



2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov



Health Care Affordability Board
September 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
9/24/2026	Stephen Shortell	As OHCA works to implement the PIP/Penalty Process, consideration and discussion might be given to the following. It is likely that many hospitals and physician organizations will not meet the state's spending growth targets. Thus, a process will be needed to prioritize those organizations subject to the PIP/Penalty. There is now considerable evidence that risk-adjusted prospective value-based payment models and participation in Accountable Care Organizations (ACOs) are associated with lower costs while maintaining or improving quality of care. Also, greater investment in primary care is associated with lower hospital admissions and ED visits. As a result, OHCA should consider that hospitals and physician organizations that meet defined thresholds for earning their revenue from VBP thresholds, participating in ACOs, and making investments in primary care become eligible for "offset credits to be used as waivers exempting them from the PIP/Penalty process. For example, if an organization exceeds the 3.5 percent growth target by 1 percent, it is exempt if it earns at least 35 percent of its revenue from VBP and participates in at least two ACOs and increases its investment in primary care by at least 2 percentage points. Those organizations exceeding the target by 2 percent or more are

Date	Name	Written Comment
		exempt only if they earn at least 45 percent of their revenue from VBP models, participate in at least 3 ACOs, and increase their investment in primary care by 3 percentage points. The exact thresholds can be determined by examining available data. In brief, offset credits can be used to both help prioritize who should be subject to the PIP/Penalty process while at the same time incentivizing hospital and physician organizations to adopt VBP models, increase ACO participation, and increase PC investment - all behaviors associated with lower spending growth while maintaining or improving quality of care over time. As a member of the OHCA Advisory Committee, I look forward to discussing these and related ideas to advance the shared goals of all parties to achieve a more affordable, accessible, and high-quality healthcare system for the state.
9/27/26	Pouyan Golshani, MD	To the Health Care Affordability Board and OHCA staff: I am a practicing interventional radiologist in Southern California. I submit this comment in a personal capacity; it does not represent my medical group or any other organization. I write regarding the September 2026 issue brief, "Examining Regional Variation in Commercial Prices for Shoppable Services and Projected Savings from Reference Pricing." The brief and its public datasets are a valuable contribution. I offer four points. 1. A correction to the Key Points. The Key Points state that regional reference pricing would reduce aggregate fully insured commercial spending by "\$1.3 billion or 34.7% of current levels." Table 1 and the text show that 34.7% is the share of spending on shoppable services, and that the reduction in statewide claims spending is 3.18%. Aligning the Key Points with Table 1 would prevent the larger figure from being quoted out of context. 2. Site of service and claim type. The brief reports very wide within-region ranges, such as

Date	Name	Written Comment
		colonoscopy with biopsy from about \$20 to \$7,000 in one region. From clinical and billing experience, a range that wide for one procedure code often combines professional and facility claims, and hospital outpatient, ambulatory surgery center and office settings. If the percentiles were not separated by claim type and site of service, it would help to say so and to publish a version that is. A median drawn from mixed claims could fall below the cost of delivering the service in any facility setting, or could understate the savings available from site-of-service differences. 3. A complementary data source. The brief notes that it covers only the fully insured market and excludes capitated services. Machine-readable files that hospitals post under the federal Hospital Price Transparency rule report payer- and plan-specific negotiated rates, including for self-insured plans. They have real limitations (inconsistent formats, missing data, and rates that do not always match paid claims) and are not a substitute for claims data. They could serve as an independent cross-check on unit prices. 4. Procedures beyond the CMS shoppable list. In a preprint that has not yet been peer reviewed, a co-author and I examined posted commercial facility rates for 14 common interventional radiology procedures. State-level median rates varied 3.7- to 8.3-fold between the highest- and lowest-priced states, and national median commercial rates ranged from 1.34 to 3.60 times the corresponding Medicare outpatient facility payment (doi:10.64898/2026.05.09.26352821). These are national, state-level findings from hospital-posted rates. They are not California claims and should be read with that limitation. They suggest that schedulable image-guided procedures may merit inclusion in future price-variation work. I would be glad to share methods with OHCA staff if useful.

Date	Name	Written Comment
10/8/2026	America's Physician Groups	See Attachment #1
10/23/2026	California Association of Public Hospitals and Health Systems	See Attachment #2
10/23/2026	Health Access California	See Attachment #3
10/23/2026	Marshall	See Attachment #4
10/23/2026	California Hospital Association	See Attachment #5

AMERICA'S PHYSICIAN GROUPS

October 7, 2026

Elizabeth Landsberg, Director
Department of Health Care Access and Information
Members of the Health Care Affordability Board
2020 West El Camino Avenue
Sacramento, CA 95833

Re: Response to the Report on Promoting High Value Health Care in California, 2023–2024

Dear Director Landsberg and Members of the Board:

America's Physician Groups' advocacy begins with the operational experience of physician organizations. APG identifies common challenges across its membership and translates those experiences into practical policy recommendations. Our members' experience accepting financial and clinical responsibility for patient populations informs our recommendations to the Office of Health Care Affordability on how California can improve affordability while sustaining quality and access.

We welcome OHCA's October 7 report on promoting high value health care. Its support for movement from fee-for-service payment to quality-linked alternative payment models, recognition of capitated physician organizations, and separate treatment of HMO and PPO coverage provide an important foundation for further policy development. We urge OHCA to build on that foundation by integrating comparative total cost of care measurement, identifying the contributions of delegated delivery structures, and aligning affordability oversight with the authority organizations possess to manage spending.

These recommendations continue the positions presented at our September 1, 2026 meeting and in APG's September 1 briefing letter, June 25 letter on the Progressive Enforcement Framework, July 29 meeting request, and prior comments on cost and market impact review. Across those discussions, our central point has been consistent: California's delegated physician organizations are existing affordability infrastructure, and accountability must follow authority.

Recognizing the payment structures California seeks to expand

OHCA explicitly states that its alternative payment model adoption goals are intended to promote a shift from FFS payment and better align incentives for equitable, high-quality, cost-efficient care. The report identifies LAN Categories 3A, 3B, 4A, 4B, and 4C as qualifying arrangements when linked to quality performance (pp. 19–20, 26). APG supports this direction. Shared-savings and shared-risk models offer important pathways into value-based care, while population-based payment can provide physician organizations with prospective resources and financial accountability to support coordinated care across a patient population.

California should also recognize organizations that have already made this transition. Through professional capitation, shared risk, and global-risk arrangements, delegated physician organizations have invested in population health management, care coordination, quality improvement, and utilization management. Restricted Knox-Keene licensees accepting global risk are an especially important expression of this infrastructure. APG believes California should preserve and expand these mature arrangements as it encourages broader movement toward population-based payment.

The report's findings are consistent with this policy direction. Aggregate FFS payments increased 10.4% between 2023 and 2024, compared with 4.1% for capitation and full-risk payments (p. 27). These figures describe growth in payment dollars, rather than risk-adjusted per-member performance, and do not establish causation. They nevertheless warrant further investigation of how payment arrangements relate to spending levels and growth. OHCA also cites IHA Atlas evidence of clinical quality scores 7% to 9% higher for physician organizations in capitated arrangements than for those outside such arrangements (p. 14), and identifies population health management supported by capitation among cost-reducing strategies (p. 55).

