Department of Health Care Access and Information
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Sacramento, CA 95833
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Health Care Affordability Board
November 2026
Public Comment

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

Date	Name	Written Comment
10/30/2026	Adventist Health	See Attachment #1
10/29/2026	America's Physician Groups	See Attachment #2
10/30/2026	California Association of Health Plans	See Attachment #3
10/30/2026	California Association of Public Hospitals and Health Systems'	See Attachment #4
10/29/2026	California Children's Hospital Association	See Attachment #5
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10/30/2026	California Nurses Association and Labor Organizations	See Attachment #9
10/30/2026	Health Access	See Attachment #10
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10/28/2026	Kaweah Health	See Attachment #12
10/26/2026	Kern Medical	See Attachment #13
10/30/2026	Kindred Hospitals	See Attachment #14
10/29/2026	Mayers Memorial Healthcare District	See Attachment #15
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10/28/2026	PIH Health	See Attachment #17
10/20/2026	Ridgecrest Regional Hospital	See Attachment #18
10/30/2026	Saint Agnes Health	See Attachment #19
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10/30/2026	SEIU California	See Attachment #21
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10/27/2026	Sierra View Medical Center	See Attachment #23
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10/30/2026	UC Health	See Attachment #26
10/30/2026	United Hospital Association	See Attachment #27

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

October 30, 2026

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

Subject: Comments on Proposed Penalty Framework Regulation *(Submitted via email to ohca@hcai.ca.gov)*

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

Thank you for the opportunity to comment on the Office of Health Care Affordability's (OHCA) proposed financial penalty framework for healthcare entities that exceed the cost growth target after completing a performance improvement plan.

Adventist Health shares OHCA's commitment to making health care more affordable for Californians. As one of California's largest safety-net health systems and the largest provider of rural health care west of the Mississippi River, we understand firsthand the importance of ensuring patients can access affordable, high-quality care close to home.

However, we are concerned that the proposed penalty framework would undermine the goal of making health care more affordable. Rather than improving affordability for patients, it risks diverting critical resources away from care delivery, weakening access in rural and underserved communities, and imposing significant financial burdens without clear evidence that patients will see lower costs.

We have three primary concerns.

First, the proposed penalties would reduce resources available for patient care and disproportionately affect rural and safety-net communities and unfairly penalize providers that serve a high volume of Medi-Cal patients.

California's health care delivery system is already facing significant financial pressures, including workforce shortages, inflation, rising pharmaceutical and supply costs, seismic requirements, emergency preparedness obligations, impacts anticipated with H.R. 1 implementation, and chronic underpayment in government programs.

For Adventist Health, these concerns are particularly acute because many of the patients we serve live in rural and medically underserved communities, and nearly 80 percent of our patients are covered by Medi-Cal or Medicare. In many of these communities, our hospitals, clinics, and providers are the primary source of care. Policies that divert limited healthcare resources away from patient care risk make it harder for individuals and families to access the services they depend on close to home.

The proposed penalty structure would also place a disproportionate burden on safety-net and rural health systems that are already operating on extremely thin or negative margins. California's not-for-profit hospitals serving a high proportion of Medi-Cal patients operate with median margins of approximately negative 5%, and Adventist Health's margin is similarly negative at roughly 5%. Every dollar directed toward penalties is a dollar unavailable for patient care, workforce investments, facility improvements, and maintaining essential services.

Importantly, OHCA should not subject Medi-Cal reimbursement to enforcement calculations or effectively penalize providers for serving patients covered by these programs. Reimbursement under this program is substantially below the actual cost of providing care. As a result, providers with a high share of Medi-Cal patients should not face enforcement actions driven by spending associated with government programs that already reimburse below cost. Including cost growth associated with government payers in the penalty framework would create a disincentive for providers that care for California's most vulnerable populations and could unfairly penalize health systems precisely because they fulfill a safety-net mission.

Second, there is no assurance that these penalties will make care more affordable for patients.

Patients experience affordability challenges through premiums, deductibles, prescription drug costs, and out-of-pocket expenses. Yet the proposed framework focuses primarily on penalizing providers and does not ensure that any resulting savings are passed along to consumers.

Without a direct connection between penalties and lower patient costs, providers could lose resources while Californians see no meaningful relief from the expenses they face every day.

Third, if OHCA moves forward with a penalty framework, it should adopt a more balanced and measured approach.

Healthcare cost growth is influenced by factors beyond the control of providers, including inflation, workforce shortages, patient acuity, state and federal requirements, and public health and emergency preparedness obligations.

Any enforcement framework should require sustained target exceedance before penalties are considered, provide meaningful exceptions for reasonable causes, and phase in penalties gradually to avoid unintended consequences for patients and communities.

At a minimum, OHCA should:

- Require **multiple years of sustained target exceedance** before any penalty is imposed.
- **Account 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.
- Provide **robust exceptions for reasonable causes**, including workforce shortages, inflation, patient acuity, public health emergencies, and government reimbursement shortfalls.

- **Standardize and clearly articulate the process for explaining growth above the target and enumerating additional reasons for justifiable growth**, as established under the statutory waiver process.
- **Establish a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied.
- **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.

We share OHCA's goal of making health care more affordable. However, affordability cannot be achieved by weakening the providers patients rely on for care. For many of the rural communities Adventist Health serves, there is no alternative provider available if resources are reduced or services are scaled back. When safety-net providers lose resources, patients lose access.

We respectfully urge OHCA to substantially revise the proposed framework to ensure that efforts to improve affordability do not come at the expense of access to care. 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,



Julia Drefke

Executive, Public Affairs & Community Impact

Adventist Health

CC: Office of the Governor, Deputy Cabinet Secretary Richard Figueroa

Director of the Department of Health Care Services Michelle Baass

Attachment #2

AMERICA'S PHYSICIAN GROUPS

October 29, 2026

Elizabeth Landsberg
Director
California Department of Health Care Access and Information

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

Re: Comments on Proposed Progressive Enforcement Regulations and Incorporated Guidance

Dear Director Landsberg and Deputy Director Pegany:

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 that support high-quality, coordinated, affordable care.

APG appreciates the opportunity to comment on OHCA's proposed spending target enforcement regulations, Performance Improvement Plan Submission Guide, and Spending Target Performance Measurement Manual. We support meaningful affordability accountability and suggest that OHCA align enforcement with each entity's contractual responsibilities and practical ability to act. Providers should be responsible for that which they control. The framework must also preserve the statutory protection for an entity that fully complies with its approved performance improvement plan (PIP) by the established deadline, even if it does not meet the spending target.

These comments address the October 8, 2026 draft package and the additional explanations in the October Board staff presentation. The proposal has significant implications for California's delegated physician organizations, including IPAs, medical groups, and restricted Knox-Keene licensees. APG suggests that OHCA require review of the division of financial responsibility (DOFR) and related agreements before enforcement, validate attribution and source data, and impose achievable corrective obligations.[i]

Affordability depends on payment and delivery structure

Coverage models influence the conditions under which providers deliver care. Delegated HMO arrangements combine prospective payment, defined patient populations, and continuing responsibility for care coordination. These inputs support investments in primary care relationships, interdisciplinary teams, and infrastructure for managing utilization. Traditional FFS PPO arrangements offer different incentives and organizational supports. Provider performance therefore must be evaluated in the context of the coverage and payment structures in which providers operate.

OHCA's October 7, 2026 report provides additional evidence about payment structure. From 2023 to 2024, statewide capitation and full-risk payment dollars grew 4.1%, compared with 10.4% for FFS payments (p. 27, Figure 9). In 2024, quality-linked APM adoption was 81.4% among commercial HMO/POS members versus 31.3% among commercial PPO/EPO members (p. 31, Figure 12). Reported primary care spending was 5.1% of

TME for HMO/POS coverage versus 3.3% for PPO/EPO coverage (p. 39, Figure 18). Source: OHCA high value report

These OHCA measures require careful interpretation. The 4.1% and 10.4% figures describe aggregate payment-dollar growth, not risk-adjusted spending per member or a direct HMO–PPO comparison. Changes in enrollment and payment mix can affect those totals. APM adoption measures member attribution rather than the proportion of each member's spending paid through an APM (pp. 60–61). Primary care estimates also face limitations in allocating capitation and observing downstream payments (pp. 62–63). The report therefore supports examining payment structure, without independently establishing the comparative performance of individual delegated organizations. Other analysis, like the Integrated Healthcare Association's ATLAS, combines cost and quality data into a total cost of care comparative measure. This measure is useful to purchasers and consumers as a comparison tool to discern value for money spent on health care.

We urge your consideration of comparative data sources, like the ATLAS, because it can provide relevant context. IHA's May 2025 California analysis, which excluded Permanente medical groups, found that HMO coverage models outperformed PPO non-ACO arrangements by 15 percentage points on a composite of nine clinical quality measures and had adjusted total cost of care that was $2,304 lower per member annually. Average annual cost growth from 2019 through 2023 was 6.46% for the HMO cohort, compared with 8.02% for PPO ACOs and 8.32% for PPO non-ACO arrangements. PPO members also incurred greater out-of-pocket spending.

The Berkeley Forum's California-specific analysis provides a stronger foundation for interpreting these findings. Its 2014 peer-reviewed article, building on the original 2013 report, identified integrated care and risk-adjusted global budgets linked to quality measures as a central strategy for improving value. It projected $110 billion in savings over 2013–2022 across seven initiatives, with much of the savings attributed to integrated care and global budgets. These were modeled opportunities, rather than realized savings, but the analysis explicitly connected payment reform and care integration to more affordable, high-quality care (pp. 217–220). Source: The Berkeley Forum — A Roadmap for Improving Healthcare in California

Read together, the Berkeley Forum analysis, IHA's observed cost and quality results, and OHCA's current payment and investment data provide a substantive basis for treating coverage and payment design as an affordability intervention. The evidence supports moving beyond scrutiny of spending outcomes to the incentives and care-delivery capabilities that produce them. Although these sources use different methods and do not isolate every causal factor, their combined policy implication is stronger than a call for further study: California's affordability framework should evaluate and encourage structures that align population responsibility, prospective payment, and quality, while holding each entity accountable for the spending drivers it can address. This approach also distinguishes lower delivery costs from reductions in plan liability achieved through greater member cost sharing. We urge the Board to consider that enforcement alone may not of itself achieve the objective of lowering health care costs in California.

Implications for the enforcement approach

The resulting policy question is whether OHCA's enforcement approach sufficiently addresses the coverage designs, payment arrangements, and allocation of responsibility that produce spending outcomes. Although OHCA's broader program promotes alternative payment models and enforcement also applies to other health care entities, corrective obligations imposed on physician organizations may have limited effect if they leave the relevant plan-level incentives and retained responsibilities unexamined. Comparative outcomes also matter: relatively low total spending and favorable quality can coexist with growth above a uniform target.

Attributed spending and contractual authority

OHCA's proposed measurement manual includes all covered medical spending for attributed members, including care delivered by providers outside the attributed physician organization. That measure extends beyond the services for which a delegate receives payment or accepts financial responsibility.

A physician organization may manage professional services while a health plan retains responsibility for hospital contracting, pharmacy benefits, or behavioral health services. The degree of delegated financial risk and operational responsibility varies by contract.

Consequently, an organization's attributed spending can increase because of hospital prices, drug costs, or other expenditures beyond its direct contractual authority. Care coordination may still influence utilization in some of these categories. Distinguishing price effects, utilization effects, and retained plan responsibilities is therefore important when assessing both the causes of excess growth and the corrective actions available to a particular entity.

APG suggests that OHCA establish an adjustment process accounting for spending outside delegated control and demonstrated cost and quality performance. Consistent criteria and documentation should preserve comparability and retain visibility into spending relevant to statewide affordability. Sharp Healthcare has proposed such an adjustment mechanism and APG supports it.

Foundation arrangements require an additional distinction

The OHCA statute expressly includes a medical foundation exempt from licensure under HSC section 1206(l) within the definition of physician organization. HSC § 127500.2(r)(4). A physician organization is a provider under subdivision (t)(1), and a provider is a health care entity under subdivision (k). A section 1206(l) foundation therefore qualifies on its own statutory basis, distinct from affiliated medical groups or IPAs that independently satisfy the applicable definitions. The foundation's status does not depend on treating it as interchangeable with its contracted physician organization.

APG suggests that OHCA expressly recognize these separately qualifying entities when identifying the accountable organization, mapping contracts, attributing expenditures, and assigning corrective obligations. Where the foundation holds the health plan contract and the medical group holds a clinical-services agreement with the foundation, review should follow that contractual chain and identify each entity's actual authority and financial responsibility. Affiliation alone does not establish identical contracting powers or operational duties. Any aggregation or related-entity treatment should be explained and should avoid duplicative attribution or corrective demands for the same spending.

A foundation-affiliated medical group reports that it contracts with a foundation to provide clinical services and does not hold the health plan contracts. The foundation manages enrollment and assignment and is responsible for the contracting and administrative functions described here. This member experience illustrates why OHCA must identify the entity that holds each contract, bears financial responsibility, controls operational decisions, and maintains the relevant data. The account is reported operating experience, not an independently verified finding about all foundation or delegated arrangements.

The medical group reports that it does not negotiate insurer contracts, pharmaceutical purchasing arrangements, or agreements with outside behavioral health or emergency physician organizations. It does not manage hospital nursing or clinic staff labor costs, supply-chain costs, or capital expenditures. Physicians influence clinical decisions and resource use, but that influence does not give the medical group authority to change prices or expenditures established by another entity. Treating the group, foundation, hospital, and health plan as interchangeable would overlook these distinctions.

The member also reports an instance of substantial hospital charges for care delivered outside its system without timely notification. Charges are not equivalent to allowed or paid amounts, and this account does not establish the spending OHCA would attribute or the party contractually responsible for payment. It illustrates why an attributed patient's outside care does not, by itself, establish that the physician organization had notice, an opportunity to coordinate care, or authority over the resulting expenditure.

APG suggests that OHCA require staff to review the applicable contracts and DOFR, together with foundation service agreements and other documents identifying the responsible entity, before any enforcement action. Written findings should distinguish contractual financial responsibility, control over prices, clinical influence

over utilization, and access to timely information. Comprehensive spending measurement can remain useful for statewide monitoring while enforcement obligations reflect those separate roles.

The statute expressly requires consideration of control

Health and Safety Code section 127502.5(a) requires the Director to consider the extent of an entity's control over the applicable components of its cost target. Subdivision (i) permits a waiver of enforcement for reasonable factors outside an entity's control. These provisions supply a direct statutory basis for mandatory DOFR and related-contract review; the cases discussed below provide additional interpretive support.

Section 127502.5(d)(1) makes PIP noncompliance and failure to meet the cost target separate, conjunctive conditions for a spending-target penalty. It expressly protects an entity that fully complies with its approved PIP by the deadline, while allowing OHCA to require further PIP modification until the target is met. Failure to meet the target alone is therefore insufficient for that penalty. This protection does not eliminate continuing target obligations or separate procedural-penalty authority under subdivision (h).

Impossible performance and California law

These regulations should be premised upon a simple principle: Providers should be responsible for that which they control.

Civil Code section 3531 states, "The law never requires impossibilities." In Board of Supervisors v. McMahon, 219 Cal.App.3d 286, 299–301 (1990), the court recognized that impossibility can excuse statutory performance and can encompass extreme and unreasonable practical difficulty. For a physician organization, the relevant showing would identify the contract or expenditure it is asked to change, who holds the authority to change it, and why the organization cannot achieve the required action through its available powers.

Applying these principles through mandatory DOFR review

APG suggests that OHCA require staff, before any enforcement action, to review the applicable DOFR, plan and foundation agreements, and evidence of actual operational authority. Written findings should identify the spending driver, the entity controlling it, the physician organization's financial responsibility and available actions, and the connection between those actions and the proposed corrective result. Financial risk, price-setting authority, and clinical influence are distinct: accepting a category of risk does not necessarily confer authority over every price within that category, while lack of price control does not eliminate responsibility for utilization the organization can appropriately manage.

A PIP should require feasible actions within the organization's authority and specify documented commitments from other entities when shared action is necessary. APG suggests that OHCA not treat failure to achieve a result dependent on an independent party's uncommitted action as proof that the physician organization failed to perform an achievable obligation. The legal argument is strongest when supported by the actual agreements, data-access limitations, and a documented explanation of what the organization can and cannot change. The California impossibility principle supports fact-specific review rather than a categorical conclusion that the draft regulation is unconstitutional.

Impossibility of corrective performance in attributed spending

The practical concern is the ability to perform the corrective obligation, not merely the ability to submit a PIP document. A physician organization can describe a hospital rate increase or a pharmaceutical price increase without possessing authority to reverse it. If a plan or foundation independently holds the relevant contract, attributing the expenditure to the medical group does not supply the missing negotiating power. Requiring a PIP that promises to correct that increase can therefore create an administrative obligation without a workable path to the required result.

For example, a group might reasonably commit to reducing avoidable admissions or moving clinically appropriate procedures to ambulatory settings. It cannot reasonably guarantee that another entity will reduce a hospital payment rate or drug price. Where both price and utilization contribute to growth, APG suggests that OHCA separate the components and evaluate the group's achievable utilization commitments. It should not presume that cuts elsewhere can offset every external increase, particularly when doing so could impair access, quality, equity, or workforce stability.

Mandatory DOFR and delegation-agreement review should be the immediate safeguard before enforcement. The record should identify financial responsibility, contracting authority, clinical influence, available data, dependencies on independent entities, and the feasible actions remaining after those limits are considered. An organization asserting inability should document its agreements, practical constraints, and reasonable efforts; APG suggests that OHCA respond with written findings. A jointly undertaken intervention requires documented commitments from the entities whose participation is necessary. This review does not replace the broader examination of TME attribution methodology proposed below.

Recommended regulatory safeguard

Before requiring a physician organization to submit or implement a performance improvement plan, the Office shall review the applicable division of financial responsibility, delegation agreements, foundation service agreements, and evidence of actual operational authority. The Office shall identify in writing the spending components within the organization's control and the feasible corrective actions available to it. The Office shall not require an organization to undertake an action it lacks legal or operational authority to perform, or condition successful implementation on an independent entity's action absent an enforceable commitment to that action. A supported claim of inability to perform shall receive a reasoned written determination and an opportunity for review before the disputed obligation is used as a basis for escalation or penalty. This proposed safeguard would operate alongside existing statutory waiver, PIP-compliance, and procedural requirements.

Scope and selection for enforcement

APG suggests that OHCA expressly identify the lines of business subject to the proposed enforcement framework, including whether its present scope is limited to commercial business, and distinguish that scope from broader statewide spending reporting. A clear regulatory statement is needed rather than reliance on oral descriptions of intended implementation. We request clarification without assuming the statute categorically excludes other markets.

Selection standards should distinguish sustained, material, unexplained growth from an isolated annual spike. APG suggests that OHCA consider multiyear performance, appropriately comparable peers, geographic cost levels, population and service differences, good-faith affordability efforts, and existing capitation or value-based accountability. Comparisons require consistent risk and geographic adjustment and should not protect inefficient baseline spending. Existing risk arrangements should inform proportionality and prevent duplicative corrective demands or financial sanctions for the same spending; they should not create blanket immunity.

APG suggests that OHCA preserve the opportunity to submit other relevant explanations under proposed § 97452(b)(4)(H). Recognition of legitimate spending drivers should remain flexible. For nonsupervisory organized labor costs, the regulation should require final, actual costs and clarify that consideration during enforcement does not depend on a prior target-adjustment request under § 97448. The process should prevent double counting and treat comparable documented workforce investments fairly.

