not more likely.

Under no circumstances should Medicaid funding mechanisms that increase hospital revenues such as hospital provider taxes, the Managed Care Organization Tax, or use of intergovernmental transfers (IGTs) or certified public expenditures (CPEs) be ignored or discounted in estimation of entity spending. Every dollar in the health care system starts in a consumer's pocket—either as taxes or wages. The point of the Office of Health Care Affordability is to hold accountable health care entities for this spending extracted from consumers.

3. Enforcement Framework: Performance Improvement Plans, Mid-Year Milestones, and Statutory Constraints

A. OHCA May Assess Penalties for Noncompliance of Performance Improvement Plans for Failure to Comply with Mid-Year Milestones

The statute provides OHCA with two bases for determining penalties for performance improvement plans. The first basis is tied to failing to meet the cost

[6] https://ebudget.ca.gov/2026-27/pdf/Revised/BudgetSummary/HealthandHumanServices.pdf

[7] www.hcai.ca.gov: OHCA, *Issue Brief: Commercial Health Care Spending Trends* (2023), finding that "price increases, rather than changes in utilization, were the primary driver of spending growth in California's commercial market."

target while also not complying with the performance improvement plan. The second pathway is a penalty as a result of repeated failures to implement the performance improvement plan itself.

> Section 127502.5 (d)(1) states that "if the director determines that a health care entity is not *compliant with an approved performance improvement plan and does not meet the cost target,* the director may assess administrative penalties commensurate with the failure of the health care entity to meet the target". Entities that have fully complied with the performance improvement plan by the deadline will not be assessed penalties.

This describes a scenario where the entity is not meeting the performance improvement plan and continues to exceed the spending target. An entity that misses the spending target despite efforts to implement a performance improvement plan presents a different circumstance than an entity that fails to implement its performance improvement. The statute recognizes this distinction.

> Section 127502.5 (h)(1) provides that "The director may directly *assess administrative penalties when a health care entity has failed to comply* with this chapter by doing any of the following: (D) *"Repeatedly failing to implement the performance improvement plan".*

The statute does not specifically require failure over multiple years before OHCA may determine that an entity is "repeatedly" noncompliant. Repeated non-compliance can occur within a single performance improvement plan. For example, an entity developed a plan with four milestones, and it then missed every milestone, the entity failed to implement the approved plan. Milestones may not necessarily be annual, they could be quarterly or semi-annually, to support state monitoring, which gives both OHCA and the entity an opportunity to respond to repeated failures. An entity could ignore all milestones within a multi-year performance improvement plan or fail every milestone within a year.

Because performance improvement plans can span up to three years and may include quarterly and semiannual reviews, OHCA should not wait until the conclusion of a multi-year performance improvement plan to determine that an entity has failed to comply with its approved corrective plan. OHCA must be able to intervene otherwise, the entity could wait until the final year to perform and avoid

accountability. If entities are able to ignore the performance improvement for multiple years, enforcement fails.

Both sections operationally are different but give OHCA the authority to address any entity that is failing to implement the performance improvement plan within the period for performance improvement, and an entity that is not meeting the cost target.

B. "Stacking" Performance Improvement Plans

For performance improvement plans that extend over multiple years, OHCA staff suggested the possibility of "stacking" year-long performance improvement plans. Health Access supports this approach to facilitate earlier enforcement of the spending target if there is a multi-year performance improvement plan. Health Access recognizes that some transformations in care delivery may take multiple years to achieve. Finding a balance between this recognition and the concern expressed by the Board and others that entities will use the lengthy enforcement process mandated by statute to delay or even avoid compliance requires a thoughtful approach and careful drafting of any performance improvement plans.

C. Penalties for Knowing or Willful Failure to Comply

Violations under Health and Safety Code Section127502.5 (h)(1) are intentional failures to comply with the statute, undermining the spending target and the statute's affordability goals. These are instances when an entity "knowingly" or "willfully" fails to submit data, refuses to comply with requirements of the Office, or fails to implement a performance improvement plan. This obstructs the Office's ability to protect consumers from rising health care costs. Because of the effect these actions have on consumers, such actions warrant meaningful, escalating penalties.

For most circumstances detailed in this section of the law, the Board and staff do not yet have experience[8]. For example, no entity has yet been asked to develop a performance improvement plan so as yet, no entity has "neglected" to file an acceptable plan or repeatedly failed to implement it. Similarly, to the best of our knowledge, no entity has "knowingly" "falsified" information (though some have made various errors).

[8] Data submission penalties for failure of plans and insurers to submit timely, complete and accurate THCE data are another example of such penalties.

At this stage, Health Access supports the Board adopting the scope and range of penalties for failures associated with performance improvement plans and making those penalties commensurate with the failure to meet the growth target for the following reasons:

- The Board has already had considerable discussion about performance improvement plans,
- The amount by which an entity has exceeded the target is knowable at the time a performance improvement plan is requested, and
- Basing penalties for failing to file or comply with a performance improvement plan as provided under (h) (1) (B), (C) and (D) on the commensurate amount to exceeding the penalty is consistent with the penalty for exceeding the spending target.

4. Equity Adjustment to the Growth Target Methodology for Payers

Health Access supports revisiting equity adjustments to the growth target methodology for payers in the future, as discussed by the Board at its May 2026 Board meeting.

In the near term, Health Access seeks transparency of which payer has what level of social risk in each market segment. Without information on basics such as size of enrollment or market role, we have difficulty assessing the behavior of health plans and insurers with respect to social risk. The presentation indicates that for commercial coverage, two payers have much higher social risk than the other payers. Our assessment of the implications of this fact is very different if these two payers represent smaller regional plans concentrated in the Covered California markets than if these two payers represent a majority of the statewide commercial market. We were troubled by the broad range of social risk for payers in both the Medicare Advantage and Medi-Cal managed care market segments. Again, without knowing which plan is which, it is impossible to offer intelligent commentary, much less to proffer policy improvements designed to increase equity as well as affordability.

Health Access observes that looking at social risk by market segment is already an equity adjustment to the spending target methodology because Medi-Cal

distinguishes its population by income from commercial coverage while Medicare beneficiaries are distinguished by age and disability. In addition, the reimbursement structures for both Medi-Cal and Medicare include provisions for benefits and payments not contemplated in commercial coverage, whether it is durable medical equipment, long term care or housing supports in Medi-Cal or various efforts by Medicare Advantage plans designed to reduce hospital readmissions. Any proposal to ignore market segments is a proposal to erase this equity adjustment to spending target methodology.

We support the observation that, while the current data presented shows limited variation for each payer over time in the proportion of members with the highest social risk, consistency in social risk may be due to limits on the level of social risk payers are willing to assume. We appreciate the multi-year look by payer and market segment provided in the appendix and ask that future analysis look at multiple years rather than year over year change.

We encourage OHCA to revisit the equity adjustment framework in future years. Health Access appreciates that the recognized measures adopted by OHCA will stratify by race, ethnicity, and other measures of social vulnerability. We want to encourage appropriate investment in addressing social determinants by payers, including greater investment in human services.

Conclusion

Thank you for your consideration of these comments. California consumers have shouldered rising health care prices for far too long; this work represents steps forward in ensuring affordability is within reach.

Sincerely,

Katrina Walters-White
Regulatory Advocate

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

?rr_afkclr!1/

PEBBLE BEACH
COMPANY

June 18, 2026

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

Subject: **Taking a Collaborative Approach to Protecting Healthcare Access and Increasing the Quality of Healthcare in Monterey County**
(Submitted via email to Megan Brubaker at ohca@hcai.ca.gov)

Dear Chair Johnson:

Pebble Beach Company proudly provides non-contributory health insurance coverage to our employees and their families. Montage Health operates Community Hospital of the Monterey Peninsula, an important component of the overall Montage Health system that many of our employees utilize to receive high caliber of care on the Monterey Peninsula. For our employees and their families, affordability and access to high-quality providers and specialists close to home and work is of paramount importance. Our employees greatly value the quality and value of health care received through Montage Health and, when possible, overwhelmingly choose to utilize the Community Hospital of the Monterey Peninsula for their care.

Pebble Beach Company believes a robust healthcare system is vitally important to our overall community health. Controlling rising health care costs is a valuable endeavor and doing so in a manner that also supports a robust healthcare delivery system and does not result in the loss of programs or services is critically important for the overall healthcare system in Monterey County.

