California Hospital Association

July 31, 2026

Elizabeth Landsberg
Director, Department of Health Care Access and Information
2020 W. El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments on Spending Target Progressive Enforcement Framework**
(Submitted via email to Megan Brubaker)

Dear Director Landsberg:

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 spending target measurement and enforcement frameworks. However, hospitals are deeply concerned with multiple aspects of the frameworks and urge the office and board to adopt the following essential changes:

- **Test the hospital spending methodology before it is used to assess compliance with the spending target.** The sources of volatility must be better understood, and the outpatient intensity adjustment requires close attention given the incompleteness and untested nature of the data source.
- **Assess hospital performance against the spending target on a multiyear basis.** Otherwise, hospitals will simply cycle in and out of compliance due to extreme revenue volatility that bears no relationship to their efforts to meet the spending targets.
- **Conjoin inpatient and outpatient spending into a single growth measure.** This will ensure hospitals are accountable for keeping their overall spending growth under the target and ease the office's enforcement burden.
- **Enforce only against entities that exceed the target on both their commercial and all-payer lines.** Hospitals rely on all payers to ensure their revenues cover their costs, with commercial payments making up for growing shortfalls from Medicare and Medi-Cal. The statewide and hospital sector targets must apply to all payers to account for the impacts of the One Big Beautiful Bill Act (OBBBA) and focus OHCA's enforcement resources appropriately.
- **Ensure entities have meaningful opportunities to improve their spending performance prior to the imposition of financial penalties**. OHCA must adhere to the spirit and dictates of the progressive enforcement process established by the Legislature, provide latitude for hospitals to develop and implement their own cost-reducing strategies, and afford appropriate time for performance improvement.

- **Reduce the proposed spending target penalties from their current astronomical levels.** OHCA's proposed penalties would devastate hospitals' financial condition and endanger access to care — the exact opposite of OHCA's stated goals.

Further detail on each of these concerns and recommended solutions are provided below.

Clarify How Performance Against the Spending Targets Will Be Measured

The first spending target enforcement year is now in effect — in fact, it has already concluded for the more than 150 hospitals whose fiscal year ended on or before June 30.[1] And yet, hospitals still have major unanswered questions as to how their spending will be assessed against the targets and lack confidence that OHCA's methodologies will accurately reflect year-over-year changes in the components of spending that are within their control. While OHCA's approach has positive and essential features, it has yet to be validated. These questions and concerns must be addressed to assure hospitals that their efforts to comply with OHCA's spending limits will be successful. Absent that clarity, hospitals making good-faith efforts to comply will have no assurance that they will be able to avoid enforcement. **To firmly resolve these outstanding ambiguities, the forthcoming enforcement regulations must clearly specify how OHCA will measure hospitals against the spending targets and how data reliability will be assured.**

Include Volume and Intensity Adjustments, as Currently Contemplated

OHCA has spent more than a year developing its approach for measuring hospital spending growth with the help of a dedicated workgroup. The resulting methodology has essential features that aim to prevent fluctuations in volume and service intensity from biasing determinations of whether hospitals exceeded their target. Without such volume and intensity adjustments, OHCA would discourage hospitals from serving more patients, sicker patients, and offering resource-intensive services. The 2022-23 hospital spending growth data presented by OHCA aptly demonstrate the importance of these adjustments: Median commercial outpatient spending growth flipped from negative 7% when only volume was accounted for to positive 4.2% when both volume and intensity were considered. Conversely, median Medi-Cal inpatient spending flipped from positive 1.5% to negative 1.2% when an intensity adjustment was included. **If a 3.5% spending target had applied in 2023, around 15% of hospitals would have mistakenly been identified as having met or missed the target solely due to the absence of an intensity adjustment.** OHCA must retain both the volume and intensity adjustments in its final methodology.

Further Test the Hospital Spending Methodology

While conceptually promising, more work is needed to validate OHCA's approach for measuring hospital spending, particularly with respect to how OHCA plans to estimate intensity for outpatient services. Its approach utilizes a new and incomplete data source — the Healthcare Payments Database — that only covers 20% of hospital-reported commercial outpatient visits statewide. For many hospitals, the coverage is likely even lower. The result is that OHCA will capture the spending and utilization of all commercial outpatient services, but have no insight into the resource intensity of 80% of these services. Missing just one patient

