HCAi Department of Health Care Access and Information
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Health Care Affordability Board
October 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
10/30/2026	Children's Hospital Los Angeles	See Attachment #1.
11/6/2026	UC Berkeley Labor Center	See Attachment #2.
11/9/2026	Sutter Medical Group	See Attachment #3.
11/9/2026	California Nurses Association	See Attachment #4.
11/10/2026	Health Care LA, IPA	See Attachment #5.
11/11/2026	Sutter North Medical Group	See Attachment #6.
11/11/2026	Palo Alto Foundation Medical Group	See Attachment #7.
11/11/2026	Gould Medical Group	See Attachment #8.
11/11/2026	MedPOINT Management	See Attachment #9.
11/12/2026	Health Access CA	See Attachment #10.
11/12/2026	California Hospital Association	See Attachment #11.

Date	Name	Written Comment
11/13/2026	California Association of Public Hospitals and Health Systems	See Attachment #12.
11/13/2026	California Association of Health Plans	See Attachment #13.
11/13/2026	Providence	See Attachment #14.

See Attachment #1

CHLA OHCA Health Care Affordability Board Meeting General Public Comment

- Good morning, Chair Johnson and Members of the Board.

- Children's Hospital Los Angeles (CHLA) is deeply concerned that the proposed enforcement framework does not adequately account for the unique role pediatric specialty hospitals play in California's healthcare system.

- As California's largest freestanding pediatric hospital, CHLA cares for children from every county in the state and provides highly specialized services including pediatric transplantation, oncology, rare disease treatment, advanced neonatal care, and trauma services.

- Many of the children treated at CHLA cannot simply be redirected to another hospital. Families relocate to Southern California so their children can receive care at CHLA, and providers across the state refer their most medically complex patients because the expertise required often does not exist elsewhere.

- Under OHCA's proposed methodology, CHLA could face an estimated $147.5 million penalty, including approximately $46.6 million related to commercial patients and more than $100 million related to Medi-Cal patients.

- A penalty of that magnitude is not something a pediatric safety-net hospital can absorb without consequences. CHLA currently operates with approximately 21 days cash on hand, and a penalty of this size would significantly impact resources available for patient care, specialized programs, and future investments.

- The proposal also fails to account for the unique cost drivers associated with pediatric specialty care. Between FY25 and FY26, CHLA's gene therapy program grew from 34 to 43 patients, increasing pharmaceutical costs from approximately $54 million to $78 million. In FY25, CHLA performed 121 pediatric transplants, with average costs exceeding $800,000 per case.

- These costs do not reflect inefficiency. They reflect children receiving life-saving care.

- CHLA is also concerned about the workforce implications. Pediatric hospitals already compete nationally for highly specialized nurses, physicians, pharmacists, therapists, and researchers. Financial pressures already limit how aggressively CHLA can respond to the market. Penalties of this size would further constrain investments in recruitment,

retention, workforce development, and career pathways at a time when specialized pediatric talent is increasingly difficult to recruit.

- CHLA respectfully urges OHCA to recognize that a one-size-fits-all approach does not work for pediatric safety-net hospitals and to adopt a framework that accounts for patient complexity, specialized care, and the unique role children's hospitals play in serving California's most vulnerable patients.

- Thank you.

UNIVERSITY OF CALIFORNIA, BERKELEY

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November 5, 2026

Secretary Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Department of Health Care Access and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

Department of Health Care Access and Information
2020 W. El Camino
Sacramento, CA 95814

Dear Secretary Johnson, Director Landsberg, and Deputy Director Pegany,

The UC Berkeley Labor Center is a public service and outreach program of the Institute for Research on Labor and Employment, founded in 1964. The Labor Center's health care research program aims to inform policymaking related to access to health coverage and health care affordability for workers and their families. We submit this letter to update and reaffirm the analysis we presented in our September 2023 report "What Can We Afford: Aligning Office of Health Care Affordability spending target with Californians' ability to afford increases" and to respond to recent discussions of the role of inflation in thinking about California's target growth rates for health care spending.

Target setting represents real progress but affordability challenges persist

In 2024 California's Office of Health Care Affordability (OHCA) set target growth rates for total health care expenditure per capita of 3.5% for 2025 and 2026, 3.2% for 2027 and 2028, and 3.0% for 2029, based on the historical 20-year average of median household income growth. Basing the targets on median household income growth is a reflection of the board's focus on and commitment to consumer affordability. More than two years after targets were initially set, we recalculate the 20-year average and reaffirm that this measure of consumer affordability is an appropriate basis for setting health care spending growth targets.

In addition to setting initial targets, OHCA has defined hospitals as a sector and set lower targets for a small set of high-cost hospitals. The focus on hospital expenditures is important

since 36% of personal health care expenditures nationally go toward paying for hospital care. In California within the commercial market 55% of claims spending was for hospital services in 2024. Data show that hospitals constitute the most substantial category not only in the amount of spending, but also in recent growth in spending: from 2022 to 2024, 40% of the growth in all national health spending was due to growth in spending on hospital care.

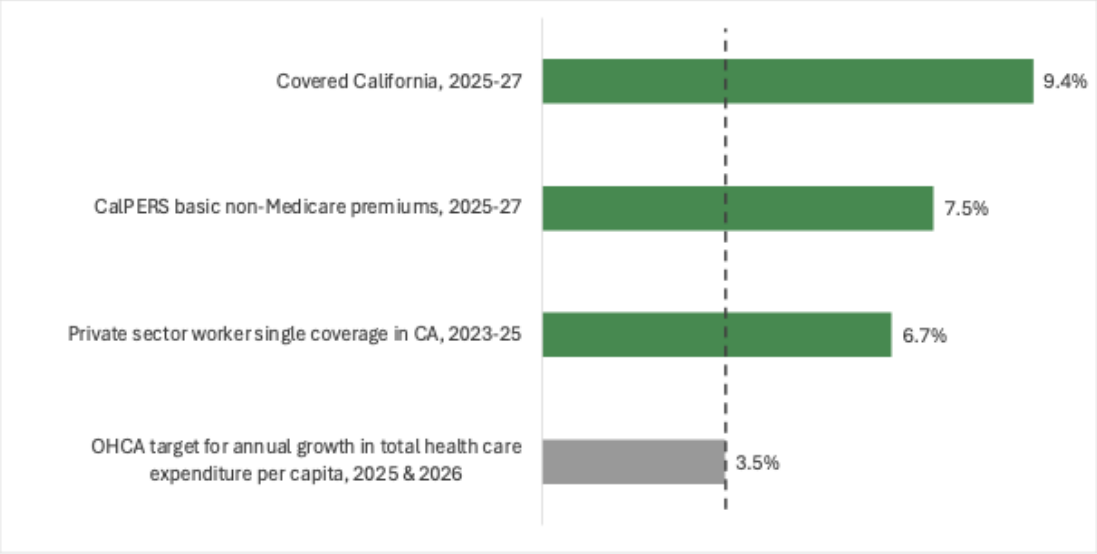
Growth in health care expenditures has been and continues to be high. Personal health care expenditures per capita in the 20 years from 2006-2025 grew at an average annual rate of 5.3% (see figure 2). Despite the slight drop in the 20-year average from 5.4% to 5.3%, growth rates in personal health care expenditures per capita nationally have been high in recent years (8.5%, 7.3% and 7.0% in 2023, '24, and '25).[1] OHCA statute calls on the office to calculate the *actual* growth rate in total health care expenditure per capita in California. OHCA's first two health care spending trend reports found that California's growth rates in total health care expenditure per capita in the commercial market have also been high: 6.4% from 2022 to 2023, and 7.1% from 2023 to 2024.

Commercial premium growth is high and Californians continue to struggle with costs and skip or delay care

California consumer health care affordability challenges continue. Recent California health insurance premium growth has been well above the target 3.0-3.5% total health care expenditure annual growth rate. Figure 1 shows the average of the most recent three years of data on annual premium growth; 7.5% per year in CalPERS for basic, non-Medicare premiums 2025-27, 6.7% for single coverage among private-sector workers in California 2023-25, and 9.4% per year in Covered California 2025-27.

[1] In our 2023 brief "What Can We Afford," we used trends in the National Health Expenditure measure of California's personal health care expenditures per capita as the closest available proxy for this data historically. California data is only available through 2020 so we continue to use national historical and projected data for 2021-2025 as a proxy.

Figure 1. Average annual premium growth and OHCA total health care expenditure target



Notes: Average annual premium time frames vary but represent the most recent three years for a given data source.
Sources: Covered California; CalPERS health plan premium announcements; Medical Expenditure Panel Survey Insurance Component, California private-sector.

In 2025, 4 in 10 Californians reported that it has gotten harder to afford health care in the past several years. Among those who said it had gotten harder, 71% reported that monthly health insurance premiums were harder to afford; deductibles (51%), hospital copays (45%), and copays at a doctor's office (44%) were also common reasons for why health care had gotten harder to afford.

These existing affordability challenges impede equitable access to quality care for California families. In 2025, 59% of surveyed Californians reported that they or a family member skipped or delayed care in the last year due to cost. Even higher shares of lower-income (70%), Latino/x (67%), and Spanish speaking (71%) families reported skipping or delaying care. The access and equity concerns raised by the lack of affordability have been a consistent and appropriate focus of the board.

Median household income is still the right metric

In our September 2023 brief "What Can We Afford," we reviewed four California-specific economic indicators that could be considered in setting the health care expenditure growth target:

- median hourly wage,
- median household income,
- inflation as measured by the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), and
- gross state product (GSP), a state-specific equivalent of federal gross domestic product (GDP).

Updating each metric's 20-year average to the latest data increases the values somewhat (see figure 2), but not the fundamental analysis or the conclusion: all grew markedly more slowly than per capita health care spending over the last two decades (see figure 3), and median household income is the best consumer-focused measure to which to tie the target.

Figure 2. Average annual historical growth rate of select economic indicators, California 2002-2021 and 2006-2025

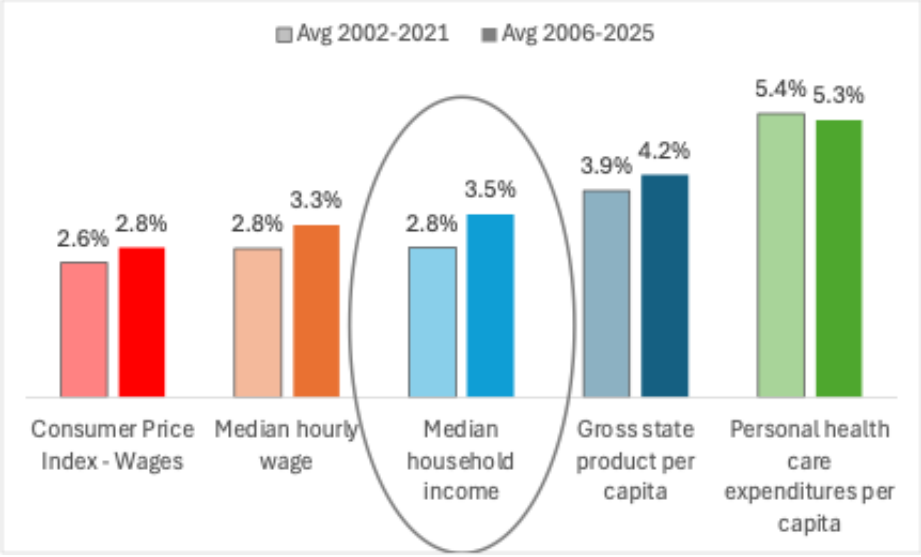
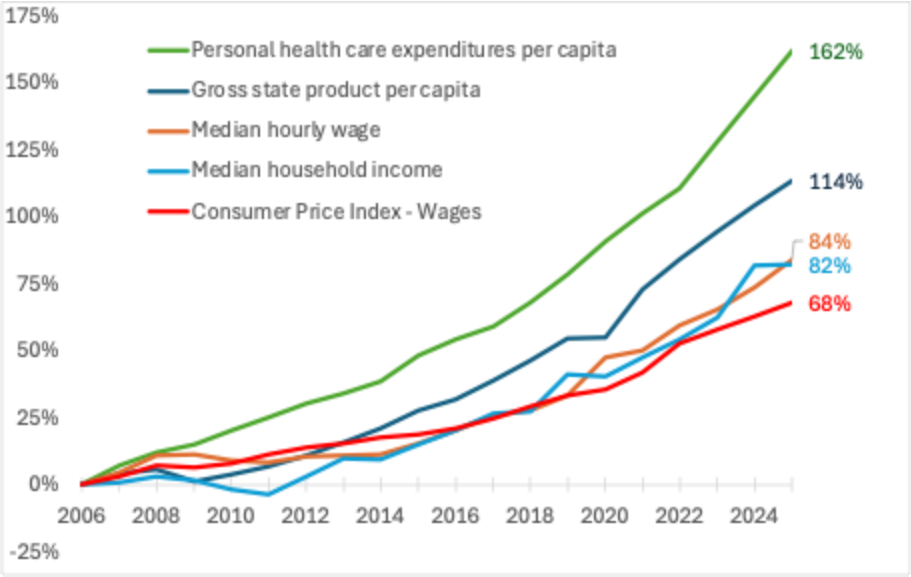


Figure 3. Cumulative historical growth rate of select economic indicators, California, 2006-2025



Notes: Personal health care expenditures per capita is included for comparison purposes as the closest available proxy for total health care expenditures per capita. An estimate of personal health care expenditures per capita was not available for California beyond 2021; U.S. data was used for 2021-2025.
Sources: UC Berkeley Labor Center analysis of data from Center for Medicare and Medicaid Services, U.S. Bureau of Economic Analysis, Economic Policy Institute analysis of U.S. Census Bureau Current Population Survey, Federal Reserve Bank of St. Louis analysis of U.S. Census Bureau Current Population Survey, California Department of Finance.

If historical health care spending had been held to any of these economic indicators, Californians would have experienced savings, but targets tied to household income, wages, or consumer prices would have produced substantially greater savings than one tied to GSP (figure 3). In addition, GSP and other broad measures of economic growth may provide useful context, but they do not tell us whether health care is becoming more affordable for families. Median household income, by contrast, provides a direct proxy for changes in the resources available to a typical household to absorb rising health care costs. Median household income also has an advantage during economic downturns: it captures changes in household resources better than median wages, which can rise artificially if lower-wage workers disproportionately lose their jobs.

How to think about inflation

Inflation tracks the changes in the prices consumers pay across a wide range of goods and services, but it is not directly relevant to the ability of households to afford health care spending increases. When inflation spikes consumers often need to spend more on other essential items, making it harder to pay for health care. Additionally, as OHCA stated in March 2024 Board slides, "using projected costs [such as projected inflation] would reinforce current unsustainable cost trends, and is at odds with the purpose of a spending target, which is to change the trajectory of health care spending." For these reasons historical median household income growth continues to be a more appropriate basis for a target centered on consumer affordability than inflation measures.

Broad inflation measures such as CPI-W track a comprehensive basket of consumer goods and services, from gas to groceries, rather than the specific input costs faced by health care entities. While recent inflation has been driven by gas prices, the inflation spikes during the pandemic were rooted in supply chain issues and sudden changes in demand. The degree to which inflation impacts a family depends on their specific circumstances, consumption, and decisions. Similarly, the extent to which broad measures of inflation like CPI-W impact particular health care entities will vary based on their unique operational realities.

More targeted measures already exist to track the specific input costs faced by health care entities: the Inpatient Prospective Payment System (IPPS) Hospital Market Basket reflects changes in the prices of a set basket of goods and services that are representative of what hospitals tend to use, while the Medicare Economic Index (MEI) measures changes in physician-practice costs. Both rely on the Employment Cost Index (ECI), a measure of changes in labor costs, including wages and benefits. These are established federal measures used to track changes in the costs of delivering health care.[2] In a given year, each measure may be above or below the trends in general inflation, as shown in figure 4. From 2011 to 2026, cumulative growth in California CPI-W was 57%, while the IPPS hospital market basket grew 52% and the

[2] The Centers for Medicare & Medicaid Services (CMS) develops the IPPS Hospital Market Basket and MEI and uses them to inform Medicare payment policy. The ECI, published quarterly by the U.S. Bureau of Labor Statistics (BLS), tracks changes in employer compensation costs across industries, including health care.

MEI physician office market basket grew 50% (figure 5). Each of these inflation measures showed lower cumulative growth than the 68% that would have come from a constant 3.5% growth rate.

Each of these industry-specific inflation measures can help benchmark national trends in industry-specific input costs, and could help identify genuine cost pressures that may warrant consideration. Importantly, those pressures can be demonstrated after the fact, based on the actual experience of particular hospitals and other health care entities, rather than assumed prospectively and built into a higher statewide target in advance. Health care spending growth should not be treated as immutable.

Figure 4. Historical and projected annual percentage change in inflation indices, 2011-2031

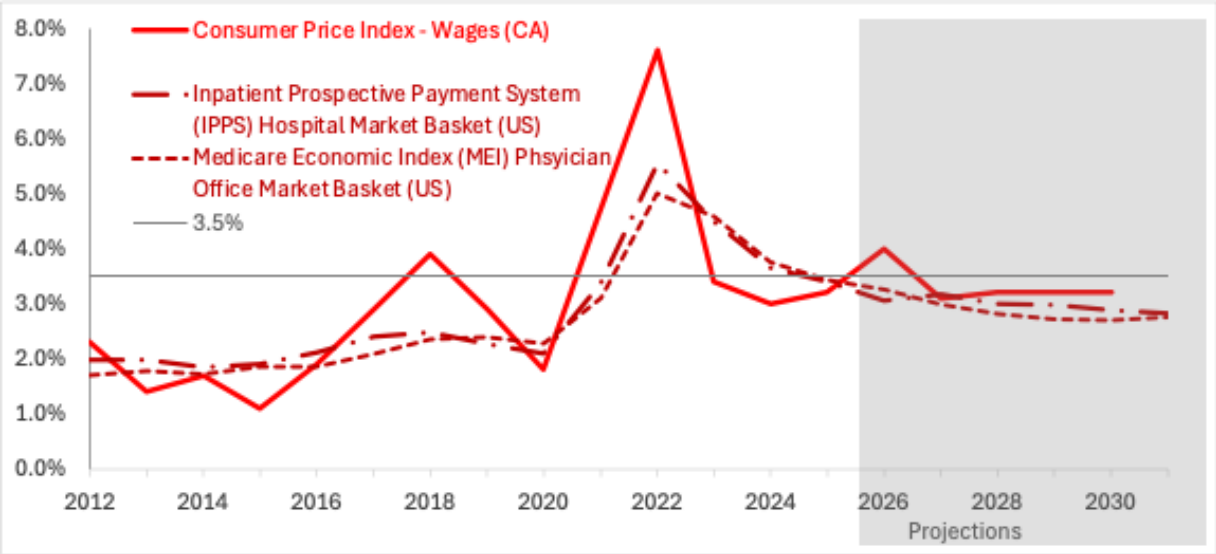
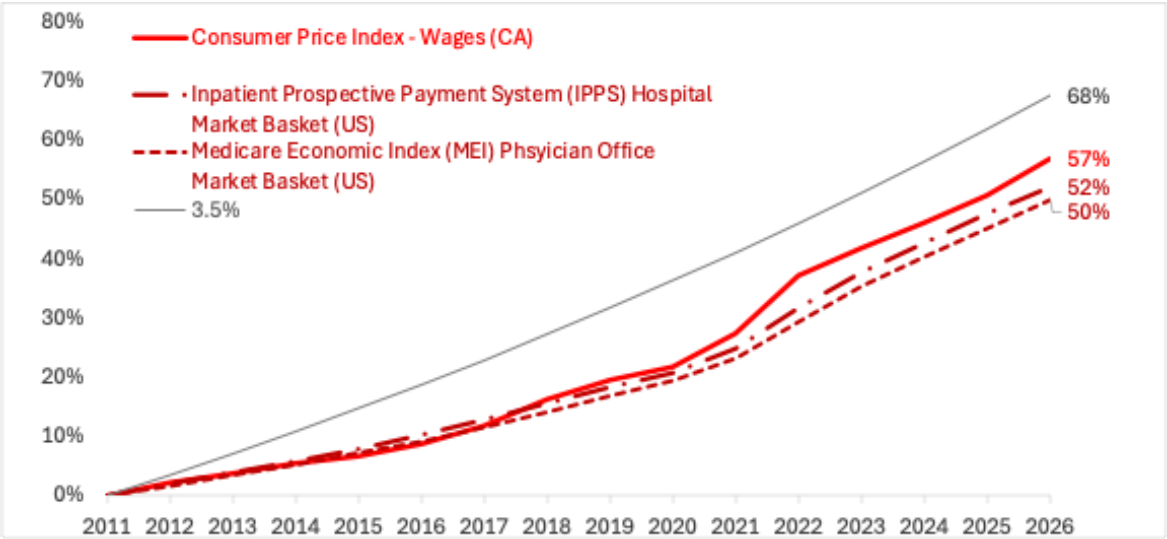


Figure 5. Cumulative historical annual percentage change in inflation indices, 2011-2026



Notes: CPI-W data are California specific; IPSS and MEI are national.
Sources: UC Berkeley Labor Center analysis of 2023-based IPPS and 2017-based MEI market basket data from Center for Medicare and Medicaid Services; CPI-W data from California Department of Finance.

Automatically adjusting the target based on inflation would risk treating higher input prices as a sufficient justification for higher spending growth, without preserving incentives to improve productivity, purchase inputs more efficiently, or otherwise contain costs. It would also assume that broad economy-wide inflation accurately reflects the cost pressures facing health care providers, which is not always the case. For these reasons, inflation rates may provide useful context for evaluating spending growth but should not replace consumer affordability as the basis for the target.

Continue using a 20-year average to limit target volatility

Growth in economic indicators like median household income fluctuate year to year. Using an historical 20-year average to set the OHCA cost growth target reduces its volatility, as we detailed in our letter on target setting from March 2024. Figure 6 shows what targets would have been based on a 5-year, 10-year, and 20-year look-back period, using historical data on the growth in median household income in California going back to 1984. The 20-year average (the solid blue line in figure 6) stays close to 3.0%, ranging from a low of 2.4% to a high of 3.7%. In contrast, both the 5- and 10-year averages would have resulted in a less predictable and consistent series of targets.

Figure 6. Hypothetical health care spending targets using 5-year, 10-year, and 20-year historical averages of California median household income growth, 2004-2025



Source: UC Berkeley Labor Center analysis of Federal Reserve Bank of St. Louis analysis of U.S. Census Bureau Current Population Survey

Whether slower spending growth ultimately translates into lower growth rates for premiums and out-of-pocket costs or other benefits for consumers is a separate question that should be evaluated through consumer-facing affordability measures. But that distinction strengthens, rather than weakens, the case for the current benchmark: median household income establishes what consumers can afford; separate measures are needed to determine whether savings generated by slower health care spending growth are reaching them. The Board should therefore preserve the consumer-focused benchmark based on the 20-year average of median household

income growth while also tracking premiums, deductibles, cost-related barriers to care, and other measures of whether affordability is improving in practice.

Sincerely,

Miranda Dietz
Miranda Dietz
Director, Health Care Program

Emily Ramirez
Emily Ramirez
Policy Researcher

See Attachment #3

Sutter Medical Group

November 9, 2026
Elizabeth Landsberg, Director California Department of Health Care Access and Information
Vishaal Pegany, Deputy Director Office of Health Care Affordability
California Department of Health Care Access and Information

Re: Comments on Proposed Progressive Enforcement Regulations and Incorporated Guidance

Dear Director Landsberg and Deputy Director Pegany,

Sutter Medical Group appreciates the opportunity to comment on OHCA's proposed spending target enforcement regulations. We support meaningful accountability on healthcare affordability in California and suggest that OHCA align regulations and enforcement with a delegated medical group's responsibilities and realistic ability to both respond to OHCA and act on any regulatory requirements.

Groups in a delegated model should be responsible for costs which they control. SMG contracts to provide professional services to patients of a 1206(1) medical foundation and does not contract with health plans. The Foundation contracts with health plans for hospital care, pharmacy benefits, behavioral health services, rehabilitation services, out-of-network care, etc., and is responsible for labor, capital and supply costs. Consequently, our group's attributed spending can increase because of hospital prices, drug costs, or other expenditures beyond our direct contractual authority. SMG partners to manage utilization and clinical quality, a model in California which has considerable evidence of benefit to overall cost and patient outcomes. Our performance therefore must be evaluated in the context of the coverage and payment structures in which the medical group operates.

SMG suggests that OHCA recognize the clear distinction of responsibility between a 1206(1) foundation and its affiliated medical group(s), and establish an adjustment process to account for spending outside a group's control. Where the foundation holds the health plan contract and the medical group holds a clinical services agreement with the foundation, review should follow that contractual chain and identify each entity's actual authority and financial responsibility.

A critical point with reporting, response to OHCA requests or improvement plans, is that since our medical group does not contract with health plans or other entities, we likely have no legal mechanism to obtain information to support or rebut information from OHCA which the plan or entity withholds, much less that it be timely and accurate.

SMG suggests that OHCA require review of the agreements between our group and foundation to validate attribution and source data and determine responsibility, and avoid imposing unachievable corrective obligations on our group.

SMG suggests that OHCA convene interested organizations to develop a California-specific alternative to unadjusted attributed Total Medical Expenditure as the standard for physician-organization accountability. SMG welcomes the opportunity to work with HCAI and OHCA on a measurement and enforcement framework that advances affordability, preserves effective delegated care arrangements, and assigns achievable corrective obligations to the entities positioned to perform them. We further request that you share this letter with your Board.