As such, Pebble Beach Company recognizes that OHCA's decisions on this important topic will have an effect on our communities for years to come. Pebble Beach Company respectfully requests that OHCA take a collaborative approach—with input from all community stakeholders—to address affordability. Doing so will protect healthcare access and increase the quality of healthcare in Monterey County.

Sincerely,

David Stivers
President and Chief Executive Officer
Pebble Beach Company

PEBBLE BEACH
COMPANY

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
Sen. John Laird
Speaker Robert Rivas
Assemblymember Dawn Addis

Attachment #32

GLENDORA HOSPITAL

150 W. Route 66 • Glendora, California 91740
(626) 852-5000 • www.glendorahospital.com

June 17, 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, Glendora 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.**

Glendora Hospital 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

Glendora Hospital is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs grew by 9.5%, with aggregate cost increase of 8.7%. 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:

- Glendora Hospital has had to delay investments designed to increase Behavioral Health Services capacity to meet the needs of the community
- Glendora Hospital is continuing to look for ways to gather the resources necessary to make multi-million dollar investments in our facilities to meet the state's 2030 seismic compliance goals.

And yet, those efforts might not be enough. However, Glendora 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 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 Glendora Hospital'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 Glendora 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 OBBBA.

Glendora Hospital is committed to helping patients afford the care they need. That's why we offer financial assistance and medical debt forgiveness.

Penalties at the levels proposed by OHCA would threaten Glendora Hospital's viability, jeopardize our patients' health, and endanger the livelihoods of the of the employees who rely on us. Glendora 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 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. Glendora 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.

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

Anthony Quintero

Anthony Quinterro
Chief Executive Officer
Glendora Hospital

cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández Elizabeth Mitchell
Dr. Richard Kronick Donald B. Moulds, PhD
Ian Lewis Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Alex Padilla, CA U.S. Senate
Adam B. Schiff, U.S. Senate
Sasha Renee Perez California 25th State Senate District
Blanca E. Rubio California 48th Assembly District
Kathryn Barger 5th District Supervisor, Los Angeles County

College Hospital Costa Mesa
301 Victoria Street ▪ Costa Mesa ▪ CA ▪ 92627

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

June 18, 2026

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, College Hospital Costa Mesa 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.**

College Hospital Costa Mesa 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

College Hospital Costa Mesa is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs which are the biggest driver of our expenses grew by 9.5%. 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:

- College Hospital Costa Mesa has had to delay investments designed to increase Behavioral Health Services capacity to meet the needs of the community
- College Hospital Costa Mesa is continuing to look for ways to gather the resources necessary to make multi-million dollar investments in our facilities to meet the state's 2030 seismic compliance goals.

And yet, those efforts might not be enough. However, College Hospital Costa Mesa 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 College Hospital Costa Mesa 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 College Hospital Costa Mesa, 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.

Penalties at the levels proposed by OHCA would threaten College Hospital Costa Mesa's viability, jeopardize our patients' health, and endanger the livelihoods of the of the employees who rely on us. College Hospital Costa Mesa 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. College Hospital Costa Mesa 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 Costa Mesa, Orange County residents who pass through our doors each year. College Hospital Costa Mesa 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,
Warren Bradley

Warren Bradley
Chief Executive Officer
College Hospital Costa Mesa

cc: **Members of the Health Care Affordability Board:**
Dr. Sandra Hernández Elizabeth Mitchell
Dr. Richard Kronick Donald B. Moulds, PhD
Ian Lewis Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Alex Padilla, CA U.S. Senate
Adam B. Schiff, U.S. Senate
Stephen Choi, California State Senate District 37
Cottie Petrie-Norris, California Assembly District 74
Katrina Foley, Orange County Board of Supervisors District 2

COLLEGE MEDICAL CENTER

2776 Pacific Avenue • Long Beach, California 90806
562/ 997-2000 • www.collegemedicalcenter.com

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

June 17, 2026

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, College 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. OHCA must pursue a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.**

College 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 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

College Medical Center is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs grew by 9.5%, our medical supply costs grew 18.6%, and our drug costs grew by 1.4%. 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:

- College Medical Center has had to delay investments designed to increase Emergency Department and Behavioral Health Services capacity to meet the needs of the community
- College Medical Center is continuing to look for ways to gather the resources necessary to make multi-million dollar investments in our facilities to meet the state's 2030 seismic compliance goals.

And yet, those efforts might not be enough. However, College Medical Center 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 College Medical Center'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 College 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 OBBBA.
- Other costs that result in meaningful improvements for patients but that would put our hospital at risk for exceeding the cap.

College Medical Center is committed to helping patients afford the care they need. That's why we offer financial assistance and medical debt forgiveness.

College Medical Center also understands that affordability in the long term can't happen without focused efforts now. That's why we have made or are looking toward future investments in health information exchange technology, residents' training, community-based care and other quality programs to address social determinants of health.

Penalties at the levels proposed by OHCA would threaten College Medical Center's viability, jeopardize our patients' health, and endanger the livelihoods of the 1,414 number of workers who rely on us. College 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 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. College 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 Long Beach and Los Angeles County residents who pass through our doors each year. College 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,

Joe Avelino

Joseph Avelino, RN, BSN, MHSA, CPHQ
Chief Executive Officer
College 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
Alex Padilla, CA U.S. Senate
Adam B. Schiff, U.S. Senate
Nanette Barragan, 44th Congressional District
Lena Gonzalez California 33rd State Senate District
Mike Gipson California 69th Assembly District)
Josh Lowenthal California 65th Assembly District City of Long Beach
Janice Hahn – 4th District Supervisor, Los Angeles County

?rr_afkclr!13

Dublin
CHAMBER OF COMMERCE

6300 Village Parkway, Suite 100
Dublin, California 94568
(925) 828-6200
info@dublinchamberofcommerce.org

www.dublinchamberofcommerce.org

June 16, 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 Dublin Chamber of Commerce knows firsthand the importance of our San Francisco Bay Area's local hospitals 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 the Dublin Chamber of Commerce 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.**

The Dublin Chamber serves not only our business community with over 260 member businesses but as a partner with government and civic organizations that make up the Tri-Valley, a vibrant area of over 225,000 residents in Dublin, Pleasanton and Livermore. Ours is a community that has experienced double digit growth in the last decade and there is more in the foreseeable future. We partner with our local and regional hospitals to meet several vital community health priorities. We agree with the comment letter from the California Hospital Association which suggests many clarifying points which are reasonable and would bring about better public policy. Without the amendments and clarifications, the unintended consequences of the current proposal will take many years to unwind. Unreasonable fines will only make the situation worse.

OHCA's decisions now will have a ripple effect on our communities for years to come. On behalf of the business community and residents we serve, the Dublin Chamber of Commerce urges you to consider the California Hospital Association's approach to contain costs and providing the services that our community requires.

Sincerely,

Ingeborg E. Houston
President/CEO
Dublin Chamber of Commerce

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
Ca Assemblymember Rebecca Bauer-Kahan
Ca Senator Jerry McNerney

CAPH
CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

June 18, 2026

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

Re: Concerns with Spending Target Enforcement Framework and Financial Penalties

Dear Chair Johnson,

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

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

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

---

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

net providers to the brink and jeopardize services for our Medi-Cal and uninsured patients. As OHCA and the Board seek to adopt new policies regulating health care spending in California, the historic changes to health coverage and funding that we are facing must be at top of mind. We urge OHCA and the Board to carefully consider the following issues as it develops and adopts the spending target enforcement framework and financial penalties:

Outstanding.measurement.questions¿We are nearly halfway through the first enforceable performance year, yet hospital spending measurement metrics have not been finalized, and it is unclear how performance would be determined, including:

- If both the inpatient and outpatient metrics will be used to determine performance and if these will be combined or looked at separately;
- If performance would be determined across an all-payer metric, commercial, and/or if Medi-Cal and Medicare would also be assessed separately; and
- If more than one metric is looked at, how would performance be reconciled if an entity meets the target for some but not all metrics.