Making the HMO and PPO distinctions useful for policy

The report appropriately distinguishes commercial HMO/POS and PPO/EPO coverage. In 2024, quality-linked Category 3 and 4 adoption was 81.4% in HMO/POS coverage and 31.3% in PPO/EPO coverage. Primary care spending represented 5.1% of total medical expense in HMO/POS coverage and 3.3% in PPO/EPO coverage, with annual per-member primary care spending of \$368 and \$275, respectively. Most strikingly, 83.4% of HMO/POS primary care spending flowed through capitation and full-risk payments, while 97.2% of PPO/EPO primary care spending flowed through FFS (pp. 31, 39, 41–42).

OHCA's separate 2034 adoption goals—95% for commercial HMO coverage and 60% for commercial PPO coverage—recognize these different starting points (p. 26). The findings support APG's longstanding position that California policy must account for differences in coverage, provider payment, and delivery organization. Common standards for quality, access, and affordability can coexist with different means of achieving those outcomes. Rules developed around fragmented FFS arrangements should be evaluated for their operational fit before being applied to coordinated, delegated models.

Integrating total cost of care to inform employers and consumers

APG recommends that OHCA integrate total cost of care measurement and reporting into future high value system reports, using the IHA Atlas approach to compare relative HMO and PPO performance. Reporting payment-model adoption and primary care investment is useful, but employers and consumers also need to understand the cost and quality results associated with their coverage choices.

The IHA Atlas provides a relevant model because it enables comparisons across insurance types, geographic regions, and provider risk-sharing categories, alongside clinical quality, utilization, and member cost-sharing measures. OHCA should collaborate with IHA to present comparable, risk- and geography-adjusted annual per-member total cost of care levels and growth for HMO/POS and PPO/EPO coverage, using consistent covered services and transparent treatment of pharmacy

spending, member cost sharing, and high-cost claims. Reporting should also show quality, access, and patient experience so that lower spending is evaluated together with the care patients receive.

Cost levels and growth should both be visible. A delivery organization that already operates efficiently may have limited opportunity to achieve further reductions, while a higher-cost arrangement may remain expensive even after its growth moderates. Reporting both measures would give purchasers a more complete understanding of affordability and help distinguish existing efficiency from recent changes in trend.

This information should be presented as an educational tool, with clear explanations for employers choosing coverage offerings and consumers evaluating those choices. Total cost of care is distinct from premiums and an individual enrollee's expected out-of-pocket costs; those differences should be explained. Accessible comparisons could help purchasers understand how coverage design, payment incentives, and care coordination relate to overall value, while supporting informed decisions based on their needs and available options.

Identifying delegated organizations and measuring their contribution

The report recognizes risk-bearing organizations and restricted and limited Knox-Keene plans within the definition of physician organization (pp. 68–69). Its payer-level findings, however, do not separately identify professional-risk delegation, global-risk delegation through restricted licensees, or fully integrated delivery systems. Future reporting should distinguish these structures and show Category 3 and Category 4 participation separately where the data permit. This would help OHCA identify which arrangements translate payment reform into measurable improvements in affordability, quality, and access.

The report acknowledges that allocating capitation to primary care involves estimation and that downstream distribution within physician organizations is not visible (pp. 62–63). That limitation should not obscure the comparative outcome evidence supporting capitated care. The report itself cites higher clinical quality scores among capitated physician organizations, while the IHA Atlas provides evidence of better quality and lower total cost of care when providers and health plans share financial risk. Such results offer a more direct assessment of delivery system performance than tracing individual downstream payments. Payment distribution data can illuminate resource allocation, but their absence does not establish inadequate primary care investment or poor performance. Prospective payments support physicians, interdisciplinary care teams, care management, and shared clinical infrastructure; physician compensation alone cannot represent the full investment. OHCA should therefore assess primary care investment alongside risk-adjusted total cost of care, clinical quality, access, and patient experience, rather than allow incomplete payment visibility to outweigh demonstrated outcomes. APG can help refine measurement to capture these broader investments while minimizing additional reporting burdens.

Measuring primary care network stability and patient assignment

OHCA should also assess network stability and the tenure of patient-PCP relationships within delegated physician organizations and compare those measures across HMO and PPO provider networks. APG members' operational experience indicates that delegated arrangements support enduring primary care relationships through patient attribution, prospective payment, and responsibility for care coordination. These features can strengthen continuity of care, support

efficient management of chronic conditions, and provide a more predictable financial foundation for the primary care workforce.

OHCA should assess primary care network stability and the tenure of patient-PCP relationships across all health plans, including PPO and HMO products. Reporting should examine both the proportion of members assigned to an identifiable primary care provider and the duration of those relationships. Together, these measures would reveal whether each coverage model establishes and sustains the primary care relationships necessary for care coordination. Delegated physician organizations organize care around assigned patient populations and ongoing PCP responsibility. Comparing network stability and the tenure of patient-PCP relationships across coverage models would help illuminate how that structure supports continuity of care, efficiency, and stability of the primary care workforce.

Aligning oversight with affordability objectives

The report strengthens the case for APG's proposed RBO adjustment factor. As discussed on September 1, OHCA should recognize both demonstrated value-based performance and the boundaries of each organization's contractual, financial, and operational control. An organization's responsibility for managing utilization does not necessarily give it authority to negotiate hospital rates, control pharmaceutical prices, or manage benefits retained by a health plan. Enforcement attribution and performance improvement requirements should reflect those distinctions.

Before requiring a performance improvement plan or imposing financial enforcement, physician organizations should receive sufficient underlying plan-supplied data to review, validate, and rebut their attributed spending. Corrective requirements should address spending drivers the organization can meaningfully influence, with engagement, technical assistance, reasonable opportunities to cure, and proportionate treatment of good-faith participation. Comparative total cost of care should supplement THCE analysis, while the assignment of enforcement responsibility should remain grounded in actual authority.

Recommendations

APG respectfully recommends that OHCA:

- Integrate comparative total cost of care into future reports. Report risk- and geography-adjusted per-member cost levels and growth for HMO/POS and PPO/EPO coverage alongside quality, access, and patient experience. Present the comparisons clearly to help employers and consumers make informed coverage decisions.
- Identify the contribution of delegated delivery models. Distinguish professional-risk delegation, restricted-license global-risk arrangements, and fully integrated delivery systems, and report LAN Category 3 and Category 4 participation separately where feasible.
- Evaluate primary care investment through both resources and outcomes. Recognize investment in care teams, care management, and shared clinical infrastructure, and assess performance using cost, quality, and access results alongside payment allocation data.
- Measure network stability and the tenure of patient-PCP relationships. Compare PCP assignment and the duration of patient-PCP relationships across HMO and PPO products to assess continuity and the foundations for effective care coordination.

- Align affordability oversight with actual authority. Establish an RBO adjustment factor recognizing demonstrated value-based performance and spending outside delegated control; provide underlying attribution data for review and correction; and focus performance improvement requirements on spending drivers the organization can meaningfully influence.
- Convene a technical discussion with APG and IHA. Develop these reporting and measurement improvements using consistent definitions and reliable existing data while minimizing additional reporting burdens.

APG and our members welcome continued collaboration on these recommendations. California can strengthen affordability by learning from established delivery models and making their comparative performance understandable to purchasers and the public.

Sincerely,

A handwritten signature in blue ink, appearing to read 'WJ Barcellona', with a stylized flourish at the end.

William J. Barcellona, Esq., MHA
Executive Vice President, Government Affairs
America's Physician Groups

cc: Vishaal Pegany, Deputy Director, Office of Health Care Affordability

References

OHCA, Report on Promoting High Value Health Care in California, 2023–2024, October 7, 2026. Page references above refer to this report.

APG, September 1, 2026 briefing letter; June 25, 2026 Progressive Enforcement Framework letter; July 29, 2026 meeting request.