Sincerely,
Michael Conroy MD, FACP
CEO and President, Sutter Medical Group

See Attachment #4

October 30, 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

2020 W. El Camino Ave., Ste. 1200
Sacramento, CA 95833

RE: Comments on Proposed Emergency Regulations – Health Care Spending Targets, Progressive Enforcement (22 CCR §§ 97445–97459)

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

The undersigned labor organizations appreciate the opportunity to provide comments on the Office of Health Care Affordability's (OHCA) proposed regulations establishing a progressive enforcement process for health care entities that exceed California's health care spending targets. As organizations representing workers across California's health care system and broader labor movement, we share a commitment to ensuring that health care is affordable and accessible for all Californians, while protecting the workers who deliver essential care and services. We believe a strong, transparent, and accountable enforcement process is critical to achieving OHCA's mission and ensuring that efforts to contain health care costs do not come at the expense of patient care, access to services, or workforce stability. Regrettably, the proposed regulations lack the clear, consistent transparency and public engagement that we believe is critical for this process to honor the statute's intention.

California is facing unprecedented threats to health care affordability and access. The federal cuts enacted through H.R. 1 threaten to destabilize an already strained health care system. According to research by the UC Berkeley Labor Center and UCLA Center for Health Policy Research, 2.2 million additional

Californians are projected to become uninsured by 2030, nearly doubling the state's uninsured rate.[1] Earlier research by the UC Berkeley Labor Center estimated that reductions of $10 billion to $20 billion in annual federal Medi-Cal funding could result in the loss of 109,000 to 217,000 California jobs, approximately two-thirds of them in health care sectors.[2] And for California workers with job-based coverage, premiums have been skyrocketing; premiums for single coverage among private sector workers in the state have grown an average of 6.7% every year from 2023 to 2025.[3] Six in ten California families reported skipping or delaying care in the last year due to cost.[4]

These threats make the mission of the Office of Health Care Affordability (OHCA) more important than ever. OHCA was established to confront the escalating health care costs that have placed enormous financial burdens on working families and to hold health care entities accountable for spending growth that exceeds what Californians can afford. At a time when patients face the prospect of losing coverage and health care workers face growing uncertainty, California must ensure that health care corporations are not permitted to shift the consequences of rising costs onto patients and frontline caregivers.

We support meaningful enforcement of the health care spending targets. However, the proposed regulations do not establish sufficient public transparency, meaningful stakeholder participation, or enforceable safeguards against cost-cutting measures that undermine patient care and workforce stability. We urge OHCA to strengthen the regulations in the following areas:

1. Require public disclosure and participation when entities exceed spending targets (§ 97452)

The proposed regulations allow health care entities to submit explanations and supporting data concerning their excessive spending growth directly to OHCA without establishing a corresponding opportunity for public review or response. This creates an enforcement process that relies heavily on information provided by the very entities subject to oversight.

We recommend that OHCA:

- Publicly disclose preliminary determinations of excess spending growth, the entities' explanations for exceeding targets, and supporting financial data.
- Require OHCA to notify any labor union representing workers at a health care entity when the agency makes a preliminary determination that the entity has

[1]Dietz, Miranda, et al.“ Over two million more Californians projected to lack health insurance by 2030.” *UC Berkeley Labor Center*. May 25, 2026, https://laborcenter.berkeley.edu/over-two-million-more-californians-projected-to-lack-health-insurance-by-2030/
[2]Manzanilla, Alexis, et al. “Inequities in job based health coverage for california low wage workers.” *UC Berkeley Labor Center*. May 15, 2026, https://laborcenter.berkeley.edu/inequities-in-job-based-health-coverage-for-california-low-wage-workers
[3] “Information from the private sector and State and local governments on the health insurance coverage offered to their employees.” *Medical Expenditure Panel Survey (MEPS) Insurance Component (IC)*. https://datatools.ahrq.gov/meps-ic/
[4] Joynt, Jen. “The 2026 CHCF California Health Policy Survey.” *California Health Care Foundation*. February 2026, https://www.chcf.org/wp-content/uploads/2026/02/CHCFHealthPolicySurvey2026.pdf

failed to meet its health care cost growth target, and ensure that those unions receive timely notification at every subsequent stage of the enforcement process.

- Establish a public comment period before final enforcement determinations, allowing patients, consumers, and labor unions to challenge or supplement entities' representations.
- Require OHCA to publicly explain its decisions to modify spending calculations, decline enforcement, or select a particular enforcement action, including the evidence and factors relied upon.

2. Establish meaningful public testimony and hearing rights (§ 97454).

While the regulations contemplate public testimony, the decision to require testimony remains discretionary, and the provisions focus on testimony from the health care entity rather than the public. Nurses and other frontline workers have firsthand knowledge of staffing reductions, service closures, and corporate practices that may contribute to rising costs or compromise patient care.

We recommend requiring a mandatory public hearing and/or establishing a formal process through which consumer organizations or affected labor unions may request a hearing. Such hearings must provide meaningful opportunities for testimony from patients, workers, and community representatives, including the ability to respond to the entity's claims for failing to meet the cost growth target.

3. Strengthen transparency and public oversight of technical assistance and performance improvement plans (§§ 97453–97455).

The regulations provide limited accountability for technical assistance, requiring entities to consider recommendations in good faith without clear public reporting requirements. Although proposed performance improvement plans (PIPs) are subject to a 10-business-day comment period and approved plans are publicly posted, the regulations do not expressly require publication of the underlying progress reports or establish ongoing opportunities for public input.

We recommend:

- Require public disclosure of entity-specific technical assistance recommendations, implementation commitments, and measurable evidence of the entity’s progress.
- Publicly posting PIP progress reports, performance metrics, supporting data, and final compliance determinations throughout implementation.
- Establish opportunities for public comment on progress reports, significant PIP modifications, and final compliance determinations.

4. **Require an independent workforce stability and patient care impact analysis (§ 97455).**

We appreciate that the proposed regulations identify workforce stability as a consideration when approving PIPs and evaluating compliance. However, these provisions do not expressly require entities to submit a comprehensive workforce impact analysis or provide for independent verification of their claims.

Health care corporations must not be permitted to meet spending targets through reductions in bedside staffing, diminished services, or other practices that compromise patient safety. Nor should negotiated wage increases, collectively bargained benefits, or investments in safe staffing be treated as interchangeable with excessive administrative spending, corporate profits, or executive compensation.

We urge OHCA to require every proposed PIP to include a workforce stability and patient care impact analysis examining staffing levels, vacancies, turnover, layoffs, use of temporary staff, service reductions, and compliance with applicable staffing and labor standards. Affected labor unions must have an opportunity to review and respond to the analysis before PIP approval.

5. **Ensure enforcement decisions are transparent, consistent, and meaningful (§§ 97452, 97455–97457).**

The effectiveness of the spending targets ultimately depends on whether health care entities face meaningful consequences for failing to comply. The proposed regulations provide OHCA with considerable discretion in determining whether enforcement is warranted, which actions to pursue, and the amount of administrative penalties weighed upon the health care entity.

OHCA should publicly disclose the rationale for all enforcement decisions, including decisions not to pursue enforcement, penalty calculations, and any reductions or adjustments to penalties. These disclosures should identify the evidence considered and explain how the decision advances affordability and protects patients.

California's health care affordability crisis cannot be solved behind closed doors. Nurses, frontline caregivers, patients, consumers, and working families are the people most directly affected by rising health care costs and the decisions health care corporations make in response to financial pressures. They deserve a meaningful voice in the process intended to protect them.

We urge OHCA to strengthen these regulations by making public transparency, labor and consumer participation, workforce protections, and meaningful enforcement of central requirements, not discretionary considerations. Doing so will help ensure that California's health care spending targets deliver genuine affordability without sacrificing access to care, patient safety, or the frontline workforce.

Thank you for your consideration.

Sincerely,

Jessica Hay
Legislative Advocate
AFSCME California

Elmer Lizardi
Legislative Advocate
California Federation of Labor Unions

Tristan Brown
Legislative Director
California Federation of Teachers

Carmen Comsti
Director of Government Relations
California Nurses Association/National Nurses United

Benjamin Eichert
Director of Public Policy and Legislative Affairs
National Union of Healthcare Workers

Beth Malinowski
Government Affairs Advocate
SEIU California

Health Care LA, IPA

November 9, 2026

Elizabeth Landsberg
Director
California Department of Health Care Access and Information

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

RE: Health Care LA IPA in support of America's Physician Groups Comments regarding Proposed Progressive Enforcement Regulations

Dear Director Landsberg and Deputy Director Pegany:

Health Care LA IPA (HCLA) is a not for profit network of Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs) serving 670,000 Los Angeles residents since 1991. HCLA echoes the concerns raised by Mr. William Barcellona of America's Physician Groups (APG) as related to the proposed spending target enforcement regulations and Performance Improvement Plan Submission.

As stated in the letter to OHCA from APG dated October 29th 2026, it is imperative that OHCA follows the contractual obligations as defined by the Division of Financial Responsibility (DOFR) within the contracts between Managed Care Plans (MCPs) and delegated entities such as HCLA. Failure to delve into the details of DOFRs and controllable costs will result in highly problematic performance improvement plans (PIPs) where implementing the needed cost reductions are outside the control of the agency receiving the PIP and simply cause additional administrative burden on entities that are already heavily regulated and burdened.

I have included below an example for just one service, Emergency Room utilization, that show the variations within the different DOFRs between MCPs and IPAs.

PLAN A

EMERGENCY ADMISSIONS (IN AREA)		
FACILITY COMPONENT		PLAN RESPONSIBILITY
PROFESSIONAL COMPONENT	IPA RESPONSIBILITY	
EMERGENCY ADMISSIONS (OUT-OF-AREA)		
FACILITY COMPONENT		PLAN RESPONSIBILITY
PROFESSIONAL COMPONENT		PLAN RESPONSIBILITY

PLAN B

EMERGENCY ADMISSIONS (IN AREA – NO ADMISSION)		
FACILITY COMPONENT	IPA RESPONSIBILITY	
PROFESSIONAL COMPONENT	IPA RESPONSIBILITY	
EMERGENCY ADMISSIONS (OUT-OF-AREA – NO ADMISSION)		
FACILITY COMPONENT		PLAN RESPONSIBILITY
PROFESSIONAL COMPONENT		PLAN RESPONSIBILITY

PLAN C-SHARED RISK

EMERGENCY ADMISSIONS (IN AREA – NO ADMISSION)		
FACILITY COMPONENT		PLAN RESPONSIBILITY
PROFESSIONAL COMPONENT	IPA RESPONSIBILITY	
EMERGENCY ADMISSIONS (OUT-OF-AREA – NO ADMIT)		
FACILITY COMPONENT		PLAN RESPONSIBILITY
PROFESSIONAL COMPONENT		PLAN RESPONSIBILITY

PLAN C-CAPITATED HOSPITAL

EMERGENCY ADMISSIONS (IN AREA – NO ADMISSION)		
FACILITY COMPONENT		CAPITATED HOSPITAL RESPONSIBILITY
PROFESSIONAL COMPONENT	IPA RESPONSIBILITY	
EMERGENCY ADMISSIONS (OUT-OF-AREA – NO ADMISSION)		
FACILITY COMPONENT		PLAN RESPONSIBILITY
PROFESSIONAL COMPONENT		PLAN RESPONSIBILITY

PLAN D

EMERGENCY ADMISSIONS (IN AREA)		
FACILITY COMPONENT		CAPITATED HOSPITAL RESPONSIBILITY
PROFESSIONAL COMPONENT	IPA RESPONSIBILITY	
EMERGENCY ADMISSIONS (OUT-OF-AREA)		
FACILITY COMPONENT		CAPITATED HOSPITAL RESPONSIBILITY
PROFESSIONAL COMPONENT	IPA RESPONSIBILITY	

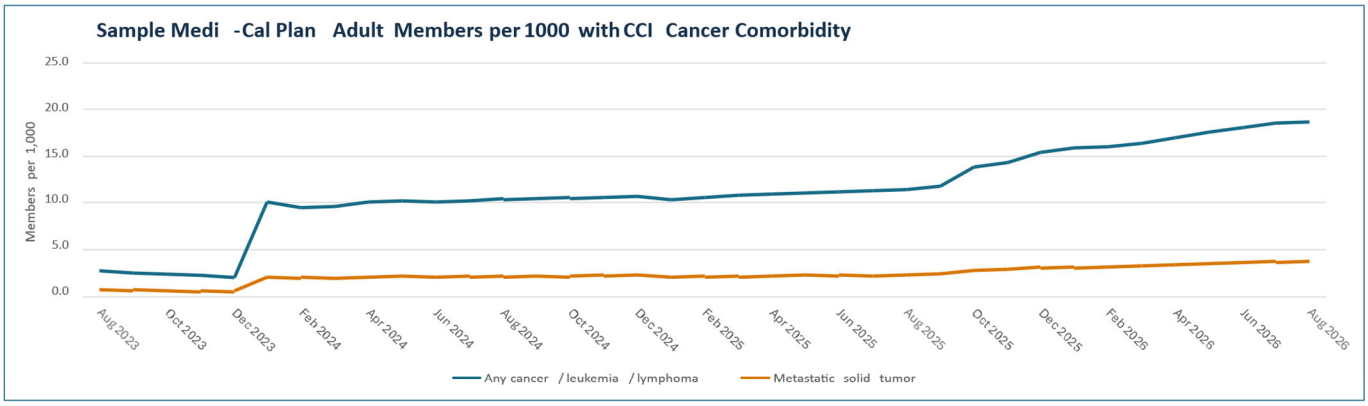
PLAN E

EMERGENCY ADMISSIONS (IN AREA)		
FACILITY COMPONENT		PLAN RESPONSIBILITY
PROFESSIONAL COMPONENT	IPA RESPONSIBILITY	
EMERGENCY ADMISSIONS (OUT-OF-AREA)		
FACILITY COMPONENT		PLAN RESPONSIBILITY
PROFESSIONAL COMPONENT		PLAN RESPONSIBILITY

HCLA supports OHCA's initiative on controlling spending. As illustrated above, the control does not always fall under the responsibility of the same entity as determined largely by health plan preferences in contracting models. As such, the attribution of facility costs in OHCA's evaluations and subsequent PIPs becomes essential in holding the correct entity accountable for reducing costs.

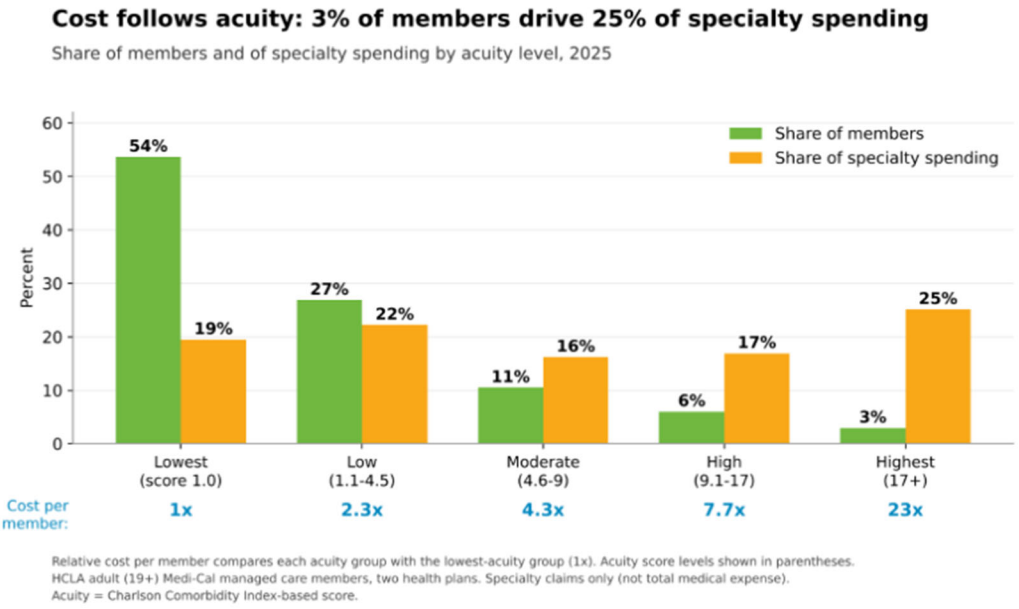
Other factors such as patient acuity also contribute to the ability of entities to control spending. HCLA is a high performer for DHCS' preventive services screenings and has seen our patients with cancer rise dramatically over the past 2 years. As we screen more, we find more.

HCLA IPA's Incidence of Cancer has increased Exponentially in the Past 3 Years



- Calculation methodology:
  - Assessed number of monthly eligible adult members with documented cancer related CCI comorbidity per 1000 members.
    - Leukemia/lymphoma/localized tumor: 2X CCI weight
    - Metastatic Solid Tumor: 6X CCI weight

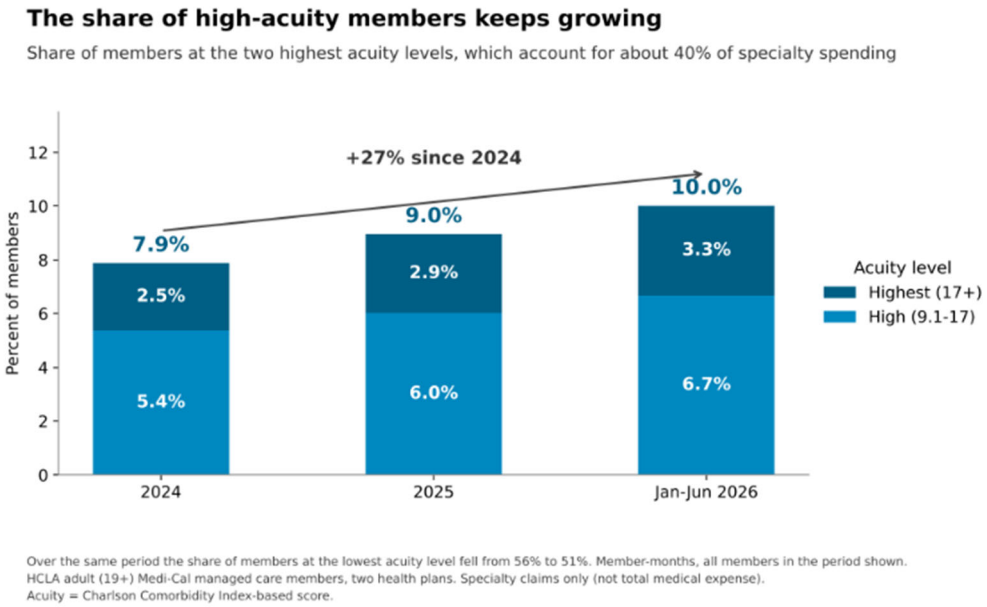
With greater incidence of cancer and other chronic diseases, our costs have increased directly with acuity increases. HCLA followed more than 17,000 members who were continuously enrolled from October 2023 through June 2026. Their acuity rose 39% and their specialty cost per member rose 40%.



v

In 2025, the 3% of members with the highest acuity accounted for 25% of specialty spending. A member in that group costs about 23 times as much as a member with no recorded conditions. At the other end, the 54% of members at the lowest acuity level accounted for 19% of spending. Spending is driven by a small group of clinically complex members. Care need, not a delegate's pricing or contracting choices, determines who falls into that group.

The share of members at the two highest acuity levels rose from 7.9% in 2024 to 10.0% in the first half of 2026, an increase of 27%. Those two levels account for about 40% of specialty spending. Over the same period the share at the lowest level fell from 56% to 51%. With more members in the costliest groups, average cost per member rises even if nothing about how care is delivered or priced changes.



HCLA's Medi-Cal members are becoming more clinically complex. For the same members, specialty cost per member has risen in step with acuity, and spending is concentrated in the highest-acuity members. This is a driver of attributed spending that a delegated physician organization does not set, which is why enforcement should account for what each entity controls and adjust for factors such as acuity.

HCLA supports OHCA convening interested organizations to address the draft's methodological and procedural concerns and develop a California-specific alternative to unadjusted attributed TME as the standard for physician-organization accountability. The Massachusetts framework arose in a materially different market. The joint work should test a methodology using appropriately adjusted total cost of care, quality, and patient financial burden, with attribution tied to contractual responsibilities and capacity to influence spending, while retaining comprehensive statewide spending monitoring. It should also identify any regulatory or statutory changes needed for implementation.

Sincerely,

Sabra Matovsky, MBA, FACHE
Chief Executive Officer
Health Care LA IPA

cc: Kimberly Carey, CEO/MedPOINT Management

Sutter North Medical Group

November 11, 2026

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

Vishaal Pegany
Deputy Director, Office of Health Care Affordability

Re: Request for Further Study of California's Delegated Physician Group Model Prior to Finalization of Spending Target Enforcement Regulations *(Submitted via email to ohca@hcai.ca.gov)*

Dear Director Landsberg and Deputy Director Pegany:

On behalf of Sutter North Medical Group, we appreciate the opportunity to comment on OHCA's proposed spending target enforcement regulations. We support the Office's goal of improving affordability and ensuring accountability across the health care system. We are concerned, however, that the current proposal does not adequately reflect the operational realities of California's delegated physician group model and could assign responsibility for spending categories and performance measures that physician organizations neither control nor possess the authority to change.

California's delegated care model has evolved over decades and remains one of the nation's most successful frameworks for delivering coordinated, value-based care. Physician organizations operating within this model frequently assume responsibility for clinical management, care coordination, quality improvement, population health programs, and utilization management. At the same time, many significant drivers of total health care expenditures remain controlled by other entities, including health plans, hospitals, pharmacy benefit managers, drug manufacturers, vendors, and affiliated organizations that negotiate contracts or make investment decisions independent of physician groups.

Before finalizing regulations that would impose financial penalties or performance improvement obligations on delegated physician organizations, we respectfully request that OHCA undertake additional study and stakeholder engagement regarding the unique characteristics of California's delegated care system.

1. Convene a Working Group to Evaluate the Delegated Physician Organization Model

We respectfully request that OHCA convene a formal stakeholder working group consisting of physician organizations, foundations, health plans, hospitals, purchasers, and affordability experts to examine how accountability should operate within California's delegated care framework.

The current proposal appears to assume that physician organizations possess operational control over spending categories such as hospital costs, pharmacy expenditures, out-of-network services, behavioral health costs, and system capital investments. In many circumstances, physician groups do not negotiate these contracts, establish these prices, purchase these services, or receive the information necessary to influence them effectively.

Similarly, proposed requirements regarding primary care investment and spending allocations raise important methodological questions that warrant further discussion. Physician organizations often deliver care management, chronic disease management, care navigation, and population health services through integrated and centralized models that may not align cleanly with traditional spending classifications. Programs supporting hypertension, diabetes, heart failure, transitional care, case management, and other population-health initiatives may be delivered through shared infrastructure and multidisciplinary teams, making simple attribution methodologies incomplete or misleading.

Given the complexity of these issues, a collaborative evaluation process would produce better policy outcomes than immediate implementation of mandates based on assumptions that may not accurately reflect physician group operations.

2. Study the Division of Responsibility Between Physician Organizations, Foundations, and Other Affiliated Entities

We urge OHCA to undertake a comprehensive assessment of how financial responsibility, operational authority, contracting authority, and data stewardship are divided among physician organizations, foundations, hospitals, and health plans.

Many physician groups contract to provide clinical services and manage patient care but do not directly negotiate or control:

- Health plan contracts;
- Hospital rates and facility pricing;
- Pharmacy benefit arrangements;
- Pharmaceutical purchasing agreements;

- Vendor contracts;
- Capital expenditures;
- System infrastructure investments; or
- Numerous administrative functions that affect total medical expenditures.

Any accountability framework should carefully distinguish between an entity's ability to influence care delivery and its authority to control the underlying spending that drives cost trends. Assigning responsibility without corresponding authority risks creating requirements that are difficult or impossible to implement in practice.

3. Align Improvement Requirements with Available Data and Actual Control

We respectfully request that OHCA commit to developing improvement requirements that recognize the practical limitations physician organizations face when obtaining information from entities with which they do not contract directly.

Many physician groups rely on data supplied by health plans, foundations, and other organizations to understand attribution, utilization, expenditures, and performance measures. Yet those entities may not be obligated to provide timely, complete, or actionable information necessary for physician organizations to evaluate or challenge OHCA findings, develop corrective strategies, or demonstrate compliance.

Holding physician groups accountable for outcomes dependent upon data or actions controlled by unaffiliated entities creates significant implementation challenges. Any performance improvement framework should therefore be designed around information and interventions that physician organizations can realistically access and influence.

4. Recognize the Demonstrated Success of California's Delegated Care Model

As OHCA considers its enforcement framework, it should recognize the substantial body of evidence demonstrating that California's delegated physician organization model has produced some of the strongest cost and quality outcomes in the country.

The state's physician-led, population-based care model has supported:

- Coordinated care management;
- Greater adoption of value-based payment arrangements;
- Enhanced chronic disease management;
- Improved quality performance; and
- More sustainable long-term cost trends compared with many traditional fee-for-service environments.

These successes did not emerge from command-and-control regulatory structures. Rather, they resulted from aligned incentives, clinical accountability, coordinated care infrastructure, and long-term investments by physician organizations committed to managing the health of defined patient populations.

Before imposing new mandates, OHCA should ensure that its regulatory framework preserves and strengthens these successful arrangements rather than inadvertently weakening the very delivery models that have demonstrated value for California patients.

Conclusion

We respectfully request that OHCA slow the implementation of physician organization enforcement requirements and first develop a more comprehensive understanding of California's delegated care environment. Specifically, we urge OHCA to:

1. Convene a stakeholder working group focused on delegated physician organizations;
2. Study contractual and operational responsibility among physician groups, foundations, hospitals, and health plans;
3. Develop accountability measures that reflect actual authority, data access, and ability to influence spending; and
4. Recognize the demonstrated quality and affordability advantages of California's delegated care model.

Thoughtful study and stakeholder engagement now will produce a more accurate, workable, and effective affordability framework while avoiding requirements that are misaligned with the realities of physician organization operations.

We appreciate your consideration and look forward to working collaboratively with OHCA to develop policies that advance affordability while preserving California's successful physician-led care delivery system.