Medi_Cal.Financing.Considerations¿Public hospitals play an enormous role in the Medi-Cal program — not only as providers, but also as a source of financing. Most of their Medi-Cal revenues come through self-financed payments, meaning the hospitals themselves, not the State, provide the non-federal share. Public hospitals receive as revenue only the federally matched (net) portion, and it is only that portion that helps cover the cost of care. However, many public hospitals report the gross amount of these payments, which includes the non-federal share they provide, in their Hospital Annual Financial Disclosure Reports. This differs from how private hospitals report supplemental funding under the Hospital Quality Assurance Fee Program, and it substantially inflates reported revenues. For example, several public hospital systems have a payer mix of more than 60% Medi-Cal and self-finance the majority of those payments, so using gross figures significantly overstates their inpatient net patient revenue. OHCA's enabling statute points to the need to account for this, directing that "with respect to Medi-Cal, the methodology shall consider provision of nonfederal share … associated with Medi-Cal payments, such as expenditures by providers … that serve as the nonfederal share associated with Medi-Cal reimbursement."[2] We are concerned that it remains unclear how self-financed payments will factor into hospitals' performance against the target.

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

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

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

Proposed.penalty.magnitude¿OHCA's proposed structure begins with an amount "initially commensurate" with an entity's failure to meet the target and then adjusts for justification factors. OHCA's own illustrative analysis of 2023 data showed "initially commensurate" penalties ranging from $4 million to $350 million. Financial penalties of this magnitude could lead to significant instability in the health care safety net, risking service line and facility closures for entities already facing historic payment cuts. As the Board takes up the range of penalties in June, we strongly encourage it to reconsider the proposed penalty structure and set a measured starting point, especially this early in the implementation of the spending target.

Enforcement.is.in.the.context.of.federal.and.state.cuts¿Cuts to Medi-Cal under H.R. 1 along with state budget decisions made recently and those that are currently being contemplated could result in nearly $4 billion in additional annual losses for public health care systems. To stabilize revenues and prevent closures, some systems may seek Medi-Cal managed care base rate increases and/or commercial rate increases. Depending on how these flow through the measurement metrics, such strategies could push a system's performance above the target. As just one example, we are concerned that it remains unclear how needed revenue growth like this would be accounted for during the enforcement process.

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

---

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

[4] Ibid.

[5] Ibid.

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

In addition, we recommend OHCA adopt safeguards to limit the instances of health care entities being unduly penalized, such as by defining performance failure as failure to meet the spending target across a number of metrics. For hospitals, a framework could consider if the hospital failed to meet performance requirements on both the inpatient and outpatient metrics under consideration, for both commercial and all-payer metrics.

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

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

Sincerely,

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

Cc: Members of the Health Care Affordability Board:
- Dr. Sandra Hernández
- Dr. Richard Kronick
- Ian Lewis
- Elizabeth Mitchell
- Donald B. Moulds, Ph.D.
- Dr. Richard Pan

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

Washington Health

June 18, 2026

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

Subject: Spending Target Enforcement Must Protect Patient Access and Hospital Viability
(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, Washington Health writes to raise serious concerns about the process outlined to date. The stakes are high: penalties at the levels proposed would be devastating for the patients we serve and could threaten access to care in our community. We request the board to pursue a collaborative enforcement approach that gives hospitals a meaningful opportunity to demonstrate improvement before fines are imposed.

Washington Health urges the OHCA board to establish regulations that balance affordability with continued access to care. On measurement and process, we ask that the board:

- Provide a clear explanation of how penalties are calculated, including the specific formulas, variables, and weighting that were used in the penalty assessment model, in order for hospitals to verify and replicate the penalty calculation prior to assessment of the penalty.
- Clarify in writing how cost is defined and the data sources used for cost calculations.
- Include a risk adjustment for patient acuity, case mix index, and payor mix, prior to comparing costs against established benchmarks.
- Apply geographic cost-of-living differentials when establishing and applying target benchmarks to ensure fairness and equity across diverse markets.
- Base violation determinations on multiple years of data rather than a single year, which cannot reliably distinguish a meaningful trend from normal year-over-year volatility.

On enforcement and penalties, we ask that the board:

- Establish a collaborative performance improvement process that includes measurable milestones, a specific, measurable, achievable, relevant and time-bound (SMART) implementation that is commensurate with the complexity of the corrective action required, and a formal OHCA Board review before any penalty is issued.
- Establish the right of a hospital to submit a corrective action plan in lieu of receiving a financial sanction for first-time or minor overages.
- Establish that successful completion of a corrective action plan will result in full abatement of the assessed penalty.
- Adopt a tiered penalty structure that clearly differentiates between minor variances and materially sustained violations of cost targets.
- Enforce spending targets prospectively from the date that the methodology is finalized, ensuring that hospitals are not penalized for decisions made before the rules governing decisions were established.

2000 Mowry Avenue
Fremont, CA 94538
510.797.1111

www.washingtonhealth.com

- Exclude (or incorporate weighting of) external cost drivers, including pharmaceutical manufacturer pricing, consumer price index inflation, and regional labor market conditions.
- Extend a formal grace period or safe harbor provision to hospitals that exceed targets due to documented extraordinary circumstances (i.e. public health emergencies, natural disasters, significant market disruptions, capital expenses associated with technology adoption or new clinical services).
- Require OHCA staff to meet quarterly or semi-annually with hospitals to review their cost trajectory, identify areas of concern, and implement course corrections before year-end penalties are alleged/assessed.
- Enact a formal, independent appeals process or administrative hearing that allows hospitals to contest violation determinations before financial penalties are imposed, ensuring due process and providing a meaningful opportunity to present evidence that spending growth is justified to an impartial officer.
- Adopt clearly defined timelines within which the Office must respond to appeals and reconsideration requests. Ensure that alleged penalties assessed, including any penalty remit timelines, are tolled during the appeal process.

Penalties at the levels proposed by OHCA will threaten Washington Health's viability, jeopardize our patients' health, and endanger the livelihoods of the nearly 2,000 workers who rely on us to remain a financially sustainable institution. OHCA's one-size-fits-all enforcement approach will have detrimental impacts on our ability to sustain access to high-quality, equitable care and a stable workforce – priorities we share with OHCA.

The measurement and enforcement framework that OHCA adopts will directly determine whether Washington Health can continue to be there for the residents of Southern Alameda County who depend on us for life-saving health care. We have submitted these comments in good faith and with a genuine desire to work collaboratively toward a more affordable and accessible healthcare system for all Californians. We urge the board to incorporate these recommendations into its final rulemaking and to pursue an enforcement approach that recognizes the complexity of the environment in which community hospitals like Washington Health operate every day.

Sincerely,

Kimberly Hartz, CEO
Washington 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 Dr. Aisha Wahab
Assemblymember Alex Lee
Assemblymember Liz Ortega

ąąċĦő ů IJŰąǁмOY

June 18, 2026

Kim Johnson, Chair
Office of Health Care Affordability Board
2020 W. El Camino Avenue
Sacramento, CA 95833
Submitted via Email to Megan Brubaker

SUBJECT: SPENDING TARGET ENFORCEMENT FRAMEWORK

Dear Chair Johnson and Members of the Board:

On behalf of the California Children's Hospital Association (CCHA) and California's eight nonprofit children's hospitals, we appreciate the opportunity to comment on the Office of Health Care Affordability's ongoing development of a spending target enforcement framework and contribute to the shared goal of improving health care affordability for California families.

California's children's hospitals share OHCA's goal of ensuring that patients and families have access to affordable, high-quality health care. We support accountability for excessive spending growth and recognize the important role that spending targets can play in promoting a more sustainable health care system. However, an effective enforcement framework should distinguish between persistent noncompliance and normal year-to-year variation and should avoid imposing penalties so large that they create unintended consequences for access to pediatric care.

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

(1) Evaluates performance over multiple years rather than a single year of spending growth;

(2) Provides hospitals with a meaningful opportunity to explain unusual circumstances and other factors contributing to temporary spending growth before a violation is determined;

(3) Establishes a meaningful performance improvement process and opportunity for corrective action before monetary penalties are considered; and

(4) Ensures that any future penalties are proportionate, account for each hospital’s financial condition and unique mission, and do not jeopardize access to essential pediatric services.

Children's hospitals occupy a unique role within California's health care system. They serve as regional referral centers for the state's most medically complex children, provide highly specialized services that are often unavailable elsewhere, train the next generation of pediatric providers, conduct pediatric research that advances treatments for childhood diseases, and care for a disproportionate share of children enrolled in Medi-Cal and the California Children's Services program. These responsibilities create cost pressures and year-to-year variability that differ significantly from those faced by many other hospitals.