Payer measures and consultation with existing regulators

APG suggests that OHCA clarify separate medical and nonmedical spending measures for payers and fully integrated delivery systems. HSC section 127502.5(f)(1) expressly addresses enforcement of growth in administrative costs and profits. APG suggests that OHCA disclose entity-specific TME and TNME calculations

and explain the classification and evaluation of taxes, assessments, reserve changes, and other components. The review should consider existing medical loss ratio requirements and distinguish discretionary expense growth from mandated expenditures and investments in care management or technology that may improve medical spending over time.

HSC section 127502.5(b)(4) requires consultation with the applicable payer regulator before enforcement actions involving a regulated payer, not merely when setting a penalty. The regulation should specify when consultation occurs, how it informs the proposed action, and how consistency with existing regulatory obligations is documented. The statutory requirement applies to payers; APG suggests that OHCA also coordinate with DMHC or other appropriate agencies when physician-organization corrective obligations affect delegated duties or restricted-license requirements. This distinction preserves the scope of the express consultation mandate while addressing the practical interdependence of plans and delegates.

Data validation and the Hill Physicians example

Hill Physicians Medical Group has reported to APG that its review of an early test analysis supplied by OHCA staff identified discrepancies in the number of attributed lives and health plan contracts associated with Hill. APG has not independently verified that account.

An early test analysis is not a final enforcement determination, and discrepancies identified during testing may be corrected before enforcement. Nevertheless, errors in attributed populations or contract mappings could affect subsequent spending calculations. The example illustrates the importance of reconciling foundational data and documenting corrections before relying on the resulting analysis.

A relevant implementation question is how OHCA will validate third-party submissions, resolve conflicting records, and notify affected organizations of corrections. The reliability of a final determination depends on the accuracy of both the source data and the methods applied to them.

The foundation-affiliated medical group reports that it works with its foundation to update primary care physician lists for monthly reporting to health plans, yet insurer attribution errors remain common. Reported examples include delays adding or removing members after coverage changes, assignment to physicians who do not maintain patient panels, and disruption when plan contracts begin or end. Patients may also be attributed before establishing care with a primary care physician. APG suggests that OHCA reconcile eligibility periods, panel status, contract effective dates, and relationships among plans, foundations, and medical groups before drawing conclusions about spending growth.

Response procedures and evidentiary standards

The proposed regulations would give an entity 45 calendar days from the date of OHCA's preliminary determination to respond. An entity disputing the spending calculation would need to provide its own calculation and supporting facts. The draft further provides that OHCA may modify its calculation if the entity demonstrates, by clear and convincing evidence, that it is incorrect.

That is a substantially higher burden than preponderance of the evidence. Preponderance requires a showing that a fact is more likely true than not true; clear and convincing evidence requires establishing that it is highly probable.

The procedural question is whether an entity receives the information needed to meet that burden within the available response period. The draft does not establish an express, enforceable mechanism requiring disclosure of the complete underlying health plan information and other evidence supporting the preliminary determination before the 45-day period begins.

If a physician organization lacks those materials at the outset, part of the response period may be consumed obtaining information rather than testing the calculation. The practical adequacy of 45 days depends on the completeness, accessibility, and complexity of the supporting record. Incomplete disclosure combined with a

heightened evidentiary burden raises due process concerns about the opportunity to examine and contest the basis for an adverse determination; this is an issue for legal evaluation, rather than a conclusion that the draft is unlawful.

The foundation model adds a practical obstacle to rebuttal. The member reports that the medical group does not maintain direct plan contracts and may have to request information through the foundation; it cannot assume that a plan will provide the requested records. The group also lacks the administrative, clerical, and legal staff needed to independently obtain, reconcile, and contest the complete spending record. These reported operational constraints demonstrate why an opportunity to respond requires an enforceable means of obtaining the evidence.

Disclosure and response period design

A complete supporting record would include the relevant health plan submissions, member and expenditure attribution records, contract mappings, adjustments, calculations, methodologies, and other materials relied upon. Disclosure procedures would also need to address confidentiality, secure access, and the treatment of information concerning other entities.

APG suggests that OHCA complete disclosure and material data reconciliation before issuing the preliminary notice, so that the entity receives at least 45 days with a usable supporting record. The regulation should define completeness, establish a process for identifying missing information, and allow additional response time when material information is supplied or revised later. PIP proposal extensions concern a separate stage and do not answer the preliminary-response concern.

For a foundation-affiliated group, completeness should include usable records accessible to the responding entity, rather than disclosure only to its foundation or another system affiliate. APG suggests that OHCA provide a secure process for obtaining source records and resolving inconsistencies, suspend the response period while material records remain unavailable or require reconciliation, and grant extensions reflecting the volume and complexity of the record and documented third-party delays. Member experience indicates that 45 days may be impractical for this work.

The preliminary-response extension in proposed § 97452(b)(3)(A) is limited to a requested extension of up to 15 calendar days. APG suggests that OHCA allow longer and, when justified, successive extensions based on the work required. The grounds should expressly include ordinary but substantial data retrieval, validation, actuarial analysis, reconciliation with other entities, and organizational complexity, rather than emphasizing extraordinary disruptions. PIP submission extensions should likewise accommodate operational, financial, and clinical review, and the available extension periods should appear in the regulation itself.

APG suggests that OHCA adopt preponderance of the evidence for correcting disputed calculations under proposed § 97452(c), alongside the qualified review and written findings discussed below. Before advancing an entity to public testimony or a PIP, APG suggests that OHCA explain why material supporting information or a requested adjustment was rejected and permit a meaningful challenge. Public reporting should distinguish measured exceedance, validated explanatory adjustments, and the residual amount relied on for enforcement.

APG suggests that OHCA separate correction of a materially disputed calculation from the subsequent explanation of residual spending growth. A defined reconciliation process, with written decisions and reasonable deadlines, should resolve material data and calculation disputes before the entity must complete its substantive explanation. APG suggests that OHCA provide tolling or an appropriately extended response period for that work. An entity should be able to submit alternative explanations without conceding that the disputed calculation is correct. This would avoid forcing a full causal analysis of an excess amount that may later change substantially.

The evidentiary standard presents both a burden-of-proof question and a decision-making problem. The draft invokes clear and convincing evidence without establishing the qualifications of the person applying that standard, an independent review mechanism, or criteria explaining how conflicting submissions will be

evaluated. Financial and actuarial expertise may support spending calculations, but does not itself establish competence to apply legal evidentiary standards. Without these safeguards, the sufficiency of a physician organization's rebuttal could depend on the individual reviewer, producing potentially arbitrary or inconsistent outcomes across cases.

Replacing clear and convincing evidence with preponderance of the evidence would reduce the organization's burden, but would not resolve this underlying problem. Either standard requires a qualified, impartial decision-maker, a complete administrative record, and a written determination explaining the treatment of material evidence and the reasons for accepting or rejecting the organization's calculation. The process should also provide independent review of disputed findings before enforcement consequences attach. If OHCA retains a clear-and-convincing burden for rebuttal, a corresponding requirement that OHCA establish the accuracy of its final attribution and calculations would address the allocation of evidentiary burdens, but would not substitute for these procedural protections.

The consequences of a determination also bear on procedural design. Public findings, corrective obligations, and financial penalties increase the importance of reliable data and a meaningful opportunity to respond. The proposal includes procedural penalties for specified failures involving PIP submission and information requirements. The availability of cure periods, treatment of good-faith efforts, and proportionality of penalties are therefore relevant to implementation.

Technical assistance and public proceedings

Technical assistance should offer a defined opportunity to implement suitable recommendations and obtain a written determination that no further escalation is warranted. APG suggests that OHCA establish objective criteria, allow a reasonable implementation period, and acknowledge documented progress, rather than a guarantee that following advice will meet the target. Public testimony should have objective selection criteria explaining why that step serves a corrective purpose; bad faith or persistent unjustified noncooperation could be relevant factors. These are proposed safeguards, not assertions that current law limits testimony to bad faith.

The regulation should expressly require technical assistance for entities exceeding the target, consistent with HSC section 127502.5(c)(1) and staff's stated approach, rather than leave its availability uncertain. Proposed § 97453(a) begins conditionally with a Director's requirement for assistance. APG suggests that OHCA also explain how an entity may reasonably reject unsuitable advice while demonstrating good faith, and how implementation efforts affect later escalation.

APG suggests that OHCA publish an operational timeline distinguishing data review, technical assistance, public testimony, PIP preparation, and approval. It should identify permissible overlap, expected decision intervals, and the opportunity to implement suitable assistance before escalation. Testimony should remain a meaningful opportunity to affect the decision whether a PIP is necessary, with a written explanation of how the entity's evidence, responsiveness, and efforts were evaluated. Progressive steps should not function as predetermined formalities.

APG suggests that OHCA explain the legal basis, purpose, participants, and effect of any closed-session Board input on a proposed PIP and reconcile the process with Bagley-Keene requirements. Confidential submissions should be handled through lawful procedures; confidentiality concerns do not themselves establish unlimited discretion to close a meeting.

Confidential information and protected disclosure

APG suggests that OHCA provide default confidential treatment for nonpublic enforcement materials and narratives to the fullest extent permitted by law, with an alternative clear designation process if default treatment is not adopted (Relevant provisions: proposed §§ 97454 and 97455(i); HSC § 127502.5(c)(4)–(5). Requested protections should continue when information is transmitted to another regulator, subject to

governing law. Before disputed information is disclosed, the submitting entity should receive notice and an opportunity to substantiate privacy, trade-secret, competitive, or other protected interests. APG suggests that OHCA reconcile these protections with required public summaries and reporting; an entity's designation should trigger a reasoned confidentiality determination rather than operate as an unlimited veto over lawful disclosure.

Corrective actions must reflect operational authority

One APG foundation-affiliated member identifies actions physicians can help implement: moving clinically appropriate surgical cases to ambulatory surgery centers, agreeing on a narrower range of clinically suitable supplies to support purchasing efficiencies, and reducing avoidable emergency visits and readmissions. Implementation may nevertheless require foundation or facility participation, purchasing authority, staffing, and infrastructure. APG suggests that OHCA require each PIP to identify participating entities' responsibilities and obtain documented commitments for actions dependent on another entity.

The foundation-affiliated member reports that the foundation captures and reports utilization, quality, and cost data and owns or operates the supporting systems. Care navigation, case management, chronic disease programs, equipment, and facility process improvements depend on foundation-managed infrastructure in which physicians participate. APG suggests that OHCA permit appropriately validated submissions from the responsible data custodian, avoid duplicative group reporting, and preserve each entity's opportunity to review and contest data used to assess it.

Compliance design also has an affordability consequence. Requiring a medical group to hire staff or acquire systems to duplicate foundation reporting adds expense without necessarily improving measurement. APG suggests that OHCA coordinate related-entity submissions, protect confidential information, and distinguish an entity's failure to cooperate from a documented inability to obtain records controlled by another party. Corrective obligations and procedural penalties should account for those circumstances and preserve the proposed cure and review protections.

Preserving the statutory protection for full PIP compliance

The distinction between PIP compliance and target attainment must govern the entire process, beginning with approval. If successful implementation is defined exclusively as meeting the spending target, an organization could complete every approved corrective action yet be classified as noncompliant solely because the target was missed. APG suggests that OHCA preserve an independent determination of full performance of approved, achievable obligations so the protection in HSC section 127502.5(d)(1) retains practical effect. A PIP may include spending goals without making target attainment the exclusive test of compliance.

APG suggests that OHCA identify at approval the actions, metrics, milestones, documentation, and deadlines that establish full compliance. Evaluation should separately determine whether those obligations were performed and whether the applicable spending target was met. Where the first determination is favorable, a target miss alone should not defeat the protection in HSC section 127502.5(d)(1). OHCA may address continuing spending concerns through lawful prospective modifications, while preserving the distinction between substantive spending-target penalties and separate procedural violations.

Recommended amendment to the PIP approval compliance and penalty provisions

For purposes of determining eligibility for a spending-target penalty, the Office shall make separate written findings regarding compliance with the approved performance improvement plan and attainment of the applicable spending target. The approval shall specify the measurable obligations and deadlines establishing full compliance. Failure to meet the spending target shall not, by itself, establish failure to comply with those obligations. An entity that fully complies with the approved plan by the established deadline shall not be assessed a spending-target penalty under Health and Safety Code section 127502.5(d)(1). This provision does not limit lawful prospective plan modifications or independent procedural-penalty authority.

Forward looking improvement and historical target values

HSC section 127502.5(c)(1) describes entity-proposed strategies and actions to improve spending performance during a specified period, subject to OHCA review and approval. APG suggests that OHCA reconcile this design with proposed § 97455(h), which assigns a target value tied to the enforcement-triggering year or a Board-established value no lower than that target. The issue is how that benchmark will guide future improvement without converting PIP compliance into an unconditional promise of target attainment. The statute retains an overall target-compliance objective; it does not eliminate OHCA's authority to review, require revisions to, or approve the entity's proposed plan.

A delay between the performance year and the start of a PIP can produce simultaneous benchmarks: a historical target used in the PIP and a different target applicable to a later annual reporting year. APG suggests that OHCA identify the baseline, measurement period, growth calculation, and treatment of each benchmark, and explain how annual enforcement will interact with an ongoing plan. APG suggests that OHCA emphasize prospective, incremental, sustainable improvement in controllable spending, with coordinated obligations and a reasonable period for interventions to work. Exceeding either benchmark alone must not be described as establishing both conditions necessary for a spending-target penalty.

The data used to evaluate a PIP must correspond to its implementation period. The most recent THCE file available at the time of review may describe spending before the intervention began. APG suggests that OHCA specify data vintages, reporting lags, reconciliation procedures, and acceptable interim measures, and should not treat pre-intervention spending as evidence that the intervention failed. This issue directly affects proposed § 97455(g)(3)(H) and the Guide's assessment and final-report requirements.

Successful PIP implementation requires agreed standards

The regulation, PIP definition, completeness review, and approval criteria should consistently focus on measurable corrective actions addressing unjustified spending within the entity's authority. Approval should specify goals, outcomes, metrics, milestones, balancing measures, and the standards for successful implementation. APG suggests that OHCA not retrospectively impose new criteria when judging performance. Revisions to the definition and proposed § 97455(d)(1)–(3), (d)(6)(A), and (g)–(h) should distinguish successful implementation from target attainment. Feasibility must be established before approval; a plan cannot become achievable solely because the organization was required to submit it.

The PIP Submission Guide should allow operational, process, utilization, and milestone measures appropriate to the intervention, available data, and delivery structure, alongside spending outcomes where measurable. Progress and final reports should recognize implementation lags, partial results, and leading indicators. Entities should explain measurement limits and should not be required to guarantee downstream consumer or purchaser savings they cannot control or reliably observe.

Balancing measures should protect affordability, access, quality, equity, and workforce stability through an assessment tailored to the PIP's actual activities. APG suggests that OHCA identify material risks and their evidentiary basis, and the entity should propose corresponding protections. Before requiring additional safeguards or finding noncompliance based on adverse effects, APG suggests that OHCA identify the evidence, explain its connection to the PIP, and allow a reasonable response and prospective mitigation. This approach preserves protective review while avoiding generic requirements unrelated to the intervention.

Successive performance years should not generate overlapping PIPs requiring the same work. APG suggests that OHCA permit coordinated addenda that retire completed or inapplicable requirements and add justified measures. APG suggests that OHCA adopt a policy reserving discretionary penalties during an ongoing PIP for documented bad-faith conduct, consistent with separate statutory procedural authority. References to a waiver or limitation of the Director's authority should be clarified to distinguish a statutory waiver of enforcement from other decisions about escalation.

Approval criteria public input and opportunities to cure

APG suggests that OHCA explain the legal basis and intended role of the proposed ten-business-day comment period on a complete PIP, how comments will influence approval, and how an entity may respond to material assertions. APG suggests that OHCA protect confidential materials and distinguish evidence-based review from unsupported public allegations. The absence of an express statutory public-comment requirement does not itself establish that the procedure exceeds rulemaking authority. APG suggests that OHCA distinguish review of a proposed assessment and reporting design from evaluation of progress or final reports that do not yet exist. Relevant proposed provisions: § 97455(d)(4)–(6).

The affordability approval criterion should define the expected benefit for consumers and purchasers and the evidence needed to demonstrate it. Lower delivery costs, reduced premiums or cost sharing, and purchaser savings are different outcomes involving different decision-makers and timing. A physician organization should demonstrate the effects it can reasonably measure without guaranteeing an independent plan's premium or benefit-design decisions. The Guide's references to Medi-Cal purchaser affordability also reinforce the need to clarify the current enforcement scope and distinguish generally applicable guidance from presently enforced markets.

Before an incomplete or unacceptable submission supports procedural penalties, APG suggests that OHCA identify each deficiency, the action needed to cure it, the applicable standard, and a reasonable response period reflecting the complexity of the requested change. Documented good-faith efforts should inform extensions and any decision that a repeated failure has occurred. The regulation should explain the relationship between cure opportunities, substantive disagreements, and noncooperation. Relevant proposed provision: § 97456(a)(2).

The initial implementation years should build a documented understanding of spending drivers, available corrective tools, and the time needed for changes to produce results. APG suggests that OHCA publish deidentified lessons and explain how penalty policy advances affordability, while avoiding duplicative or disproportionate sanctions. This learning-oriented approach should inform discretion within existing law rather than be presented as a suspension of statutory duties.

Validated adjustments must carry through to penalties

APG suggests that OHCA apply consistent treatment of validated costs outside the entity's control across the enforcement finding, public reporting, PIP evaluation, and penalty base. The proposed amendments should specify how those adjustments reduce the initially commensurate amount, with an auditable calculation that avoids double counting and identifies the residual unexplained growth. Section 5 of the Measurement Manual should incorporate the same adjustment rules for each entity type. Recognition of an explanation during review should not be disconnected from the amount used to calculate a financial sanction.

The draft describes a penalty ceiling of 125 percent of the initially commensurate amount. APG suggests that OHCA expressly recognize a range beginning at zero, explain the selected percentage, and describe what regulatory consultation contributes to the decision. The adjustment criteria should recognize existing risk-bearing accountability, demonstrated affordability and care-transformation investment, quality and equity performance, and good-faith efforts to address external cost drivers. APG suggests that OHCA define market impact, including how appropriately adjusted geographic cost comparisons will be used. These are requests to structure discretion, not claims that each proposed factor is already legally required. Relevant proposed provisions: §§ 97455(h)(1)–(5) and 97457(a).

Requested implementation clarifications

APG suggests that OHCA address the implementation priorities detailed above through explicit requirements for DOFR review, reliable attribution, accessible evidence, adequate response periods, qualified review, written findings, cure opportunities, and separate determinations of PIP compliance and target attainment.

A workable framework must connect coverage and payment inputs to provider behavior, measured outcomes, and the actions available to each entity. Mandatory DOFR review, accurate attribution, and fair procedures are necessary to that assessment. The framework must also preserve a distinct, achievable standard for full PIP compliance so that failure to meet the spending target alone does not nullify the statutory protection against a spending-target penalty. These substantive and procedural changes should be evaluated together.

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

Thank you for considering these comments. APG welcomes the opportunity to work with HCAI and OHCA on an enforcement framework that advances affordability, preserves effective delegated care arrangements, and assigns achievable corrective obligations to the entities positioned to perform them.

Sincerely,



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

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[i] draft spending target enforcement regulations dated October 8, 2026. Performance Improvement Plan Submission Guide. Spending Target Performance Measurement Manual. October 14 staff presentation.