Sincerely,



Steven D. Blair, ~~MD~~, MBA

President/CEO

Sutter North Medical Group

See Attachment #7

From:	PAFMG Office of the CEO
To:	HCAI OHCA
Subject:	Request for Further Study of California"s Delegated Physician Group Model Prior to Finalization of Spending Target Enforcement Regulations
Date:	Wednesday, November 11, 2026 3:28:58 PM
Attachments:	image.png

You don't often get email from pafmgofficeoftheceo@sutterhealth.org. Learn why this is important

CAUTION: This email originated from outside of the organization.

November 11, 2026

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

Vishaal Pegany
Deputy Director, Office of Health Care Affordability

Re: Request for Further Study of California's Delegated Physician Group Model Prior to Finalization of Spending Target Enforcement Regulations *(Submitted via email to ohca@hcai.ca.gov)*

Dear Director Landsberg and Deputy Director Pegany:

On behalf of Palo Alto Foundation Medical Group (PAFMG), a multispecialty group comprised of approximately 3,000 physicians and APCs providing care to over one million patients in the San Francisco Bay Area, we appreciate the opportunity to comment on OHCA's proposed spending target enforcement regulations. We support the Office's goal of improving affordability and ensuring accountability across the health care system. We are concerned, however, that the current proposal does not adequately reflect the operational realities of California's delegated physician group model and could assign responsibility for spending categories and performance measures that physician organizations neither control nor possess the authority to change.

California's delegated care model has evolved over decades and remains one of the nation's most successful frameworks for delivering coordinated, value-based care. Physician organizations operating within this model frequently assume responsibility for clinical management, care coordination, quality improvement, population health programs, and utilization management. At the same time, many significant drivers of total health care expenditures remain controlled by other entities, including health plans, hospitals, pharmacy benefit managers, drug manufacturers, vendors, and affiliated organizations that negotiate contracts or make investment decisions independent of physician groups.

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Similarly, proposed requirements regarding primary care investment and spending allocations raise important methodological questions that warrant further discussion. Physician organizations often deliver care management, chronic disease management, care navigation, and population health services through integrated and centralized models that may not align cleanly with traditional spending classifications. Programs supporting hypertension, diabetes, heart failure, transitional care, case management, and other population-health initiatives may be delivered through shared infrastructure and multidisciplinary teams, making simple attribution methodologies incomplete or misleading.

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- Improved quality performance; and
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These successes did not emerge from command-and-control regulatory structures. Rather, they resulted from aligned incentives, clinical accountability, coordinated care infrastructure, and long-term investments by physician organizations committed to managing the health of defined patient populations.

Before imposing new mandates, OHCA should ensure that its regulatory framework preserves and strengthens these successful arrangements rather than inadvertently weakening the very delivery models that have demonstrated value for California patients.

Conclusion

We respectfully request that OHCA slow the implementation of physician organization enforcement requirements and first develop a more comprehensive understanding of California's delegated care environment. Specifically, we urge OHCA to:

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2. Study contractual and operational responsibility among physician groups, foundations, hospitals, and health plans;
3. Develop accountability measures that reflect actual authority, data access, and ability to influence spending; and

4. Recognize the demonstrated quality and affordability advantages of California's delegated care model.

Thoughtful study and stakeholder engagement now will produce a more accurate, workable, and effective affordability framework while avoiding requirements that are misaligned with the realities of physician organization operations.

We appreciate your consideration and look forward to working collaboratively with OHCA to develop policies that advance affordability while preserving California's successful physician-led care delivery system.

Sincerely,

Kurt VandeVort, M.D.

Chief Executive Officer

Palo Alto Foundation Medical Group

ABOUT PALO ALTO FOUNDATION MEDICAL GROUP

Palo Alto Foundation Medical Group (PAFMG) is among the largest multi-specialty medical groups in the nation. Founded in 1930 as the Palo Alto Medical Clinic, PAFMG has grown over nearly a century to include nearly 3,000 physicians and APCs across over 60 specialties. The group has consistently been recognized for excellence in quality of care and innovation, earning Top Quality recognition from the Integrated Healthcare Association for more than 20 consecutive years.

PAFMG actively holds the prestigious 2025–2026 American Medical Association's Joy in Medicine Gold recognition. This award highlights health systems that use data-driven strategies to reduce physician burnout and support professional well-being.

PAFMG is aligned with Palo Alto Medical Foundation (PAMF)/Sutter Health, a non-profit healthcare system. Through this partnership, PAFMG receives operational and administrative support, and leverages the latest technology, allowing clinicians to focus on delivering exceptional care to more than one million patients. PAFMG proudly serves communities throughout Alameda, San Mateo, Santa Clara, and Santa Cruz counties.

Office of the CEO
Palo Alto Foundation Medical Group (PAFMG)

Palo Alto Foundation Medical Group
Aligned with Palo Alto Medical Foundation – Sutter Health

This is a no-reply email address. You may reach Dr. VandeVort directly at Kurt.VandeVort@sutterhealth.org. Thank you.

See Attachment #8

From: Wafa, Tamim A., MD
To: HCAI OHCA
Subject: Comments on Proposed Progressive Enforcement Regulations
Date: Wednesday, November 11, 2026 3:43:19 PM
Attachments: image.png

You don't often get email from tamim.wafa@sutterhealth.org. Learn why this is important

CAUTION: This email originated from outside of the organization.

Gould Medical Group

Serving California's Central Valley Since 1948

November 10, 2026

Elizabeth Landsberg, Director

Vishaal Pegany, Deputy Director

Office of Health Care Affordability

California Department of Health Care Access and Information

Re: Comments on Proposed Progressive Enforcement Regulations

Dear Director Landsberg and Deputy Director Pegany:

Gould Medical Group has provided care across California's Central Valley for more than 75 years. We are a physician-led, community-based organization committed to the patients and communities we have served since 1948. We support OHCA's goal of greater affordability, but the proposed enforcement framework does not fit the way delegated medical groups like ours operate.

We do not contract with health plans or insurance companies. Our work is governed by a Professional Services Agreement with Sutter Health and a designated 1206 (L) Medical Foundation. We do not own or operate hospitals, pharmacies, laboratories, or imaging centers. The Foundation holds the health plan contracts and bears responsibility for hospital services, pharmacy, behavioral health, out-of-network care, and related costs. Our group's role is to deliver professional clinical services and to help manage utilization and quality within that structure.

Because of this arrangement, total medical expenditure attributed to Gould Medical Group can rise for reasons outside our contractual control—hospital pricing, drug costs, or other services

we neither price nor contract. Holding the medical group accountable for unadjusted attributed spending or requiring us to implement corrective plans for factors we do not control, would be both impractical and unfair. We also lack direct contractual relationships that would allow us to obtain timely data from plans or other entities when OHCA seeks information or responses.

We urge OHCA to recognize the distinction between a 1206(l) foundation and its affiliated medical group, to review the actual agreements that define each party's responsibilities, and to create a practical adjustment process for spending beyond a group's control. Accountability should rest with the entities that hold the contracts and the financial levers. We are prepared to work with HCAI and OHCA on a measurement approach that supports affordability while remaining realistic for delegated groups.

I am respectfully requesting that OHCA share the letter with Board members to read prior to the next Board meeting.

Sincerely,

Tamim Wafa, MD
President and CEO
Gould Medical Group

M: 209-534-9335

Gould Medical Group

Docusign Envelope ID: A4B56120-C28D-8AA2-810D-555D093135D0

Attachment #9

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

November 11, 2026

Elizabeth Landsberg
Director
California Department of Health Care Access and Information

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

Re: MedPOINT Management in Support of Written Comments of America's Physician Groups (APG) and Health Care LA IPA (HCLA) Regarding Proposed Progressive Enforcement Regulations

Dear Director Landsberg and Deputy Director Pegany:

MedPOINT Management (MPM) is a Management Services Organization founded in 1987 serving managed care IPAs throughout California. Currently, MPM is responsible for coordinating care for over two million members through the various contracts that our clients hold across a multitude of Managed Care Plans.

MPM hereby expresses its strong support of the written comments made by APG in its October 29 letter to OHCA as well as those from HCLA in its November 9 letter regarding the Proposed Progressive Enforcement Regulations. MPM further emphasizes the call and need for the establishment of an OHCA workgroup to discuss the complexities around these proposals.

Thank you for your consideration.

Sincerely,

DocuSigned by:
Alexandra Carey
BB843278595143B...

Alexandra Carey

Chief Operating Officer

MedPOINT Management

Cc: William Barcelona, Esq/America's Physician Groups

Sabra Matovsky, CEO/ Health Care LA IPA

HEALTH ACCESS FOUNDATION

PRESIDENT
Lynne Faulks

SECRETARY/TREASURER
Denzel Tongue

MEMBERS
Serina Correa

James Crouch

Consuelo Hernandez

Marty Lynch

Andie Martinez Patterson

November 12, 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

2020 W. El Camino Ave., Ste. 1200
Sacramento, CA 95833

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

Health Access California, the statewide consumer coalition committed to quality, affordable health care for all Californians, comments on the interim health care spending report, spending target adjustment for 2028 and beyond, and the proposed enforcement regulations.

Executive Summary

- Health Access appreciates the interim report on health care spending trends in California 2023-24, including:
  - The focus on the worsening affordability of commercial coverage, including analyses of census data over the last 20 years.
  - Transparency by naming health insurers and detail on many topics, giving an overview of health care spending and the health care system.
  - A recognition by us that key populations are excluded, including the half of Medicare recipients with traditional Medicare and Medi-Cal fee-for-service.
  - Underlying costs for hospitals, doctor services, and outpatient drugs continue to climb while insurer profits are up by over a billion dollars.
  - A significant and unexplained climb in Medi-Cal managed care spending of over 20%, in the context of declining Medi-Cal enrollment.
- Growth target adjustment: Health Access continues to support the use of median family income over the prior 20 years as the most appropriate measure of the ability of Californians to afford health care, to oppose the use of measures of wealth of the economy such as gross domestic product and also to reject use of the consumer price index. Hikes in CPI mean consumers are less able to afford health care, not better able to pay for it.
- Spending target enforcement: Health Access continues to press for greater transparency of the early stages of enforcement, starting with notice to the entity.
- Spending target enforcement: Health Access recommends setting up a workgroup to develop alternatives to the current methodology for attributing costs to large physician

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

organizations because the current methodology does not fit with California law or the complexity and scale of the California delivery system.

The Interim Report: Health Care Spending Trends in California, 2023-2024

Worsening Affordability of Commercial Coverage

Health care is not affordable for Californians. They cannot afford premiums for individual coverage or the share of premium for employer coverage. They cannot afford to go to the doctor, pick up the prescription or get a lab test. Going to the emergency room or hospital is often financially devastating. Seven out of ten Californians skip or delay care because of costs and get worse as a result. They are in the words of a recent publication "Worried Sick"[1].

Health Access appreciates the elements of the interim report which describe the impact of rising health care costs on consumer affordability in California, looking back at 2004-2024. Median household income grew 3.7% while share of premium and deductibles grew by almost twice as much, 5.9%-7.2%. Employers shifted a greater share of health care costs to workers both in terms of share of premium as well as both prevalence and magnitude of deductibles. Share of premium paid by workers grew more quickly than the total cost of premiums. We particularly appreciate the use of the Medical Expenditure Panel Survey data since this reflects spending as reported by consumers[2].

Health Access also appreciates the analysis of "member responsibility", which reflects what consumers paid for care in deductibles, copays and coinsurance as opposed to what insurers and health plans paid. While the average member responsibility for copays and deductibles amounts to $345 for an HMO and $910 for a PPO, this amount does not reflect the reality that some California consumers face much higher expenses if they have higher health needs and that about half of Americans would need to borrow money if they faced a $1,000 emergency room bill[3]. These are good reasons why Californians are "worried sick".

Transparency by Entity, Detail Galore

Health Access appreciates the detail provided in the interim report, particularly identifying specific health plans and physician organizations in most, but not all sections of the report. This transparency is foundational to OHCA's mission. The lack of similar transparency in the analysis of the differences in equity among health plans was very troubling. Health Access recommends that reporting, whether on spending or equity or other measures, identify individual entities by name and that market share of entity be included as is done in most sections of this report.

---

[1] https://www.chcf.org/wp-content/uploads/2026/02/CHCFHealthPolicySurvey2026.pdf and https://www.chcf.org/resource/2026/09/28/listening-california-health-care-costs/

[2] https://hcai.ca.gov/wp-content/uploads/2026/10/Interim-Report-Health-Care-Spending-Trends-in-CA-2023-2024-3.pdf pp. 10-13.

[3] https://www.bankrate.com/banking/savings/emergency-savings-report/#how-pay

One question we have is why the report focuses on "total medical expenditures" for health plans and insurers, a measure which excludes administrative costs and profits for health plans and insurers while failing to report on "total health care expenditures" which includes not only the insurer's overhead and profits but also what the insurer paid for hospitals, physician services, outpatient drugs, labs, imaging and other medical expenses. At least for health plans and insurers, the report should include both "THCE" (total health care expenditures, including overhead and profits) and "TME" (total medical expenditures, which insurers pay for doctors, hospitals and prescription drugs). Health Access recommends including both "THCE" and "TME".

The report also provides detail on a wide range of questions, from the share of enrollment and spending in large group, small group and individual commercial market segments to the differences in costs for HMOs and PPOs to market share by entity for commercial, Medicare Advantage and Medi-Cal managed care. While there have been scattered reports on each of these, assembling all this information in one place is a marked step forward in terms of oversight of the health care system in a single place. This fulfills one of Health Access' goals for the Office—that it provides oversight of the financing of most of the health care system in California.

Populations Excluded: Medi-Cal Fee-for-Service, Traditional Medicare and the Uninsured

Health Access appreciates the addition of Medi-Cal managed care to the earlier report from June 2026 that included commercial coverage and Medicare Advantage. We note that this report, like the earlier one, does not include data on Medi-Cal fee-for-service, a small but growing segment of the Medi-Cal program[4], nor does it include data on traditional Medicare, about half of all Medicare enrollees even in California[5]. These omissions mean that the information on Medicare spending is at best partial. The definition of payer in California law of public programs includes both fee-for-service and managed care plans for both Medicare and Medi-Cal. Health Access recommends that future reports include spending on fee-for-service Medi-Cal and traditional Medicare, consistent with the law. The omission of half the Medicare enrollment that is in traditional Medicare rather than Medicare Advantage and the growing share of Medi-Cal fee-for-service are significant and should be remedied in future reports[6].

We appreciated the information that the OHCA data captures 16.2 million out of 19.6 million commercial enrollees in last month's Board presentation. The omission of private-sector self-insured plans is understandable given rulings by the U.S. Supreme Court on the ability of states to compel data from such plans.

[4] While Medi-Cal fee-for-service had become a small share of the Medi-Cal program, under 5% of enrollment, the shift of the "unsatisfactory immigrant population" (UIS) from managed care to fee-for-service in 2027 will increase the share in fee-for-service. The UIS population includes asylees, refugees, and recent lawful permanent residents in this country less than five years (the five-year bar) as well as undocumented Californians.

[5] Total Number of Medicare Beneficiaries by Type of Coverage | KFF State Health Facts

[6] If the recent state action to shift the unsatisfactory immigration status (UIS) population from Medi-Cal managed care to fee-for-service is undone or revised such that coverage is substantially similar to Medi-Cal managed care, then that omission may be less troublesome. For now, it is a gap in the data.

Underlying Costs Climbing, Insurer Profits Up Lots

Insurer profits from commercial coverage climbed from less than half a billion dollars to over $1.5 billion, a $1 billion increase that accounted for almost all of the $1.2 billion increase in non-medical expenses. Despite this profit-taking by health plans and insurers, most of the climb in costs was due to more expensive care in terms of doctors, hospitals and outpatient prescription drugs. Profits and administrative costs continue to be around 10% of premiums in the commercial market, suggesting that a medical loss ratio of 90% might well be feasible for commercial coverage.

The major underlying costs of health care are physician professional services, hospital care, and outpatient prescription drugs. These costs continue to climb for both commercial coverage (8.6%) and Medicare Advantage (14.8%). If the role of insurers and health plans is to negotiate on costs and quality, then in future years, the existence of enforceable spending growth targets should result in health plans using their negotiating power to control costs while improving quality and equity.

Notable is the actual decline of outpatient prescription drug costs for Medicare fee-for-service, a side effect of Medicare finally negotiating on prescription drug prices, something that should be expanded and extended to commercial coverage.

Medi-Cal Managed Care Plan Spending

We are dismayed to see that Medi-Cal managed care spending increased by 20% on a per capita basis from 2023 to 2024. The drop in enrollment with the concomitant worsening of the risk mix may explain this at least in part. If that or other explanations apply, it would be helpful for the report and the staff presentation to reflect such explanations. The changes in what is included and excluded such as the MCO tax and other payments do not seem sufficient to explain a 20% hike, especially from 2023-2024.

As the Department of Health Care Services continues to implement state budget cuts to coverage for both immigrants and seniors and persons with disabilities who will once again be subject to the asset test as well as the work requirements in H.R. 1 in the years to come, declining enrollment is likely to further worsen risk mix.

Spending Growth Target Adjustment?

Health Access continues to support use of median family income over the twenty years as the best measure of Californians' ability to afford health care costs, including both premiums and cost sharing such as deductibles, copays, and coinsurance. We continue to oppose the use of measures of the wealth of the economy such gross domestic product or use of measures of general inflation such as the consumer price index.

Measures of the wealth of the economy do not reflect the ability of families to afford premiums for coverage or the costs to obtain care in terms of deductibles and copays. As is now well documented in surveys in both California and nationally, most Californians skip or delay care because of the cost of obtaining care, even when they have insurance[7].

The wealth of the overall economy does not fix the lack of affordability for consumers under our current health care system. Funding the health system from the wealth of the economy would require an entirely different financing approach, relying on progressive public revenues and public governance for all or virtually all Californians instead of the current health system which relies on regressive financing of employer coverage and individual coverage for middle income consumers as well as public programs for seniors, people with disabilities and some but not all low income Californians.

The consumer price index reflects prices paid by consumers, not costs paid by health care providers. Measures used by the federal Centers for Medicare and Medicaid Services which do reflect the costs to health care providers generally trend lower than the consumer price index over the last twenty years.

Based on recently published analysis by the UC Berkeley Labor Center[8], we recognize that updating median family income from 2001-2021 to 2005-2025 would increase the target for future years from 3% to 3.5%. We look at this in the context of the reality that premiums in recent years have grown two or three times faster than the growth in median family income. At the same time, deductibles and other cost sharing are both higher and more prevalent. The Office's interim report on health care spending found that premiums and deductibles increased by 5%-7% from 2004-2024 while median household income increased by about half as much, 3.7%[9]. Whether it is 3% or 3.5% or 3.7% that is the basis for the growth target, that is still a vast improvement over increases in premiums of 7% and deductibles increasing 6%-7%.

Enforcement: Proposed Regulations

Health Access has attached our formal comments on the proposed emergency regulations on enforcement as part of this letter.

Enforcement: Lack of Transparency

Health Access asks that at the time an entity is notified it has exceeded the target, the Office make public a list of which entities exceeded the target and by how much. We also ask that at each stage when enforcement proceeds or not, the list be updated to reflect whether the entity will proceed to further stages of enforcement

[7] https://www.chcf.org/wp-content/uploads/2026/02/CHCFHealthPolicySurvey2026.pdf and https://www.chcf.org/resource/2026/09/28/listening-california-health-care-costs/
[8] https://laborcenter.berkeley.edu/wp-content/uploads/2026/11/UCB-November-2026-Letter-to-OHCA_11_05_2026.pdf
[9] https://hcai.ca.gov/wp-content/uploads/2026/10/Interim-Report-Health-Care-Spending-Trends-in-CA-2023-2024-2.pdf

or if not, why not, at least in general terms such as “data corrections”, “high-cost drugs”, “high-cost patients”. Without this action by the Office, the Board, the Legislature, stakeholders and others will be left operating blind for months and perhaps years while the entity is able to share its knowledge widely.

The delay is consequential in terms of the Board’s work. The law requires that the Board decide by June 1 whether to adjust the growth target for the subsequent year. How can the Board make this determination without knowing how many entities exceeded the target by how much and for what reasons in the prior year?

An entity will know for months prior to the annual report whether it exceeded the target. The Board will not. The public will not. The Legislature will if the entity complains to it. And months may extend to years if there are disputes between the entity and the Office over data questions.

Enforcement: Problematic Attribution Model for Large Physician Organizations

The California law on spending targets attributes to each entity the spending or revenue for that entity. These types of entities are specified in California law: licensed health facilities, health insurers or health plans, and physician organizations with 25 or more doctors. For large physician organizations, spending or revenue is what the physician group spends or is paid for, not other costs such as hospital care or physician services not provided by that physician organization. This is why California law allows the collection of audited financials or the equivalent for large physician organizations.

By contrast, Massachusetts uses a multistep approach to measuring spending and assessing organizational accountability. Individuals are initially attributed to primary care physicians, with spending then rolled up to the managing physician group with which those physicians are affiliated. The Massachusetts Health Policy Commission may then consider those physician groups in the context of their broader health system affiliations when evaluating spending performance and determining whether to require a Performance Improvement Plan. Massachusetts also benefits from a smaller scale than California. The population of Massachusetts is smaller than the population of Los Angeles County or the greater San Francisco Bay Area. The result is that there are about 40 hospitals in Massachusetts, instead of more than 400 hospitals as in California. The larger scale, greater complexity and regional variability of the delivery system in California as well as the differences in the underlying laws call for a different approach than in Massachusetts.

Attributing spending for specialists, hospitals, and outpatient drugs to a large physician organization would make sense if the large physician organization was controlled by a hospital system that included specialists. Sometimes this is the case in California. Sometimes it is not.

Some ask whether the attribution model in the draft regulations double-counts hospital spending since hospital spending will be measured by revenues to hospitals for inpatient and outpatient care provided by a hospital and reported to HCAI in the longstanding hospital financial data collection.

While clinically the choices of physicians and the protocols used by a physician organization may affect avoidable hospitalizations and use of generic drugs and biologics, as well as other choices that affect spending, under California law what the physician organization is responsible for is the professional services provided by the physicians in the large physician organization.

Models developed for laws and health systems in other states may not make sense in California. The Office has already determined to use a different approach for hospital spending which reflects California law, current financial reporting and the care delivery system. If we are using a different approach for hospital spending than the approach in other states, why not a different approach for large physician organizations?

Health Access proposed a workgroup, just as was done for hospital spending, to work through the various technical issues to get to a happier place. In the immediate future, if staff insists on the current approach, clarity on what would be disregarded in the enforcement process through a manual or guide would provide clarity to regulated entities and other stakeholders.

We continue to be troubled as well by the insistence on looking at a subset of a subset of physician organizations envisioned by law and overlooking the higher cost physician organizations such as specialty groups. Again, risk bearing organizations (RBOs) are a subset of commercial spending (2.5 million lives according to DMHC). Adding the two Permanente medical groups and some but not all of the University of California medical groups may provide a semblance of greater market share while still overlooking most of the PPO commercial market, which OHCA's own report finds is the more expensive part of the market. It is the statistical equivalent of looking for your keys under the street lamp instead of where you dropped them. It misses the point.

Conclusion

We appreciate the interim spending report, including its overview of the California health system, and look forward to more extensive reporting in the future. With respect to adjusting the growth target for future years, Health Access continues to support the use of median family income over the prior twenty years and to oppose use of either gross domestic product or consumer price index. We offer comments and recommendations on the draft enforcement regulations, particularly with respect to the transparency of enforcement and the attribution of spending to large physician organizations.

We appreciate your consideration of our comments.

Sincerely,



Beth Capell, Ph.D.
Policy Consultant



Amanda McAllister-Wallner
Executive Director

Attachment: Health Access letter on proposed emergency regulations on enforcement.

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,
Senator Caroline Menjivar, Chair Senate Budget Subcommittee 3 on Health and Human Services, Attn.: Scott Ogus
Assemblymember Dawn Addis, Chair, Assembly Budget Subcommittee 1 on Health, attn.: Patrick Le
Josephine Figuroa, Deputy Commissioner, California Department of Insurance

October 30, 2026

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

2020 W. El Camino, Ste. 1217
Sacramento, CA 95833

RE: Comments on Proposed Emergency Regulations – Health Care Spending Targets, Progressive Enforcement (22 CCR §§ 97445–97459)

Dear Ms. Landsberg and Mr. Pegany,

Health Access California, the statewide consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments and draft revisions for the proposed regulations on enforcement of the health care growth spending targets.

Our major substantive concerns include the following:

- First, the lack of transparency of the determinations of the Department to proceed, particularly in the early stages of the enforcement process, failing to provide adequate public notice. Health Access recommends that public notice be provided throughout the early stages of enforcement, from initial notice to the entity, to the determination to proceed to further enforcement, the provision of technical assistance, and "public" testimony be posted and that the notice include at least a summary of the reasons for enforcement proceeding or not, such as data corrections, summarized enforcement considerations and type of technical assistance.
- Second, attribution of "total medical expenditures", including hospital costs, outpatient prescription drugs, and other costs to physician organizations, which both excludes the majority of physician organizations and attribute costs to the physician organizations for which those organizations have no legal or financial responsibility, even if there is some clinical responsibility.

We also support many provisions of the draft regulations, including:

- The requirement that entities subject to a performance improvement plan comply with the applicable target.
- The requirement that an entity demonstrates by clear and convincing evidence that it did not exceed the target.
- The requirement that an entity subject to a performance improvement plan demonstrates how that plan will maintain or improve quality and equity and we offer a suggestion on how the entity may demonstrate that access is maintained or improved.
- The requirement that cost savings from compliance with the relevant target inure to the benefit of consumers, rather than being lost in the black box of the health care system.

Comments by Section of Proposed Regulations

All comments in this section refer to Title 22, Division 7, Chapter 11.5, Article 2 Health Care Spending Targets.

Section 97445. Definitions

> *(a) "Accountable health care entity" refers to a payer, fully integrated delivery system, a physician organization, and a hospital health facility.*

This definition is substantially narrower than the definition of "provider" in Health and Safety Code (HSC) 127500.2 (t). If the intent is that the definition of "accountable health care entity" evolve over time to be the same or substantially similar to the definition of payer and provider in the law, we do not object. If the intent is to narrow the law, we are opposed.