Unlike many sectors of the health care system, relatively small changes in patient acuity can have a substantial effect on children's hospital spending trends. A single year may include a cohort of children receiving a newly approved gene therapy costing millions of dollars per treatment, an increase in referrals for pediatric transplants or complex oncology care, or a small number of patients whose unusually severe complications require exceptionally resource-intensive treatment. Because pediatric specialty care is concentrated among a limited number of children's hospitals, these circumstances can meaningfully affect annual spending growth calculations despite reflecting appropriate, medically necessary care that hospitals are expected to provide.

As a result, spending growth measured over a single year may not accurately distinguish between sustained cost growth and temporary fluctuations associated with caring for medically complex children. The enforcement framework should therefore evaluate performance over multiple years and provide hospitals with a meaningful opportunity to explain unusual circumstances that contribute to short-term increases in spending. The framework should also provide OHCA with the ability to consider whether an exceedance reflects sustained spending growth that warrants intervention or temporary circumstances that do not.

CCHA is also deeply concerned by potential penalty amounts that could reach tens or even hundreds of millions of dollars based on a single year of performance. The

potential magnitude of these penalties is best illustrated by applying OHCA's proposed approach to historical spending data. According to the penalty modeling tool developed by the California Hospital Association using 2023 commercial spending data, several California children's hospitals would have faced projected penalties exceeding $50 million, including one projected penalty exceeding $117 million.

In several cases, the modeled penalties would have entirely wiped out a hospital's annual operating margin. For two of our member hospitals that entered the cycle already managing negative operating margins, these assessments would severely compound their financial shortfalls. Furthermore, for two members performing with positive operating income in 2023, the framework's penalties would have completely stripped away their baseline margins and pushed the hospitals significantly into the red—exceeding annual net operating income by over $66 million in one case.

Imposing tens of millions of dollars in penalties under these conditions raises serious concerns about how the framework would impact access. If a specialized provider's cost growth exceeds the 3.5% target while the institution is still operating at a deficit, that growth reflects the soaring cost of essential care delivery—not excess profit. Children's hospitals maintain neonatal intensive care units, pediatric trauma centers, behavioral health services, transplant programs, and oncology services that families depend upon throughout California. Because penalties of this magnitude can far exceed a hospital's operating margin, they risk requiring reductions that extend beyond operational efficiencies and affect the availability of critical services that children and families rely upon.

CCHA appreciates OHCA's efforts to develop a progressive enforcement framework that includes technical assistance and performance improvement plans prior to the imposition of monetary penalties. As OHCA continues developing its regulations, it is important that these early intervention mechanisms remain central to the enforcement process and that monetary penalties serve as a true last resort. In addition, any penalties ultimately imposed should be calibrated to encourage improvement, account for a hospital's financial condition and unique mission, and avoid unintended consequences for access to pediatric care.

Other states with spending growth targets have demonstrated that accountability and affordability can be advanced through transparent reporting, performance improvement planning, and graduated enforcement approaches designed to protect access to care. California should similarly adopt an approach that encourages improvement while preserving the pediatric care infrastructure that children and families rely upon.

For these reasons, CCHA respectfully urges OHCA to adopt an enforcement framework that evaluates performance over multiple years, provides hospitals with a meaningful

opportunity to explain unusual circumstances contributing to temporary spending growth, prioritizes technical assistance and performance improvement before monetary penalties are imposed, and incorporates a graduated penalty structure that is proportionate, takes into account each hospital's financial condition and unique mission, and does not jeopardize access to essential pediatric services.

Thank you for your consideration.

Sincerely,

Mira Morton
Vice President of Government Affairs
California Children's Hospital Association

Michele Lew
SVP & Chief Government Relations Officer
Stanford Medicine Children's Health

Jena Jensen
Vice President, Chief Advocacy & Public Policy Officer
Rady Children's Health

Shandra Secor
Vice President
Office of Government Relations
Loma Linda University Health

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

Lynne Ashbeck
Senior Vice President, Chief Community Impact Officer
Valley Children's Healthcare

Eric Anthony
Vice President of Government Relations, UCSF Health
Office of Community and Government Relations

Lindsey Berman
Associate Vice President, Policy and Government Affairs
Children's Hospital Los Angeles

ROY LEE
First District Supervisor

BOARD OF SUPERVISORS
County Administration Building
105 East Anapamu Street
Santa Barbara, CA 93101
Telephone: (805) 568-2190
www.countyofsb.org

COUNTY OF SANTA BARBARA

June 18, 2026

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

Subject: OHCA Enforcement Penalties

Dear Chair Johnson,

Our local hospitals: Santa Barbara Cottage Hospital, Goleta Valley Cottage Hospital and Santa Ynez Valley Cottage Hospital provide essential services to our community. Santa Barbara residents depend on Cottage Health for their health care, especially in emergencies. **That's why the County of Santa Barbara is deeply concerned about how our community 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 our 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. And with its 11 beds and small emergency room, Santa Ynez Valley Cottage Hospital offers crucial emergency services to the rural Santa Ynez Valley. Cottage also funds training programs for new doctors, nurses and other health care workers, which are essential for health care services and our local economy.

We understand that OHCA is considering implementing multi-million dollar penalties against hospitals like our local Cottage Health hospitals. This would have a tremendous impact on access to care in Santa Barbara County. Our community is already facing tremendous funding challenges due to H.R. 1 and other government policies that are stripping money out of the safety net. The community cannot afford to lose more funding for healthcare services.

OHCA's decisions now will have a ripple effect on our communities for years to come. On behalf of the Santa Barbara County and the residents we serve, I urge you to take a collaborative approach that protects access while improving affordability.

Sincerely,

Roy Lee
Supervisor, First District
Santa Barbara County

SHARP

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

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

Sutter Health

State Government Affairs

2200 River Plaza Dr.
Sacramento, CA 95833

June 18, 2026

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

Subject: OHCA Enforcement

Dear Chair Johnson:

On behalf of Sutter Health, we appreciate the Office of Health Care Affordability's (OHCA) commitment to improving affordability for Californians. We share this goal and have long invested in care delivery models that advance value, improve outcomes, and reduce unnecessary cost growth.

However, we have significant concerns that the enforcement framework currently under consideration, particularly the potential for substantial financial penalties, could unintentionally undermine access to care and adversely impact the very patients OHCA seeks to protect.

Financial Penalties Risk Reducing Patient Access

Sutter Health operates an integrated system of care that serves diverse communities, including many patients with complex needs and limited access alternatives. The imposition of significant financial penalties—especially in a context of persistent, externally driven cost pressures—would force difficult tradeoffs that ultimately affect patient care.

Hospitals and health systems are already managing unprecedented increases in labor, pharmaceutical, and supply costs, many of which are outside of our control. At the same time, reimbursement levels, particularly from public programs, do not keep pace with these rising expenses.

Against this backdrop, punitive financial penalties would not reduce underlying cost drivers. Instead, they would:

- Constrain our ability to maintain essential service lines, particularly those that operate at a loss but are critical for community access (e.g., behavioral health, maternal care, emergency services)
- Delay or reduce investments in infrastructure, including seismic compliance and facility modernization

- Limit expansion of community-based and preventive care programs that are essential to long-term affordability
- Create pressure to reduce workforce or limit hiring, exacerbating existing workforce shortages

These outcomes would directly impact patients through reduced access, longer wait times, and fewer local care options.

One-Size-Fits-All Enforcement Does Not Reflect Care Delivery Realities

The current approach also risks oversimplifying the complexity of health care delivery. Year-to-year spending variations often reflect appropriate and necessary investments—such as expanding outpatient access, adopting new therapies, or responding to evolving patient needs.

Evaluating performance based on a single year of data, or across disaggregated service lines and payer categories, may produce misleading conclusions and penalize organizations making the right investments for patients.

A more accurate and fair approach would:

- Use multi-year evaluation periods to account for normal variation and strategic investments
- Recognize differences in patient populations, payer mix, and regional cost pressures
- Allow providers to contextualize performance through a transparent and standardized review process

A Collaborative Model Will Achieve Better Results

Sutter Health strongly believes that California can achieve its affordability goals more effectively through partnership rather than punishment.