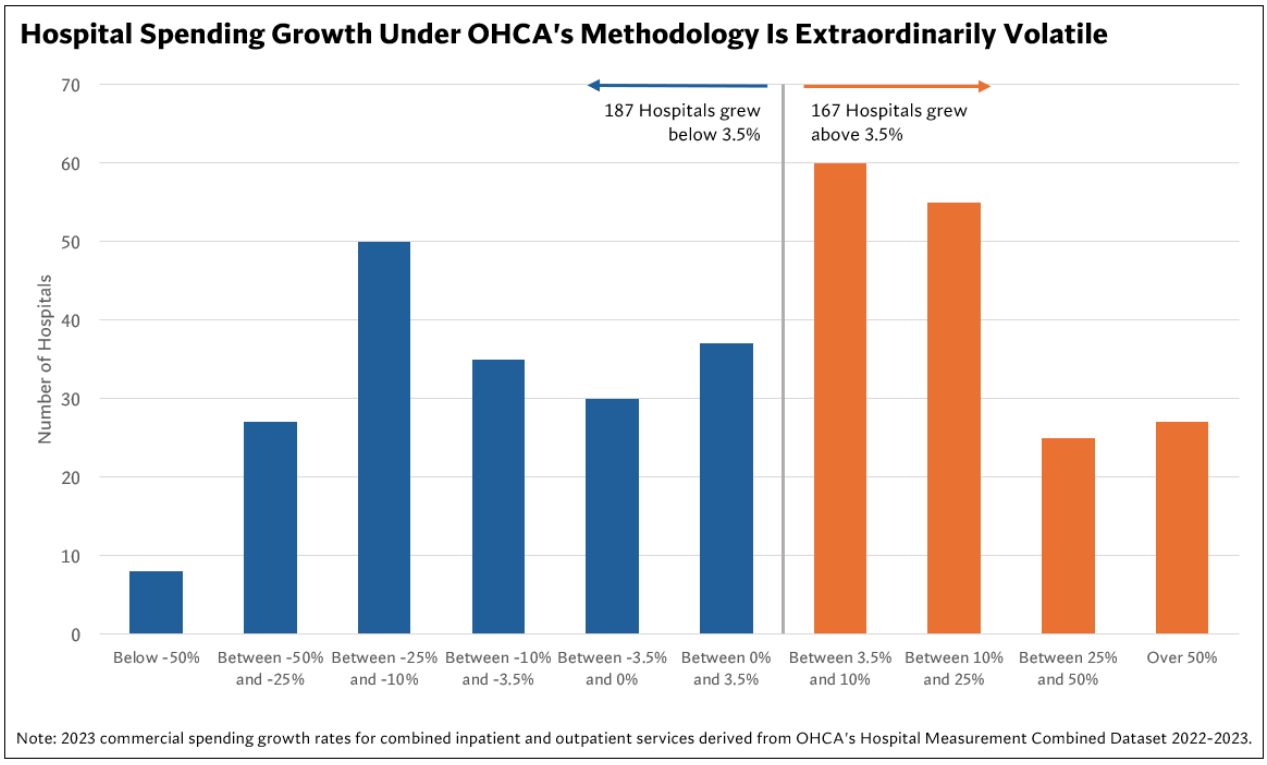
[1] OHCA has indicated it will assess hospital spending growth on a hospital fiscal, rather than calendar year, basis due to data reporting schedules.

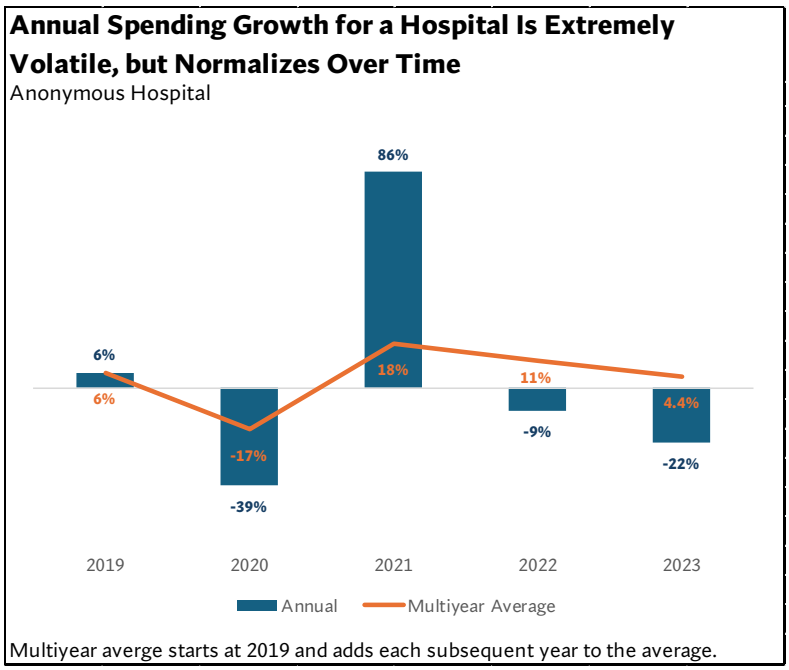
receiving a million-dollar drug infusion will inevitably bias OHCA's measurement of outpatient growth, and cause hospitals to erroneously fall subject to OHCA's onerous and unpredictable enforcement process.