IHA, Better Quality, Lower Costs When Providers and Health Plans Share Financial Risk, May 10, 2022: <https://www.iha.org/news-events/atlas-results-2020-healthcare-quality-cost/>



October 23, 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 and Proposed Update to the Quality and Equity Measure Set

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, and on OHCA's proposal to add health care-associated infection measures to the Quality and Equity Measure Set, ahead of the October 2026 Health Care Affordability Board meeting.

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

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

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

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

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

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 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

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.

administratively and Medicare Advantage plans generally pay hospitals at or near those 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.

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 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, and these hospitals 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 which 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. Additionally, even in cases where sustainable revenue reductions are possible, public health care systems have limited control over the volume and intensity of the services they provide and the payments that they receive. For example, the majority of patients at many public health care systems are covered by public insurance, meaning that payments for most services are already highly regulated and largely determined by federal and state agencies. While the draft Guide provides a helpful structure for PIP proposals, it does not include examples of strategies OHCA would

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.

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: CAPH appreciates that 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.

OHCA proposal to add HAI measures to the Quality and Equity Measure Set: CAPH supports the direction of OHCA's proposal to add four health care-associated infection (HAI) measures—*Clostridioides difficile* infection (CDI), central line-associated bloodstream infection (CLABSI), methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection, and catheter-associated urinary tract infection (CAUTI)—to the hospital measures in the Quality and Equity Measure Set. These measures are already used in the Centers for Medicare & Medicaid Services' (CMS's) Hospital-Acquired Condition Reduction and Hospital Value-Based Purchasing programs, and CDI is included in the Medi-Cal Quality Incentive Pool program in which public health care systems participate.

Aligning with the California Alignment for Hospital Quality Initiative (Cal-HQ) is also a sensible way to focus statewide improvement efforts. However, we request additional clarity on the data source OHCA will use for these measures. OHCA's [memo](#) states that it will rely on publicly reported data "from CDPH or CDC." The California Department of Public Health's (CDPH's) HAI reports cover all CDPH-licensed general acute care hospitals, while federal sources such as CMS Care Compare do not include every California hospital. We urge OHCA to name CDPH's public HAI reporting as the source, so that all hospitals, including all public health care systems, are measured consistently and on the same basis as Cal-HQ.

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:

David Chase

Sandra Hernández, MD

Richard Kronick, PhD

Ian Lewis

Donald B. Moulds, PhD

Mikah Owens, MD

Richard Pan, MD

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

Vishaal Pegany, Deputy Director, Office of Health Care Affordability



BOARD OF DIRECTORS

Mayra Alvarez
The Children's Partnership

Ramon Castellblanch
California Alliance for Retired Americans

Juliet Choi
Asian and Pacific Islander American Health Forum

Jenn Engstrom
California Public Interest Research Group

Jeff Frietas
California Federation of Teachers

Lorena Gonzalez Fletcher
California Labor Federation

Alia Griffing
AFSCME California

Kelly Hardy
Children Now

Michelle Johnston
National Multiple Sclerosis Society

Linda Nguy
Western Center on Law and Poverty

Maribel Nunez
Inland Empire Partnership

Tia Orr
Service Employees International Union State Council

Joan Pirkle Smith
Americans for Democratic Action

Joshua Stehlik
California Immigrant Policy Center

Kiran Savage-Sangwan
California Pan-Ethnic Health Network

Rhonda Smith
California Black Health Network

Nicole Thibeau, PharmD
Los Angeles LGBT Center

Joseph Tomás Mckellar
PICO California

Michael Young
California Teachers Association

Sonya Young
California Black Women's Health Project

Amanda McAllister-Wallner
Executive Director

Organizations listed for
identification purposes

October 22, 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, speaks to the impact of H.R. 1 and state budget cuts depriving millions of Californians of health insurance and the millions more facing unaffordable coverage today. We offer extensive comments on the draft enforcement regulations, the 2028 growth target, connecting the work of OHCA to the rates paid by consumers and other purchasers, and more.

Executive Summary:

- The people hurt most by H.R. 1 and the state budget cuts are those Californians who will become uninsured and those who are “worried sick” because of unaffordable health care.
- Health Access opposes elements of the draft regulations on enforcement, particularly the lack of transparency, questions attribution of physician organization costs, and supports other elements.
- Health Access supports the addition of measures of health-acquired infections to the equity and quality measure set for hospitals.
- We are pleased that most hospitals met the spending target or came close to it.
- Health Access continues to support use of the most recent twenty years of data on median family income as the basis for the growth target and to oppose use of the gross domestic product or the consumer price index.
- Reporting on alternative payment model adoption and primary care spending suggest the need for further analysis and measures so that these benchmarks have the intended transformative effect.
- Health Access continues to support the proposed benchmark for behavioral health to shift care upstream and out of hospital emergency rooms.
- OHCA targets should be connected to rate review to provide that consumers and other purchasers benefit from slowing the growth of health care costs.

I. **Millions Losing Health Insurance, Tens of Millions with Insurance Cannot Afford Care: H.R. 1 and State Budget Cuts Hurt Consumers the Most**

The uninsured live sicker and die younger, with the constant threat of medical bankruptcy¹. Six of ten Californians face high health care costs. They choose between food and health care, while 40% have medical debt². The insured with high costs lose their health. The uninsured lose their health and sometimes their lives. Hospitals, health plans, and large physician organizations lose revenue.

Because of H.R. 1 and state budget actions, more than two million Californians are estimated to lose coverage by the year 2030, without further action to protect coverage³. Over 730,000 Californians have already lost Medi-Cal within the last year, about two thirds citizens and lawful residents while a third are undocumented⁴.

Californians who depend on Covered California have lost \$2.5 billion in enhanced federal subsidies due to the expiration of those subsidies. While the California budget provided \$190 million in state subsidies, that replaces only a fraction of the federal subsidies⁵. Some of the almost 2 million Californians enrolled in Covered California in 2026 will just go without coverage while hundreds of thousands more will shift to bronze coverage with higher deductibles of almost \$7,000.

Over ten million Californians get their health insurance through their job, or that of a family member⁶. Median deductibles for family coverage in California in 2027 are estimated to be \$4,800 and some people pay thousands more.

Consumers choose between food and a doctor's visit, between rent and the prescription. Consumers without insurance go without care, risking their health and their lives. Consumers with health insurance face escalating costs for their share of premium, deductibles and other out-of-pocket costs. Almost half of all Californians distrust the health care system. Two-thirds of people who skip care distrust the health care system. Californians are "worried sick" because of health care costs⁷.

Shifting costs to consumers and other purchasers of commercial coverage would worsen this crisis of affordability and would increase the number of uninsured. Cost shifting harms the majority of consumers.

¹ [The government is shut down over health care. But does insurance save lives? - The Washington Post](#) and [The Impact of Health Insurance on Mortality | Annual Reviews](#)

² CHCF, Worried Sick, Sept 2026: https://www.chcf.org/resource/2026/09/28/listening-california-health-carecosts/?utm_source=ActiveCampaign&utm_medium=email&utm_content=Worried%20Sick%3A%20What%20Californians%20Say%20About%20Health%20Care%20Costs&utm_campaign=09%2028%2026%20Worried%20Sick%20Affordability%20Blast

³ Dietz, [Over two million more Californians projected to lack health insurance by 2030](#)

⁴ <https://www.chcf.org/blog/2026/07/24/what-data-tell-us-about-730000-californians-who-have-left-medi-cal/>

⁵ [Brief 1 IRA ACA Premium Impacts 2026.pdf](#)

⁶ CHCF [California Health Insurers, Enrollment — 2025 Quick Reference Guide](#)

⁷ CHCF Worried Sick, Sept.2026

Hospital charity care provides scant relief for the uninsured or the underinsured. In 2022, California hospitals spent 0.8% of revenue on charity care, about \$1.1 billion on charity care out of \$130.3 billion in revenue⁸. Some hospitals with the highest prices pay their executives more than the hospital spends on charity care⁹.