Attachment #3

California Association of Health Plans

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

October 30, 2026

Sent via email:
ohca@hcai.ca.gov

Megan Brubaker
Department of Health Care Access and Information
Office of Health Care Affordability
2020 West El Camino Avenue, Suite 1200
Sacramento, CA 95833

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

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

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

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

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

I. Draft Progressive Enforcement Regulations

A. Clarify the scope and basis of payer enforcement

1. Payer markets and populations subject to enforcement

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

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

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

2. TME and TNME methodology

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

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

CAHP requests that OHCA:

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

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

3. Align the PIP definition with the statute

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

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

CAHP recommends the following definition:

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

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

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

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

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

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

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

C. Ensure that enforcement considerations meaningfully affect the process

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

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

OHCA should expressly recognize:

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

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

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

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

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

D. Establish transparent criteria for selecting entities for further enforcement

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

CAHP recommends that OHCA consider:

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

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

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

E. Make technical assistance a genuine first step

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

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

OHCA should also clarify:

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

F. Clarify the purpose and timing of public testimony

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

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

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

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

G. Incorporate required interagency consultation

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

The enforcement regulations should explain:

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

H. Clarify administrative penalties and adjustments

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

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

Penalty-adjustment factors should recognize:

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

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

I. Establish workable PIP standards

1. Preserve the two-part statutory test

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

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

2. Establish criteria for requiring a PIP

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

3. Provide adequate PIP-development time

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

4. Reconsider public comment on proposed PIPs

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

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

5. Revise PIP approval factors

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

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

6. Avoid overlapping PIPs

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

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

7. Define procedural-penalty triggers

OHCA should define:

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

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

8. Create a confidentiality safe harbor

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

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

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

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

II. Draft Performance Improvement Plan Submission Guide

A. Preserve entity-specific outcomes and measures

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

Acceptable outcomes should include:

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

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

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

B. Establish evaluation criteria when the PIP is approved

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

C. Recognize timing and attribution limitations

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

D. Tailor balancing measures to actual risks

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

E. Provide notice before requiring additional safeguards

Before requiring a modification or finding noncompliance, OHCA should:

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

F. Address overlapping PIPs and confidentiality consistently

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

III. Draft Spending Target Performance Measurement Manual

A. Exclude validated external costs from initially commensurate calculations

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

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

B. Continue technical review of payer methodologies

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

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

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

C. Evaluate appropriate risk and intensity adjustments

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

D. Improve identification of non-retail pharmaceutical spending

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

E. Establish an ongoing measurement and attribution forum

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

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

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

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

Conclusion

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

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

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

Sincerely,



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

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."[1] 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 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

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

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.[2] 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%,[3] even though Medicare fee-for-service rates are set administratively and Medicare Advantage plans generally pay hospitals at or near those rates.[4] OHCA attributed this volatility to hospital-reported contractual adjustments and low

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[2] 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.

[3] 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.

[4] 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.

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 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

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(2017). An analysis of private-sector prices for hospital admissions (Working Paper 2017-02). Congressional Budget Office.

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.

Adjustments for intensity:

- *Inpatient intensity adjustments.* The case mix index uses MS-DRG weights, which are developed and maintained for the purpose of reimbursement for Medicare beneficiaries. Because OHCA is evaluating patients across multiple payers, we recommend that OHCA adjust for intensity based on a case mix index calculated using All Patient Refined Diagnosis Related Groups APR-DRGs instead.
- *Outpatient intensity adjustments.* Average visit intensity depends on the completeness of Health Care Payments Database claims, which vary by payer and may not include all self-insured plans. Many hospital outpatient services, including clinic visits and services paid on fee schedules, may not carry APC weights. We recommend that OHCA provide additional transparency into the completeness of Health Care Payments Database claims by hospital and market, set a minimum claims threshold for calculating average visit intensity, and explain how services without APC weights are handled.

Fiscal condition of public hospital affiliates:

In the draft regulations, §97457(a)(2) directs OHCA to consider the revenues, reserves, profits, and assets of entities that "control, govern, or are financially responsible for" the entity. For county-operated hospitals, this could be read to include the county itself. For University of California health systems, it could include the University. Those entities' revenues and reserves are largely restricted or committed to other public purposes and are not available to the hospital. County support for a public hospital is itself evidence of financial strain, not capacity to pay a penalty. We urge OHCA to clarify that for public entities, §97457(a)(2) does not treat the general revenues or reserves of a county, the University of California, or another governmental parent as resources of the hospital.

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October 29, 2026

Elizabeth Landsberg
Director, Department of Health Care Access and Information
2020 W. El Camino Ave.
Sacramento, CA 95833
Submitted via email to Megan Brubaker

SUBJECT: PROPOSED EMERGENCY REGULATION: HEALTH CARE SPENDING TARGETS PROGRESSIVE ENFORCEMENT

Dear Director Landsberg:

On behalf of California's not-for-profit children's hospitals, the California Children's Hospital Association (CCHA) appreciates the opportunity to comment on the Office of Health Care Affordability's (OHCA) proposed spending target progressive enforcement regulations and accompanying guidance.

California's children's hospitals share OHCA's goal of improving health care affordability while preserving access to high-quality pediatric care. We recognize that meaningful accountability is essential to achieving the state's spending growth objectives. We also appreciate the Legislature's decision to establish a progressive enforcement process that provides health care entities with opportunities to explain spending growth, obtain technical assistance, and implement performance improvement plans (PIPs) before financial penalties are considered. CCHA's principal concern is ensuring that this process works as intended in practice.

Hospitals must be accountable for addressing spending growth, but the enforcement framework should also recognize the complexity of managing health care spending. Meaningful improvement requires hospitals to address multiple, interconnected drivers of spending, implement promising strategies, and continually evaluate and refine their approaches as circumstances evolve. Progress should be evaluated in that context, rather than assuming that an unmet spending target necessarily reflects a failure to take meaningful action.

These issues are particularly important for children's hospitals, which provide highly specialized care to patients with complex and sometimes unpredictable needs. A relatively small number of patients requiring organ transplants, intensive care, or newly available high-cost therapies can materially affect a children's hospital's annual spending growth, even when the hospital is successfully implementing strategies to improve efficiency.

These challenges will also be compounded by substantial changes anticipated in Medi-Cal

financing beginning in 2028, the full implications of which remain uncertain as federal implementing regulations continue to be developed. Children's hospitals will be adapting their operations, financing arrangements, and care delivery strategies in response to significant reimbursement reductions at the same time as they may be required to develop and implement PIPs under OHCA's enforcement framework. Hospitals will need flexibility to improve their spending performance while adapting to these changes.

We offer the following comments and requests for clarification to help ensure that progressive enforcement supports meaningful, sustained improvement without inadvertently discouraging innovation or jeopardizing access to care.

1. Clarify How OHCA Will Evaluate Good-Faith Implementation of Performance Improvement Plans

CCHA appreciates the proposed regulations' distinction between failing to meet a spending target and failing to comply with an approved PIP. Under proposed Section 97455(h), an administrative penalty for excess spending growth may be imposed when an entity both fails to comply with its approved PIP and fails to meet the applicable spending target.

It is less clear how OHCA will determine whether a hospital has complied with its PIP. Proposed Section 97455(g)(3) identifies several considerations, including implementation of planned strategies and activities, completion of milestones, achievement of performance improvement goals, and the entity's subsequent spending performance — these factors may not always point to the same conclusion.

Hypothetical Scenario 1: Successful intervention, but spending remains above target

Consider a children's hospital that develops a PIP to reduce avoidable emergency department utilization among children with complex chronic conditions. The hospital invests in expanded care coordination, after-hours clinical support, and improved access to specialty consultations. It implements every element of the approved plan, and avoidable emergency department visits decline. Nevertheless, the hospital's overall spending growth remains above the target because of an unexpected increase in children requiring high-cost inpatient care or newly available treatments.

In this circumstance:

- Would OHCA consider the hospital to have complied with its PIP?
- Would OHCA evaluate the impact of the hospital's interventions on the spending and utilization they were designed to address, or focus primarily on whether the hospital's overall spending growth met the applicable target?
- If the hospital implemented its approved plan and achieved the intended improvements in emergency department utilization, but aggregate spending growth remained above the target, would OHCA consider a financial penalty warranted?

Hypothetical Scenario 2: Good-faith implementation, but anticipated improvements do not materialize

Alternatively, suppose the same hospital implements its approved care coordination program, but the intervention does not reduce avoidable emergency department visits as anticipated. The hospital has fulfilled its commitments, monitored its results, and identified opportunities to improve its approach, but the original strategy has not yet produced the expected savings.

- Would OHCA distinguish this circumstance from a hospital that simply failed to implement its approved plan?
- If the hospital implemented its approved plan in good faith but did not achieve the anticipated results, would OHCA consider it compliant with its PIP, or could it still face a financial penalty?

Clarifying these distinctions is essential to ensuring a genuinely progressive enforcement framework. A hospital that declines to implement its PIP, a hospital that implements an intervention that proves less effective than anticipated, and a hospital that implements a successful intervention but experiences unrelated spending growth, should not necessarily be treated alike.

Hospitals should remain accountable for implementing approved strategies, monitoring their effectiveness, and responding when circumstances change or interventions fall short. However, failure to achieve an anticipated spending outcome should not, by itself, establish PIP noncompliance or justify a financial penalty.

This distinction also has important implications for patient access and workforce stability. If hospitals believe that failure to achieve a particular spending outcome could expose them to substantial financial penalties, they may favor strategies that produce immediate, predictable financial results over approaches that require investment, experimentation, and time to demonstrate effectiveness. In some circumstances, this could create pressure to reduce staffing, constrain services, or defer investments in care delivery improvements. Such incentives would be difficult to reconcile with the Legislature's direction that PIPs should not erode access, quality, equity, or workforce stability.

A progressive enforcement process should encourage hospitals to identify opportunities for improvement, test promising strategies, evaluate their effectiveness, and make adjustments based on what they learn. Not every intervention will produce the anticipated results, and some may require refinement or replacement. That does not mean the hospital's efforts were insincere or that the intervention was unreasonable when proposed.

Recommendations: CCHA supports CHA's recommendation that PIP compliance be based on good-faith implementation of approved strategies rather than achievement of specific

spending outcomes. We ask OHCA to clarify how it will distinguish good-faith implementation from noncompliance when determining whether penalties are warranted. We also support giving hospitals opportunities to amend their PIPs when circumstances change or when a different approach may be more effective.

2. Clarify How Historical Spending Growth Will Translate into Prospective Performance Improvement Obligations

It is unclear how historical spending growth will shape a hospital's obligations under a subsequent PIP. By the time OHCA reviews the spending data, considers the hospital's explanation, and requires a PIP, several years may have passed. The hospital must then address spending growth under clinical, operational, and financial circumstances that may differ substantially from those in the original measurement year.

Hypothetical Scenario 3: From Historical Spending Growth to Future PIP Obligations

Consider a hypothetical children's hospital whose spending grew by 4.5% in 2026, exceeding the applicable 3.5% target. In 2028, OHCA reviews the hospital's spending explanation and determines that some portion of the excess growth was justified. The hospital is subsequently required to develop a PIP, which it will implement over the following years. Several questions arise:

- How does OHCA's determination regarding the causes of excess spending in 2026 affect the hospital's obligations during the PIP period?
- If OHCA concludes that some portion of the historical growth was justified, how will that determination inform the expectations for future spending improvement?
- Will OHCA assess the hospital's progress primarily against the applicable spending target in subsequent years, the effectiveness of the specific interventions in its PIP, or some combination of the two?
- How will OHCA account for material changes in patient needs, clinical practice, reimbursement, or other circumstances that occur between the original spending year and the period in which the PIP is implemented?

We recognize that OHCA must evaluate whether improvement plans are producing meaningful results. Our concern is that the proposed framework does not yet clearly explain how OHCA will connect retrospective spending determinations, prospective improvement strategies, and subsequent spending outcomes when evaluating compliance.

Recommendation: CCHA requests clarification regarding how these different time periods and measures will be considered throughout the enforcement process. This clarification would help hospitals develop realistic, meaningful improvement strategies and understand how their efforts will ultimately be evaluated.

3. Explain How OHCA Will Evaluate and Document Justified Spending Growth

CCHA supports CHA's recommendation that hospitals have a meaningful opportunity to explain spending growth and obtain a determination that some or all of the growth was justified. Proposed Section 97452 allows hospitals to explain excess spending growth by providing information about factors that contributed to the increase. This opportunity is particularly important for children's hospitals, where a small number of patients requiring highly specialized services can significantly affect annual spending growth, even without increases in the hospital's underlying prices or changes in efficiency.

However, the proposed regulations do not clearly explain how OHCA will determine whether spending growth attributable to these factors is justified or how such a finding would affect subsequent enforcement. The following examples illustrate these uncertainties.

Hypothetical Scenario 4: Determining Whether Excess Spending Growth Is Justified

A children's hospital exceeds its spending target after treating several patients with a newly approved, high-cost gene therapy. The hospital documents the cost of these treatments and demonstrates how much they contributed to its spending growth.

- Would OHCA consider the spending associated with these treatments justified because high-cost drugs are among the factors identified in the regulations?
- If OHCA agrees that the additional spending was justified, would it exclude that amount when determining whether the hospital exceeded its spending target?
- If not, how would OHCA account for that justified spending when deciding whether to require a PIP and what spending improvements the hospital would be expected to achieve through that plan?

The distinction matters. OHCA could exclude justified spending when determining whether a hospital exceeded its target, or consider that spending only when deciding whether to require a PIP and what improvements to expect. The proposed regulations appear to contemplate the latter approach but do not explain what would qualify as justified spending or how that finding would affect enforcement. We encourage OHCA to clarify both questions.

Hypothetical Scenario 5: Spending growth driven by changes in patient needs

A children's hospital treats substantially more patients requiring organ transplants and newly approved gene therapies than it did the previous year. Its spending growth exceeds the target. The hospital explains that the increase reflects changes in the care its patients required, rather than higher prices for the same services. It also believes that OHCA's adjustments for patient volume and service intensity do not fully account for these changes.

- If OHCA determines that only some of the hospital's excess spending growth was justified, will it explain which factors it accepted or rejected, and why?

- How will OHCA's finding that some spending growth was justified affect its decision to pursue further enforcement, require a PIP, or calculate any subsequent financial penalty?

Recommendations: (1) We encourage OHCA to clarify how findings regarding justified growth will be documented and carried forward through the progressive enforcement process. (2) We also strongly support CHA's recommendation that OHCA disclose the calculations underlying its spending growth determinations and establish a meaningful process for identifying and correcting errors. Hospitals need enough information about OHCA's calculations to verify the results, identify potential errors, and understand why their spending was found to exceed the target.

4. Provide Illustrative Examples of the Complete Enforcement Process

CCHA recommends that OHCA publish worked examples showing how the progressive enforcement process would operate from an initial spending determination through a potential financial penalty. While the regulations and guidance describe the individual steps, examples would help hospitals understand how decisions made at each stage affect what happens next.

Recommendation: We encourage OHCA to provide worked examples showing how it would evaluate a hospital's spending growth, consider the hospital's explanation for exceeding the target, establish PIP expectations, and determine whether further enforcement is warranted.

We particularly encourage OHCA to use the two PIP compliance scenarios described earlier in this letter: one in which a hospital achieves measurable improvements through its PIP but still exceeds the spending target, and another in which the hospital faithfully implements its PIP but the intervention does not produce the anticipated results.

For each scenario, the example should show how OHCA would determine PIP compliance, whether a financial penalty would be warranted, and how any penalty would be calculated. The examples should include actual spending calculations where relevant.

5. Ensure That Financial Penalties Reinforce, Rather Than Undermine, Progressive Enforcement

CCHA recognizes that financial penalties may be appropriate for noncompliance. Given their potential magnitude and consequences, however, the circumstances warranting penalties must be clearly defined.

Financial penalties should distinguish between hospitals that fail to implement their PIPs and those that make good-faith efforts but fall short of their spending goals. We also encourage OHCA to consider how substantial penalties could affect children's hospitals and their

patients. Large penalties could force hospitals to reduce staffing or cut specialized services that children cannot easily access elsewhere, harming patients without necessarily making health care more affordable.

Recommendations: CCHA supports CHA's recommendations regarding the proposed penalty structure, including reducing the potential magnitude of penalties, strengthening mitigating factors, and appropriately limiting procedural penalties.

6. Support for CHA's Technical Recommendations

In addition to the concerns described above, CCHA also supports the technical recommendations submitted by the California Hospital Association (CHA). In particular, we support CHA's recommendations regarding accurate hospital spending measurement, including the treatment of Medi-Cal supplemental payments; the use of multiyear, all-payer spending assessments; and appropriate limits on financial penalties. We encourage OHCA to consider CHA's recommendations alongside the questions and examples raised in this letter.

Conclusion

For children's hospitals, meaningful improvements in efficiency and care delivery can occur even as overall spending increases due to changes in patient needs, new treatments, or other justified reasons. A successful enforcement framework must recognize both realities. The clarifications and examples requested in this letter will help hospitals understand how OHCA plans to evaluate their spending and improvement efforts, allowing them to make informed decisions about how to comply with the state's spending targets.

Thank you for considering our comments. If you have any questions or would like additional information, please contact me at (916) 203-0488 or mmorton@ccha.org.

Sincerely,



Mira Morton
Vice President of Government Affairs

California Hospital Association

October 30, 2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section VI. Confidentiality Protections Must Be Substantially Broadened

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

Section VIII. Technical changes

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

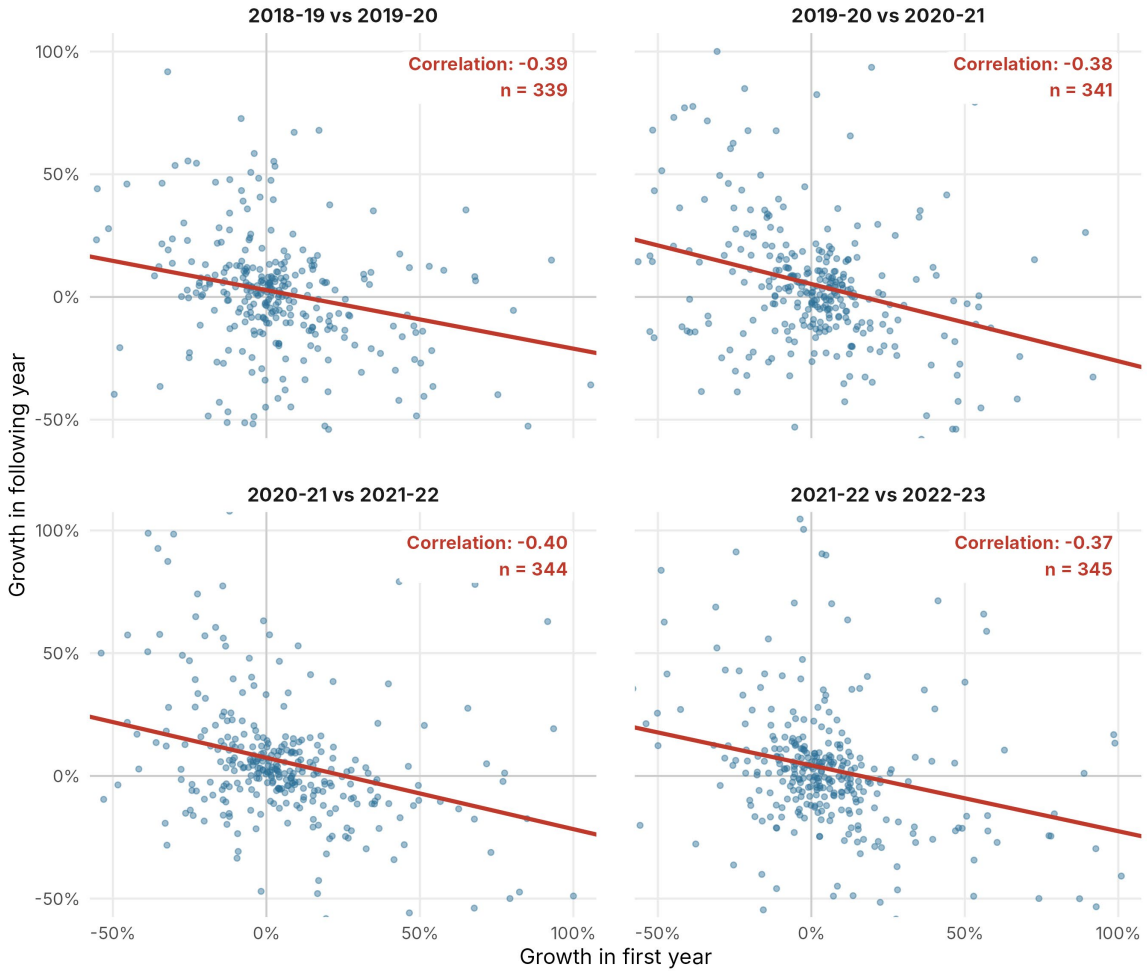
Under the proposed regulations, a hospital violates its spending target when its "year-over-year combined payer-specific spending growth… exceeds the applicable spending target," as calculated under the Spending Target Performance Measurement Manual (Manual).[2] Every subsequent step — notice, PIP, and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

[2] See proposed § 97452(a)(3).