We encourage OHCA to prioritize a collaborative enforcement framework that:

- Provides health systems with early feedback and clear expectations before performance improvement plans and penalties are considered
- Establishes a structured performance improvement process, allowing organizations time to implement sustainable cost-reduction strategies prior to levying financial penalties

- Recognizes and credits investments that improve value and access to care, such as population health programs, value-based care models, and efforts to address social drivers of health
- Aligns incentives across payers, providers, and regulators to address root causes of cost growth, rather than focusing solely on aggregate spending outcomes

OHCA also has an opportunity to serve as a convener and partner by:

- Sharing data and best practices across the system
- Facilitating alignment with commercial and public payers
- Supporting innovation through pilot programs and flexible regulatory pathways
- Considering adjustments or accommodations where cost growth is driven by factors such as workforce investments or expanded access

Shared Responsibility for Affordability

Health care affordability cannot be achieved by providers alone. It requires coordinated action across the entire system, including pharmaceutical pricing, labor markets, and payer dynamics.

Sutter Health remains committed to doing our part. We have made significant investments in:

- Value-based care models that improve outcomes while controlling costs
- Digital health and outpatient care expansion
- Community partnerships that address health inequities and prevent avoidable utilization

We are eager to continue this work in alignment with OHCA's goals.

Conclusion

We respectfully urge OHCA to adopt an enforcement framework that balances accountability with flexibility and recognizes the operational realities of delivering care in today's environment. A punitive approach risks destabilizing providers and reducing access. A collaborative approach that is grounded in transparency, shared responsibility, and continuous improvement, will better serve patients and ensure a sustainable, equitable health care system for California.

We appreciate the opportunity to provide input and look forward to continued partnership with OHCA.

Sutter Health

Thank you for your consideration,

Preston Young
Senior Director, State Government Affairs
Sutter 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

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

Children's Hospital Los Angeles Medical Group

California Association of Neonatologists

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

Sutter Children's Center Sutter Medical Center, Sacramento

Children First Medical Group, Emeryville

Rady Children's Specialists of San Diego

Department of Pediatrics California Pacific Medical Center San Francisco

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

Department of Pediatrics UC San Diego School of Medicine

Stanford Children's Health Stanford University School of Medicine

Department of Pediatrics UC Davis Children's Hospital

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

Department of Pediatrics UC Irvine Medical Center

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

Miller Children's and Women's Hospital Long Beach

CHOC Children's Specialists, Orange County

Cottage Children's Medical Center - Santa Barbara

Shriners Hospitals for Children - Northern California

Community Regional Medical Center, Fresno

Cedars-Sinai Guerin Children's

June 18, 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 Children's Specialty Care Coalition (CSCC) knows the importance of Cottage Health when it comes to the healthcare of the Santa Barbara community. From routine care to emergency needs, the local hospital is a pillar of the community. **That's why CSCC is deeply concerned about how the Santa Barbara community would be impacted if the Office of Health Care Affordability (OHCA) implements aggressive, unreasonable penalties that harm patient care.**

CSCC represents over 3,000 pediatric subspecialty care physicians throughout California, and our mission is to ensure that children and youth with complex health care needs have access to equitable, timely and high quality care, provided by pediatric subspecialists who are able to thrive in California's health care environment, through strong leadership, education and advocacy.

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. And with its 11 beds and small emergency room, Santa Ynez Valley Cottage Hospital offers crucial emergency services to the rural Santa Ynez Valley.

Cottage Health also invests in the future of the regional health care workforce through training programs for new doctors, nurses, and other health care professionals. These programs are essential to maintaining access to care, supporting the local economy, and sustaining high-quality, professional health care services. Furthermore, Cottage Health's contributions extend well beyond the walls of its hospitals. 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.

OHCA's decisions now will have a ripple effect on communities for years to come. CSCC urges you to take a collaborative approach that protects access while improving affordability.

Sincerely,

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

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

Attachment #43

College Hospital Cerritos
10802 College Place ▪ Cerritos ▪ CA ▪ 90703

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

June 17, 2026

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, College Hospital Cerritos 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.**

College Hospital Cerritos 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

College Hospital Cerritos is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs which are the biggest driver of our expenses grew by 9.5%. 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:

- College Hospital Cerritos has had to delay investments designed to increase Behavioral Health Services capacity to meet the needs of the community
- College Hospital Cerritos is continuing to look for ways to gather the resources necessary to make multi-million dollar investments in our facilities to meet the state's 2030 seismic compliance goals.

And yet, those efforts might not be enough. However, College Hospital Cerritos 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 College Hospital Cerritos 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 College Hospital Cerritos, 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.

Penalties at the levels proposed by OHCA would threaten College Hospital Cerritos's viability, jeopardize our patients' health, and endanger the livelihoods of the of the employees who rely on us. College Hospital Cerritos 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. College Hospital Cerritos 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 Cerritos, Los Angeles and Orange County residents who pass through our doors each year. College Hospital Cerritos 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,

Steve Witt
President/Chief Executive Officer
College Hospital Cerritos

cc: Members of the Health Care Affordability Board:
Dr. Sandra Hernández Elizabeth Mitchell
Dr. Richard Kronick Donald B. Moulds, PhD
Ian Lewis Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Alex Padilla, CA U.S. Senate
Adam B. Schiff, U.S. Senate
Jesse Arreguin California State Senate
Buffy Wicks California Assembly District 14
Janice Hahn 4th District Supervisor, Los Angeles County

SANTA CLARA VALLEY HEALTHCARE

?rr_af k c l r !22

Administration
777 Turner Drive
San Jose, CA 95128

(408) 885-4010
www.SCVH.org

June 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 June 2026 Health Care Affordability Board Meeting

Dear Chair Johnson,

The County of Santa Clara and its healthcare operations division, Santa Clara Valley Healthcare, appreciate the opportunity to comment on the Office of Health Care Affordability's proposed financial penalties for spending target performance and the proposal to adjust spending targets for organized labor.

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
- A renowned Rehabilitation Center ranked best in the West and #6 nationally by U.S. News and World Report.

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. It is from that lens that we offer the following comments and concur with the points raised in the California Association of Public Hospitals May 2026 comments to your Board.

Santa Clara Valley Healthcare provides a wide-array of high-intensity services to patients with complex healthcare needs. Many of these services have been eliminated by other providers in our community due to low reimbursement and/or high operating costs. These services include:

- Burn Care
- Trauma Care
- Neonatal Intensive Care
- Labor and Delivery Services
- Acute Psychiatric Services
- Spinal Cord, Stroke and Traumatic Brain Injury Rehabilitation Services.

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 proposed for elimination 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 alternative approaches to the penalty framework, like what has been adopted by Oregon for its cost growth target program.

Sincerely,

DocuSigned by:
Paul Lorenz
47ECF3A78343489...

Paul E. Lorenz
Chief Executive Officer
Santa Clara Valley Healthcare

MemorialCare

!ŭŭI·ŎKY'Ŝyŭ Inp

17360 Brookhurst Street, Suite 160
Fountain Valley, California 92708
memorialcare.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 : Attn: Megan Brubaker at OHCA@hcai.ca.gov

Dear Chair Johnson:

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 (including Miller Children's and Women's Hospital Long Beach), 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.

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 3% spending target". And we publicly 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.

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.

For these reasons, MemorialCare shares the Office of Health Care Affordability (OHCA) goals to improve affordability and access to high-quality health care. **However, the combined impact of California's first statewide spending target and now proposed enforcement methodology falls short of achieving those two goals and will impact access to patient care in the long term.**

17360 Brookhurst Street, Suite 160
Fountain Valley, California 92708
memorialcare.org

MemorialCare 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 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 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**.**

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:
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis

17360 Brookhurst Street, Suite 160
Fountain Valley, California 92708
memorialcare.org

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

UNIVERSITY OF CALIFORNIA HEALTH

University of California Health
1111 Franklin Street
Oakland, CA 94607

universityofcalifornia.health

June 18, 2026

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

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

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

Dear Secretary Johnson,

On behalf of the University of California (UC) Health, I am writing to offer recommendations to assist the Office of Health Care Affordability (OHCA) and the Health Care Affordability Board (Board) as they continue developing hospital spending measurement methodologies, enforcement policies, and penalty frameworks.

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-changing treatments and cures.

Spending Measurement

Retain Volume and Intensity Adjustments in Final Methodology. UC Health appreciates OHCA's careful attention to the development of a hospital spending measurement methodology. OHCA has thoughtfully included volume and service intensity adjustments that help ensure hospitals are not inadvertently disadvantaged for serving more patients, caring for higher-acuity populations, or providing resource-intensive services that are essential to patient care. UC Health encourages OHCA to retain these features of the hospital spending measurement design in its final methodology.

