March 19, 2026

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

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

Dear Chair Johnson:

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

To Protect Access to Care, OHCA Should Incorporate Additional Factors into Its Enforcement Decisions

Over the past year, OHCA has discussed and sought feedback from stakeholders on the spending target enforcement process. One area of focus has been how to waive or cease enforcement for regulated entities whose spending grew faster than the target for justifiable reasons. OHCA has stated that it will not implement a waiver process, noting that such a process would not allow for enough "flexibility." Rather, OHCA would rely on the Department of Health Care Access and Information (HCAI) director's discretion to determine which entities should move through the progressive steps of enforcement. CHA continues to urge OHCA to reconsider this decision and instead implement a waiver process to provide regulated entities with a standardized, transparent, and legally authorized opportunity to engage with the office on the factors that drove their spending growth.

OHCA has stated that enforcement decisions by the director would be based on a set of "enforcement considerations." To date, OHCA has introduced nine potential factors that are broadly reasonable. When enumerating these factors in regulation, OHCA should clarify that these factors include certain constituent elements that are critical for protecting access to high-quality hospital care.

- **Extend "Investments in Primary and Preventive Care" to other investments in patient-centered care.** Achieving the health care system of tomorrow requires investment, such as bringing on new behavioral health beds, establishing new ambulatory care sites as an alternative to inpatient care,

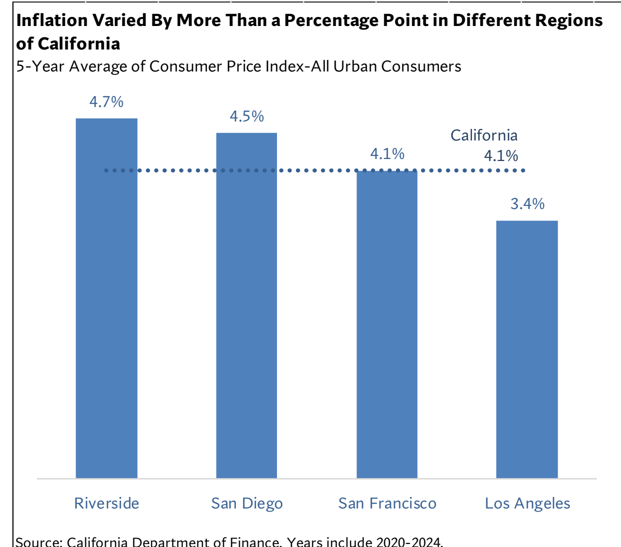
updating out-of-date diagnostic equipment, introducing the latest genomic and information technologies, or expanding much-needed specialty care services. These types of investments improve patient care and outcomes, and are necessary to meet the needs of an aging population. To avoid creating a chilling effect on these important investments, OHCA must clarify that they will be considered potentially justifiable reasons for exceeding the spending targets.

- **Incorporate payer mix as a component of population characteristics, entity baseline costs, and changes in state and federal law.** Patients' source of coverage is a key driver for both their care needs (e.g., a senior on Medicare often requiring different care than a newborn on Medi-Cal) and the reimbursement a provider receives. For California hospitals, Medicare and Medi-Cal pay only $0.83, on average, for every dollar in costs. Payments from commercial payers help offset these shortfalls, but still don't cover the full loss for many hospitals. (This is an important reason why more than 40% of California hospitals operate at a loss, losing money each day providing patient care.) The health care cuts enacted by the One Big Beautiful Bill Act (OBBBA) will reduce access and coverage for children and families on Medi-Cal and Covered California. Moreover, California is entering an unprecedented era of demographic change where 22% of Californians will be 65 or older by 2040 (compared to 14% in 2020), resulting in hundreds of thousands of additional Medicare enrollees. These coverage and demographic changes mean that uncompensated care and payment shortfalls from government payers will only grow, endangering the viability of hospital services across the state. Variation in hospitals' commercial payments correlates to their shortfalls in Medi-Cal and Medicare reimbursement, which results in hospitals mistakenly looking costly when only commercial reimbursement is considered; when all payers are taken into account, the hospital proves to be considerably less costly. To prevent penalizing hospitals that care for greater numbers of Medicare and Medicaid patients, OHCA should commit in advance to incorporating payer mix into the population characteristics, entity baseline costs, and changes in state and federal law enforcement considerations.
- **Consider providers' financial conditions as part of entity baseline costs.** Health care throughout the state is under threat. The OBBBA will eliminate coverage for nearly 2 million Californians and reduce payments for Medi-Cal providers already paid below cost. Dozens of hospitals statewide are at short-to-medium term risk of closure. Last year alone, hospitals and health systems eliminated more than 3,000 jobs (a number that is nearly 50% higher than average for the last five years). To remain viable over the next several years, hospitals will be forced to cut their expenses through force reductions or service lines cuts or take steps to increase their revenues, which could result in them exceeding the targets. OHCA must consider an entity's baseline financial condition when assessing its performance against the targets.