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Combining Inpatient and Outpatient Spending Has Significant Benefits

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

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

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

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

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

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

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

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

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

Incorporate the Hospital Spending Measurement Methodology by Reference

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

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

[9] See, e.g., HSC § 127502.5(a).

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

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

Intensity Adjustments Must Be Appropriate for All Patient Populations

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

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

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

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

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

[11] See Gov. Code § 11342.600.

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

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

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

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

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

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

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

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

The Notice Must Include the Underlying Data and Calculations

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

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

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

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

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

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

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

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

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

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

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

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

Publication Must Not Imply Wrongdoing

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

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

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

Request: OHCA must:

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

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

Notices Must Reach Hospital Leadership

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

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

The Statutory Considerations Are Mandatory, Not Optional

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

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

Additional Enforcement Considerations Must be Specified

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

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

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

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

OHCA Must Consider Non-Organized Labor Costs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The following example illustrates how this could work in practice.

Hospital A

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

Unexplained Growth < Target
NO FURTHER ENFORCEMENT

Hospital B

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

Unexplained Growth > Target
POTENTIAL FURTHER ENFORCEMENT

OHCA Must Establish the Statutorily Required Waiver Process

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

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

III. Enforcement Must Be Progressive, as the Statute Requires

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

Technical Assistance Must Be Advisory

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

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

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

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

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

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

Public Testimony Needs Tighter Parameters

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

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

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

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

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

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

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

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

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

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

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

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

PIPs Must Include Action Steps, Not Goals

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

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

PIPs Must Be Tailored to Improve Spending Performance

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

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

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

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

OHCA May Not Dictate PIP Strategies

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

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

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

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

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

PIP Timelines Should Be Extended and Clarified

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

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

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

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

Draft PIPs Must Be Confidentially Maintained by OHCA

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

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

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

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

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

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

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

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

Hospitals Must Be Able to Amend Their Plans

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

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

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

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

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

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

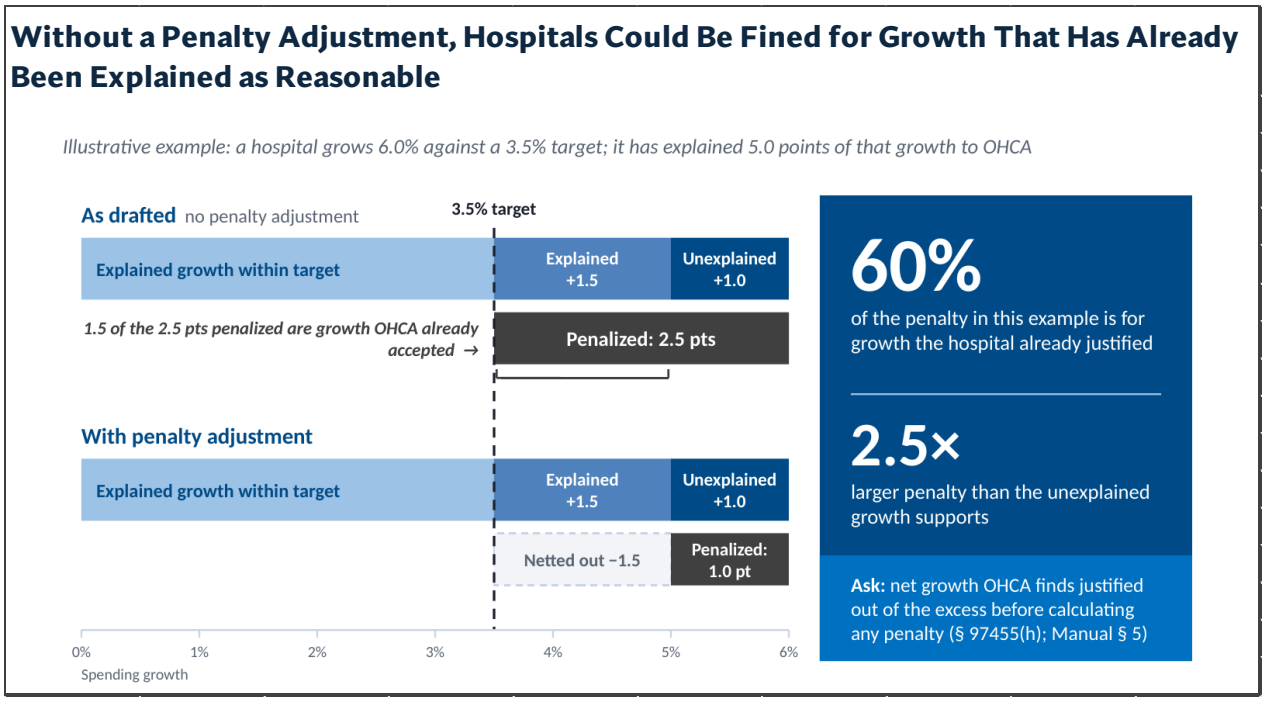
> "(A) The nature, number, and gravity of the offenses.
>
> (B) The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity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

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

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

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

[25] See HSC § 127502.5(d)(6).



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

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

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

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

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

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

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

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

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

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

OHCA's authorizing statute is crystal clear: "If the director determines that a health care entity is not compliant with an approved performance improvement plan and does not meet the cost target, the director may assess administrative penalties."[29] As discussed in section X of this letter, this statutory provision establishes a two-part test for financially penalizing a health care entity. The regulations affirm the two-part test, clarify what the applicable spending target is, and specify that the applicable spending target should be identified in the PIP. However, the PIP submission guide contains no directions for identifying the applicable spending target, leaving it an open question of whether it would be subsumed under D.5 of the guide. Doing so would effectively collapse the two-part test into one, in clear violation of state law.

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

Clarify That Inpatient and Outpatient Penalties Offset, and Across Markets

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

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

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

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

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

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

VI. Confidentiality Protections Must Be Substantially Broadened

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

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

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

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

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

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

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

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

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

OHCA Must Deem Additional Sensitive Documents and Information Confidential

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

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

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

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

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

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

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

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

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

VIII. Technical Changes

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

Conclusion

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

Sincerely,



Ben Johnson
Group Vice President, Financial Policy

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

Attachment #7

October 30, 2026

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

Re: OHCA's Proposed Penalty Framework Regulations

Dear Director Landsberg:

Children's Hospital Los Angeles (CHLA) appreciates the opportunity to comment on the Office of Health Care Affordability's proposed enforcement and penalty framework.

CHLA supports the goal of improving healthcare affordability. However, the proposed framework does not adequately account for the realities of pediatric specialty and safety-net care. A one-size-fits-all enforcement structure may have consequences for access to care for California's sickest children.

Unlike most hospitals, CHLA provides care that often cannot be replicated elsewhere. As California's largest freestanding pediatric hospital, CHLA cares for children from every county in the state. More than 70 percent of CHLA's patients are covered by Medi-Cal, and the hospital provides highly specialized services including pediatric transplantation, oncology, neonatal intensive care, trauma care, rare disease treatment, and other advanced specialty care. CHLA cares for 26% of the state's California Children's Services (CCS) patients and serves as a critical referral center for children with the most complex medical conditions, many of whom have few, if any, alternative care options elsewhere.

For that reason, CHLA urges OHCA to:

- Base enforcement determinations on multiple years of data rather than a single year's performance; and
- Account for the impending impacts of federal Medicaid changes and evaluate spending growth across all payer categories rather than assessing penalties separately by payer.

These safeguards are particularly important for pediatric hospitals, where annual spending variations are often driven by factors outside of a hospital's control.

CHLA's experience illustrates this challenge. Between FY25 and FY26, gene therapy volume increased from 34 patients to 43 patients, increasing pharmaceutical costs from approximately $54 million to $78 million. In FY25, CHLA performed 121 pediatric transplants, including 62 bone marrow transplants, with average transplant costs exceeding $800,000 per case and heart transplant costs averaging approximately $2 million per patient. These costs do not reflect inefficiency. They reflect children receiving life-saving care.

Year-over-year spending growth is also influenced by pharmaceutical price increases, workforce market pressures, rising supply costs, and advances in pediatric medicine. In FY25, pharmaceutical costs increased by 8 percent, labor costs increased by 7.8 percent, and medical supply costs increased by 4 percent, all exceeding OHCA's proposed growth target and largely reflecting external market conditions rather than operational decisions.

The proposed penalties are particularly concerning given CHLA's financial reality. CHLA operates with limited financial flexibility while maintaining highly specialized pediatric programs that require ongoing investment in people, technology, and infrastructure. In addition, CHLA must invest approximately $273 million in remaining seismic upgrades to retain all licensed beds and meet California's 2033 seismic compliance requirements. Medi-Cal, which covers the majority of CHLA's patients, consistently reimburses below the cost of providing complex,

life-saving care. Chronic underpayment for pediatric specialty and critical care, combined with anticipated federal Medicaid reductions and other policy changes that will further strain California's healthcare safety net, could significantly impair CHLA's ability to invest in the services, workforce, and innovations patients depend on.

Under OHCA's updated methodology, CHLA's 2022-2023 spending data would generate an estimated penalty of approximately $147.5 million, including $46.6 million for commercial patients, $584,000 for Medicare, and $100.3 million for Medi-Cal. For a hospital with approximately 21 days cash on hand, a penalty of that magnitude would consume a substantial portion of CHLA's available financial cushion. Resources of this scale cannot be absorbed without significant consequences.

The impact would extend beyond finances. CHLA employs nearly 6,900 individuals and depends on highly specialized physicians, nurses, pharmacists, researchers, and clinical staff to deliver advanced pediatric care. Significant financial penalties would reduce resources available for recruitment, retention, workforce development, and career pathways at a time when specialized pediatric talent is already difficult to recruit nationwide. Workforce stability is one of OHCA's stated objectives, yet penalties of this scale risk undermining that goal.

Most importantly, penalties of this magnitude threaten access to pediatric specialty care that exists in only a handful of locations nationwide. Families relocate to Southern California so their children can receive care at CHLA. Children are referred from every county in California because the expertise required to treat their conditions often does not exist in their local communities. If a community hospital reduces services, patients may be able to seek care elsewhere. If CHLA is forced to reduce capacity, there are limited alternatives available to absorb the children who depend on these highly specialized programs.

The consequences of a spending target framework should not fall most heavily on the providers caring for California's most medically fragile children.

CHLA respectfully requests that OHCA adopt a more tailored approach that recognizes the unique role of pediatric safety-net hospitals, relies on multi-year assessments, and evaluates performance across all payers rather than imposing separate enforcement actions on individual payer categories.

Thank you for your consideration.

Sincerely,



Lindsey Berman

Children's Hospital Los Angeles

CALIFORNIA MEDICAL ASSOCIATION

October 30, 2026

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

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

RE: Draft Proposed Spending Target Enforcement Regulations, Draft Performance Improvement Plan Submission Guide, and Draft Spending Target Performance Measurement Manual, dated 10/8/2026

Dear Secretary Johnson:

On behalf of our over 50,000 physician and medical student members of the California Medical Association (CMA), we appreciate the opportunity to provide feedback on the Office of Health Care Affordability's (OHCA or the Office) draft proposed spending target enforcement regulations, draft Performance Improvement Plan (PIP) Submission Guide, and draft Spending Target Performance Measurement Manual, dated October 8, 2026.

CMA believes the enforcement process and penalties being developed should consider the current compliance landscape. According to the 2023-2024 data compiled by OHCA, most health care entities are not on track to meet the 3-3.5% spending growth target set for 2025-2029. The same is also true for the states with a longer history of setting spending targets. Many stakeholders continue to believe that the spending targets set by OHCA will not be possible to meet without harming access to care given the increased costs to deliver medical care, including workforce costs. Establishing an enforcement framework that is clear, workable, fair, and consistent with protecting access, quality, and equitable health care delivery is a top priority for CMA.

Physician organizations (as defined in statute) are directly subject to PIPs and any potential penalties under this framework, CMA's members therefore have a significant stake in how the spending targets will be enforced. We appreciate OHCA's willingness to engage with stakeholders before these proposals are finalized. We offer the following comments and concerns to advance our shared goal of improving health care affordability for Californians while maintaining access to high-quality, equitable care.

Address Attribution Methodology Issues for Costs Beyond a Physician Organization's Control and Misattributed Members - §97452(b)(4)-(6), (c), & (d)

In our August comments on an early iteration of OHCA's draft enforcement framework, CMA shared concerns about penalizing physician organizations for costs beyond their control, and urged OHCA both to establish a clear and predictable process to remove those costs from

consideration during the enforcement process, and to correct the problems in OHCA's attribution methodology to prevent those external costs outside their control from being attributed to physician organizations in the first place.

Lack of Clarity in Application and Weighting of Enforcement Considerations

While the October 2026 draft of the proposed regulations include factors an entity may raise and OHCA would consider when deciding whether to subject an entity to enforcement, they do not provide clarity or guidance on how OHCA would weigh these enforcement considerations. The proposed regulations at subsection 97452(b)(4) state that an accountable health care entity shall demonstrate the impact of relevant factors that contributed to its exceeding the spending target; and subsection 97452(d) states the Director "may consider" the entity's responses and other factors when determining whether to subject an accountable entity to enforcement. But it leaves complete discretion to OHCA, such that an entity could demonstrate that every identified factor in regulation applied to the entity's excess spending, and the Director could still decide to subject the entity to enforcement. Even in the case of an erroneous spending growth calculation, if an entity shows "by clear and convincing evidence" that OHCA incorrectly calculated its spending growth, the proposed regulation at subsection 97452(c) states that OHCA "*may* modify" the preliminary determination that the entity exceeded its spending growth target (emphasis added). CMA strongly recommends greater clarity in these provisions both to provide some predictability to physician organizations and other health care entities generally, and to ensure greater consistency in how these standards are applied.

Omission of Risk Adjustment and Equity Adjustment

The draft proposal also continues to omit factors for risk adjustment and equity adjustment. Health and Safety Code section 127502, at subdivisions (f) and (g) requires OHCA to establish risk and equity adjustment methodologies for the reporting of data. These statutory requirements were a recognition of the fact that the health and socio-economic status of a patient population materially impact the cost of providing care to that population in ways that are beyond the provider's control. They were also a recognition of the adverse outcomes to access, equity, and quality of care that would follow if the state penalized providers for treating patients with high-cost, high acuity, and chronic conditions. Proposed subsections 97452(b)(4)(A) and (B) describe "distribution of social risk" and high-cost patient outliers, but these do not capture all the factors relevant to risk adjustment (which looks at relative health or morbidity of an entity's risk pool compared to its peers) and equity adjustment (including the full array of social determinants of health, such as income, education, geography, and among other factors).

Costs Beyond an Entity's Control

Proposed subsection 97452(b)(4) also does not expressly explain how a physician organization is expected to raise the fact that, in addition to these factors, a meaningful share of its attributed spending is outside of its control.[1] Penalizing a physician organization for

[1] Under the attribution methodology example presented to OHCA's physician organization workshop and to the Health Care Affordability Board in June, costs, such as behavioral health specialty care provided by another provider group, PMB pharmacy claims, and hospital ER claims will be attributed by the health plan to a physician

failing to meet a spending growth target or PIP benchmarks, when performance is based in large part on costs the physician group has no ability to control, would incentivize physician organizations to try to contain these external costs using the only means available to them: 1) stop or reduce recommending certain treatments or prescribing certain medications, and 2) stop accepting patients with acute or complex health conditions, all at the expense of patient health, health access, and long-term health outcomes. Both of these are outcomes that all stakeholders want to avoid.

The enforcement considerations listed in proposed subsections 97452(b) and (d) do not squarely address this issue. The factors primarily focus on reasons why the spending grew, but not whether the health care entity had the ability to control the spending. That gap is notable given that, as noted above, Health and Safety Code section 127502.5(a) directs the Director to consider "the extent to which each entity has control" over its cost target components. This statutory factor is not reflected anywhere in the draft proposed regulation. And unlike population characteristics, high-cost outliers, and the other listed factors, which OHCA may weigh at its discretion, an entity's control over its costs is a factor that the statute requires the Director to consider.

CMA recommends accounting for costs outside an entity's control expressly in the proposed regulation, as well as in the proposed formulas in the draft Spending Target Performance Measurement Manual. Otherwise, we remain concerned that penalizing health care entities for costs that are outside of their control may erode access, quality, workforce stability, and health outcomes, which may further drive spending growth and cost of care.

Misattributed Members

There are also methodological issues with attributing members to a physician organization who are not actual patients of the practice. This was expressly built into the THCE methodology as a measure of expediency to ensure all members in payers' data are attributed to a health care entity, regardless of the accuracy. Attribution of the underlying total health care expenditures data, according to the THCE Data Submission Guide at page 18, is performed as follows:

1. First, identify members for whom utilization management and claims payment functions have been delegated to a physician organization listed on the OHCA Attribution Addendum through a capitated payment arrangement. Report data for these members using the Capitated, Delegated Arrangement attribution method.
2. Next, attribute remaining members to a total cost of care Accountable Care Organization (ACO) arrangement that includes a physician organization listed on the

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

OHCA Attribution Addendum. Report data for these members using the ACO Arrangement attribution method.

3. Any members who cannot be attributed using one of the above methods may be attributed to a physician organization listed on the OHCA Attribution Addendum using a submitter-developed, rules-based approach for assigning total medical expense. Report data for these members using the attribution method Payer Developed Attribution.

Under OHCA's cost attribution methodology, an attributed member's total medical expenses for the whole month will be attributed to the physician organization, even those expenses that are outside the practice's control. This will lead to significant misattribution on a per-member-per-month basis. The THCE Data Submission guide states this approach "ensures that the weight of the monthly spending is accurately reflected in the average." But when an entity's attributed spending includes both costs outside the entity's control *and* costs for misattributed members, the impact of these attribution methodology issues compounds. For a physician organization with thousands or tens of thousands of lives, these misattributions can significantly skew their spending growth performance.