Continue Refining Hospital Spending Methodology to Reflect Actual Underlying Spending. While OHCA's application of volume and service intensity adjustments is conceptually promising, more work is needed to ensure that the measurement of hospital spending accurately reflects

underlying spending trends. A particular issue is the use of the Healthcare Payments Database (HPD) in OHCA's outpatient spending measurement methodology. According to the California Hospital Association (CHA), the HPD captures only 20 percent of hospital-reported commercial outpatient visits statewide. UC Health is concerned that the HPD may not capture certain high-intensity, high-cost outpatient services that are important drivers of spending. As OHCA continues refining its methodology, we encourage ongoing validation against hospital-reported data sources and continued engagement with stakeholders to assess whether outpatient spending measures accurately reflect changes in utilization, intensity, and cost. UC Health urges OHCA to continue assessing the methodology's accuracy and recommends that as part of the enforcement process OHCA work closely with hospitals to determine whether unmeasured changes in service intensity may have contributed to spending growth in excess of the cost target.

Assess Performance Relative to Spending Targets on a Multiyear Basis. OHCA's 2022-2023 hospital spending data reveal important lessons for spending measurement and the enforcement of cost growth targets. The charts presented to the Board at the April 2026 meeting show an extremely wide range in year-over-year spending growth across hospitals.[1] For the commercial line, spending changes ranged from more than a 50-percent decrease to a nearly 150-percent increase. (The range shown would have been even wider had OHCA not excluded several hospitals from the data for display purposes.) Perhaps even more instructive was the Medicare data, which showed spending changes that ranged between an over 50-percent decrease to a roughly 70-percent increase. Because hospitals did not receive year-over-year payment increases from Medicare anywhere near these magnitudes, these findings raise important questions regarding the reliability of drawing conclusions from a single year of spending data.

UC Health would like to call attention to the figure on the bottom of page 3 of CHA's May 2026 comments to the board.[2] The figure shows multiyear spending growth for an anonymous hospital between 2019 and 2023. That hospital experienced an 86-percent increase in 2021, a rate of growth that falls within the range shown in OHCA's 2022-2023 hospital spending data. If spending performance were evaluated based solely on that year, this hospital may have been subject to OHCA's progressive enforcement process. However, over the full five-year period, the hospital's average annual growth rate was just 4.4 percent. This example demonstrates that annual spending growth can be highly volatile and provides strong support for a multi-year approach to assessing performance against spending targets. Evaluating performance over multiple years would provide a more stable and accurate assessment of long-term spending trends and help ensure that enforcement resources are directed towards entities exhibiting sustained growth above established targets.

[1] See slides 108 through 110 in the April 2026 staff presentation: https://hcai.ca.gov/wp-content/uploads/2026/06/April-2026-Board-Meeting-Presentation.pdf
[2] See public comments to the board, attachment #3: https://hcai.ca.gov/wp-content/uploads/2026/06/April-2026-Public-Comments-to-Board-1.pdf

Enforcement Process

Ensure Transparency in OHCA's Enforcement Decision-Making. Over the course of the last year, OHCA has made several important decisions regarding the design of its enforcement process. One example is the decision not to implement a waiver process that would allow hospitals to proactively demonstrate to OHCA that spending growth was driven by factors beyond their control. Instead, OHCA intends to consider those factors in the enforcement process. While we understand OHCA's interest in minimizing administrative workload, we believe additional transparency regarding how hospitals are selected for deeper stages of enforcement would strengthen public confidence in the process. Accordingly, UC Health recommends OHCA provide the Board with a data-based rationale when advancing a hospital through progressive enforcement, particularly in circumstances where other hospitals may have higher spending growth rates or similar growth rates but larger spending bases. Such transparency would help demonstrate that enforcement decisions are being applied consistently and are grounded in objective measures of spending performance.

Limit Enforcement to Entities that Exceed Both Commercial and All-Payer Spending Targets. OHCA's enforcement approach by payer category would benefit from additional clarity. While OHCA's discussions to date suggest a particular focus on commercial spending growth, the extent to which Medicare and Medi-Cal spending will be incorporated into enforcement decisions remains unclear. Greater clarity regarding how spending growth across payer categories will be considered would improve transparency and predictability for health care entities. One approach would be to designate a hospital as exceeding its spending target only when it exceeds both its all-payer and commercial targets. Considering all payer categories is important because it reflects the full scope of services hospitals provide and helps avoid overemphasizing spending trends within a single payer segment. This issue will become increasingly important as hospitals confront reductions in public program payments and increases in uncompensated care as a result of H.R. 1 implementation and state budget cuts and policy changes.

Consider the Public Hospital Financing Model in Medi-Cal. If Medi-Cal spending is considered in the enforcement process, OHCA must account for the unique financing structure of California's public hospitals, which include UC and county health systems. Public hospitals are the only hospitals in California that do not receive direct state General Fund support for Medi-Cal services. Instead, public hospitals self-finance the non-federal share of Medi-Cal payments through intergovernmental transfers and certified public expenditures. Furthermore, because hospital revenue data reported to HCAI include both federal funds and self-financed contributions, spending measured by OHCA overstates the net reimbursement actually received by public hospitals. UC Health requests OHCA make methodological adjustments to ensure public hospitals are assessed on a basis comparable to other providers.

Combine Inpatient and Outpatient Spending into a Single Measure. A hospital that exhibits inpatient spending growth of 1 percent, outpatient spending growth of 5 percent, and overall spending growth of 3 percent should not necessarily be considered to have exceeded the spending target. OHCA should evaluate inpatient and outpatient spending together through a weighted approach that reflects overall spending performance rather than assessing the categories independently.

Performance Improvement Plans (PIP) Must Provide a Meaningful and Realistic Opportunity to Improve Performance. The Legislature made clear in OHCA's authorizing statute that health care entities must have an opportunity to improve performance and compliance prior to the imposition of monetary penalties. Because hospitals cannot retroactively change spending that has already occurred, PIPs should apply beginning with the first annual measurement year following their approval. PIPs should also give entities sufficient time for operational changes and cost-management strategies to take effect. OHCA should also establish clear criteria regarding PIP approval, evaluation, and successful completion so that entities understand expectations and can implement effectively.

Factors that contribute to spending growth, including federal or state mandates and policy changes, macroeconomic conditions, and market-based cost inputs are generally outside the control of hospitals. As such, OHCA should focus on actions and outcomes that are realistically achievable when evaluating and approving PIPs. Moreover, PIPs must be implemented in a manner that preserves access, quality, equity, and workforce stability. UC Health urges OHCA to consider these factors when evaluating and approving proposed PIPs and deciding whether entities have made meaningful progress towards compliance.

Penalties

UC Health appreciates OHCA's proposed two-step approach to penalties, which recognizes that the final penalty amount should reflect more than the simple degree to which an entity exceeded the spending target. We support OHCA's proposal to consider penalty adjustment factors and other relevant circumstances before determining a final penalty. However, we are concerned that OHCA's proposed methodology for calculating an "initially commensurate" penalty may produce starting penalty amounts that are disproportionate to the statute's objectives and that could unduly influence the remainder of the penalty determination process.

Revise the "Initially Commensurate" Penalty Methodology to Ensure a Balanced and Individualized Assessment. At the April 2026 board meeting, OHCA noted that its authorizing statute requires penalties to be "initially commensurate" with the degree to which an entity exceeds its spending target and proposed defining an "initially commensurate" penalty as the difference between an entity's actual spending growth and the spending growth that would have occurred had the entity met its target. Applying this methodology to historical data, OHCA estimates that initial penalties could range from approximately $4 million to $350 million. While the statute requires penalties to be "commensurate with the failure" to meet the target, it does not require penalties to be directly proportional to excess spending growth, nor does it define "commensurate" in the manner proposed by OHCA. In fact, the statute directs the Director to consider several additional factors—including the nature and gravity of the offense, the entity's fiscal condition, and market impact—when determining penalties. These provisions suggest that the Legislature intended a more balanced and individualized assessment than a formula that treats excess spending as the presumptive penalty amount. Moreover, beyond a certain threshold, increasingly large penalties are likely to provide diminishing additional incentives to reduce spending growth. It is difficult to conclude that a $50 million penalty would create five times the incentive to improve performance as a $10 million penalty. At some point, the marginal compliance benefit of larger penalties may be outweighed by the risk that penalties undermine access, quality, equity, workforce stability, and other statutory objectives.

UC Health therefore encourages OHCA to consider alternative approaches to establishing the initial penalty amount, including the use of penalty ranges, graduated tiers based on the degree of noncompliance, or reasonable maximum penalties that better align the penalty with its intended incentive function. Regardless of the methodology selected, OHCA should ensure that the initial penalty serves as a starting point for analysis rather than effectively determining the outcome before adjustment factors are applied.