Additionally, OHCA must make strides toward understanding and accounting for the extraordinary in measured hospitals spending growth before enforcement takes place. Solidifying the measurement approach up front will save OHCA from having to engage dozens or hundreds of hospitals within the initial phase of the enforcement process on justifiable reasons they exceeded their target. While improvement can be expected, the approach likely will never stamp out all unexplained volatility. OHCA will have to work closely with hospitals that exceed their target to distinguish real growth above the target from measured growth that is simply the relic of a faulty methodology.

Assess Hospital Compliance Against the Spending Targets on a Multiyear Basis

OHCA's 2022-23 hospital spending data reveal incredible volatility in individual hospitals' measured spending growth. As the figure below shows, 35 (nearly 10% of) hospitals saw annual commercial spending growth of greater than 50% or less than negative 50% between 2022 and 2023. A further 52 hospitals had growth between 25% and 50% or negative 25% and negative 50%. This volatility extends to government payers as well. Undoubtedly, these annual growth rates are not reflective, over a two-year period, of what OHCA aims to measure — the annual change in hospital unit prices. Hospitals did not receive 25% year-over-year rate increases or decreases from Medicare.



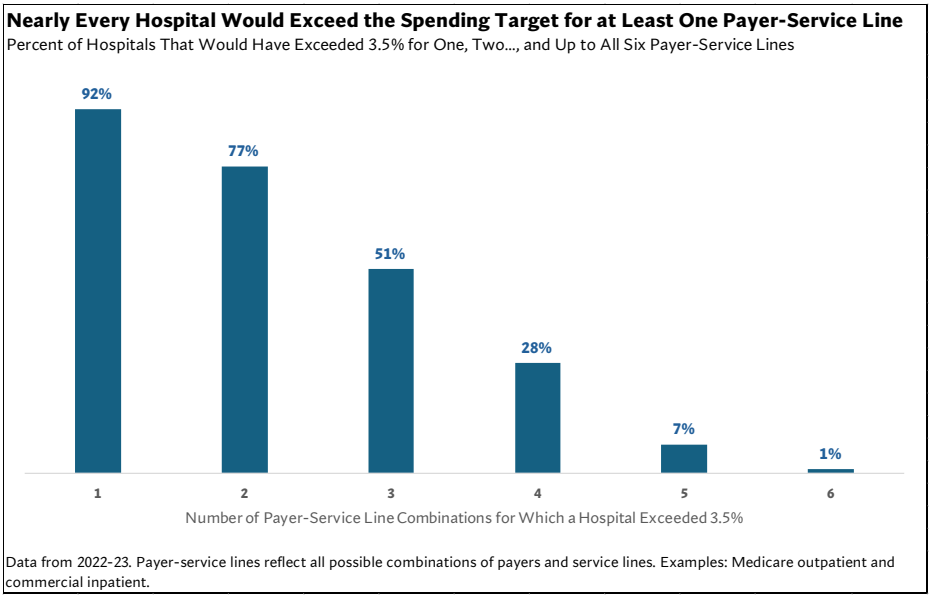


The figure on the left shows inpatient spending growth over a longer period for an individual hospital, revealing that high growth rates over a single annual growth period are **not** indicative of a sustained trend of either explosive price growth or radical price cutting. Instead, the figure shows that on a multi-year basis, the average annual growth rate normalizes to something OHCA could more meaningfully compare against the spending target. Ultimately, these data demonstrate that OHCA must measure hospital spending growth on a multiyear basis to avoid arbitrary punishment of hospitals that just happen to be in the boom cycle of their measured, **but not actual**, price growth.

Clarify What It Means to Be Accountable Against the Spending Targets

Despite having only approved statewide and overall hospital spending targets, OHCA has stated an intent to measure spending growth against the targets separately for each payer category (i.e., commercial, Medicare, and Medi-Cal) and, for hospitals, potentially separately for each service category (i.e., inpatient and outpatient). Adopting this approach would yield six distinct ways in which a hospital could be found in violation of the spending targets. As the figure below shows, had the target been in place in 2023, almost no hospital would have been safe.