So-called “uncompensated care” includes both bad debt and charity care. In 2022, California consumers had far more hospital bad debt (\$862 million) than charity care (\$482 million)¹⁰. Bad debt means a patient is pursued in collections. Bad debt is bad for consumers; far from a handout or a hand up, this debt can affect all aspects a consumer’s financial well-being, from obtaining housing to having their wages garnished. Hospitals can write off bad debt as a business expense, patients cannot. Uncompensated care is a polite term for medical debt and debt collection activities.

Health plans get paid to provide coverage for consumers. Hospitals and physician organizations get paid to take care of patients. When fewer Californians have coverage, revenues for health plans, hospitals, and physician organizations will decline.

II. Draft Enforcement Regulations: Lack of Transparency

a. Enforcement Transparency: Concealing Which Entities Exceed the Target for Months, Even Years

Health Access opposes the provision in the draft regulations that conceals for months or even years which entities have exceeded the spending target and the reasons an entity did not proceed to further enforcement. The draft regulation delays for months or even years any public notice of the first stages of progressive enforcement. The entity knows enforcement has begun. The Board, the Advisory Committee, the Legislature and stakeholders do not.

Here is what would happen under the proposed regulations, if not amended:

- OHCA gives an entity initial notice that the entity exceeded the target without any public notice or transparency.
- The entity has 45 days to respond to OHCA. There is no public notice of the entity’s response or the reasons the entity provided for exceeding the target.
- OHCA staff then is allowed to take time to consider the reasons the entity alleges for exceeding the target.
 - This could be another 45 days. It could be months or even years.
 - Again, nothing is public at this stage of progressive enforcement.
 - There is no opportunity for stakeholders to weigh in, to counter the entity’s assertions, whether it is on high-cost drugs, the inability of a plan to negotiate hospital costs, incorrect attribution of costs, or other factors asserted by the entity.

⁸ <https://hcai.ca.gov/visualizations/hospital-financial-data-interactive-series-hospital-financials/>

⁹ [High Hospital Costs in Santa Barbara County - Health Access](#) and [High Cost Hospitals in the Southern Bay Area - Health Access](#)

¹⁰ <https://hcai.ca.gov/visualizations/hospital-financial-data-interactive-series-hospital-financials/>

- The regulations appropriately allow further back and forth between the OHCA staff and the entity to clarify or provide further information. That will take more time. Weeks and months will slide by.
- Then the entity is given notice of whether there will be further enforcement.
- At some unspecified later time, the public is finally given notice that an entity has exceeded the target through a posting on the website. That public notice consists only of the excess spending growth¹¹.
 - We are not certain whether this notice includes all entities that were ever considered by OHCA to have exceeded or only a subset that excludes entities that have data corrections.
 - The regulations do not require OHCA to publish when the entity was given notice.
 - The regulations do not require OHCA to describe, even in summary fashion, why enforcement did not proceed. Was it data corrections? Factors outside the entity's control that partially or fully accounted for the excess spending? That excess spending was de minimis, the equivalent of doing 67 mph in a 65-mph zone? And other stakeholders do not know to ask, because no one knows that enforcement was under consideration for the entity. Even categorizing entities would be helpful.
 - If lots and lots of entities have data errors or data corrections, that will be important to know.
 - It will be equally important to understand which factors OHCA considered to be outside the control of the entity. For example, other states have failed to consider the role of the 340B program in reversing the impact of high-cost drugs on hospitals and other entities and thus accounting for the impact of some categories of high-cost patients.

The entity knows it is in the first stages of enforcement. The entity is free to share the information however and with whomever it chooses—with the Legislature, with the Governor's Office, with its fellow entities, with its trade association, even in an OHCA Board meeting or Advisory Committee meeting. Meanwhile, the Board, the Advisory Committee and other stakeholders will be operating blind, for months or longer. How can the Board proceed to set future targets or take the other actions required under the law when they have no idea how many entities exceeded the target, by how much and for what alleged reasons until months or even years after enforcement begins?

Putting an entity on a public list of entities that exceed the target is a mild, first step in enforcement. Many entities will not proceed beyond this stage, whether it is because of data corrections or "enforcement considerations". Part of what OHCA is building is the pressure to change behavior on the part of entities. This is especially critical in the commercial market, which lacks a rate setting process and where antitrust considerations can, and should, preclude collusion among purchasers.

Health Access again 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.

¹¹ The proposed regulation reads:

Title 22, Section 97452 (e) The Office shall notify an accountable health care entity in writing 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 pursuant to section 127502.5(c)(1).

b. *Technical Assistance: Lack of Public Notice, Lack of Clarity*

The proposed regulations on technical assistance suffer from a similar lack of public notice as well as a lack of clarity.

The draft regulations say:

Title 22, Section 97453 (c) Subject to section 127502.5(c)(4) of the Code, the Office may post the following on the Department's website:

- (1) Technical assistance template letters without specific information about an accountable health care entity.

This means that the Office may post nothing and comply with these regulations. It is not clear whether the name of the entity that received technical assistance will be disclosed.

This lack of transparency is compounded by the failure of the regulations to specify which entities receive technical assistance under what circumstances. The only indication in the draft regulation of which entities will receive technical assistance is that statement "if the Director requires technical assistance".

Staff presentations indicate that "all" entities exceeding the target will receive technical assistance but also that entities that during the 45-day period have sufficient data corrections to explain the excess spending will not receive technical assistance. This is confusing. Which is it? All or just some? The staff appears to mean that an entity that receives notice of exceeding the target will not receive technical assistance if the entity has sufficient data corrections to explain the excess, but an entity will receive technical assistance if the entity asserts enforcement considerations. Given the brevity of staff presentations and the silence of the regulations, we may have confused what is intended.

If all entities that have exceeded the target move forward to technical assistance, the director should indicate why some entities move to the next stage of enforcement, while others stop at technical assistance. This is a critical juncture of progressive enforcement, where for many entities over the target, enforcement may stop here. If that is the case, the public should know what enforcement considerations informed that OHCA decision and why other entities move to next steps in enforcement. This applies whether all entities, including those with data corrections, receive technical assistance or not.

Under the current proposed regulations and accompanying manual and guide, the fact of which entities get technical assistance and under what circumstances is not publicly known. If it is not appropriate to amend the regulations, it is certainly appropriate to provide clarity in a manual or guide similar to those for performance improvement plans or spending target measurement.

c. *"Public" Testimony is Not Public*

The regulations do not require that "public" written testimony be publicly posted. This may be an oversight. It should be corrected so that those affected know what the process will be.

Oral "public" testimony may be presented at a OHCA Board meeting subject to the open meetings law or it may not be. The draft regulations say "if" it is presented in a Board meeting, it is subject to the open meetings law. That leaves open the possibility that "public" oral testimony could be in another setting. We do not object to a different public meeting. We do object to lack of public notice and public oversight. The point of "public" testimony is that it is public.

Health Access supports the provisions of the draft regulations on public testimony that allow the Director to consider the good faith and due diligence of the entity in being responsive to being required to present public testimony. If this step is the last step in the enforcement process and there is no further enforcement, it is a serious one and should be taken seriously.

d. *Lack of Enforcement Transparency*

Without public notice at each of these earlier stages of enforcement, from the initial notice to the entity through technical assistance and then "public" testimony, the Board will not know what is going on and neither will other policymakers and stakeholders. Stakeholders will not be able to provide input on whether an assertion of enforcement considerations has merit or is ill-founded or misdirected.