The potential magnitude of spending incorrectly attributed to physician organizations under OHCA's attribution methodology underscores the need for review and appeal processes, and the need to approach enforcement with caution, in order to avoid potentially irreversible harm to California's healthcare delivery ecosystem.

Current Framework Shifts Burden of Flawed Attribution Methodology on Health Care Entities

OHCA has publicly acknowledged many of these attribution methodology concerns, and attempts to solve for these issue on the back end, by putting the onus on an accountable health care entity to document these external costs, calculation or data errors, and other factors to explain any of the entity's excess spending growth. This approach shifts the burden of fixing errors in OHCA's attribution methodology to physician organizations, by requiring practices to shoulder the cost of analyzing and refuting third party spending data, and the cost of maintaining documentation of patient prescription drug costs and other spending outside its control so it can identify and explain them to OHCA two to three years after the fact.

Increasing regulatory costs on physician practices as a workaround instead of fixing the underlying attribution methodology is a problematic approach, especially when physician practices are already under pressure to cut spending. The better approach would be to determine compliance based on spending that is within the entity's control at the outset, for members who are actual patients of the entity. This approach would reduce the unnecessary regulatory costs of having to analyze and respond to noncompliance notices.

To that end, CMA believes enforcement should be paused until both the underlying data and the office's cost attribution methodology are at least reasonably accurate. Otherwise, OHCA would be penalizing activity that is not in fact contributing to spending growth by holding an entity accountable for costs entirely outside its control, and doing so at the expense of public health. We have heard stakeholders repeatedly state at OHCA advisory committee and board

meetings about gross inaccuracies in the THCE data, including the number of covered lives attributed to a medical group. These inaccuracies need to be resolved, and the public should have confidence in the accuracy of data being used to determine compliance before OHCA begins enforcement activities.

Provide Advance Data Review/Correction Process

Given the reported inaccuracies in spending attribution, and the potential financial implications for exceeding the spending target, CMA strongly recommends that OHCA provide a data validation and correction process for physician organizations to review and verify or dispute spending data attributed to them, ideally well before the enforcement phase. In contrast to payers or hospitals, physician organizations are the only health care entities subject to spending targets whose compliance is determined based on data submitted by a third party (payers). Physician organizations need additional time to review and analyze this data, and attempt to reconcile it with their own data and identify and resolve potential errors or discrepancies. Establishing such a process would reduce the number of errors and disputes later in the compliance process, and provide greater confidence in the accuracy of the underlying data and OHCA's compliance determinations.

Establish Working Group for Attribution Methodology

CMA also recommends that OHCA establish a working group to consider solutions and alternative approaches to OHCA's current attribution methodology to ensure physician organizations and other accountable healthcare entities are only held accountable for costs within their control.

We continue to urge OHCA to establish costs outside of the health care entity's control as a separately identified factor at each relevant stage of the enforcement process. This might include having the payer separate out attribution categories such as pharmacy claims from the costs attributed to the health care entity or allowing a physician organization to submit documentation identifying specific attributed costs it did not negotiate, direct, or otherwise control in the preliminary enforcement considerations stage, confirming that a PIP need only address the "key causes of spending growth" within a physician organization's control, and accounting for documented uncontrollable costs in OHCA's evaluation of whether a PIP is likely to bring an entity into compliance.

But CMA recognizes there may be multiple paths to addressing these issues, and OHCA may need to employ different strategies in the short-term and long-term to improve its attribution methodology. A working group would provide an appropriate setting to weigh different options and reach a more workable solution.

Extend Response Period and Increase Flexibility for Extensions – § 97452(b)(3)

CMA recommends providing a longer period for accountable entities to respond to a preliminary determination from OHCA that an entity has exceeded the spending target, as well as providing more flexibility for extensions. A physician organization will likely need more than 45 days to review and analyze cost data, especially when sourced from a third party,

identify and compile data and validate documentation to support its contentions, and prepare a response to OHCA. Extensions of 15 days are similarly inadequate. This is particularly true for large, complex organizations, who would need to review and analyze large and complex datasets from multiple payors to validate OHCA's calculations and the underlying third-party data. For different reasons, these timelines are also insufficient for smaller group practices that may lack the resources and expertise to effectively review OHCA's preliminary determination, spending growth calculation, and the underlying payer data, and prepare an appropriate response with the necessary documentation. Setting such short periods would likely result in most entities requesting multiple extensions, creating additional administrative work for entities and OHCA staff to request and process extension requests.

CMA also recommends broadening the proposed factors for granting extensions. The draft proposed factors solely focus on catastrophic events, natural disasters, and "unforeseen" disruptions. A personnel, operational, or technical disruption will impede an entity's ability to provide a response within the regulatory timeframes, unforeseen or otherwise. Similarly, a smaller physician organization or other entity during even normal operations and staffing levels may nonetheless lack sufficient staffing resources to analyze, validate, and attempt to explain or refute the underlying data used to make a preliminary determination within these timelines. Accordingly, factors for granting an extension should also consider the volume of data to review, the workload required to respond, and the entity's existing resources to manage this workload.

Finally, the regulations should provide greater clarity as to when an extension will be granted or denied. The draft proposal grants total discretion to the office to decide, which makes it unclear when an entity can expect to receive a requested extension, and creates the potential for inconsistent application of standards. CMA supports providing flexibility in the enforcement process to allow accountable health care entities to learn how to comply with these requirements, but OHCA should also provide entities with some predictability about when an extension request will be approved.

Change Evidentiary Standard to Preponderance of Evidence – § 97452(c)

The draft proposed regulations require entities to demonstrate errors in OHCA's spending growth calculation by "clear and convincing evidence." This standard subjects entities to a disproportionately high evidentiary bar. CMA believes a preponderance of the evidence standard is more appropriate given the data inaccuracies and attribution methodology problems that have been identified to date, particularly for physician organizations that would have to refute data supplied by third party payers.

OHCA should also revise the draft proposal to state that the Office "shall"—not "may"—modify its preliminary determination of excess spending growth when an entity has demonstrated an error in OHCA's calculation.

> (c) The Office ~~**may**~~ **shall** modify the preliminary determination of excess spending growth if the accountable health care entity's response under subsection (b)(3) shows, by ~~**clear and convincing**~~ **a preponderance of the** evidence, that the Office's

calculation of excess spending growth is incorrect. A modification does not preclude the Office from proceeding with progressive enforcement if the entity's spending growth remains above the spending target.

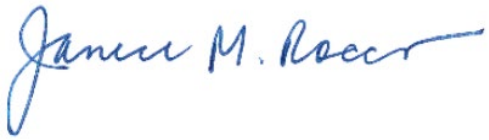
Pause Procedural Penalties until Technical Assistance is Sufficiently Available

CMA believes that penalties should be paused until OHCA can provide technical assistance to any health care entity that is determined to exceed its spending growth target, fails to file an acceptable PIP, or is determined to have failed to comply with or implement its PIP. Given that we are in the initial years of implementing spending growth targets, enforcement should begin with a focus on helping entities come into compliance. The goal of this law is to curb growth of healthcare costs, not to generate penalties that could potentially force practices and other health care entities to reduce or cease their operations.

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

CMA appreciates the opportunity to provide feedback, and to work with OHCA on efforts to develop a spending target enforcement process that improves health care affordability for Californians while maintaining access to high-quality, equitable care. Please feel free to contact me at jrocco@cmadocs.org with any questions.

Sincerely,



Janice Rocco
Chief of Staff, California Medical Association

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

October 30, 2026

The Honorable Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Health Care Access and Information Department

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

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

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

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

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

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

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

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

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

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

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

We recommend that OHCA:

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

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

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

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

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

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

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

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

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

We recommend:

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

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

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

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

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

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

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

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

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

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

Thank you for your consideration.

Sincerely,

Jessica Hay
Legislative Advocate
AFSCME California

Elmer Lizardi
Legislative Advocate
California Federation of Labor Unions

Tristan Brown
Legislative Director
California Federation of Teachers

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

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

Dear Ms. Landsberg and Mr. Pegany,

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

Our major substantive concerns include the following:

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

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

- The requirement that entities subject to a performance improvement plan comply with the applicable target.

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

Comments by Section of Proposed Regulations

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

Section 97445. Definitions

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

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

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

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

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

This definition lacks clarity as drafted because providers, including hospitals and large physician organizations, also have administrative costs and profits. The definition would

have greater clarity if it referred to the administrative cost and profits of payers and the fully integrated delivery system.

Section 97452 Spending Target Enforcement

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

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

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

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

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

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

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

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

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

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

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

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

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

With respect to (B) on the impact of high-cost patient outliers, Health Access recognizes that there are some high-cost patient outliers like complicated trauma cases or organ transplants that are not primarily due to high-cost drugs but that many other high-cost patients are primarily due to high-cost drugs and should be addressed under the proposed subparagraph (C).

With respect to (C) on the impact of high-cost drugs, Health Access very much supports the requirement that the impact be measured after accounting for any

remuneration or financial considerations for the use of these drugs. We would urge the Office to confer with those who are expert in the 340B program as it affects hospital revenues positively. There has been much discussion of the 340B program in Congress and that may be a source of expertise on the specifics of this program.

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

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

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

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

Health Access appreciates the clarity provided to entities here.

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

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

> *(d) Additional factors in determining whether enforcement proceeds include entity's prior spending growth, impact on consumer access and affordability, baseline costs, amount of excess spending growth, and entity actions that impair or impede enforcement.*

Health Access supports this list of additional factors that will allow the Director to distinguish between a have-not small, rural hospital that is not part of a larger health system and very high-cost hospitals, or between a health insurer with substantial market

share and ample tangible net equity and a health plan with few lives in the commercial market.

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

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

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

Health Access recommends that the Office post a list of entities that includes the further enforcement action, if any, and the categories of reasons why an entity did not proceed to further enforcement, such as corrected calculations, high-cost drugs, or de minimis excess spending. This is what would be posted on the Department's website, in addition to the posting of the preliminary list of entities over the target. If there was an earlier list of entities that exceeded the target and a subset of entities do not proceed to further enforcement, then there should be a list of those entities that will not proceed to further enforcement steps and a public description of why OHCA made that determination. If sibling state agencies such as Covered California and CalPERS are using information on entities that exceeded the target in their negotiations, they would also benefit from knowing why further enforcement is or is not anticipated.

In Oregon, their Health Authority posts the list of entities over the target, and then a description of interactions between the Authority and the entity to validate data, and the reasonableness determination made for each entity over the target.[1] This helps stakeholders track the enforcement process, and patterns as enforcement is implemented.

Section 97453 Technical Assistance

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

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

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

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

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

Section 97454 Public Testimony

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

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

Section 97455 Performance Improvement Plan and Spending Target Penalties

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

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

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

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

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

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

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

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

(e) Progress reports

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

(g) Compliance with performance improvement plan

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

(h) Administrative Penalty for Exceeding the Spending Target

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

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

ample reserves, whether those are large health systems or health plans merged with pharmacy benefit managers.

The regulations do not include consideration of Medi-Cal match, something that is contemplated in the law in Section 127502 (d) (5). We have reviewed the comments by the California Association of Public Hospitals and Health Systems. We agree that the current HCAI hospital financial reporting on the Quality Assurance Fee (QAF) for private hospitals is at best uneven. Health Access has long recognized the importance of county hospitals and health systems in serving the uninsured and Medi-Cal populations. We distinguish the role of the county hospitals from the role of the University of California health system, which is expanding exponentially and which is far less focused on serving underserved communities than county hospitals[2].

(i) Confidentiality

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

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

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

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

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

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

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

Section 97456 Procedural Penalties for Impeding or Impairing Target Enforcement

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

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

Section 97457 Penalty Justification Factors

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

Performance Improvement Plan Submission Guide

D. 6. Affordability for Consumers and Purchasers

Health Access supports the requirement that a performance improvement plan detail how each goal positively impacts affordability for consumers and other purchasers. Too

often cost savings at the provider or payer level get lost in the black box of the health care system and only the bottom of the entity benefits, not the consumer or other purchaser.

D. 8. Balancing Measures

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

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

D. 9 Sustainability

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

Comments on Spending Target Performance Measurement Manual

2 Payer Calculations

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

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

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

4 Physician Organization: Year over Year Growth in Attributed TME

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

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

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

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

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

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

Thank you for your consideration of these comments,

Sincerely,





Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Executive Director

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

JOHN MUIR HEALTH

October 28, 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:

John Muir Health has significant concerns with 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.**

John Muir Health 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 the statute requiring penalties to account for the "nature" of the violation.

Like many health systems in the state, John Muir Health is currently experiencing labor, medical supply and drug cost growth far in excess of the 3.5% spending target. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing

impossible choices: scale back the services and access our community relies on to avoid potential penalties, or provide the care our patients need and risk fines that would wipe out what little financial cushion we have.

To adapt to the new financial environment, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), John Muir Health has reduced costs by $300 million since 2022 through efficiency measures while maintaining quality and safety. We have been forced to make difficult decisions to close two outpatient rehabilitation locations and our Wound Care Center, while also selling our Home Health service as part of a joint venture agreement. In August, we had one of the largest layoffs in our history, letting go of 75 employees, including more than a dozen leaders. We also face more than $2 billion in costs to meet the state's unfunded 2030 seismic compliance goals. This is on top of the $1.2 billion we have already invested in seismic safety, including patient care towers at our Concord and Walnut Creek Medical Centers.

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

Worse, OHCA intends to separately enforce the targets for every payer, giving hospitals three separate ways to violate the target. For John Muir Health that means major losses in Medi-Cal and Medicare will not offset any incremental increases we receive from commercial payers. As a result, John Muir Health 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.

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

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

Penalties at the levels proposed by OHCA would threaten John Muir Health's viability, jeopardize our patients' health and our community programs, and undermine our ability to continue investing in the 6,800 dedicated employees who care for our community every day. We are the second largest private employer in Contra Costa County.

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

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be here for the Contra Costa, Alameda and Solano County residents who pass through our doors each year. John Muir Health appreciates the opportunity to comment and encourages the

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

Sincerely,

Mike Thomas
President and CEO
John Muir Health

cc: Members of the Health Care Affordability Board:
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
Senator Jesse Arreguin
Senator Christopher Cabaldon
Senator Tim Grayson
Assemblymember Anamarie Avila Farias
Assemblymember Rebecca Bauer–Kahan
Assemblymember Lori Wilson

Kaweah Health

October 28, 2026

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

Kaweah Health has serious concerns about the proposed regulations establishing an enforcement and penalty framework for hospitals that fail to meet the state's spending targets. The proposal does not give hospitals reasonable protections, and those protections are essential to preserving access to care and preventing further destabilization of California's increasingly fragile health care infrastructure. OHCA should instead adopt a collaborative approach to enforcement that gives hospitals a meaningful opportunity to improve spending trends.

As a public health care district serving Tulare County and the surrounding Central Valley, Kaweah Health operates a 613-bed hospital and is a Level III trauma center, a critical lifeline for emergency care in a largely rural region. Our emergency department treats roughly 282 patients every day, with some days as high as 350 patients. We also run a graduate medical education program that trains the next generation of physicians in a part of the state facing severe provider shortages. A majority of our community is covered by Medi-Cal, which leaves us especially exposed to the Medi-Cal and Medicare cuts ahead. Our margin for error is thin, and the enforcement design OHCA adopts will directly shape whether we can continue to serve our community.

We urge the OHCA Board to revise the proposed regulations to balance affordability with continued access to care by:

- **Basing violations on multiple years of data.** Year-over-year spending swings are volatile, and only multiyear assessments can reliably distinguish hospitals that have genuinely exceeded their targets.
- **Initiating enforcement only when a hospital exceeds the target across all payers on a combined basis.** This accounts for impending cuts to Medi-Cal and Medicare payments and the growing ranks of the uninsured.
- **Standardizing the process for explaining growth above the target** and enumerating additional reasons for justifiable growth, such as rising patient volume, consistent with the statutory waiver process.

- **Establishing a collaborative performance improvement process** that gives hospitals a real opportunity to improve before fines are levied.
- **Penalizing only growth that has been determined to be unjustified.** This gives essential meaning to the statutory requirement that penalties account for the "nature" of the violation.

Kaweah Health is facing cost growth well above the 3.5% target. In the first quarter of fiscal year 2027 (July through September 2026), compared with the same period last year, our salaries and wages grew 6.4%, medical and other supplies (which include pharmaceuticals) grew 12.6%, and physician fees grew 14.6%. Total operating expenses rose 4.9%, from $242.0 million to $254.6 million. This growth tracks the growth in the patients we serve: our average daily census rose 13.9% over the same period, from 388 to 442 patients. Measured per patient day, our total operating expenses actually fell about 7.7%. Maintaining round-the-clock trauma readiness and a residency program also carries fixed staffing and supply costs that do not flex with a spending cap. At the same time, OHCA is capping the resources we have to pay for them, forcing an impossible choice: cut staff and services now to avoid potential penalties, or provide the care our patients need and risk fines that would erase what little financial cushion we have.

To adapt to OHCA's spending restrictions and a challenging financial environment, including the largest health care cuts in history under the One Big Beautiful Bill Act (OBBBA), we [have taken/anticipate taking] the following steps:

- Reviewing service lines and clinics that have a negative impact on our operating margin with the potential to close those that we can no longer support.
- We reduced contract labor spending by 33% in the first quarter of this fiscal year, from $6.3 million to $4.8 million.
- We have paused or canceled investments that would provide much needed access to care, such as rural health clinic and community health worker expansion.
- Kaweah Health no longer has the resources to make the investment in replacement facilities needed to meet the state's 2030 seismic compliance goals.

Even so, these efforts may not be enough, and OHCA's hospital spending methodology produces results that do not reflect our own experience. OHCA has indicated that it will base determinations on a single year of data, which can be badly misleading. Our own results show how much a short window can distort the picture. Our operating margin swung from negative $6.7 million in the first quarter of last fiscal year to a positive $2.9 million during the first quarter of this year. In September alone, supply expense ran 17.2% above the prior year, while the three-month figure was 12.6%. One period in isolation does not accurately reflect our spending trends, which is why multiyear assessments are necessary.

The proposal also enforces the targets separately for each payer, giving hospitals three distinct ways to violate the target. For Kaweah Health, this means major losses in Medi-Cal and Medicare would not offset any incremental increases from commercial payers. Because a high portion of our patients are covered by Medi-Cal, our revenue is heavily tied to rates set by the state and federal

governments. We received $28.1 million in supplemental government program payments in the first quarter alone, and carried $97.8 million in Medicare and Medi-Cal settlements receivable at September 30. A hospital like ours has little ability to offset losses in one payer line with gains in another, which makes payer-by-payer enforcement especially unworkable for safety-net providers. We could 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.

Kaweah Health is committed to helping patients afford the care they need. For fiscal year 2026 we adjusted 12,416 claims for $13,392,344 related to Charity/Financial assistance for approximately 3,771 patients.

We also understand that long-term affordability requires focused effort now. That is why we are investing in population health initiatives that address social determinants of health for underserved populations such as chronic disease management, pre-natal / maternal health, preventative screenings, connecting patients to housing initiatives and community health fairs, positively impacting thousands in our region.

Penalties at the levels OHCA proposes would threaten Kaweah Health's viability, jeopardize our patients' health, and endanger the livelihoods of the more than 4,600 full-time-equivalent employees and contract staff who rely on us. Our cushion is already thin: we hold 88 days of cash on hand, down from 113 days on June 30 and below the 117-day Moody's median for Baa-rated systems, and our year-to-date operating margin is 1.1%.