OHCA would have had to initiate enforcement actions against **326 (92%) of the 356 hospitals that reported data**. It would have had to issue notice and technical assistance to and investigate the reasons why each of these 326 hospitals exceeded the target. The 326 hospitals would have had to supply extensive information justifying why, for example, their Medicare inpatient spending grew above the target — even if their overall spending growth was within the state's limits. And OHCA would have to determine the reasonableness of spending growth for each payer and service line for 326 hospitals based on no fewer than nine distinct enforcement



considerations. This would not be a prudent use of attention and resources —for OHCA or the hospitals themselves. Moreover, this approach would discourage hospitals from taking concrete and proactive steps to comply with the targets as they would still be virtually assured to violate the target for one payer-service line or another for reasons they do not control. To address barriers to efficient, fair, and appropriately targeted enforcement — and to properly inform hospitals, and other entities where applicable, of how the targets will be enforced — OHCA should codify the following policies in its forthcoming enforcement regulation package.

Conjoin Inpatient and Outpatient into A Single Measure

Hospitals are subject to the hospital spending targets established by the board. No targets have been established that apply distinctly to inpatient or outpatient services. Accordingly, hospitals must be held accountable based on all the patient care they provide. A hospital whose inpatient spending grows by 1%, outpatient spending grows by 5%, and combined total spending grows by 3% has not violated a 3.5% hospital-sector spending target — and must not be assessed as having done so. OHCA must remedy this problem by conjoining inpatient and outpatient spending in one of two ways:

- **Average the inpatient and outpatient growth rates to estimate a single measurement of growth for each hospital.** Weighting the inpatient and outpatient growth rates by service line patient revenues would account for hospitals' differing service mixes. This would streamline enforcement by limiting the number of hospitals exceeding a hypothetical 3.5% spending target on their commercial payer line in 2023 from 354 to 167 hospitals.[2]
- **Only enforce against hospitals that exceed the targets for both their inpatient and outpatient service lines.** Again, using 2023 data and considering only commercial spending growth, this would limit the scope of enforcement from 354 to 90 hospitals.

Only Enforce Against Entities That Exceed Both Their Commercial and All-Payer Spending Targets

To date, OHCA has focused on commercial health care spending growth as its key area of concern. In keeping, OHCA could simply disregard Medicare and Medi-Cal spending growth and only enforce the targets based on commercial spending growth. However, this would ignore more than 70% of the services a hospital provides, and therefore more than 70% of the payments upon which hospitals rely. Payer mix and cross subsidization, where commercial payments make up for large and growing shortfalls in payments from public payers, are fundamental features of hospital finance that cannot be ignored.

These patterns of hospitals' finance were present in OHCA's reporting on hospital spending trends in 2022 and 2023. For example, the data showed that statewide median Medicare and Medi-Cal inpatient payments were, respectively, 57% and 39% lower than commercial payments, and that statewide median reimbursement fell year-over-year for both Medicare and Medi-Cal. When the three payers are combined, the result is 0.5% annual growth in median reimbursement — far lower than each of 1) the 7% growth reported for commercial payers, 2) the state's first spending target of 3.5%, and 3) overall inflation of 3.9% in California in 2023.

Furthermore, health care coverage losses are happening now and growing due to OBBBA and other federal and state policy changes. Hundreds of thousands of residents have already dropped their Covered California coverage due to the expiration of enhanced subsidies, and millions are expected to fall off Medi-Cal coverage.

[2] 354 hospitals had data allowing for the calculation of their spending growth rates for their commercial payer line, while 356 hospitals (referenced on page 4) had data for any payer line, including for Medi-Cal and Medicare.

While reimbursement will drop, patients' care needs will not, leading to unprecedented increases in uncompensated care that hospitals do not have financial capacity to withstand.

To protect access to hospital care in the face of OBBBA's cuts and properly account for payer mix differences among hospitals, OHCA **must only initiate enforcement against hospitals that exceed their target on both their all-payer and commercial lines.** The all-payer line should account for all payments and services rendered — not only those from commercial, Medicare, and Medi-Cal — to properly capture the effects on overall reimbursement from the increase in the ranks of uninsured patients and uncompensated care.

Account for Complexity of Medi-Cal Financing

Medi-Cal financing of hospital services is bewilderingly complex. Faced with base reimbursement rates that fall far short of covering the cost of care, hospitals have been forced to "self-finance" the nonfederal share of Medi-Cal hospital expenditures to ensure they can continue caring for their communities. Self-financing comes in the form of provider taxes, intergovernmental transfers, and certified public expenditures that hospitals pay to the state or incur which are used to "draw down" federal Medicaid funding. Because hospitals incur the nonfederal share of cost, their net reimbursement equals only the federal funding. However, HCAI reports of hospital revenues include both the federal and self-financed nonfederal shares of this funding, overstating the net reimbursement hospitals receive.

In 2024, nearly half (48%) of total Medi-Cal managed care reimbursement for hospitals was self-financed — causing **total reimbursement in Medi-Cal managed care to be overstated according to HCAI financial reporting by 20% that year**.[3] 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 this population. To meet its statutory obligations under provisions such as Health and Safety Code (HSC) § 127502(d)(5) and accurately reflect the realities of Medi-Cal finance, OHCA must account for self-financing in its measurement of hospital spending growth against the targets.

