California Hospital Association

January 22, 2026

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

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

Dear Chair Johnson:

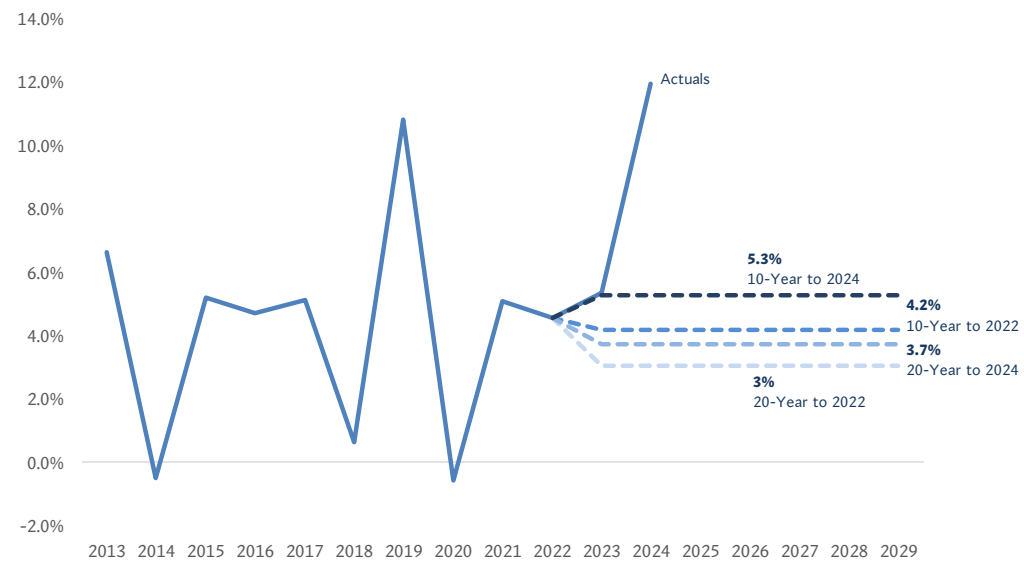
California's hospitals share the Office of Health Care Affordability's (OHCA's) goal to create a more affordable, accessible, equitable, and high-quality health care system. On behalf of nearly 400 hospitals, the California Hospital Association (CHA) appreciates the opportunity to comment.

OHCA Must Update Spending Targets to Reflect Current Economic Trends

The December board meeting included an update and helpful discussion of recent economic and health care spending trends. The conversation revealed a deep disconnect between the 3% statewide spending target and the trends illustrated by more recent data — as well as with the rationale on which OHCA based that 3% spending target. In selecting median household income growth as the basis of the spending target, OHCA declared its intent that per capita health care spending should not grow faster than Californians' incomes. However, since the target was set in early 2024, two additional years of data have become available, revealing that **a typical California household's income has grown at nearly 3 times the rate assumed by OHCA (8.6% versus 3%).** The figure on the next page further illustrates the divergence between OHCA's selected value and alternative approaches to establishing expectations for current and future median household income growth. As shown, the 10-year average growth rate (updated to include the last two years of available data) is closest to the actual values, while the 20-year historical period based on outdated data diverges farthest from the actuals. In fact, in 9 out of the 12 years included in this snapshot, the 20-year average undershot actual growth (in each of these years, by

more than 1 percentage point). Technical analysis also reveals the superiority of using shorter time windows to predict future values.[1]

OHCA's 20-Year Historical Average of Median Household Income Growth Is Out of Alignment with the Last 10 Years' Trends



Furthermore, the state's most recent economic outlook projections in the Governor's proposed January 2026-27 budget anticipate elevated growth of economic indicators similar to median household income to persist, forecasting average wages and personal income to grow by 4.3% and 4.6%, respectively, between 2025 and 2029 on average (in the long term, median household income typically grows at a rate between these two economic indicators). Data for the past 10 years of growth for per capita health care spending, inflation, and per capita gross state product similarly all point in the same direction — that the spending target is far too low.

An inadequate spending target undermines OHCA's mission in a plethora of ways:

- It sows doubt among health care entities as to whether meeting the target is within their control, and whether undertaking challenging and uncertain efforts to reduce their spending would even allow them to successfully avoid missing the target and penalization.
- It will likely result in hundreds of entities violating the target in a given year, overwhelming OHCA's ability to properly carry out its compliance activities and provide individual attention to those progressing through the enforcement process as statutorily required.
- Statewide health care spending that continues to grow far beyond the target will ultimately give lawmakers, providers, and other stakeholders the impression that the office is not effectively pursuing its goals.

[1] Using pseudo out-of-sample techniques, CHA tested whether 10- or 20-year windows generated median household income growth predictions closer to actuals since 1984. The 10-year average performed better in terms of both mean absolute errors and bias reduction. While both windows systematically underestimate growth (likely due to the Great Recession period), the bias for 20-year average was far higher.