We are also concerned that OHCA may penalize organizations before they have had the chance to improve through voluntary strategies. We know our organization best, and we worry that one-size-fits-all strategies imposed from outside would undermine our ability to sustain high-quality, equitable care and a stable workforce, priorities we share with the Office.

The measurement and enforcement process OHCA establishes will determine whether we can continue to be there for the 483,546 Tulare County residents who rely on Kaweah Health each year, including more than 100,000 emergency department visits.

Kaweah Health appreciates the opportunity to comment and encourages the OHCA Board to incorporate the recommendations of the hospital field in future rulemaking. We look forward to working with the Office as these rules are finalized and to collaborating on a more affordable and accessible health care system for all Californians.

Sincerely,



Marc G. Mertz

Kaweah Health

Chief Executive Officer
Kaweah Health

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

KernMedical | 160 YEARS Health for Life.

October 26, 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:

Kern Medical has strong concerns with 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.**

Kern Medical 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.

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

To adapt to OHCA's new spending restrictions and the challenging financial environment, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), we anticipate taking multiple steps that may impact services, staffing, and resources to invest in our facilities.

And yet, those efforts might not be enough. OHCA's hospital spending methodology produces wild results that do not reflect Kern Medical's own experience. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. Consider that for Kern Medical, year-over-year data show total expense increases fluctuate between six to nine percent these past four years. One year in isolation does not give an accurate picture of Kern Medical'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 Kern Medical, that means major losses in Medi-Cal and Medicare will not offset any incremental increases we receive from commercial payers. As a result, Kern Medical 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.

Kern Medical is committed to helping patients afford the care they need. As one of California's 17 designated public health systems, our programs include financial assistance, free clinics for certain services, and free vaccination programs.

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

Penalties at the levels proposed by OHCA would threaten Kern Medical's viability, jeopardize our patients' health, and endanger the livelihoods of the 2,500 staff who rely on us. Had the 3.5% spending target been in place in 2023, Kern Medical would have faced penalties under the proposed constructs by OHCA. Such a fine would inevitably require re-evaluations of service and staffing levels, threatening care in our communities. Problematically, these fines would even be based on spending growth that OHCA itself has previously deemed as reasonable.

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

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

Kern Medical 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,



Scott Thygerson
Chief Executive Officer

cc: Members of the Health Care Affordability Board:
Kim Johnson
Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Donald B. Moulds, PhD
Dr. Richard Pan
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Senator Shannon Grove, Senate District 12
Senator Melissa Hurtado, Senate District 16
Assemblymember Dr. Jasmeet Bains, Assembly District 35
Assemblymember Stan Ellis, Assembly District 32

Kindred Hospitals

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:

Kindred Hospitals has strong concerns with 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.

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

Kindred Hospitals 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 (at minimum three) 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.

- Revisiting the penalty framework to penalize only excessive growth that has been determined to be unjustified, which provides essential definition and meaning to the statutory requirement that penalties account for the "nature" of the violation.

Kindred Hospitals is currently experiencing cost growth in excess of the 3.5% spending target. Labor, medical supply, and pharmaceutical costs have all risen sharply — driven by market forces, inflation, and workforce dynamics that we cannot unilaterally control. Facing such uncontrollable cost growth at the same time as OHCA is putting a lid on the resources we have to pay our bills is forcing challenging decisions: reduce 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.

If the proposed regulations are implemented as written, and given the financial pressures that will accompany them, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), Kindred Hospitals may be forced to consider steps such as:

- Closing or reducing services.
- Pausing or canceling investments in new technology and other capital improvements, as well as reducing resources necessary to meet the 2030 seismic goals.

And even these measures might not be enough. OHCA's hospital spending methodology produces wild results that do not reflect Kindred's own experience. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. Year-over-year spending can be distorted by one-time events, changes in patient acuity, and payer mix shifts entirely outside a hospital's control. One year in isolation does not give an accurate picture of a hospital'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 Kindred, that means major losses in Medi-Cal and Medicare will not offset any incremental increases we receive from commercial payers. As a result, Kindred 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 Kindred's viability, jeopardize our patients' health, and endanger the livelihoods of the more than 3,000 workers who rely on us. Had the 3.5% spending target been in place in 2023, Kindred Hospitals would have faced a starting penalty amount of approximately $5.4 million on its commercial lines and $28 million across all payer lines (based on estimates prepared by the California Hospital Association).

Such a fine would inevitably require re-evaluations of service and staffing levels, threatening care in our communities. Money directed to penalties is money that cannot be spent on patient care, workforce retention, or the facility investments the state is requiring separately of us. Problematically, these fines would even be based on spending growth that OHCA itself has previously deemed as reasonable.

Kindred Hospitals 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. Our hospitals serve medically complex patients who require continued care and extended recovery time, filling the gap between an acute care hospital and a skilled nursing or inpatient rehabilitation facility. We know our organization best and are worried that one-size-fits-all strategies imposed from the outside would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce - a priority OHCA is statutorily charged with protecting and one we share with the office.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the more than 7,000 California residents who pass through our doors each year.

Kindred Hospitals 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,

Adam Darvish

Adam Darvish
SVP Specialty Hospitals Operations, West Region
Kindred Hospitals

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

Chief Executive Officer
Ryan Harris

MAYERS MEMORIAL
HEALTHCARE DISTRICT

Board of Directors
Jeanne Utterback, President
Abe Hathaway, Vice President
Tami Vestal-Humphry, Treasurer
Lester Cufaude, Director
James Ferguson, Director

October 29, 2026

Health Care Affordability Board
Office of Health Care Affordability
California Department of Health Care Access and Information

Re: Request for a Low-Volume Hospital Exemption from Spending Targets

Dear Members of the Board:

On behalf of Mayers Memorial Healthcare District, I respectfully request that the Office of Health Care Affordability establish an exemption from statewide and hospital-sector spending targets for hospitals operating at or below 25% of the statewide average hospital patient volume. This exemption would recognize the financial realities facing low-volume hospitals, particularly critical access hospitals, where essential services must remain available despite limited patient volumes, challenging payer mixes, and limited negotiating power.

OHCA's framework recognizes patient volume as a factor the Board may consider when establishing exemptions. We urge the Board to translate that consideration into a clear, measurable standard that protects access to essential rural services.

Low volumes create unavoidable fixed-cost pressures. Critical access hospitals must maintain the staff, equipment, facilities, and support services necessary to provide care around the clock. At Mayers, our emergency department sees approximately 14 patients per day, but we must maintain emergency readiness 24 hours a day, seven days a week. These costs cannot decline proportionately when fewer patients arrive. A small decrease in visits can increase cost per encounter even when total spending remains stable and management operates efficiently.

Volume and acuity adjustments alone cannot fully account for this minimum cost of maintaining access. Hospitals serving small, geographically isolated communities have limited opportunities to spread essential operating costs across additional patients. Reducing those costs can require reducing services or availability, with direct consequences for the communities that depend on them.

Payer mix further limits financial flexibility. Rural hospitals serve substantial Medicare and Medi-Cal populations and have limited ability to influence the payment rates established by those programs. A relatively small commercially insured population limits opportunities to offset reimbursement shortfalls. Changes in coverage, payer mix, or supplemental funding can therefore materially affect financial stability without any corresponding change in efficiency.

Small hospitals also have limited negotiating power. Low purchasing volumes constrain our ability to secure favorable pricing for pharmaceuticals, supplies, equipment, technology, and purchased services. Rural

workforce shortages create additional pressure through recruitment costs, temporary staffing, and employee housing needs. At the same time, small rural hospitals have limited leverage when negotiating commercial reimbursement. We often face rising input costs without a comparable ability to increase payment rates.

For these reasons, we recommend that OHCA:

- **Establish an exemption for hospitals with patient volumes at or below 25% of the statewide average**, using a publicly defined, consistently applied measure that reflects both inpatient and outpatient activity.
- **Use a three-year average of hospital volumes and the statewide benchmark** to reduce the effects of annual fluctuations and avoid abrupt changes in exemption status.
- **Recognize the cost of maintaining essential services**, including continuous emergency readiness, when defining the volume measure and evaluating the exemption.
- **Use existing HCAI reporting wherever possible** to determine eligibility and minimize additional administrative costs.

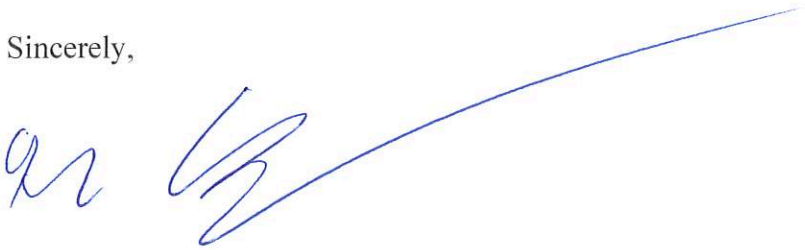
The proposed 25% threshold would provide a transparent starting point for identifying hospitals whose operating circumstances differ substantially from those of the average California hospital. OHCA should evaluate the threshold using its existing hospital data and publish the methodology and estimated impact before implementation.

Mayers supports responsible cost management and the goal of making health care more affordable. However, spending targets must recognize the limited control low-volume hospitals have over their underlying cost structure. Applying uniform growth expectations without a meaningful exemption risks placing additional pressure on hospitals whose financial challenges stem from maintaining essential access in communities with too few patients to achieve economies of scale.

For rural residents, losing a local service can mean longer travel, delayed treatment, and greater difficulty obtaining care. A carefully designed low-volume exemption would allow OHCA to advance affordability while preserving the essential health care infrastructure that rural Californians depend on.

Thank you for considering this request. We welcome the opportunity to work with OHCA staff and the Board on a practical, data-driven exemption that recognizes these structural challenges.

Sincerely,



Travis Lakey
Chief Financial Officer
Mayers Memorial Healthcare District

MemorialCare

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

October 29, 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: Attn: Megan Brubaker at OHCA@hcai.ca.gov

Dear Director Landsberg:

I am writing on behalf of MemorialCare, a nonprofit, integrated health care delivery system located in both Los Angeles and Orange Counties that has four hospitals and over 220 community-based ambulatory sites of care to provide our concerns with 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 regulations fall short of providing reasonable protection 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 pursue a collaborative approach to enforcement and penalty structure that provides hospitals with a meaningful opportunity to improve spending trends.**

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

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

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

MemorialCare

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

Since the 2024 OHCA Board meeting, the enforceable spending target of 3.5% has been set for 2026, and even with that slight adjustment our system would not be able to meet this target, and therefore subject to excessive financial penalties. As a result, our hospital system would be unfairly penalized for having reduced total cost care for years.

Our hospital lowered costs, but it would be penalized anyway. As an example, MemorialCare Long Beach Medical Center's commercial inpatient revenue per case mix adjusted discharge fell by 8.1% during the recent measurement period (2023), meaning healthcare expenditures went down. They fell even though our hospital negotiated small rate increases ranging from 3% to 5% with health plans. Despite lowering the cost of care during the measurement period, OHCA's formula gives our hospital no credit for lowering the costs for employers and patients. Our hospital will be fined for a price it never set.

Using the same data, Long Beach Medical Center's Medicare inpatient revenue per case mix adjusted discharge rose 15%, and outpatient revenue rose 16% - even though the reimbursement increases from Medicare that year were just 4.3% and 3.8%, respectively. Those rates are set by the Federal government. No hospital can negotiate those rates; they must simply accept them. However, OHCA's formula could levy a financial penalty on Long Beach Medical Center of up to $27 million based on a Medicare pricing structure over which the hospital has no control.

Therefore, the combined impact of California's first statewide spending target at 3.5% combined with the promulgated enforcement and penalty structure falls short of achieving the OHCA goals to improve access and affordability for patient care long term**. For these reasons, we respectfully ask you to consider a new structure for enforcement and penalties.**

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

- Basing the determination of a violation on multiple years of data to avoid the volatility of year-over-year spending swings; only multiyear assessments can reliably distinguish hospitals that genuinely exceeded their target.

- Standardizing the process for explaining growth above the target 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.

And yet, those efforts might not be enough. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. One year in isolation does not give an accurate picture of each of our four distinct MemorialCare hospital spending trends, which includes a free-

standing children's hospital. For this reason, multiyear assessments of hospital spending growth against the targets are necessary.

Even worse, OHCA intends to separately enforce the targets for every payer, giving hospitals three separate ways to violate the target. For MemorialCare, that means major losses in Medi-Cal and Medicare will not offset any incremental increases we receive from commercial payers. As a result, MemorialCare would still be penalized for efforts to sustain access, quality, and jobs during a time of persistently elevated inflation and the largest Medicaid cuts in the nation's history.

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to provide the same level of services to our community. MemorialCare appreciates the opportunity to comment and encourages the OHCA staff to incorporate these recommendations into future rulemaking.

We look forward to working with the staff as these rules are finalized and to continuing to collaborate on a more affordable and accessible health system for Californians. If you have any additional questions, please contact me at kpugh@memorialcare.org.

Sincerely,



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

cc: Members of the Health Care Affordability Board:

- 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

Assemblymember Cottie Petrie Norris
Senator Tom Umberg

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

Hearing Impaired
TDD: 562.696.9267
PIHHealth.org

October 28, 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:

PIH Health, which owns and operates three hospitals in Downey, Downtown Los Angeles, and Whittier; 31 medical office buildings; and a multi-specialty medical group; and employs nearly 8,000 people, has strong concerns with 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 healthcare infrastructure. OHCA must instead adopt a collaborative approach to enforcement that provides hospitals with a meaningful opportunity to improve spending trends.

PIH Health 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.

PIH Health is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs, medical supply costs, and drug costs grew significantly. Facing 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.

And yet, those efforts might not be enough. OHCA’s hospital spending methodology produces wild results that do not reflect PIH Health’s own experience. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. One year in isolation does not give an accurate picture of PIH Health’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 PIH Health, that means major losses in Medi-Cal and Medicare will not offset any incremental increases we receive from commercial payers. As a result, PIH Health 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 PIH Health’s viability, jeopardize our patients’ health, and endanger the livelihoods of the 8,000 workers who rely on us.

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

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the three million residents of our service area.

PIH Health 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 healthcare system for Californians.

Sincerely,



James R. West
President and Chief Executive Officer
PIH Health

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

Ridgecrest
REGIONAL HOSPITAL

October 20, 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:

Ridgecrest Regional Hospital has strong concerns with 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.**

Ridgecrest Regional Hospital 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.

Ridgecrest Regional Hospital is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs grew by 14%, our medical supply costs grew 9%, and our drug costs grew by nearly 16%. 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, including the largest health care cuts in history from the One Big Beautiful Bill Act (OBBBA), we Ridgecrest Regional Hospital may have to take the following steps:

- Ridgecrest Regional Hospital would likely have to close" L&D services because of the need to maintain on call availability. We currently lose over $4 million year for this service. Patients must now travel 90 miles farther to receive that type of care.
- Ridgecrest Regional Hospital will likely have to pause or cancel investments in community events for schools and nonprofit organizations.
- Ridgecrest Regional Hospital no longer has the necessary capability to fund seismic requirements to fund the state's 2030 seismic requirements.
- 100 % of our labor costs fall out of collective bargaining agreements and we have not control over the rapid wage inflation yet we have to remain competitive in order to recruit qualified employees.
- Ridgecrest Regional Hospital just recently had to access an emergency loan from the State of California distressed loan program in order to continue services. We are currently trying to pay back that loan and still will lose, over, $1m in 2026/2027.

And yet, those efforts might not be enough. OHCA's hospital spending methodology produces wild results that do not reflect Ridgecrest Regional Hospital own experience. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. Consider that for Ridgecrest Regional Hospital, year-over-year data show that since 2017, our year-over-year annual expense increase ranged from 1% in some years to as much as 16% in others. One year in isolation does not give an accurate picture of Ridgecrest Regional Hospital 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 Ridgecrest Regional Hospital that means major losses in Medi-Cal and Medicare will not offset any incremental increases we receive from commercial payers. As a result, Ridgecrest Regional Hospital 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.

Ridgecrest Regional Hospital is committed to helping patients afford the care they need. That's why we offer financial assistance programs, medical debt forgiveness, clinics for certain services, free vaccination programs. If possible, quantify the number of patients who pass through these and other programs each year and/or the dollars those patients saved.

Ridgecrest Regional Hospital also understands that affordability in the long term can't happen without focused efforts now. That's why we're committed to community-based care, value-based contracts, quality programs, programs to address social determinants of health, and other ways to drive down costs.

Penalties at the levels proposed by OHCA would threaten Ridgecrest Regional Hospital viability, jeopardize our patients' health, and endanger the livelihoods of the 894 number of workers who rely on us.

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

The measurement and enforcement process OHCA establishes will directly impact whether we can continue to be there for the 32,000 city/county residents who pass through our doors each year.

Ridgecrest Regional Hospital 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,

James Suver
CEO/President
Ridgecrest Regional Hospital

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

Attachment #19

Saint Agnes Health
A Member of Trinity Health

Administration - Advocacy

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

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:

Saint Agnes Health continues to have strong concerns with the proposed regulations recently promulgated by the Office of Health Care Affordability (OHCA), which established an enforcement and penalty framework for hospitals that fail to meet the state's spending targets. Unfortunately, OHCA's proposed regulations appear to fall short of providing reasonable protections for 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 analyze and improve spending trends.

Saint Agnes Health 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 the 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 outlined 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.

Saint Agnes Health
A Member of Trinity Health

Saint Agnes Health is currently experiencing cost growth far in excess of the 3.5% spending target. Last year, our labor costs grew by 31%, our medical supply costs grew by 41%, and our drug costs grew by 24%. Facing such uncontrollable costs growth along with impact of One Big Beautiful Bill Act (OBBBA) while at the same time as OHCA is putting a cap on the resources we have to pay our bills with is forcing challenging decisions: cut service lines and staff now to avoid potential penalties or provide care our patients need but risk fines that would wipe out what little financial cushion we attempt to maintain.

To best adapt to OHCA's new spending restrictions and the challenging financial environment, we continue to reposition our nonprofit business to adapt to the new financial environment, including the impacts of OBBBA, and as such leaned into the following steps as part of our Mission:

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

As organizational leaders reflect on operations and the above daily, the Saint Agnes Health management team knows that those efforts might not be enough and will ultimately impact patients access to critical care in Central Valley.

Saint Agnes Health understands that affordability in the long term can't happen without focused efforts now. That is why we are committed to our mission and investing in community-based care through our Holy Cross Services, Rural Mobile Health Units, Community Health Worker outreach, reducing hypertension rates, increasing maternal care access, and continuing to grow our medical residency programs. However, penalties at the levels proposed by OHCA would threaten Saint Agnes Health's ability to address patients' social determinants of health and provide Community Benefit at the current level of $121 million annually.

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

Saint Agnes Health
A Member of Trinity Health

The measurement and enforcement process OHCA establishes will directly impact whether we can continue with the Saint Agnes Health 96-year legacy and provide critical services to the 1.1 million residents of Fresno County who pass through our doors each year.

Saint Agnes Health 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, accessible, and equitable health care system for Californians.

Sincerely,



Helen Herrera
Director, Advocacy and Health Equity
Saint Agnes Health

cc: Members of the Health Care Affordability Board:
- Dr. Sandra Hernández
- Dr. Richard Kronick
- Ian Lewis
- Elizabeth Mitchell
- Donald B. Moulds, PhD
- Dr. Richard Pan
- Elizabeth Landsberg, Director, Department of Health Care Access and Information
- Vishaal Pegany, Deputy Director, Office of Health Care Affordability
- Senator Anna Caballero
- Senator Shannon Grove
- Assemblymember Esmeralda Soria
- Assemblymember David Tangipa
- Assemblymember Joaquin Arambula

Mountains COMMUNITY HEALTH

October 29, 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:

San Bernardino Mountains Community Hospital District has strong concerns with 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.**

San Bernardino Mountains Community Hospital District 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.