> *(n) "Performance Improvement Plan" is defined as an action plan to bring the entity into compliance with an applicable spending target.*

We support the clarity that a performance improvement plan is intended to bring the entity into compliance with the relevant spending target.

> *(z) "Total medical expenses" or "TME" means total health care expenditures excluding administrative cost and profits.*

This definition lacks clarity as drafted because providers, including hospitals and large physician organizations, also have administrative costs and profits. The definition would have greater clarity if it referred to the administrative cost and profits of payers and the fully integrated delivery system.

Section 97452 Spending Target Enforcement

> *(b) The Office shall provide written notice to an entity that OHCA determined that the entity exceeded the target.*

At the time the preliminary notice is provided to the entity, the fact that notice has been provided, including the name of the entity and date of the notice, should be posted to the Office's website. Add (2) (F) to read:

> "(b) (2) (F) At the time the preliminary determination is provided to the entity, the Office shall post on its website the name of the entity, the amount of the growth in excess of the target, and the date of the notice."

Under the current proposed regulations, no public notice is provided until months or even years after notice is provided to the entity. This means that the Board, the Legislature, stakeholders, and perhaps even the Governor's Office will be in the dark about which entities have exceeded the target. Each entity that receives notice will be free to characterize the Office and its work to whomever and however the entity chooses while the rest of us operate blind. Keeping this part of the process secret benefits the health care entities that the targets are meant to hold accountable for their excess spending. Early exposure of excess spending growth harming consumers and other purchasers is a mild deterrent.

Under (e), the Office posts notice of an entity's excess spending only after the Office makes the final determination of excess spending growth. The entity gets notice, 45 days later the entity responds, then OHCA considers the information provided by the entity for an unspecified period of time which is likely to be at least week if not months or even years of back and forth with the entity, then OHCA makes a final determination and then later sometime after that OHCA posts its determination. How is the Board supposed to do its work if it has no knowledge of what entities or how many have exceeded the target or targets it set?

We also note that Covered California and CalPERS both have annual contracting cycles and might find it useful to know in a timely manner which health plans, hospitals, and large physician organizations exceeded the growth target and by how much.

> Add 97452 (b) (7) to read: The Office shall post to its website a list of the entities that have disputed the Office's determination of excess spending and the summary reasons offered by the entity, such as any of the factors listed in (b) (4) or calculations as provided in (b) (5) or (b) (6).

Adding this step, especially when combined with the proposed (b) (2) (F) public posting of the names of the entities that have exceeded the target will provide the Board, policymakers and stakeholders with a sense of the progress of enforcement.

> *(b) (3) (C) Office discretion to grant or deny extension requests for 45-day response*

Health Access supports the clarity in (3) (C) that the Office has sole discretion to grant or deny extension requests. In the case of hospitals and payers (health plans and insurers as well as the fully integrated delivery system), the data used for the determination of excess spending is the entity's own data so the entity should be well aware if it is likely to have exceeded the target.

> *(4) The entity's response shall demonstrate the impact of relevant factors that contributed to the entity's excess annual spending growth, including but not limited to the following, as applicable.*

Health Access supports this list of possible relevant factors as consistent with the law.

With respect to (A) which refers to "unique" population characteristics or changes, we trust that the term "unique" will be narrowly construed. Too often, terms intended to narrowly constrain a policy become overly broad in common usage. For example, an entity may claim it is "uniquely" challenged by having a high proportion of Medi-Cal or Medicare patients when its patient mix is more dominated by commercial coverage than the regional or statewide averages.

With respect to (B) on the impact of high-cost patient outliers, Health Access recognizes that there are some high-cost patient outliers like complicated trauma cases or organ transplants that are not primarily due to high-cost drugs but that many other high-cost

patients are primarily due to high-cost drugs and should be addressed under the proposed subparagraph (C).

With respect to (C) on the impact of high-cost drugs, Health Access very much supports the requirement that the impact be measured after accounting for any remuneration or financial considerations for the use of these drugs. We would urge the Office to confer with those who are expert in the 340B program as it affects hospital revenues positively. There has been much discussion of the 340B program in Congress and that may be a source of expertise on the specifics of this program.

With respect to (D) investment in primary and preventive care, Health Access supports this as a matter of policy. We question how this will be interpreted with respect to a "hospital health facility" as defined in Section 97445 (a) since it is not the licensed hospital that usually provides either primary or preventive care.

With respect to (E) changes in state or federal law, Health Access recognizes that there are some changes in law that entities should be able to plan for and it should not be presupposed that a change in law should justify cost increases.

As all of these factors require some interpretation and discretion from the Office, Health Access reiterates the need for these determinations to be made public in a timely manner.

> *(5) and (6) on material facts, calculation and documentation if an entity disputes the determination of the Office on excess spending.*

Health Access appreciates the clarity provided to entities here.

> *(c) The Office may modify its preliminary determination if the entity shows by "clear and convincing evidence" that the Office's calculation was incorrect.*

Health Access appreciates the moderately high evidentiary standard of "clear and convincing evidence", the midpoint between preponderance of evidence and beyond a reasonable doubt.

> *(d) Additional factors in determining whether enforcement proceeds include entity's prior spending growth, impact on consumer access and affordability,*

baseline costs, amount of excess spending growth, and entity actions that impair or impede enforcement.

Health Access supports this list of additional factors that will allow the Director to distinguish between a have-not small, rural hospital that is not part of a larger health system and very high-cost hospitals, or between a health insurer with substantial market share and ample tangible net equity and a health plan with few lives in the commercial market.

Health Access raises a question about the language in (d) that implies that OHCA may decide not to move forward with enforcement, including technical assistance, based on factors in (b)(4) through (b)(6) and in 127502.5(a) of the code and additional factors outlined in (d)(1)-(3). In OHCA staff presentations, they have conveyed that all health care entities would be subject to technical assistance, and then OHCA would use enforcement considerations to decide whether entities move forward to additional enforcement actions beyond technical assistance. Which is it? Does each and every entity that exceeds the target receive technical assistance? Or for some entities is the preliminary notice and the initial response the end of enforcement? This lack of clarity is compounded by the statement in the next section, (e), that the Office shall notify the entity of "the type of enforcement action, if any". We read this as maybe an entity gets technical assistance or maybe they do not.

(e) The Office shall notify an entity of the Office's final determination of excess spending growth and the type of enforcement action, if any. The Office shall publish the entity's excess spending growth on the Department's website.

From a consumer perspective, this means the Office notifies an entity of its final determination and the type of enforcement action, if any. Some unspecified time later, possibly weeks after the entity receives notice of further enforcement and easily months or even years after the preliminary notice, the Office posts the entity's excess spending growth without specifying what further enforcement action will occur, if any or the summary reason(s) enforcement did not proceed, if any.

Health Access recommends that the Office post a list of entities that includes the further enforcement action, if any, and the categories of reasons why an entity did not proceed to further enforcement, such as corrected calculations, high-cost drugs, or de minimis excess spending. This is what would be posted on the Department's website, in addition to the posting of the preliminary list of entities over the target. If there was an earlier list

of entities that exceeded the target and a subset of entities do not proceed to further enforcement, then there should be a list of those entities that will not proceed to further enforcement steps and a public description of why OHCA made that determination. If sibling state agencies such as Covered California and CalPERS are using information on entities that exceeded the target in their negotiations, they would also benefit from knowing why further enforcement is or is not anticipated.

In Oregon, their Health Authority posts the list of entities over the target, and then a description of interactions between the Authority and the entity to validate data, and the reasonableness determination made for each entity over the target.[10] This helps stakeholders track the enforcement process, and patterns as enforcement is implemented.

Section 97453 Technical Assistance

In subsection (a), it says "if the Director requires technical assistance for an" entity, the Director shall notify the entity. This implies that some entities that exceeded the target will not receive technical assistance. Yet staff presentations have repeatedly said that "every" entity or "all entities" that exceeded the target will receive technical assistance. Which is it? All or some? The cross reference to Section 97452 provides no additional clarity when it says in (e) that the Office shall notify an entity of the type of enforcement action, *if any.* Maybe an entity gets technical assistance, maybe it does not. The proposed regulations lack clarity.

The proposed regulations also fail to provide transparency with respect to technical assistance. In 97453 (c), the proposed regulation says the Office "may post" technical assistance template letters. That also means the Office may not post anything.

Given the lack of clarity as to which entities will receive technical assistance, the lack of transparency is particularly troubling. Again, because under the proposed regulations, there is no public notice of which entities receive technical assistance, much less the reasons why an entity fails to proceed to further enforcement, the Board, other policymakers and the public are operating blind. Health Access asks that OHCA post which entities receive technical assistance, summaries of what technical assistance was given to the entities, and the enforcement factor or other factor that OHCA used to determine that the entity should not move forward to future enforcement actions. Given that in OHCA presentations, they have noted that many entities may stop enforcement after technical assistance, there should be transparency over which entities proceed to

[10] Cost Growth Target Accountability Program (Oregon Health Authority)

public testimony and or PIPs, which do not, and why, and what technical assistance was given.

Health Access appreciates subsections (e) and (f) that require the entity to consider the technical assistance but that clarify that reliance on the technical assistance does not prevent further enforcement.

Section 97454 Public Testimony

This section is silent on whether written testimony is public or not. This is not consistent with the law. The regulations should be modified to require that written testimony is public and will be posted on the Office's website.

With respect to oral public testimony, the proposed regulations permit but do not require the oral public testimony to be at a duly noticed meeting of the Health Care Affordability Board. Health Access does not object to public testimony occurring at a meeting other than the Health Care Affordability Board so long as that meeting is a duly noticed public meeting subject to the Bagley-Keene Act.

Section 97455 Performance Improvement Plan and Spending Target Penalties

> *(d) (4) After the Office deems the performance improvement plan submission complete, the Office shall post the proposed plan on the Department's website and accept public comments for 10 days.*

Health Access supports this transparency and opportunity for public input on proposed performance improvement plans.

> *(d) (5) The Office shall obtain input from the Board in a closed session.*

The provision is not consistent with the statute. The statute says

> 127501.10.(e)(2) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code), except that the board **may** hold closed sessions when considering matters related to the office assessing administrative penalties and requiring performance improvement plans under Section 127502.5.

Health Access recommends that (d) (5) be revised to be consistent with California law by saying “The Office **<u>may</u>** ~~**shall**~~ obtain input from the Board in a closed session.”

> *(d) (6) The Director shall assess whether to approve or reject a performance improvement plan by considering various factors, including the likelihood that the plan will achieve compliance with the applicable spending target and the adequacy of measures to mitigate adverse impacts on access, quality, equity and workforce stability.*

Health Access supports the list of factors included in this subsection, most particularly, the requirement that the plan brings the entity into compliance with the relevant spending target and the requirement that the entity itself mitigate adverse impacts on access, equity, quality, and workforce stability. We offer comments on the performance improvement plan guide on addressing access measures, using existing access standards under laws administered by the Department of Managed Health Care and the Department of Health Care Services.

(e) Progress reports

The regulations do not require public reporting of progress reports during the performance improvement plan process. Health Access asks that periodic public reporting on progress reports for performance improvement plans, either through updates to the Board or via other reporting be included in section (j) on public posting of performance improvement plans.

(g) Compliance with performance improvement plan

Section (g) details the factors which the Director is to consider in determining whether an entity has satisfied the performance improvement plan. These factors include whether the entity implemented the plan, the adequacy of the measures to mitigate adverse impacts on access, quality, equity, and workforce stability as well as whether the entity achieved the goals of the plan. Health Access supports the consideration of these factors.

(h) Administrative Penalty for Exceeding the Spending Target

An entity may be subject to an administrative penalty if both of the following apply: 1) the entity does not comply with the approved performance improvement plan and 2) the entity also does not meet the spending target included in the plan.

Health Access continues to support an administrative penalty that is initially commensurate with the amount of excess spending as consistent with California law and to oppose proposals based on laws in other states. Health Access also supports the adjustment factors for the penalty specified in California law, including the fiscal condition of the entity. Health Access is not interested in bankrupting standalone small, rural hospitals but we support substantial penalties for large, multi-state entities with ample reserves, whether those are large health systems or health plans merged with pharmacy benefit managers.

The regulations do not include consideration of Medi-Cal match, something that is contemplated in the law in Section 127502 (d) (5). We have reviewed the comments by the California Association of Public Hospitals and Health Systems. We agree that the current HCAI hospital financial reporting on the Quality Assurance Fee (QAF) for private hospitals is at best uneven. Health Access has long recognized the importance of county hospitals and health systems in serving the uninsured and Medi-Cal populations. We distinguish the role of the county hospitals from the role of the University of California health system, which is expanding exponentially and which is far less focused on serving underserved communities than county hospitals[11].

(i) Confidentiality

Health Access supports the plain statement that a performance improvement plan, progress report, final report and related materials are public record. This should be amended to make two changes: first, to include notice of an administrative penalty, if any, and second, to provide that the Board and the public shall receive notice of each of these in a timely manner after the entity receives notice. We note that the nearly monthly meetings of the Board provide ample opportunity for public notice as does the website.

Health Access continues to support the clarity that “nonpublic” information refers to information that is “confidentially maintained” and does not include any information that is otherwise lawfully made available to the public from any publicly available source. This is similar to the standard for the Department of Managed Health Care. Sad to say, we have all too often observed overly broad assertions of confidentiality that attempt to prevent disclosure of information already in the public domain. The clarity and strong

[11] UCLA Health expansion raises costs and concerns - Los Angeles Times

protection for the public record form the basis for the oversight of the spending target compliance.

(j) Public Posting of Performance Improvement Plans and Administrative Penalty

Health Access supports the provisions of this section that require a list of entities required to implement a performance improvement plan and a list of entities assessed a penalty as well as a performance improvement plan at the stages at which it is proposed, approved, and implemented.

This section has three important omissions. First, it does not specify when public posting will occur after the precipitating event occurs. Posting should be timely. Second, it does not include public posting of progress reports. Third, it does not include the amount of the administrative penalty or applicable penalty adjustment factors.

The clarity of this section of the proposed regulations on public posting of performance improvement plans and any administrative penalty stands in welcome contrast to the lack of clarity and absence of transparency for the earlier stages of enforcement, from the notice that an entity exceeded the target, to technical assistance and even "public" written testimony.

Section 97456 Procedural Penalties for Impeding or Impairing Target Enforcement

Health Access supports the proposed regulations on procedural penalties for impeding or impairing enforcement of the target. We support the clarity provided by defining "repeatedly failing" as two or more failures to perform under the approved performance improvement plan and the clarity provided for "repeatedly fails to file" in (a) (1) and (a) (2). The standard of "knowingly" fails to provide information or "knowingly" falsifying information are established legal standards and ones that we hope will rarely be invoked.

Unfortunately, the section omits entirely any mention of public posting of procedural penalties or the entities subject to them. The Board and the public ought to know if such penalties are imposed and which entities were subject to them. This could readily be remedied by adding (f) on public posting of procedural penalties that includes a list of the entities and the relevant provisions such as "repeatedly fails to implement" a plan.

Section 97457 Penalty Justification Factors

Health Access supports this proposed section as consistent with the existing law.

Performance Improvement Plan Submission Guide

D. 6. Affordability for Consumers and Purchasers

Health Access supports the requirement that a performance improvement plan detail how each goal positively impacts affordability for consumers and other purchasers. Too often cost savings at the provider or payer level get lost in the black box of the health care system and only the bottom of the entity benefits, not the consumer or other purchaser.

D. 8. Balancing Measures

Health Access supports the use of OHCA's equity and quality measure set as balancing measures for equity and quality for respective health care entities. We also support the use of the workforce stability standards, while recognizing that further development of these standards may be helpful in the years to come.

Health Access recommends that the balancing measures be expanded to include the access measures used by both the Department of Managed Health Care such as time-and-distance standards, timely access, and network adequacy and also the Department of Health Care Services for network adequacy for Medi-Cal managed care. These access standards apply to the health plan but also to providers such as hospitals and primary care. Adding access measures would strengthen the provisions of the balancing measures.

D. 9 Sustainability

Health Access supports the requirement that the entity explain how achieving the goals of the plan will be sustained over time.

Comments on Spending Target Performance Measurement Manual

2 Payer Calculations

Health Access supports calculation of payers year over year growth. We note that the law requires that the fully integrated delivery system provide comparable information for payers, hospitals, and physician organizations.

3 Hospital: Year over Year Growth in Inpatient and Outpatient Unit Spending

Health Access supports the proposed measurement for inpatient and outpatient hospital unit spending, both adjusted for intensity of care, and combined into a single measure weighted by the ratio of services.

4 Physician Organization: Year over Year Growth in Attributed TME

Health Access opposes the proposed regulations with respect to physician organizations for the following reasons.

First, only a subset of physician organizations is captured and the more expensive parts of the physician organization universe are currently excluded. Included are the risk bearing organizations which serve 2.5 million, a subset of the HMO enrollment, plus the two Permanente medical groups plus some but not all of the University of California medical groups. This subset excludes medical groups that contract with PPOs as well as some that contract with HMOs. We know from research well-known to OHCA staff that PPOs are the more expensive part of the commercial market and less likely to prioritize HCP-LAN levels 3 and 4 and less likely to prioritize primary care.

This approach also excludes groups focused on specialty care. Health Access knows from our work on surprise medical bills here and nationally how high costs can be for these groups.

Second, the proposed approach “attributes” to those physician organizations costs for which they have no legal or financial responsibility. While the physicians in those organizations can take steps to reduce costs by prescribing generics and biosimilars and attempting to minimize avoidable hospitalizations and emergency room visits, unlike with hospitals that participate in the 340B program, the price of prescription drugs and hospitalizations is not within the control of the physician group. If the law permitted OHCA to look at health systems, as it should, this attribution method would make sense. But it does not. The law requires OHCA to look at the cost of the physician organization, not the costs inuring to a health system. This is further compounded by the lack of alignment of some physician organizations in California with health systems.

Third, while health plans and hospitals will be submitting their own data, using health plan attributed data for physician organizations seems to be creating lots of challenges and mismatches. One of the questions we have is whether it is possible to use financial data from the physician organizations, as the law envisions.

The law gives OHCA the authority to collect audited financials or the equivalent from physician organizations. It also gives OHCA the authority, and responsibility, to look at any physician organization with 25 or more doctors. Health Access has suggested a workgroup to work through data issues, just as was done for hospitals.

Thank you for your consideration of these comments,

Sincerely,





Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Executive Director

CC: Members of the Health Care Affordability Board
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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,
Senator Caroline Menjivar, Chair Senate Budget Subcommittee 3 on Health and Human Services, Attn.: Scott Ogus
Assemblymember Dawn Addis, Chair, Assembly Budget Subcommittee 1 on Health, attn.: Patrick Le
Josephine Figuroa, Deputy Commissioner, California Department of Insurance

November 12, 2026

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

Subject: **CHA Comments for the November 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) goals of creating 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 November 2026 board meeting.

On October 8, 2026, OHCA released its proposed regulations pertaining to the enforcement of the spending targets, along with additional technical guidance on spending measurement and performance improvement plans (PIPs). The proposed regulations and supplemental guidance represent a pivotal juncture in OHCA's work, as the rules and regulations established will guide the behavior of hundreds of providers and payers, drive changes in the availability and quality of care, and determine the breadth and scope of the office's enforcement responsibilities. CHA submitted detailed comments on the proposed regulations for the comment period that closed on Oct. 30, urging OHCA to make dozens of essential changes and to open a second public comment period prior to seeking Office of Administrative Law approval. That comment letter is attached.

CHA continues to urge that OHCA update the spending target to reflect current income trends and cost drivers, as well as clarify how resubmitted Annual Financial Disclosure Report (AFDR) filings are being evaluated both in the upcoming reassessment of the high-cost hospital designations and in measuring hospital performance against the target.

OHCA Must Change Its Enforcement Regulations to Meet its Mandate

Critical changes to the spending target enforcement regulations are needed if OHCA is to uphold its mandate to protect access to care, quality of care, and the stability of the health care workforce while promoting affordability. As currently drafted, OHCA's proposed regulations would force hospitals to eliminate service lines, curtail investments that enhance patient access and care, reduce their workforce,

and potentially even close entirely. To prevent massive disruptions in patients' access to care, OHCA must:

- Address the deficiencies in the hospital spending measurement methodology by statistically validating OHCA's intended approach and, to the extent year-over-year spending growth cannot be reliably measured, using multi-year performance measurement and statistical testing.
- Publish a spending measurement methodology hospitals can replicate, along with the full data behind it.
- Measure performance on an all-payer basis to account for growing shortfalls in government reimbursement for hospitals, including from the One Big Beautiful Bill Act, and reduce measurement error in determinations of compliance with the spending target.
- Measure hospitals against the spending target that corresponds to their performance year to account for the variance between calendar-year spending targets and fiscal-year hospital reporting.
- Establish the statutorily required waiver process to consider all uncontrollable and reasonable factors that explain spending growth above the target, in accordance with a standardized and transparent methodology.
- Ensure PIPs are tailored to improve spending performance, developed by the entities themselves, protected from outside pressure, and evaluated separately and distinctly from compliance with the spending target.
- Account for reasonable spending growth and hospital financial challenges in calculating the spending target penalties.
- Extend confidentiality protections through every step of the enforcement process.
- Analyze how the spending target penalties will affect access, quality, equity, and the health care workforce.
- Obtain further input from accountable health care entities before finalizing the rules, including through a second comment period before the start of the Office of Administrative Law process and by pursuing regular rulemaking.

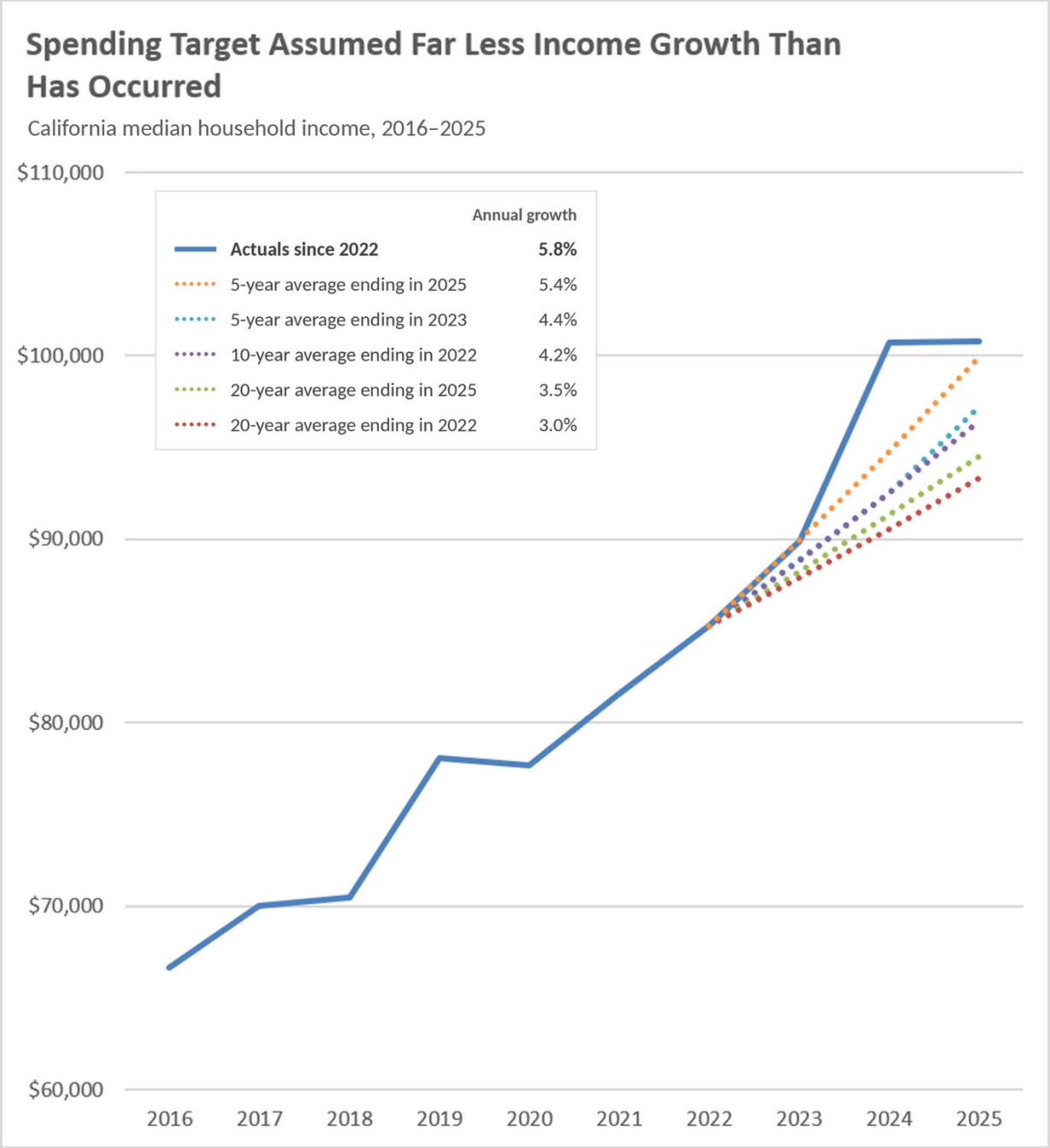
Spending Target Should Be Updated to Include the Most Recent Data and Incorporate Cost Drivers

The spending target was established based on a principle that health care spending should not grow faster than Californians' incomes. To operationalize this principle, OHCA set the target equal to the 20-year average of median household income growth through the most recent year available at the time of adoption (2022).

Since then, household income trends have sharply diverged from the 20-year historical average. In fact, as the following figure shows, median household income growth over the past three years has been nearly double the 20-year historical average. Accordingly, the spending target value does not conform to the principle OHCA posited during its adoption.

The figure further shows that the 20-year historical average diverges from actual trends to an inordinate degree compared to alternative approaches that implicitly place more weight on recent trends and ignore the Great Recession, the worst economic correction since the Great Depression.