Enforcement Must Be Progressive and Collaborative, Not Rushed and Punitive

As OHCA develops and promulgates formal enforcement regulations, it must conform with and expound upon the protections and processes established in state law, including but not limited to the law's clear direction that enforcement must be progressive.

Health Care Entities Must Have an Opportunity to Improve Spending Trends Under a Performance Improvement Plan (PIP)

The enforcement provisions of the California Health Care Quality and Affordability Act are unambiguous: Health care entities must have opportunities to justify and remediate their spending trends prior to any enforcement action, including the imposition of monetary penalties. HSC § 127502.5(a)) mandates that the office "enforce the cost targets established by this chapter against health care entities in a manner that ensures compliance with targets, **allows each health care entity opportunities for remediation**, and ensures health care entities do not implement performance improvement plans in ways that are likely to erode access,

[3] Managed care is Medi-Cal's predominant delivery system, covering 94% of all Medi-Cal enrollees.

quality, equity, or workforce stability" (emphasis added).[4] State law further delineates a progressive enforcement process that starts with technical assistance, moves to (optional) public testimony, then mandatory performance improvement plans, and finally, as a last resort, monetary penalties.[5]

The Legislature did not intend the early steps of enforcement to be a "check-the-box" exercise. Rather, the process must include meaningful opportunities and adequate time for health care entities to implement cost-reducing strategies to meet the state's spending growth goals. This starts with giving entities the voluntary opportunity to put the technical assistance they receive from OHCA into action and engage in dialogue with the office on pathways to improvement. Next, it plainly requires PIPs to be forward-looking; health care entities cannot go back in time to alter prior policies, practices, or service offerings. Therefore, PIPs should apply starting in the first annual measurement period following their approval. Second, entities must be given a reasonable amount of time to implement their PIPs. The returns on many cost-reducing strategies, like primary care investments, regularly lag the upfront investments. To balance the urgency of improving affordability and the time and work involved in system improvement, the Legislature thoughtfully established that PIPs may be imposed for a period of up to three years.[6] Third, the PIPs must be self-directed. OHCA's role is to approve, not develop, the PIPs. Health care entities must have a meaningful opportunity to develop and implement their own strategies, like investing in community-based care or adopting alternative payment methodologies, to comply with their target. OHCA's role is oversight to ensure the improvement plans' goals are reached and do not have negative unintended consequences.

Spending Target Penalties May Only Be Levied After an Entity Has Failed Both Its PIP and Lawfully Established Target

California law states that, except in narrow circumstances specified in HSC § 127502.5(h)(1) for willful, egregious, or repeated noncompliance, a financial penalty may only be imposed "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" (emphasis added).[7] This provision, among others, establishes multiple protections that must be incorporated into the forthcoming regulations.

Procedural Penalties Must Be Narrowly Tailored to Address Gross Misconduct and Set at Reasonable Levels

For the narrow instances in state law where there is egregious misconduct, OHCA has proposed procedural penalties distinct from the spending target penalties. Critically, these procedural penalties may not serve as an alternative approach to enforcement where entities' legal right to remediation is ignored and nullified. Rather, they must be narrowly tailored to the purpose established in law — addressing willful, egregious, or repeated noncompliance. OHCA's proposal oversteps these guardrails and seeks penalty limits that are out of line with comparable agencies.

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[4] Also see the Legislature's findings and declarations in HSC § 127500.5(m): "It is the intent of the Legislature in enacting this chapter that enforcement actions to address growth in per capita total health care expenditures are implemented in a progressive manner, such that health care entities are assisted to come into compliance with cost targets, including through technical assistance and performance improvement plans, before assessing administrative penalties unless there are egregious violations as specified in Section 127502.5."
[5] See HSC § 127502.5(a) and (d)(1).
[6] See HSC § 127502.5(c).
[7] See HSC § 127502.5(d)(1).

At the June OHCA board meeting, office staff presented procedural penalties as a mechanism by which OHCA could penalize entities prior to the conclusion of a PIP, including at implementation milestones within the PIP itself and for repeated failure to file an acceptable PIP. While imposing procedural penalties may be appropriate for gross misconduct like knowingly failing to provide required information, falsifying information, or repeatedly neglecting to file a PIP, extending these penalties beyond circumstances of clear bad faith or willful noncompliance is directly at odds with the statutory guardrails the Legislature established. A good-faith disagreement over what cost-reducing strategies are appropriate for an organization does not constitute egregious misconduct. Nor is it appropriate or legally sound to separately penalize an entity demonstrating a good-faith effort to implement cost-reducing strategies but where the benefits do not materialize as quickly as anticipated. In any board action and associated rulemaking, OHCA must make clear that entities are entitled to progressive enforcement of the spending targets and that procedural penalties may only be imposed in cases of unambiguously and documented egregious conduct in defiance of OHCA rules related to information sharing, data reporting, and PIP submission and implementation.