San Bernardino Mountains Community Hospital District is currently experiencing cost growth far more than the 3.5% spending target. In FY26, our labor costs increased by 17%, and pharmaceutical costs by 9%, compared to FY25. 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.

OHCA's hospital spending methodology produces wild results that do not reflect San Bernardino Mountains Community Hospital District's own experience. Troublingly, OHCA has indicated that it will base its determinations on only a single year of data, which may be woefully misleading. One year in isolation does not give an accurate picture of San Bernardino Mountains

Community Hospital District'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 San Bernardino Mountains Community Hospital District, which means major losses in Medi-Cal and Medicare will not offset any incremental increases we receive from commercial payers. As a result, San Bernardino Mountains Community Hospital District 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.

San Bernardino Mountains Community Hospital District is committed to ensuring that financial challenges do not prevent patients from receiving the care they need. To support this commitment, we offer a Foundation-supported charity care fund and financial assistance programs for patients who may be unable to afford the cost of their care.

Penalties at the levels proposed by OHCA would threaten San Bernardino Mountains Community Hospital District's viability, jeopardize our patients' health, and endanger the livelihoods of the dozens of workers who rely on us. Had the 3.5% spending target been in place in 2023, San Bernardino Mountains Community Hospital would have faced a starting penalty amount of $460,000 on its commercial line and $7,560,000 across all payer lines. Such a fine would inevitably require re-evaluations of service and staffing levels, threatening care in our communities. Problematically, these fines would even be based on spending growth that OHCA itself has previously deemed as reasonable.

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

The measurement and enforcement processes established by OHCA will directly impact our ability to continue providing essential healthcare services to the residents of the San Bernardino Mountains community who rely on our hospital each year.

San Bernardino Mountains Community Hospital District 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,

Mark Turner, Chief Executive Officer

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
Rosilicie Ochoa-Bogh, CA Senator
Tom Lackey, CA Assemblymember, District 34

SEIU CALIFORNIA

UNITE. FIGHT. WIN.

October 30, 2026

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

Submitted via OHCA@hcai.ca.gov

Re: **OHCA Health Care Spending Targets Progressive Enforcement Proposed Regulations - Supplemental Recommendations to Joint Labor Letter**

Dear Chair Johnson,

On behalf of SEIU California's 750,000 members and their families, I am writing to express our recommendations to strengthen the OHCA Health Care Spending Targets Progressive Enforcement Proposed Regulations (Title 22 CCR 97445 to 97459). The emergency regulations, as proposed and posted on October 8, 2026, hold significant weight and represent how OHCA will (or will not) live up to the vision set forth in its authorizing statute. It is with this gravity that SEIU CA offers supplemental recommendations to a joint letter submitted earlier today by Janice O'Malley on behalf of a coalition of labor unions including AFSCME California, California Federation of Labor Unions, California Federation of Teachers, California Nurses Association/National Nurses United, National Union of Healthcare Workers, and SEIU California. Californian's unions - including those representing workers at entities that will be subject to this progressive enforcement process - stand united in requesting OHCA:

- Publicly disclose preliminary determinations of excess spending growth, the entities' explanations for exceeding targets, and supporting financial data.
- Require OHCA to notify any labor union representing workers at a health care entity when the agency makes a preliminary determination that the entity has failed to meet its health care cost growth target, and ensure that those unions receive timely notification at every subsequent stage of the enforcement process.
- Establish a public comment period before final enforcement determinations, allowing patients, consumers, and labor unions to challenge or supplement entities' representations.
- Require OHCA to publicly explain its decisions to modify spending calculations, decline enforcement, or select a particular enforcement action, including the evidence and factors relied upon.

In addition to these recommendations, SEIU CA also proudly offers the following:

- Definitions, including definition of "accountable health care entity," must be revised to be consistent with, not narrower than, OHCA regulations intention.

- Retrospective NOLA-like process must be anticipated and acknowledged in the final enforcement regulations.
- Labor unions of a health care entity must be able to request a retrospective NOLA and status updates throughout the enforcement process.

Accountable Health Care Entity Definition

Similar to our concerns regarding the definition of "provider" in the emergency NOLA regulations, we remain concerned that the definition of "accountable health care entity" in Section 97445 is narrower than the statutory definition. While we appreciate the definition may reflect current enforcement priorities, it excludes providers that were always intended for inclusion. Of particular concern, there is no reference to skilled nursing facilities or primary care clinics. We request this definition be broadened to be more inclusive and consistent with statutory intent.

Retrospective NOLA-like Process

While we understand the NOLA is a target adjustment done months in advance of the target year, while enforcement will be occurring after the target year, we do believe that the potential of a retrospective organized labor cost adjustment as part of the enforcement process should be acknowledged. A health entity, even if they chose not to initiate a NOLA prior to the enforcement year, should be able to choose to initiate the NOLA-like process for a retrospective adjustment of labor costs for an enforcement year in relation to a preliminary determination.

Requests by Associated Parties and Impacted Unions

While the recently approved emergency NOLA regulations failed to make clear that an associated party could initiate the NOLA process. These regulations offer an opportunity to not only recognize the interplay between the NOLA and enforcement processes, but offer that an associated party can be able to initiate a NOLA-like process retrospectively during the enforcement process.

Additionally, OHCA should identify a clear process by which labor unions representing workers at a health entity can outreach to and engage with OHCA staff throughout the enforcement process from the initial preliminary determinations of excess spending growth through progressive enforcement plan design, implementation, and evaluation. With local labor relations ever evolving, it is critical that unions can stay informed to best represent workers at impacted institutions.

Confidentiality of Documents

While we appreciate the extensive process outlined for determining the justification for confidentiality of documents, it is important that these regulations are in keeping with statute. The board can, and should, disclose otherwise confidential information in open session if that disclosure is in the public interest:

> *127502.5. (c)(4) The office, the board, and the members of the board shall keep confidential all nonpublic information and documents obtained under this subdivision,*

and shall not disclose the confidential information or documents to any person, other than the Attorney General, without the consent of the source of the information or documents, except in an administrative penalty action, or a public meeting under this section if the office believes that disclosure should be made in the public interest after taking into account any privacy, trade secret, or anticompetitive considerations.

Daylight on Progressive Enforcement

As noted in the joint labor letter, California's health care affordability crisis cannot be solved behind closed doors. We are deeply concerned that Section 97455 (Spending Target Performance Improvement Plan and Spending Target Penalties) envisions all discussion with the board prior to approving or rejecting a proposed progressive improvement plan (PIP) in a closed session. We respectfully request that this be revisited to bring clear public transparency to this process. In fact, statute is aligned with this intentionally using “may” not “shall”:

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

The concerns and recommendations are consistent with our prior comments submitted on the Nonsupervisory Employee Organized Labor Cost Adjustments (NOLA). Regrettably, those comments - including concerns regarding transparency and the role of labor unions representing health care workers - were ignored. We hope OHCA chooses a different approach here - so progressive enforcement places consumers and the workforce that we know is essential to the quality, timely, and culturally appropriate care at the center of this process.

Even with the significant concerns raised here, SEIU CA, a champion of health care transparency and affordability, believes in the potential, transformative role of the Office Of Health Care Affordability (OHCA). As you review these comments, and make appropriate adjustments, and as you hear industry noise requesting delays, we urge OHCA to stay the course on the critical timeline before us. We appreciate OHCA's engagement with stakeholders and welcome further conversation.

Sincerely,



Beth Malinowski
Government Relations Advocate
SEIU California

cc:
Members, Health Care Affordability Board

Kim Johnson, Secretary, California Health and Human Service
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
CJ Howard, Assistant Deputy Director, Office of Health Care Affordability

Attachment #22

SHARP

October 27, 2026

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

SUBJECT: Sharp HealthCare Comments on Proposed Emergency Regulations, Health Care Spending Targets Progressive Enforcement (22 CCR §§ 97445–97459), and Draft Spending Target Performance Measurement Manual

Dear Director Landsberg:

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

Sharp appreciates the opportunity to comment on OHCA's proposed emergency regulations and the draft Spending Target Performance Measurement Manual ("Manual"), both dated October 8, 2026. Although the proposal adds needed detail, it does not provide predictable adjustments, adequate access protections, or a meaningful opportunity to improve before penalties apply.

As drafted, the regulations fail to establish a fair, reliable, and workable enforcement framework. The draft regulations authorize OHCA to determine violations using unvalidated data and short-term, payer-specific results; disregard justified spending growth and costs beyond a hospital's control; and expose hospitals to significant penalties without meaningful due process or a genuine opportunity to improve. Rather than isolate and address unjustified cost growth, these deficiencies risk diverting essential resources from patient care and undermining access to critical services.

To advance affordability while protecting access to care for patients and the communities hospitals serve, **Sharp urges OHCA to revise the proposed regulations and Manual to:**

- **Measure spending targets across multiple years and across all payers** to distinguish sustained excess growth from normal volatility and payer-mix changes;
- **Validate the methodology before enforcement** with complete data, reproducible calculations, and accurate treatment of hospital payment arrangements;
- **Establish standardized spending target adjustments** for Medi-Cal utilization, provider efficiency, and alternative payment models ("APMs");
- **Exclude costs outside a hospital's control** through a defined waiver process with clear standards and timelines;
- **Ensure a fair preliminary determination process** with sufficient response time, access to OHCA's calculations, and appropriate evidentiary standards;

- **Require meaningful remediation before penalties**, including sequenced enforcement, workable PIPs, and protection for good-faith implementation;
- **Limit penalties to unjustified excess spending** after all adjustments and waivers, with safeguards for essential services and hospital viability; and
- **Reserve procedural penalties for willful or repeated noncompliance** and protect confidential payer, pricing, and workforce information.

1. Determine Violations Using Multiple Years of Data and All Payers Combined

Sharp supports OHCA staff's September 2026 recommendation to combine inpatient and outpatient metrics when assessing hospital performance. However, the proposed regulations and Manual would still determine violations based on a single year of payer-specific results. Under proposed § 97452(a)(3), a hospital violates the target when its "year-over-year combined payer-specific spending growth, calculated by market," exceeds the target. This one-year measure is highly sensitive to contract settlements, the timing of supplemental payments, coding and case-mix changes, and an unusually low base year. As Sharp noted in its July 31, 2026, comments, a multi-year assessment is necessary to distinguish sustained excess growth from normal volatility.

OHCA should also evaluate performance across payers. Separate commercial, Medi-Cal, and Medicare measurements disregard hospitals' blended reimbursement and create multiple independent opportunities to exceed the target. Government reimbursement often does not cover the cost of care, while commercial reimbursement helps sustain services across the institution. Measuring each payer in isolation can therefore characterize a necessary change in one market as excess growth even when total all-payer growth remains at or below the target. As Sharp explained in its August 14, 2026, letter, enforcement should account for material differences in payer mix and the public health mission carried by high Medi-Cal providers.

> **Recommendation:** Determine compliance using a rolling multi-year average (e.g., three years) and initiate enforcement only when a hospital exceeds the target on both a multi-year and an all-payer combined basis. OHCA should also establish a reasonable tolerance band so that minor variances do not trigger enforcement.

2. Validate the Measurement Methodology and Account for How Hospitals Are Paid

The Manual relies on Hospital Annual Financial Disclosure Report revenue, Medicare MS-DRG weights for inpatient intensity, and Medicare APC weights applied to incomplete HPD claims for outpatient intensity. These inputs have not been sufficiently validated or made reproducible at the hospital level. Medicare-based weights may not reflect the acuity and resource use of commercial and Medi-Cal patients or services such as obstetrics, neonatal care, behavioral health, and specialty pharmaceuticals. Before this methodology determines a violation or penalty, OHCA should validate it with complete hospital-level data and provide the information needed to reproduce calculations and correct errors.

The methodology also does not adequately address supplemental funding, hospital-financed Medi-Cal amounts, capitation, global budgets, and other non-fee-for-service arrangements. Sharp delivers more than 26% of its hospital patient volume under full-risk capitation, yet those patients account for approximately 15% of net patient revenue. The Manual does not specify how these payments will be assigned across periods, payer markets, services, or entities. Enforcement must reflect net reimbursement and the services, prices, and expenditures within a hospital's contractual, financial, and operational control.

Recommendation: Before finalizing the enforcement regulations and Manual, OHCA should validate the methodology with complete hospital-level data, make each hospital's calculation reproducible, and establish a process to correct incomplete or anomalous data. OHCA should validate Medicare-based intensity weights for each payer and service category, measure net Medi-Cal reimbursement after hospital self-financing, align supplemental and capitated payments with the correct period and entity, and apply a standardized adjustment for full-risk and other advanced APM arrangements. Until then, results should be used for testing and technical assistance, not for determining violations or imposing penalties.

3. Establish Spending Target Adjustment Factors and Methodology

The proposed regulations and Manual fail to establish standardized adjustments for provider efficiency, Medi-Cal utilization, or participation in APMs, despite the statute's direction to account for differences among providers and patient populations. Without transparent adjustment factors, a uniform target can misclassify the effects of an efficient operating baseline, a high public-payer mix, risk-based payment arrangements, and mandated workforce investments as excess spending. That result would undermine a fair assessment of performance and penalize the very strategies OHCA is charged with advancing.

Sharp has spent decades reducing avoidable utilization, operating from an efficient baseline, and participating in risk-based contracts covering both hospital and physician services. Sharp also serves approximately 35% of San Diego County's Medi-Cal inpatient discharges, while accounting for 28% of inpatient discharges across all payers countywide. In addition, Sharp proudly invests across represented and non-represented employees to maintain staffing, preserve internal equity, and comply with state mandates. Unless OHCA quantifies and credits these factors, the framework will penalize Sharp for advancing affordability and sustaining access for populations and communities the statute directs OHCA to protect.

Recommendation: Incorporate standardized, transparent adjustments for provider efficiency, Medi-Cal utilization, and APM participation, with published eligibility criteria, data sources, and calculation methodologies. Make adjustments available prospectively whenever possible; otherwise, require OHCA to quantify and credit these factors when determining justified growth and calculating any penalty.

4. Establish a Waiver Process for Costs Outside a Hospital's Control

Sharp appreciates that Section 97452(b)(4) identifies factors a hospital may use to explain excess spending growth, including changes in law, high-cost drugs, acts of God, and nonsupervisory organized labor costs. However, the regulations do not establish how those factors will be documented, quantified, or credited, or require justified growth to be removed from excess spending or a penalty calculation. Because the Director only "may consider" a hospital's response (§ 97452(d)), a hospital could fully substantiate costs outside its control and still face enforcement.

The listed factors are also incomplete. They should include public-program payment reductions and resulting payer-mix shifts; inflation in labor, supplies, and pharmaceuticals; mandated wage, staffing, and seismic costs; and investments needed to preserve or restore access, such as Sharp's July 2026 assumption of operations of Sharp Tri-City Medical Center.

Recommendation: Establish a standardized waiver process in regulation, documentation and quantification standards, and defined timelines. Spending growth attributable to an approved factor should be excluded from excess spending growth and from any penalty.

5. Create a Fair and Workable Preliminary Determination Process

The response process in § 97452(b) is not commensurate with the complexity or consequences of a preliminary determination and does not allow providers a meaningful opportunity to review, test, and challenge that determination:

- **Response period.** The 45-day period is insufficient for a provider to reconcile OHCA's data, identify attribution or timing errors, quantify justified costs, prepare an alternative calculation, and assemble supporting documentation. A discretionary 15-day extension limited to extraordinary events does not cure that defect.
- **Complete supporting record.** The draft does not require OHCA to disclose the evidence supporting its preliminary determination before the response period begins. A hospital cannot reasonably investigate discrepancies or prepare a rebuttal without access to the data, methodology, attribution records, and other materials OHCA relied upon.
- **Burden of proof.** Requiring a hospital to establish by "clear and convincing evidence" that OHCA's calculation is incorrect imposes an inequitable burden when OHCA controls the methodology and underlying data. It also exceeds the preponderance-of-the-evidence standard that applies on appeal under § 97459(c).
- **Supplemental requests.** OHCA may request additional information without providing a minimum response period, while failure to respond may cause its calculation to stand (§ 97452(b)(6)). A provider should not lose its challenge because of an undefined or impracticable deadline.
- **Publication.** Section 97452(e) permits OHCA to publish excess growth without the hospital's explanation, identified errors, or justified adjustments. Publishing a disputed, unadjusted result as fact creates reputational harm before a fair determination is complete.

> **Recommendation:** Require OHCA to provide, with the preliminary determination, the complete supporting record, including its calculations and methodologies, underlying data, relevant health plan submissions, member and expenditure attribution records, contract mappings, adjustments, and all other materials relied upon, subject to appropriate confidentiality protections. The response period should begin only after OHCA provides the complete record and should be suspended and extended if information is incomplete, supplied later, or materially revised. Hospitals should receive at least 90 days to respond, with extensions for good cause; the preponderance-of-the-evidence standard should apply; supplemental requests should allow at least 30 days for response; and results should be published only after OHCA considers all adjustments and the hospital's response. At a minimum, if OHCA retains the clear-and-convincing standard for a hospital's challenge, OHCA should bear the same burden to establish the accuracy of its attribution and calculations before issuing a final determination or imposing enforcement.

6. Give Hospitals a Meaningful Opportunity to Improve Before Any Penalty

The Health Care Quality and Affordability Act established progressive enforcement (technical assistance, public testimony, and PIPs) before financial penalties. The proposed regulations preserve those steps in name but do not provide a reliable path to remediation:

- **No required progression.** The Director may select any enforcement action and retains express authority to impose penalties directly (§ 97452(d), (f)). Hospitals therefore have no assurance that technical assistance and remediation will occur before punishment.
- **Unworkable PIP deadlines.** Hospitals have 45 days to develop a comprehensive PIP and as few as five business days to cure deficiencies, while proposed plans are publicly posted before approval (§ 97455(b), (d)). These deadlines leave little time for operational analysis, leadership approval, or meaningful collaboration with OHCA.

- **No protection for good-faith implementation.** Neither progress reports nor full implementation of an approved PIP creates a presumption of compliance, and OHCA may rely on "any other information" it deems relevant (§ 97455(e)(3), (g)(3)(J)). A hospital can therefore complete every approved action and still face a penalty, eliminating a clear path to success.

> **Recommendation:** Require enforcement steps to proceed in sequence, with no penalty for a first-time exceedance; make PIPs collaborative and hospital-driven, with at least 90 days to submit and a minimum three-year implementation period; allow PIP modifications for changed circumstances; and establish a safe harbor under which a hospital that substantially implements an approved PIP in good faith is not subject to a spending target penalty.

7. Base Penalties on Unjustified Excess Spending Growth Only

Section 97455(h) permits penalties up to 125% of the full difference between actual and target unit spending multiplied across adjusted patient volume—before justified costs are removed. The penalty may therefore exceed the spending at issue and fall hardest on hospitals serving the most patients, including safety-net and high Medi-Cal providers. That is punitive, not corrective.

For Sharp, projected commercial penalties would exceed $73 million, based on OHCA's Hospital Measurement Combined Dataset for 2022–2023.[1] Sharp already absorbs more than $742 million in annual uncompensated care and serves approximately 35% of San Diego County's Medi-Cal patients. Removing tens of millions of dollars from a nonprofit system would reduce capacity to sustain essential services, particularly at safety-net facilities such as Sharp Chula Vista and Sharp Grossmont.