Keeping the early stages of enforcement secret benefits those entities with high costs and disadvantages those that have been trying to do the right thing by controlling costs. The OHCA cost growth target is meant to improve affordability for consumers, but the proposed regulations currently leave those they are meant to protect in the dark for critical decision-making parts of the process.

It will also prevent iterative learning about what factors are driving high health care costs.

e. *Performance Improvement Plan Transparency*

Health Access appreciates the greater public transparency around the performance improvement plan process. The experience in other states has been that such performance improvement plans are relatively infrequent: Massachusetts has imposed one in ten years while Oregon has contemplated only a few in its less lengthy history. We do not yet know how many California entities will warrant a performance improvement plan.

The regulations require periodic progress reports. The Board as well as other stakeholders should be kept updated through publicly available summaries of progress or lack of it. In the performance improvement plan

guide, providing updates on progress reports appears to be at the discretion of staff. Progress reports should be public, at least in summary form.

III. Draft Enforcement Regulations: Other Issues: Attribution to Physician Organizations, Enforcement Considerations, Confidentiality and Performance Improvement Plans

a. Draft Enforcement Regulations: Attribution to Physician Organizations

Health Access has serious concerns about the proposed growth target methodology of attributing to physician organizations total medical expenses, including hospitals, specialists, prescription drugs, labs, imaging and more. We recognize that this model was developed in Massachusetts and has been used in other states. Whether it makes sense in those states or not, we leave to policy makers and stakeholders in those states.

In Health Access' view, this approach is not consistent with the California law, ignores massive chunks of the California market, and wrongly ascribes to physician organizations costs which those entities do not control, even in the delegated risk bearing organization model, much less in the rest of California health care. Simply because another state has adopted a particular measurement model does not mean it fits here.

California law defines physician organizations as those with 25 doctors or more. It does not define health systems, nor does it require physician spending to be attributed to a health system. Instead, the California law provides that OHCA may require physician organizations to submit audited financial statements or the equivalent. This information was intended to be used to measure year over year spending and revenues to these physician organizations.

The current approach proposed in the regulations and the spending target performance measurement model includes the Permanente medical groups, some but not all the University of California (UC) medical groups and all risk bearing organizations. Risk bearing organizations (RBOs) are a subset of non-Kaiser commercial market, accounting for 2.5 million lives in that market¹². The non-Kaiser commercial market is about 7 million lives. The approach proposed in the draft regulations excludes half the non-Kaiser commercial market. It fails to capture the PPO market, even though the evidence is consistent that PPOs are higher cost than HMOs. It currently excludes physician organizations that consist exclusively of specialists, some of which are aligned with one health system and others are aligned with multiple health systems.

The definition of physician organizations in the law was deliberately broad: the approach proposed in the draft regulations is far narrower and ignores a significant share of the market and major costs.

Even in the delegated model, risk-bearing organizations (RBOs) rarely bear legal or financial responsibility for all of the costs attributed to them by this model. Instead, the division of financial responsibility between the risk-

¹²https://www.dmhc.ca.gov/Portals/0/Docs/OFR/FSSB/Aug26/AgendaItem6_ProviderSolvencyQuarterlyUpdate.pdf;

bearing physician organization and the contracting health plan has evolved over time. It has varied over time, by region, and by RBO.

We propose that OHCA staff convene a workgroup on an attribution model for physician organization spending and revenues. It should begin with the limitations of the California law and the realities of the California market. This is similar to what was done with respect to hospital spending measurement which does not use the attribution model used in Massachusetts.

b. Enforcement Considerations: Relevant Factors to Exceeding the Target

The draft regulations include a list of factors relevant to an entity exceeding the target as well as additional provisions to be used by the Director to determine whether to proceed with enforcement. The list of eight factors is similar to what have been called “enforcement considerations”.

Health Access appreciates the focused list that is consistent with prior discussions and reflects various provisions in the law. Some further comments on specifics in Title 22, 97452 (b) (4) are enumerated below:

- (A) Recognition of unique population characteristics or changes in social risk are supported by various provisions in the law that encourage OHCA to take such factors into account. We trust the use of the term “unique” signals an intent to construe this provision narrowly.
- (B) The impact of high-cost patients: Some patients will be high-cost because of high-cost drugs: we urge that those costs be looked at under the provisions of (C). Health Access recognizes that there are also some patients such as trauma patients and organ transplants that may not overlap with high-cost drugs.
- (C) The impact of high-cost drugs on the entity's excess spending growth: Health Access appreciates the clarity that drug costs will be considered net of any remuneration or financial consideration. Since the 340B program is a revenue generator for several types of health care entities, we urge the added inclusion of the possibility of revenue generation. This may already be encompassed in the proposed language but if not, it should be.
- (D) Health Access supports the inclusion of the impact of investments in primary and preventive care. We note several concerns here. First, if a hospital invests in primary or preventive care in the community but it is the licensed hospital that is subject to the target, how does that investment align with the California law as currently written? Health Access attempted to broaden the law to allow for considerations at the system level, but the California Hospital Association opposed that effort. Health Access has previously recommended that investment in primary or preventive care by a hospital be considered but that consistent with current law, the licensed hospital be subject to enforcement of the growth target. Second, are investments in primary and preventive care code words for financial control that amounts to consolidation of health care? This should be investigated prior to approving an enforcement consideration which may be cover for obtaining control of other entities such as physician organizations. Third, when the work of OHCA on behavioral health progresses further, that benchmark will deserve further consideration.
- (E) The impact of changes in state or federal law: some changes in law have very modest or delayed impacts. For example, the cost of seismic compliance could have been amortized over the last 30 or 50 years for

hospitals that chose to comply with the law. According to the California Health Benefits Review Program (CHBRP) analysis of the impact of the new infertility law on health care costs, the cost was about 0.1%¹³.

- (F) and (H) are standard catchalls in the law for things that cannot be readily anticipated or detailed. Whether it is an earthquake or a global pandemic, the impact on specific entities is highly variable. For example, an earthquake might close all or part of one hospital while another, even close by, could have significant increases in patient volume. That has been the actual experience after several major California quakes.

Health Access also supports the additional provisions in (d) that in determining whether to proceed with enforcement, the Director is to consider the entity's historical spending growth, baseline costs, impact on consumer access and affordability, the amount of excess growth, and actions to impair or impede enforcement. These are appropriate factors in the determination of whether to proceed with enforcement. A small, rural hospital that is slightly over the target should not be the focus of enforcement. High-cost hospitals, physician organizations or health plans that consistently cost more than their peers with little or no justification should be the focus.

Health Access also recognizes that the list of factors or enforcement considerations may evolve over time as the source of major costs shifts. Looking back, we can see that very high-cost drugs, some costing millions of dollars, administered in the health care setting loom large today but were inconceivable to most of us a decade or two ago.

Health Access strongly supports the provision in the draft regulations that requires "clear and convincing evidence" that the Office's calculation is incorrect. This is a well-recognized legal standard that is somewhat higher than the very minimal "preponderance of evidence" but a long way from the highest standard, used in American criminal law of "beyond a reasonable doubt". This puts the burden on the entity to document that the Office got it wrong when it told the entity that the entity exceeded the target.

c. Confidentiality Limited to Otherwise Non-Public Information

At several points, the draft regulations discuss "confidentiality" of materials or information submitted to the Office. The approach proposed in the regulations appears to us consistent with both the letter and the intent of the law. Health Access worked with others, including HCAI, on the drafting of this part of the law to ensure that material that was otherwise public will not be treated as confidential in this process. It has been our experience that entities often assert confidentiality about materials or information that is publicly provided in other settings, such as to federal regulators or investors.