Finally, OHCA must reassess its procedural penalty amounts and revise them downward to conform to the standards of other regulators. The following table shows that OHCA's proposed procedural penalties far exceed those in comparable regulatory frameworks. Penalties for non-submission of required data in Oregon — which has the most stringent spending target program in the country — are up to $500 per day, 1/20th of the maximum per-day penalty proposed by OHCA. Massachusetts' $500,000 penalty is the maximum penalty that may be imposed for any reason. In contrast, OHCA's bifurcated proposal would authorize spending target penalties in the hundreds of millions of dollars in addition to procedural penalties at lower, but still disproportionate levels. Moreover, Massachusetts regulations make clear that penalties are only to be imposed as a last resort, in stark contrast to the framing presented at prior OHCA board meetings that procedural penalties are a means of accelerating

OHCA's Proposed Procedural Penalties Far Exceed Comparable Sanction Authorities from Other Agencies

Agency	Violation	Maximum Financial Penalty
California Office of Health Care Affordability	Health care entity fails to perform a procedural duty, such as filing a performance improvement plan or submitting information	$500,000 per violation or $10,000 per day, depending on the type of violation
Oregon Health Authority	Payer or physician organization fails to comply with data submission requirements	$400-$500 per day
Massachusetts Health Policy Commission	Payer or physician organization fails to file or implement a PIP in good faith	$500,000 per violation (per regulation, only imposed as a last resort)
California Department of Health Care Services	Managed care plan violates its state contract, fails to comply with a corrective action plan, or fails to submit timely and accurate provider network data	$25,000 for a first violation, $50,000 for the second, and $100,000 for each subsequent violation
California Department of Managed Health Care	Health plan violates the Knox-Keene Act	$25,000 per violation
California Air Resources Board	Covered entity fails to provide a timely and adequate report	$50,000 per year
California Air Resources Board	Business with over $1 billion in annual revenues fails to report its greenhouse emmissions	$500,000 per year

financial sanctions on regulated entities.[8] California's health plan regulators, the Department of Health Care Services and the Department of Managed Health Care, have limits of $25,000 per violation of similar procedural rules and requirements. Finally, while the California Air Resources Board may fine regulated entities up to $500,000 for noncompliance with its greenhouse gas reporting rules, the penalty only applies to entities with annual revenues of at least $1 billion and reflects an annual — rather than per violation — limit. In contrast, OHCA seeks authority to apply an equivalent penalty, potentially stacked multiple times within a given year, on hospitals with annual operating revenues in the low tens of millions of dollars.

OHCA May Not Assess Spending Target Penalties Based on Midyear Compliance with a PIP

The spending target is a "target percentage for the maximum **annual** increase in per capita total health care expenditures" (emphasis added).[9] This means that a spending target penalty may only be imposed after the office has determined that, in addition to being noncompliant with the PIP, the entity violated the corresponding year's spending target. **An entity cannot fail an annual target on a sub-annual basis.** Accordingly, pursuant to OHCA's underlying regulatory framework, fining an entity for noncompliance with its target based on midyear benchmarks, monitoring, and deliverables is plainly impermissible except within the narrow circumstances covered by the procedural penalties previously discussed. OHCA must give entities a year, at minimum, to comply with their PIP and associated spending target, and not rush toward punitive measures before that phase of the progressive enforcement process is complete.

PIPs That Jeopardize Access to High-Quality and Equitable Care May Not Be Imposed

To avoid unintended consequences and reinforce a holistic approach to improving affordability, the Legislature tasked OHCA with ensuring that PIPs are not implemented "in ways that are likely to erode access, quality, equity, or workforce stability."[10] This important constraint ties the hands of both the office and entities around what cost-reducing strategies may be employed. For hospitals, cutting revenues means cutting costs — costs that are concentrated in workforce recruitment and retention, facility upgrades (including those necessary to comply with state laws), and drugs and medical supplies used in patient care. Reducing hospital spending to the levels established by the spending targets may require service reductions that impair access, reduced ability to invest in quality-assurance activities, workforce reductions, and cuts to discretionary programs that address community needs. This is not what the Legislature envisioned. Flexibility will be needed for hospitals and other entities to implement cost-reducing strategies that avoid these negative impacts.