The proposal is also far more punitive than the Massachusetts model often cited for OHCA. Massachusetts caps penalties at $500,000 and applies them only for failure to implement a PIP; California's spending-differential approach could impose penalties that are orders of magnitude larger. Penalties of that scale threaten access and system stability rather than advancing affordability.

> **Recommendation:** Replace the full-spending-differential methodology with a capped, remediation-first structure. Penalties should apply only after a hospital fails to implement an approved PIP in good faith, be calculated solely on unjustified excess growth after all adjustments and be barred when they would impair essential services or hospital viability. Section 97457 should require consideration of access, safety-net status, uncompensated care, fiscal condition, good-faith improvement, and factors outside the hospital's control.

8. Narrow Procedural Penalties

Proposed § 97456 permits penalties of up to $500,000 when a hospital twice fails to perform any PIP term and up to $10,000 per day for not filing a plan OHCA deems "acceptable." These penalties could punish good-faith disputes, implementation challenges, or delays while a hospital is actively working toward compliance. Procedural penalties should be reserved for clearly documented, willful, egregious, or repeated noncompliance.

Section 97455(i) also makes PIPs and related materials public by default, including proposed plans before approval. Premature disclosure of payer contracting, pricing, or workforce strategies could undermine negotiations and discourage candid participation in the improvement process.

[1] Includes Sharp Tri-City Medical Center.

Recommendation: Limit procedural penalties to willful or repeated noncompliance after written notice and a reasonable opportunity to cure; exclude good-faith disputes and implementation challenges; and protect payer contract, pricing, and workforce information, publishing only summaries until a PIP is approved.

Conclusion

The framework OHCA adopts will directly affect Sharp's ability to maintain access, sustain essential services, and serve the nearly one million San Diego County residents who receive care from Sharp each year. Sharp urges OHCA to publish written responses to public comments before Board action and incorporate these recommendations before finalizing the regulations and Manual.

Sharp supports meaningful health care cost accountability. That accountability must rest on a fair, transparent, validated, and remediation-first framework that gives hospitals a genuine opportunity to improve while protecting access, equity, quality, and system stability. We appreciate OHCA's continued engagement and look forward to working toward that shared goal.

Respectfully,

Susan Green

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

cc: Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Megan Brubaker, OHCA Board Liaison
Chris Howard, President & CEO, Sharp HealthCare

Attachment #23

SIERRA VIEW MEDICAL CENTER

October 27, 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:

Sierra View Medical Center has serious concerns about the Office of Health Care Affordability's (OHCA) proposed spending target enforcement and penalty regulations. We support making health care more affordable, but enforcement must not jeopardize the availability of hospital care, particularly in communities that depend on local access to essential services.

Sierra View is a 167-bed public district hospital serving Porterville and surrounding communities in Tulare County. Our hospital provides emergency and inpatient care, maternity services, cardiac and stroke care, cancer treatment, and other important services. As a district hospital, we must balance responsible financial stewardship with our obligation to meet the health care needs of our community. Regulations that do not reflect the realities of hospital operations could make that balance much more difficult.

We urge OHCA and the Health Care Affordability Board to revise the proposed regulations to:

- **Base violation determinations on multiple years of spending data.** One-year changes may reflect temporary fluctuations in patient volume, case complexity, or other factors rather than a sustained spending trend.
- **Evaluate spending across all payers on a combined basis.** An all-payer assessment would better reflect the financial consequences of public program payment reductions and potential increases in uninsured patients, instead of treating each payer category as an independent opportunity for penalties.
- **Create a consistent process for explaining justified spending growth.** Hospitals should be able to document necessary workforce, medication, medical supply, infrastructure, and patient-care costs, with clear standards aligned with the statutory waiver process.

SIERRA VIEW
MEDICAL CENTER

- **Prioritize collaborative performance improvement.** Meaningful technical assistance and reasonable time to implement hospital-specific improvements should come before financial penalties.
- **Limit penalties to excessive spending growth determined to be unjustified.** Any penalty calculation should consider the nature of the violation, the hospital's fiscal condition, and the potential consequences for patients and access to care.

Hospital expenses are not always within a hospital's control. Workforce needs, essential medical supplies, prescription drugs, regulatory requirements, and changes in the patients we serve all affect the cost of providing care. At the same time, hospitals must make ongoing investments in equipment, facilities, and clinical programs. At Sierra View, these are practical decisions about maintaining services in Porterville, not simply line items in a spending calculation.

A single-year determination or separate enforcement by payer could produce a misleading picture of our hospital's performance. It could also create pressure to defer needed investments or reduce services to avoid future financial exposure. The proposed framework should not put hospitals in a position where providing necessary patient care increases the risk of substantial penalties.

Sierra View is committed to improving quality, strengthening access to care, and using resources responsibly. Our investments in clinical services, medical education, and patient care are intended to support the long-term health needs of the Central Valley. A fair enforcement system should recognize those efforts and give hospitals a genuine opportunity to address spending trends without undermining the care patients rely on.

We ask OHCA to revise the proposed regulations to provide a transparent, multiyear, all-payer assessment and a collaborative improvement process before penalties are considered. Protecting affordability must go hand in hand with protecting access to hospital care.

Thank you for considering Sierra View Medical Center's comments. We welcome continued collaboration as OHCA finalizes its regulations.

Sincerely,

Donna Hefner

Donna J Hefner

President and Chief Executive Officer
Sierra View Medical Center

Stanford MEDICINE | Health Care

October 30, 2026

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

Subject: Comments on Proposed Penalty Framework Regulation
(Submitted via email to ohca@hcai.ca.gov)

Dear Director Landsberg:

Stanford Health Care (SHC) continues to be deeply concerned with 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 ensure 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.**

As SHC adapts to OHCA's 1.8% high-cost designated spending restrictions, we urge the OHCA board to revise its proposed regulations to balance affordability with continued access. Firstly, OHCA's proposal to determine violations on a year-to-year basis is insufficient and would yield unreliable results. OHCA must base **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 exceeded their target. This concern is particularly pronounced for the outpatient measure, which appears to rely on a subset and nonrepresentative sample of data. OHCA should improve the outpatient methodology and use a reliable dataset to ensure hospitals are not subject to counterproductive penalties.

OHCA's payer-specific enforcement approach is also inconsistent with its broader goal of improving overall health care affordability. If the objective is to control health care spending, performance should be assessed across all payers on a combined basis—not separately. We are deeply concerned with OHCA's proposed enforcement structure, which separately enforces the targets for each payer, creating three separate ways for hospitals to violate the target. This approach fails to account for the cross-subsidization inherent in hospital care. Consequently, major losses in Medi-Cal and Medicare would not offset any incremental increases we receive from commercial payers. It is problematic to hold hospitals accountable for net revenue changes from government payers, especially since hospitals do not control government reimbursement rate increases. Therefore, we urge the OHCA board to **account 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.

Moreover, penalties at the levels proposed by the OHCA board are arbitrary and counterproductive to Stanford's mission to advance patient care, access, and discovery. We are concerned that OHCA may seek to financially penalize entities before they have even had the chance to improve their spending trends based on voluntary strategies. We know our organization best and believe OHCA's proposed one-size-fits-all strategies would have detrimental effects on our ability to sustain access to high-quality, equitable care, as well as a stable workforce. As such, we urge the OHCA board to **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. We also urge the OHCA board to standardize **the process for explaining a hospital's spending growth above the target, enumerating additional reasons for justifiable growth**, as established under the statutory waiver process. OHCA must also **establish a collaborative performance improvement process** that gives hospitals a real opportunity to improve before arbitrary and counterproductive fines are levied.

SHC is committed to helping patients afford the care they need through financial assistance programs. In FY 2025, we covered $520 million in uncompensated Medi-Cal costs and $1.375 billion in uncompensated Medicare costs. We also invest in behavioral health, services for patients experiencing homelessness, food and income security, sexual assault response, patient financial advocacy, cancer survivorship, and other wellness programs. Through partnerships with Federally Qualified Health Centers, community hospitals, and medical practices, we also provide free Stanford Medicine specialty second opinions.

We remain committed to the workforce caring for patients with complex, high-acuity needs requiring intensive services beyond those typically available in community hospitals. Although federal funding and Medicare partially offset research and graduate medical education costs, they do not fully cover these important costs dollar for dollar. Despite this creating a financial loss for us towards compensated care, we consider these vital investments towards patient care, medical education, and research. In fact, In FY 2025, we invested more than $207 million in health professions education, supporting resident physicians, fellows, medical students, and nursing and allied health trainees.

We encourage the OHCA board to incorporate hospital-sector recommendations into future rulemaking. We look forward to working with the Office to finalize these rules and advance a more affordable, accessible health care system for Californians.

Sincerely,



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

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
Assemblymember Marc Berman
Senator Josh Becker
Senator Diane Papan

Sutter Health

State Government Affairs

2200 River Plaza Dr.
Sacramento, CA 95833

October 30, 2026

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

Subject: Proposed Regulations Establishing OHCA's Enforcement and Penalty Structure *(Submitted via email to ohca@hcai.ca.gov)*

Dear Director Landsberg:

Sutter Health appreciates the opportunity to comment on the Office of Health Care Affordability's proposed regulations establishing a framework for enforcement actions and financial penalties tied to the state's health care spending targets.

Sutter Health shares OHCA's goal of making health care more affordable for California families. Affordability, however, must be pursued in a manner that preserves patients' access to care, protects essential community services, and recognizes the significant financial pressures confronting providers across the state. We are concerned that the proposed enforcement framework places excessive emphasis on punishment rather than partnership and could unintentionally accelerate service reductions, workforce constraints, and deferred investments in patient care.

As drafted, the regulations would expose hospitals and health systems to substantial financial penalties based on annual spending measurements that may not accurately reflect long-term performance, local market conditions, or cost drivers outside a provider's control. At a time when hospitals continue to face rising labor expenses, increasing pharmaceutical costs, inflationary pressures, growing regulatory obligations, and uncertainty surrounding federal health care funding, the proposed approach risks further destabilizing California's health care delivery system.

To create a more balanced and effective framework, Sutter Health urges OHCA to consider several modifications.

First, compliance determinations should be based on multi-year performance rather than a single measurement year. Health care spending can fluctuate significantly from year to year as a result of workforce investments, capital projects, changes in patient acuity, public health events, and other temporary factors. A multi-year assessment would provide a more accurate representation of organizational spending trends and reduce the likelihood that providers are penalized based on statistical anomalies or short-term fluctuations.

Second, OHCA should evaluate spending performance across an organization's total payer mix rather than separately measuring commercial, Medicare, and Medi-Cal populations. Providers do not operate separate delivery systems for individual payer categories. California hospitals care for all patients regardless of coverage source, and losses associated with public programs frequently require cross-subsidization to maintain access to care. An enforcement methodology that evaluates each payer category independently risks creating distorted results that do not reflect an organization's overall financial reality.

Third, the regulations should establish a transparent and clearly defined process through which providers may explain spending growth that is attributable to legitimate and unavoidable circumstances. Hospitals may experience spending increases driven by workforce shortages, investments in access expansion, implementation of innovative care models, increased patient complexity, compliance requirements, or other factors that advance patient care and community health. The regulations should provide greater certainty regarding how such circumstances will be evaluated.

Fourth, OHCA should prioritize corrective action and performance improvement efforts before imposing financial penalties. Meaningful collaboration between providers and regulators is more likely to produce sustainable reductions in health care costs than a system that relies principally on monetary sanctions. Organizations should be given adequate opportunity to develop and implement improvement strategies before punitive measures are considered.

Finally, any assessment of penalties should distinguish between spending growth that reflects reasonable and necessary investments in patient care and growth that is determined to be excessive and unjustified. Enforcement actions should be calibrated to the nature of the conduct at issue and should recognize the unique circumstances facing individual providers.

Sutter Health serves millions of patients across Northern California through hospitals, ambulatory facilities, physician organizations, and other care settings. We continue to invest in programs designed to improve affordability, health outcomes, and access, including population health initiatives, value-based care arrangements, behavioral health services, community-based care models, and financial assistance programs that help patients receive needed care regardless of their ability to pay.

These investments are critical to meeting the needs of California's growing and aging population. Yet they require resources and long-term planning. An enforcement framework that imposes significant financial penalties based on limited data could force organizations to reconsider investments in workforce development, facility

modernization, access expansion, and other community benefits that support patients and families.

Sutter Health remains committed to working constructively with OHCA, policymakers, purchasers, labor organizations, and other stakeholders to advance affordability while maintaining access to high-quality care. We believe California can achieve both objectives, but doing so will require a regulatory framework that reflects the realities of health care delivery and supports partnership rather than punishment.

We respectfully request that OHCA revise the proposed regulations consistent with the recommendations outlined above. We appreciate your consideration and look forward to continued engagement as the rulemaking process moves forward.

Thank you for your consideration,



Preston Young
Senior Director, State Government Affairs
Sutter Health

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

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October 30, 2026

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

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

Subject: Spending Target Measurement and Progressive Enforcement Regulations

Dear Secretary Johnson,

On behalf of the University of California (UC) Health, I am writing to urge the Office of Health Care Affordability (OHCA) and the Health Care Affordability Board (Board) to reconsider several aspects of the proposed spending measurement and enforcement regulatory package that OHCA has released for informal comment.

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

Spending Measurement

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

Continue Refining Hospital Spending Methodology to Reflect Actual Underlying Spending. While OHCA's application of volume and service intensity adjustments is conceptually reasonable, more work is needed to ensure that the measurement of hospital spending accurately reflects underlying spending trends. A particular issue is the use of the Healthcare Payments Database (HPD) in OHCA's outpatient spending measurement methodology. According to the California Hospital Association (CHA), the HPD captures only 20 percent of hospital-reported commercial outpatient visits statewide. UC Health is concerned that the HPD may not capture certain high-intensity, high-cost outpatient services that are important drivers of spending. UC Health urges OHCA to continue assessing the methodology's accuracy and recommends that as part of the enforcement process OHCA work closely with hospitals to determine whether unmeasured changes in service intensity may have contributed to spending growth in excess of the cost target.

Retain Combined Inpatient and Outpatient Spending in Final Methodology. UC Health appreciates OHCA's recent move to combine inpatient and outpatient spending into a single weighted measure. A hospital that exhibits inpatient spending growth of 1 percent, outpatient spending growth of 5 percent, and overall spending growth of 3 percent should not necessarily be considered to have exceeded the spending target.

Assess Performance Relative to Spending Targets on a Multiyear Basis. UC Health appreciates the discussion between staff and the Board in recent months about the volatility of hospital spending under OHCA's hospital spending measurement methodology. We also appreciate the opportunity for hospitals to weigh in on this issue during the progressive enforcement workshop for hospitals OHCA held in July and at recent Board meetings. The high volatility of hospital spending under OHCA's methodology is now well established and provides strong support for a multiyear approach to assessing performance against spending targets. Evaluating performance over multiple years would provide a more stable and accurate assessment of long-term spending trends and help ensure that enforcement resources are directed towards entities exhibiting sustained growth above established targets.

Enforcement Process

Ensure Transparency in OHCA's Enforcement Decision-Making. Over the past year, OHCA has made several important decisions regarding the design of its enforcement process. One example is the decision not to implement a waiver process that would allow hospitals to proactively demonstrate to OHCA that spending growth was driven by factors beyond their control. Instead, OHCA intends to consider those factors in the enforcement process. While we understand OHCA's interest in minimizing administrative workload, we believe additional transparency regarding how hospitals are selected for deeper stages of enforcement would strengthen public confidence in the process. Accordingly, UC Health recommends that OHCA provide the Board with a data-based rationale when advancing a hospital through progressive enforcement—starting with the preliminary determination of spending growth relative to the target—particularly in circumstances where other hospitals may have higher spending growth

rates or similar growth rates but larger spending bases. Such transparency would help demonstrate that enforcement decisions are being applied consistently and are grounded in objective measures of spending performance.

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

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

Performance Improvement Plans (PIP) Must Provide a Meaningful and Realistic Opportunity to Improve Performance. The Legislature made clear in OHCA's authorizing statute that health care entities must have an opportunity to improve performance and compliance prior to the imposition of monetary penalties. That opportunity starts with a deliberative process that allows for the creation of a realistic and actionable PIP. UC Health requests that OHCA modify its proposal to allow health entities more time to design PIPs and respond to OHCA feedback. Specifically, we recommend OHCA extend these deadlines to 90 calendar days (instead of 45 calendar days) and 30 calendar days (instead of 5 business days), respectively.

Moreover, because hospitals cannot retroactively change spending that has already occurred, PIPs should apply beginning with the first annual measurement year following their approval. PIPs should also give entities sufficient time for operational changes and cost-management

strategies to take effect. OHCA should also establish clear criteria regarding PIP approval, evaluation, and successful completion so that entities understand expectations and can implement their plans effectively.

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

Penalties

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

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

UC Health therefore requests OHCA to revisit the Board's August 2026 action and consider alternative approaches to establishing the initial penalty amount, including the use of penalty

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

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

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

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

Consider the Public Benefits Provided by the University of California and its Academic Health Centers, Including Support for Workforce Training. In the case of UC’s academic medical centers, we also urge OHCA to consider our role as California's public academic health system. The University’s tripartite mission of education, research, and public service translates directly into substantial public benefits provided through our academic medical centers. In fiscal year 2024–25, UC academic health centers provided an estimated $4.6 billion in uncompensated care associated with Medicare and Medicaid patients. UC’s academic medical centers also provided more than $1 billion in support to UC Schools of Medicine in 2024–25, helping train the next generation of California's health care workforce and advance biomedical research. This support helps sustain the education and training infrastructure that prepares physicians and other health professionals to serve Californians. The Legislature has recognized workforce stability and development—including graduate medical education, teaching, and training—as important goals for the state’s health care affordability program. OHCA should therefore account for the potential effect of penalties on these contributions when determining

their amount. This would not change the spending target or exempt UC from enforcement; it would help ensure penalties do not undermine workforce investments the state has identified as important to sustain.

We appreciate the Board's consideration of UC Health's unique role as California's public academic health system. We hope that the Board and OHCA staff will consider the recommendations outlined in this comment letter as they finalize the spending measurement and enforcement regulatory package. UC Health remains committed to working collaboratively with OHCA and other stakeholders to address health care affordability and our shared commitment to accessible, affordable, equitable, high-quality care for all Californians.

Sincerely,



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

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

Attachment #27

United Hospital Association

October 30, 2026

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

RE: UHA Comments on OHCA Enforcement Framework

Dear Director Landsberg:

On behalf of the United Hospital Association (UHA), and its 105 hospital members, we appreciate the opportunity to comment on the Office of Health Care Affordability's (OHCA) ongoing development of its spending target enforcement framework. UHA supports the comments submitted by the California Hospital Association (CHA) and urges OHCA to carefully consider the concerns and recommendations outlined in that letter.

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

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

UHA remains deeply concerned about the magnitude of penalties under consideration. In our analysis of UHA member hospitals that were included in the 2022-2023 comparable hospital dataset, we estimate penalties across all payers could total approximately $677.5 million. These penalties are attributable to all categories, including $365.5 million attributable to commercial spending, $188.1 million to Medicare, and $123.9 million to Medi-Cal. A single year of exceeding a spending target could result in penalties that reach tens or even hundreds of millions of dollars—amounts that exceed annual patient care earnings for many hospitals. Penalties of this scale would not improve affordability; they would threaten access to care by forcing reductions in services, delaying investments, and destabilizing hospitals that serve vulnerable communities.

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

United Hospital Association

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

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

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

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

Sincerely,



Janelle Blanco
Executive Director

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