OHCA can and should modify its spending target to account for current economic conditions. Furthermore, it should perform the review ordered by the Legislature under Health and Safety Code Section 127502(d)(4) and incorporate all predictable and broad-based trends as express adjustments to the spending target, including for elevated inflation, labor costs, health care technology prices, payer mix, and federal and state policies and mandates.



OHCA Must Share How Resubmitted AFDR Data Is Used for the High-Cost List and Assessment Against the Spending Target

At its November 2026 meeting, the board will revisit the high-cost hospital designation methodology. OHCA is expected to compare the list as currently designated with a version that incorporates hospitals' resubmitted AFDR filings (OHCA's primary data source for measuring hospital spending), as the board previously urged the office to do. Since long before OHCA was established, hospitals have routinely refiled their AFDR data to correct errors and incorporate updates. The high-cost hospital designations, and the associated reduced spending target, compelled hospitals to reevaluate their data for accuracy. Many hospitals discovered errors, such as attribution to the wrong payer categories. These errors were apparent at the time OHCA adopted the high-cost list. For example, the originally constituted list of 11 hospitals had data that jumped around enormously from year to year without explanation, clearly pointing to data anomalies rather than changes in the hospitals' underlying financials. While certain hospitals with data issues were removed from the final list of seven hospitals, not all data issues were addressed. OHCA must take an honest look at its approach for identifying high-cost hospitals and the data it is using to make decisions upon which hospitals' futures depend — before its decisions upend Californians' health care.

Questions for High-Cost Hospital Reassessment: To make this a fair and transparent process for hospitals, OHCA must answer the following questions before the list is finalized:

- What criteria did OHCA use to decide whether a resubmitted AFDR filing would be incorporated into the reassessment?
- Did OHCA set a deadline after which refiled reports were not accepted? If so, what was the date, and how was it communicated to hospitals?
- For which reporting years were resubmissions accepted for the reassessment?
- Did OHCA accept all filings accepted by HCAI's AFDR team? What, if any, alternative criteria were applied?

Questions for Spending Target Compliance Measurement: Answers to the above questions are important not only for the high-cost hospital designations, but also for measurement purposes related to the spending target. OHCA assesses hospital spending using the complete AFDR file, which is released with a delay, so hospitals' resubmissions for a given year may often be filed before that assessment takes place. Those resubmissions should be incorporated. OHCA should clarify:

- Which resubmitted filings will OHCA accept when assessing hospital performance against the spending target?
- What deadline will apply for resubmitted filings to be incorporated into that assessment, and how will it be communicated to hospitals in advance?

Hospitals ask OHCA to publish its answers to these questions, along with the hospital-level data underlying both versions of the list, so that each hospital can understand and comply with OHCA's rules.

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

California Hospital Association

October 30, 2026

Director Landsberg
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 Emergency Regulation Text: Health Care Spending Targets — Progressive Enforcement (draft dated Oct. 8, 2026)

California's hospitals share the Office of Health Care Affordability's (OHCA's) goal to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of nearly 400 hospitals, the California Hospital Association (CHA) appreciates the opportunity to comment on OHCA's proposed regulations,[1] dated Oct. 8, 2026, pertaining to the enforcement of the spending targets, alongside the draft Performance Improvement Plan Submission Guide (Guide) and Spending Target Performance Measurement Manual (Manual), also dated Oct. 8, 2026.

Hospitals are deeply concerned with the proposed regulations and supplemental guidance, which:

- Adopt an approach for measuring hospital spending that is unvalidated and unreliable
- Fall far short of establishing a transparent and standardized enforcement process
- Risk penalizing hospitals for spending beyond their control
- Stray from legislative directives and intent

Major changes are needed if OHCA is to uphold its mandate to protect access to care, quality of care, and the stability of the health care workforce. Given the extent of the changes proposed, hospitals also urge OHCA to open a second public comment period prior to seeking Office of Administrative Law approval. Hospitals' most critical recommendations include, but are not limited to:

[1] Office of Health Care Affordability, *Proposed Emergency Regulation Text: Health Care Spending Targets — Progressive Enforcement*, Cal. Code Regs., tit. 22, §§ 97445–97459 (draft dated Oct. 8, 2026).

- **Address the obvious deficiencies in the hospital spending measurement methodology prior to the initiation of any enforcement action.** This must include statistical validation of OHCA's intended approach and, to the extent year-over-year spending growth cannot be reliably measured, the use of multi-year performance measurement and statistical testing.

- **Measure performance on an all-payer basis.** Growing shortfalls in government reimbursement for hospitals, including imminent cuts from the state and federal governments, will make it impossible for many hospitals to meet the spending target for their commercial payers while also sustaining their service lines, workforces, and long-term financial health. Measurement by payer further multiplies the effects of measurement error on OHCA's determinations of compliance with the spending target, and will cause the vast majority of health care entities to miss the spending target each and every year.

- **Measure hospitals against the spending target that corresponds to their performance year.** By law, spending targets must be set for calendar years — but hospitals are measured against the targets based on their individual reporting years, which vary. OHCA must measure hospital compliance with a spending target that is no less than the weighted average spending target applicable to a hospital's reporting period.

- **Consider uncontrollable and other reasonable factors to explain spending growth above the target, in accordance with a standardized and transparent methodology.** The list of factors enumerated by OHCA must be expanded, for example, to include non-organized labor costs, macroeconomic trends, provider financial distress, and measured revenue volatility. OHCA's examination of these factors must include written determinations and a quantitative assessment of whether explainable growth led the entity to exceed the target. This should all be done in accordance with the waiver process established in law.

- **Performance improvement plans (PIPs) must be entity-proposed action steps, not goals, that are tailored to improve spending performance.** PIP development must not be vulnerable to outside pressure. Assessment of PIP performance must be separate and distinct from compliance with the spending target.

- **Guarantee adjustments to penalties to account for reasonable spending growth and hospital financial challenges.** The proposal would allow hospitals to be fined for spending growth OHCA has already determined to be reasonable at levels that could bankrupt the hospital. Correcting and validating the hospital spending measurement methodology is essential before it is used to calculate penalty amounts.

- **Extend confidentiality protections to every step of the enforcement process.** Confidentiality protections are limited to PIP submission and monitoring; they should apply to every stage of enforcement, including for the purpose of explaining excess

spending growth. PIP proposals must remain confidential to protect the deliberative process and prevent undue politicization of the enforcement process.

Further requested changes and rationales for each change are provided below. The letter is organized as follows:

Section I. OHCA Must Correct, Clarify, and Validate its Hospital Spending Measure Before Using it in Enforcement

Section II. Preliminary Spending Target Compliance and Reasonableness Determinations Must Be Standardized, Transparent, and Correctable

Section III. Enforcement Must Be Progressive, as the Statute Requires

Section IV. Performance Improvement Plan Proposals Must Constitute Entity-Directed Actions to Improve Spending Performance that Preserve Access and Quality

Section V. Penalties Must Be Clearly Defined, Proportionate, and Limited to What the Statute Allows

Section VI. Confidentiality Protections Must Be Substantially Broadened

Section VII. Information Provided to OHCA Should Be Attested Based on Knowledge, Information, and Belief

Section VIII. Technical changes

I. OHCA Must Correct, Clarify, and Validate its Hospital Spending Measure Before Using it in Enforcement

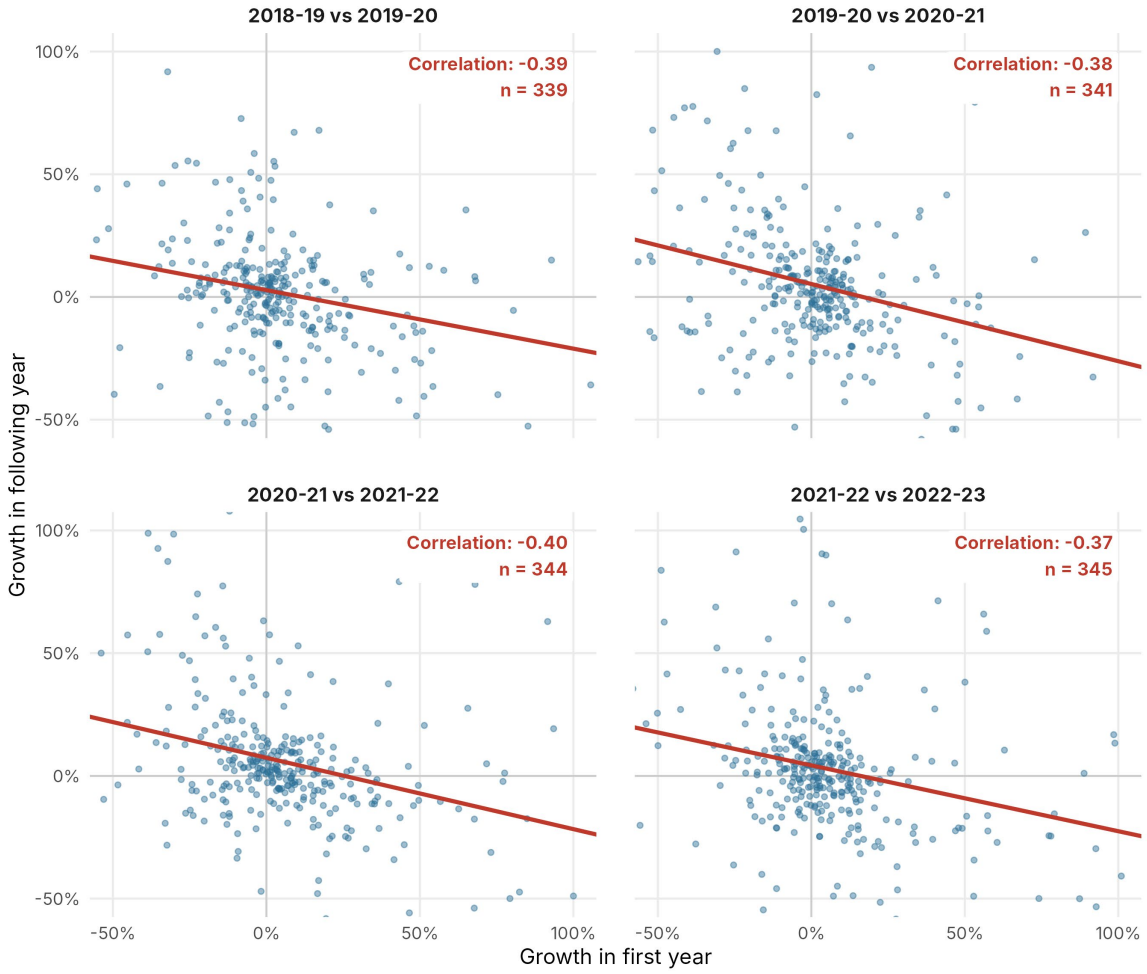
Under the proposed regulations, a hospital violates its spending target when its "year-over-year combined payer-specific spending growth… exceeds the applicable spending target," as calculated under the Spending Target Performance Measurement Manual (Manual).[2] Every subsequent step — notice, PIP, and penalty — rests on that growth calculation. Unlike the payer and physician organization spending measurement approaches, OHCA's hospital spending methodology is novel; it has no precedent in other state spending target programs, and its accuracy and reliability remain unvalidated. Moreover, OHCA's intent to measure spending growth by payer category (i.e., commercial, Medi-Cal, and Medicare) creates triple jeopardy for hospitals, ignores imminent cuts, and contravenes state law by establishing de facto sector targets without following the mandated process, including approval from the OHCA board. In sum, significant further work must be done to validate the hospital spending methodology, address all identified deficiencies, and meet the Act's procedural requirements before OHCA moves forward with enforcement. These prerequisite steps should be clearly reflected in the spending target enforcement regulations before finalization.

[2] See proposed § 97452(a)(3).

Volatility in Measured Spending Remains a Major Concern, Necessitating Data Validation and Other Corrective Measures

Under the regulations, OHCA would measure growth from a single base year to a single performance year (Manual Section 3, t−1 to t). As the following figure shows, a single year of hospital growth does not convey a persistent trend and is too noisy to support enforcement.

High Hospital Spending Growth One Year Reverses in the Next, Raising Major Data Reliability Questions



Notes:
Commercial inpatient NPR per CMAD, comparable hospitals, 2018-2023. Each point is a hospital.
Red line = line of best fit for hospitals with growth between -50% and +100% in both years.
Correlation uses all hospitals and reflects the Spearman-rank correlation, which measures how consistently hospitals' growth rankings carry from one year to the next (−1 = rankings fully reversed, 0 = no relationship, +1 = identical rankings) and thereby is not susceptible to outliers.
NPR = net patient revenue; CMAD = case-mix adjusted discharge; Growth = the year-over-year percent change.

CHA analyzed commercial inpatient NPR per CMAD for comparable hospitals from 2018 to 2023. The typical hospital's own growth rate varied from year to year with a standard deviation of 20.7 percentage points. A hospital's growth in one year is negatively correlated with its growth in the next (Spearman correlation of negative 0.37 to negative 0.4 for each pair of

consecutive years). A one-time spike or dip in reported revenue raises one year's growth and lowers the next. This is the signature of measurement noise, not persistent pricing behavior. OHCA's own examples point to the same conclusion: Commercial combined growth ranges from **negative** 78% to **positive** 540%. OHCA attributed these swings to prior-year contractual adjustment true-ups, changes in consultants or methods, inpatient/outpatient allocation errors, and low payer volumes. Minimum volume thresholds help with small volumes, but OHCA's own volatile examples involved hospitals with thousands of discharges or visits.

Request: OHCA must adopt the following safeguards as formal requirements for assessing hospital spending growth within the enforcement considerations process:

1. **Multi-year performance measurement.**[3] For example, measure average annual growth over multiple performance years, compared with the average target for the performance period. If OHCA concludes that a violation must be determined on a single year, the regulation should, at minimum, clearly state that OHCA may not proceed beyond technical assistance when a hospital's multiyear growth is at or below the target.
2. **A statistical threshold.** Hospital Annual Financial Disclosure Report (AFDR) revenue is a full count, not a sample, so the relevant uncertainty is reporting noise, which can be measured from each hospital's own history. OHCA should find a hospital to have exceeded the target only when its excess growth is larger than its normal year-to-year variation — for example, when the lower bound of a 95% interval, based on the hospital's or its peer group's historical variability, lies above the target. Variance in the intensity adjustment in the outpatient setting can be estimated directly by resampling the Health Care Payments Database (HPD) patient-visits as described in another section of this letter.
3. **Minimum inpatient discharges and visit volumes** set on statistical reliability and applied to enforcement, not only reporting. Because HPD coverage of outpatient visits by hospital is so poor, for outpatient spending methodology purposes, there must be minimum coverage thresholds specifically for the percentage of AFDR-reported visits for which there is a corresponding ambulatory payment classification (APC) within the HPD-derived data.
4. **A published validation report.** An enforcement decision that could result in a financial penalty in the hundreds of millions of dollars must meet a high threshold for reliability. Before proceeding with enforcement against hospitals,[4] OHCA must demonstrate that its hospital spending methodology does exactly this. The Centers for Medicare & Medicaid Services' (CMS) measure development guidance calls for reliability testing of this kind. It lists accepted methods, including the intraclass correlation coefficient (ICC) applied to data from adjacent time periods, which will show whether differences in measured

[3] By incorporating these safeguards as procedural enforcement considerations, OHCA would still assess compliance with the spending target on an annual basis but only progress an entity beyond technical assistance once the relevant safeguard has been met.

[4] Including by issuing a preliminary determination pursuant to proposed § 97452(b) or reporting any individual hospital's spending performance pursuant to proposed § 97452(e).

growth reflect true differences between hospitals rather than year-to-year fluctuations.[5] According to RAND Corporation, a reliability score of 0.9 on the ICC is the conventional threshold for conclusions about individual entities, and 0.7 to 0.8 for groups.[6] OHCA's reliability tests and findings must be published in a report, subject to public comment, and also include additional contextual data for each year on, for example, how many hospitals would have been flagged, how many were flagged in consecutive years, and how results differ between single-year and consecutively longer multi-year measurement. The report should also include outpatient representativeness tests (described in the next section) and recommended minimum discharge and visit volume thresholds. OHCA could use data from prior years (e.g., 2018 to 2024) to perform these analyses and publish the results.

Specific Shortcomings in the Outpatient Methodology Must Be Addressed Before It Is Used to Assess Compliance

OHCA measures outpatient unit spending as outpatient NPR divided by intensity-adjusted visits (Manual § 3.2). Including an intensity adjustment makes sense, but it must work in practice.

The Intensity Adjustment Rests on a Small and Potentially Unrepresentative Sample of Visits

While visit counts come from the AFDR, the intensity adjustment — Average Visit Intensity (AVI) — comes from a separate source: the sum of Ambulatory Payment Classification (APC) weights as reported in HPD claims, divided by the number of HPD visits that carry an APC weight (Manual § 3.4; Methodology Steps 5–12). The methodology assumes HPD visits are representative of all the hospital's outpatient visits. That assumption has not been tested, and there are strong reasons to doubt it.

OHCA identifies only about 20% of the commercial outpatient visits reported in the AFDR in the HPD. The gap is largely structural:

- Self-funded employer plans submit data only voluntarily and are largely unrepresented in the HPD. The AFDR counts all of these patients, as well as their patient care revenues.
- The AFDR counts encounters in hospital outpatient cost centers. HPD visits are built from facility claims billed under the hospital's NPI, so encounters billed under another NPI that is not mapped by OHCA do not appear.

If the 20% of visits OHCA can see differ in intensity from the 80% it cannot, AVI — and the growth in AVI — will reflect the makeup of the sample rather than the hospital's actual services. In practice, missing a single million-dollar drug infusion will bias OHCA's intensity measure and could trigger enforcement action — simply because OHCA was missing data.

[5] Centers for Medicare & Medicaid Services, Measures Management System Hub, *Reliability* (updated July 2025), https://mmshub.cms.gov/measure-lifecycle/measure-testing/evaluation-criteria/scientific-acceptability/reliability (as of Oct. 30, 2026).
[6] J.L. Adams, *The Reliability of Provider Profiling: A Tutorial*, RAND Corporation, TR-653-NCQA (2009), p. 8.

Services and Visits Without APC Weights Are Not Addressed
Many outpatient services have no separately payable APC, including laboratory tests paid under the clinical fee schedule, therapy services, packaged items, and some drugs. A visit with no APC-weighted claim line drops out of the AVI calculation entirely (Methodology Steps 8–10). The methodology's imputation (Methodology Steps 6d–6f) fills in missing weights only for services that already have an APC, so it does not restore these visits. Yet AVI is applied to all AFDR visits, which assumes the excluded visits are as intensive as those that remain. The regulations also do not say how a hospital with no AVI for a payer will be measured against the target for its outpatient spending or combined inpatient and outpatient spending measures.

Hospitals Cannot Replicate the Calculation
CHA replicated Steps 1 through 10 of the published Methodology in the HPD enclave and found it cannot be followed as written. It omits the 2021 CMS Addendum A file that the calculation requires and the standard HPD claim filters for primary, non-denied, non-orphaned claims. As written, its calendar-year crosswalk join in Step 5d drops claims from the first part of the reporting period for fiscal-year hospitals. Step 8d is also ambiguous about which claim lines' weights are summed. Most fundamentally, hospitals cannot access Medicare fee-for-service HPD data, so no hospital can verify the Medicare outpatient measure, even if it were able to successfully go through the process of requesting access to the HPD data. Yet proposed § 97452(b)(5) requires a hospital disputing OHCA's figure to submit its own calculation "in accordance with" the Manual.

Request: OHCA must take four steps before using the outpatient measure for enforcement:

1. **Test whether HPD visits are representative, hospital by hospital and payer by payer, and publish the results.** First, report coverage: the outpatient visits with APC weights that OHCA uses to calculate AVI, as a share of AFDR outpatient visits, and establish a minimum reliability threshold. Second, test consistency, limited to managed care: compare annual growth in gross outpatient revenue per visit calculated from the HPD with growth in gross outpatient revenue calculated from the AFDR managed care columns, for the same hospital, payer, and period. The HPD figure is total charges on visits with APC weights, divided by those visits. If the two growth rates differ by more than a reasonable tolerance, the visits used for AVI do not represent the hospital's outpatient services, and the HPD AVI should not be used for that hospital and payer. Gross revenue is used because NPR is not available in the HPD, and because it removes accounting adjustments that have no bearing on AVI. Third, report a confidence interval for each AVI, estimated by resampling the hospital's HPD patient visits and certify reliability based on the variance between the samples.
2. **Specify the treatment of unweighted services, and of hospitals and payers that fail the tests or have no AVI.** In those cases, the outpatient component, and thus the combined measures, should not be used to find a violation.
3. **Correct the published methodology and incorporate it by reference**.

4. **Share the data with hospitals.** Before any notice, OHCA should give each hospital its HPD visit counts, APC weight sums, and the counts retained at each step of the calculation.

These tests use data OHCA already holds. They answer directly whether the visits OHCA can see stand in for the visits it cannot, and they give hospitals the inputs they need to check OHCA's work and be confident in its results.

Combining Inpatient and Outpatient Spending Has Significant Benefits

Manual § 3.3 combines inpatient and outpatient growth into a single measure. CHA supports the combined measure (conditional upon comprehensive validation), which improves — but by no means solves — both measurement reliability problems and enforcement burdens. Moreover, combining the service lines also partly offsets a deficiency in OHCA's data source. For managed care, hospitals do not report inpatient and outpatient net patient revenue (NPR) separately. HCAI estimates inpatient NPR using a gross revenue ratio and treats outpatient NPR as the remainder (Hospital Measurement Methodology, Steps 4a and 12b). As a result, without combining the measures, OHCA would hold hospitals accountable for performance on service line spending for which it does not have actual NPR data.

Only Hospitals That Miss the Target on an All-Payer Basis Should Be Deemed in Violation

Under proposed § 97452(a)(3), a hospital fails to comply when its combined growth, "calculated by market," exceeds the target. As drafted, a hospital whose growth exceeds the target in any one market would be in violation, even if low growth in its other markets cause it to come in well below the target on an all-payer basis.

The Legislature did not authorize OHCA to measure compliance with a hospital-wide spending target market by market. Instead, statute clearly commands spending growth to be assessed at an aggregate level as the target applies to per capita **total** health care expenditures,[7] which in turn is defined as "**all** health care spending in the state by public and private sources...."[8] (**Emphases** added.) Outside of establishing specific market-based sectors or subsectors, which have not been adopted nor proposed, OHCA simply lacks the statutory authority to measure and enforce multiple payer-specific targets on a single entity.

Measuring by market also multiplies the effect of noise. Each hospital would have three opportunities annually to be penalized, and OHCA's own data comparing 2022 to 2023 show about half of hospitals above 3.5% in each market: 157 of 334 for commercial, 154 of 339 for Medicare, and 164 of 334 for Medi-Cal. Absent an implausible drop in the volatility of the reported data, over 80% of hospitals will be caught in OHCA's enforcement process every single year.

The per-market approach also holds hospitals responsible for prices they do not set. CMS sets Medicare fee-for-service rates and DHCS sets Medi-Cal fee-for-service rates. Medicare

[7] See HSC § 127500.2(j).
[8] See HSC § 127500.2(v).

Advantage and Medi-Cal managed care rates are commonly benchmarked to those fee-for-service rates. In addition, a sizable volume of Medi-Cal managed care revenue is received via state-directed payments where hospitals similarly do not have any control over how DHCS distributes fixed funding pools nor where it sets the controlling minimum rate or uniform dollar increase. Enforcing against growth in administratively set rates would penalize hospitals for decisions made by other government agencies that are wholly outside of hospitals' control. This not only violates the plain language of OHCA's authorizing statute,[9] but also raises significant preemption concerns around obstructing the ongoing administration of both the Medicare and Medicaid programs, most notably with respect to maintaining access to care through adequate hospital reimbursement. This potential interference with the purposes of these federal programs under the Supremacy Clause (U.S. Const. art. VI, cl. 2) is likely most severe for self-financed Medi-Cal payments under either delivery system, where both the growth and the nonfederal share funding obligation (up to 50% of the total payment depending on the population) are outside of the hospital's prerogative.

Request: OHCA must find a violation only when a hospital's all-payer growth exceeds the target. All-payer growth should be calculated based on all net patient revenue and intensity-adjusted utilization and be inclusive of uncompensated care (by including the AFDR payer categories other than commercial, Medi-Cal, and Medicare, such as self-pay). Under this approach, growth below the target in one market automatically offsets growth above it in another, and the penalty follows the same netting. OHCA must further account for spending growth attributable to decisions from other government programs. These changes would align the measure with the entity-level target, reduce false flags, and limit enforcement to spending growth hospitals actually control.

Incorporate the Hospital Spending Measurement Methodology by Reference

The Manual provides high-level guidance on how hospital spending would be assessed against the spending targets and how hospitals' penalties would be calculated. However, it lacks significant methodological detail, making it impossible for hospitals to recreate and validate their spending growth values based on the Manual or any other regulatory guidance. For example, hospitals cannot even tell from the Manual which AFDR revenue categories make up each market. The detailed steps for calculating hospital measures appear only in OHCA's separate methodology document, *Methodology to calculate inpatient net patient revenue per case mix adjusted discharges and outpatient net patient revenue per intensity adjusted outpatient visits by payer* (April 17, 2026) (Methodology).[10] That document is posted on OHCA's website but is **not** incorporated by reference. (Even the Methodology fails to properly identify the AFDR page, column, and line that defines the Complete Data Set field, behind each calculation, creating unnecessary ambiguity.)

Request: OHCA must incorporate the Methodology by reference in the regulations, with all appropriate changes to the Methodology so that hospitals can trace the details of these

[9] See, e.g., HSC § 127502.5(a).