Spending Target Penalties Must Not Endanger Access to High-Quality and Equitable Care

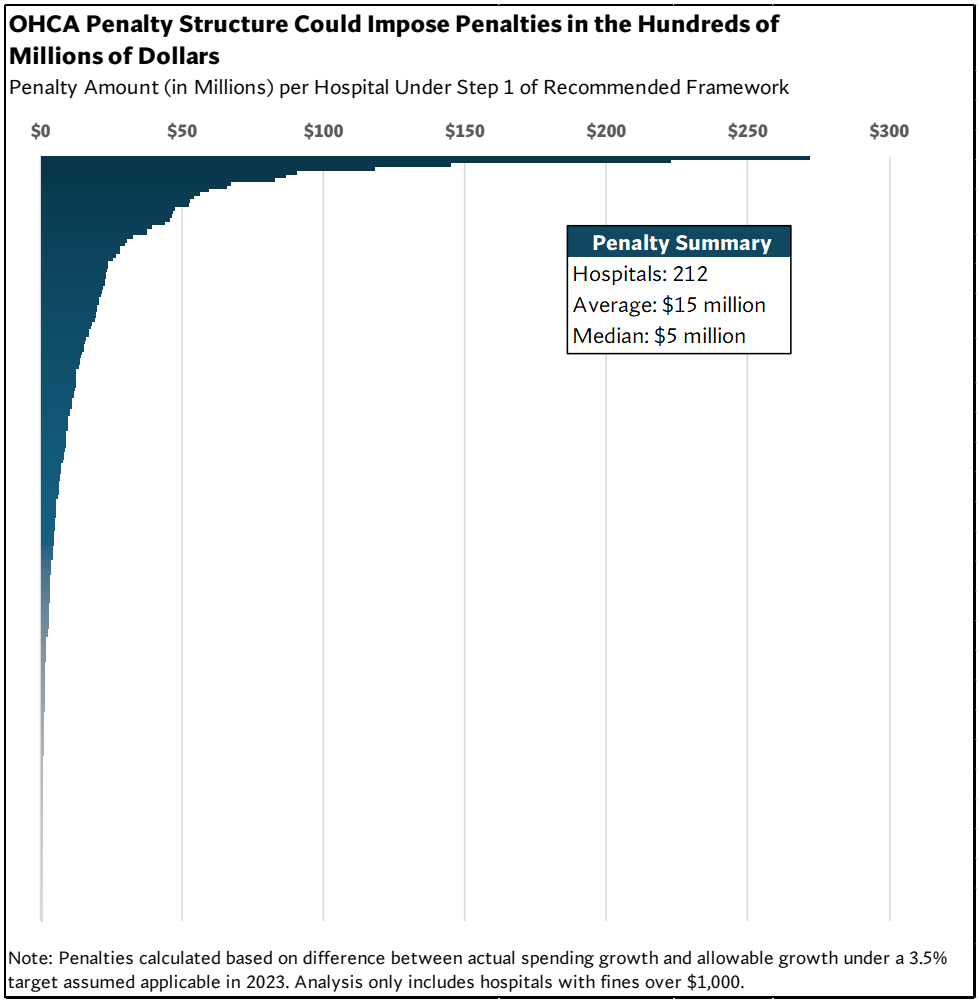
At the April board meeting, OHCA presented a two-step framework for determining the scope and range of spending target penalties for entities that fail their PIP and exceed their spending target. First, the office would set an initial amount equal to the amount by which the entity exceeded its allowable growth under its target. Then, the office would adjust that amount to account for various factors, including the nature, number,

[8] See Code of Massachusetts Regulations 958 10.15.
[9] See HSC § 127500.2(j).
[10] See HSC § 127502.5(a).

and gravity of the offenses; the entity's fiscal condition; the entity's market impact; and input from other state agencies.

OHCA's Recommended Penalty Structure Could Result in Enormous Penalties

OHCA's charge is to promote affordability without jeopardizing access to high-quality, equitable care and the stability of jobs. Unfortunately, financial penalties at the levels contemplated in OHCA's proposal would do just that and reflect the type of punitive approach to affordability the Legislature expressly disavowed. As the figure on the right shows, absent significant downward adjustments under step 2 of the framework, entities that exceed their spending target for even a single year could potentially be subject to fines in the hundreds of millions of dollars. **Had the 3.5% target been in place in 2023, the penalties would have exceeded the prior three-year cumulative total of operating earnings for 117 hospitals.** Fines of these magnitudes would threaten the viability of affected hospitals, placing access to care and health care jobs at serious risk. Enormous downward adjustments would be needed to reduce the penalties to practicable levels, rendering the process unpredictable, inscrutable, and capricious.