Adjust Penalties for Reasonable Factors and to Minimize Unintended Consequences. After determining an initial penalty amount, OHCA should apply adjustment factors in a transparent and consistent manner. UC Health supports OHCA's proposal to consider justification factors as part of the penalty determination process, but we encourage OHCA to expand beyond those outlined in statute and clearly define those factors to ensure that penalties appropriately reflect the circumstances of each case. At a minimum, OHCA should consider the degree to which an entity's spending growth was attributable to factors outside of its control, including government mandates and broader economic conditions.

OHCA should also consider the entity's good-faith efforts to develop and implement a PIP, demonstrated progress toward achieving PIP goals, prior compliance history, and cooperation throughout the enforcement process. Establishing clear criteria and transparent weighting for these factors would promote fairness, consistency, and predictability across similarly situated entities while preserving the Director's discretion to make individualized determinations based on the facts of a particular case.

OHCA should also ensure that penalties do not discourage investments that advance its broader statutory goals. For example, OHCA should consider the degree to which an entity is expanding access to primary care, behavioral health services, workforce development, and other initiatives that advance population health, improve health outcomes and reduce long-term costs. Similarly, OHCA should consider whether a proposed penalty could adversely affect these investments, along with patient access, quality of care, health equity, or workforce stability. A penalty framework that recognizes these considerations would better align with the Legislature's intent to promote affordability while preserving access to high-quality care.

Consider the Public Benefits Provided by the University of California and its Academic Health Centers. In the case of UC’s academic medical centers, we also urge OHCA to consider our role as California's public academic health system. The University’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 academic health centers provided an estimated $4.7 billion in uncompensated care associated with Medicare and Medicaid patients. UC’s academic medical centers also provided more than $1 billion in support to UC Schools of Medicine in 2024–25, helping train the next generation of California's health care workforce and advance biomedical research. OHCA should carefully consider the extent to which penalties may impair these public benefits and the unique statewide responsibilities carried out by UC. Doing so would help ensure that enforcement actions advance affordability goals without undermining access, workforce development, research, or other public purposes that benefit Californians.

We appreciate the Board’s consideration of UC Health’s unique role as California’s public academic health system. We hope that the Board and OHCA staff will consider the

recommendations outlined in this comment letter as they continue refining spending measurement methodologies, enforcement policies, and penalty frameworks. UC Health remains committed to working collaboratively with OHCA and other stakeholders to address health care affordability and our shared commitment to accessible, affordable, 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
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, Ph.D.
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
K. Jones, Assistant Secretary, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Gavin Newsom

Mountains COMMUNITY HEALTH

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, 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 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 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 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 are now seriously assessing what patient care and support functions and services can be outsourced to lower our operational costs.

And yet, those efforts might not be enough. However, San Bernardino Mountains Community

Mountains
COMMUNITY HEALTH

Hospital District 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 San Bernardino Mountains Community Hospital District, the most recent audited year-over-year data reflect 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 exceeded 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.

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

Mountains
COMMUNITY HEALTH

Sincerely,

Mark Turner
Chief Executive Officer
San Bernardino Mountains Community Hospital District

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
State Senator Rosilicie Ochoa Bogh
Assemblymember Tom Lackey

hoag.

?rr_afkclr!26

Hoag Memorial Hospital Presbyterian
OneHoag Drive, PO Box 6100
Newport Beach, CA 92658-6100

June 18, 2026

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

Re: Recommendations Regarding OHCA Spending Target Enforcement Framework
(Submitted via email to Megan Brubaker at ohca@hcai.ca.gov)

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

On behalf of Hoag Memorial Hospital Presbyterian, thank you for your continued leadership and thoughtful work to improve the affordability of health care for Californians. We appreciate the opportunity to provide comments as the Office of Health Care Affordability (OHCA) continues to develop its spending target enforcement framework.

Hoag shares OHCA's commitment to improving affordability while preserving access to high-quality, equitable care. We believe these objectives are complementary and can best be achieved through an enforcement process that is transparent, predictable, collaborative, and recognizes the complex financial realities facing California's hospitals.

As OHCA finalizes its regulations, we respectfully encourage the Board to adopt an approach that provides health care organizations with a meaningful opportunity to improve performance before financial penalties are imposed. Specifically, we recommend that the regulations:

- Clearly define how spending growth will be measured, including how payer mix, service mix, and other relevant factors will be incorporated into the assessment.
- Evaluate performance using multiple years of data to reduce the effects of year-to-year variability and better distinguish sustained spending trends from temporary fluctuations.
- Establish a consistent and transparent process for organizations to explain circumstances contributing to spending growth, consistent with the statutory waiver process.
- Create a collaborative performance improvement process that allows providers to implement corrective actions before enforcement penalties are considered.
- Phase in any financial penalties while accounting for significant circumstances beyond a provider's control, including investments in patient care, workforce needs, community benefit activities, and an organization's overall financial condition.

California hospitals continue to operate in one of the most challenging financial environments in decades. The healthcare ecosystem and infrastructure in our community has never been as

fragile as the one we are experiencing now in our humble opinion. Like many health systems throughout the state, Hoag has experienced cost growth that significantly exceeds the current 3.5 percent spending target. Labor expenses, pharmaceutical costs, medical supplies, and other essential operating costs have increased at rates well above the proposed benchmark, largely due to factors outside the control of hospitals.

At the same time, providers are preparing for the substantial financial impacts associated with recent federal policy changes, including the One Big Beautiful Bill Act (OBBBA). These combined pressures require hospitals to make difficult operational decisions while continuing to meet the growing health care needs of their communities.

In response, Hoag has already undertaken numerous initiatives to improve efficiency and manage costs, including:

- Outsourcing selected non-patient facing staffing functions where appropriate;
- Negotiating long-term pharmaceutical purchasing agreements to reduce expenses;
- Delaying recruitment for many positions despite increasing community demand for services;
- Reducing administrative and overhead positions where feasible;
- Deferring selected capital investments, technology upgrades, and facility improvements while preserving patient care.

These actions reflect our ongoing commitment to responsible stewardship of resources. Nevertheless, significant uncertainty remains because key elements of the enforcement methodology—including measurement standards, payer and service-line treatment, and compliance expectations—have not yet been finalized.

This uncertainty makes long-term planning particularly difficult. We are also concerned that reliance on a single year of spending data may not accurately reflect an organization's overall performance. Hospitals frequently experience fluctuations resulting from extraordinary events, changes in patient acuity, workforce shortages, or other temporary factors. A multi-year assessment would provide a more balanced and reliable evaluation of spending trends.

Similarly, if compliance is evaluated separately across multiple payer categories and service lines, hospitals could face several independent enforcement determinations despite strong overall financial stewardship. We respectfully encourage OHCA to carefully consider how its measurement methodology can accurately reflect the total performance of an organization.

Hoag remains committed to making health care accessible and affordable for every member of our community. Our longstanding investments include financial assistance programs, medical

debt forgiveness, free clinical services, vaccination programs, and numerous community health initiatives.

The Melinda Hoag Smith Center for Healthy Living is one example of this commitment. The Center has become a nationally recognized model for integrated community-based care, serving the most vulnerable populations throughout Orange County through preventive services, behavioral health resources, family support, and chronic disease management. Building on its success, Hoag is actively exploring a second location in another community with significant unmet needs, particularly for single-parent families and children with special health care needs.

These types of investments improve outcomes, reduce downstream costs, and advance many of the same objectives that OHCA seeks to achieve.

Accordingly, we are concerned that substantial financial penalties—particularly before providers have had a meaningful opportunity to demonstrate improvement—could unintentionally reduce the very investments that strengthen community health. Significant penalties may also limit hospitals' ability to preserve essential services, invest in innovation, support workforce development, and maintain access for the patients who depend on us.

We also respectfully encourage OHCA to continue recognizing its statutory responsibility to promote a stable health care workforce. Workforce investments are fundamental to maintaining access and quality, and labor cost growth has been one of the most significant drivers of increased hospital expenses across California. We encourage the Board to consider these costs appropriately within the enforcement framework and to ensure that hospitals are not discouraged from making necessary investments in the physicians, nurses, and other caregivers who serve California's patients.