[10] See https://hcai.ca.gov/wp-content/uploads/2026/05/Hospital-Measurement-Methodology-April-2026.pdf.

calculations back to how they submit AFDR data to HCAI. Without incorporation, OHCA could fundamentally modify how hospital performance is measured against the spending targets without going through notice and comment. Given the Methodology is undoubtedly a standard of general application requiring adoption consistent with the California Administrative Procedure Act[11] and necessarily intertwined with spending target measurement and enforcement, failing to incorporate it by reference would amount to an unenforceable underground regulation.

Intensity Adjustments Must Be Appropriate for All Patient Populations

OHCA adjusts inpatient spending using a case mix index (CMI) built from Medicare Severity Diagnosis Related Group (MS-DRG) weights, and outpatient spending using Average Visit Intensity (AVI) built from Medicare Ambulatory Payment Classification (APC) weights (Manual § 3.4; Methodology Step 3 and 6).

Both weighting systems are calibrated on the Medicare population. They are not designed for pediatric, obstetric, newborn, and other patients Medicare rarely covers — but who make up much of the commercial and Medi-Cal markets OHCA measures. For hospitals that serve many of these patients, CMI and AVI may understate the resources their patients need, artificially inflating NPR per case mix-adjusted discharge and per intensity-adjusted visit. The Manual is also silent on how OHCA will handle changes in coding, such as MS-DRG version transitions.

Request: OHCA should allow all-payer groupers such as All Patient Refined DRGs (APR-DRGs) for inpatient services and Enhanced Ambulatory Patient Groups (EAPGs) for outpatient services, or another adjustment, as a demonstration that OHCA's spending growth calculations are in error following a notice of preliminary determination. Doing so would keep the intensity adjustment from biasing determinations of compliance with the spending target.

OHCA Must Properly Account for Hospital Contributions to the Nonfederal Share of Medi-Cal Expenditures When Measuring Spending Performance

In the face of declining state fiscal support for hospital reimbursement that already fell well short of covering the cost of care, the Medi-Cal program has become increasingly reliant on "self-financed" payments to meet its foundational legal obligations to maintain adequate access for enrollees. The exact mechanism of self-financing depends on the hospital's ownership type: private hospitals contribute to the nonfederal share of supplemental payments in assessed provider taxes under the Hospital Quality Assurance Fee program, while designated public and district hospitals do so through intergovernmental transfers (IGTs) and/or certified public expenditures supporting a variety of base and supplemental payments. But the end result is the same under either category whereby a hospital makes payment to the state, or incurs expenditures, which are used to claim federal Medicaid funds. Because hospitals incur these expenses, representing up to 50% of the resultant total payment, their net reimbursement equals only the federal funding.

[11] See Gov. Code § 11342.600.

Despite this, HCAI reporting of hospital revenues includes both the federal and self-financed shares and thus overstates the actual reimbursement hospitals receive. In 2024, nearly half (48%) of total Medi-Cal managed care reimbursement for hospitals was self-financed, resulting in an overstatement in the AFDRs of total statewide Medi-Cal managed care revenue by 20%. Between 2022 and 2024, self-financed hospital reimbursement grew by more than $5 billion, while state-financed reimbursement grew by less than $1 billion. As a result, while payments in Medi-Cal managed care appear to have grown by 2.5% annually over this period, in truth, they grew by just 0.4% — far below the cost of caring for these populations. And this impact becomes even more pronounced when accounting for self-financing of multiple fee-for-service payment streams for both public and private hospitals.

Request: OHCA must explicitly address this dynamic in the immediate rulemaking by excluding any and all self-financed amounts from Medi-Cal revenue as measured against the spending targets. Failing to offset self-financed expenditures will substantially overstate actual Medi-Cal reimbursement received and potentially trigger adverse enforcement consequences for costs completely outside hospitals' control. Continuing to ignore this reality not only conflicts with the mandatory consideration of factors contributing to excess spending beyond the entity's purview under HSC § 127502.5(a), but it also runs afoul of the specific command on OHCA to account for hospitals' provision of nonfederal share associated with Medi-Cal payments.[12] In addition, OHCA should also ensure hospitals are credited for any provision of nonfederal share used to financially support the Medi-Cal program outside of direct patient care reimbursement, such as Hospital Quality Assurance Fee or IGT proceeds used to fund DHCS administration.

II. Preliminary Spending Target Compliance and Reasonableness Determinations Must Be Standardized, Transparent, and Correctable

The notice of preliminary determination under proposed § 97452(b) is a hospital's first and, under the proposed regulations, only opportunity to check OHCA's calculation before it becomes final and public. As drafted, the notice gives hospitals a result without the inputs, sets an unreachable standard for correcting errors, and leaves open what happens when a hospital shows its growth was justified. Ultimately, this process fails to provide assurance that hospitals will not be penalized for factors beyond their control.

Hospitals Must Be Measured Against a Target That Matches Their Reporting Year
Statute defines the spending target as the target percentage for the maximum annual increase in per capita total health care expenditures and further requires it to be set for each calendar year.[13] However, OHCA measures hospitals on their AFDR reporting year, assigning each report to the calendar year in which its reporting period ends (Methodology Step 1d). About 40% of comparable hospitals in the AFDR report on a July–June fiscal year, and others begin in September, October, or other months. A fiscal year ending June 2027 is half 2026 and half 2027. This means that, without correction, there is a mismatch between the period in which a

[12] See HSC § 127502(d)(5).
[13] See HSC § 127500.2(j), HSC § 127502(c)(3) and (l).

spending target applies and, for hospitals that do not report on a calendar-year basis, hospital spending that will be measured against that target. For example, hospitals on a July 1 reporting basis would already, for the entire second half of calendar year 2026, be measured against the reduced 2027 3.2% spending target despite that reduced target not taking effect, per the board's action, until January 1, 2027. This is not only inequitable, but contrary to the law and associated board action.

Request: When determining compliance for hospitals that report on a non-calendar fiscal year, OHCA should apply the higher of 1) the calendar-year target that would otherwise apply to that fiscal year and 2) the average of the calendar year spending targets weighted by the number of months of the fiscal year that fall in each calendar year: For example, hospital with a fiscal year running from July 1, 2026 through June 30, 2027, would face a blended target of (3.5% x 6+ 3.2% x 6) / 12 = 3.35%, rather than the 3.2% target for 2027. No hospital should face a lower target because of when its fiscal year begins.

The Notice Must Include the Underlying Data and Calculations

Under proposed § 97452(b)(2), the notice includes only the hospital's name and address, the applicable target, its growth, the amount by which it exceeded the target, and the 45-day response deadline.

A hospital cannot check that result without its inputs. Several of these inputs are calculated by OHCA from data hospitals cannot see or reproduce from the Manual as drafted: CMI by payer from patient-level discharge data, data from the HPD including visit counts found in the HPD, AVI, and Medicare fee-for-service data within the HPD which is available only to state agencies. Yet proposed § 97452(b)(5) requires a hospital that disputes OHCA's figure to submit its own calculation "in accordance with" the Manual within 45 days.

Request: In addition to the information that already would be provided, the regulations should specify that preliminary determination notices to hospitals must include, for each payer, year, and care setting as appropriate: NPR and how it was estimated; discharges, and CMI; AFDR visits, HPD visit counts (including with and without an associated APC), APC weight sums, and AVI. OHCA may also consider sharing these figures with every hospital prior to formal noticing. Such information is essential for hospitals to have a meaningful opportunity to examine errors against their own more detailed data rather than try to rebuild OHCA's calculation from data it cannot access. Finally, within the regulations, OHCA should expressly authorize hospitals to substitute the HPD-derived outpatient intensity adjustment with one derived from hospitals' complete data, including, but not limited to, Enhanced Ambulatory Patient Groups (EAPGs).

Replace the "Clear and Convincing" Standard with a Preponderance Standard

Under proposed § 97452(c), OHCA may modify its preliminary determination only if the hospital shows "by clear and convincing evidence" that OHCA's calculation is incorrect.

Subjecting entities to this unnecessarily heightened burden has no credible basis in OHCA statute and raises foundational fairness questions, particularly given the stakes involved in triggering the time and expense of performance improvement, let alone the exposure to severe penalties down the line (not to mention the relatively high volatility routinely acknowledged for

the underlying data set and the uneven playing field this would bring to regulated entities in comparison to what OHCA is subject to). This places the highest civil standard of proof on the party with the least access to the operative data and the most to lose in terms of consequences stemming from an uncorrected error. OHCA holds the derived inputs and the analytical code; hospitals hold neither. The standard is also inconsistent with proposed § 97459(c), which applies a preponderance standard in penalty appeals, as well as the standard that would predominantly apply in civil litigation challenging OHCA enforcement actions. And because OHCA "may" modify its figure, it need not correct even a demonstrated error that, for a host of legitimate reasons including the relative lack of time, may not rise to the level of meeting this heightened standard.

Request: OHCA should instead adopt a preponderance of evidence standard and for the regulatory text to explicitly require ("shall") correction of any error a health care entity demonstrates as having met that standard, including errors resolved through an amended AFDR filing. A calculation that will drive public reporting, initiation of progressive enforcement, and, ultimately, multi-million-dollar penalties should be one OHCA can support — not one hospitals must disprove to an elevated standard.

Allow Additional Extensions for Good Cause, with a Deadline for OHCA to Decide

Proposed § 97452(b)(3)(A) allows a single extension of up to 15 days, requested at least 14 days before the response is due. OHCA has "sole discretion" to grant or deny the request and no deadline to decide.

A complete response may require the reconstruction of calculations from several highly complex datasets, forensic accounting of recent revenue and cost drivers, and extensive engagement with the office. More time will be needed for many entities. In addition, requiring a request two weeks early, with no decision deadline for the office, leaves a hospital unsure whether it has 31 days or 60 for a final response. The rule also differs from the PIP Submission Guide, which allows requests up to five days before the deadline (Section C).

Request: OHCA should allow additional extensions for good cause, accept requests up to the response deadline, and decide within five business days, with the request deemed granted if OHCA does not respond. This gives hospitals the time required to develop a data-based response, as well as certainty as to when it is due.

Publication Must Not Imply Wrongdoing

Under proposed § 97452(e), after the 45-day response period OHCA notifies the hospital of its final determination of excess spending growth and the enforcement action, if any, and publishes the hospital's excess spending growth on HCAI's website. Proposed § 97455(j) separately requires posting lists of hospitals required to implement a PIP or assessed a penalty.

Because publication follows the hospital's response, OHCA will already have decided whether the growth was justified. Moreover, given the volatility described in Section I, many posted figures will reflect measurement noise, not a true signal of hospital pricing trends. Yet the regulation requires posting the "excess spending growth" either way, with no statement of

OHCA's conclusion and no hospital response. The posting will be read as a finding of wrongdoing even when OHCA has made no such finding.

Request: OHCA must:

- State in each posting whether OHCA found the growth justified in whole or in part, show the growth that remains after justified factors are removed (see CHA's recommended approach starting on page 15), and state that publication is not a finding that the hospital's growth was unreasonable.
- Post the hospital's response, or a summary it approves, alongside OHCA's figure.

These steps keep the public record accurate and make clear that a hospital listed above the target has not, on that basis alone, been found to have unjustifiably failed to comply with the spending target.

Notices Must Reach Hospital Leadership

Under proposed § 97452(b)(1), the notice goes to the email address used to register in the Total Health Care Expenditures (THCE) Data Portal or to the hospital's SIERA primary contact. Hospitals designate the SIERA contact for financial data reporting, not to receive notices that trigger enforcement.

Request: A notice that starts a 45-day clock must go to the people responsible for responding. OHCA must send notices to the hospital's CEO and CFO, with a copy to the SIERA contact. This ensures the right people receive the notice in time to respond and guide their organizations through OHCA's complex enforcement process.

The Statutory Considerations Are Mandatory, Not Optional

In determining whether an entity is subject to the progressive enforcement process, OHCA will refer to a list of enforcement considerations to assess whether an entity's excess growth is justifiable. OHCA's draft regulations note that the Director "may" consider entities' explanation of their growth based on the enforcement considerations, in its decision on which entities progress to the enforcement process (see proposed §97452(d)). However, this runs counter to statute, whereby the Director must consider "factors that contribute to the spending in excess of the applicable target, and the extent to which each entity has control over the applicable components of its cost target" (HSC § 127502.5(a)). Consideration of these factors is not optional.

Request: OHCA's draft regulations must be consistent with statute in applying the consideration of uncontrollable spending growth and other factors, such as investments in preventive care, as a mandatory step.

Additional Enforcement Considerations Must be Specified

OHCA's proposed list of enforcement considerations contains a number of essential factors to assess enforcement on entities. However, OHCA's list must be expanded to account for other critical investments and factors outside of an entity's control; without this, hospitals will be penalized regardless of their good-faith efforts to comply with the target, which could force

them to make changes that will not only curtail their ability to sustainably operate in their communities, but also negatively impact patients' access to care.

Request: OHCA must enumerate additional factors that drive hospital spending growth for reasons outside hospital control (e.g., payer-mix shifts, Medi-Cal/Medicare rate and policy changes), as well as factors that increase patient access and care (e.g., investments in specialty care), detailed in the table below, in its regulations.

OHCA's Proposed Set of Enforcement Considerations Is Missing Several Critical Factors	
Proposed Factors for Enforcement Considerations	*Factors that Should Be Added*
Population characteristics	Macroeconomic trends, including as applicable on a regional basis
High-cost patient outliers	All labor costs
High-cost drugs	Payer mix
Entity baseline costs	Investments in specialty care
Historical spending growth	Provider financial distress
Impact on consumer access and affordability	Changes in service offerings
Investments in primary and preventative care	Payment settlements and other factors driving revenue volatility
Changes in state and federal law	
Acts of God or catastrophic events	
Amount of entity's excess spending growth	
Entity's actions that impair/impede enforcement of target	
Impact of non-supervisory organized labor costs	
Any other information deemed relevant to entity spending growth	

OHCA Must Consider Non-Organized Labor Costs

At OHCA's Patient and Consumer Forum on Health Care Affordability on October 6, 2026, OHCA presented all nonsupervisory labor costs, not only nonsupervisory organized labor costs, among the factors it would consider in explaining excess spending growth.[14] The proposed regulations, potentially inadvertently, list only organized labor costs. If finalized, this fundamental inequity would mean non-organized workers would shoulder the burden of meeting OHCA's spending limits, while organized workers would get a free pass. Making matters worse, organized components of a provider's workforce already receive favorable dispensation through the non-supervisory organized labor adjustment to the spending target. Workforce stability for non-organized workers would inevitably be threatened and undermined, contrary to

[14] CHA has consistently urged OHCA to treat all labor costs, not only organized labor costs, as an enforcement consideration. See, e.g., CHA comment letter to OHCA dated April 16, 2026. At OHCA's July 8, 2026, workshop on progressive enforcement and performance improvement plans, CHA noted that hospitals compete for the same limited workforce, organized and non-organized alike, and asked OHCA for clarity up front on whether non-organized labor costs would be considered. Deputy Director Vishaal Pegany responded that hospitals could make the case for those costs during the 45-day response period and that OHCA could consider them on a case-by-case basis, but was not required to. CHA was therefore encouraged that the presentation OHCA posted for its October 6, 2026, Patient and Consumer Forum, created that morning, listed "non-supervisory labor costs" among the enforcement considerations. However, OHCA later replaced the presentation on its website, without public notice, with a version created at 5:51 p.m. that day, after the forum ended, listing "non-supervisory **organized** labor costs" (emphasis added). Both versions remain on OHCA's website. See original and revised; archived copies for original and revised slides.

state law's directive that OHCA protect health care workforce stability broadly, not only for a subset of workers.

The catch-all in proposed § 97452(b)(4)(H), which allows an entity to submit "any other information the entity determines is relevant to its spending growth," does not solve this problem. It may allow hospitals to submit information on non-organized labor costs, but it does not require OHCA to consider it. Given OHCA's shifting statements on this question, non-organized labor costs must be included in the regulation itself.

Just as health care cannot be delivered without its frontline workers, hospitals and health care organizations cannot function without their shift supervisors, clinical care managers, and organization leaders. OHCA must recognize health care organizations' imperatives to attract and retain competent and dedicated workers throughout their entire organizations.

Request: OHCA must specify both organized and non-organized labor cost growth as enforcement considerations to protect workforce stability and prevent egregiously inequitable treatment of workers who have elected not to organize. OHCA should further clarify that it will consider labor costs as an explanation for excess spending growth regardless of whether a requested adjustment was made pursuant to § 97448.

OHCA Must Explain How It Will Apply the Considerations, with Written Findings

While statute tells OHCA that it must consider various factors in its enforcement considerations, it does not tell OHCA exactly how it must do so. Unfortunately, the proposed regulations do not address this open question.

Proposed § 97452(b)(4) invites hospitals to show the impact of factors that drove their growth, such as population changes, high-cost outliers, drug costs, changes in law, and labor costs. However, proposed § 97452(c) addresses only errors in the calculation, and under proposed § 97452(d) the Director only "may consider" the entity's response. Nothing in the regulation says what happens when an entity shows its growth was driven by those factors. OHCA also has no deadline to issue a final determination or to act on its requests for supplemental information under proposed § 97452(b)(6).

It is unclear what objective criteria and standardized and transparent process OHCA will use to judge entities' growth. Greater clarity is needed so entities can understand how they will be treated should they exceed the spending target due to uncontrollable influences and/or spending in service of improving Californians' health.

Request: Detail in the regulations how OHCA will operationalize the enforcement considerations, including how OHCA will share with entities its assessment of the validity of entities' reported factors driving growth (e.g., high-cost drugs, investments in primary and preventative care). For growth that a hospital attests is attributable to factors beyond its control or is otherwise reasonable, OHCA must issue written findings on each factor raised and a final determination within a set period after the response, such as 60 days. Requests for supplemental

information should give the hospital a reasonable time to respond. These changes give the response process a defined outcome and keep it from remaining open indefinitely.

OHCA Must Quantify Justified Growth and Remove It from Measured Growth for the Purpose of Progressive Enforcement Decisions

Neither the regulations nor the Manual explain how the enforcement considerations will be assessed and integrated for the purpose of determining that spending growth beyond the target was justified.

Without a transparent methodology, hospitals cannot know how a combination of reasonable factors might affect OHCA's enforcement decisions. Even more problematically, OHCA would have no consistent and objective process to make its decisions, raising equal protection and other legal concerns.

Request: To ensure transparency and fairness, OHCA must establish within the regulations a methodology to:

1. Estimate the quantitative impact on spending growth of each reasonable factor cited by a health care entity, contingent on acceptance by the office.
2. Estimate the total explained portion of an entity's spending growth based on the sum of each factor in Step 1.
3. Subtract the explained portion of spending growth from total spending growth.
4. Determine the entity unjustifiably exceeded the spending target only if the unexplained portion remaining in Step 3 exceeded the spending target.

The following example illustrates how this could work in practice.

Hospital A

	Growth
A. Spending target	3.5%
B. Measured spending growth	6%
C. Uncontrollable or reasonable factors	
Labor cost growth	2.0%
Drug cost growth	1%
State-mandated facility upgrades	0.5%
Preventive care investments	1%
Higher uncompensated care costs	0.5%
Subtotal	5.0%
D. Unexplained growth (B - C Subtotal)	**1%**

Unexplained Growth < Target
NO FURTHER ENFORCEMENT

Hospital B

	Growth
A. Spending target	3.5%
B. Measured spending growth	6%
C. Uncontrollable or reasonable factors	
Labor cost growth	1%
Drug cost growth	0.5%
State-mandated facility upgrades	
Preventive care investments	
Higher uncompensated care costs	0.5%
Subtotal	2.0%
D. Unexplained growth (B - C Subtotal)	**4.0%**

Unexplained Growth > Target
POTENTIAL FURTHER ENFORCEMENT

OHCA Must Establish the Statutorily Required Waiver Process

State law requires that OHCA give an entity that exceed the target a reasonable opportunity "to respond and provide additional data, including information in support of a waiver" so OHCA can assess whether an entities' excess growth was acceptable.[15] Yet, OHCA has disregarded this requirement, opting to instead rely upon the Director's discretion over enforcement decisions because it will grant OHCA greater flexibility. Hospitals continue to believe this is inconsistent with statute, which only confers OHCA discretion in adopting requirements for the procedural filing of waiver requests.[16] CHA remains concerned with this approach as it provides for far less transparency, standardization, and procedural certainty compared to a formal waiver process.

Request: OHCA must establish the waiver process based on the intent and letter of OHCA's authorizing legislation. The waiver process should provide for a standardized, transparent, and legally mandated opportunity that is needed for entities to engage with the office at the appropriate time in the process.

III. Enforcement Must Be Progressive, as the Statute Requires

Lawmakers couldn't have been more clear in directing OHCA to enforce the spending targets in a progressive manner and afford health care entities opportunities for remediation. To fulfill this directive, OHCA's process must be properly progressive and allow entities to have meaningful opportunities and adequate time to implement cost-reducing strategies to meet the state's spending target before the enforcement process culminates in financial penalties.

Technical Assistance Must Be Advisory

The first step in the progressive enforcement process is for OHCA to provide entities with technical assistance (TA). In contrast to PIPs, TA is entirely advisory. Nevertheless, it is a critical first step in enforcement that must not be bypassed in the rush to more aggressive forms of enforcement.

Request: To be actionable and therefore meaningful, TA must be tailored to the class and context of different health care entities, including differently situated hospitals, such as rural hospitals, academic medical centers, and financially distressed hospitals. Proposed § 97453(b) should be expanded accordingly.

Rather than simply taking the form of a template letter, OHCA must give entities the opportunity to engage in dialogue with OHCA, as well as to consider and put into action aspects of TA that meet their circumstances prior to progression to the next stage of enforcement. Entities' efforts to implement TA should be recognized and accounted for by OHCA in its decision on whether an entity should later face stricter enforcement. New provisions should be added to proposed § 97453 to clarify this process.

Finally, additional protections are needed to affirm that TA is strictly advisory and that any TA not adopted by entities may not be determined as impeding the enforcement process. A new

[15] See HSC § 127502.5(b)(2) and (3).
[16] See HSC § 127502.5(b)(2) and (i).

paragraph should be added to § 97453(f) in parallel to the language of the existing subdivision to clarify that an entity's decision not to implement TA shall not create a presumption of noncompliance with the office's enforcement of the spending target. Furthermore, subdivision (e) should be amended to clarify that the accountable health care entity shall "make reasonable efforts to implement technical assistance **to the extent the elements are determined in the sole judgment of the accountable health care entity to be suitable**."

Public Testimony Needs Tighter Parameters

Following TA, OHCA may compel entities to provide written and/or oral public testimony at a public meeting. It is unclear how OHCA will determine entities required to make public testimony, and when a written and/or oral public testimony will occur.

Request: For a transparent process, OHCA should establish objective standards on public testimony. As part, OHCA should adopt a staged approach where entities are required to first provide written testimony; second, if entities do not participate in good faith, only then would OHCA require entities to provide oral public testimony.

Critically, oral public testimony must not become spectacle, but an opportunity for mutual learning between the entity and OHCA and its board. Moreover, questions during oral public testimony must focus on the information provided by the entity related to an entity's excess spending and the issues to be addressed. As proposed in 22 CCR § 97454(b)(2), OHCA leaders could designate any individual to ask questions of the witness. The purpose of this authority to designate outside individuals is wholly unclear and opens the door to OHCA selecting opposing stakeholders, negotiating partners, and organized labor representatives as interrogators. The designee component of this provision must be stricken.

Requiring a PIP Must Rest on a Written Finding That Excess Growth Is Unjustified

The next step in the progressive enforcement process is the imposition of a PIP by the Director. How the Director makes this determination, though, is ambiguous, as the proposed regulations only states that OHCA will notify an entity if a PIP is required.[17]

Request: OHCA must establish in the proposed regulations criteria for when the Director can impose a PIP, based on its determinations outlined in Section II of this letter. At a minimum, the imposition of a PIP must rest on a written finding that a sufficient portion of an entity's growth is unjustifiable, as well as include specified reasons and supporting analysis and details as to why entities' justifications were unsatisfactory to OHCA.

Procedural Penalties May Not Be Used to Bypass the Progressive Steps of Enforcement

Except in narrow circumstances as specified in HSC § 127502.5(h)(1) for willful, egregious, or repeated noncompliance, a financial penalty may only be imposed if the entity is not compliant with an approved PIP and does not meet the cost target[18]. OHCA's proposed regulations must live up to this standard. Proposed § 97456(a)(1) through (3) specifically defines three of the

[17] See proposed § 97455(a).
[18] See HSC § 127502.5(d)(1).

circumstances constituting a willful and egregious violation, and also establish basic procedural safeguards for entities subject to potential penalties. Notably, they state that entities may not be penalized unless they have received written notice and an opportunity for cure. However, the regulations extend these safeguards to only two of the three circumstances, for repeatedly neglecting to file a PIP and repeatedly failing to file an acceptable PIP. The third circumstance, repeatedly failing to implement a PIP, contains no similar protection. Why is completely unclear.

Request: The regulations must be revised to extend the basic notice and cure protections to the third circumstance contained in proposed § 97456(a)(3). Additionally, OHCA should amend this definition to limit the application of penalties to where there is a repeated, **material** violation.

IV. Performance Improvement Plan Proposals Must Constitute Entity-Directed Actions to Improve Spending Performance that Preserve Access and Quality

PIPs Must Include Action Steps, Not Goals

OHCA's proposed regulations and related PIP guidance stray from its statutory directives. While statute establishes that PIPs shall include "specific strategies, adjustments, and action steps the health care entity proposes to implement,"[19] OHCA's guidance instead requires entities to propose goals, and subordinates the specification of any action steps proposed to meet those goals. Even more problematically, the proposed rules collapse what is required in OHCA's authorizing statute to be two distinct tests that must be met to progress an entity to the next step in the OHCA enforcement framework: (1) PIP performance and (2) spending performance.[20] As a result, the regulations leave open the question of whether OHCA could simply impose an outcome as a goal — for example, "meet the spending target" — and then determine that the PIP failed and impose a financial penalty if the entity does not achieve that outcome. Moreover, the language muddies the difference between what is in a health care entity's control, their actions and strategies, with what is not, their final spending performance, which is driven by uncontrollable factors such as whether the hospital is in the boom or bust phase of its volatile revenue cycle (as discussed earlier).