Overly broad assertions of confidentiality work against the transparency that is the foundation of OHCA's work. Health Access recognizes that some information is "proprietary", "trade secrets", or otherwise of a business confidential nature. This should be counterbalanced with the public interest in the need for health care.

¹³ The CHBRP analysis pegged the cost at 0.2% when it applied to the entire commercial market. The final version of the law limited it to the state-regulated large group market which is about half the market.

Knowing whether the entity anticipates closing a labor and delivery unit or whether the only oncology group in the region is opening are matters of access to health care in a way that knowing the recipe for Coca Cola, a classic example of a trade secret, is not.

d. Performance Improvement Plans:

i. "Target Value" Discussion

When an entity submits a performance improvement plan, what cost target should the entity propose and OHCA approve? The answer might be easy if the target were the same in the year the entity exceeded the target as well as in the year or years in which the performance improvement plan was in place. If the target for 2026 (the first enforceable year) was the same as the target for 2027 (data submission), 2028 (performance improvement submitted), 2029 (PIP implementation) and 2030 or 2031 were level at 3%, then the answer would be 3%.

But two alternative scenarios intrude: under the current cost target, the target for 2026 is 3.5% phasing down to 3% for 2029 and 2030. The current cost target of 3% is based on median family income from 2001 to 2021. Shifting the analysis to a more recent 20-year period, 2005-2025, might produce a higher target. Under either of these scenarios (target lower when the performance improvement plan is imposed or higher), what should the target value for the performance improvement plan be?

Health Access proposes that one of the "action steps"¹⁴ included in every performance improvement plan consist of a commitment by the entity to meet the target for each year the plan is in effect as well as to come into compliance with the target for the year in which the entity exceeded the target. We are troubled by the prospect that an entity might exceed the target year after year, never coming into line with it, benefiting financially from its lack of compliance, and undermining the improvements in affordability meant for consumers. We are also alert for behavior that is intended to evade the spending target penalties which may only be imposed if an entity is "not compliant with an approved performance improvement plan and does not meet the cost target"¹⁵.

Health Access recognizes that some changes will require time, as in years, to transform care delivery. Other changes, such as freezing or reducing excessive prices, can occur within a year.

A key element in the evaluation of a performance improvement plan is the following:

"Is the proposal more likely than not to ensure the entity meets future spending targets?"

This question goes to the heart of the effort: has the growth trajectory shifted so that over time, the entity is able to meet the growth target? Or is the entity still on track to exceed the target in most years, building up a high base of costs? Which approach does not reward compounding excess spending in prior years and assure

¹⁴ H&S 127502.5 (c) (1)

¹⁵ H&S 127502.5 (d) (1)

OHCA of future compliance with targets and the other requirements of the law? That is the question that we continue to ask.

ii. *Affordability for Consumers and Purchasers*

Health Access very much appreciates the provision requiring an entity to explain in their performance improvement plan how their efforts will improve affordability for consumers and other purchasers. We strongly support the following provision:

“Lower spending from PIP goals, whether through changes in utilization and/or pricing, should not solely reduce internal operating expenses for the health care entity but *positively impact affordability for consumers and purchasers.*” (emphasis added)

Too often cost savings are lost in the black box of health care costs, absorbed by the health care industry. Individual consumers and even large, sophisticated purchasers find that alleged cost savings evaporate without slowing the growth of premiums, deductibles and other cost sharing.

Health Access strongly supports this direction in the PIP guidance:

“As relevant and applicable, disaggregate savings from PIP goals by payer market, line of business, and product type, and include specifics about the impact of PIP goals on unit costs.”

This provision can help to delineate impacts for consumers covered by individual health insurance or employer coverage, and for the purchasers of employer coverage. Since both Medicare and Medi-Cal have their own rate setting methodologies and other provisions governing rates paid to plans and providers, it is possible to distinguish these public programs from the other major market segment, commercial coverage.

iii. *“Balancing Measures”: Equity, Quality and Access*

Health Access supports the provision in the draft regulations in D. 8. that requires an entity subject to a performance improvement plan to explain how it will have “balancing measures” to maintain or improve equity and quality. We appreciate the inclusion of “improving” equity and quality. For example, reducing health-acquired infections lower costs while improving quality. Reducing other medical errors also has the same effect. A performance improvement plan with measurable goals for reducing medical errors would have the happy effect of improving outcomes while reducing costs.

With respect to access, the performance improvement plan guide begins by mentioning access as well as quality, equity and workforce stability but the plan does not mention specific balancing measures for access. The guide would be strengthened by adding to the “balancing measures” guidance that the entity may provide information on access measures used by sibling state agencies such as the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) for Medi-Cal managed care. This is clearly envisioned in the law when it says:

(E) Access, quality, and equity of care measures and data, as available. Access includes timely access, language access, geographic access, and other measures of access reported through available data¹⁶.

Timely access, language access, and geographic access are reported to DMHC and DHCS. While the reporting is on health plans, it is reporting about access to providers so these are appropriate measures for both plans and providers.

IV. Health-Acquired Infections: Adding to the Quality and Equity Measure Set

Health Access advocated for the addition of health-acquired infections to the Quality and Equity Measure Set used to evaluate hospitals. Reducing health-acquired infections and other medical errors requires some investment but pays off in reducing overall costs while improving outcomes. Nobody goes to the hospital to get sick. People go to the hospital to get better. This has been a foundational principle of hospital care since Florence Nightingale showed up in the Crimea during that Crimean War in the 1850s. We continue to support the addition of these measures and appreciate the work of sibling state departments to align efforts to keep Californians healthy.

V. OHCA Growth Target: 2028 Adjustment? Consumers' Ability to Afford Care Worsened by Inflation

Health Access supports grounding the spending target in the growth in median family income for the prior twenty years. We continue to oppose use of gross state product or other measures of the wealth of the economy. The wealth of Google or Anthropic or biotech is in no way a measure of the ability of consumers to afford health care costs, whether it is deductibles, other cost sharing or their share of health insurance premiums. We continue to support the use of median family income and the use of a 20-year lookback because of the volatility of economic measures.

Health Access opposes the use of inflation as a measure for several reasons. First, the Consumer Price Index reflects a market basket of costs paid by consumers, not health care entities. For example, high gasoline prices hit consumers hard but hospitals, health insurers and large physician organizations much less. Second, when the Consumer Price Index rises above 2%, as it has for the last five to six years, consumers have less money to spend on health care, not more. This is especially true because for much of this period wages have not kept up with inflation. Third, Medicare has measures of inflation or changes in costs that are specific to physician offices and hospitals. This might be worth considering measured as a multiplier of Medicare, after taking into consideration any entity that has excessively high base costs.

VI. Hospital Revenues: Most Hospitals Met the Spending Target for 2023

Health Access supports a single weighted average for hospital inpatient and outpatient revenue. We support the use of the Medicare methodology for outpatient visit intensity. For hospitals, health plans and large

¹⁶ Health and Safety Code 127501.6 (b) (2) (E).

physician organizations, we support measuring the growth target by market segment, specifically commercial, Medi-Cal and Medicare.

We are pleased that when the OHCA staff applied this methodology to hospital revenues and reported it in the September 2026 Board presentation¹⁷, it found that a majority of hospitals had revenue increases below the 3.5% growth target for the 2022-2023 period. This was true for commercial coverage as well as Medi-Cal and Medicare.