For these reasons, the OHCA board should update the spending target to ensure it is realistic, attainable, and responsive to recent trends. While incorporating drivers of health care spending directly into the calculation of the target would be the best approach, tying the target to more recent economic conditions would be a step in the right direction.

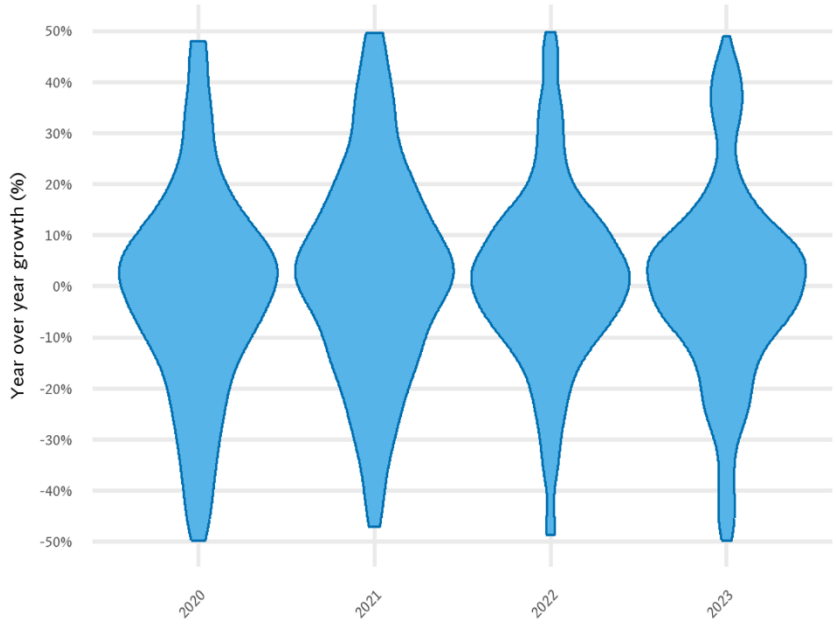
Performance Improvement Plans Are a Mandatory and Important Step in Collaboration Toward Shared Goals

OHCA's spending targets do not reflect many of the economic, policy, and public health realities that health care entities face. These conditions drive up the cost of care, increase uncompensated care, and result in patients being sicker by the time they visit the hospital. A reasonable and collaborative enforcement process is essential if OHCA is to pursue its full mission: promoting affordability while maintaining and improving health care access, quality, equity, and workforce stability.

As part of the enforcement process, after completing prior steps, OHCA has authority to direct entities that exceed the target to undertake performance improvement plans (PIPs). These would be developed by the entity and ultimately approved by OHCA. This progressive enforcement step provides entities with an opportunity to work toward improved affordability in collaboration with OHCA.

Yet, at the December 2025 board meeting where OHCA staff presented its initial proposed PIP process, some board members questioned whether the process was even necessary. They noted that PIPs are simply a deferral of enforcement, and suggested that OHCA should bypass the PIP process to directly levy fiscal penalties on these entities. OHCA staff correctly clarified to the board that the PIP process is a required component of the progressive enforcement process, providing entities the opportunity to develop and implement meaningful improvement to improve their spending trends. As OHCA staff continue to develop and define the PIP process, California's hospitals urge staff and the board to incorporate the following considerations.

Commercial Inpatient Spending Growth is Highly Volatile Across Hospitals and Years



Commercial spending defined as Commercial Inpatient Net Patient Revenue per Case-Mix Adjusted Discharge. Half of hospital measurements across observation years are within 2.1 percentage points of the 3.5% spending target.

PIP Implementation Should Be Based on Multiyear Performance and Statistical Confidence

Hospital spending growth, as OHCA intends to measure it, is anything but stable. Every year, hospitals'

inpatient revenues on a volume- and service intensity-adjusted basis regularly explode or crash, alternating between these cycles year-to-year. This enormous variation is vividly apparent in the figure on the prior page, which illustrates that in any single year-to-year period, huge numbers of hospitals will grow above the target, **despite the fact that their multiyear trajectory is closer in line with OHCA's targets.** Ultimately, this makes it absolutely necessary for OHCA to base enforcement decisions, including which entities are subject to a PIP, on a multiyear evaluation of entities' performance against the spending targets. For example, OHCA could initiate the PIP process for entities that miss the target in 3 out of 5 years. OHCA should further consider using statistical testing techniques to determine whether measured growth rates differ from the targets with statistical confidence, as is done in Oregon.