Request: The regulations and associated guidance must conform to the statutory language and require that health care entities submit "strategies, adjustments, and action steps," not "goals," as part of their PIP.

PIPs Must Be Tailored to Improve Spending Performance

The Legislature carefully balanced two competing prerogatives within OHCA's enabling statute: that sustainably improving spending trends takes time and enforcement timeframes cannot be entirely open-ended. Accordingly, the Legislature set a three-year time limit on PIPs, while also not mandating that the three-year PIP must immediately result in compliance with the spending target. HSC § 127502.5(c)(1) states that the PIP shall include "action steps the entity proposes to implement **to improve spending performance** during a specified time period" (emphasis added). However, the regulations and incorporated documents ignore this statutory language

[19] See HSC § 127502.5(c)(1).
[20] See HSC § 127502.5(d)(1) alongside further discussion on page x of this letter.

and instead tie the guidance to achievement of compliance with the spending target.[21] Furthermore, the draft regulations and guidance describe PIPs as being intended to and evaluated on whether they "reduce spending." In contrast, spending targets are benchmarks for year-over-year **increase** in spending, which cannot be negative.

Request: OHCA must conform to statutory language when describing the intended impact of the PIP on spending performance. Additionally, OHCA must clarify that the criteria for evaluating and requiring revisions to a PIP are intended to reduce **the rate of growth** in spending, not negatively reduce it compared to prior or existing levels.

OHCA May Not Dictate PIP Strategies

Health care entities understand their organizations best. That's why statute empowers health care entities, not OHCA, to author their PIPs. OHCA's role, by contrast, is to approve or reject that proposal. In fact, state law only narrowly grants OHCA the opportunity to require modifications after an entity has completed its PIP but missed its spending target.[22] A practice of requiring particular strategies would also be a standard of general application that has not been adopted through the Administrative Procedure Act, and therefore constitute an invalid underground regulation.

Request: The regulations must set objective approval criteria, stating that a PIP **shall** be approved if it addresses the identified causes of excess growth, includes specific strategies and action steps reasonably designed to reduce spending growth, is not likely to erode access, quality, equity, or workforce stability, and otherwise reflects a complete submission.

PIP Strategies Must Protect Access, Quality, Equity, and Workforce Stability

State law prohibits OHCA from approving a PIP that is likely to erode any of the above balancing measures (e.g., access). The regulations frame this as a limitation on what strategies a health care entity may propose or implement. However, the regulations fail to fully articulate OHCA's responsibility to not approve a PIP that impairs any of these key objectives.

Request: OHCA must add a provision to § 97455 stating that OHCA shall not approve, require, or direct, including through approval or a request for revisions, any PIP, strategy, or action upon a showing by a health care entity that the action is likely to erode access, quality, equity, or workforce stability.

PIP Timelines Should Be Extended and Clarified

The development of a PIP will require the dedication of enormous time and resources, including but not limited to coordination across departments, extensive data analysis, operational planning, and board consultation and approval before entities can submit to OHCA for consideration. It is critical that entities are given adequate time to develop and revise a PIP proposal.

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[21] See § 97455(d)(6)(A), § 97455(d)(3) and PIP Submission Guide § D.5.
[22] See HSC § 127502.5(d)(1).

Request: Given the importance of a PIP implementation, OHCA must consider and incorporate the following areas in the draft regulations:

1) Submission Timeline: OHCA should extend the PIP submission timeline from the proposed 45 calendar days to 90 calendar days.
2) Extension Request: Any extension request from entities should be afforded up to the deadline of the initial PIP submission. An automatic 30-day initial extension should be granted and OHCA must broaden the circumstances it considers for extension requests for the initial PIP submission, PIP progress reports, and PIP final report (e.g., administrative and operational barriers), not just emergency-related factors.
3) Timeline for PIP revision: Entities must have at least 30 days to revise their PIP proposals if OHCA requires revisions.
4) Timing of PIP implementation: OHCA should clarify when a PIP would begin following approval. To correspond to the spending target that would coincide with implementation of the PIP (as required for the purpose of assessing financial penalties for failure to implement the PIP and comply with the target, the PIP should start at the start of the next performance year following PIP approval).

Draft PIPs Must Be Confidentially Maintained by OHCA

OHCA's authorizing statute requires it to publicly release (1) the identity of a health care entity implementing a PIP and (2) a summary of the entity's compliance with the requirements of a PIP.[23] In requiring a summary of "compliance," statute clearly directs public release only **after** approval, and then only of the entity's identity and compliance summary. Furthermore, the law establishes a presumption in favor of enforcement matters being conducted away from the public eye by expressly authorizing consideration of PIPs and penalties under closed sessions of the board.[24] Nowhere does statute direct or contemplate the public posting of proposed PIPs, as OHCA intends under the proposed regulations. The authors of OHCA's enabling statute decided not to publicize PIP proposals, thereby safeguarding the deliberative process, protecting the highly sensitive information submitted as part of the PIP, and preventing undue politicization of the OHCA enforcement process. OHCA's proposal runs contrary to the law, undermines legislative intent, and introduces outside influence to PIP development and approval.

Request: OHCA must remove the provisions in the regulation and PIP guidance document that direct the office to publicly post proposed PIPs and revert to the requirements of state law by only posting the identity of health care entities subject to a PIP, as well as summaries of their compliance post-approval.

Define Board Input into PIPs and Allow Hospitals to Be Heard Before Decisions and Findings

Prior to approving or rejecting an entity's proposed PIP, OHCA must first obtain input from the board. This process must be further clarified so entities have an understanding of the content OHCA will bring to the board for discussion, the scope of the board's deliberation, and the types

[23] See HSC § 127502.5(c)(2).
[24] See HSC § 127501.10(e)(2).

of opportunities that are provided to entities for correction to their proposed PIP prior to receiving OHCA's determination.

Request: OHCA should adopt the following actions in the regulations:

1) Define how the board provides input on the proposed PIP, including the criteria the board will apply in its assessment. Specifically, the Board should evaluate entities' PIPs on their identified causes of excess growth and assess whether entities' proposed strategies and actions are likely to reasonably reduce spending growth while preventing erosion of the balancing measures— all while giving entities the latitude to propose and implement a PIP that is tailored to their respective organization.
2) Ensure all authorized matters are conducted in closed session, given the sensitive and confidential information in entities' proposed PIPs.
3) Provide entities with notice of (including draft final findings and calculations, as applicable) and opportunity to respond to any issues raised by OHCA, the board, or public comment, prior to entities receiving approval or rejection of their proposed PIP. Entities should be given at least 30 days to respond to preliminary findings and the opportunity to amend their initial proposals given the significance of having to carry out the PIP.

Hospitals Must Be Able to Amend Their Plans

During the implementation of a PIP, entities are required to submit progress reports — including information on entities' progress and any barriers or delays that may impact PIP implementation — so that OHCA can monitor compliance. Review of the progress reports could result in OHCA directing that a PIP be modified.

Request: The authority to modify a PIP should be extended to health care entities, given both their authorship of and responsibility for implementing the PIP. Doing so should be allowed in circumstances where entities determine it necessary to improve their spending performance, protect and promote OHCA's balancing measures, and ensure the strategies are consistent with the needs of the entity and its patients. Additionally, to ensure a clear process, OHCA must establish that barriers it accepts and approved PIP modifications do not result in entities' "failure to implement" their PIP.

V. Penalties Must Be Clearly Defined, Proportionate, and Limited to What the Statute Allows

OHCA's board recently approved a penalty framework that is without parallel in any other state. Penalties could start in the hundreds of millions of dollars for a single hospital in a single year and for a single payer line. The starting penalties are 20 times higher than the next strictest state spending target program. The starting penalties would exceed multiple years of operating earnings for dozens, if not hundreds, of hospitals. Penalties of these magnitudes raise serious constitutional takings and due process concerns. While the board can and should rescind its approval and replace the penalty framework with a more measured, transparent, and attainable penalty structure, OHCA has authority within the board-approved framework to materially address the clear deficiencies.

"Nature, number, and gravity" Must Be Defined, Account for Growth Already Determined to Be Reasonable, and Recognize Improved Performance

State law directs OHCA to consider the following general factors to determine financial penalties:

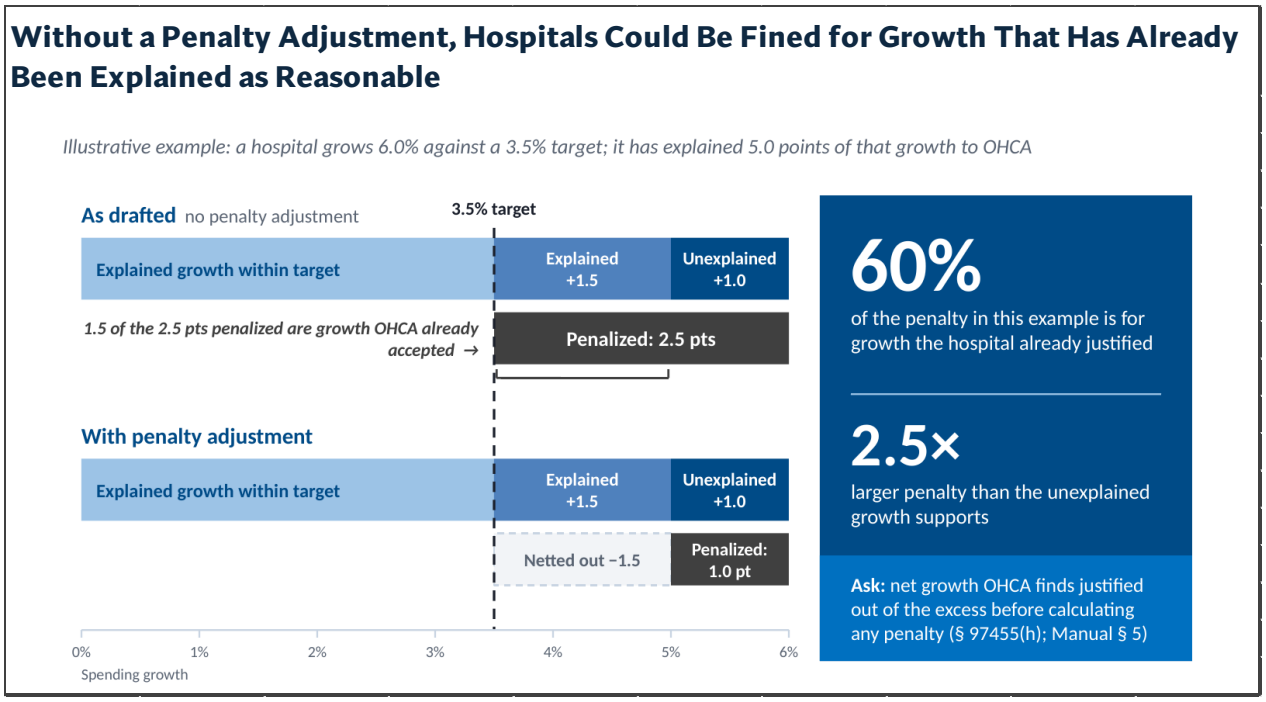
> "(A) The nature, number, and gravity of the offenses.
>
> (B) The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.
>
> (C) The market impact of the entity."[25]

The regulations simply restate the statutory language above, alongside adding a separate statutory provision related to consideration of the provision of the nonfederal share of Medi-Cal payments. Failing to further define how OHCA will apply the highly general factors from statute subjects entities to profound uncertainty as to how OHCA will determine their penalty amounts. With penalties potentially ranging from $0 to hundreds of millions of dollars for a single violation of the spending target, entities would have no ability to predict and plan for these potentially enormous fines.

Such uncertainty would even extend to areas where OHCA has already made a formal determination. When determining whether an entity must file and implement a PIP, OHCA must consider spending growth beyond an entity's control. Under the proposed regulations, OHCA would consider other contextual factors as well, such as investments in preventive care. As discussed in Section II of this letter, this assessment should involve quantitative estimates of the portion of spending growth attributable to reasonable factors, which then should drive the office's determination of whether to proceed and impose the PIP. But it shouldn't stop there. This same assessment can and must be used to adjust the penalty amount based on the relevant penalty justification factors.

Request: OHCA must clearly define the penalty justification factors listed in § 97457. The definition of "nature, number, and gravity" must include spending that OHCA has previously determined to be reasonable due to being uncontrollable or desirable. To operationalize the definition, OHCA should incorporate a mandatory adjustment to the final penalty calculation based on its estimate of uncontrollable and otherwise reasonable spending growth. The figure below illustrates how this adjustment could be performed and why it is essential. Otherwise, entities have no assurance that they will not be punished for factors beyond their control or spending OHCA has deemed desirable, like investments in primary care.

[25] See HSC § 127502.5(d)(6).



Penalties Must Not Threaten a Hospital's Financial Sustainability or Access to Care

OHCA's approved penalty framework, without significant downward adjustment in application, will result in exorbitant penalties that would bankrupt entire hospitals and undermine access to lifesaving care for all the patients that depend on them. OHCA's proposed penalty justification factors borrow directly from statute, but lack meaning due to a lack of clarity in how they would be applied.

Request: OHCA must specify how an entity's fiscal condition would affect the penalties imposed by OHCA. The regulation should clearly state that a penalty may not impair a hospital's financial sustainability or patients' access to care, including but not limited to impairing the health care entity's ability to earn a sustainable operating margin.

Properly Identify the Range of Penalties in the Regulations and Confirm That Any Penalty above the Commensurate Amount Must Be Based on Penalty Justification Factors

The board approved the scope and range of spending target penalties to be as follows: "An amount that is initially commensurate with the failure of the health care entity to meet a spending target. The initially commensurate amount is the difference between a health care entity's actual spending and the spending if the target had been met. The range of penalties assessed shall be between of 0% and 125% of the initially commensurate amount after applying the penalty justification factors."[26]

The draft regulations, by contrast, define the range as "up to 125% of the initially commensurate amount of excess spending."[27] This departure from the board-approved text conceals the

[26] See slide 38 of the August 2026 Health Care Affordability Board Meeting Presentation.
[27] See § 97455(h)(4).

intended floor of the penalties (0%). Additionally, the draft regulations fail to distinguish between the initially commensurate penalty and the range of penalties allowed following consideration of the penalty justification factors.[28] As a result, it is not clear within the draft regulations that any penalty above the initially commensurate amount must be expressly justified based on the penalty justification factors approved by the board.

Request: OHCA should redraft § 97455(h)(4) to conform with the board action. OHCA should further clarify that penalties exceeding the initially commensurate amount may only be applied based on the penalty justification factors approved by the board.

PIPs Must Clearly Distinguish between the Action Steps an Entity Commits to Implement and the Applicable Spending Target

OHCA's authorizing statute is crystal clear: "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."[29] As discussed in section X of this letter, this statutory provision establishes a two-part test for financially penalizing a health care entity. The regulations affirm the two-part test, clarify what the applicable spending target is, and specify that the applicable spending target should be identified in the PIP. However, the PIP submission guide contains no directions for identifying the applicable spending target, leaving it an open question of whether it would be subsumed under D.5 of the guide. Doing so would effectively collapse the two-part test into one, in clear violation of state law.

Request: OHCA must establish a new subsection under Section D of the PIP submission guide for the purpose of identifying the applicable spending target and include express language declaring that failure to meet the identified spending target shall not constitute a violation of the PIP.

Clarify That Inpatient and Outpatient Penalties Offset, and Across Markets

Manual § 5.3 calculates a hospital's initially commensurate penalty as the inpatient amount plus the outpatient amount. Each equals the "average excess spending" per unit multiplied by performance-year volume. The Manual does not say whether a negative amount, where spending in one setting is below target, offsets a positive one. While the formulas show the amounts offsetting, the term "excess spending" introduces unnecessary ambiguity since spending under the target would never be described as "excess" under the spending target framework.

Request: OHCA should clearly state in the regulation that amounts below the target offset amounts above it across the two care settings. OHCA should also rename "average excess spending" in the Manual to a neutral term, such as "spending difference from target."

[28] See slide 39 of the August 2026 Health Care Affordability Board Meeting Presentation.
[29] See HSC § 127502.5(d)(1).

Penalties Require Reliable Measurement
Under proposed § 97455(h), a hospital may be penalized if it does not comply with its PIP and does not meet the spending target identified in the PIP. Neither the regulation nor the Manual says what annual periods will be used to assess compliance with the target in conjunction with the PIP.

The single-year noise described in Section I applies with even more force here, because the measurement could directly trigger a penalty.

Request: OHCA must measure the PIP-period target with the same safeguards CHA recommends for the initial determination: growth over the full PIP period from a multi-year base, an all-payer measure, statistical thresholds, and the corrected and validated methodology. A penalty must rest on a finding OHCA can show is not an artifact of reporting noise.

VI. Confidentiality Protections Must Be Substantially Broadened

Confidentiality Must Be Assured through Every Step of the Enforcement Process
The proposed regulations establish a process for entities to disclose information and data to OHCA for the purpose of demonstrating that their excess spending growth was due to enforcement justification factors[30] or that OHCA's calculation of their overall spending growth was incorrect. As under a PIP, information and data provided under this process may include nonpublic information that meets OHCA's corresponding proposed definition.[31] However, the proposed regulations establish no process for ensuring sensitive information — such as payer-provider contracts or collective bargaining agreements — shared with OHCA during this enforcement determination stage is confidentially maintained by the office.

Request: To address this deficiency, OHCA must extend the confidentiality protections afforded to information provided related to a PIP to every stage of the enforcement process.

Establish a Procedural Safe Harbor Following a Denial of Confidentiality
OHCA should revise its proposed regulations to establish clearer, more predictable rules that facilitate the secure submission of information and data by accountable health care entities. As currently drafted, proposed 22 CCR § 97455(i)(5) states:

> *"If a request for confidentiality is denied, the accountable health care entity may request to withdraw or replace any information or documents with public versions."*

This phrasing fails to provide entities with meaningful assurance that proprietary information will not be disclosed following a request to withdraw. As the text provides that an entity may only *"request to withdraw,"* it is silent on whether OHCA retains the ultimate discretion to deny the withdrawal and publish the documents against the submitter's wishes.

Request: OHCA should adopt an unambiguous right-of-withdrawal process, as used by the Department of Managed Health Care (DMHC) under the Knox-Keene Act and its implementing

[30] See § 97452(b)(4) and (d).
[31] See § 97455(i)(1).

regulations.[32] Amending proposed § 97455(i)(5) to mirror this established standard would give submitting entities the baseline certainty they require: If confidentiality is denied, they maintain the unilateral right to pull back the sensitive submission before it enters the public record. To achieve this clarity, CHA proposes that OHCA revise proposed § 97455(i)(5) as follows:

> *"If a request for confidentiality is denied, the accountable health care entity ~~may request to~~* ***shall have the right to*** *withdraw or replace any information or documents with public versions****, and any material for which confidential treatment is denied shall not be deemed filed****."*

OHCA Must Deem Additional Sensitive Documents and Information Confidential

In accordance with antitrust law, medical information privacy protections, the protection of trade secrets, and other federal and state laws, certain types of information and documents are by their nature nonpublic. OHCA's cost and market impact review (CMIR) regulations recognized this reality and deemed related documents, such as contract rates and stock purchase agreements, as confidential.[33] The PIP submission guide similarly identifies certain documents and information as per se confidential. However, the list omits certain pieces of information that merit similar treatment within the enforcement process.

Request: OHCA should move the provisions establishing the per se confidential treatment of select information and documents from the PIP submission guide to the regulations themselves, ensure such treatment applies to the provision of such information and documents at any stage of the enforcement process, and add the following items to the existing list:

- Pricing and contracting information beyond payer contracts and contract rates, including fee schedules, planned or projected price changes, and pricing analyses
- Internal financial statements, budgets, projections, and cost accounting beyond what is already disclosed through public reporting
- Supply and pharmaceutical acquisition costs, rebates, and discounts
- Protected health information

Finally, OHCA should clarify how the process will differ for information and documents that are deemed confidential. This should include that there is no requirement to write a statement to justify the confidential treatment of such information and that OHCA automatically maintains their confidentiality indefinitely unless otherwise expressly requested.

VII. Information Provided to OHCA Should Be Attested Based on Knowledge, Information, and Belief

The proposed regulations and guidance require officers of health care entities to attest that information provided in public testimony or as part of a PIP to be true and correct or accurate.[34]

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[32] See 28 CCR § 1007(e), which provides that: *"Material for which confidential treatment is requested shall not be deemed filed unless the request is granted and may be withdrawn by the submitter if the request is denied…"*
[33] See § 97437(c).
[34] See § 97454(c)(2) and PIP Submission Guide Appendix A.

An "accurate and true" verification standard goes well beyond what is typically report by government agencies or the courts. Moreover, public testimony and PIPs are certain to include information that a signing officer won't be able to know with certainty. For example, a PIP will likely include projections of the financial and operational performance of the health care entity.

Request: OHCA should modify the attestation requirements in § 97454(c)(2) and PIP Submission Guide Appendix A by requiring verification based on knowledge, information, and belief.

VIII. Technical Changes

- The proposed regulations use "required submitter" in place of "accountable health care entity" in at least two provisions (§ 97456(b)(1) and § 97452(b)(3)(B)(iii)) that would meaningfully alter the rights and responsibilities of hospitals, which fall into the latter but not former category. These drafting errors should be corrected prior to finalization.
- The Manual's formulas (§ 5.3 Hospital Calculations) calculate spending "at target" as prior-year spending multiplied by one plus the target. The variable definitions in § 5.5 state this differently: "IP NPR per CMAD at Target," "Outpatient NPR per IAV at Target," and the parallel definitions for other entities are each defined as prior-year spending "multiplied by the target value for the performance year." Read literally, with a 3.5% target, spending at target would equal 3.5% of prior-year spending. Assuming zero spending growth, 96.5% of a hospital's spending in the second year would be counted as excess and subject to penalty. OHCA must align the descriptions in Sections 2, 3, and 4 with the formulas in Section 5.
- The Manual weights inpatient growth and outpatient growth respectively by an "IP NPR Payer-Specific Share" and "OP NPR Payer-Specific Share" from the base year. However, neither term is defined in the § 3.4 variables table or anywhere else in the Manual. Without defined weights, a hospital cannot reproduce its combined growth. OHCA must define each weight as the payer-specific share of base-year NPR using the same inpatient/outpatient split it uses to calculate unit spending and add this definition to Section 3.4. Fixed base-year weights make the measure reproducible and keep shifts in care between settings in the performance year from changing how the two settings are weighted.
- Proposed § 97445(ii) defines hospital growth as "a weighted combined growth measure for each payer type," and § 97452(a)(3) applies it "calculated by market." Yet the Manual's hospital formulas in Manual Section 3 carry only a time subscript. "Market" is never defined for hospitals, and the regulations use "payer type" and "market" interchangeably. OHCA must add a payer subscript to every hospital formula and define each hospital market by the AFDR columns it draws from.
- Manual § 3.4 defines inpatient and outpatient NPR as net patient revenue "on an allowed amount basis as reported in the Hospital Annual Financial Disclosure Report." "Allowed amount basis" is a claims concept from the THCE Data Submission Guide with no defined meaning in the AFDR. AFDR NPR also includes prior-period contractual adjustments and settlements, which OHCA itself has identified as a leading cause of volatility in its hospital measures.

Conclusion

California's hospitals appreciate the opportunity to comment and look forward to continued engagement as OHCA moves toward finalizations of enforcement regulations. These rules and regulations will guide the behavior of hundreds of providers and payers, determine the breadth and scope of the office's enforcement responsibilities, and guide difficult office decisions on which individual entities are subject to ever more stringent enforcement actions, and which get a free pass. Rulemaking must not be rushed; rather, it must deeply consider and promote all of OHCA's objectives, including the promotion of health care access, affordability, quality, equity, and workforce stability.

Sincerely,



Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
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Dr. Richard Pan
Vishaal Pegany, Deputy Director, Office of Health Care Affordability

CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

November 13, 2026

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

Re: Draft Spending Target Enforcement Regulations

Dear Chair Johnson,

On behalf of the California Association of Public Hospitals and Health Systems (CAPH), I am writing to comment on the Office of Health Care Affordability's (OHCA's) draft spending target enforcement regulations, Spending Target Performance Measurement Manual, and Performance Improvement Plan Submission Guide, dated October 8, 2026, ahead of the November 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 push safety net providers to the brink and jeopardize services for our Medi-Cal and uninsured patients. As OHCA and the Board seek to adopt new policies regulating health care spending in

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

California, the historic changes to health coverage and funding that we are facing must be top of mind. We urge OHCA and the Board to carefully consider the following issues as they finalize the spending target enforcement regulations and supporting guidance:

Medi-Cal financing considerations: Most public health care systems' Medi-Cal revenues come through self-financed payments, meaning the systems themselves, not the State, provide the nonfederal share, and they receive as revenue only the federally matched (net) portion. However, many hospitals in public health care systems report the gross amount of these payments, which includes the nonfederal share they provide, in their Hospital Annual Financial Disclosure Reports. This differs from how private hospitals report supplemental funding under the Hospital Quality Assurance Fee Program, and it substantially inflates reported revenues.

The Spending Target Performance Measurement Manual incorporated by reference in the draft regulations measures hospital spending using inpatient and outpatient net patient revenue as reported in the Hospital Annual Financial Disclosure Report, with no adjustment for self-financed payments. As a result, both the measure that will determine whether a public hospital has exceeded the spending target and the initially commensurate penalty amount, the formula-based starting point for any penalty, will incorporate these inflated revenues. In a year in which a public health care system increases the nonfederal share it provides in order to draw down federal funding, its measured Medi-Cal spending growth will rise by the full gross amount, even though the system's net benefit is only the federal portion. In other cases, reduced federal matching rates for certain services resulting from provisions of the One Big Beautiful Bill Act (OBBBA) may require public health care systems to provide a larger nonfederal share to sustain the same gross payment. Reported revenue for those services would remain stable even as net revenue falls, so OHCA's measurement would not reflect the system's actual financial circumstances. OHCA's enabling statute requires that, in setting spending targets, "with respect to Medi-Cal, the methodology shall consider provision of nonfederal share … associated with Medi-Cal payments."[2] The same principle should apply to measuring performance against those targets.