Equally, we are appalled that a small fraction of hospitals had growth increases over 50% and that another chunk had growth increases 20%-50%. We recognize that some of this overage is likely to disappear on further examination. It may be due to revenue volatility or data errors. This is why it is important that there is transparency of the reasons why an entity fails to proceed through enforcement: it makes a difference whether it is data errors, short-term volatility in revenues or enforcement considerations that are demonstrably outside the control of the entity.

Enforcement begins when OHCA publishes the list of entities that have exceeded the target. For those that came close, simply publishing the failure to meet the target may be sufficient punishment in the early years. For those that missed it by a mile, we feel very differently, and that is why we have supported the full range of enforcement actions.

VII. High Value Health Care Report

a. Alternative Payment Model Adoption

Health Access was struck by the discrepancy between the adoption of alternative payment models in terms of the number of lives affected and the dollars spent on a fee-for-service basis. The fact that 85% of lives are attributed to alternative payment models but 70% of dollars are paid on a fee-for-service basis says to us that the approach taken to measuring alternative payment models may not have the transformative effect it was intended to have by those who drafted these provisions. This discrepancy is especially striking when we consider that the measurement excludes the small but growing share of Medi-Cal enrollees in fee-for-service and the reality that almost half of Medicare enrollees are in traditional or fee-for-service Medicare. Transforming physician practice, particularly primary care, may require additional or different approaches to get the transformative effect intended. We are grateful that both covered lives and dollars spent were measured: that was very much the right call. But it reveals that California has more to do on this score. Perhaps the OHCA Investment and Payment Workgroup should be tasked with considering additional measures or measures at a different level of the system.

b. Primary Care: Apples and Oranges? Or Apples and Zucchini?

¹⁷ <https://hcai.ca.gov/wp-content/uploads/2026/09/September-2026-Board-Meeting-Presentation-1.pdf>

For primary care, as with alternative payment models, the report includes no data on Medi-Cal fee-for-service or traditional Medicare despite the importance of these market subsegments.

Kaiser spending data on primary care may not be comparable to that of other plans because of delivery system structure. Further examination of what the payments pay for is needed before adoption of further requirements related to primary care. Key questions include do payments to doctors by non-Kaiser plans include the cost of running business (scheduling, office space, other staff on primary care team)? Is Kaiser just counting the salary of primary care practitioners but not the other costs of supporting their work such as scheduling, office space, pharmacists, or other care team members? That is why we ask whether Kaiser/non-Kaiser is apples and oranges or apples and zucchini: how comparable is the spending? There may be other distinctions such as community clinics versus primary care doctors serving primarily the commercial population that are equally significant. Further analysis may be helpful as may be additional measures. The point is to shift to greater reliance on primary care.

VIII. Behavioral Health: Aimed at Community and Prevention

As OHCA works to develop a behavioral health benchmark, Health Access continues to support a behavioral health benchmark that

“Increased investment should help individuals in need of behavioral health to receive more timely, high quality, and culturally responsive care, in more appropriate settings, and with less out-of-pocket spending via improved access to outpatient and community-based services that are in-network”.

Put another way, behavioral health should be delivered in the community or the outpatient setting while hospital emergency departments serve those with acute or emergent conditions, just as for physical health. Corrections should be a path to needed care, not a Dickensian warehouse for those facing significant behavioral health needs.

IX. OHCA and Rate Review

The most common question we get about OHCA from consumers and purchasers is not “what are the targets” or “how does enforcement work”. Real people want to know when the work of OHCA will pay off in moderating increases in premiums and deductibles or better yet, result in lower premiums, deductibles and other cost sharing? This is especially true given the affordability crisis that consumers and other purchasers of commercial coverage face today.

It is outrageous that under the affordability standard of the California individual mandate, a family would need to make \$440,000 a year to afford both the employer and worker share of premium and deductible for family coverage. That calls into question the viability of employer coverage that half of all Californians depend on for their health insurance. The OHCA targets should connect to rate review by the respective regulators, DMHC and

the California Department of Insurance. What is the point of OHCA? If it is about consumer affordability, then it needs to pay off in the rates.

Health Access is disappointed in the Governor's veto of SB 1037 (Weber Pierson). We will continue working on how to connect the work of OHCA to what California consumers and other purchasers pay in premiums and cost sharing. Controlling underlying health care costs is meaningless to Californians unless we feel the difference in our pocketbooks.

We note the contribution of Katie Van Deynze, senior policy and legislative advocate, to these comments. Thank you for your consideration of these comments.

Sincerely,



Beth Capell, Ph.D.

Policy Consultant



Amanda McAllister-Wallner

Executive Director

CC: Members, Health Care Affordability Board

Richard Figueroa, Deputy Cabinet Secretary, Office of the Governor

Christine Aurre, Legislative Affairs 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 Figueroa, Deputy Commissioner, California Department of Insurance



October 30, 2026

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

Subject: Comments on Proposed Penalty Framework Regulation

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

Dear Director Landsberg:

Marshall continues to have strenuous objections to the proposed regulations recently promulgated by the Office of Health Care Affordability (OHCA), which establish an enforcement and penalty framework for hospitals that fail to meet the state's spending targets. OHCA's proposed regulations fall short of providing reasonable protections to hospitals, protections which are needed to protect access to care and prevent further destabilization of the state's increasingly fragile health care infrastructure. OHCA must instead adopt a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends, while simultaneously basing their penalty calculations on valid data.

Marshall urges the OHCA board to revise its proposed regulations to balance affordability with continued access to care by:

- **Basing the determination of a violation on multiple years of data** to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target
- **Accounting for the impending cuts in Medi-Cal and Medicare payments and growing ranks of the uninsured** by only initiating enforcement against hospitals that exceed the spending targets across all their payers on a combined basis.
- **Standardizing the process for explaining growth above the target and enumerating additional reasons for justifiable growth**, as established under the statutory waiver process
- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied
- **Revisit the penalty framework and only penalize hospitals based on excessive growth that has been determined to be unjustified**, the latter of which provides essential definition and meaning to statute requiring penalties to account for the "nature" of the violation.

Marshall is currently experiencing cost growth far in excess of the 3.5% spending target. Last year alone, our labor costs grew by 3.9%, our drug costs grew by 28.4% and our physician contracts costs rose 6.9%. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: cut staff and services now to avoid potential penalties, or provide the care our patients need but risk fines that would wipe out what little financial cushion we have.



To adapt to OHCA's new spending restrictions and the challenging financial environment, we have taken the following steps:

- Marshall has reorganized and reduced our Executive Leadership overhead;
- We have reduced 33 FTE over the last 12 months;
- We have paused investments in outpatient services that our patients need;
- We have asked the voters of our county to fund our remaining seismic work with a new sales tax.

And yet, those efforts might not be enough. OHCA's hospital spending methodology produces wildly variant results that do not reflect Marshall's actual experience. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which will be misleading. One year in isolation does not give an accurate picture of Marshall's spending trends. For this reason, multiyear assessments of hospital spending growth against the targets are necessary.

Worse, OHCA intends to separately enforce the targets for every payer, giving hospitals three separate ways to violate the target. For Marshall, that means major losses in Medi-Cal and Medicare (~75% of our gross charges) will not offset any incremental increases we receive from commercial payers (~16% of our gross charges). As a result, Marshall would still be penalized for efforts to sustain access, quality, and jobs in the face of persistently elevated inflation and the largest Medicaid cuts in the nation's history.