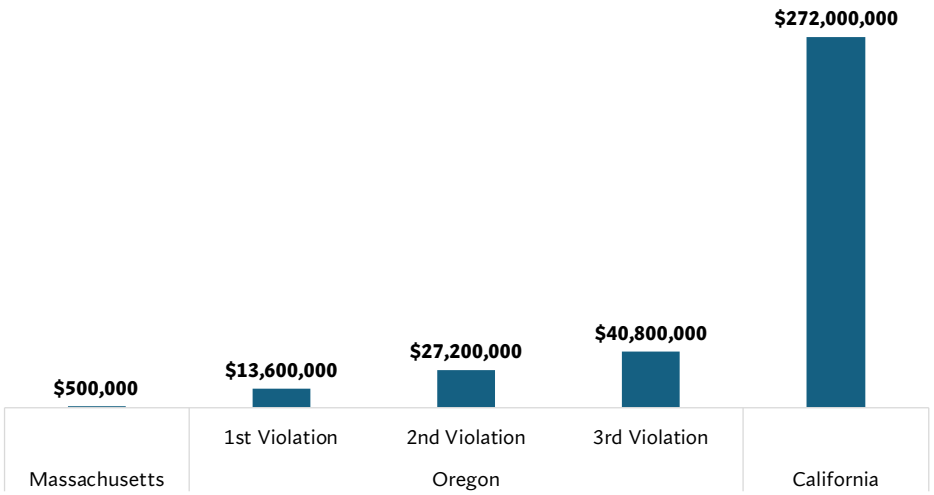
Other States Provide a Model for a More Reasonable Penalty Structure

OHCA is closely modeled after spending target programs in Massachusetts and Oregon, both of which rely on PIPs and financial penalties as their principal means of enforcement. However, the penalties in these other states vary significantly from OHCA's recommendation. In Massachusetts, the maximum financial penalty for failing to implement a PIP is $500,000. In Oregon, the financial penalty for failing to meet the state spending target starts at 5% of an entity's spending above the target (after the entity has been found to have exceeded

the target with statistical significance and without good cause in three out of five years). The penalty then increases by 5 percentage points for every additional instance of an entity exceeding the target (using the same multiyear formula). The figure on the right shows what a true outlier OHCA's recommended penalty structure could be compared to its peers, with OHCA's penalties starting at 20 times those in Oregon. OHCA should align with its peer states' penalty structures and modify its recommended framework accordingly.

California's Recommended Penalty Structure Would Be a Major Outlier

Largest Potential Financial Penalty for a Hospital Under Each State's Penalty Framework



Note: Penalties calculated based on difference between actual spending growth and allowable growth for hospitals under a 3.5% target assumed applicable in 2023. Oregon estimates apply its penalty framework to California using the 2023 hospital data. Massachusetts, by contrast, has a flat maximum penalty.

Adjustments to Initial Penalty Amounts Are Critical to Protect Access to Care

OHCA has recommended applying various adjustments to consider an individual entity's circumstances when determining final penalty amounts. Such adjustments are essential, particularly if step 1 of OHCA's penalty-setting framework is adopted, but also under a more restrained approach such as that used in Oregon. These adjustments must account for the following circumstances:

- *Hospital financial status* — To protect access to care, penalties must not undermine a hospital's ability to sustain services and remain viable. **OHCA should cap the penalty amount at a reasonable percentage of a hospital's patient care earnings.**
- *Factors beyond a hospital's control* — New mandates that raise costs, inflationary pressures, and changes in patient needs all influence a hospital's spending, despite their best attempts to remain under the spending limit. **OHCA should deduct the costs associated with these factors from the penalty.**
- *Efforts to improve access to high-quality, patient centered care* — Investments in primary and behavioral health care, for example, cost more at the outset but result in long-term savings and better health for Californians. **OHCA should deduct the costs the value of these investments from the penalty.**
- *Success in reducing spending trends until the imposition of the penalty* — **OHCA should credit an entity for any improvement in its spending performance, even if the entity has not yet met the target.**

Without these adjustments, OHCA's penalties would be unduly punitive and ultimately undermine its statutory responsibility to improve affordability while maintaining equitable access to care. While OHCA has only committed to considering the financial condition of entities when determining penalty amounts, the

latter three factors are plainly constitutive of the "nature" or "gravity" of any given offense. Specifying these factors within the regulation, alongside others as appropriate or mandated by state law, would give necessary meaning to OHCA's statutory directives and promote clarity around how OHCA's rules will be operationalized, to the benefit of both the office and regulated entities.

Conclusion

California's hospitals appreciate the opportunity to comment and look forward to continued engagement as OHCA moves toward promulgation of the spending target penalties and 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; guide difficult office decisions on which individual entities are subject to ever more stringent enforcement actions and which get a free pass; and, if approved in their current form, set penalties that existentially threaten the viability of hospital care across the entire state. 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

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