Ultimately, the enforcement framework adopted by OHCA will have a meaningful impact on hospitals' ability to fulfill their mission. We believe that affordability and access are best advanced through a regulatory approach that promotes continuous improvement, recognizes real-world operating conditions, and fosters collaboration between providers and the State.

Thank you again for the opportunity to provide these comments. Hoag looks forward to continuing to work collaboratively with OHCA as these regulations are finalized. We remain committed to advancing a health care system that is both more affordable and more accessible for all Californians.

Sincerely,

President & CEO
Hoag Memorial Hospital Presbyterian

cc: Members of the Health Care Affordability Board

- Dr. Sandra Hernández
- Dr. Richard Kronick
- Ian Lewis
- Elizabeth Mitchell
- Donald B. Moulds, Ph.D.
- Dr. Richard Pan
- Elizabeth Landsberg, Director, Department of Health Care Access and Information
- Vishaal Pegany, Deputy Director, Office of Health Care Affordability

Community Hospital
of the Monterey Peninsula
Montage Health

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, 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 OBBBA.
- 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 care and special care for special needs.

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:
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

DISTRICT HOSPITAL
LEADERSHIP FORUM

June 18, 2026

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

Subject: Comments on Spending Target Enforcement and Penalty Framework

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

Dear Chair Johnson:

As the Office of Health Care Affordability (OHCA) Board prepares to continue its discussion of spending target enforcement and penalties at the June 24, 2026, Board meeting, the District Hospital Leadership Forum (DHLF) appreciates the opportunity to share our concerns. DHLF supports the state's goal of improving health care affordability for Californians. However, as the statute requires, that goal cannot be achieved in a way that reduces access to care, destabilizes essential community providers, or penalizes hospitals for cost growth and policy changes outside of their control.

For California's district and municipal hospitals, this issue is not theoretical. District and municipal hospitals are local governments, with publicly elected Boards of Directors, responsible for meeting the health care needs of their communities. Over two-thirds are rural, more than half have a critical access hospital designation, and approximately 50% of their inpatient days are for services provided to Medi-Cal beneficiaries. Collectively, they deliver 20,000 babies and provide over 3.5 million outpatient visits each year. District and municipal hospitals represent only 8% of hospitals statewide, yet they serve as safety-net providers in communities with few alternatives.

In May, OHCA staff released topics for future discussion around the enforcement and penalty framework. Two areas raise significant concerns for district and municipal hospitals: the potential scale of penalties and the proposed enforcement timeline.

Proposed "commensurate" penalty framework could devastate access to care.

Staff's May materials discuss calculating penalties that are "commensurate" with the degree to which an entity exceeds a spending target and include examples of penalties ranging from $4 million to $350 million. Penalties at that level would not be a reasonable enforcement tool for many district hospitals. They would be existential.

Many district hospitals operate near break-even margins and have annual net patient revenue between $25 million and $50 million. For these hospitals, even the lower end of the example range could force service closures, staffing reductions, or threaten continued operations. In many communities, the district hospital is the only local access point for emergency care, outpatient services, inpatient care, obstetrics, surgery, rehabilitation, or other essential services. A penalty framework that could force a community to lose its only health care provider cannot be considered "commensurate" with improving affordability.

Exceeding a spending target may reflect factors unrelated to inappropriate spending, including increased Medi-Cal supplemental payments, higher patient acuity, state and federal policy changes, labor costs, pharmaceutical and supply costs, right-sizing outdated payer contracts, increased uninsured rates, or necessary rate increases to preserve access in the face of federal coverage losses. Penalizing hospitals for these factors would not improve affordability; it would shift broader system cost pressures onto providers least able to absorb them.

Massachusetts, often cited as the model for health care cost growth benchmarking, authorizes penalties of up to $500,000 for failure to comply with the performance improvement plan process. It has not relied on uncapped or percentage-based penalties tied to hospital revenue or total spending. Massachusetts has used the PIP process collaboratively, including with Mass General Brigham, which completed a state-mandated PIP and achieved more than $176 million in savings. California should not adopt a penalty framework that is materially more punitive than the model state it has relied upon, particularly before hospitals have clear rules, complete data, and a meaningful opportunity to implement prospective improvement strategies.

Proposed enforcement timeline is flawed and does not provide entities a meaningful opportunity to comply.

OHCA staff's proposed enforcement timeline, including slide 95 from the May Board presentation, appears to contemplate penalties that could be assessed years after the performance period in question. Due to payment lags, data collection delays, and the time required to develop and implement a PIP, the timeline could create situations where entities face overlapping PIPs and penalties before they have had a meaningful opportunity to implement changes.

For example, if an entity does not learn that it exceeded the 2025-26 spending target until mid- or late-2028, how is that entity expected to implement a PIP that retroactively adjusts 2025-26 spending? By that point, the hospital will already be operating under payer contracts, payment rates, staffing plans, service-line decisions, and capital commitments established before the PIP process begins. A retroactive PIP cannot reasonably correct prior-year spending trends or unwind payer contracts after the fact.

This timing issue is even more problematic for Medi-Cal. A significant portion of Medi-Cal payments, including supplemental payments, may not be received until nearly two years after the service period. If those payments contribute to year-over-year growth that exceeds the target, is the hospital expected to return authorized Medi-Cal funding to DHCS and CMS? Would a hospital be penalized for receiving payments designed to support access for Medi-Cal patients? These questions must be resolved before enforcement begins.

There may also be situations where providers and plans are right-sizing outdated contracts, a rural hospital updates a chargemaster that has not been revised in years, or patients shift into outpatient care. Each circumstance could produce spending growth over multiple years. Under the proposed timeline, an entity could exceed the target in 2026-27 and 2027-28 before it has a practical opportunity to implement corrective action for the 2025-26 performance period.

A fair enforcement process must be prospective, not retroactive. OHCA should not assess penalties for later performance years when a provider has not yet received final data, understood the basis for the finding, or had an opportunity to implement an approved PIP. At minimum, OHCA should pause subsequent enforcement for related years while a provider is actively implementing a Board-approved PIP in good faith.

OHCA must establish a clear, balanced enforcement framework before enforcement begins.

Hospitals cannot comply with rules that have not yet been finalized. Before any enforcement action is taken, OHCA must clearly explain how spending growth will be assessed, including how payer mix, service mix, outpatient care, patient acuity, volume, and intensity will be considered.

OHCA should avoid separate enforcement across every payer and service line. Separate inpatient and outpatient, commercial, Medicare, and Medi-Cal enforcement would create multiple ways for a hospital to violate the target, even if total spending trends are reasonable. This is particularly problematic for district hospitals, which often serve as sole community providers and deliver significant outpatient care. Shifting care into outpatient settings is often better for patients and less costly than care provided within the four walls of the hospital. DHLF supports California Hospital Association's recommendation that OHCA should designate a hospital as exceeding its target only if it exceeds the target across all payers and service lines.

OHCA must also account for the complexity of Medi-Cal financing, including provider taxes, intergovernmental transfers, certified public expenditures, supplemental payments, and other self-financed funding mechanisms. District hospitals often help finance the Medi-Cal program through public funds. These mechanisms are lawful, federally approved, and essential to sustaining access for Medi-Cal patients. Treating these payments as

ordinary revenue growth would misstate a hospital's financial position and could penalize hospitals for participating in programs designed to preserve access.

Additionally, performance improvement plans must provide a meaningful opportunity to comply with spending targets. They should begin with technical assistance, allow hospitals to explain the reasons for spending growth, and provide sufficient time to implement locally appropriate strategies.

Any penalty framework must be reasonable, phased in, and adjusted to avoid harming patient care. Penalties should not exceed a hospital's ability to pay, should account for the hospital's financial condition, and should be reduced to reflect factors beyond the hospital's control, including labor costs, workforce shortages, state and federal policy changes, and investments that improve access, quality, equity, patient-centered care, and long-term affordability.

The measurement and enforcement process OHCA establishes will directly impact whether district hospitals can continue to serve the communities that rely on them. The wrong enforcement framework will not improve affordability. It will reduce access, destabilize essential providers, and force hospitals to make decisions that harm rural and underserved communities.

DHLF appreciates the opportunity to comment and encourages the OHCA Board to incorporate these recommendations into future rulemaking. We look forward to working with OHCA as these rules are finalized and to collaborating on a more affordable, accessible, equitable, and sustainable health care system for Californians.

Sincerely,

Nathan Davis
Senior Vice President, Finance Policy
District Hospital Leadership Forum

cc:
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