We recognize that this reflects the data currently available to OHCA, and we appreciate the Department of Health Care Access and Information's ongoing work to update hospital financial reporting to provide greater visibility into self-financed payments. Until those changes are in place, however, public hospitals must contend with inflated spending measurement and, potentially, inflated initially commensurate penalty amounts. We urge OHCA to explicitly recognize the provision of nonfederal share as a factor in an entity's

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

response to a notice of preliminary determination (§97452(b)(4)) and in the Director's determination of whether to proceed with enforcement (§97452(d)), rather than only as a penalty justification factor at the end of a multi-year process (§97457(a)(4)). We also ask OHCA to clearly outline how the provision of nonfederal share will be weighed in determining penalty amounts.

The same issue affects the draft Performance Improvement Plan (PIP) Submission Guide. Section D.6 of the Guide requires entities to show that PIP savings positively impact affordability for consumers and purchasers and do not "solely reduce internal operating expenses." For Medi-Cal lines of business, entities must describe how each goal "positively impacts affordability for the State of California as a purchaser." Public health care systems finance much of their Medi-Cal revenue themselves. Reducing these payments would mostly reduce federal matching funds, not State General Fund spending, and could impair access to care for Medi-Cal and uninsured patients. A public hospital required to implement a Medi-Cal PIP may therefore be unable to demonstrate affordability gains in the way the Guide requires. We urge OHCA to revise Section D.6 to account for self-financed Medi-Cal payments and to provide guidance on how public health care systems can meet this requirement.

Data volatility: CAPH supports combining the inpatient and outpatient measures into a single payer-specific growth measure, as discussed at the September Board meeting. The draft regulations appear to adopt this approach, but the Measurement Manual's penalty calculation still treats the two measures separately.[3] We urge OHCA to confirm that the combined measure will be used both to determine whether a hospital has exceeded the target and to calculate any penalty.

Even with a combined measure, OHCA's own analysis shows year-over-year swings that are difficult to explain from an operational perspective, such as Medicare inpatient growth ranging from −148% to 864%,[4] even though Medicare fee-for-service rates are set administratively and Medicare Advantage plans generally pay hospitals at or near those

[3] The draft regulations define hospital performance as "year-over-year combined payer-specific spending growth" (§97445(ii)), and Section 3.3 of the Measurement Manual includes a weighted combined growth calculation. However, Section 5.3 of the Manual calculates separate inpatient and outpatient initially commensurate penalty amounts and adds them together, and does not specify whether below-target growth in one component offsets above-target growth in the other. The combined measure was presented to the Board in September as a discussion item.

[4] Office of Health Care Affordability. (2026). September 2026 Health Care Affordability Board Meeting Presentation, slides 40–42, 44, 49, and 54. Department of Health Care Access and Information. Under the combined measure, only 51% to 55% of hospitals were at or below the 3.5% target in each market for 2022–23.

rates.[5] OHCA attributed this volatility to hospital-reported contractual adjustments and low patient volumes. We urge OHCA to take steps to address these measurement issues before the Manual is used for enforcement, such as by adopting the minimum volume thresholds mentioned during the September Board meeting.

Intensity adjustment: The Measurement Manual adjusts inpatient spending using Medicare Severity Diagnosis Related Group (MS-DRG) weights and outpatient spending using Medicare Ambulatory Payment Classification (APC) weights. These weights are calibrated on the Medicare population and may not reflect the resources needed to care for obstetric, newborn, and pediatric patients, who make up a large share of the Medi-Cal patients that public health care systems serve. The outpatient adjustment also assumes that claims drawn from the Health Care Payments Database (HPD) are representative of a hospital's outpatient service mix. However, per the California Hospital Association, only about 20% of hospital-reported commercial outpatient visits can be identified in the HPD, in part because self-funded employer plans submit data only voluntarily.[6] In addition, visits for services without APC weights, such as laboratory tests, are excluded from the calculation of average visit intensity, even though the result is applied to all of a hospital's outpatient visits. We recommend that OHCA:

- Adjust for inpatient intensity using All Patient Refined Diagnosis Related Groups (APR-DRGs), and allow hospitals to use APR-DRGs to submit data in response to a notice of preliminary determination;
- Publish data on the completeness of HPD outpatient claims by hospital, payer, and setting;
- Set a minimum visit threshold, based on the share of a hospital's reported outpatient visits that are captured in the HPD with APC weights, for calculating average visit intensity; and
- Clarify how services without APC weights will be treated.

PIP process: Under the draft regulations and PIP Submission Guide, entities that are required to submit PIPs have only 45 days to respond to the requirement, with the

[5] Studies have found that Medicare Advantage plans pay hospitals at or slightly below traditional Medicare rates, in part because Medicare generally limits payments to non-contracted providers to traditional Medicare rates. See Berenson, R. A., Sunshine, J. H., Helms, D., & Lawton, E. (2015). Why Medicare Advantage plans pay hospitals traditional Medicare prices. *Health Affairs, 34*(8), 1289–1295; and Maeda, J. L., & Nelson, L. (2017). An analysis of private-sector prices for hospital admissions (Working Paper 2017-02). Congressional Budget Office.

[6] California Hospital Association. (2026, October 30). CHA Comments on Proposed Emergency Regulation Text: Health Care Spending Targets — Progressive Enforcement (draft dated Oct. 8, 2026), p. 6.

possibility of a 30-day extension. Even a mid-sized hospital is a large organization, with hundreds or thousands of employees, complex operations, and millions of dollars in annual costs. Hospitals will need more than six to ten weeks to bring together financial, operational, and clinical leadership to identify areas where sustainable changes can be made that will lead to meaningful spending reductions over the course of a multi-year PIP without affecting staffing, services, access, or quality, as the Guide requires. We recommend that OHCA lengthen the initial PIP submission period from 45 to 60 days and increase the extension window from 30 to 45 days.

Additionally, public health care systems require more guidance on how to draft a successful PIP. For hospitals, the goal of a PIP will be to reduce revenue growth to below the target rate. Most hospitals in public health care systems face very low or negative margins already, have historically been underfunded, and are facing substantial reimbursement cuts due to the OBBBA and state budget decisions in the coming years, while labor and supply costs continue to grow. Finding ways to further reduce revenue without cutting services or staff—changes that could threaten workforce stability and access to care—may not be possible if these hospitals face spending target enforcement. Some public health care systems report that labor accounts for 65% to 75% of their total expenses, leaving little room to reduce costs without affecting staff. Even in the cases where sustainable revenue reductions are possible, public health care systems have limited control over the volume and intensity of the services they provide and the payments that they receive. For example, the majority of patients at many public health care systems are covered by public insurance, meaning that payments for most services are already highly regulated and largely determined by federal and state agencies. While the draft Guide provides a helpful structure for PIP proposals, it does not include examples of strategies OHCA would consider acceptable for hospitals. We urge OHCA to provide clearer guidance on what a successful PIP could look like given the constraints facing public health care systems.

Draft regulations should more closely adhere to the approved framework: The draft regulations largely reflect the enforcement framework the Board approved in August and the process OHCA described to the Board over the past year. In two places, however, the draft regulations add requirements or remove flexibility beyond what was presented to the Board. We urge OHCA to revise the following provisions to align with the framework presented to and approved by the Board:

- *PIP extensions*. The PIP guidance presented to the Board in August stated that entities may request one extension of up to 30 calendar days with an explanation of the need. The draft regulations would allow OHCA to grant an extension only when a

natural disaster, catastrophic event, or similar extraordinary event prevents timely submission (§97455(b)(2)(A)), while the PIP Submission Guide continues to describe discretionary extensions. Developing a PIP that meets the Guide's requirements will be a substantial undertaking for any hospital, and extensions should be available when a hospital acting in good faith needs additional time for operational reasons. We urge OHCA to align the regulation with the framework presented to the Board and the Guide.

- *Penalty justification factors.* At the August and September Board meetings, OHCA stated that the penalty justification factors would allow it to consider external factors such as changes in state and federal policy when determining the final penalty amount. However, §97457 of the draft regulations lists only the four factors approved by the Board, which do not expressly address changes in state or federal law. We urge OHCA to state in the regulation that these considerations, including the impact of the OBBBA and other changes in state and federal law, will be weighed under the approved factors, so that this flexibility is preserved as described to the Board.

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

Sincerely,

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

Cc: Members of the Health Care Affordability Board:
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See Attachment #13

California Association of Health Plans

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October 30, 2026

Sent via email:
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Re: Draft Progressive Enforcement Regulations, Performance Improvement Plan Submission Guide, and Spending Target Performance Measurement Manual

Dear Director Landsberg, Deputy Director Pegany, and OHCA Staff:

On behalf of the California Association of Health Plans (CAHP), thank you for the opportunity to comment on the Office of Health Care Affordability's (OHCA) draft progressive enforcement regulations, draft Performance Improvement Plan (PIP) Submission Guide, and draft Spending Target Performance Measurement Manual.

CAHP and its member plans support the shared goal of improving health care affordability for California consumers and purchasers. We also appreciate that the draft package provides substantially more information regarding the progressive enforcement process. Nevertheless, significant questions remain regarding how entities will be selected for further enforcement, how legitimate external spending drivers will be evaluated, what constitutes successful remediation, how PIPs will operate, and how eventual penalties will be calculated.

CAHP is not requesting a rigid formula that governs every circumstance. Flexibility is necessary because spending drivers and market conditions vary substantially among entities. However, flexibility should be accompanied by sufficient standards, transparency, and procedural safeguards to ensure that similarly situated entities are treated consistently and understand what is expected at each stage of enforcement.

I. Draft Progressive Enforcement Regulations

A. Clarify the scope and basis of payer enforcement

1. Payer markets and populations subject to enforcement

CAHP requests that OHCA expressly identify the payer markets and populations subject to spending-target enforcement. The regulations should clarify how OHCA will treat individual and family, small-group, large-group, and self-funded commercial populations.

These markets differ significantly in mandated benefits, Medical Loss Ratio requirements, broker commissions, administrative structures, pharmacy arrangements, and employer decision-making authority. Those differences may materially affect TME and TNME trends and should remain visible in measurement and enforcement.

Where self-funded spending is reported or attributed to a payer, OHCA should distinguish between the payer's reporting or administrative role and decisions retained by the employer. A payer should have an opportunity to demonstrate that spending growth was materially attributable to employer-controlled benefit design, pharmacy, network, program-participation, or other decisions over which the payer lacked meaningful authority.

2. TME and TNME methodology

Proposed section 97452(a)(1) would deem a payer or fully integrated delivery system noncompliant when the year-over-year growth of either TME or TNME exceeds the target. This provision raises significant questions.

TNME includes diverse expenses such as taxes, regulatory assessments, administrative operations, reserve changes, technology and care-management investments, reinsurance, and profits or losses. These items are not uniformly discretionary and may be volatile from year to year. Independent TNME enforcement could also discourage investments that increase administrative expenses in the short term but reduce medical spending and improve affordability over time.

CAHP requests that OHCA:

1. Explain the statutory and policy basis for applying the statewide target independently to TME and TNME;
2. Publish payer-specific TME and TNME calculations before those measures are used for enforcement;
3. Explain how required expenses, external cost drivers, and affordability investments will be treated;
4. Evaluate whether combined THCE or another methodology would better reflect the relationship between medical and nonmedical spending; and
5. Continue technical engagement with plans and actuaries before finalizing the payer methodology.

CAHP recognizes that perspectives differ regarding whether TME and TNME should be combined or separately assessed. At minimum, OHCA should not finalize the current approach without further analysis of volatility, market differences, required administrative costs, and possible disincentives to affordability investments.

3. Align the PIP definition with the statute

Proposed section 97445(n) defines a PIP as an action plan intended to bring an entity into compliance with an applicable spending target. CAHP recommends revising the definition to track Health and Safety Code

section 127502.5(c)(1), which focuses on identifying the causes of spending growth and implementing strategies, adjustments, and action steps to improve spending performance.

CAHP recommends the following definition:

> *"Performance improvement plan" means a plan that identifies the causes of spending growth and includes specific strategies, adjustments, and action steps the health care entity proposes to implement to improve spending performance during a specified period.*

This revision would preserve the statutory distinction between successful PIP implementation and ultimate target attainment.

B. Provide adequate response periods and a fair process for calculation disputes

The proposed 45-calendar-day response period may not provide sufficient time for complex organizations to collect, validate, analyze, and explain the information required by OHCA. CAHP recommends:

1. Extending the initial response period;
2. Permitting extensions longer than 15 calendar days;
3. Broadening extension criteria beyond extraordinary events; and
4. Recognizing that ordinary data collection and validation challenges may justify additional time.

Where an entity disputes OHCA's calculation of excess spending growth, the substantive response period should be tolled until that dispute is resolved. An entity should not simultaneously be required to challenge the existence or amount of an exceedance and explain the causes of an exceedance that remains unsettled.

CAHP also requests that OHCA reconsider the proposed clear-and-convincing-evidence standard. Member views differ regarding the appropriate alternative, but OHCA should explain the legal basis for imposing a heightened burden on the regulated entity and why that standard is appropriate for correcting OHCA's own calculations.

C. Ensure that enforcement considerations meaningfully affect the process

CAHP supports OHCA's recognition of factors that may explain excess spending growth, including high-cost patients, pharmaceuticals, legal changes, primary care investments, and labor costs. The regulations should go further by explaining:

- How each consideration will be evaluated;
- What evidence entities may submit;
- How validated considerations affect escalation;
- How those considerations affect the published exceedance amount; and
- How they affect any eventual penalty calculation.

OHCA should expressly recognize:

- Organized and non-organized labor costs;
- Labor stoppages;
- Downstream payer impacts of provider labor adjustments;
- State and federal benefit mandates;
- Taxes and financing changes;
- High-cost patients;
- High-cost providers and contracted entities;
- High-cost pharmaceuticals, including non-retail drugs;
- New technologies, devices, and treatments;
- Regulatory directives, including DMHC All Plan Letters;
- Federal No Surprises Act requirements and independent dispute-resolution outcomes; and
- Other legitimate circumstances outside the entity's control.

Where OHCA approves or validates a labor-related cost or adjustment for a provider or another regulated entity, that same recognized cost should be treated consistently when it flows through contracted reimbursement and appears in payer spending. The same cost should not create duplicative accountability across entities.

OHCA should permit regulated entities to use reliable entity-specific evidence. THCE, HPD, DMHC, statutory, and other regulatory datasets may provide context, but should not displace validated information establishing the actual costs incurred by the entity. Public fiscal estimates may not capture implementation expenses, downstream utilization, provider capacity, or multi-year effects.

The catch-all in proposed section 97452(b)(4)(H) should be retained so OHCA can consider legitimate circumstances that cannot reasonably be anticipated in regulation.

Finally, OHCA should provide a written explanation when it rejects an entity's evidence and allow the entity to challenge that decision before public testimony, a PIP, or further escalation.

D. Establish transparent criteria for selecting entities for further enforcement

Proposed section 97452(d) grants substantial discretion without adequately describing how OHCA will decide which entities move forward.

CAHP recommends that OHCA consider:

- Sustained multi-year exceedances rather than isolated annual spikes;

- Materiality;
- Peer comparisons among similarly situated entities;
- Remaining unexplained growth after enforcement considerations are evaluated;
- Geographic-area cost comparisons;
- Provider-specific pricing or utilization drivers;
- Good-faith affordability efforts;
- Existing risk-bearing, capitation, integrated-delivery, and value-based arrangements; and
- The entity's remaining practical opportunity to implement additional affordability strategies.

OHCA should issue written reasoning before advancing an entity to public testimony or a PIP and provide a meaningful opportunity to respond.

E. Make technical assistance a genuine first step

OHCA has publicly described technical assistance as the first stage for entities that exceed a target. The regulations, however, state, "If the Director requires technical assistance," which could be read to make this step discretionary.

CAHP requests that the regulations clearly state whether technical assistance is required before further escalation. Technical assistance should provide a meaningful early-stage remediation opportunity while preserving the entity's judgment regarding which strategies are appropriate for its circumstances. Good-faith engagement and demonstrated progress should be relevant to whether further enforcement is warranted.

OHCA should also clarify:

- How long entities will have to implement technical assistance;
- Whether technical assistance, public testimony, and PIP development are sequential or overlapping;
- How good faith and reasonable efforts will be evaluated; and
- The anticipated duration of the pre-PIP enforcement process.

F. Clarify the purpose and timing of public testimony

CAHP requests objective criteria governing which entities must provide public testimony. The regulations should explain:

- The purpose of testimony within progressive enforcement;
- How an entity's responsiveness, cooperation, and good faith will be measured;
- How testimony affects the decision to require a PIP;

- The timing between technical assistance, testimony, and PIP development;
- Whether stages may overlap; and
- How confidential or competitively sensitive information will be protected.

CAHP does not recommend limiting testimony solely to bad-faith situations, but entities should understand why testimony is required and how it will affect subsequent decisions.

G. Incorporate required interagency consultation

Health and Safety Code section 127502.5(b)(4) requires OHCA to consult with DMHC, DHCS, or the Insurance Commissioner, as applicable, before taking enforcement action against a regulated payer.

The enforcement regulations should explain:

1. When consultation occurs;
2. How it affects enforcement timing;
3. How OHCA ensures technical assistance and PIPs are consistent with laws administered by the payer's primary regulator; and
4. How OHCA will address proposed actions requiring approval involving solvency, rates, networks, benefits, or other regulated matters.

H. Clarify administrative penalties and adjustments

The regulations should expressly state the Board-approved penalty range of zero to 125 percent of the initially commensurate amount and explain how OHCA will determine the appropriate point within that range.

The initially commensurate amount should be calculated only after subtracting costs OHCA has validated as legitimate external drivers. A cost should not be accepted as outside an entity's reasonable control during enforcement and then remain in the base used to calculate a financial penalty.

Penalty-adjustment factors should recognize:

- Risk-bearing and value-based arrangements;
- Care transformation and affordability initiatives;
- Primary care and behavioral health investments;
- Quality and equity investments and performance;
- Good-faith responses to external cost drivers; and
- Meaningful measures of market impact beyond market share alone.

Financial penalties should remain a last resort within a genuinely progressive process.

I. Establish workable PIP standards

1. Preserve the two-part statutory test

OHCA has confirmed that spending-target penalties require both failure to implement the PIP and failure to meet the target. Accordingly, the regulations should not make reaching the target synonymous with PIP compliance.

PIP compliance should be demonstrable through meaningful corrective actions, agreed milestones, and good-faith implementation, even if external circumstances prevent ultimate target attainment.

2. Establish criteria for requiring a PIP

Before requiring a PIP, OHCA should determine that significant spending growth remains unexplained after evaluating legitimate cost drivers and that the entity has meaningful authority to address the remaining growth.

3. Provide adequate PIP-development time

The 45-day deadline should be extended or accompanied by broader extension authority. PIPs may require financial, clinical, operational, contracting, and regulatory review.

4. Reconsider public comment on proposed PIPs

CAHP questions the statutory basis and practical need for a 10-business-day public comment period on an individual proposed PIP. The statute already authorizes OHCA to review, modify, and approve PIPs with Board input and separately provides public transparency regarding entities subject to PIPs and their compliance.

If OHCA retains public comment, it should explain how comments will be used and ensure that comments cannot introduce new requirements unrelated to the statutory approval criteria.

5. Revise PIP approval factors

OHCA should remove or revise any approval criterion that asks whether the PIP is likely to achieve target compliance. That standard conflates successful PIP implementation with target attainment.

OHCA should also define what it means for a PIP to "positively impact affordability for consumers and purchasers" and move criteria concerning the sufficiency of future progress reports to the compliance-evaluation stage.

6. Avoid overlapping PIPs

Where subsequent performance years involve the same drivers, OHCA should permit the existing PIP to be amended through an addendum instead of requiring duplicative concurrent PIPs. Addenda could remove

completed measures and incorporate new strategies while providing the original PIP a reasonable opportunity to work.

7. Define procedural-penalty triggers

OHCA should define:

- An "acceptable" PIP;
- A "reasonable opportunity to cure";
- How cure efforts will be evaluated; and
- How procedural and spending-target penalties will avoid becoming duplicative or disproportionate.

Financial penalties imposed during an active PIP should be reserved for documented failure to participate or implement in good faith, rather than ordinary implementation challenges.

8. Create a confidentiality safe harbor

Proposed section 97455(i)(5) states that an entity "may request to withdraw or replace" information when confidentiality is denied. This could allow OHCA to reject the withdrawal request and disclose the original information.

CAHP recommends aligning the process with 28 CCR section 1007(e) and replacing section 97455(i)(5) with:

> *If a request for confidentiality is denied, the accountable health care entity shall have the right to withdraw or replace the information or documents with public versions, and material for which confidential treatment is denied shall not be deemed filed.*

This protection is necessary to support candid submissions of contracting, financial, operational, and other competitively sensitive information.

II. Draft Performance Improvement Plan Submission Guide

A. Preserve entity-specific outcomes and measures

The Guide should permit entities to select outcomes and measures appropriate to their spending drivers, interventions, data, and organizational structures.

Acceptable outcomes should include:

- Operational measures;
- Process measures;
- Utilization measures;
- Milestones;

- Leading indicators; and
- Direct spending outcomes where reasonably measurable.

The Guide should not limit success to direct spending reductions or target attainment.

B. Establish evaluation criteria when the PIP is approved

Each approved PIP should identify the agreed goals, outcomes, metrics, milestones, balancing measures, and standards for successful implementation. An entity should not later be evaluated against requirements not contained in the approved PIP.

C. Recognize timing and attribution limitations

Entities should be permitted to report partial results, leading indicators, and implementation progress when outcomes require time to materialize. Entities should not be held responsible for consumer, purchaser, provider, or market outcomes they cannot control or reliably measure.

D. Tailor balancing measures to actual risks

OHCA should identify which proposed PIP interventions create a material risk to access, quality, equity, affordability, or workforce stability. The entity should then propose mitigation strategies tailored to those specific risks, rather than being required to address every domain generically.

E. Provide notice before requiring additional safeguards

Before requiring a modification or finding noncompliance, OHCA should:

1. Identify evidence of a material adverse effect;
2. Explain its connection to the PIP;
3. Give the entity an opportunity to respond; and
4. Permit prospective mitigation.

F. Address overlapping PIPs and confidentiality consistently

The Guide should expressly permit amendments and addenda instead of duplicative concurrent PIPs, reserve mid-PIP financial penalties for documented bad-faith implementation failures, and apply confidentiality protections consistently throughout the PIP process.

III. Draft Spending Target Performance Measurement Manual

A. Exclude validated external costs from initially commensurate calculations

Section 5 should be revised so formulas for all entity types exclude costs OHCA has validated under section 97452(b)(4) as legitimate external drivers outside the entity's reasonable control.

A validated external cost should not remain in the amount used to calculate a penalty. Doing so would impose a financial consequence for spending OHCA itself determined was not reasonably avoidable and could undermine access, quality, and workforce stability.

B. Continue technical review of payer methodologies

CAHP does not recommend a specific replacement formula at this time because member perspectives differ regarding combined THCE and separate TME/TNME enforcement.

OHCA should nevertheless continue evaluating its payer methodology against approaches used by regulators, researchers, and industry experts, particularly where the current methodology may produce volatile or anomalous TNME growth rates. Further actuarial work should consider:

- Combined THCE;
- Premium-PMPY methodologies;
- Applicability to self-funded populations;
- Applicability to Medi-Cal managed care;
- Differences among commercial market segments; and
- Treatment of required administrative costs and affordability investments.

C. Evaluate appropriate risk and intensity adjustments

OHCA should evaluate whether payer methodologies require intensity and risk adjustment, particularly where analogous adjustments are being developed for provider-sector measurement.

D. Improve identification of non-retail pharmaceutical spending

Hospital-administered and other non-retail pharmaceutical costs may be embedded within broader medical expenditures and difficult to identify. OHCA should evaluate whether existing THCE or HPD data can be refined to identify these costs without creating unnecessary new reporting burdens.

E. Establish an ongoing measurement and attribution forum

Measurement and attribution policies should not be treated as one-time products. CAHP recommends a recurring stakeholder forum addressing:

- Hospital measurement;
- Physician-organization attribution;
- Payer risk and intensity adjustment;
- Provider-level cost drivers;
- TME/TNME methodology;

- Coordination between THCE and HPD data; and
- Potential duplication where the same spending is attributed to multiple entities.

The forum should include actuaries, data submitters, compliance staff, contracting experts, and other appropriate technical representatives.

Conclusion

CAHP recognizes the significant work OHCA has undertaken to develop the progressive enforcement package. The regulations should establish a process that is meaningful enough to promote genuine affordability improvement while remaining progressive, transparent, and workable.

The central objective should be to distinguish avoidable spending from growth driven by mandates, labor, pharmaceuticals, provider pricing, federal requirements, and other circumstances outside an entity's reasonable control. Technical assistance and PIPs should provide genuine remediation opportunities; successful PIP implementation should remain distinct from target attainment; confidential information should receive meaningful protection; and penalties should reflect only the spending and conduct for which the entity can reasonably be held accountable.

CAHP appreciates OHCA's consideration of these comments and welcomes continued discussion before the package advances to formal review.

Sincerely,



Anete Millers
Vice President of Legal and Regulatory Affairs
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Providence

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November 13, 2026

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

Re: Comments on Proposed Health Care Spending Targets

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

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

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

We respectfully offer the following considerations for your continued work:

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

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

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

information in a confidential manner. We also request OHCA consider developing a process for hospitals to proactively identify sensitive information to OHCA prior to its inclusion in any public meetings or materials.

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

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

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

Sincerely,



Laureen Driscoll
South Division Chief Executive
Providence