Entities Must Be Given an Appropriate Timeline for PIP Submission and Implementation
OHCA has proposed providing entities with 45 days to submit a PIP, along with the opportunity to request an extension of up to 30 days; the PIP itself would last up to three years. To ensure entities have adequate time to weigh strategies and actions to come into target compliance, and to develop meaningful plans which will involve coordination and extensive analysis with a number of departments, OHCA should extend its proposed PIP submission time frame. For example, Oregon's PIP process for its spending target program allows entities 90 days and an extension of up to 45 days for their PIP submission. Additionally, entities should be afforded adequate time to implement and make progress on their PIPs, while collaboratively engaging with OHCA as they take effect.

Entities Must Be Given Appropriate Flexibility to Tailor Their PIPs
OHCA has noted that entities will need to include specific goals, strategies, adjustments, and action steps in the development of their PIPs. While OHCA staff, with input from the board, will approve each entity's PIP, it is vital that entities have latitude to develop and carry out individually tailored cost-saving strategies that **they** identify as appropriate for their own organizations. This flexibility would allow entities to implement strategies within their administrative and operational functions, while striving to maintain health care access, quality, equity, and workforce stability.

Confidentiality Must Be Protected During PIP Implementation and Assessment
The PIP process will result in entities sharing sensitive information and documents with OHCA — not just so that OHCA can approve the PIP, but also so it can adequately assess the entity's performance and completion of the PIP. Pursuant to statutory protections, it is critical that OHCA does not disclose confidential information or documents shared during this process. Efforts to publicize this confidential information would not only jeopardize the entity's administration and operations, but also lead to faulty misconceptions and conclusions by those outside the process.

PIP Rules Must Be Clearly Articulated in Regulation – Lastly, as OHCA finalizes steps in the PIP process, California's hospitals urge OHCA to clearly enumerate these steps and rules in the regulations it plans to promulgate this year so the entire enforcement process is clear and transparent for all regulated entities.

OHCA Must Consider Using Payer-Specific Case Mix Indices When Estimating Annual Spending Growth Rates

At the December board meeting, OHCA proposed using all-payer case mix index (CMI) in the calculation of outpatient commercial net patient revenue (NPR) per case-mix adjusted discharge (CMAD), citing the high overall correlation between all-payer and commercial CMI from both outpatient and inpatient data. While correlation at a point in time may appear strong in the aggregate, this framing does not address how the substitution of all-payer CMI for payer-specific CMI behaves at the hospital level over time, nor the consequences it may have in determining whether an entity has met the 3.5% spending target.

Because CMI scales the denominator in the calculation of CMADS, even modest differences between all-payer and payer-specific CMI can translate into meaningful differences in measured year-over-year growth rates.

To evaluate the policy implications of this choice, CHA calculated year-over-year commercial inpatient NPR per CMAD growth from the Annual Financial Disclosure Reports (AFDR) and HCAI Patient Discharge Data (PDD) from 2019-23 using 1) commercial CMI and 2) all-payer CMI, restricting the analysis to hospitals with meaningful commercial activity and valid year-over-year comparisons. This isolates the effect of the CMI choice itself, holding all other factors, including utilization, NPR, and payer mix constant.

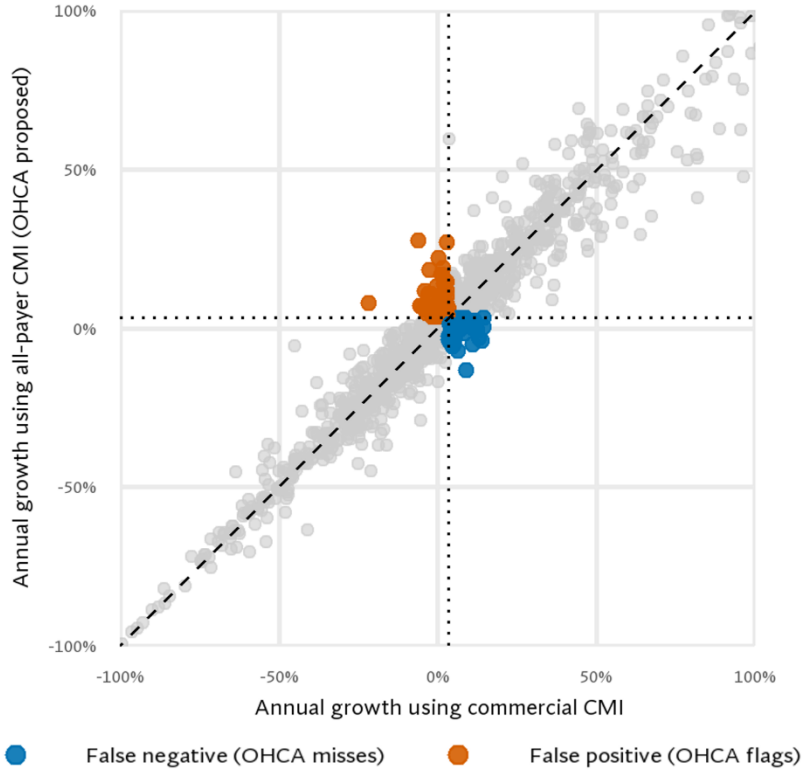
This analysis raises major questions about the appropriateness of proxying payer category-specific CMIs using all-payer CMI. Specifically, it shows:

- **Hospital level growth rates are materially distorted under OHCA proposed inpatient spending measurement approach**. About 75% of hospital spending growth measurements across observation years experience a greater than or equal to 1 percentage point change in the measured growth rate solely due to the choice of CMI.
- Half of hospitals are **within roughly two percentage points of the threshold**, making measured growth highly sensitive to this methodological choice.
- **The choice of CMI materially affects measurement against the spending target.** Approximately 8% of hospital measurements across observation years are misclassified as above or below the 3.5% target depending solely on the use of all-payer versus payer-specific CMIs. Roughly 15-20 hospitals (3-5% of all hospitals) per year are falsely flagged as exceeding the target
- **Cumulative exposure to misclassification is substantial.** Over the full observation period from 2019 to 2023, 13.6% of **hospitals — more than 1 in 8 — are falsely identified as having exceeded a hypothetical spending-growth target for these years of 3.5% at least once** due solely to the use of all-payer rather than commercial CMI.

False positives and false negatives are roughly balanced in the aggregate (see figure on the next page), indicating that the issue does not reflect a systematic bias but does generates arbitrary enforcement risk. Because this reclassification arises from a methodological choice rather than any true underlying

Using All-Payer CMI Changes Which Hospitals Are Flagged as Over the 3.5% Target

Commercial Spending Growth: Payer-Specific vs All-Payer CMI



Axes limited to −100% to +100%. Each point is a hospital-year. Dotted line represents 3.5%

spending behavior, it is a wholly avoidable risk. In OHCA's proposed threshold-based spending target enforcement program, methodological precision at the hospital level is essential. **OHCA must reconsider using payer-category-specific CMIs in place of all-payer CMIs for growth calculations in the inpatient setting.**

Furthermore, **this analysis calls into serious question whether an all-payer outpatient average visit intensity adjustment can be used as a proxy for a commercial average visit intensity adjustment**, as proposed at the December board meeting, as a means for overcoming the major data limitations in the Healthcare Payments Database.

High-Cost Hospital Determinations Do Not Appropriately Reflect Updated Data

OHCA has designated hospitals as "high cost" and intends to assess hospital compliance with the spending targets based on hospitals' AFDR. While hospitals have filed these reports annually for decades, they have never been used for regulatory compliance purposes similar to OHCA's. As a result, hospitals have identified errors in prior years' submitted data, which they are now working to correct. The data submission system for hospitals' AFDR allows hospitals to refile data should they discover errors or problems with past submissions. To date, several hospitals have submitted refiled financial statements that have to materially affected the measures used to assess the high-cost designation, including corrections that change their calculated commercial NPR per CMAD and commercial-to-Medicare payment-to-cost ratio. These refilings may alter not just whether an individual hospital is designated as high cost, but also the value of the 85th percentile threshold that demarcates that group of hospitals.

However, data presented at the December board meeting on these high-cost hospital measures for the designated seven high-cost hospitals indicate that refiled hospital data have not been incorporated into the analysis. (In addition, for the commercial NPR per CMAD measures, the values presented differed

slightly — without explanation —from figures OHCA previously shared. While the difference is small, unexplained changes raise questions about version control and methodological consistency.

To ensure OHCA is using the best possible data, OHCA must incorporate refiled data and reassess which hospitals should be designated as high-cost. Given the significant regulatory consequences associated with being a high-cost hospital, data accuracy and reliability are essential.

Evidence Gaps in the Oregon Hospital Payment Cap Study

The December board meeting's executive updates included a discussion of a *Health Affairs* study of Oregon's hospital payment cap program. Notably, the study does not assess patient affordability outcomes such as premiums, out-of-pocket costs, or access, and therefore does not demonstrate meaningful affordability gains for patients. Instead, the analysis focuses on hospital finances, operations, and patient experience, and finds largely no statistically significant changes after implementation of the hospital payment cap.

Critically, the cap applied to only about 15% of the Oregon commercial market, a limitation the authors explicitly acknowledge; they go on to explain that this limits the degree to which the report may be generalized to broader markets. The authors also note that potential hospital responses to the cap such as cost shifting cannot be ruled out, as several estimates are directionally consistent with such behavior. In addition, the study relies on the National Academy for State Health Policy Hospital Cost Tool and Medicare cost report data, which the authors recognize have known reporting and auditing limitations. As one board member discerningly noted, it is unclear how a hospital payment cap program can successfully promote the affordability of hospital services without any measurable impact on any relevant hospital financial measure, including revenues and operating margins. Clearly, something is missing from this story.

Conclusion

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

Sincerely,

Ben Johnson
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