Importantly, OHCA should also incorporate additional factors that account for key drivers of health care spending to balance access, quality, equity, and workforce stability with affordability. The factors recommended below would allow for a more comprehensive assessment of whether entities justifiably exceeded the target:

- **Macroeconomic trends:** OHCA's adoption of the spending target is based on median household income growth of a 20-year historical period that does not reflect current economic trends. Inflation in California during this period averaged just 2.8%, compared to an average inflation growth of 4.1% in the past five calendar years (from 2020-24) per the California Department of Finance tracker. Meanwhile, global trade

uncertainty and tariffs have increased costs for the supplies hospitals rely on to provide care. According to Kaufman Hall, western states' year-over-year hospital costs per day from 2024 to 2025 increased at 13% for supplies, like personal protective equipment, and pharmaceuticals. Moreover, trends in the cost of doing business vary for hospitals in different regions of the state — sometimes by as much as 1.3 percentage points, as illustrated in the figure at right. To avoid punishing entities due to global unrest-induced supply shocks and other economic trends far beyond their control, OHCA should consider macroeconomic trends during enforcement.



- **Labor costs.** Labor costs make up 55-60% of hospitals' total operating costs and are growing rapidly. Over just the past year, these expenses have increased by 6%. While OHCA's governing statute contains a provision expressly authorizing it to adjust the spending target for actual or projected organized labor costs (See Health & Safety Code127501.4(j)(2)), state law provides flexibility as to how OHCA considers other labor costs when assessing entities' performance against the targets. To reflect the reality that bargained and non-bargained wages often grow in concert and prevent inequitable treatment of hundreds of thousands of health care workers, OHCA must consider **all** labor cost growth as an enforcement consideration.
- **Other reasonable causes.** While the additional factors above should cover several reasons an entity may justifiably exceed the spending target, there may be other factors that cannot be predicted in advance that may also contribute to an entity's excess — but justifiable — growth. In regulation, OHCA should specify that the director may consider additional, non-enumerated factors in enforcement decisions.

Avoidable Emergency Department Use Reflects Broader Access Constraints

In June 2025, HCAI released an analysis using data from the Healthcare Payments Database showing that potentially avoidable emergency department (ED) visit rates vary widely across California and are consistently highest for Medi-Cal enrollees, at approximately 47-65 visits per 1,000 member-years across regions, compared to 14-19 for commercial enrollees. This pattern is reflected on a national scale in a study of Medicaid patients that also shows higher ED utilization compared to commercial patients, driven by higher rates of reported barriers to timely access to primary care and worse continuity of care.[1]

When Medi-Cal beneficiaries struggle to access primary care and other preventive care due to limited availability, long wait times, and after-hours constraints, EDs are an appealing option: open at all hours, appointment-free, and accepting of all patients. However, that means that patients are often seeking care in a more costly setting and are sicker by the time they seek care, requiring more intensive treatment. Ultimately,

[1] Cheung, P. T., Wiler, J. L., Lowe, R. A., & Ginde, A. A. (2012). National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries. *Annals of emergency medicine*, *60*(1), 4–10.e2. https://doi.org/10.1016/j.annemergmed.2012.01.035

the alarming disparity between Medi-Cal and commercial patients in their avoidable ED visit rates points to the importance of expanding access to primary care for Medi-Cal beneficiaries.

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
Group Vice President, Financial Policy

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