Penalties at the levels proposed by OHCA would threaten Marshall's viability, jeopardize our patients' health, and endanger the livelihoods of the 1,400 workers who rely on us. Had the 3.5% spending target been in place in 2023, Marshall would have faced a starting penalty amount of **\$8.3 million** on its commercial line and **\$22.6 million** across all payer lines. Such a fine today would threaten our very existence and therefore threaten the delivery of care in our county.

Marshall is also concerned that OHCA may seek to financially penalize entities before they have had the chance to improve their spending trends based on voluntary strategies. The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the El Dorado County residents and the many visitors who pass through our doors each year.

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

Sincerely,

Maia Schneider

Maia Schneider
Executive Director, Business and Strategy



cc: Members of the Health Care Affordability Board:

David Chase

Kim Johnson

Dr. Sandra Hernández

Dr. Richard Kronick

Ian Lewis

Donald B. Moulds, PhD

Dr. Mikah Owen

Dr. Richard Pan

Vishaal Pegany, Deputy Director, Office of Health Care Affordability

Honorable Joe Patterson, California Assembly Member

Honorable Marie Alvarado-Gil, California State Senate



October 23, 2026

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

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

Dear Chair Johnson:

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

The following comments focus on OHCA's recently released *Interim Report: Health Care Spending Trends in California, 2023–2024* and on recent research CHA urges the board to consider as it interprets those trends. CHA will address the details of OHCA's proposed progressive enforcement regulations and supplemental guidance in a separate comment letter.

In brief, the interim report shows spending growth was broad-based and driven by multiple factors — including price, utilization, and service intensity — that the report's category totals cannot yet separate. OHCA should understand these various drivers across all payers before drawing conclusions about individual hospitals or other entities.

Spending Growth Was Broad-Based and Its Drivers Need Further Analysis

OHCA's interim report tracks changes in health care spending across commercial, Medicare, and Medi-Cal managed care, including total medical expenses (TME) and health plan total non-medical expenses. The report shows that TME per member per year (PMPY) grew 7.8% in the commercial market, 7% in Medicare, and 20.1% in Medi-Cal managed care from 2023 to 2024, with most commercial payers above 7%¹. These results mirror national trends: National health spending grew 7.2% in 2024 as utilization remained elevated, and

¹ California Department of Health Care Access and Information, Office of Health Care Affordability. Interim Report: Health Care Spending Trends in California, 2023–2024. October 7, 2026.

Medicaid spending per enrollee grew 16.6% as eligibility redeterminations resulted in a higher proportion of enrollees with greater health care needs and higher utilization².

Commercial growth was spread across service categories, with every claims category growing between 5% and 12.4% PMPY. Hospital inpatient and outpatient services together held a stable share of commercial TME from 2023 to 2024. Within hospital care, the mix was not evenly divided: Inpatient spending grew 5% PMPY, the slowest of any commercial claims category, while outpatient spending grew 12.4%, a pattern consistent with care moving from inpatient to outpatient settings (a trend that is not only good for patients, but also reduces overall health care spending). Retail pharmacy, gross of rebates, grew 11.9%, more than twice the rate of hospital inpatient spending. Hospital outpatient spending also includes emergency department visits that do not result in admission. Hospitals provide this care regardless of patients' ability to pay, and its growth reflects patient need and access to other care, not discretionary hospital decisions.

The interim report looks at TME by claims and non-claims spending categories, which could help inform areas of spending growth. Service category totals for hospital care in the report cannot distinguish price from volume, acuity, or site of care shifts, yet the report describes commercial growth as "driven by increases in hospital outpatient spending." Statements about what drives spending growth should rest on evidence that separates these factors, and CHA urges the board not to draw conclusions about the sources of spending growth from category totals alone. The category totals also do not reflect changes in enrollment, payment arrangements, or utilization, all of which shifted between 2023 and 2024. Movement of members between capitated and fee-for-service arrangements, for example, can shift spending from non-claims to claims categories without any change in the underlying care, making category-level growth rates difficult to interpret on their own. Hospitals ask OHCA to account for changes in enrollment mix, payment arrangements, and utilization when describing category-level spending growth.

Finally, while the measures above track spending across the system, California families experience affordability through premiums and out-of-pocket costs. In the fully insured commercial market from 2023-2024, premiums grew 9.7% PMPY, and insurer profit rose from \$31 to \$109 PMPY, or from 0.5% to 1.5% of premium. Total non-medical expenses, which OHCA will measure against the spending target, grew 12.8% — well above the 3.5% target for 2025. Commercial member cost sharing grew 8.4% PMPY, including 12.8% in HMO-POS products. Because lower insurer spending does not necessarily translate into lower premiums, hospitals ask that OHCA track over time whether slower spending growth reaches consumers through lower premiums and cost sharing.

Growth Above the Target Is Not the Same as Inefficiency

Spending growth combines prices, utilization, patient need, service mix, and technology, and recent evidence indicates that price growth is not the primary driver. In a study of Blue Cross Blue Shield of Massachusetts commercial claims published in *Health Affairs*, Chernew and colleagues found that after adjusting for general inflation, prices for medical services were relatively flat, rising 1.3% in fiscal year 2025 (well below the rate of growth in utilization at 4.8%), while prescription drugs in total accounted for almost 30% of total spending

² Hartman M, Martin AB, Benson J, Catlin A, National Health Expenditure Accounts Team. National health care spending increased 7.2 percent in 2024 as utilization remained elevated. *Health Affairs*. 2026;45(1):10–20. doi:10.1377/hlthaff.2025.01683

growth³. The authors conclude that “price growth after accounting for general inflation was not the major contributor to spending growth,” finding instead that utilization and prescription drug spending accounted for the majority of growth. A spending target focused on restraining provider prices is therefore unlikely to address the factors actually driving cost growth.

Inflation also shapes how spending growth is judged against a spending target. In a research article in *Health Affairs*, Professor Keith Ericson of Boston University found that meeting six states’ (Connecticut, Delaware, Massachusetts, Oregon, Rhode Island, and Washington) nominal 2022–23 spending benchmarks would have required real per capita health care spending to decline, on average, 1.6% per year⁴. Actual real spending grew only 0.7% per year, and health care’s share of state GDP remained essentially flat. In other words, states appeared to overspend largely because their targets did not account for inflation. Ericson brings these concepts together in his assessment of OHCA’s spending target and penalty structure in *Health Affairs*, noting that growth above a benchmark warrants scrutiny but does not by itself show inefficiency or conduct an entity could reasonably have changed⁵. For the spending target to be a meaningful measure of affordability, OHCA should account for inflation and broader economic conditions, as well as other major drivers of health care spending, when evaluating hospitals against the target.

Conclusion

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

Sincerely,



Victoria Valencia
Vice President, Data Analytics

cc: Members of the Health Care Affordability Board:

David Chase
Dr. Sandra Hernández
Dr. Richard Kronick

³ Chernew ME, Day MP, Cutler DM, Guerriere M. Spending Growth In A Large Massachusetts Insurer Driven By Volume And Intensity. *Health Affairs*. 2026;45(10):1106–1111. doi:10.1377/hlthaff.2026.00282

⁴ Ericson KM. Inflation Distorted State Health Care Spending Benchmarks: Nominal Growth Targets Called For Real Spending Cuts, 2022–23. *Health Affairs*. 2026;45(8):925–933. doi:10.1377/hlthaff.2026.00046

⁵ Ericson KM. Could California’s Health Care Spending Benchmark Become A Global Budget? *Health Affairs Forefront*. August 19, 2026. doi:10.1377/forefront.20260811.619128

Ian Lewis
Donald B. Moulds, PhD
Dr. Mikah Owen
Dr. Richard Pan

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